



AMERICAN UNIVERSITY OF BEIRUT

A GLOBAL HEALTH PERSPECTIVE ON MASS  
ATROCITIES IN SYRIA:  
HOW THE R2P PARADIGM MAY STRENGTHEN  
PROTECTIONS FOR HEALTH WORKERS AND FACILITIES

by  
WILLIAM PETER KILNER

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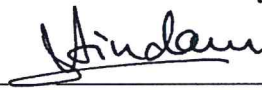
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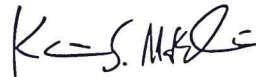
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# ABSTRACT

## OF THE THESIS OF

William Peter Kilner for

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Title: A global health perspective on mass atrocities in Syria:  
How the R2P paradigm may strengthen protection for health workers and facilities

This study will make a case for the applicability of the responsibility to protect (R2P) doctrine to targeted attacks on health workers and facilities before proceeding to outline a series of recommendations on how to enhance protections for health care providers and patients, especially in health systems at risk of human rights abuses. R2P refers to the responsibility of individual states and the international community to protect populations from four categories of atrocity crime: genocide, war crimes, ethnic cleansing and crimes against humanity. We will take Syria as a case study, where, over the past nine years, a catalogue of R2P crimes have been perpetrated, principally by the state. Attacks on health workers and facilities have constituted some of the most egregious of those crimes, amounting to war crimes and arguably crimes against humanity. We will take a closer look at the role played by international and local actors in preventing, curbing or mitigating these atrocities. I will show that in most cases the factors determining the success or failure of efforts to provide protection hold across different contexts. This is the basis upon which I submit a series of general recommendations on how to advance the implementation of R2P in the health sector.

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## ABBREVIATIONS

ACU	Assistance Coordination Unit
CTC	Counter-Terrorism Court
COI	Independent International Commission of Inquiry on the Syrian Arab Republic
CSO	Civil Society Organisation
EWARN	Early Warning, Alert and Response Network
EWARS	Early Warning, Alert and Response System
FSA	Free Syrian Army
HD	Health Directorate
HRC	Human Rights Council
HRuF	Human Rights up Front
HRW	Human Rights Watch
ICC	International Criminal Court
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICISS	International Commission on Intervention and State Sovereignty
ICRC	International Committee of the Red Cross
ICU	Intensive Care Unit
IDA	Independent Doctors Association
IDP	Internally Displaced Persons
IHL	International Humanitarian Law
IHRL	International Human Rights Law
IIIM	International, Impartial and Independent Mechanism
INGO	International Non-Governmental Organisation
IR2P	Individual Responsibility to Protect
ISIS/IS	Islamic State of Iraq and Syria
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NATO	North Atlantic Treaty Organization
OHA	Opposition-Held Area
OHCHR	Office of the High Commissioner for Human Rights
OPCW	Organisation for the Prohibition of Chemical Weapons

P5	Five Permanent Members of the Security Council: China, France, Russia, UK and US
PHC	Primary Healthcare Center
PHEIC	Public Health Emergency of International Concern
PHR	Physicians for Human Rights
PPE	Personal Protective Equipment
R2P	Responsibility to Protect
SAMS	Syrian American Medical Society
SARC	Syrian Arab Red Crescent
SCPR	Syrian Center for Policy Research
SNGO	Syrian Non-Governmental Organisation
SSA	Surveillance System of Attacks on Healthcare
UNGA	United Nations General Assembly
UNICEF	United Nations International Children's Emergency Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNSC	United Nations Security Council
UOSSM	Union of Medical Care and Relief Organizations
UPR	Universal Periodic Review
WHO	World Health Organization
WSOD	World Summit Outcome Document

# 1. INTRODUCTION

## 1.1. Research aim

The civil war in Syria has like no other conflict in the post-Soviet Union era tested the functionality of the system designed to guarantee international peace and security. Beyond concerns over the international dimensions of the conflict, for the best part of a decade the Syrian population has been repeatedly subjected to all manner of atrocities mostly at the hands of its own government. Thus, not only has the international community failed to put an end to hostilities and stabilize the region, it has patently failed to protect civilians inside Syria. Many attribute the failure to take collective action to a lack of consensus in the Security Council. While I certainly agree that this is an important factor, it should not distract us from the reality that many actors are responsible for protecting civilians in conflict.

The responsibility to protect (R2P) concept sets out the responsibility of the state on the one hand, and the international community on the other, to protect populations from the most serious violations of human rights. In elaborating the concept, consecutive Secretary-Generals have detailed a menu of options for preventing and protecting against grave human rights abuses. And while the maintenance of international peace and security may ultimately be the responsibility of the Security Council, averting and responding to egregious human rights violations concerns a broader spread of actors. The UN and many of its Member States have acknowledged as much in principle. What remains, in the words of the former UN Secretary-General Ban Ki-moon, is to move ‘from the realm of rhetoric to the realm of doctrine, policy and action’ (UNSG, 2009: para. 13). And it is here that I hope to make a contribution by

applying the R2P paradigm to a real-world scenario in order to identify obstacles that may be preventing relevant actors within the international community from exercising their responsibility to protect.

## **1.2. The responsibility to protect**

The debates shaping the R2P doctrine emerged largely from international developments in the 1990s. The collapse of the Soviet Union at the beginning of the decade was a determining factor in those developments. For one thing, the lowering of the hammer and sickle flag over the Kremlin for the final time on Christmas day in 1991 marked a new departure for the Security Council, which found itself reinvigorated with the thawing of the Cold War. More generally, the fall of communism in Eastern Europe gave rise to calls for democratic representation and, in places where those demands went unheeded, violent struggles for self-determination. Concerned by political ferment in the old Eastern Bloc, and with the rapid contraction of its once great adversary, NATO began conceiving a new, more active role for itself in maintaining European regional security (Gray, 2018: p. 45). From 1991 to 1995, the threat to ethnic minorities in the context of struggles for political autonomy in the former Yugoslavia prompted NATO to stage several Security Council-backed interventions in the Yugoslav Wars. In 1999, a few months after a massacre of Kosovo Albanians perpetrated by Serbian security forces, NATO launched a bombing campaign in Yugoslavia aimed at preventing a further humanitarian catastrophe in the region by forcing the Serb army to withdraw from Kosovo. On this occasion, NATO acted without explicit Security Council authorization, a fact that caused significant controversy among Member States.

Away from the theatre of Eastern Europe, another conflict came to play a decisive role in the discourse on humanitarian intervention. Over 100 days in 1994, ethnic Hutus unleashed genocidal violence against the minority Tutsi community, slaughtering around 800,000 with machetes. Beyond the appalling scale of the atrocity, the Rwandan genocide is remarkable for the failure of the international community to intervene. These historic events have prompted the R2P scholar Bellamy (2006) to question what can be done to prevent ““future Kosovos” (cases where there are competing or incompatible interests and values at stake) and “future Rawandas” (cases where states lack the political will to take decisive action in the face of genocide, mass murder, and/or ethnic cleansing)’ (p. 3). These two cases are archetypal and lend support to the argument that military intervention justified on humanitarian grounds, commonly referred to as humanitarian intervention, is a fiction: whenever third states express an interest in a situation, for example Kosovo, there is unlikely to be a consensus on specific objectives; where there are no conflicting interests, there will likely be a shortage of political will.

Gray (2018) argues that ‘until relatively recently unilateral intervention was not put forward as a legal doctrine by states’ (p. 40). The UK is one of the few states to have openly espoused the doctrine of humanitarian intervention, and mainly for the purpose of justifying its actions in Iraq during the 90s following the First Gulf War (Gray, 2018, p. 43). Opponents of such a right have, among other things, always been wary of powerful states claiming a right of unilateral intervention and using that right to intervene for reasons that are not unambiguously humanitarian. For states of the Non-Aligned Movement, and the Global South more generally, a ‘right to humanitarian intervention’ is perceived to pose a threat to the sovereignty of independent states.

Under the authority of the Canadian Government, the International Commission on Intervention and State Sovereignty (ICISS) set out to reconcile competing concerns that, on the one hand, the international community has a duty to protect civilian populations from atrocity crimes and, on the other, a right to unilateral intervention may be abused by powerful states for their own gain. The Commission arrived at the proposal to reconceptualise sovereignty: sovereignty narrowly understood as a state's freedom of action over its own jurisdiction would be modified by giving primacy to the protection, or security, of people on its territory, thereby curbing potential abuses of irresponsible state authorities. The implication being that sovereignty is inviolable so long as the state fulfils fundamental obligations towards its population. In the words of the ICISS, 'sovereignty implies a dual responsibility: externally – to respect the sovereignty of other states, and internally, to respect the dignity and basic rights of all people within the state' (ICISS, 2001: p. 8). Of no less importance is the fact that, despite some initial uncertainty arising from analysis of the relevant documents (Focarelli, 2008, p. 200), it is now generally accepted that the R2P doctrine does not include a right to unilateral military intervention in the absence of Security Council authorisation, reflected by the fact that 'no state currently claims that the doctrine gives such a right'—not even the UK (Gray, 2018, p. 60).

The emerging norm of R2P was subject to debate at the 2005 World Summit, which was the largest ever assembly of Heads of State and Government, making the relevant paragraphs of the Summit's Outcome Document (WSOD) the most authoritative expression of the R2P doctrine to date. The WSOD clearly states that 'each individual State has the responsibility to protect its populations from genocide, war crimes, ethnic cleansing and crimes against humanity' (UNGA, 2005, para. 138).

What's more, the document calls upon the international community to encourage and help states to exercise this responsibility and, in the event national authorities are manifestly failing in this responsibility, to 'take collective action, in a timely and decisive manner, through the Security Council ... to protect their populations from genocide, war crimes, ethnic cleansing and crimes against humanity' (para. 139). Thus the WSOD develops the ICISS' external component of dual responsibility: Member States are not only expected to respect the sovereignty of other states, they are expected to actively assist the latter in discharging their domestic responsibility to protect all people within the state.

### **1.3. An interdisciplinary approach**

As already mentioned, this study should be viewed as a contribution to the larger effort of moving 'from the realm of rhetoric to the realm of doctrine, policy and action' in respect of R2P. Implicit in this call to action is a recognition that building consensus around a concept, though an important first step, will not automatically have an effect on the way states cooperate with one another. Indeed, efforts to implement R2P testify to the fact that agreement on a principle does not guarantee agreement on modes of action, as we will see when we discuss the controversy caused by the Security Council's authorisation of military intervention in Libya. This holds true for every aspect of the R2P paradigm and not only the controversial intervention-by-military-force option. That is, while the dovetailing responsibilities of the international community and national authorities may be elegantly described by the WSOD and subsequent reports of the



Secretary-General, the framework rarely comes close to reflecting the way responsibility is distributed in real-world R2P situations.

This is partly due to the impossibility of concisely accounting for the enormous variety of atrocities that constitute one of the four most serious of crimes. Another factor that helps to account for the mismatch between the principle and the practice of R2P is the fact that, in an R2P situation, the kind of response will be largely determined by the identity of the perpetrator. When the state is the author of atrocity crimes, for example, the international community has an unequivocal responsibility to protect. It is important also to mention that the responsibility to protect appears to be most fully embraced at the interpersonal level. The role of local actors cannot be overemphasised. For while the WSOD focuses on the responsibility of national authorities, Member States, and the UN system, in truth it is often the case that acts of R2P are undertaken by individuals or small groups on the ground who put themselves in harm's way to protect family, friends, neighbours or colleagues.

What emerges from these observation is that moving 'from the realm of rhetoric to the realm of doctrine, policy and action' involves a host of variables that are determined by the context. I argue that only by operationalising the R2P framework in real-world situations are we able to study these variables, and only once the variables are known do we begin to see the modalities by which different actors discharge their responsibility to protect. Focusing on the targeting and weaponisation of health care in Syria will allow me to study the nature of a given category of crimes and the role different actors have/might have played in preventing or protecting against these crimes. Attacks on health care have profound effects not only in terms of the immediate risk to patients and staff; they have much wider implications on population health by

disrupting women's access to perinatal care, the treatment of noncommunicable diseases, and the implementation of vaccination campaigns. Such attacks have also depleted stocks of medications and medical equipment and have caused medical personnel to flee Syria en masse. It is important to understand the repercussions of these attacks for two main reasons. Firstly, while preventing the crimes in the first place may require political checks and balances, robust legislation and an independent judiciary, the absence of such conditions should not discourage relevant actors from making efforts to mitigate the worst effects of the crimes by whatever means possible, and here they should be assisted by the resource-rich within the international community. Secondly, it is important to use appropriate metrics in measuring the scale of the harm caused by attacks on health care in order to allow a court or tribunal to properly assess the gravity of the crimes in question.

It is for these reasons that I have opted for an interdisciplinary approach which posits that the responsibility to protect paradigm may be the appropriate vehicle for strengthening protections for health workers and facilities and advancing the state of global health security.

#### **1.4. The four R2P crimes**

The emerging norm of R2P was a subject of debate at the 2005 World Summit, the largest ever assembly of Heads of State and Government, making the relevant paragraphs of the Summit's Outcome Document (WSOD) the most authoritative expression of the R2P doctrine to date. The WSOD clearly states that 'each individual State has the responsibility to protect its populations from genocide, war crimes, ethnic

cleansing and crimes against humanity’ (UNGA, 2005, para. 138). These are the four most serious crimes, commonly referred to as mass atrocities—though this is not a legal and precise term—to which the responsibility to protect applies.

War crimes signify serious breaches of International Humanitarian Law (IHL), which is only activated by a decision of the International Committee of the Red Cross (ICRC). In respect of Syria, this occurred on 14 July 2012, when the ICRC declared that the situation had reached the threshold of an internal armed conflict. Technically speaking this means that IHL did not apply from March 2011 to July 2012 and that parties cannot be tried for war crimes for their actions during this period.

In the event, the activation of IHL did little to correct the behaviour of parties to the conflict and many war crimes were perpetrated from July 2012 onwards. What’s more, I will argue that the Syrian military and security forces’ systematic targeting and weaponisation of health from the very beginning of the conflict lend support to the charge of crimes against humanity.<sup>1</sup> According to Article 7(1) of the Rome Statute, crimes against humanity contain three main elements: a physical element, relating to attacks directed against any civilian population; a contextual element, which specifies that the physical element is widespread or systematic; and a mental element, meaning the perpetrator acts knowing that his/her action is part of the attack (UNOGPR2P, n.d.). Academics and human rights reporters have been describing the Syrian authorities’ targeting of health care providers and facilities as crimes against humanity since 2015 (Johns Hopkins & SAMS, 2015; PHR, 2016; PHR, 2019). Chapters one and two will

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<sup>1</sup> Unlike war crimes, crimes against humanity do not require the prior activation of IHL.

review reports by human rights and medical organisations to arrive at a conclusion as to whether the evidence meets the three criteria of crimes against humanity.

### **1.5. Early days of the uprising**

This study will focus on the regime's targeting of health care through the duration of the conflict. Before characterising the pattern of attacks against health facilities and personnel in Chapters one and two, we will briefly summarise the context in which these attacks were perpetrated.

The Arab Socialist Ba'ath party has ruled Syria continuously since seizing power in the 1963 coup d'état. In 1971, Hafez al-Assad initiated a coup against the *de facto* leader of the party, Salah Jadid, and appointed himself head of the government. Hafez al-Assad came from the Alawi religious minority who, it is estimated, constituted 65 percent of all noncommissioned officers in the Syrian military by the mid-1950s due to preferential recruitment by the French Mandate authorities (Landis, 2012). Today, most of the key positions in the State apparatus are occupied by the minority Alawite sect. Under Hafez al-Assad, the rival ideologies of the ruling Alawite minority's Baathist socialism and the Sunni Muslim majority's Islamic law resulted in sectarian strife culminating in the 1982 uprising by the Muslim Brotherhood in the city of Hama, which was brutally quashed by the regime. Syrian forces shelled and destroyed several neighbourhoods of the city, killing between 10,000 and 25,000 people, most of them civilians. Impunity often gives rise to recidivism and so it is significant that 'these documented mass killings and numerous violations of human rights remain unpunished' (COI, 2011: para. 16). The "events" in Hama and other cities such as Aleppo left scars

in the collective consciousness, and when peaceful protests were met with state violence in 2011, those painful memories were reawakened (Hanano, 2012; Hussein, 2013; Ismail, 2011).

While investment in public health and education were a boon to life expectancy and literacy under Hafez al-Assad, the economic model of cronyism in which political elites grew rich from state revenues and the business class was lured by privileged access to state contracts meant that when Bashar al-Assad came to power in 2000, he inherited a state with major structural problems (Hinnebusch, 2012). To begin with many were optimistic that the western-educated Bashar would pave the way for a more liberal and open society. And there were moves in this direction as Syria witnessed a brief proliferation of civil society activity in what was known as the Damascus Spring. Collins (2019) describes how ‘independent newspapers were given government licences, political prisoners of every hue were released, critical discussion of the government was encouraged, and civil society groups were established that focused on human rights’ (p. 13). However, this brief opening did not last and soon the term “civil society” came to be associated with criticism of the regime and thus the “opposition” (Collins, 2019). More broadly, Bashar’s efforts to address structural problems with the governance of the Syrian Arab Republic through a process of ‘authoritarian upgrading’ resulted in ‘the overconcentration of power and patronage in the ruling clan’ which ‘debilitated the clientelist networks that connected the regime to society’ (Hinnebusch, 2012). This gave rise to grievances similar to those that sparked popular protests across the region in early-2011—protests that precipitated regime change in Tunisia and Egypt.

Early efforts to organise demonstrations in Syria were not sufficient to mobilise the masses. It was only after a group of children in the southern city of Daraa were arrested for graffitiing an anti-government message on their school wall that the peaceful protests began to gain momentum. Residents of Daraa were angered by the security forces' brutal treatment of these children and that anger soon spread north to the suburbs of Damascus, Hama, and Homs. The regime tried to quash the protests with force as it had to done to quell the 1982 uprising, but this time the circulation of videos of security personnel firing on unarmed protestors mobilised large segments of the population and there were reports that four million people were on the streets by the fifth week of the protests (Ismail, 2012). The government-imposed media blackout from March 2011 made obtaining independent reports of the situation inside Syria very difficult and insurgents filled the information gap with amateur reports that were hard to verify (Fenton, 2012). Nevertheless, defectors from military and security forces involved in policing and quelling the protests were interviewed as part of the OHCHR's independent fact-finding mission in 2011 and supported reports of the state's use of excessive force when they told the commission that 'they had received orders to shoot at unarmed protestors without warning' (COI, 2011: para. 41).

## **1.6. Implementing R2P in Libya**

The international community was well aware of the alarming developments in Syria in those first weeks and months as it became clear that the escalating violence was costing thousands of innocent lives. In March a similar situation in Libya, in which the authorities were using violence to put down popular protests, resulted in the adoption of

Security Council Resolution 1973, authorising Member States to take all necessary measures, not excluding militarily intervention, ‘to protect civilians and civilian populated areas under threat of attack’ (UNSC, 2011a: para. 4). Following the resolution, a NATO-led operation carried out 9,000 air strikes over seven months, helping to create the conditions for the overthrow and violent death of Colonel Gaddafi (Gray, 2012). At the end of March, as the NATO operation in Libya was still in its infancy, US secretary of state, Hilary Clinton, ruled out the possibility of a similar military intervention in Syria (The Guardian, 2011).

The Libyan experience had a profound effect on the international community’s response to the unfolding crisis in Syria. On the one hand, it was clear that the US had little appetite for becoming embroiled in another conflict in the Middle East. On the other, the apparent failure of the NATO operation in the north African state was repeatedly cited by Russia in justifying its use of the veto to block draft resolutions on Syria. The overthrow of Gaddafi and the absence of strong state institutions left a power vacuum that has resulted in a recurrent civil conflict, serving as ‘a bitter reminder that military force is a blunt instrument whose ability to solve complex internal crises is limited’ (Azzam & Pison Hindawi, 2016). In the words of Gray (2012), ‘many states asked whether the military operation had gone beyond the Security Council authorization; some also asked whether R2P carried an inherent mission creep, beyond the protection of civilians’ (p. 63). This was certainly the analysis of Russia, who argued that a Libya-style intervention should be ‘excluded from global practices once and for all’ (UNSC, 2011b: p. 4). When it came to responding to the situation in Syria, in the absence of a unified and resolved Security Council, Member States preferred to pursue individual geopolitical interests, with the West and its allies providing financial

and military support to opposition groups such as the Free Syrian Army (FSA) while Russia stood by the Assad regime in the face of growing international condemnation. As such, rather than prioritising the protection of the Syrian population from state violence, the actions of the guardians of international peace and security actively damaged the chances of dialogue between the parties to the conflict in Syria.

### **1.7. R2P, Agency, and the Syrian case**

In his first report on the responsibility to protect, Secretary-General Ban Ki-moon set out a three-pillar strategy to advance ‘the agenda mandated by the Heads of State and Government at the [2005 World] Summit’ (UNSG, 2009: p. 2). Pillar one refers to the ‘enduring responsibility of the State to protect its population, whether nationals or not, from genocide, war crimes, ethnic cleansing and crimes against humanity, and from their incitement’ (p. 8). When discussing pillar one, pundits and policymakers often allude to the state’s *primary responsibility* to protect. Pillar two is ‘the commitment of the international community to assist States in meeting [their pillar one] obligations’ (p. 9). It is characterised as having two principle axes: international assistance and capacity-building. While the two are not mutually exclusive nor necessarily chronological, the first axis approximately corresponds with the various modes in which the international community may help states ‘under stress before crises and conflicts break out’ (UNGA, 2005: para. 139), while the second axis is more commonly associated with medium- to long-term international development initiatives, and therefore the structural prevention of mass atrocities. Finally, pillar three—timely and decisive response—is ‘the responsibility of Member States to respond collectively



in a timely and decisive manner when a State is manifestly failing to provide such protection.’ The Secretary-General is quick to point out that, ‘though widely discussed, pillar three is generally understood too narrowly,’ specifying that,

A reasoned, calibrated and timely response could involve any of the broad range of tools available to the United Nations and its partners. These would include pacific measures under Chapter VI of the Charter, coercive ones under Chapter VII and/or collaboration with regional and subregional arrangements under Chapter VIII. (UNSG, 2009: p. 9).

While the majority of states participating in UN General Assembly dialogues on R2P (GA dialogues on R2P henceforth) have come to accept that pillar three is broader than military intervention and R2P is broader than pillar three, the same cannot be said for the scholarly community. Indeed, a notable trend in the academic literature has been to foreground the connection between R2P and the now obsolete concept of humanitarian intervention (Focarelli, 2008; Mamdani, 2010; Chomsky, 2011). In doing so, critics have opted to ignore the far wider implications of R2P and the break it represents with the stand-alone notion of protection by military intervention. Others, such as Mégret, explicitly acknowledge that R2P goes beyond humanitarian intervention by ‘developing a full strategy to avert atrocities’ (2009: p. 575). Significantly for the present study, Mégret recognises the dangers of ‘investing too much hope in the ability of the international community alone to avert atrocities’ and exhorts us to ‘think further about the international-local interface’ (p. 591). This message has subsequently been picked up by practitioners and scholars alike, and has allowed a novel concept to grow out of R2P, that of an individual responsibility to protect (IR2P). Former Special Adviser to

the Secretary-General on the R2P, Edward Luck, and his wife, Dana Luck, have argued that,

This reconceptualization of R2P begins with the premise that neither prevention nor the protection of vulnerable populations can be realized without individuals taking responsibility and assuming risk. For if R2P is only about collective responsibilities – those of governments and institutions – then it will confront recurring and often disabling collective action dilemmas and a pervasive lack of accountability. (Luck & Luck, 2015: pp. 207-208).

As we will see, while collective action dilemmas have plagued efforts to put an end to the bloodshed in Syria, there are many examples of individuals assuming burdensome responsibilities, although effective interfacing between the international and the local has varied over what has been a protracted conflict.

Pison Hindawi situates Luck & Luck's new concept carefully when surmising that IR2P does, 'without exonerating institutional actors from their obvious responsibilities, recognize at the very least the right of people of conscience, worldwide, to take matters in their own hands even in the worst cases of international paralysis' (2016: p. 29). Recalling the responsibilities of institutional actors in this way is especially important in the case of Syria, as it is one of the most prominent examples of international paralysis in the 21<sup>st</sup> Century. Ultimately those failures created the conditions for local actors and individuals to take matters into their own hands, and in that sense the many individual acts of protection in Syria can be partly accounted for by a failure of collective responsibility. Nevertheless, as suggested above, the individual and the collective—much like the local and the international—should not and do not

exist independently, and enhancing interactivity between the different levels will be a recurring theme in the concluding recommendations of this study.

In addition to focusing on, as Pison Hindawi puts it, a ‘heretofore underappreciated layer of actors’, this study will argue that what Dunford and Neu (2019) identify as an insurmountable contradiction of R2P—the notion of ‘already existing intervention’—is precisely the area where we might hope to make the most progress. They contend that,

Members of the ‘international community’ continue to be presented as helpers or bystanders, not as potential contributors to humanitarian crises. We use the term ‘already existing intervention’ in order to escape this binary according to which the international community either acts by ‘intervening’ or fails to act by ‘standing aside’. To this end, the term refers very broadly to actions — taken by foreign states, multinational corporations, international organisations and/or other actors operating across borders — that contribute to the emergence of atrocity crimes. (Dunford & Neu, 2019: p. 1083).

The authors are right to characterise members of the international community as potential contributors to humanitarian crises. They also make a valuable point that actions taken by foreign states, multinational corporation and international organisations, etc., may in fact contribute to the emergence of atrocity crimes, and the term ‘already existing intervention’ is a useful way of capturing this. However, I take issue with the exclusively negative import of their definition. Acknowledging that international actors are in many cases already present on territories where there may be a risk of atrocity crimes, and that business, development and humanitarian activities

impact upon intercommunal relations and the social contract in manifold ways, we may use this as a departure point for thinking about how to integrate a human rights approach into these activities in order to contribute to the prevention of atrocity crimes and the protection of populations. In other words, while Dunford & Neu conceptualise ‘already existing intervention’ to mean the types of actions ‘that contribute to the emergence of atrocity crimes’, my definition is more optimistic in pointing to the possibility that international actors might also exercise a positive influence on the course of events in accordance with pillar two of the framework. Key to this will be establishing better partnerships with local actors and tapping into the ready-made networks of solidarity and protection that exist between individuals for reasons that go beyond mandated responsibilities.

## **1.8. Methodology**

### ***1.8.1. Literature review***

As already discussed, this is an interdisciplinary project that explores interactions between the fields of human rights and public health. Such an approach meant reviewing a wide range of academic and grey literature, mostly available online.

In building a picture of the relevant facts, it was important to begin by reviewing reports of health care-related violations of international human rights law (IHRL) and international humanitarian law (IHL) in the context of the conflict in Syria. This involved searching websites of the major human rights groups and humanitarian actors for relevant reports. Human rights groups included Amnesty International, Human Rights Watch (HRW) and Physicians for Human Rights (PHR). I also referred to

reports published by the International, Impartial and Independent Mechanism on Syria (IIIM) and the Independent International Commission of Inquiry on the Syrian Arab Republic (COI). Humanitarian actors included the ICRC, MSF and the Syrian American Medical Society (SAMS). Having read the literature, it was clear to me that the targeting and weaponisation of health care became an increasingly important dimension of the conflict and this particular dimension warranted the application of the R2P paradigm.

Reports published by groups with medical expertise often described some of the broader implications of the bombing of hospitals and targeting of medical staff, highlighting the consequences for the Syrian health system, access to medical care, and longer term effects on key indicators of health. This encouraged me to review literature dealing specifically with the impact of the Syrian conflict on health security, which, it seems to me, should be taken into account when evaluating the gravity of the crimes in question. I was already familiar with much of this literature thanks to a very comprehensive reading list compiled by two professors in the Faculty of Health Sciences at the American University of Beirut and former physicians in Syria, Dr. Mohamed Fouad and Dr. Samer Jabbour, who run the course *Public Health and Armed Conflict*.

The next step involved developing a conceptual framework informed by the responsibility to protect doctrine so as to assess the effectiveness of different actors' responses to health care-related human rights abuses. I referred to two bodies of literature on R2P: documents containing official expressions of the emerging norm (largely grey literature) and scholarly articles written by academics and lawyers. The grey literature included the 2005 World Summit Outcome document, the UN Secretary-

General's annual reports on R2P, and summaries of the UN General Assembly's dialogues on R2P. I benefitted from the guidance of my academic adviser, Coralie Pison Hindawi, an R2P scholar, in identifying academic papers that deal with the most salient issues and controversies in my area of interest. Bibliographic searches of the recommended articles allowed me to gain a deeper understanding of the background to some of their core arguments.

Ordering the literature review in this way allowed me to establish a factual picture of the targeting and weaponisation of health care in Syria before exploring the literature on R2P. Having a clear sense of the type of atrocities that were the focus of my research question, as well as the different actors involved in protecting populations from abuses, made it easier to navigate the R2P literature and pursue some lines of inquiry over others.

### ***1.8.2. Interviews***

Originally it was hoped that the literature review would provide the foundation for a series of interviews with key informants who had direct experience of the situation in opposition-held areas of Syria, including Syrian medical professionals and Syrian NGOs, and diaspora groups who worked between Syria and a foreign country. The outbreak of the COVID-19 pandemic early in 2020 and the resulting restrictions on air travel made it impossible to visit Gaziantep in Turkey where the interviews were due to take place and this meant conducting interviews over Skype instead.

Another limiting factor was that not all of the informants identified responded to the invitation to participate in the study. The extensive body of research into the atrocious health care conditions in opposition-held areas of Syria suggests that many Syrian

health professionals and NGO staff have already been interviewed by researchers and, understandably, there is probably a degree of interview fatigue among the target groups. Nevertheless, I was able to interview five key informants using video conferencing software: Zedoun Al Zoubi, CEO of Union of Medical Care and Relief Organizations (UOSSM), a health-focused Syrian NGO; Monther Etaky, Media and Advocacy Officer at Independent Doctors Association (IDA), another health-focused Syrian NGO; Mazen Alhousseiny, Organisational Development Manager at Syria Relief, a Syria-focused charity registered in the UK; Mr. D (anonymised), a former employee at Syrian American Medical Society (SAMS), a health-focused charity established by Syrian expatriates in the US; and Mairead Collins, Senior Advocacy Adviser on Syria, Iraq and Lebanon for Christian Aid, a charity registered in the UK. I was also able to communicate via email with Dr. Ayman Jundi, Chairman of the Board of Trustees for Syria Relief.

Speaking with individuals who were very familiar with the Syrian context, most of whom had lived and worked in Syria, been involved in cross-border humanitarian relief, and kept in touch with friends and family who remained in the country, raised new questions that encouraged me to explore the literature further. One question that came to shape my approach following the interviews was the nature of interactions between the international humanitarian system and local actors responding to the unfolding atrocities. While the proper role of international organisations has long been a source of debate in the humanitarian sector, it seems to take on a new resonance in the Syrian context where international actors have often been prevented from accessing precisely those parts of the country most in need of humanitarian relief. Under those circumstances, Syrian NGOs and other local actors assumed a responsibility to protect

populations that went well beyond their capacity, often with little to no support from the international community.

### *1.8.3. Study limitations*

In respect of the literature review, one of the limiting factors when it came to building a factual picture of the progressive targeting and weaponisation of health was the fact that most of the reports were published by non-Syrian sources due to restrictions on freedom of speech and freedom of the press inside the country. These concerns are somewhat mitigated by the fact that the reports relied on were published by trustworthy sources such as Amnesty International and PHR—advocacy groups that employ experts in the field of human rights and that are known for adhering to rigorous reporting standards. Nevertheless, the reports, generally published in English, are clearly designed to influence foreign policymakers and may be considered part of an advocacy agenda that exceeds the conflict in Syria. While human rights activists may point to the universality of their agenda, skeptics might counter that the international system for addressing human rights abuses is imperfect and that if advocacy on human rights is to be effective, it should be more attuned to the context in which abuses are perpetrated. This would of course necessitate greater input from Syrian voices.

Here I should add that, while reliance on English language sources published by human rights groups was partly determined by the volume of these sources compared with Arabic language sources, I do not read Arabic well and this prevented me from exploring more Arabic language material. Language may have also been a factor in my ability to recruit research participants. It is possible that Syrians would have been more amenable to being interviewed had I been able to properly introduce myself and my



project in their native tongue. The possibility of interviewing in Arabic would have also greatly increased the number of potential interviewees and may have allowed me to recruit more participants.

As already mentioned, the COVID-19 pandemic prevented me from traveling to Gaziantep where I intended to carry out the majority of interviews. This meant I had to rely exclusively on email for the recruitment of research participants. The small number of interviewees and the fact that none of them were based in Syria means the findings from the interviews come from a limited range of perspectives. Ideally I would have liked to interview Syrian medical or NGO staff inside Syria to get a better understanding of the salient issues in the eyes of those most exposed to the violence.

### **1.9. Presentation of thesis structure**

In the introduction I have conveyed some sense of the conditions that gave rise to the formulation of the responsibility to protect doctrine. I have situated my research question within the discourse on R2P and begun establishing the applicability of R2P to the conflict in Syria and, in particular, the targeting of health facilities and personnel by the Syrian regime. I have sought to characterise the trajectory of the R2P narrative by referring to the Libya dossier, which had the effect of concentrating attention on the most controversial aspect of R2P: military intervention. Finally, I have begun to build my case that R2P should not be written off as a result of the Libyan experience, suggesting that the paradigm offers many promising alternatives to military intervention. This approach leads me to explore the issue of agency: who exercises responsibility and how can we ensure that actors exercising responsibility are doing so

in a mutually supportive way? In the five chapters that follow, I will explore whether a decade of conflict in Syria can provide any answers to these questions.

In chapters one and two I analyse reports of human rights abuses and international crimes perpetrated in Syria. Chapter one focuses primarily on human rights violations committed during the early days of the uprising while chapter two picks up the narrative in July 2012, when the ICRC declared that the situation in Syria had reached the threshold of internal armed conflict, thereby activating international humanitarian law (IHL). The purpose of dividing the chapters in this way is to highlight that far from helping to dampen the conflict, the activation of IHL was followed by an escalation in hostilities and, of particular significance for our purposes, an increased incidence of attacks on health facilities and workers, which from this point on can be classified as war crimes. Such a pattern of worsening atrocities signals the Syrian government's contempt for IHL. Hence the imperative of finding new ways of giving effect to the provisions of international law that would incentivise conciliatory behaviours and foster greater security, and to do so before an accumulation of human rights abuses amounts to their normalisation in a given context.

I show that the pattern of health-related human rights abuses has its origins in the early days of the conflict when security personnel and hospital staff began committing widespread violations of medical neutrality. Things escalated in the months and years that followed, with regime forces engaging in the systematic bombardment of hospitals and ambulances. These developments are read against the evolving conflict dynamics inside Syria and the international community's efforts to broker a peaceful settlement. In wrapping up the first two chapters, my analysis leads me to conclude that the intentional targeting of health facilities and personnel had reached the threshold of

crimes against humanity by 2015, and likely earlier. Characterising the progressive nature of the targeting and weaponisation of health and the failure of the international community to mediate between the various parties to the conflict sheds light on weaknesses in the protection paradigm envisaged by R2P. Among other things, these chapters identify two inter-related obstacles to the implementation of R2P, namely, establishing effective early warning systems on the one hand and the attribution of responsibility for protecting against crimes perpetrated by state authorities on the other. These practical challenges give direction to the following three chapters which explore the responsibilities of different actors, from UN organs that espouse a priori the R2P doctrine to individuals made responsible by force of circumstances.

Much of the R2P debate has taken place within and focused on the UN system. Chapter three offers an analysis of how the General Assembly, Security Council and Human Rights Council tried to prevent/respond to the commission of atrocity crimes in Syria. To the extent the UN system attempted to exercise a responsibility to protect, we can point to both achievements and failures. Ultimately this chapter serves to acknowledge the potentially important role to be played by organs of the UN in protecting populations from atrocities, especially if those atrocities are perpetrated by agents of member states. The chapter also serves to demonstrate the shortcomings of this system in practice. Concluding that the system's dysfunctions in respect of R2P—namely the unresponsiveness of the General Assembly and the lack of consensus in the Security Council—are so deep-seated as to appear intractable in the short term, we are forced to reckon with the hard truth that, at the apex of UN system, there are currently limited opportunities for implementing the R2P paradigm. This is not to say that member states lack the will to carry the agenda forward. Nor do I seek to downplay the

complementarity of R2P with the mandate of the Human Rights Council. It is to say that in practice the dysfunctions of the decision-making parts of the system make it advisable to temper our expectations of UN initiatives, which is why it is so important to recognise that other actors, whether or not by choice, exercise a responsibility to protect. I will argue that progress on implementing R2P can be made only if we work towards an ecology of protection wherein multiple layers of actors understand their proper contribution towards the protection of populations, from individuals through civil society and state authorities all the way up to the higher reaches of the UN. Most importantly of all, that ecology needs to generate bonds of trust between the different layers to ensure the same protective purpose is being served.

Having characterised the UN's efforts to protect the Syrian population from war crimes affecting health care in chapter three, we will go on to analyse the role of non-UN actors in chapter five. Chapter four offers a transition by reminding us that the intentional destruction of a health system has far-reaching consequences that invoke responses from a diverse set of actors. It also introduces the concept of health security, which offers a three dimensional framework for operationalising R2P with regard to the health sector. We will see that each of the three dimensions interact with the responsibilities of the global health community under R2P. It is a matter of concern, therefore, that the World Health Organization has narrowly focused on only one aspect of health security, failing to give due consideration to the potentially devastating impact of conflict on health systems, and the destabilising consequences of failing to address health inequities and poverty. Ultimately, this chapter introduces the notion that, if it is a realistic expectation to empower people to provide health security for themselves and their communities, it follows that people should be similarly empowered to protect the

security of their health from serious threats, especially when those threats are of man-made origin. This is the premise upon which, in chapter five, I argue for greater support to actors who can meaningfully exercise a responsibility to protect health care, in Syria and beyond.

Chapter 5 will take a closer look at how the UN initiative of cross-border humanitarian assistance to communities in opposition-held areas was of limited effectiveness. The humanitarian relief that did make it across conflict lines was for the most part delivered by Syrian actors, though many towns were completely cut off even from this aid, serving as a reminder of the limited reach of international actors. The chapter will try to give a balanced representation of the very real challenges faced by the UN and the wider ‘formal’ humanitarian system in protecting the most vulnerable from the suffering engendered by a merciless conflict on the one hand, and the deep sense of frustration experienced by Syrian actors—principally Syrian CSOs and expatriate NGOs—at the sight of their international, upstream partners cooperating with the regime and allegedly disregarding humanitarian principles in the process. If these allegations are true, they call into question the relevant international agencies’ commitment to accountability and justice, and thus their fitness to exercise a responsibility to protect. The rift between the UN and Syrian actors clearly undermines the objective of an ecology of protection wherein the different layers of actors reinforce one another. The chapter suggests avenues for ensuring that local actors are given a level of support by the formal humanitarian system that more nearly compensates the extreme levels of risk carried by those offering the most immediate and tangible forms of protection on the ground.

Questions around agency—who exercises responsibility and how can we ensure that actors exercising responsibility are doing so in a mutually supportive way—are core themes that run through each of the five chapters. It is only fitting, therefore, that the conclusion brings together the most salient answers to questions bearing on agency within the R2P paradigm. Having argued in chapters four and five that non-state, Syrian actors compensated for the shortcomings of the international humanitarian system in terms of protecting populations from atrocity crimes and their after-effects, the conclusion is an opportunity to offer concrete suggestions on how to better integrate local actors into the R2P framework in recognition of the very important role they have played in Syria despite the challenges arising from the unfitness of prevailing institutional arrangements for channeling resources to frontline actors. Having also identified the deleterious effects of counter-terrorism legislation on protections for health workers and facilities under IHL, I submit recommendations for a more comprehensive set of legal instruments and institutional fixtures geared towards the protection of health security from would-be authors of international crimes. Finally, our diagnosis that the WHO’s failure to establish accountability mechanisms in service of its human rights obligations leads us to propose a role for the Human Rights Council in assisting the former to integrate a human rights perspective into all areas of its mandate.

## 2. EMERGING PATTERNS

Maltreatment of patients and health professionals in the early stages of the uprising reflected a complete disregard for the principle of medical neutrality within the state's security apparatus and even among some health workers, both groups public sector employees. The abuses that will be described below constitute clear indicators that the state was failing to provide safety and security to patients and health workers long before the situation reached the threshold of armed conflict. This raises questions about the international community's responsibility to engage in operational prevention by applying pressure on the state to put an end to human rights violations. Much of the available testimonial evidence of medical protections being breached as Syrian security forces cracked down on protestors comes from the October 2011 report by Amnesty International, *Health Crisis: Syrian Government Targets the Wounded and Health Workers*. That these abuses went relatively undocumented serves as a reminder of the long-standing restrictions on journalists and human rights reporters in the Syrian context, and calls attention to the fact that a key element in the effective prevention of atrocity crimes is the freedom to report incidents that represent a disregard for certain fundamental protections, such as the protection of medical staff and patients. If the central authorities are not only failing to protect those providing and benefitting from medical care, but are in fact complicit in the violations, the international community needs to consider which actor is best placed to sound the alarm.

## **2.1. Abuses in hospitals**

### ***2.1.1. By staff***

While most people who have followed the conflict in Syria will be familiar with some of the abuses committed by the state's security apparatus, as well as by the armed groups that emerged as the violence escalated, it is perhaps not so well known that medical personnel have also been guilty of breaching their duty of care. Amnesty International was perhaps the first international human rights organisations to draw attention to these abuses. In October 2011, only a few months in to the uprising, Amnesty International published a report that documented how

Wounded patients perceived as government opponents have been verbally and physically assaulted by medical staff, health workers, and security personnel in at least four government-run hospitals—the National Hospital in Homs, the National Hospital in Tell Kalakh, and the National Hospital in Banian, all of which fall under the Ministry of Health; and the military hospital in Homs, which falls under the jurisdiction of the Ministry of Defence. (Amnesty International, 2011: p.7).

The report contains testimonies of eye-witnesses and victims of abuses committed by staff. In early April 2011, while working in the emergency room at the National Hospital in Homs, where they were receiving many cases coming in with firearm injuries, a doctor described how he remembers 'hearing shrieks of pain', and that when he went over to see what was happening he found 'a male nurse hitting [a boy aged around 15] on his injury and swearing at him as he poured surgical spirit on the injured foot in an act that clearly intended to cause the boy additional pain ...' (p.9).



In addition to verbal and physical assaults, some health care workers have shown flagrant disregard for the ethical imperative of impartiality by denying treatment to the wounded. In May 2011, “Jamil” suffered a gunshot wound to the foot and was subsequently taken to the Homs military hospital by soldiers where he was held ‘against his will and without contact with his family for two weeks during which doctors and nurses refused to change the dressing on his injured foot, causing it to swell and become infected.’ Jamil reported that when he asked the doctor to clean his wound, the latter would respond by saying ‘I’m not going to clean your wound ... I’m waiting for your foot to rot so that we can cut it off’ (p.13).

The testimonies provided in Amnesty International’s report suggest a couple of patterns. Firstly, abuses appeared to be more common and more egregious in Homs military hospital than national hospitals; and secondly, there are more reports of male and female nurses committing abuses than doctors, although doctors appeared to be more likely to violate medical ethics in the military hospital than national hospitals.

### ***2.1.2. By security forces***

On 22 March 2011,

Government forces entered Daraa National Hospital, cleared it of non-essential staff, and positioned snipers on the roof. The snipers remained stationed there until May 2013, firing on sick and wounded people approaching the entrance to ensure that only government soldiers or civilians from government-controlled neighborhoods would receive care. (PHR, 2020a).

There is no doubt that this was a significant turning point in the uprising, which occurred only one month after protestors—inspired by pro-democracy movements in

Tunisia, Libya and Egypt—first took to the streets to call for reforms in peaceful and small-scale demonstrations. It constituted a clear breach of International Human Rights Law (IHRL), which is applicable in times of peace as well as war. Specifically, the occupation of Daraa National Hospital, as well as all the other incidents recounted in this section, violated the International Covenant on Economic, Social and Cultural Rights, to which Syria is party. Art. 12 of the Covenant obliges all States Parties to take steps to achieve ‘the creation of conditions which would assure to all medical service and medical attention in the event of sickness’ (UNGA, 1966: art. 12(d)). Such a flagrant breach of IHRL casts doubt on a State Party’s commitment to its other obligations under international law. Nor do the events described in this section appear to constitute isolated incidents in which individuals merely over-reached their authority. Rather, the events appear to constitute a pattern of systematic abuse which has been described as ‘the weaponisation of health care’ by the Syrian regime. The weaponisation of health care is ‘a strategy of using people’s need for care as a weapon against them by violently depriving them of it’ (Fouad et al., 2017). That Syrian authorities were prepared to sanction if not actually direct the targeting of health care to quell what was still a nascent uprising in mid-2011 should perhaps have encouraged the international community to contemplate how far Assad’s regime would be willing to push this strategy when faced with armed and organised opponents.

Such extreme measures were taken in Daraa because the city was viewed as the source of the uprising and witnessed some of the largest protests. In other cities we have numerous eye-witness accounts of security personnel entering restricted areas of hospitals without authorization, intimidating staff, and arresting patients, who would then be transported either to a military hospital where they were treated more like

prisoners, including being subjected to abuse from staff and denied medical treatment, or an overcrowded detention center lacking adequate medical facilities and where they would likely be tortured. PHR also documents numerous incidences of government forces indiscriminately firing weapons upon or inside hospitals in Damascus, Hama, and elsewhere. The upshot of the deteriorating security situation in hospitals was that some patients, even the severely wounded, stopped seeking much-needed medical care at hospitals.

Not only did the regime target perceived political dissidents in the form of wounded protestors, from the first few months of the conflict, health workers were also vulnerable to arrest and torture for treating patients with injuries associated with the uprising. The reasons for the detention of medical staff include treating injured protestors without informing the authorities, active participation in the demonstrations, or being suspected of reporting human rights violations committed by Syrian security forces (Amnesty International, 2011).

It is perhaps worth noting that of the 21 health workers interviewed by PHR for their report *“My Only Crime was That I Was a Doctor”*: *How the Syrian Government Targets Health Workers for Arrest, Detention, and Torture*, more than three quarters were arrested between 2011 and 2013. However, the authors stress that ‘the report cannot provide a comprehensive picture of how detention was used in the persecution of health workers in Syria’ and that ‘PHR was able to reach only individuals fortunate enough to have survived Syrian security branches and detention facilities’ (PHR, 2019: p. 13). Though we do not and probably never will have a clear idea of the scale of these abuses, the reports that have emerged once again demonstrate the regime’s patent disregard for its obligations under IHRL. Syria is party to both the International

Covenant on Civil and Political Rights, which protects individuals from arbitrary arrest or detention (UNGA, 1966: art. 9(1)), as well as the Convention against Torture, which is unequivocal that ‘no exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture’ (UNGA, 1984: art. 2(2)). What arguably adds to the severity of these crimes is the fact that the victims were health professionals. Seeing their colleagues disappear for no apparent reason other than performing their normal duties acted as a powerful deterrent on others, and should be considered an important factor in the mass exodus of the Syrian medical community during the first few years of the uprising. Thus, not only were Syrian authorities perpetrating grave human rights abuses, they were effectively catalyzing the decline of the health system.

## **2.2. Impeding and attacking medical transports/ambulances**

Early on in the conflict, medical transports began to be impeded. Amnesty International (2011) reported that

[Syria’s security forces] have impeded ambulances responding to call-outs. They have searched and questioned Syrian Arab Red Crescent (SARC) workers while on duty. They have threatened ambulance crews with being shot at or detained. They have also examined and questioned patients being taken to hospital by ambulance. (p. 18).

PHR (2011) recount an example of wounded protestors being prevented from reaching hospitals by security forces stationed at the hospital entrance. According to one paramedic, even emergency response had been instrumentalised by regime security,

with ‘two security personnel accompany all ambulances carrying wounded patients to hospitals’ (PHR, 2011: p. 7).

Over the next couple of years the situation became increasingly dangerous for ambulance crews and patients, as affirmed by the head of Dar Al-Shifaa Hospital in eastern Aleppo who cited one account ‘in which a government helicopter shot rockets at an ambulance, killing the driver, a nurse, and a wounded person who had been in the ambulance’ (SAMS, 2013: p. 23). Shortly before this 2013 report was published, the SARC in Homs saw their entire fleet of ambulances damaged. A report published in 2015 remarked that ‘attacks on ambulances are so frequent that they have affected routine services, especially childbirth’ (Johns Hopkins & SAMS, 2015: p. 21). As the conflict progressed, ambulances increasingly came under attack, from bullets to air-to-surface bombardment (SAMS, 2017), and, most appallingly of all, double-tap strikes using barrel bombs (Johns Hopkins & SAMS, 2015).

Documenting the commitment of SARC employees to the relief effort despite the life-threatening nature of their tasks allows us to introduce Svoboda & Pantuliano’s (2015) argument that criticism of SARC for its lack of neutrality and impartiality is ‘partly rooted in a misunderstanding of the SARC’s role and legal status’ (p. 11). While senior staff within the organisation are answerable to the national authorities in Syria, something that is enshrined in law, there is no doubt that the SARC has been an integral part of the emergency response and humanitarian relief efforts in both government- and rebel-held governorates. The fact that dozens of its volunteers have been killed ‘and many more subject to arrest and harassment by the government as well as attacks by various armed groups opposing the government’ should be enough to persuade most observers that the SARC is not a puppet of the regime. Simply casting actors as either

having or lacking humanitarian principles is sometimes to ignore political factors outside of their control—factors that determine the space for humanitarian action in man-made humanitarian disasters.

### **2.3. Contextual developments**

The following summary of events will help to frame our portrayal of unfolding atrocities in Syria. The dynamics of the conflict, the actions of state and non-state actors, and the reactions of the international community, all contribute to a more nuanced understanding of the events in question. An important development in this respect is the regime's loss of territory, which pushes the conflict into a new phase and results in the rise of heavier weaponry. The de facto control of large swathes of Syrian territory by armed opposition groups raises important questions about the international community's responsibility to protect given that the three-pillar formulation of R2P does not envisage a role for non-state actors. Likewise, it raises questions about the WHO's responsibility towards populations outside government-controlled areas.

In response to the regime's increasingly brutal suppression of the popular uprising, military defectors established the Free Syrian Army (FSA) in July 2011. This was followed two months later by the amalgamation of several opposition groups to form the Syrian National Council (SNC), which in early-2012 was recognised as the 'legitimate representative' of Syria by the Group of Friends of the Syrian People, a collection of over 60 countries and organisations, including Britain, France, Saudi Arabia, Turkey and the United States. On 16 November 2011, Syria was suspended from the Arab League and a majority of members agreed to impose economic and

political sanctions over the Assad regime's failure to put an end to the bloodshed (Batty & Shenker, 2011). On 22 December an Arab League observer mission was dispatched to Syria with the consent of the regime. By late-January 2012, the Arab League announced the suspension of the mission on the account of the deteriorating security situation (BBC, 2012).

An op-ed by Brookings criticized the incompetency of the mission, 'which was made up not of the most experienced human rights practitioners available, but rather of delegations from each member state' (Shaikh, 2012). There was skepticism that Syria's signing of the Arab League initiative to allow the observer mission in to the country, as part of an effort to end the mounting crisis, had been done in good faith, since the terms of the agreement would have required the removal of Syrian forces and heavy weapons from city streets, and most likely encouraged a major mobilization of protestors bent on toppling the regime (Associated Press, 2011). Instead, allowing the observer mission into the country but keeping them on a short leash bought the regime time to quash the uprising by ratcheting up the violence: between the mission's arrival on 22 December 2011 and 16 January 2012 the UN reported 400 killings perpetrated by Syrian forces, prompting the ignominious withdrawal of the mission. In 2012 'the conflict escalates to all-out civil war' as 'foreign assistance to both sides fuels the violence and adds proxy wars to the internal conflict' (Glass, 2016).

There were a series of important developments in 2012 relating to the international community's efforts to engage with the Government of Syria and stem further bloodshed. Soon after the suspension of the Arab League observer mission in late-January, Kofi Annan was appointed joint UN and Arab League peace envoy for Syria. On 11 March there were widespread media reports that Annan's first talks with

Assad had ended with little sign of progress towards initiating a peace process. A month later, on 12 April, a UN-sponsored ceasefire takes effect and violence by the Syrian forces reportedly decreases. This does not last long as the latter reportedly resume attacks on civilians and opposition fighters, prompting the UN Security Council to authorize the deployment of a team of monitors in Syria to observe the ceasefire, with the first monitors arriving the following day. On 16 June UN News (2012) reported the suspension of the mission 'owing to an intensification of armed violence across the country' over the previous 10 days. It was labelled as 'the clearest sign yet' that Kofi Annan's peace plan had collapsed (Evans, 2012). The same article reported that shots had been fired at a car carrying UN observers in the town of Haffeh the previous Tuesday, though nothing was said about the affiliation of the gunmen.

A month later the armed insurgency in Syria came to be recognised as a civil war. On 14 July 2012, the International Committee of the Red Cross (ICRC), the guardian of the Geneva Conventions, declared that the conflict in Syria had reached the threshold of an internal armed conflict. Indeed, President Bashar al-Assad had already indicated in a speech on 26 June that his country was in a state of war (Nebehay, 2012). The qualification activated the application of International Humanitarian Law (IHL) to the situation in Syria, meaning that parties to the conflict could from that point on be prosecuted for war crimes, such as ordering or perpetrating attacks on civilians or using disproportionate force against civilian areas. Crucially, IHL makes explicit the duty of care for the wounded and sick regardless of affiliation, i.e. the imperative of medical neutrality. Under IHL, protections for medical personnel and health care facilities vary according to the character of the conflict—whether international or not—and, of course, the particular treaties to which the state in question is party. In short, there is no single



treaty that elaborates medical care obligations in different kinds of conflict and, as we shall see below, the dispersion of provisions across treaty law has meant that Syria has accepted medical care obligations applicable in international armed conflict while escaping similar obligations in non-international armed conflict. Clearly this does not absolve Syria from protecting medical personnel, activities, units, transports, nor humanitarian relief personnel and objects, as these protections are well established in international customary law (ICRC, n.d.). Rather, the scattered nature of provisions protecting health care and humanitarian relief in conflict opens the door to competing legal paradigms, such as counter-terrorism legislation, and risks eroding the force of prevailing international customary law. We will return to the issue of conflicting bodies of law and the relevance of R2P to this discussion after concluding our characterisation of contextual developments.

In 2012, after the abandonment of both the Arab League observer mission in January and the UN Supervision Mission in Syria (UNSMIS) in June due to the deteriorating security situation, the important question of monitoring the conduct of warring factions was left unanswered. To add to the list of frustrated international efforts, Kofi Annan resigned from his position as the UN and Arab League peace envoy for Syria on 2 August following the collapse of his peace plan. His replacement, Algerian diplomat Lakhar Brahimi, was also unable to implement a ceasefire and resigned in 2014. Hoeling (2015) offers three reasons for the failure of Annan and Brahimi's attempts to mediate between the warring parties. Firstly, deadlock in the Security Council delayed the response and by the time Annan was appointed envoy to Syria hostilities had escalated to the point where neither side was willing to make concessions. Secondly, because Syria continued to enjoy the support of Russia and

China, advocacy efforts of the Joint Special Envoy were not bolstered by a truly international sanctions regime. Thirdly, the observer mission simply was not equipped for the level of violence it encountered.

Over the course of 2013 Jihadists increasingly came to dominate the opposition in the absence of a single recognised authority with legitimacy inside Syria, and the use of heavy weaponry enabled the regime to regain the military advantage. PHR (2015) documented the first two car bomb attacks on hospitals in November, attributing responsibility to non-state armed groups. In December, the seizure of FSA bases by jihadists prompted the US and the UK to suspend “non-lethal assistance” to rebels in northern Syria (FT, 2013). Such developments played into the regime’s portrayal of the uprising as a terrorist conspiracy.

In an interesting coincidence of timing, less than two weeks before the ICRC declared that the conflict in Syria had reached the threshold of an internal armed conflict thereby activating IHL, Syrian authorities enacted Law No. 19 (law 19/2012), the Counter-Terrorism law. This law has been used by the regime as the legal basis upon which it has persecuted medical personnel in violation of its obligations under international customary law. While the activation of IHL did not afford health workers many more protections in the Syrian context, it did introduce the possibility that crimes perpetrated by Syrian officials could henceforth be prosecuted as war crimes. The Counter-Terrorism law, whether the intention of the regime or not, frames the internal crisis in terms of sovereign state vs. organised terrorists; rhetoric which many members of the international community have used in recent years. As such, it is possible to argue that Syrian authorities saw in law 19/2012 a means of complicating the arithmetic of international law and justice.

## **2.4. Impact of counter-terrorism legislation**

Global developments make the discussion about the impact of counter-terrorism legislation on humanitarian action increasingly urgent. Since the 9/11 attacks on the World Trade Center, the UN Security Council has passed several resolutions addressing support of terrorism by states, most notably resolution 1373 (2001) which laid the foundations of the counter-terrorism narrative. Various inter-governmental bodies have subsequently been established to address issues from global money laundering and terrorist financing—see the Financial Action Task Force (FATF)—to rule of law-based training on how to address terrorism—see The International Institute for Justice and the Rule of Law (IIJ). The mobilisation of considerable resources in the name of counter-terrorism seems to have taken place without states giving serious consideration to the impact of this new paradigm on International Humanitarian Law. For example, counter-terrorism measures may prevent humanitarian organisations negotiating access to populations when those populations live in areas under de facto control of militias designated terrorist groups.

In the context of states being encouraged to implement counter-terrorism measures, Lewis & Modirzadeh (2020) have asked the question of whether a counterterrorism body can and should ‘authoritatively and authentically interpret and assess compliance with international humanitarian law (IHL)’. The reason for their asking this question is that ‘in the absence of sufficiently precise and legally grounded definitions [of terrorism and violent extremism], several states have in effect criminalized certain activities underlying humanitarian relief and protection efforts, even where those activities are covered by IHL.’ Crucially for this study, the authors recognise that “support” to terrorism may in some instances include such things as the

provision of medical care to actors deemed to be either terrorists themselves or, as in the case of Syria, quite simply the provision of health care in areas outside of government control. The authors are unequivocal that a state contravenes its obligations to comply with applicable IHL when it legislates ‘that the provision of any impartial medical care in territory under the de facto control of a nonstate party to an armed conflict constitutes a criminal offense’ (Lewis and Modirzadeh, 2020).

This is precisely what happened in Syria. Law No. 19 of 2012, better known as the Counter-Terrorism Law, effectively replaced Syria’s state of emergency that, after remaining in effect for 48 years, had been lifted following the popular protests that began in March 2011. The law defines terrorism as ‘every act that aims at creating a state of panic among the people, destabilizing public security and damaging the basic infrastructure of the country by using weapons, ammunition, explosives, flammable materials, toxic products, epidemiological or bacteriological factors or any method fulfilling the same purposes’ (HRW, 2013). Human Rights Watch (2013) argue that ‘the reference to “any method” opens the door to labelling virtually any act as a terrorist offense’ while a spokesperson for the UN High Commissioner for Human Rights has described the law as ‘broad and ill-defined’ (Colville, 2014). The broad scope of the law has reportedly resulted in prosecutions for a wide range of activities, including those related to health care such as providing medicines to protesters and distributing humanitarian aid (HRW, 2013; TIMEP, 2019; VDC, 2015;). Based on research and information from colleagues, one Syrian lawyer estimated that, as of mid-June 2013, at least 50,000 had been referred to the Counter-Terrorism Court (CTC), while another lawyer working on cases of political detainees in Damascus reported that at least 35,000

nonviolent political detainees were being tried by the court, leading him to believe that the court was established for the purpose of targeting the opposition (HRW, 2013).

The CTC was established by Law No. 22 of 2012; less than one month after the Counter-Terrorism Law came into effect on 2 July 2012. The court is exceptional in a number of respects. First of all, it has jurisdiction over cases implicating both civilian and military individuals. While the law does grant defendants a right to defence, in practice it has been reported that lawyers are often prohibited from seeing their clients before the trial begins (TIMEP, 2019). In the assessment of Human Rights Watch (2013), by omitting to outline trial procedures, Law No. 22 ‘effectively grants the court sweeping discretion to determine its procedures.’ Moreover, the law expressly states that ‘the CTC is not obligated to adhere to the regular trial and due process standards set forth by Syrian law’ (TIMEP, 2019). This finds expression in the fact that the CTC breaks with the standard procedure enshrined in international law that criminal trials be held in public. The court’s lack of transparency is compounded by the fact that the judges ‘who do not enjoy immunity for actions taken during the course of their work—tend to act in a politicized manner’ (TIMEP, 2019). Numerous sources have also affirmed that forced confessions extracted during torture are admissible as evidence before the court (HRW; 2013, TIMEP, 2019; VDC, 2015). Finally, article 3 of law 22/2012 ‘gives the judge Attorney discretionary power to refer to the terrorism tribunal any case under examination’, which helps to explain how cases concerning the provision of medical care or delivering humanitarian aid have been referred for trial (VDC, 2015: p. 33).

A recent report published by Physicians for Human Rights recounts stories of health workers that were arrested and subsequently tortured to extract “confessions”. According to the researchers’ findings,

Syrian security forces inflicted torture on detainees as an integral part of the interrogation process. Interviewees reported that Syrian security forces regularly beat, humiliated, and subjected them to stress positions. In some cases, they were burned, shocked with electricity, and sexually assaulted. Interviewees described an interrogation process aimed to force “confessions” to activities considered treasonous under the Syrian Counter-Terrorism Law 19 (2012), as well as to gather information on other health workers and health care activities. In many cases, interrogations centered on the interviewees’ involvement in medical work. (PHR, 2019: p. 4).

Such reports offer grisly insights into the modus operandi of the Syrian security apparatus. They also make it abundantly clear that the provision of health care was being treated as though it were a terrorist activity. In short, if the accounts are to be believed, the Syrian security forces have committed the war crime of torture against personnel protected under international customary law. Clearly there can be no legal basis for such actions and we should be left in no doubt as to the purpose for which law 19/2012 was intended: suppression of dissent at all costs. Nevertheless, it is concerning that the Syrian state apparently believes that it is acting within the bounds of the law, or at the very least, that it will not be held to account for its actions. This may in part arise from inadequate protections for health workers under international law, leaving authorities with a sense that they can legitimately pursue policies that advance state security at the expense of human security and, more specifically, health security. To

better appreciate the shortcomings of international law in this regard, let us now turn our attention to the body of treaty law which lays down protections for health workers.

We have already alluded to the fact that respect for and protection of medical personnel and facilities are central tenets of International Humanitarian Law, first established in articles 1 and 2 of the Geneva Convention of 1864. An important thing to bear in mind in respect of the civil conflict in Syria is that the 1864 Convention, the four treaties of 1949, and Additional Protocol I (AP I) of 1977 imposed medical-care obligations principally in relation to international armed conflicts (IACs) as opposed to non-international armed conflicts (NIACs). The expansion of obligations has been summarised in this way:

Under the First Geneva Convention of 1949, in an IAC no person may be convicted or ill-treated for having nursed a wounded combatant—irrespective of that combatant’s nationality and conduct. In 1977, states expanded that norm to prohibit all forms of punishment against any person who carries out medical activities compatible with medical ethics, regardless of who benefits therefrom (including, for instance, civilians in the conflict zone). The expanded norm is found, for contracting states, in Additional Protocol I (AP I), which governs IACs, and in Additional Protocol II (AP II), which governs NIACs meeting a certain threshold. (Lewis et al., 2015).

Though it has ratified the 1949 Geneva Conventions as well as AP I, Syria is not a party to AP II and therefore is not ‘obliged under IHL to refrain from punishing ethically sound medical care in NIACs’ (Lewis et al., 2015). While some may remain sceptical that the ratification of international treaties would have changed the course of the

conflict in Syria, especially in light of reported violations of treaties to which the state *is* a party such as the Convention Against Torture (CAT),<sup>2</sup> the fact that through the implementation of law 19/2012 the regime has sought to legitimise the detention and prosecution of individuals for participating in protests, providing medical assistance and documenting human rights abuses suggests that, though the regime is primarily concerned with a very self-interested notion of state security, it nonetheless perceives activities contrary to its interests through a legal paradigm, however out of kilter with international law that paradigm may be. If serious differences exist between a majority position in the international community and the position defended by Syria in respect of the validity of counter-terrorism domestic legislation and its precedence over IHL, at the very least we can admit that the alternative conceptions of security at stake—whether the focus is on human/health or state security—each intersect with legal and juridical frameworks.

Lewis et al. (2015) paint a concerning portrait in which IHL and the protections it affords to medical-care in conflict are being fragmented over time due to non-comprehensive treaties, lack of state buy-in to new treaties, and inconsistent state practice curbing the development of customary laws. Against this backdrop, ‘states are taking more aggressive approaches to preventing, intercepting, and punishing terrorism’ with the UN Security Council leading the charge by ‘requiring member states to take more and broader steps to obviate terrorist threats.’ What they find particularly concerning about these developments is that the Council has so far not mitigated the potentially corrosive effects of strident counter-terrorism action on IHL by exempting

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<sup>2</sup> In April the ‘world’s first Syria torture trial’, in which a senior member of the Syrian military is being prosecuted for war crimes, commenced in Germany (Schaer, 2020).



‘protections for medical care in armed conflict found in some key sources of IHL’ from obligations related to addressing terrorist threats. ‘To the contrary,’ they argue, ‘the Council seems to consider providing medical assistance and supplies to al-Qaeda and its associates as at least a partial ground for designating those who provide such assistance and supplies as terrorists themselves.’ When the guardian of international peace and security confers legitimacy on such a line of reasoning, it opens something of a Pandora’s box in terms of how states determine actions constituting terrorism within domestic contexts, an obvious example being Syria’s law 19/2012. Indeed the case of Syria lends support to their argument that ‘counterterrorism policies threaten to weaken the ethical foundation of IHL protections for impartial medical care.’ Arguably what matters is not so much the fact that Syria is not a party to AP II, for as we have seen it has not upheld its obligations under other international treaties in the last decade; rather, perhaps the important thing is that our attention be more highly attuned to the rippling effects of emerging paradigms within the international system. In other words, how the narrative of counter-terrorism has come to serve opposing interests and entrench hostilities between states and within them.

Let us be clear, however, that not all paradigms that have emerged in recent decades tend to make of international relations a zero-sum game. The concept of human security and the related R2P framework have very different origins to that of counter-terrorism. Responsibility to protect was not foisted upon the international community by a single state or a collection of states in pursuit of a narrow set of interests: it is the product of a collective sense of duty towards civilians—past, present and future—in the face of inhumane aggression. Thus, if counter-terrorism is indeed exacerbating ‘the fault lines in the IHL protective landscape’ (Lewis et al., 2015), it seems right to ask whether

a greater focus on a different, but not incompatible, paradigm—that of responsibility to protect—may in fact shore up the body of law so essential to the protection of human life in conflict. If R2P were to be mainstreamed into the work of the Security Council, the rippling effects, insofar as states begin to follow suit by introducing the language of R2P into legislation enacted in times of conflict and peace, may be far more salubrious than those generated by the counter-terrorism narrative. Of course counter-terrorism and R2P are by no means identical in terms of intended objectives. The point being made is that R2P posits a close interactivity between human security and state security while the counter-terrorism approach, inherently more vague in its terminology, primarily seeks to shore up state security, opening the possibility of infringing upon human rights in the process.

As battle lines were drawn and parallel health systems grew up in opposition-held areas (OHAs) (Alzoubi et al., 2019), many of those considered “opponents” of the regime—whether patients or health professionals—under the vague provisions of the Counter-Terrorism Law, lived and worked in areas beyond the reach of the regime’s security apparatus. The changing dynamics of the conflict, namely the fragmentation of the territory into areas controlled by different groups, explains the rise of heavy weaponry as the regime sought to bombard its opponents into submission. Health workers “guilty” of treating “terrorists” in opposition-held areas would be less vulnerable to arrest than to aerial bombardment. Nevertheless, there are numerous accounts of doctors in government-held areas running the risk of imprisonment, torture or death by attempting to treat patients in areas outside of government control via interfaces such as WhatsApp (SIM, 2018). In recent years, moreover, as the Syrian government has recaptured lost territory and the security apparatus has been redeployed

in those areas, medical staff who have worked in OHAs during the conflict are once again at risk of arrest under the law 19/2012. As such there is an immediate and pressing need to curb the over-reach of the Syrian authorities and protect Syrian health workers. As we have argued, that this is a problem at all may well result from a porous legal regime for the protection of health workers.

## **2.5. Conclusion**

Abuses committed by hospital staff call attention to the need to integrate a human rights perspective at the level of service delivery. Beyond the actions of those responsible for the treatment of patients, the reports make it clear that security forces committed egregious and widespread violations of international human rights law inside hospitals. We have also seen how outside hospitals medical transports were intercepted by security personnel and in a number of cases subject to attack. With the international community unable to stamp out the emerging pattern of abuses against medical staff and patients, attacking hospitals and ambulances became a favoured strategy of the regime, as we will see in the next chapter. The Syrian government sought to legitimise its actions in the name of counter-terrorism, which signals the need to resolve potential discrepancies between this area of law and IHL. Chapter two will characterise the progressive targeting and weaponisation of health care as the conflict rolled on, drawing on examples that make plain the applicability of R2P to the case of Syria.

### 3. ATTACKS ON HEALTH CARE AS R2P CRIMES

Chapter one described emerging patterns of abuses within health care environments before the uprising reached the threshold of internal armed conflict. This chapter focuses primarily on attacks that occurred from when IHL began to apply in July 2012. Separating the sections in this way serves the purpose of demonstrating that the destruction of the health system in Syria was not an inevitable result of the early human rights abuses, though such abuses represented a stark warning of things to come. Arguably the rapid erosion of health security (a concept that will be elaborated in chapter four) in Syria, and particularly in opposition-held areas, was, among many other factors, a result of failed diplomacy, slow reporting and uptake of information, and a hamstrung World Health Organization. Effective interventions would have responded quickly to the violations taking place and might have operationally prevented the escalation of attacks, or at least afforded greater protection to health actors on the ground. Before tracing the escalation of the regime's bombardment of hospitals and ambulances, which, due to the widespread and systematic nature of these attacks, seems to offer the most clear cut example of crimes against humanity in the context of health care, this section will begin with an attack that, if committed with knowledge of the target, easily meets the threshold of a war crime.

I will bring the narrative of attacks on health care to a close with a case study that has come to signify the brutality of the conflict in Syria and the serious deficit of meaningful protections for health workers and facilities under international law. The case of Aleppo and its medical staff is particularly compelling and, despite the many causes for concern, offers some seeds of optimism when we consider the determination

and resourcefulness of the individuals who managed to keep the health system functioning for years despite a massive deficit of human resources and relentless aerial bombardment. The case study thus opens up questions around the responsibility to protect: who is responsible? In respect of whom is responsibility exercised? Do individuals have a greater capacity for responsibility than institutions?

### **3.1. Bombardment of the SARC aid convoy**

One incident that seemed to epitomize the total loss of respect for humanitarian principles was the aerial attack on a UN-Syrian Arab Red Crescent (SARC) convoy in the Urem al-Kubra countryside on 19 September 2016, in which at least ten individuals died, 22 were injured, 17 trucks were damaged—some completely consumed by fire—and most of the humanitarian supplies carried by the convoy was damaged or destroyed, including vital food and medical assistance, with the UN Country Team sustaining losses of almost USD 650,000 (UNSG, 2016).

In the immediate aftermath, Peter Maurer, ICRC President, labelled the attack ‘a flagrant violation of International Humanitarian Law (IHL)’ (ICRC, 2016). UN Emergency Relief Coordinator Stephen O’Brien pointed to the fact that ‘notification of the convoy – which planned to reach some 78,000 people – had been provided to all parties to the conflict and the convoy was clearly marked as humanitarian’ (UN News, 2016).

The convoy was approved by the Ministry of Foreign Affairs and the implementation dates then approved by the same Ministry along with the Governor of Aleppo. However, it was reported that the Governor of Aleppo had twice told the UN

that its team could not accompany the convoy into opposition-held area, which the Governor and the Government of Syria both denied. Accordingly, upon reaching the last government checkpoint, the UN team returned to its offices. SARC teams then assumed responsibility for the passage of the convoy through the remaining checkpoints controlled by various armed opposition groups.

As part of the deconfliction process,<sup>3</sup> the Russian Federation and the US-led International Coalition Forces were informed in advance of ‘the date of the mission, its route, GPS coordinates, the number of trucks and a map’, while ‘regular verbal and written updates were provided on the movement of the convoy’ on the day (UNSG, 2016). The Board found no fault with the United Nations nor the SARC in respect of the normal protocols relating to the safe passage of humanitarian convoys. The Board found ‘no evidence to conclude that the incident was a deliberate attack on a humanitarian target’, although it reasoned that

aircraft operated by the International Coalition Forces, the Russian Federation and the Syrian Arab Air Force possessed the capabilities needed to carry out such an attack. Armed opposition groups did not have the capability to carry out air attacks. [It is] highly unlikely that Coalition aircraft had carried out the attack. (UNSG, 2016).

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<sup>3</sup> According to Egeland et al. (2011), deconfliction is ‘the exchange of information and planning advisories by humanitarian actors with military actors in order to prevent or resolve conflicts between the two sets objectives, remove obstacles to humanitarian action, and avoid potential hazards for humanitarian personnel. This may include the negotiation of military pauses, temporary cessation of hostilities or ceasefires, or safe corridors for aid delivery’ (p. xiv).

In light of these conclusions, SAMS' (2017) attribution of responsibility for the attack to pro-government forces, while by no means a certainty, is supported by circumstantial evidence.

As per Article 8(2)(b)(iii) of Rome Statute of the International Criminal Court, 'intentionally directing attacks against personnel, installations, material, units or vehicles involved in a humanitarian assistance or peacekeeping mission' is a serious violation of the laws and customs applicable in armed conflict and therefore a war crime (ICC, 2011: p. 5).

### **3.2. The escalation of aggression towards health facilities and personnel**

At a certain point, human rights abuses committed in health care environments was no longer simply about punishing demonstrators or those who treated them. From mid-2012 the escalation in attacks against medical facilities and transports suggests that the regime was principally concerned with destroying the capacity of the opposition to sustain itself. The rationale had changed from one of interfering with the provision of health services to assassinating doctors and nurses and destroying their places of work. This is of course a significant shift, and the purposeful destruction of the Syrian health system has no historical precedent. If R2P is to retain some currency in the international community in the coming decades, it must provide more tools for acting upon the warning signs to prevent the commission of mass atrocities.

Physicians for Human Rights (PHR) has documented attacks on health in Syria since the beginning of the uprising. According to their corroborated findings 'at least 923 medical professionals have been killed in Syria from 2011 through March 2020'

(PHR, 2020b). They assessed that Syrian government forces and their Russian allies were responsible for at least 91% of those deaths. To continue with the narrative, 2012 marked a turning point in terms of a marked escalation in the violence perpetrated against personnel and facilities. PHR found that 60% of violent deaths of health workers took place between 2012 and 2014 and were mostly caused by the shelling of health facilities. Such were the devastating effects of aerial bombardment that this was the cause of 55% of the deaths of medical personnel.

The first such attack to be reported by PHR was on al-Hourani hospital, Hama in August 2011, after tanks and troops were deployed to Hama at the end of July, with the objective of quelling mass demonstrations against the Assad regime. According to PHR (2015), ‘attacks on health care more than tripled in the second year, with government forces responsible for 97 percent of the 90 facility attacks and 99 percent of the 199 personnel deaths’ (p. 5). The report also remarks how ‘deaths as a result of shooting decreased and deaths by execution, bombing, and shelling increased’ (p. 5). Following field investigations in several governorates from August to December 2012, Human Rights Watch (2013) concluded that the Syrian Air Force deliberately targeted Dar al-Shifa hospital over a span of four months, eventually forcing the hospital to suspend its services following a missile strike on 21 November. The hospital staff refused to stop treating patients and relocated down the street where they continued to provide treatment on the basis of need, although they were subsequently attacked at this new location (PHR, 2015). HRW make the case that,

Even if opposition fighters were in or near the hospital in Aleppo city, as some information indicates, the hospital should not have been attacked without warning. Moreover, the attacks would have caused disproportionate loss of civilian life



compared to any expected military gain, a violation of the laws of war. (HRW, 2013).

According to the World Health Organization, by May 2013, 36% of all public hospitals had been totally disabled or destroyed and 78% of ambulances damaged (SAMS, 2013). PHR documented the killing of 190 medical personnel in 2012, the highest for any year of the war.<sup>4</sup> To give a sense of the massive exodus of Syrian health workers in the first few years of conflict, by 2015, 15,000 of Syria's 30,000 doctors had left the country (The Lancet, 2017). Headline figures such as these, while striking, tell us nothing about the fact that a disproportionate number of senior and specialised doctors were among those that departed, leaving younger and relatively inexperienced doctors responsible for keeping medical facilities operational.

### **3.3. Bombardment of hospitals and ambulances 2013-2015**

One example in particular illustrates the enormous impact the targeting of health facilities has on the community's access to health care. PHR documented how, on 20 June 2013, 'government forces bombed Raqqa National Hospital, located on a large, easily distinguishable compound in the city's center', injuring three medical personnel and destroying the intensive care unit. In addition to the immediate effect of causing injury to people and destruction of expensive equipment, such an attack reduces the city's capacity to cope with the resulting trauma caseload. To make matters worse, on 11 March 2014, 'government forces again bombed the hospital, destroying the governorate's only dialysis clinic, leaving its 200 patients without access to this

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<sup>4</sup> It should be noted that there were more medical personnel in Syria in 2012 than following years.

lifesaving treatment' (PHR, 2015: p. 6). This is a powerful example of how the targeting of health care in the Syrian context caused far reaching suffering. Not only were staff and patients exposed to the immediate danger of death or injury from bombardment, the systematic nature of the attacks effectively crippled the health system, reducing its capacity to treat the war-wounded and leaving people with normally manageable conditions such as diabetes susceptible to acute and life-threatening complications. The long-term effects of the targeting and weaponisation of health care is a theme that will be picked up in Chapter 4.

As the violence continued to escalate throughout 2013 and with the accumulation of failed international efforts to mediate a settlement, the regime proved itself increasingly willing to shirk its obligations under IHL and deploy internationally prohibited weapons. A John Hopkins and SAMS research team reported that,

In March 2013, a field hospital located in a suburb of Idlib—considered relatively safe because of its mountainous terrain—was attacked with cluster bombs, an internationally-banned munition type, dropped from helicopters. Two people were killed and more than 60 were injured in the vicinity of the hospital ... (Johns Hopkins & SAMS, 2015: p. 18).

By the end of 2013, the Assad regime had introduced a new weapon to its arsenal: the barrel bomb. This crude and low-cost munition has been characterised as,

an oil-drum sized container filled with explosives, bolts, hardware, scrap metal, and sometimes includes weaponized chemicals such as chlorine. They are usually dropped from helicopters. The bombs explode with enormous force and create zones of destruction larger than many other weapons. The force of the explosion can

amputate limbs and force large pieces of shrapnel into internal organs. (Johns Hopkins & SAMS, 2015: p. 15).

Much like other banned weapon types, such as cluster munitions and chemical weapons, barrel bombs violate two key principles of IHL: discrimination and proportionality. In brief, the principle of discrimination concerns legitimate targets in war, normally military vs. civilian; while the principle of proportionality concerns how much force is justifiable on military and moral grounds, for example, does the military advantage to be gained outweigh the expected loss of civilian life. Clearly barrel bombs can meet neither the discrimination nor proportionality criteria. PHR (2015) described how ‘barrel bombs obliterate anything and anyone they hit directly and inflict head to toe injuries on anyone in their large blast radius’ (p. 15). In one testimony,

Dr. E, the urologist from Dar al-Shifa Hospital who moved to a field hospital after his original hospital was destroyed, estimated that barrel bombs cause three times as many injuries on a single patient as rockets and missiles cause. These patients with multiple injuries are sometimes impossible to treat, as there is rarely enough time for multiple specialized surgeons to dedicate themselves to a single patient in need of numerous operations. (p. 15).

When barrel bombs are dropped on densely populated areas, they inflict massive casualties and devastate the urban fabric. Putting these weapons to such uses constitutes a very serious breach of IHL because of the impossibility of distinguishing between military and civilian targets. To compound matters further, the evidence suggest that barrel bombs have repeatedly been used to destroy health facilities. According to SAMS (2015), barrel bombs constituted 40% of the 70 attacks on medical facilities committed

by government forces between 15 March 2014 and 28 February 2015. In a particularly egregious incident on 18 April 2014, ‘government forces dropped a barrel bomb filled with chlorine gas near Wisam Hospital in Kafr Zita’ (SAMS, 2015: p. 7). While those inside the hospital managed to safely evacuate on that occasion, on 23 June ‘government forces again barrel bombed the hospital from helicopters, this time destroying it’, killing a newborn, a three-month-old child and a nurse (p. 7). This example suggests that, not only was an internationally-prohibited weapon being used in blatant violation of the fundamental principles of IHL, it was being used to obliterate hospitals; that is to say, facilities that have been singled out for special protections under the Geneva Conventions: protections that have been absorbed into customary international law.

A further strategy used by the regime to devastating effect is what is known as the “double tap” strike, ‘whereby government forces attack a location, wait for first responders to arrive, and attack the location again’ (SAMS, 2015: p. 7). Double tap strikes essentially target anyone who seeks to help those injured and victims very often include ambulance drivers, paramedics, and doctors who arrive on the scene. Once again, such conduct in war violates the well-established norm of protecting medical personnel and activities in conflict. On 2 October 2014, for example,

a doctor and ambulance worker responded to a barrel bomb attack in the al-Haydariya neighbourhood of Aleppo city. While the two were treating those injured in the attack, government forces barrel bombed the area again, killing them both. (SAMS, 2015: p. 7).

Launching attacks against medical personnel, activities, units and transports are clear breaches of customary international law, and constitute war crimes under the Rome Statute. The use of barrel bombs cannot be reconciled with discrimination and proportionality—principles at the heart of IHL—and again constitute war crimes under the Rome Statute. In terms of reaching the threshold of crimes against humanity, the examples before us clearly meet the physical element of being directed against any civilian population—more than that, the attacks were direct against specially protected persons and objects. As for the mental element of whether the perpetrator acts knowing that his/her action is part of the attack, barrel bombs are crude weapons dropped from helicopters. There is no question that those responsible knew what they were doing. What's more, the regularity with which the bombs targeted hospitals and were used in double tap strikes offers strong support for the analysis that the perpetrators acted with knowledge of the consequences of their actions. Finally, the contextual element, which specifies that the physical element is widespread or systematic, finds support in the data collected by human rights groups such as PHR and SAMS. The number of attacks on hospitals and medical transports perpetrated by the Syrian authorities offers compelling evidence that we are indeed speaking of crimes against humanity.

### **3.4. Case study: Aleppo**

The following case study paint a vivid portrait of life under aerial bombardment and the extraordinarily difficult conditions under which health professionals were working. The story of Aleppo centers on a small group of medical staff who went to great lengths to continue providing health services in the rebel-held east of the city. We

encounter examples of individual acts of bravery and compassion offering support for the notion of an individual responsibility to protect (Pison Hindawi, 2016; Luck & Luck, 2016). What's more, the case study illustrates the limited ability of the international community to provide assistance in the worst humanitarian situations in Syria. When reading about the Aleppo experience, a question we should keep at the back of our minds is how the international community can provide humanitarian relief and life-saving protection when faced with belligerent and hostile state authorities.

Before the outbreak of violence in Syria, Aleppo was the country's most populous city and, sitting on an ancient North-South trade route, it has long been a center of industry and trade characterised by multiculturalism. Four years of intense fighting between 2012 and 2016 reduced the once flourishing metropolis to ruins, during which time the government controlled the west of the city and various non-state armed groups controlled the east. The Syrian air force and the entry of Russia in to hostilities in 2015 proved the decisive differences in the battle for Aleppo. In July 2016 the government and allied forces encircled east Aleppo, besieging rebel fighters along with 250,000—275,000 civilians (Amnesty International, 2017). There then followed five months of intense bombardment during which civilians and civilian infrastructure, most notably hospitals, were targeted with barrel bombs, cluster munitions, bunker busters, and chemical weapons, until armed opposition groups negotiated an evacuation deal with the Russian government in December.

*2013—2014: From snipers to barrel bombs*

According to Physicians for Human Rights, ‘March to December 2013 was a period of relative calm in Aleppo’, during which time the group only documented one attack on a medical facility (PHR, 2015: p. 8). This provided a window of opportunity for the British trauma surgeon, Dr. David Nott, to travel to east Aleppo where he worked alongside and trained local doctors.<sup>5</sup> He was based in the M1 hospital near to the frontline, and describes how ‘the majority of injuries we saw were gunshot wounds sustained while traversing from one side of the city to the other’ and that victims ranged ‘from babies to pensioners’ (p. 206). Simply crossing over to the east in search of food apparently made you a legitimate target in the sights of both government and rebel snipers.

The field hospitals in east Aleppo had been given their randomly-assigned codenames by the Aleppo City Medical Council (ACMC), which was established by a man known as Dr. Abdulaziz.<sup>6</sup> Measures to protect against attacks did not stop there as ‘ambulances and other medical vehicles carried no sirens, insignia or logos, and at night drove with their headlights off’ (p. 202). Although the patients being treated in East Aleppo at the time were largely civilians with gunshot wounds sustained making the crossing at Karaj al-Hajez, the Syrian Air Force seemed to subscribe to the rationale that those with injuries were opponents of the regime; in treating them, health workers were

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<sup>5</sup> Dr Nott made these trips with Syria Relief, a UK charity established by British physicians of Syrian descent. The charity was able to gain access thanks to connections with UOSSM, an NGO established by Syrians, which was supporting the Aleppo City Medical Council’s network of clinics with equipment, medicines, and expertise. This explains how Dr. Nott was able to gain access to a city largely out-of-bounds to Westerners in light of the very fragile security situation.

<sup>6</sup> Dr. Abdulaziz had previously used the moniker Dr. White and, along with a colleague, established a network of secret hospitals to treat those injured by the uncontrolled violence. When the colleague and three other members of the group were abducted and murdered by the security forces, the name Dr. White was dropped and the group disbanded. Nott writes ‘a more co-ordinated response was urgently needed and so Dr Abdulaziz set up the Aleppo City Medical Council (ACMC)’ (Nott, 2019: p. 202).

facilitating terrorism under the 2012 law and therefore legitimate targets of aerial bombardment.

The situation in Aleppo took a turn for the worse in December 2013, when government forces began ‘showering Aleppo daily with barrel bombs’ (PHR, 2015: p.5). Hospitals were regularly the target of these attacks out and it is estimated that, between April and July 2014, the regime carried out at least 13 attacks on seven separate medical facilities in eastern Aleppo, of which 12 were barrel bomb attacks (PHR, 2015: p. 9). In the space of only 11 days, M10, one of the main trauma hospitals in east Aleppo, was attacked with barrel bombs four times.

On his second visit to the city, Dr. Nott observed the difference in the cases they were seeing: whereas in 2013 the team had operated mostly on gunshot wounds and with high success rates, now they were dealing with the effects of barrel bombs. Many patients that were brought in ‘had either died from the effects of the shockwave or had suffocated from inhaling pulverized concrete’ (Nott, 2019: p. 281). Indeed, he comments that ‘about 80 per cent of those who came in after a barrel-bomb attack died’ (p. 292). Those more amenable to treatment ‘had fragmentation injuries from the bombs or from red-hot flying debris’ and the nature of these injuries was often catastrophic (p. 281). On an almost daily basis they were presented with entire families suffering the effects of these attacks and he comments that most of the children they saw were under ten.



2014—2015

By August 2014, the rate of barrel bomb attacks dropped to a few each day and remained at this level until March 2015, causing many residents who had previously fled to return (PHR, 2015). However, things soon took a turn for the worse as the Syrian government upped the intensity of its bombing campaign, with PHR documenting 13 aerial attacks on 10 medical facilities, of which 11 were barrel bomb attacks, from April through July 2015. By August 2015, there were only 10 functioning hospitals in eastern Aleppo, down from a total of 33 prior to the outbreak of hostilities. Needless to say, these 10 hospitals were functioning at much reduced capacity having sustained structural damage, destruction of equipment, and, most importantly, a loss of personnel.<sup>7</sup>

Then came a major turning point in the war: in October 2015, Russia entered the fray in support of the Syrian government. SAMS (2017) documented that, from January through September 2015, there was one attack on health care every four days. ‘Following the Russian intervention in October 2015, that rate doubled to one attack every 48 hours’ (SAMS, 2017: p. 4). Russian firepower was focused on those areas putting up the strongest resistance and 2016 would prove to be a particularly devastating year for civilians and civilian infrastructure, nowhere more so than east Aleppo.

#### *2016: The Siege of eastern Aleppo*

On 7<sup>th</sup> July 2016, the Syrian government, supported by Russia and Iran, encircled eastern Aleppo after seizing control of Castello Road, which served as the

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<sup>7</sup> An estimated 5% of the pre-war number of physicians in eastern Aleppo remained in the summer of 2015, approximately one doctor for every 7,000 residents compared to one doctor for every 800 residents in 2010 (PHR, 2015).

city's main access route for humanitarian assistance. OCHA estimated that 250,000 to 275,000 civilians were besieged. Not only were they deprived access to basic life-sustaining goods, they also had to endure a campaign of aerial bombardment of mounting intensity.

Under siege conditions civilians faced severe shortages of water, electricity and fuel. Hospitals relied on local generators: a precarious source of power. One paramedic told Amnesty International that a lack of spare parts and fuel limited their ability to respond to attacks, 'as a result, our capacity diminished by 50% in the first two months of the siege' (Amnesty International, 2017: p. 37). Another recalled how,

During the last two months of the siege, we couldn't transfer the injured or ill people to the hospital because we barely had fuel to operate the ambulances.

That was a disaster especially that people needed us the most during that period when air and ground attacks insanely increased. (p. 37).

A cessation of hostilities agreement entered into force on 9 September, bringing a short period of calm but no humanitarian relief as the Syrian government failed to issue permits to UN humanitarian agencies, while armed opposition groups were also responsible for delaying aid deliveries, leaving 'convoys with lifesaving aid [standing] idle on the Syria-Turkish border' (al-Shalchi, 2016). The ceasefire collapsed a little more than a week later on 19 September, marking the beginning of a 'prolonged and intense Syrian and Russian aerial campaign over eastern Aleppo' (COI, 2017: p. 5). Besieged residents reported that living conditions deteriorated drastically from October onwards, when food and medical aid that had been stockpiled by humanitarian organisations prior to the siege began to run short and was further depleted by Syrian

government and Russian forces' attacks on warehouses where the aid was stored (Amnesty International, 2017).

SAMS characterised the bombardment of besieged east Aleppo City following the collapse of the nationwide ceasefire 'as the most violent ... ever documented since the start of the Syrian conflict. Cluster munitions, incendiary weapons, artillery fire, sniper fire, barrel bombs, naval mines, and bunker buster bombs were all documented in the attacks on hospitals during the siege' (SAMS, 2017: p. 5). In a series of incidents that epitomizes the violence of the period, the Commission of Inquiry found that M10, serving as the east's largest trauma hospital, had been subject to four rounds of air strikes between late September and mid-October. During this time, the hospital was bombarded with all kinds of weapons including barrel bombs, cluster munitions, bunker busters, and explosives containing chemical payloads. As a result, patients and maintenance workers lost their lives; the intensive care unit was damaged; generators, fuel storage and water tanks were destroyed; an ambulance was destroyed; medical staff sustained severe burns; the maternity ward was destroyed, until the hospital was finally put out of service. The appalling conditions in eastern Aleppo meant that 'by mid-October, a lack of resources and medical supplies forced doctors to amputate limbs, which might have otherwise been saved' (COI, 2017: p. 8). Multiple attacks on al-Hakim paediatric hospital suggest that children's health was also being targeted. An air strike on 23 July killed four newborns in incubators, while further strikes on 30 September, 16 November and 18 November resulted in further loss of life, severe damage to the building, and finally forced the hospital to cease operating (COI, 2017: pp. 9-10). Remarkably, despite reports of the atrocious conditions, several doctors who had been working in east Aleppo City before the siege 'expressed their willingness to

go back to the conflict-ravaged northern Syrian city to try to save the lives of the many people being wounded daily if a safe passage is put in place,' further evidence of the willingness of Syrian health professionals to put themselves in harm's way for the sake of their countrymen (MSF, 2016).

In November, the Secretary-General's Special Envoy for Syria, Staffan de Mistura, attempted to broker a ceasefire to facilitate humanitarian access to the besieged population. The Syrian government rejected his proposal, which sought to keep local administrations in eastern Aleppo intact, effectively collapsing the negotiations (COI, 2017). Attacks on health facilities continued at a high intensity, and by the last week of November all hospitals in the besieged part of the city had been rendered out of service (Amnesty International, 2017).

Finally armed opposition groups and Russian officers managed to broker an agreement to evacuate the remaining residents of the city:

In December 2016, parties to the conflict reached a deal which ended the hostilities in eastern Aleppo city and allowed the evacuation of members of armed opposition groups, their families and other civilian residents. According to the UN, over 37,500 people were evacuated from eastern Aleppo to opposition-held areas of Aleppo governorate between 16 and 22 December 2016. (Amnesty International, 2017: pp. 43-44).

It is difficult to imagine the experience of civilians of health workers in east Aleppo City during the 2016 siege. By early December health professionals were working in atrocious conditions. In a personal correspondence on 4 December, one Syrian doctor confided, 'I don't know if I will live or die, be arrested or go from this hell ... I don't

think I can escape without [being captured] ... Because as a doctor the regime look for me as a terrorist' (Nott, 2019: p. 333). The next day another doctor described 'shelling all the time, we managed just a little of casualties. No blood units. No fresh plasma. No oxygen generator. It's a horrible situation. We need safe corridor to evacuate civilians. Please help us' (p. 334). Another doctor painted a hellish image: 'as always planes in sky ... Bombs everywhere ... Emergency room full ... So horrible when victims dead on roads and there is no one [to remove them] leaving dead bodies for cats and dogs' (p. 334).

### **3.5. Conclusion**

This chapter has focused mainly on the aerial bombardment of hospitals and ambulances, arguing that the use of heavy weaponry against medical personnel, units and transports from 2012 onwards was part of the regime's strategy to demoralise and defeat its enemies, having failed to crush the uprising in its early stages. The emerging patterns of human rights abuses in health care environments from early-2011 to mid-2012, before the situation in Syria reached the threshold of internal armed conflict, demonstrated the regime's disregard for international human rights law and should have put the international community on guard that similar strategies would be employed in a state of war. Indeed, as IHL began to apply and the violence escalated, human rights abuses turned into war crimes. The bombardment of the SARC aid convoy is a striking example of the aggravated nature of some of these crimes. What's more, the widespread and systematic nature of attacks against civilians and protected personnel, activities and

objects, reached, in my view, the threshold of crimes against humanity by 2015, if not earlier.

The intolerable level of risk faced by Syrian medical professionals, especially those in rebel-controlled areas, meant that many fled the country once they saw which way the wind was blowing. As a result, not only was the country's health infrastructure being pummeled by the effects of war, the exodus of health professionals meant an acute deficit of expertise and manpower at a time when hospitals were being inundated with highly complex cases. The targeting of medical activities in opposition areas also acted as a deterrent against health care seeking behaviour (Armstrong, 2016). As we will go on to discuss Chapter 4, reduced health system capacity and limited access to essential health care services have contributed to a sharp decline in life expectancy at birth (SCPR, 2016). The reason for invoking the long-term effects of the human rights abuses and war crimes under discussion is to highlight that the R2P doctrine intersects with a real world ecology of health in which there are manifold connections between individuals, the community, and the environment.

The examples used to demonstrate emerging patterns of abuses and their escalation suggest numerous challenges in operationalising the R2P doctrine. The principle of operational prevention presupposes timely early warning. Early warning can be decomposed into two elements: a reliable source of information and an authority-to-be-warned. In respect of the targeting and weaponisation of health care in Syria, there were limited sources of information in those first, critical phases of the uprising as human rights abuses were mounting. Nor is it obvious where the mandate lay for handling and acting upon any warnings were they to materialise. Without an effective early warning mechanism there can be no operational prevention. Being unable to

prevent attacks, the nature of the international community's responsibility to protect underwent a change as the regime began openly vilifying health professionals as terrorists and attacking their locations.

Having missed the opportunity to operationally prevent the regime's systematic destruction of the health system, the international community was left deciding how best to offer lifesaving protection to civilians in opposition-held areas. I argue that the scope for operational prevention had significantly contracted by June 2012, when the bombardment of hospitals rapidly escalated,<sup>8</sup> and gave way to the imperative of providing humanitarian aid to civilians and offering some form of protection, either in the form of capacity strengthening or material support, to health service providers in areas where the government was beginning to lose control.<sup>9</sup> In other words, failing to prevent the commission of mass atrocities in no way exonerates the international community from its responsibility to protect; that responsibility rather evolves in line with the needs of populations of concern. This premise is the departure point for Chapter 5, which looks at the cross-border mechanism for humanitarian aid and how this affected the relationship between local and international humanitarian actors.

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<sup>8</sup> It is worth noting that no Security Council resolution was drafted to address the rapid escalation.

<sup>9</sup> The World Summit Outcome document specifies that 'the international community, through the United Nations, also has the responsibility to use appropriate diplomatic, *humanitarian* [emphasis added] and other peaceful means, in accordance with Chapters VI and VIII of the Charter, to help to protect populations from genocide, war crimes, ethnic cleansing and crimes against humanity' (UNGA, 2005: para. 139).

## 4. THE RESPONSIBILITY OF THE UN TO PROTECT HEALTH CARE PROVIDERS AND PATIENTS IN SYRIA

### 4.1. The General Assembly

#### 4.1.1. *Proper role of the General Assembly*

The 2005 World Summit Outcome document offers a signpost for thinking about the proper role of the General Assembly in advancing the R2P doctrine: ‘we stress the need for the General Assembly to continue consideration of the responsibility to protect populations from genocide, war crimes, ethnic cleansing and crimes against humanity and its implications, bearing in mind the principles of the Charter and international law’ (UNGA, 2005: para. 139). The document does not clarify the format in which the Assembly should consider R2P, nor its role in the implementation of the doctrine. Unsurprisingly, then, at the first General Assembly dialogue in 2009, one of the sticking points of the discussion was the question of the respective responsibilities of the General Assembly and the Security Council under R2P. It was reported that ‘most member states agreed that the General Assembly was the venue for dialogue on R2P. However, members disagreed about whether or not the General Assembly should guide the Security Council on when to act under Chapter VII’ (GCR2P, 2009: p. 2). Egypt was particularly vocal on this issue, insisting that the General Assembly should retain principal authority over the actual implementation of R2P. What’s more, speaking on behalf of the Non-Aligned Movement, it argued that ‘in such instances where the Security Council has not fulfilled its primary responsibility for the maintenance of international peace and security, the General Assembly should take appropriate measures in accordance with the Charter to address the issue’ (p. 8).



Egypt's mention of the Security Council's primary responsibility and the General Assembly's subsidiary responsibility for the maintenance of international peace and security is an allusion to the 1950 General Assembly resolution 'Uniting for peace', which

Resolves that if the Security Council, because of lack of unanimity of the permanent members, fails to exercise its primary responsibility for the maintenance of international peace and security in any case where there appears to be a threat to the peace, breach of the peace, or act of aggression, the General Assembly shall consider the matter immediately with a view to making appropriate recommendation to Members for collective measures, including in the case of a breach of the peace or act of aggression the use of armed force when necessary, to maintain or restore international peace and security. (UNGA, 1950: para. 1)

Thus, if R2P is understood to concern international peace and security, established protocol would appear to support Egypt's understanding of the respective roles of the two UN organs. However, the gravity of these crimes relates to their injurious effect on individuals and groups and, consequently, do not necessarily invoke those powers associated with the maintenance of international peace and security. This may help to explain why not all states agree with Egypt's interpretation: if the four most serious crimes with which R2P is concerned do not, in every scenario, amount to a threat to international peace and security, the Uniting for peace resolution's formulation of the respective roles of the Council and the Assembly is not unambiguously applicable. Indeed, it is by now well-established that the primary responsibility to protect populations from mass atrocities lies with the state; the international community has a subsidiary responsibility to protect, principally through the Security Council, only

when the state fails to do so. All of this is to say that the R2P mandate, so to speak, works on a different basis than the mandate set out in the Uniting for peace resolution.

Nevertheless, in the absence of a clear articulation of the respective roles of the Assembly and the Council in the World Summit Outcome document, the Uniting for peace resolution does offer a useful guide for understanding the complementary nature of the work of the two organs. Of particular relevance to the case of Syria is the recognition that the failure of the Security Council to discharge its responsibilities ‘calls for possibilities of observation which would ascertain the facts and expose the aggressors’. The UNGA did indeed manage to discharge this responsibility when it established the International, Impartial and Independent Mechanism for Syria (IIIM), which will be discussed in greater detail below.

There were several other developments before IIIM was established in 2017. In 2012, for example, a large majority of states voted in favour of UNGA Resolution A/RES/66/253 B which addressed the Syrian government’s failure to protect its population and deplored the Security Council’s failure to take appropriate action. In health security terms, the resolution hardly represents a breakthrough. The only mention of war crimes directed towards the health system come in a long list of gross violations of human rights, including ‘the use of force against civilians, massacres, arbitrary executions, the killing and persecution of protestors, human rights defenders and journalists, arbitrary detention, enforced disappearances, *interference with access to medical treatment* [emphasis added], torture, sexual violence, and ill-treatment, including against children’ (UNGA, 2012: p. 3).

Of course each of these abuses warrants serious scrutiny within the framework of international law and justice. Nevertheless, it is interesting that some abuses receive a more focused response than others, notably the demand that ‘the Syrian authorities strictly observe their obligations under international law with respect to chemical and biological weapons, including Security Council resolution 1540 (2004) of 28 April 2004 and the Protocol for the Prohibition of the Use in War of Asphyxiating, Poisonous or Other Gases, and of Bacteriological Methods of Warfare’ (p. 4). This serves as a reminder of the relatively detailed framework of prohibitions against biological and chemical weapons that exists as “hard law”. In contrast, and as discussed in the first chapter, IHL and the protections it affords to medical-care in conflict are being fragmented over time due to non-comprehensive treaties, lack of state buy-in to new treaties, and inconsistent state practice curbing the development of customary laws (Lewis et al., 2015). If there is a majority in the General Assembly that maintains the absolute inadmissibility of these crimes, as Resolution A/RES/66/253 B would suggest, perhaps it might put itself to the purpose of commissioning advisory opinions on the development of protocols to protect health workers in conflict.

Another interesting development relates to the format in which the Assembly should consider R2P and the move to formalize R2P onto the agenda of the General Assembly, which was first mentioned by representatives of civil society at the 2014 dialogue. At the 2017 dialogue there was widespread support for Australia and Ghana’s initiative to request that R2P be included on the formal agenda of the 72<sup>nd</sup> Session of the General Assembly. Following this dialogue, and three years after the proposal was first made, the General Assembly adopted ‘the work programme and agenda for its seventy-second session today, deciding for the first time in 12 years to include the item “The

Responsibility to Protect and the prevention of genocide, war crimes, ethnic cleansing and crimes against humanity” (UN News, 2017). What these developments illustrate is the broad based and apparently expanding commitment to R2P on the one hand, and the slow rate of institutional change on the other. Formalizing R2P onto the agenda of the UNGA, while certainly a positive development for advocates of the doctrine, had little material benefit for victims of ongoing atrocity crimes in various parts of the world. If it took three years for such an incremental change to happen, it is worth asking whether the Assembly, as a decision making body, is flexible enough to respond to the fast moving and fluid scenarios that give rise to atrocity crimes.

Egypt’s inconsistent *opinio juris* in respect of the proper role of the UNGA when faced with R2P situations may serve as a reminder of the important role ideology continues to play in advancing, or delaying, the R2P agenda. Whereas in 2009 Egypt held that the Assembly should retain principal authority over the implementation of R2P, in 2017 it cast one of the 21 votes against adopting the work programme and agenda for the GA’s 72<sup>nd</sup> session, which included the item on R2P, arguing that ‘the responsibility to protect notion included many political and legal gaps, which if left unattended could do more harm than good’ (UN News, 2017). Egypt did not make clear how in its view the Assembly could hope to exercise principal authority over the implementation of R2P without being allowed to discuss it as part of a formal agenda. It is perhaps relevant to mention that the Early Warning Project has recently assessed that Egypt is at high risk for onset of mass killing (EWP, n.d.).

#### **4.1.2. The IIIM**

Despite the limiting factors of irregular meetings and the difficulties involved in coordinating action within such a large body, in 2017 the Assembly committed to exercising its responsibility to protect. Resolution 71/248 established the *International, Impartial and Independent Mechanism to Assist in the Investigation and Prosecution of Persons Responsible for the Most Serious Crimes under International Law Committed in the Syrian Arab Republic since March 2011* (IIIM), which was designed to complement the work of the Human Rights Council-mandated Commission of Inquiry, established in August 2011.<sup>10</sup> In paragraph four of the operative part of the resolution, the General Assembly established the IIIM and detailed its mandate:

to collect, consolidate, preserve and analyse evidence of violations of international humanitarian law and human rights violations and abuses and to prepare files in order to facilitate and expedite fair and independent criminal proceedings, in accordance with international law standards, in national, regional or international courts or tribunals that have or may in the future have jurisdiction over these crimes, in accordance with international law (UNGA, 2016: para. 4).

The establishment of the IIIM is best understood against the backdrop of unsuccessful attempts to refer the situation in the Syrian Arab Republic to the Prosecutor of the

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<sup>10</sup> According the IIIM's terms of reference, 'The mandates of the Mechanism and the Commission [of Inquiry] are ... complementary in that the latter must publicly report on its findings on violations, focusing on recent incidents, broad patterns of violations and abuses and recommendations, notably to Member States, while the former focuses on collecting, consolidating, preserving and analysing documentation and evidence and preparing files concerning individual suspects for future action by national, regional or international courts or tribunals' (IIIM, n.d.: para. 30).

International Criminal Court (ICC).<sup>11</sup> The jurisdiction of the court is to prosecute individuals responsible for the most serious crimes under international law, namely genocide, war crimes and crimes against humanity; that is, the crimes with which R2P is concerned. Of the P5, France and the UK are States Parties to the Rome Statute; Russia and the US are signatories that have not yet ratified the Statute; while China is a non-signatory. The Rome Statute was a milestone in the history of international criminal law because of the role played by the Coalition for the ICC in building consensus for the court and drafting the Rome Statute. This represented a break with the past insofar as the process was led by actors outside the small coterie of powers that established the International Military Tribunal (1945 – 1946), the International Criminal Tribunal for the former Yugoslavia (1993 – 2017) and the International Criminal Tribunal for Rwanda (1994 – 2015). In some sense, it might be argued that the establishment of the IIMM, along with the Independent Investigative Mechanism for Myanmar (IIMM), are further examples of the international community beyond the permanent members of the Security Council assuming its responsibility to protect populations from atrocity crimes.

#### ***4.1.3. Conclusion***

Over a decade of informal and, more recently, formal dialogues on R2P have not entirely resolved the ambiguity pertaining to the respective roles of the General Assembly and the Security Council. In respect of Syria, the IIMM, though an important precedent in terms of the international community's assumption of its pillar three

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<sup>11</sup> Draft resolution S/2014/348 sought to refer the situation in Syria to the Prosecutor of the ICC. Russia and China vetoed the resolution. Russia alluded to the situation in Libya in defending its decision: 'one cannot ignore the fact that the last time the Security Council referred a case to the International Criminal Court (ICC) – the Libyan dossier, through resolution 1970 (2011) – it did not help resolve the crisis, but instead added fuel to the flames of conflict' (UNSC, 2014a: p. 13).

responsibility, can hardly be described as an example of the Assembly rapidly and effectively discharging its responsibility to protect. By the time the IIIM was established, atrocity crimes were the new normal in the Syrian Arab Republic. It is true that the Mechanism does signal a new departure for the Assembly and helps illuminate what is meant by the ‘possibilities of observation which would ascertain the facts and expose aggressors’ referred to in the Uniting for peace resolution. It is also true that by 2017 the situation in Syria demanded a robust response, which the Security Council was manifestly unable to provide, and that the Assembly simply had to act.

The slow process of placing the R2P on the formal agenda of the Assembly testifies to a certain institutional rigidity attributable to its size and the competing and complex agendas of its many member states. Taking these factors into account may also help to explain why UNGA resolutions tend to be rather vague. These considerations would suggest that the Assembly simply does not have the capacity for the kind of reflexive decision-making called for in unfolding R2P situations, which tend to be highly volatile and fast-moving.

## **4.2. The Security Council**

### ***4.2.1. Resolutions on Syria***

It was over a year from when the peaceful protests broke out in March 2011 before the Security Council passed its first resolution on Syria on 14 April 2012, which authorised the deployment of 30 military observers to Syria. By that point there had been several attacks on hospitals by government forces, including the takeover of Daraa National Hospital by government forces in March 2011; missiles launched at al Hourani

Hospital in Hama in August 2011 destroying an intensive care unit and a large amount of medical equipment (BBC, 2011); and from February to March 2012 the shelling of several field hospitals providing emergency first aid in Homs with one operating room entirely destroyed (PHR, 2020a). In spite of these developments, Resolution 2042 makes no mention of attacks on health care; instead, the Council limits itself to a general condemnation of the widespread violations of human rights by the Syrian authorities.

It is interesting to contrast the UNSC's silence in the face of mounting attacks on health care to its expeditious response to reports of attacks using chemical weapons in Resolution 2118 of September 2013. What makes this resolution exceptional is the Council's decision to impose measures under Chapter VII of the UN Charter in the event of non-compliance with the resolution (UNSC, 2013), meaning the Council considered that the repeated use of such weapons would constitute a threat to international peace and security. For Hoeling (2015), this implied a development within the UNSC: 'previously a divided, insecure council, it became a strong political body that would not ask but demand compliance with its resolutions' (pp. 34-35). The heightened responsiveness of the Council to the use of chemical weapons is reminiscent of UNGA Resolution A/RES/66/253 B, which demanded that 'the Syrian authorities strictly observe their obligations under international law with respect to chemical and biological weapons', and set out the relevant instruments of international law (UNGA, 2012: p. 4). As we have already discussed, while the UNGA resolution condemned 'interference with access to medical treatment' (p. 3), it did not demand that the Syrian authorities strictly observe their relevant obligations under customary international law. Security Council Resolution 2118 seems to offer further support to the reading that the



international community is prepared to take action when certain thresholds are crossed, the use of chemical weapons being one of them. Why attacks on health care do not provoke a similar reaction is difficult to understand. One reason may be that such attacks are not so readily associated with a threat to international peace and security—and the UNSC’s Chapter VII powers—as are chemical weapons attacks. This is a mistaken view. Global health security is predicated on disaggregated health securities. The systematic destruction of a health system creates a weak link in the chain of global health security, and in the event of a public health emergency of international concern, such as a pandemic, the global system is only as strong as its weakest member.

With the passage of Resolution 2139 in February 2014, the UNSC finally recognised for the first time that attacks on hospitals may amount to war crimes and crimes against humanity. The Council also demanded that

all parties respect the principle of medical neutrality and facilitate free passage to all areas for medical personnel, equipment, transport and supplies, including surgical items, and recalls that under international humanitarian law, the wounded and sick must receive, to the fullest extent practicable, and with the least possible delay, medical care and attention required by their condition and that medical and humanitarian personnel, facilities and transport must be respected and protected, and expresses grave concern in this regard at the removal of medical supplies from humanitarian shipments (UNSC, 2014b: para. 8).

However, the Council did not decide to impose measures under Chapter VII of the UN Charter in the event of non-compliance with Resolution 2139, as it had done with

Resolution 2118, again suggesting that the nature of these crimes did not meet the threshold for such decisive action. Nevertheless, it is clear that concerns around the weaponisation and targeting of health care were filtering through to the Security Council. This is most apparent in Resolution 2286, which deals primarily with the protections international law has to offer medical and humanitarian personnel in conflict. While the resolution does not concern Syria specifically, it is nonetheless relevant to our discussion in several respects.

First of all, whereas resolutions on Syria have failed to characterise the targeting of health care as a risk to the maintenance of international peace and security, Resolution 2286 does precisely that by citing the Council's conviction that 'violence, attacks and threats against medical personnel ... as well as hospitals ... may exacerbate ongoing armed conflicts and undermine the efforts of the Security Council to maintain international peace and security' (UNSC, 2016a: p. 2). Furthermore, the resolution is unequivocal that such attacks are war crimes, which confirms conclusions made in chapter one relating to the nature of the atrocities in question. Not only this, the resolution 'demands that all parties to armed conflict fully comply with their obligations under international law' and proceeds to detail the relevant legal instruments (p. 3), a demand which, once again, has been absent from resolutions on Syria.

The resolution also gestures towards the complementarity of R2P and health security by connecting the primary responsibility of States to protect the population with the obligation of all parties to armed conflict to protect medical personnel. Of particular interest to this study is the fact that the Council 'deplores the long-term consequences of such attacks for the civilian population and the health-care system of the countries concerned' (p. 3). This implies that the Council recognises the impact of

this category of war crimes on health security. This is crucial as it is only through appreciating the indirect effects of such atrocities over the long-run that the gravity of the crimes in question can be properly assessed and the imperative of preventing their recurrence in other contexts is made fully apparent.

Despite addressing many of the lacunas identified in the other resolutions discussed, Resolution 2286 cannot be considered an example of the international community exercising its pillar three responsibility in respect of Syria for the simple reasons that the resolution, being akin to a statement of general principles, makes no mention of Syria, nor does it address the issue of non-compliance. Indeed, a report published by SAMS in January 2017 found that in the period of observation since the passing of resolution 2286, the rate of attacks on hospitals and health workers in Syria increased by 89 percent (SAMS, 2017). If the resolution failed to change the course of events in Syria, its contribution to the protection of health care in conflict may be that, firstly, it established the connection between established customary international law protecting health care and the R2P paradigm and, secondly, it articulates specific responsibilities and arrangements for preventing the commission of such crimes in the future.

#### ***4.2.2. The Russian veto***

On 20 December 2019 Russia vetoed a draft resolution on Syria for the 14<sup>th</sup> time. The frequency with which Russia has used its veto power to block resolutions on Syria has led some to portray Assad's most important ally as the only obstacle preventing the Council from exercising its collective responsibility to maintain international peace and security. Following Russia's veto of a 2016 draft resolution

tabled by France and Spain that called for an end to all military flights over Aleppo, Matthew Rycroft of the UK said,

I normally begin my statements in the Council with the words “Thank you, Mr. President”. I cannot do that today, because today we have seen the fifth veto of a vote on Syria in five years from you, Mr. President — a veto that has once again stopped the Council from creating the unity needed to give the people of Syria any hope of respite from their suffering; a veto that has once again denigrated the credibility of the Security Council and respect for it in the eyes of the world; a veto that is a cynical abuse of the privileges and responsibilities of permanent membership. (UNSC, 2016b: p. 6).

It is true that Russia has consistently blocked resolutions calling for sanctions on the Assad regime, investigations into allegations of chemical weapons attacks, and cease fire agreements. Indeed, Russia has vetoed a total of six draft resolutions calling for measures in response to chemical weapons attacks alone, which makes a mockery of the optimism generated by the unanimous decision to adopt Resolution 2118 requiring the verification and destruction of Syria’s chemical weapons stockpiles. Its mutable position in respect of chemical weapons is symptomatic of the fact that, as the conflict progressed, Russia became increasingly aligned with the Syrian regime at the expense of UNSC unity.

It is nevertheless the case that the Joint Investigative Mechanism (JIM) to determine responsibility for the use of chemical weapons in Syria was established with a relatively detailed mandate, reflecting the international community’s experience of

such investigations.<sup>12</sup> When Russia blocked the renewal of the mechanism in 2017, there were several attempts to redraft the resolution, and the US even proposed an alternative mechanism, the United Nations Independent Mechanism of Investigation (UNIM). Though all of these efforts were in vain, they attest to the fact that Council members were invested in the issue. The same cannot be said of the Council in respect of the targeting and weaponisation of health care in Syria. Not only did the UNSC not pass a resolution condemning the intentional destruction of the health system and formulating an appropriate response, there is no evidence that a member state took it upon themselves even to draft such a resolution. Thus the argument that Russia was somehow at fault for the failure of the international community to protect health workers and facilities in Syria does not hold water: there was nothing for the Russians to veto in the first place.

And yet it cannot be said that the Member States were simply naïve as to the situation on the ground, nor that they failed to appreciate the protected status of health workers and facilities and the fact that the bombing of hospitals in Syria amounted to war crimes and likely crimes against humanity. Resolution 2286 is plainly a product of the situation in Syria, even if no explicit mention is made of that conflict. The resolution sets out the relevant law and establishes that violations of the kind that have taken place in Syria amount to war crimes. It makes the connection between the targeting of health care and the maintenance of international peace and security, invoking powers proper to the Security Council. The question is, why did the Security Council resolution that comes closest to approximating the issues at stake fail to mention Syria even once?

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<sup>12</sup> The JIM was a collaboration between the Organisation for the Prohibition of Chemical Weapons (OPCW) and the United Nations. The fact that an organisation with the relevant expertise already exists is itself evidence of the relatively advanced state of implementation of this area of international law.

Alternatively, why was there no subsequent resolution applying the content of Resolution 2286 to the situation in Syria? One might argue that some members decided against it as it would be unlikely to win the support of Russia. Yet sustained efforts were made to investigate chemical weapons attacks in the face of Russian intransigence. Why were similar efforts not made to investigate attacks against health facilities?

#### **4.2.3. Conclusion**

Attacks against health facilities and workers were a feature of the violence from very early in the conflict—before any allegations of chemical weapons attacks—and yet have never been meaningfully addressed by the Security Council; they have only been mentioned in passing as part of resolutions deploring the situation in general/calling for a cessation of hostilities. The only Security Council resolution that does give a fuller treatment of this category of crimes fails to even mention Syria—making it irrelevant as far as parties to the Syrian conflict are concerned.

While resolution 2286 had no positive effect on the situation in Syria, it may only be possible to assess its contribution to the consolidation of protections for health workers and facilities some years from now. Perhaps in the same way that Resolution 1373, passed shortly after the 9/11 attacks, is often emphasised as marking a seminal moment in the counter-terrorism paradigm, and Resolution 1540 represents an important contribution to the international regulation of nuclear, chemical and biological weapons, Resolution 2286 will mark a departure point in the international community's commitment to maintaining global health security.

### **4.3. The Human Rights Council**

On 3 April 2006 the Human Rights Council was established by UNGA Resolution 60/251 to replace and redress the shortcomings of its predecessor the Commission on Human Rights. In the broadest terms, the Council was mandated to promote ‘universal respect for the protection of all human rights and fundamental freedoms for all, without distinction of any kind and in a fair and equal manner’ (UNGA, 2006: para. 2). This involves addressing violations of human rights, ‘including gross and systematic violations’, and promoting ‘the effective coordination and the mainstreaming of human rights within the United Nations system’ (para. 3). This suggests that the mandate of the Council comprises both a monitoring function in respect of potential and actual human rights abusers and a coordination function in respect of the UN system-as-defender of human rights.

Over the years, states participating in the UNGA’s dialogue on R2P have repeatedly referred to the Human Rights Council as a potential flag-bearer for the R2P agenda. Two elements of the Council’s work have garnered most attention: the Universal Periodic Review (UPR) and investigative mechanisms such as the Commission of Inquiry into Syria (COI). We will begin with the Commission of Inquiry, which represented an important development in the international community’s exercise of its responsibility to protect in Syria and held out hope that the Human Rights Council would take action commensurate with its powers.

#### ***4.3.1. The Commission of Inquiry***

Being a subsidiary organ of the General Assembly, decision making in the Human Rights Council (HRC) is facilitated by a relatively small membership of 47

Member States drawn from the Assembly's 193 members. The HRC was much more responsive to the unfolding crisis in Syria than the Security Council, mainly thanks to the rule determining that decisions can be taken by a simple majority of voting members.<sup>13</sup> Therefore, unlike the Security Council, no single member has the power to veto draft resolutions.

Thus the Council was able to pass resolutions mandating fact-finding missions throughout 2011 to ascertain what was taking place inside Syria as concerns grew that Assad's regime would stop at nothing to suppress the uprising. The most significant development in this regard was Resolution S-17/1 establishing an independent international commission of inquiry to investigate all alleged violations of international human rights law since March 2011 in the Syrian Arab Republic (the Commission of Inquiry). Resolution S-17/1 was the product of the Council's seventeenth special session, during which members considered the report of the fact-finding mission submitted by the Office of the United Nations High Commissioner for Human Rights (OHCHR) pursuant to Resolution S-16/1. Significantly, the first fact-finding mission 'found a pattern of widespread or systematic human rights violations by Syrian security and military forces, including murder, enforced disappearances, torture, deprivation of liberty, and persecution' and the OHCHR assessed at the time that 'the scale and nature of these acts may amount to crimes against humanity' (Pillay, 2011). The report was released and presented to the Security Council on 18 August 2011 by the UN High Commissioner for Human Rights, who urged them to consider referring the situation in Syria to the International Criminal Court (ICC). At this relatively early stage of the

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<sup>13</sup> '... decisions of the [Human Rights] Council shall be made by a simple majority of the members present and voting' subject to a majority of the total members being present (HRC, 2007: Rule 20).



armed insurgency in Syria, there is little question that under the R2P doctrine, events in Syria had triggered the international community's pillar three responsibility 'to respond collectively in a timely and decisive manner' to protect the population in Syria from its own government. It would have been a real source of concern to the global health community that the fact-finding mission reported snipers targeting ambulance and those helping the wounded, as well as summary executions in hospitals.

Accordingly the Commission of Inquiry was mandated 'to investigate all alleged violations of international human rights law since March 2011 in the Syrian Arab Republic, to establish the facts and circumstances that may amount to such violations ... and, where possible, to identify those responsible with a view to ensuring that perpetrators of violations, including those that may constitute crimes against humanity, are held accountable' (HRC, 2011: para. 13). The Commission's findings led it to express its grave concern 'that crimes against humanity have been committed in different locations in the Syrian Arab Republic during the period under review' (COI, 2011: p. 1). The Commission recalled that 'customary international law provides that a State is responsible for all acts committed by members of its military and security forces' and concluded that the Syrian state bears responsibility for crimes and violations committed by members of its military and security forces, including crimes against humanity (para. 109).

Much like the fact-finding mission before it, the Commission found that the security apparatus had obstructed and denied medical assistance to wounded protestors and snipers had targeted those trying to assist the wounded. It also found that public and private hospitals were ordered to send the injured to military hospitals where many were beaten and tortured during investigation. Makeshift hospitals in mosques and private

homes were targeted for military raids and individuals suspected of setting up and operating these facilities were subject to arrest and torture. The Commission assessed that ‘restrictions imposed by the State on the treatment of injured protesters constitute serious violations of the right to health and the right to access medical assistance guaranteed under article 12 of the International Covenant on Economic, Social and Cultural Rights’ (ICESR) (COI, 2011: para. 96), to which Syria is party. These violations of economic and social rights constitute an important component of the systematic violations of human rights that the Commission was concerned amounted to crimes against humanity.

If the international community has a duty to defend people’s right to health against abuses by state authorities, the list of recommendations submitted by the Commission at the end of its first report is conspicuous for its silence on this issue. The only reference to health care comes in a recommendation directed towards the Syrian government to ‘support hospitals and clinics to ensure provision of adequate health care, including for those injured in the unrest’ (para. 112(j)). A critical reader might observe that such a recommendation is perfunctory if such an obligation already exists under an international covenant which the Syrian state has ratified of its own free will. No recommendation is directed toward members of the international community, such as UN agencies and international organisations that have an established presence in Syria and might have exercised leverage over the Syrian government in areas where violations and abuses were being committed, such as access to health care. Instead of making a recommendation to the effect, for example, that the World Health Organization (WHO) monitor violations of Syrians’ right to health, or at least use its privileged position to remind senior officials in relevant ministries of the state’s

obligations under the ICESR, the Commission recommended that ‘the High Commissioner establish a field presence in the Syrian Arab Republic with a protection and promotion mandate’ (para. 115). This is quite a striking example of how the international community failed to take advantage of its existing interventions in Syria, instead proposing new types of intervention requiring further resources and further inflating UN representation on the ground. This is not to suggest that any single UN agency in Syria at the time could have absorbed the entirety of the proposed protection and promotion mandate, but it seems reasonable to suggest that actors already on the ground, such as the WHO, could have done more to advance pillar three of the R2P doctrine.

#### ***4.3.2. Universal Periodic Review***

Unlike the Commission of Inquiry, which was created especially for the purpose of investigating alleged violations of human rights law in the Syrian Arab Republic from March 2011 onwards, the Universal Periodic Review (UPR) is an integral part of the Council’s mandate that was established in the same resolution as the Council itself. As already indicated, the UPR has frequently been mentioned at the UNGA dialogues on R2P as one of the Council’s best tools for strengthening protections against atrocity crimes. For example, at the 2017 dialogue,

States generally endorsed recommendations aimed at strengthening the role of the Human Rights Council in the prevention of genocide, war crimes, ethnic cleansing and crimes against humanity. These include using the Universal Periodic Review process as a tool for risk assessment and for provision of

international assistance under the second pillar of the responsibility to protect.  
(UNGA, 2017: para. 12).

Here UPR is characterised as one of the Council's means for fulfilling its overarching aim: 'the prevention of human rights violations' (UNGA, 2006: para. 5(f)). It is then situated under pillar two of the R2P architecture, which 'addresses ways to help the State bolster its capacity to prevent or curb mass atrocities' (UNSG, 2011: para. 21). Thus there is an explicit parallel between the Council's principal objective of preventing human rights violations and the international community's responsibility to prevent or curb mass atrocities. It is important to note that states undergo the UPR process every four-and-a-half years and that the order of their review is fixed in advance. This means that the calendar of reviews determines when a state will undergo its review. In other words, UPR is not an ad hoc process. This has the advantage of levelling the playing field in the sense that some states make information on the human rights situation in their country more readily available than others: the UPR ensures that all states are reviewed irrespective of what is known prior to the review. On the other hand, being fixed in advance, initiation of the UPR process is not activated by real-world situations and, therefore, may not be providing the most timely risk assessments.

#### *4.3.2.1. 2011 review*

In accordance with the calendar of review, Syria underwent the UPR process for the first time at the end of 2011 and then again in 2016. From the perspective of the UPR 'as a tool for risk assessment and for provision of international assistance under the second pillar of the responsibility to protect', the 2011 review is the more significant for the simple reason that a large number of potentially preventable atrocities were

perpetrated in the period between the two reviews. However, the timing undermined the potential impact of the first review. It took place in October 2011, with stakeholders, Syrian national authorities and the UN submitting their information between July and September. The working group was therefore reviewing relatively old information while the human rights situation inside Syria was becoming increasingly desperate by the day. The report of the working group was not published until January 2012, by which time the Commission of Inquiry had issued its first report expressing grave concern that crimes against humanity had been committed in Syria. The Commission's findings would almost appear to negate the value of the UPR at this time if the latter's only contribution was to assess the risk of a situation where human rights violations were already systematic and widespread and, in respect of which, the UN system was already on high alert.

It is worth recalling that prevention efforts under pillar two can be decomposed into structural and operational prevention. Briefly, 'structural prevention seeks to change the context from one that is more prone to such upheavals to one that is less so' while operational prevention 'strives to avert what appears to be the imminent threat of an atrocity'. Putting this into perspective, 'operational prevention thus may be related to the third pillar, on response, just as structural prevention is linked to the first pillar, on State responsibility' (UNSG, 2011: para. 21). The fact that the UPR is a relatively lengthy process that focuses on state responsibility—all recommendations contained in the working group's report are directed towards the state—suggests that it is more aligned with structural prevention than operational prevention. This all seems to lead us to the conclusion that the modalities of the UPR limited its usefulness in preventing further atrocities in Syria.

While the 2011 UPR came too late in the day for it to have much impact in terms of preventing atrocity crimes in Syria, which it seems were already taking place, the review nonetheless consolidated important information gathered separately by the UN and Syrian stakeholders. The different reports suggest that concerns over the health care situation in Syria predated March 2011. These concerns center on issues related to health inequities and poverty in the country. Arcadu and Zagaria (2015) emphasise the foundational importance of equitable access to health care for health security more broadly: ‘the fight against an epidemic, the set of actions across the disaster risk management cycle and the response to humanitarian crises should be activated from a platform that addresses health inequities’ (p. 16). In Syria, prevailing health inequities have been exacerbated by the conflict. Northeast Syria, for example, has long experienced higher levels of poverty than any other part of the country (El Laithy & Abu-Ismaïl, 2005: p. 27). Even though the regime has not engaged in the same level of purposeful destruction of health infrastructure in this area, it is still the case that places such as Al-Hasakeh, Deir ez-Zor, and Raqqa have some of the worst health indicators in the country and the most limited capacity to respond to outbreaks of infectious diseases. Deir ez-Zor, for example, was particularly affected by outbreaks of polio in 2013 and cholera in 2015. An outbreak of COVID-19 here could be disastrous as it has recently been estimated that the governorate has no available ICU beds with ventilators (Gharibah & Mehchy, 2020)—equipment used in the treatment of patients with severe symptoms of the virus. The same is true for Aleppo where the health infrastructure has been largely destroyed by sustained aerial bombardment from 2012, leaving the governorate with an estimated five available ICU beds with ventilators (ibid.). It is remarkable that, while the health situation in Aleppo is desperate after years of the

regime barrel bombing hospitals in attacks that likely amount to crimes against humanity, the health situation is equally dire in various locations in the northeast as a result of exacerbated poverty and underdevelopment.

It goes without saying that the states participating in the working group of the 2011 UPR had every reason to encourage Syria to allow the Commission of Inquiry unhindered access to its territory, and many did so. In other recommendations, Mexico and Canada referred to the issue of discrimination against the Kurdish minority while Myanmar invited Syria to continue providing basic health care for people living in rural areas. The problem is that these recommendations lack detail and do nothing to establish accountability for specific actions. What's more, all recommendations are directed to the Syrian authorities. In circumstances where the state appears to pose the greatest threat to the fundamental rights of its population—where it is eminently failing in its primary responsibility to protect—one might think the working group would adapt its approach by directing recommendations to Syrian stakeholders and international actors instead.

Generally speaking, if recommendations are formulated for the 'improvement of the human rights situation on the ground' (HRC, 2007: para. 4(a)), they should lead towards concrete actions—the more issue-focused, the better. In respect of health care, while the mechanism is perhaps not well suited to the task of operationally preventing continued violations of fundamental rights of medical personnel and patients when such abuses are already widespread, it might do more to address the structural inequalities that make some populations considerably more vulnerable than others to the effects of conflict. In the Syrian context, this would have meant establishing accountability for health system strengthening in rural areas such as Al-Hasakeh, Deir ez-Zor and Raqqa.

Ideally the Ministry of Health would play a leading role in this, but under the circumstances it may have been necessary to explore alternatives such as strengthening the WHO's mandate in the event of demonstrated and persistent negligence by the central authorities. While this might sound like a bold step, it should not be forgotten that the Human Rights Council is mandated to 'make recommendations to the General Assembly for the further development of international law in the field of human rights' (UNGA, 2006: para. 5(c)). Encouraging specialised UN agencies to exercise greater freedom in interpreting their sometimes dated constitutional mandates in line with the overarching goal of protecting human rights seems fundamentally compatible with the Council's work. More to the point, at this stage of the uprising Syria had not been fragmented by the territorial acquisitions of the FSA and other armed groups. Thus the question of strengthening the health system in the country by investing resources in the northeast, for example, would have been less sensitive than it would become as Kurdish groups seized control of that area. Indeed, it may have been sold to the regime as a way of boosting its legitimacy in outlying areas.

#### *4.3.2.2. 2016 review*

In light of the UPR's unsuitability as a tool for responding to an unfolding R2P situation, it should come as no surprise that the recommendations made by the working group pursuant to the 2011 review went unheeded by the Syrian authorities. Of particular significance, the Commission 'reported that its investigations remained curtailed by the denial of access to the country' (HRC, 2016: para. 8), which of course limited its ability to establish facts and attribute responsibility for crimes. In terms of health care, the situation had greatly deteriorated since 2011. The Special Rapporteur on the right to health stated that the targeting and destruction of medical units amounted to



war crimes and possibly crimes against humanity. Thus by 2016 several sources, including Physicians for Human Rights, the Syrian American Medical Society, and the Special Rapporteur on the right to health had indicated that the targeting and destruction of health facilities may constitute crimes against humanity. Proving crimes against humanity in a court of law involves establishing the physical element, the contextual element and the mental element. Data collected by Physicians for Human Rights may well be sufficient to establish the physical and contextual elements. Proving the mental element, on the other hand, is more difficult as it requires establishing both the identity of the perpetrator in addition to their knowledge of the attack. Restricted access of the Commission has curtailed the international community's ability to establish the mental element. Although the WHO created its Surveillance System of Attacks on Health care (SSA) in 2016, it does not identify the perpetrator of attacks, rendering the data of limited utility in a court of law.

For its part, the Syrian government did not deny the lamentable state of the health system. Indeed, it cited facts and figures relating to the number of functioning health centres put out of commission in the course of 2016 and referred to the 'large-scale emigration of medical staff (owing to threats to be killed or kidnapped)' (SAR, 2016: para. 59). The remarkable thing about the regime's version of events is that it attributes responsibility for the widespread and systematic human rights abuses to armed terrorist group. According to this view, such groups are guilty of targeting hospitals, impeding Ministry of Health national vaccination campaigns, blockading entire regions from humanitarian access and targeting and attacking humanitarian aid caravans. In other words, the state blames terrorist groups for a catalogue of abuses for which, according to most other observers, the state apparatus bears significant

responsibility. No doubt armed opposition groups have perpetrated human rights abuses and war crimes in Syria—that much is well established. It is widely agreed, however, that the Syrian authorities have been the worst offenders. By not allowing the Commission unfettered access to the territory, the Syrian state has so far managed to protect itself from being held to account. Moreover, it has instrumentalised the counter-terrorism paradigm to continue evading its responsibility to protect and cast aspersions on its opponents. These are major obstacles which a progressive R2P doctrine needs to be able to overcome.

#### ***4.3.3. Conclusion***

Having taken a closer look at the work of the Commission of Inquiry and the Universal Periodic Review mechanism, we are in a better position to answer an important question that relates the mandate of the Human Rights Council to its responsibility to protect. That is, does the Council in fact promote ‘the effective coordination and the mainstreaming of human rights within the United Nations system’ based on the foregoing analysis?

Resolution S-17/1, besides from establishing the Commission, does very little to activate the UN system in response to the unfolding crisis. Bearing in mind that the Council is mandated with coordinating and mainstreaming human rights within the UN system, in a situation where human rights were being repeatedly violated the Council does little other than encourage ‘relevant thematic special procedure mandate holders ... to continue to pay particular attention to the situation of human rights in the Syrian Arab Republic’ (HRC, 2011: para. 11). No mention is made of national human rights

organisations nor civil society. In my opinion, this falls well short of the Council's mandated responsibilities, not to mention its responsibility to protect.

The first report of the Commission put forward a number of recommendations, and though the majority were directed towards the state, a handful were also addressed to the Human Rights Council, the High Commissioner for Human Rights, Member States and the League of Arab States. In this respect at least, the Commission begins to establish accountability for a range of actions that reflect the distribution of responsibility under the R2P framework—which is more than can be said for the fact-finding mission and the reports of the 2011 and 2016 UPR working groups—but it does not go far enough. Having attributed responsibility for crimes against humanity to the Syrian state, the Commission should have sought to harness all the resources of the UN system to challenge the criminal behaviour of the Syrian authorities. Relevant specialised agencies should have been called upon to address specific abuses. Given that the Commission found there had been 'serious violations of the right to health and the right to access medical assistance guaranteed under article 12 of the International Covenant on Economic, Social and Cultural Rights' (COI, 2011: para. 96), the Commission should have made recommendations to representatives of the global health community already present in Syria, such as the WHO, the ICRC, and MSF, to mitigate the impact of these violations. Such actors may have begun engaging Syrian health workers and civil society groups to ensure the continued availability of health care in areas experiencing violence and disruption, offering resources and any form of protection they could afford. The window of opportunity for an accumulation of interventions that might lead to operational prevention of further atrocities is very small, and as the violence escalated, the window was rapidly closing.

As discussed, the UPR mechanism is not well-suited to the task of halting systematic and widespread human rights violations. The mechanism is better suited to the task of identifying areas of structural weakness in the architecture of human rights protections, which, if left unattended, will exacerbate the impact of atrocity crimes. For example, the 2011 review drew attention to the neglect of health care services in rural communities and the active discrimination of the Kurdish minority, creating a situation of inequitable access to health in the country. By failing to respond to these issues with clear recommendations for named actors, the 2011 working group failed to establish accountability for strengthening the health system. By the time of 2016 review, the health care situation in Syria had become desperate for certain vulnerable groups, particularly women and children in areas outside of government control. The pre-existing issue of inequitable access to health care was no doubt aggravated by the targeting and weaponisation of health care during the conflict. If UPR lacks the modalities to operationally prevent the commission of mass atrocities where human rights violations are already widespread, it might do something to ameliorate access to health care for vulnerable persons in order to attenuate the impact of what may become a humanitarian crisis. Once again, timely and decisive action is key in this regard.

After reviewing the work of the Commission of Inquiry and the Universal Periodic Review, it is difficult to avoid concluding that, as far as Syria is concerned, the Human Rights Council has not lived up to its mandated responsibility of coordinating and mainstreaming human rights within the UN system. Nor has it been able through these mechanisms to fulfil its objective of working closely with national human rights organisations and civil society, opting instead to focus primarily on the state, even when the latter had effectively turned its back on much of its own population as well as the

international community. This being said, the Human Rights Council has done more than the Security Council to lay the groundwork for holding authors of atrocity crimes to account. What this suggests is that, even within the UN, different mandates and modalities produce different results. This should be a cause for optimism that further adjustments may yield a council that is far better adapted to the challenge of protecting human rights in situations where failing or abusive states refuse to cooperate.

## 5. BRIDGING R2P AND HEALTH SECURITY

In chapters one and two my analysis of reports documenting egregious violations of the right to health leads me to conclude that the international targeting of health facilities and personnel had reached the threshold of crimes against humanity by 2015 at the latest. The events described underscore the importance of allocating responsibility for protecting populations from criminal state authorities. Chapter three begins to consider this question by offering an account of how the General Assembly, the Security Council, and the Human Rights Council tried to prevent/respond to the commission of atrocity crimes in Syria. Having concluded that UN organs were unable to exercise effectively their R2P, it is time to turn to the next question: if not the UN, who does in fact exercise a responsibility to protect?

Before proceeding to look at the role of non-UN actors in chapter five, chapter four offers a transition by reminding us that the intentional destruction of a health system has far-reaching consequences that invoke responses from a diverse set of actors, not only the UN. One way of framing this is to speak of the connection between R2P and the concept of health security, a connection that is made evident by attacks on health care in the Syrian context. This connection is made plain when we depart from the premise that there is a responsibility to protect facilities from attacks primarily for the sake of the security of patients and staff. In the absence of that minimum level of security, there will be an exodus of medical expertise, health infrastructure and equipment will be damaged, and patients will avoid health centers. These factors will in turn contribute to the erosion of health security. This is essentially what happened in Syria, and as conflict caused the health system to fracture, key indicators of health

slipped and infectious diseases began to spread. With the country territorially divided into regime-held and rebel-held areas, controlling the outbreaks of polio and cholera required non-governmental actors to play an important role in the early warning and response efforts. And yet we see that the R2P paradigm pays meagre attention to the role of non-state or civil society actors. By introducing the idea of a complementarity between R2P and health security, chapter four helps us to transition from the responsibility of faceless UN entities to the responsibility of small groups and individuals. I argue that what binds R2P and health security is the focus on the protection of people. The two differ, however, in the assignment of responsibility. Authoritative expressions of the R2P doctrine have tended to focus on the responsibility of states and the international community, while health security works on the principle that people should be empowered to protect themselves. Ultimately, this chapter introduces the notion that, if it is a realistic expectation to empower people to provide health security for themselves and their communities, it follows that people should be similarly empowered to protect the security of their health from serious threats, especially when those threats are of man-made origin. This is the premise upon which, in chapter five, I argue for greater support to those actors who have meaningfully exercised a responsibility to protect health care inside Syria.

## 5.1. Human security and R2P

It is important to acknowledge that human security and state security are not mutually exclusive. This finds articulate expression in the Arab Human Development Report 2009, which argues that ‘human security and state security are two sides of the same coin’:

Ensuring human security leads not only to more opportunities for human development, but also enables states to benefit sustainably from the environment, to earn legitimacy in the eyes of the governed, to benefit from diversity, to fortify economies against global vicissitudes, to reach a higher level of food security, to imbue societies with health, and, last but not least, to be able to address sources of conflicts, and possibly avert them. (UNDP, 2009: p. VI).

In other words, human security is an essential ingredient of state security, and if appropriately addressed the two forms of security are mutually reinforcing. The final part of the quote is of particular interest as it gestures towards that man-made disaster which is more often than not a precursor to the atrocity crimes with which R2P is concerned: armed conflict.

Taking a closer look at the human security concept may help us to understand how it complements R2P. According to the Secretary-General’s 2010 report, there are ‘three essential components that encompass the principles of human security’ (UNSG, 2010: para. 19). Human security’s first component relates to the nature of the threats to which it responds. These threats are ‘multiple, complex and interrelated’ arising from one or more of the subspecies of human security: economic, food, health, environmental, personal, community and political security. The R2P doctrine, on the



other hand, ‘focuses on protecting populations from specific cases of genocide, war crimes, ethnic cleansing and crimes against humanity’ (UNSG, 2010: para. 24). While the complex threats with which human security is concerned may be contributing factors to the commission of mass atrocities, it should be evident that human security is conceptually much broader than R2P. If R2P is founded upon the absolute inadmissibility of four categories of crime, human security relates to an existential state: freedom from want and freedom from fear. In other words, human security is inherently more nebulous than R2P. Nonetheless, more often than not atrocity crimes are perpetrated in environments of fear and want, and in that sense human security may be understood to address the upstream determinants of atrocity crimes.

Human security’s second component posits the protection and empowerment of people as the basis and purpose of security. Implicit in this is the centrality of humans to human security: helping people to help themselves is the most sustainable course of action. While R2P is also fundamentally concerned with the security of people, it locates the responsibility for the species of protections it envisages with the state and the international community respectively. Finally, and this is an important distinction between the two paradigms, while ‘the use of force is not envisaged in the application of the human security concept’ (UNSG, 2010: para. 23), under R2P, the international community is invited to take collective action ‘in accordance with the Charter, including Chapter VII ... should peaceful means be inadequate’ (UNGA, 2005: para. 139). The case has already been made for an understanding of the R2P doctrine which emphasises the non-coercive measures alluded to in the World Summit Outcome document, namely diplomatic, humanitarian and other peaceful means, as well as an ongoing commitment to capacity building, in order to avoid a simplistic equation of R2P with humanitarian

intervention. This is not to deny the possibility of the Security Council sanctioning coercive action in the name of R2P should peaceful means prove inadequate. That much is uncontested. What is worth emphasising, however, is the idea that human security and R2P are complementary concepts with the potential to be mutually reinforcing. Arguably, if the actors made responsible under R2P can throw their weight behind the ‘people-centred, comprehensive, context-specific and preventive strategies’ at the heart of human security, the more likely it is that peaceful means *will* prove adequate.

## **5.2. Health security**

This subsection looks at the health component of human security, and explores ways of understanding R2P through a health security lens and vice versa.

In a concept paper for the WHO, Arcadu and Zagaria (2015) have argued that ‘health is at the center of human security, and it is directly impacted by food, environmental and economic insecurities, as well as by personal, community and political insecurities’ (p. 3). So what exactly is health security and why is it so important? According to the same researchers, experts commonly identify three dimensions of health security: (i) early detection and response to public health emergencies of international concern (PHEIC), usually infectious diseases; (ii) humanitarian crises of both natural and human-induced origin; and (iii) acute and chronic health inequities and poverty. In the 21<sup>st</sup> Century, they argue, resources have been focused on early detection and response at the expense of the other two dimensions. By way of example, the scope of the WHO’s International Health

Regulations (IHR)<sup>14</sup> is ‘the international dimension of potential impacts of an outbreak’, an approach usually referred to as ‘global health security’ (p. 10). They remark how in *The World Health Report 2007: A Safer Future*, the WHO ‘adopts this approach giving very little space to health consequences of violent conflicts, large natural disasters, and none to those disasters and emergencies deriving from poverty and health inequities’ (p. 10). This suggests that the WHO has adopted a narrow conception of health security, focusing primarily on early detection and response to PHEIC without giving due consideration to the possibility that conflict and systemic health inequities might weaken health systems and lead to a lower level of health security.

On 30 January 2020 the WHO declared the outbreak of a new coronavirus, COVID-19, a Public Health Emergency of International Concern. That this announcement came at a time when the health system in Syria was on its knees demonstrates very clearly the potential impact of armed conflict on a health system’s capacity to cope with a PHEIC. For what hope is there of early detection and response to cases of COVID-19 when an eye-watering number of government-run health facilities have been bombed out of operation, the persecution of health workers has led to a massive exodus resulting in acute shortages of human resources, and the government perseveres with its strategy of restricting medical aid to areas outside its military control? According to its constitution, the objective of the WHO is ‘the attainment by all peoples of the highest possible level of health’ and in achieving this objective, one of its main functions is ‘to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations,

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<sup>14</sup> 196 countries have agreed to implement the IHR (2005), which entered into force as a binding instrument of international law in 2007 (WHO, n.d.1).

professional groups and such other Organizations as may be deemed appropriate’ (WHO, 2006: p. 2). The organisation’s commitment to partnering with governmental health administrations presupposes that the governments with which it partners share the objective of ‘the attainment by all peoples [on their territory] of the high possible level of health’. Attacks on health care in Syria, Yemen, Afghanistan, Sudan and Libya in recent years illustrate that armed conflict poses an enormous threat to health security. The case of Syria stands out for the fact that the vast majority of these attacks were perpetrated by government forces, meaning the WHO has effectively been collaborating with the party responsible for the intentional dissolution of health security. In Chapter 5, we will look more closely at the WHO’s partnership with the Syrian government, looking in particular at the Organization’s continued support of the Central Blood Bank even while it was being instrumentalised by the regime. Another issue that will be addressed in that chapter is how the WHO’s constitutional commitment to partnering exclusively with the state has constrained its ability to assist local Syrian actors mount an effective response to the outbreak of COVID-19.<sup>15</sup>

Arcadu and Zagaria conclude their paper by recommending that further deliberation is needed on the question of managing risks related to the three major threats to human security, namely: a) health threats resulting from violent conflicts and other humanitarian crises; b) infectious diseases; and, c) health threats resulting from extreme poverty and health inequities. Furthermore, with an implicit nod towards the WHO, they recommend policymakers carefully consider how to ‘develop and adopt effective policies and strategies that address the linkages across the three health security

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<sup>15</sup> The constitution states that one of the WHO’s functions shall be ‘to furnish appropriate technical assistance and, in emergencies, necessary aid *upon the request or acceptance of Governments* [emphasis added]’ (WHO, 2006: Art. 2(d)).

drivers and avoid response that are isolated and lack synergy' (Arcadu & Zagaria, 2015: p. 16).

Arguably it is precisely these 'effective policies and strategies' addressing linkages across drivers of human security that have, to date, been missing from the discourse and practice of R2P; in particular the objective of preventing or at least mitigating the effects of war crimes and crimes against humanity. R2P may be 'narrow and deep' insofar as it relates to four crimes but that does not mean those crimes exist in a vacuum. The war crime of deliberately bombing hospitals operating as such, for example, impacts across the three drivers of health security. Not only do such attacks pose a grave risk to staff and patients in hospitals, they deter others from seeking health care, they disproportionately impact vulnerable groups, namely the poor and those suffering with pre-existing health conditions such as non-communicable diseases (two groups which significantly overlap), and they reduce the capacity of health systems to detect and respond to outbreaks of infectious diseases. In light of the interconnectedness of health security and the protection of health facilities and staff in conflict, and as an item that *already* exists on the formal agenda of the UN General Assembly, R2P may be an appropriate way to begin addressing 'policies and strategies that address the linkages across the three health security drivers' that Arcadu and Zagaria call for.

### **5.3. The long-term consequences of attacks on health care**

This subsection is intended to demonstrate the long-term effects of the deliberate destruction of the health system on population health. My view is that the devastating impact of the targeting and weaponisation of health, not only on those directly affected,

but on the wider population relying on affected health services, should be taken into consideration when evaluating the gravity of the crimes in question.

Having already characterised the progressive targeting and weaponisation of health in a previous section, it is now time to turn to the effect of the health system's greatly diminished capacity on population health. A natural starting point for thinking about the health of a population is its life expectancy. The Syrian Center for Policy Research (SCPR) found that in Syria this dropped from 70 years of age in 2010 to an estimated 55.4 in 2015 (SCPR, 2015: p. 8). Of course, this is largely attributable to the violence directly causing a large number of deaths and disabilities. Nevertheless, the violence also took an enormous toll on the supply side of the health system, reducing the availability of health services and triggering a regression in key health indicators. SCPR, perhaps the foremost Syrian think tank working on public policy-oriented research, gave the following analysis of the significant reduction of life expectancy in Syria:

The sharp decline in life expectancy at birth, as a result of the crisis, reflects a large number of deaths and disabilities on one hand, and the fragmentation of the health system and the deterioration of nutritional standards and living conditions on the other hand. The health infrastructure has been damaged, and the number of health workers has largely decreased as a result of killing, kidnapping, or migration, that have led to the qualitative and quantitative decline of health services, including reproductive and sexual health services and children's health. (SCPR, 2016: p. 53).

The availability and quality of essential health care, such as maternal and child services, are important indicators of the indirect effects of conflict on population health. SCPR

found that pregnant women's access to health care was markedly lower in 2014 than before the crisis. While this was true for all governorates, northern and northeastern governorates, corresponding with opposition-held areas (OHAs) at that time, suffered the most severe setbacks. According to SCPR, by 2014 'deprivation of reproductive health reached 69.7 per cent in Raqqa, 44.5 per cent in Aleppo, and 41.2 per cent in Al-Hasakeh' (SCPR, 2016: p. 57). At this point it is perhaps useful to recall the dimensions of health security we discussed above as a way of interpreting these figures. There is little doubt that deprivation experienced in Aleppo was largely a product of the destruction of health infrastructure, with hospitals and health workers having been under constant attack since early 2012. Therefore, in health security terms, we are dealing with a humanitarian crisis of human-induced origin. In respect of Al-Hasakeh and Raqqa, the analysis is not so straightforward. In comparison with Aleppo, these governorates have not been subject to the same intensity of bombardment. The northeast has, however, long experienced higher levels of poverty than any other area in Syria (El Laithy & Abu-Ismaïl, 2005: p. 27). Whatever the complex of reasons for underdevelopment in Raqqa and Al-Hasakeh, in the past decade both governorates have experienced enormous upheavals, with different armed groups seizing control of major cities and strategic locations.

If poverty and uneven development are a reflection of the regime's historical neglect of these areas, that trend has continued into the conflict. Rather than focusing its firepower on areas far-removed from Damascus, even where groups widely-recognised as terrorist organisations were in the ascendancy, the regime seems to have pursued a policy of weaponising the health needs of affected populations, a policy that has continued into the COVID-19 pandemic, with authorities in Damascus refusing to

collect test samples of the virus from northeast Syria for testing and to approve new testing laboratories in Al-Hasakeh and Deir ez-Zor (HRW, 2020). From before the conflict until today, the health situation in the northeast, and particularly in Al-Hasakeh, is perhaps best understood as arising from that third and too often neglected dimension of health security: acute and chronic health inequities and poverty. The case of Raqqa is unique given the fundamentalism of ISIS (Islamic State of Iraq and Syria), which emerged as the dominant force in the governorate in January 2014 (AsiaNews, 2014). While the available data on Raqqa is limited, a study of Mosul, another city captured by ISIS in 2014, found that patients with non-communicable diseases encountered consistent barriers to care, ‘including drug shortages, insecurity and inability to afford privately sold medication’ and that, by 2016, ‘all patients had completely or partially lost access to care’ (Baxter et al., 2018: p. 1).

What this analysis brings to the fore is the resilience of the health infrastructure in Aleppo governorate compared with Raqqa and Al-Hasakeh. At a time when hospitals and health workers were operating under constant threat of barrel bombs and sniper fire, the fact that pregnant women in Aleppo had better access to health care than their counterparts in governorates relatively unaffected by aerial bombardment for SCPR’s reporting period is perhaps a reflection of a better-organised and better-resourced health system. Pregnant women’s access to health care is, however, only one indicator and does not tell the full story. The rate of vaccination coverage is another useful indicator for assessing the indirect effects of conflict on population health. SCPR reported that ‘these rates declined from 98.9 per cent before the crisis to 75.2 per cent’ in 2014 (SCPR, 2016: p.58). Aleppo recorded the lowest availability, with a decline in vaccination coverage rates of 32.6 per cent. SCPR accounted for this by referring to ‘the



ongoing military operations, the absence of security and the rule of law, in addition to the difficulty of maintaining the vaccines as a result of electrical power outages in many areas' (p. 59). Al-Hasakeh did not fare much better, experiencing a drop of 27 per cent. Below we will discuss how lower vaccination rates resulted in a polio outbreak in 2013; a case which demonstrates very clearly the potential toll of conflict on public health.

These examples from Syria lend support to the case for taking a holistic approach to health security. Addressing inequality and poverty would be central to such an approach, for equitable access to health care is the foundation of health security. As we have seen, Aleppo proved remarkably resilient to the regime's efforts to destroy health infrastructure there, which is most likely a reflection of the city's pre-conflict prosperity and its long tradition of quality health care. On the other hand, while health infrastructure has not been targeted in the northeast as it has in other parts of the country, historical and ongoing neglect of these governorates by the state has left them particularly vulnerable to (i) the humanitarian crisis induced by armed conflict and (ii) the 2020 coronavirus pandemic for which, at the time of writing, there is no available vaccine. For our purposes, an important question would seem to be, how does the international community's pillar three responsibility to protect populations from mass atrocities such as the systematic bombardment of health facilities—activated in the event the state fails in its primary responsibility—interact with its ongoing responsibility under pillar two to provide populations with the foundation of health security, i.e. equitable access to health care?

In moving from pillars one and two, which refer to the ongoing obligations of the state and the international community towards populations more or less vulnerable to atrocity crimes, to pillar three, which refers to the international community's

responsibility to ‘take collective action in a timely and decisive manner’, it is assumed that, while the state is divested of its responsibility, this is not the case for the international community. Implicit in this formulation of the R2P doctrine is the idea that the deterioration of a human rights situation in a given country signals the failure of the state to exercise its responsibility to protect, calling into question the legitimacy of its claim to sovereignty. This is so, we are given to understand, because sovereignty is a privilege of authorities responsible enough to protect their populations from mass atrocities. The international community, on the other hand, reserves its right to protect populations of concern regardless of how effectively it discharges its responsibilities under pillar two of the doctrine.

Understandably the contingency of state sovereignty in contrast to the immutable rights of the international community is a source of controversy in the literature (Mamdani, 2010). While I recognise that the conception of ‘sovereignty as responsibility’ at the heart of R2P risks playing into a model of international relations in which some members of the international community appoint themselves global policemen, I would emphasise that the three-pillar model also serves as a reminder that the international community has a responsibility to prevent atrocity crimes alongside the state, and that the viability of its pillar three responsibility to act in a timely and decisive manner, potentially with recourse to coercive measures, is a function of the consensus that exists within the community. In my view, building consensus around actions oriented towards the prevention of mass atrocities under pillar two is a prerequisite for achieving consensus on stronger measures under pillar three. Quite besides from laying the foundations for effective pillar three action, consensus on pillar two action is more

likely to make that action effective in and of itself in terms of preventing atrocity crimes, thereby avoiding the need to have recourse to pillar three.

If in the context of the weaponisation and targeting of health care in Syria, implementation of pillar three would have meant the international community putting an end to the bombing of hospitals, which at no point during the conflict has seemed a likely prospect, we ought to ask the related but understudied question of what constitutes pillar two? Recalling health indicators taken from the various governorates, we inferred that the reduction in quality and availability of health services in Aleppo is best explained by the destruction of health infrastructure and restricted access of medical supplies to the governorate. These conditions are directly associated with the conflict and the regime's targeting and weaponisation of health care. Despite a sustained campaign of aerial bombardment that lasted years, Aleppo's health system did keep functioning in a display of resilience that attests to the robustness of the city's health infrastructure, not to mention the skill, dedication and resourcefulness of the health personnel that remained.

In respect of Al-Hasakeh and Raqqa, though the health infrastructure in these governorates experienced nowhere near the level of destruction as that seen in Aleppo, there was a similar drop off in health indicators. By way of an explanation, I would argue that acute and chronic health inequities and poverty predating the conflict undermined health security in the northeast, making governorates such as Al-Hasakeh and Raqqa especially vulnerable to the shocks caused by conflict. Unlike the case of Aleppo, the remedy to health insecurity in the northeast lay less in stopping the bombing of hospitals than the careful planning and implementation of policies designed to strengthen the health system and promote the even development of health services

across the country. The international community could start living up to its health sector-related obligations under pillar two of the R2P doctrine by establishing appropriate means of incentivising the state in question to implement recommendations of the Special Rapporteur on the right to health following his/her periodical report on the situation in the country. And let us not forget Sustainable Development Goal 3.8, which is to ‘achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all’ (WHO, n.d.2). The stated goal of universal health coverage is an expression of the international community’s commitment to health security in principle. Realising this commitment requires more than the articulation of uncontroversial goals, however; it requires addressing the drivers of health insecurity, on the list of which health inequities and poverty rank highly. Where individuals are unable to realise their right to health due to neglectful or discriminatory policies of their government, the international community has a responsibility to address the shortcomings of the state in question. Failing to do so may well contribute to the deterioration of human rights situations, leave the state in question with a sense of impunity, and make the health system especially vulnerable to external shocks.<sup>16</sup>

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<sup>16</sup> It is perhaps interesting to consider the example of the Rohingya population of Rakhine State, Myanmar. According to a report published by the World Bank (2018), Rakhine State has by far the highest Multidimensional Disadvantage Index (MDI) of any Burmese state. Essentially the MDI measures the extent to which a state is disadvantaged by looking at the combined effect of deprivations in the areas of education, employment, health, water and sanitation, housing and assets. There is little doubt that Rakhine State’s high MDI score is the product of ‘longstanding discrimination perpetrated primarily by the central state and particularly the military’, including ‘human rights abuses, arbitrary land confiscation, restriction on language and cultural expression, economic marginalization, and lack of political control’ (Burke, 2016: p. 263). In other words, the “clearance operations” carried out by Myanmar’s military from late-2017, in which soldiers used murder, gang rape, and other forms of shocking violence to instil fear in the Rohingya population, forcing over 700,000 to flee to neighbouring Bangladesh by mid-August 2018, should not be considered an isolated event, but rather an episode of

Before delving further into the detail of the international community's efforts to protect civilians in Syria and build the capacity of actors on the ground, we will present two case studies of previous outbreaks of infectious diseases largely attributable to the decline in vaccination rates and the deterioration of sanitary standards. The case studies encourage us to think analytically about the question of health governance in civil conflict, juxtaposing the response of the MoH supported by the WHO on the one hand with ad hoc coalitions of actors in opposition-held areas on the other. The case studies implicitly demonstrate the interconnectedness of the three drivers of health security: the risk of outbreaks of infectious diseases dramatically increases in conflicted areas, especially where local health systems are under-resourced.

#### **5.4. Case study: 2013 polio outbreak**

As the conflict progressed and the Syrian government lost control of large swathes of territory stretching from the north west to the east of the country, as well as pockets in the south, the health system began to fracture as government officials withdrew from areas captured by opposition militia groups. Generally speaking, health governance was left to health directorates, NGOs, and the remaining hospital employees in rebel-held areas (Alzoubi et al., 2019). The acute shortage of staff, as described above, was compounded by the government's control of humanitarian aid, including medical supplies, to populations in opposition-held areas (OHAs). Kennedy and

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aggravated human rights violations on the back of years of state neglect. The case of Myanmar, much like that of Syria, shows us why the international community should take its pillar two, capacity-building responsibilities seriously. The pursuit of discriminatory policies by the state, resulting in uneven development and weak social and economic infrastructure in certain areas, should not be ignored by an international community committed to preventing atrocity crimes.

Michailidou have rightly called attention to the fact that, ‘in 2012, the Syrian Government and UN agencies agreed that the Syrian Arab Red Crescent (SARC)—whose leadership is appointed by Assad—would coordinate the humanitarian response in all of Syria’ (2017: p. 694). In effect Assad was able, with the agreement of the UN, to control the passage of medical supplies into OHAs. UNICEF and WHO estimated that the polio vaccination rate dropped from 83% at the outset of the conflict in 2011 to 52% in 2012 and it was unvaccinated children in rebel-controlled areas that accounted for most of this decline (Kennedy and Michailidou, 2017). No doubt restrictions on the passage of medical supplies into OHAs is one of the main reasons for this drop in vaccination rates.

Kennedy and Michailidou (2017) were unable to confirm the government’s claims that it continued to carry out vaccinations in rebel-controlled areas after the civil war began, however, several of their interviewees ‘who had worked extensively in rebel-controlled areas categorically stated that the government did not conduct vaccination campaigns in areas under opposition control’ (p. 694). Not only that, ‘the Assad regime refused to allow the WHO and other UN agencies to operate in rebel-controlled areas’, and the head of WHO Syria as well as the WHO Assistant Director-General for polio confirmed that the organisation has to comply with the wishes of its state partner, even if that means neglecting communities that happen to live in areas where the government has lost control (p. 694).

With the withdrawal of the MoH and the WHO from OHAs, non-state actors established the early warning and response network (EWARN) in 2013 to facilitate the detection and response to outbreaks of infectious diseases. On 17 October 2013, the Turkish government first confirmed the presence of polio in samples taken from Deir

ez-Zor the previous month, with no assistance from the Syrian government or the WHO. Once the outbreak had been confirmed, the WHO was still unable to gain access to the affected rebel-controlled areas in Syria. Accordingly,

Efforts to contain the polio outbreak within rebel-controlled areas were carried out by Organizations that worked outside the restrictive structures of the UN system.

The Polio Control Task Force (PCTF), an *ad hoc* coalition led by the ACU [Assistance Coordination Unit] and consisting of several NGOs, such as the Syrian American Medical Society, was formed in November 2013 to coordinate the response to the outbreak. (Kennedy and Michailidou, 2017: p. 695).

The additional effort required to form the PCTF meant that the immunization campaign in rebel-controlled areas only began on 2 January 2014, more than two months after the first cases were confirmed. In comparison, an effective response was organised in approximately two weeks in areas where the WHO could operate unimpeded.

Ultimately, however, the PCTF's activities brought the outbreak to an end, with the last confirmed polio case reported on 21<sup>st</sup> January 2014. This is a telling example of how NGOs and other actors intervened to protect the health of the most at-risk populations when state authorities and UN entities were unwilling or unable to do so.

The polio outbreak shone a glaring light on the UN's inability to service the health needs of vulnerable populations in areas considered unsympathetic to the regime. As 2014 wore on, the relentless bombardment of health facilities, the besiegement of towns and restriction of humanitarian aid conspired to force the international community to take collective action in the form of UN Security Council resolution 2165. This resolution, authorising cross-border humanitarian aid, will be discussed in

detail in Chapter 5; for present purposes it is worth saying that despite the obvious restrictions under which UN humanitarian agencies were operating, the passage of resolution 2165 did provide the WHO with an alternative avenue for action in rebel-controlled areas of Syria without compromising its partnership with the Syrian Ministry of Health. Unfortunately the evidence suggests that the cross-border mechanism was of limited effectiveness, with Syrian authorities pursuing a policy of ignoring or denying most inter-agency requests for passage into opposition-held areas (UNSC, 2015). What's more, reports of WHO's slow response to calls for coronavirus-related assistance in the northwest in recent months seem to offer further evidence that the cross-border mechanism cannot compensate for incapacitated local health systems, especially when faced with outbreaks of infectious diseases (Hill & Al-Hlou, 2020). As such, the authorisation of cross-border humanitarian aid, though in principle a positive step, has done relatively little to mitigate the Syrian regime's punitive treatment of populations in OHAs, with restriction of medical supplies in particular intended to cause acute suffering.

### **5.5. Case study: cholera outbreak**

Asides from safe delivery of vaccines—and the attendant difficulties of establishing an uninterrupted cold chain across international borders and conflict areas—another issue to consider when it comes to outbreaks of infectious diseases is early warning and response. Sparrow et al. (2016) found that 'cases of suspected cholera began appearing in northern Syria in October 2015' (p. 2). A combination of factors led to the re-emergence of cholera in the Syrian context. According to the WHO, 'cholera



transmission is closely linked to inadequate access to clean water and sanitation facilities' (WHO, 2019). The ICRC published a report the same year as the cholera outbreak in which they estimated that half of Syria's water infrastructure was dysfunctional or destroyed, with availability of safe water at only 5-30% of pre-crisis levels (ICRC, 2015). Circumstantial evidence suggests that the Russian and Syrian militaries have carried out airstrikes on water facilities in rebel-held areas, with one attack cutting off the water supply to a rural population of 1.4 million (Triebert, 2015). Insufficient access to safe drinking water 'forced the increasing use of river water and further drove the spread of WBD [water-borne disease]' (Sparrow et al., 2016: p. 3).

The targeting of civilian infrastructure, the displacement of populations to overcrowded IDP camps, poor sanitary conditions within the camps and the neglect of water and sanitation facilities more broadly in rebel-controlled areas created the conditions for cholera. The polio outbreak is an example of how the control of infectious diseases requires unhindered access to populations of concern. By the time of the cholera outbreak in 2015, efforts had been made to address the issue of access in the form of UN Security Council Resolutions 2165 and 2191. Setting aside for a moment assessments of the efficacy of the cross-border mechanism, the cholera outbreak draws our attention to the fact that actors faced with the threat of public health emergencies in conflict zones are not exclusively concerned with the issue of humanitarian access. Surveillance and testing are prerequisites for an effective response to outbreaks of infectious diseases. The systematic destruction of laboratories in northern Syria meant that samples of suspected cholera cases from these areas would need to be taken either to the laboratory in Damascus—effectively inaccessible to health workers based in areas outside of government control—or Ankara in Turkey, which would require an

interrupted cold chain across dangerous frontlines and a hard international border. Sparrow et al. (2016) have argued that ‘the WHO’s insistence on laboratory confirmation of cholera is inappropriate in a conflict zone such as Syria where access to the one recognised national laboratory in Damascus is limited’ (p. 8). Fractured health governance in Syria ultimately resulted in two separate infectious disease surveillance networks: EWARS and EWARN. With technical support and funding from the WHO, the Syrian MoH established EWARS in September 2012 (WHO, n.d.; MoH, 2013). EWARS was originally intended as a surveillance system for all 14 of Syria’s governorates. However, the withdrawal of MoH and WHO officials from areas where the regime lost control appears to have affected the completeness of countrywide reporting.

The Assistance Coordination Unit (ACU) was established in the Syrian National Coalition in December 2012 to coordinate humanitarian aid in Syria. The ACU established EWARN in June 2013 with the help of the US Centers for Disease Control and Prevention (CDC) (ACU, 2015). Ultimately it performs a similar function to the MoH EWARS although it has fewer sentinel surveillance sites covering only 12 of Syria’s 14 governorates. When Sparrow et al. compared the weekly surveillance reports of waterborne diseases from the two systems, they ‘identified significant under-reporting and delays in the government’s surveillance’:

On average, EWARS reports were published 24 days (range 12–61) after the reference week compared with 11 days (5–21) for EWARN. Average completeness for EWARS was 75% (55–84%), compared with 92% for EWARN (85–99%). Average timeliness for EWARS was 79% (51–100%), compared with 88% for EWARN (70–97%). EWARS made limited use of rapid

diagnostic tests, and rates of collection of stool samples for laboratory cholera testing were well below reference levels. (Sparrow et al., 2016: p. 1).

The authors argued that the government's surveillance was 'inadequate due to lack of access to non-government held territory, an incentive to under-report the consequence of government attacks on health infrastructure, and an impractical insistence on laboratory confirmation' (p. 1). Bound by the nature of the agreements it enters into with member states, the WHO acknowledges only cases of infectious diseases reported by governments, and therefore in the case of Syria was presumably unable to use the more complete and timely data being provided by EWARN for two reasons. Firstly, the ACU was not part of the government with which the WHO had partnered, and, secondly, EWARN could not perform laboratory testing on the samples, as required by the WHO. The results of their study prompted Sparrow et al. to formulate a series of recommendations for policy and practice. Firstly, in conflict scenarios, information provided by non-state parties on outbreaks of infectious diseases should be admissible. Secondly, the authors suggested that 'international actors operating independently of the government' should look at ways of legitimising and strengthening existing systems of surveillance, coordination and response, such as EWARN in Syria (p. 10). Finally, they contended that 'it is time to recognise that reliance on a laboratory diagnosis of cholera, polio and other contagious disease as the sole confirmation of the presence of a disease is impractical in conflict and should be supplemented by onsite screening tests and clinical diagnosis' (p. 10).

## **5.6. Conclusion**

In drawing this section to a close, it might be useful to pose a pair of questions. First of all, what can R2P learn from human security? Recalling one of the three essential components that encompass the principles of human security according to Secretary-General Ban Ki-moon, ‘the protection and empowerment of people form the basis and the purpose of security.’ Implicit in this is the idea that people are best situated to protect themselves from want and fear if given the opportunities and resources to do so. This is in contrast to the classical conception of R2P, which situates the primary responsibility to protect people with the state, and a supplementary responsibility with the international community. Thus, while the goal of the two paradigms may be very similar—shielding people from insecurity and/or violence—the actors made responsible under each differ. The examples explored above illustrate that, in dividing responsibility between a sovereign state and an international community often understood to be comprised of the UN system and its member states, R2P anticipates that at least one of the responsible parties will live up to its responsibility to protect. This expectation has not been borne out by events in Syria.

The second and equally important question to ask is how can R2P contribute to health security? The simple answer is to say that politics and conflict matter. It is understandable that the World Health Organization, in its global partnerships, would prioritise early detection and response to public health emergencies of international concern (PHEIC), usually infectious diseases, given the transnational nature of these threats. However, recent experience in Syria shows us that early detection and response to infectious diseases relies on obliging national authorities (under the current model) and health system capacity. With limited sway over those conditions, the World Health Organization is unlikely to achieve its stated priority. A pressing issue for the WHO is

whether or not it has a responsibility towards the Syrian people that is separable from its relationship with the Syrian government. Pillar two of the R2P doctrine would suggest that it does have such a responsibility, while the constitution of the WHO, originally formulated in 1946 when the paradigm of state security prevailed over all else in international relations, makes no mention of it. R2P naturally encourages consideration of questions of accountability for prevention and protection, questions which are otherwise absent from the paradigm of health security which the WHO has helped to formulate.

In the next chapter we will take a forensic look at the relationship between Syrian NGOs and the 'formal' humanitarian system in order to emphasise ambiguities and tensions between the mandates of the various actors involved in the humanitarian response in Syria, all the while identifying ways the R2P doctrine might offer directions for rethinking prevailing arrangements.

## 6. RESPONSIBILITY TO PROTECT HEALTH CARE ON THE GROUND IN SYRIA

This chapter will apply the R2P lens to health care inside Syria and explore how the international community came increasingly to rely on local health actors as part of the localisation of humanitarian aid. Shortages in opposition-held areas made the cross-border delivery of medical supplies an imperative that the Security Council could not ignore. Their knowledge of the context and embeddedness in community networks made Syrian NGOs indispensable partners for INGOs and UN agencies in the cross-border relief effort. Despite this, the ‘formal’ humanitarian system has been criticised by some for the unrealistic standards it imposed on its local partners. This, in addition to allegations that UN agencies based in Damascus have been compromised by working too closely with the regime, led to a break between a large group of prominent Syrian NGOs and the UN system. With recourse to various examples, we will consider what the R2P notion of ‘capacity building’ means in the context of a humanitarian crisis.

### **6.1. Shortage of medical supplies**

Restricting medical supplies to its perceived opponents has consistently been deployed as a strategy by the regime, from the early days of the uprising when soldiers at checkpoints confiscated medicines and equipment needed to treat injured protestors, to the removal of large quantities of medical aid from convoys dispatched to resupply entire towns in areas where the government had lost control.

A massive increase in trauma cases meant a surge in demand for medical supplies. The regime was able to weaponise people’s need for health care by preventing

medics from restocking essential medical supplies. A volunteer in field clinics established in private homes reported that ‘soldiers arrested anyone found with medical supplies at checkpoints, making it dangerous to bring supplies into neighbourhoods that are monitored by government forces’ (PHR, 2011: p. 9). The shortage of medical supplies, alongside a shortage of personnel, would become one of the pre-eminent characteristics of the regime’s weaponisation of health. In June 2013, SAMS reported that,

There is a shortage of IV fluid, blood products, basic laboratory tests, hemodialysis kits, oral and IV antibiotics, pain medications, anesthesia, orthopaedic supplies, surgical supplies, electricity, diesel fuel, phone lines, internet service, ambulances, nurses, medics, doctors, personal protective equipment, and much more. Most of the facets of Syria’s previous fully-functioning and modern, specialized health care system have disintegrated. (SAMS, 2013: p. 14).

As one Syrian physician succinctly put it, ‘how do you save your bleeding patient, if you have no blood, no IV fluid, no surgeons, no electricity and no transportation?’ (SAMS, 2013: p. 14). Those caught attempting to provide medicine to the “opposition” could expect to face severe punishment: ‘in one case in 2012, a nurse from Rif Dimashq was arrested for providing medicine to the opposition’ and after being tortured in detention, ‘his family were notified of his death in August 2014’ (PHR, 2015: p. 4). By 2015, the situation was only getting worse for those in OHAs, with the government systematically obstructing the delivery of medical aid to those areas.

Although Security Council Resolution 2165 (2014) called for the authorization of UN humanitarian agencies and their implementing partners to provide humanitarian assistance, ‘including medical and surgical supplies,’ to people in need throughout Syria, the Syrian government continued to ‘block critical humanitarian aid deliveries to opposition-controlled areas’ (PHR, 2015: p. 20). In its trademark style of giving with one hand while taking away with the other, ‘the Assad government began a pattern of systematically removing medical assistance from the few aid convoys it allowed to enter besieged areas, taking out medicine, vaccinations, surgical equipment, and even baby formula’ (The Syria Campaign, 2017: p. 14).

We have seen how very difficult it was for the P5 to come together on the question of Syria: most draft resolutions backed by France, the UK and the US were vetoed by Russia and China, and vice versa. Nevertheless, as the internal armed conflict ran into its third year, all of the P5 acknowledged their responsibility to act, or at least not to exercise their veto, in respect of critical shortages of life-sustaining goods such as food and medicine and thus resolution 2165, authorising cross-border delivery of humanitarian goods, was passed in July 2014.

## **6.2. The cross-border mechanism**

### ***6.2.1. UNSC resolution 2165***

From 2011 to 2013, UN agencies based in Damascus were unable to provide humanitarian relief to opposition-controlled areas. In July 2014, against the backdrop of a rapidly deteriorating humanitarian situation inside Syria, the Security Council passed resolution 2165 authorising ‘the movement of aid across international borders and



conflict lines without the agreement of the Syrian government’ (Kennedy & Michailidou, 2017: p. 696). The resolution, which reaffirms ‘the primary responsibility of the Syrian authorities to protect the population in Syria’, refers to 4.5 million living in hard-to-reach areas and 240,000 trapped in besieged areas (UNSC, 2014c: p. 2). The mention of the ‘unjustified withholding of consent to relief operations’ reminds us that up until this point of the conflict, humanitarian operations on the Syrian territory required the consent of the central authorities. So it was that the resolution authorised ‘United Nations humanitarian agencies and their implementing partners ... to use routes across conflict lines and the border crossings of Bab al-Salam, Bab al-Hawa, Al Yarubiyah and Al-Ramtha’ (p. 3). The resolution also established a monitoring mechanism ‘to confirm the humanitarian nature of these relief consignments’ (p. 3). These provisions were only given effect for a period of 180 days, at which point they would be subject to review by the Council.

### ***6.2.2. UNSC resolution 2191***

Five months later, the Council met once again to discuss the question of cross-border humanitarian aid and agreed to renew the key provisions of resolution 2165, on this occasion for a period of twelve months. Resolution 2191’s reference to the lack of effective implementation of resolution 2165, ongoing attacks on medical facilities, and besiegement of populated areas, among many other grave violations of IHL, highlights the fact that the humanitarian situation on the ground did not appear to be improving. A further indication of the weak implementation of resolution 2165 is the reference to ‘all forms of violence and intimidation to which those participating in humanitarian operations are increasingly exposed, as well as attacks on humanitarian convoys and acts of destruction and looting of their assets’ and the fact that ‘most people in hard-to-

reach and besieged areas remain difficult for the United Nations and their implementing partners to reach with humanitarian assistance' (UNSC, 2014d: p. 2). Despite the Council's 'deep concern at the continuing and new impediments to the delivery of humanitarian assistance across border and across conflict lines', resolution 2191 does not revise or add to the substantive provisions of resolution 2165 in any way. This is hardly surprising given that the original resolution only avoided being vetoed by omitting any automatic sanctions or consequences for breach of its provisions (Svoboda and Pantuliano, 2015). The key provisions of resolution 2165 appeared to be the most that could be hoped for from a deeply divided Security Council.

### **6.2.3. UNSC resolution 2258**

At the expiry of 12 months, it was clear that the humanitarian situation had further deteriorated, with 4.5 million still living in hard-to-reach areas and 393,700 civilians trapped in besieged areas—an additional 150,000 from 18 months previously by UN estimates. The Council expressed its grave concern at the lack of effective implementation of resolutions 2165 and 2191, citing a host of very serious violations of IHL. The resolution explicitly refers to 'the decline in the number of people reached with humanitarian assistance' and 'noting in this regard that in 2015, the United Nations has only been able to reach 3.5 per cent of people in besieged areas with health assistance and 0.7 per cent with food assistance per month' (UNSC, 2015: p. 3). A further impediment to humanitarian assistance across conflict lines was the decline in convoy approvals by the Syrian authorities: 'as of 31 October, only 27 out of the 91 inter-agency requests made in 2015 by the United Nations had been approved in principle by the Syrian authorities, and that between 2013 and 2015, the percentage of inter-agency convoys approved in principle declined from 65 per cent to 29 per cent' (p.

3). Thus it would seem that, far from ameliorating the humanitarian situation inside Syria, the period of cross-border humanitarian operations actually coincided with an increasingly restrictive environment for the provision of aid. Despite all this evidence of the limited efficacy of prevailing arrangements, resolution 2258 once again did little other than renew the key provisions of resolution 2165.

### **6.3. The growing importance of SNGOs**

Having characterised the overall humanitarian situation inside Syria following the authorisation of cross-border aid, let us now turn our attention to the impact of resolution 2165 as far as United Nations humanitarian agencies and their implementing partners were concerned. Duclos et al. (2019) have commented that ‘though collaboration between national and international humanitarian actors had started in 2012, the 2014 resolution was a milestone to institutionalise those links’ (p. 3). This institutionalisation of linkages has a clear expression in OCHA’s decision to establish a regional hub in Gaziantep in 2015 to facilitate coordinated cross-border humanitarian assistance. It is worth mentioning that cross-border operations from Turkey to Syria were by far the most important ‘in terms of quantity, number of actors and dollar value’ (Els et al., 2016: p. 13); indeed, two of the four border crossings opened by resolution 2165 were between Turkey and Syria. Turkey to Syria relief operations will therefore be our main geographical focus.

The legislation also meant that the WHO had official permission to participate in the relief effort to rebel-controlled areas, principally by providing much-needed medical supplies and assisting with efforts to rebuild local health systems. What’s more, the

WHO opened offices in Gaziantep where it assumed a leading role in the health cluster—the mechanism to coordinate various actors working on cross-border operations and strengthen health provision inside rebel-controlled areas of northern Syria. As such, the WHO office operating out of Turkey looked to resolution 2165 for its mandate, while the WHO office in Damascus maintained its close partnership with the Syrian Ministry of Health and other government ministries and appears to have avoided challenging the central authorities by, for example, offering assistance to non-state actors in areas outside of government control.

As of June 2020, the health cluster in Turkey comprised 120 partners, including 33 INGOs, 47 national NGOs, 6 UN agencies and 8 donors (WHO, n.d.4). Representing the most numerous stakeholder in the cluster, it is clear that national NGOs, many of which might be more appropriately described as Syrian NGOs, are by now substantially integrated into the ‘formal’ humanitarian system. It is important to acknowledge that a number of NGOs were operating across international borders prior to resolution 2165, such as Syria Relief, a charity established by Syrian expats living in the UK that has been providing medical assistance and training to health care professionals inside Syria since 2011 (A. Jundi, personal correspondence, April 8, 2020). What’s more, Syrian NGOs such as the Independent Doctors Association (IDA), established in 2012 by doctors from Aleppo, were providing essential services inside opposition-held areas where large international humanitarian actors were struggling to gain access and were receiving donations from across the border before the passage of resolution 2165. Thus resolution 2165 should be viewed primarily as an instrument to enable UN agencies to gain access to opposition-held areas across international borders in order to provide humanitarian aid; local and diaspora actors were already doing do.

There is little question that the experience and knowledge of Syrian NGOs made them indispensable in the health cluster response once the Security Council mandate for cross-border relief had been secured. What's more, as the violence escalated, many international humanitarian organisations were no longer prepared to send their staff to work on the ground in areas outside of government control. Accordingly, Syrian humanitarian actors were responsible for delivering 75% of humanitarian assistance to Syria in 2014 (Els et al., 2016). In their study for the Lancet-AUB Commission on Syria, Duclos et al. (2019) describe how 'international humanitarian staff based in Turkey had generally not been able to visit projects inside Syria since late 2013', however, 'Syrian staff regularly crossed into Syria', meaning that 'NGOs relied extensively on their Syrian cross-border staff' (p. 3). This tendency to depend more heavily on Syrian humanitarian actors is also apparent in research done by Collins (2019), who observed that 'over time, cross-border operations for INGOs were reduced, and reliance on Syrian NGOs increased' (p. 18). It should be clear from these accounts that Syrian groups and individuals have shouldered the responsibility to provide some form of protection to civilian populations on the Syrian territory, particularly in rebel-controlled areas, from the very beginning of the crisis and continue to do so to this day, while the international community's engagement has been patchy and highly susceptible to conflict dynamics and geopolitics.

### ***6.3.1. Case study: Independent Doctors Association (IDA)***

In addition to the large international humanitarian organisations such as MSF and foreign NGOs such as SAMS, the enormous demand for health care services as the conflict began to rage in 2012 resulted in a number of Syrian health care professionals establishing their own NGOs to cater to the needs of local populations. One such NGO

is the Independent Doctors Association (IDA), which was founded in 2012 by doctors from Aleppo. The organisation established several primary healthcare centers (PHCs) in and around Aleppo governorate, where it also ran an expanded programme on immunization. In September 2016, during the siege of Aleppo, IDA's PHCs and hospital in the city came under aerial bombardment by the Syrian regime supported by the Russian air force, causing many services to be suspended and relocated to the countryside, while some centers ceased operations entirely in areas where the regime recaptured territory (M. Etaky, personal correspondence, March 23, 2020). One of the most important and enduring projects of the IDA is the Muhammad Wassim Ma'az Hospital located on the Syrian-Turkish border in the Aleppo countryside. It was opened in August 2014 and serves more than 750,000 people in the areas of Azaz, Afrin, Bab and Jarablus. And this is not IDA's only hospital: having had to cease operations in Aleppo after being targeted over seven times, Hope Hospital, specialising in pediatric and maternity services, was re-established in Jarablus district in 2017. The hospital serves a catchment population of 120,000 people.

The IDA head office is now, like many Syrian NGOs, located in Gaziantep, Turkey. An employee of the association was unequivocal about their relationship with the Syrian government: the security related risks of working in government-controlled areas have to be taken seriously. IDA's position on the matter is that there is no way to act in accordance with humanitarian principles under the supervision of the Syrian regime. As such, IDA finds it difficult to imagine a safe future for likeminded NGOs and their staff in Syria if and when the regime reclaims territory currently held by opposition and Kurdish groups. Nevertheless, IDA is trying to introduce much higher standards of care than existed pre-crisis and that continue to characterise health care in

regime-controlled areas. Health centers such as the Muhammad Wassim Ma'az hospital are central to health care in the north and this in itself is an important legacy of NGOs such as IDA.

### ***6.3.2. Case study: Syria Relief***

In their research on local and diaspora actors in the Syria response, Svoboda and Pantuliano (2015) found that 'some diaspora groups in particular have seen very rapid growth, both in membership and in formal organisation: one group, for example, emerged out of 'haphazard initiatives by family networks' and now has almost 900 staff and volunteers in Syria and the UK and an office in Turkey' (p. 11). This is reminiscent of the UK-based charity, Syria Relief, which started out as an informal initiative by a group of Syrian expats during the very early stages of the uprising. To get things off the ground, the group contacted their friends, contacts and acquaintances to raise some funds for displaced communities in northwest Syria: in 48 hours, they raised over £20,000. The Charity was formally registered by the end of August 2011 and now they are turning over around £22m a year. Remarkably 96% of their expenditure goes on programmes inside Syria (A. Jundi, personal correspondence, April 8, 2020).

Syria Relief started out by delivering medical supplies to hospitals and medical centres inside Syria and sending Syrian UK-based specialist surgeons and emergency physician to hospitals in opposition-controlled areas. They have set up or funded a number of hospitals, including a major trauma centre and a maternity hospital as well as a number of PHCs across northern Syria. Since 2012 they have been training doctors and nurses inside Syria and, more recently, in Gaziantep and Hatay in Turkey. (A.

Jundi, personal correspondence, April 8, 2020). While health care is a major focus of their activities, Syria Relief is a multi-sector charity and its programmes include education, livelihood, water, sanitation and hygiene (WaSH), and family and orphan support. Currently, education is the charity's largest programme (A. Jundi, personal correspondence, August 10, 2020).

#### **6.4. Factors impeding SNGOs' contribution to the development of health services in Syria**

As a result of their central role in providing humanitarian relief inside Syria, Syrian NGOs gained access to increased funding and were transformed from 'grassroots initiatives into organisations managing multi-location, high-budget projects' (Collins, 2019: p. 18). However, accessing humanitarian funding involves bureaucratic hurdles that appear to have posed challenges to organisations that originally drew their strength—and resources—from community networks. A good example of this is the Humanitarian Pooled Fund (HPF), which is a 'multi-donor, earmarked fund managed by UNOCHA to fund the Humanitarian Response Plan' and to which Syrian NGOs have had direct access since 2014, following resolution 2165. However, organisations are only eligible following 'registration in Turkey (or another country) and UNOCHA validation of the organisation's capacity to manage resources' (Duclos et al., 2019: p. 5). Such obstacles may help to explain why Els et al. (2016) found that 'while Syrian humanitarian actors were responsible for delivering 75% of the humanitarian assistance



in 2014, they received only 0.3% of the direct and 9.3% of the indirect cash funding available for the overall Syria response' (p. 3).<sup>17</sup>

In addition to the apparent mismatch between the proportion of funding received by SNGOs and the proportion of humanitarian assistance they deliver, Els et al. (2016) found that Syrian humanitarian actors were much less likely to obtain overheads than the UN/INGOs by whom they were generally subcontracted and of even greater concern is that often they were not fully reimbursed for their services. What's more, the authors found that 'high salary differences between UN agencies, INGOs and Syrian humanitarian actors were reported to hamper Syrian NGOs' capacities as qualified staff leave for better-paid jobs with international organisations' (p. 3). Nor were these salary differences negligible: from information collected on the income of staff employed in the humanitarian response in Syria, the researchers estimated that the average salary of a senior officer in a UN agency is over five times the salary of an equivalent position in an SNGO. This has a detrimental effect on the performance of SNGOs, as 'continuously building the capacity of their staff, just to see them leave for better-paid positions with INGOs and UN agencies (their so-called partners) is an uphill battle for local actors. One that continues to keep them locked into an 'underdog' position vis-à-vis international actors' (p. 23). Nevertheless, there is a recognition among SNGOs and INGOs that 'raising salaries too high inside Syria may adversely impact local

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<sup>17</sup> Though it appears to be the case that funding, especially indirect funding—i.e. 'funding that is channeled through one or more intermediary Organizations between the original donor and the ultimate recipient agency' (Degnan & Kattakuzhy, 2018: p. 2)—has been made increasingly available to Syrian NGOs, 'putting a figure on funding of Syrian groups is extremely difficult, in part due to the lack of data beyond first-level recipients, and in part because many donors are reluctant to disclose the names of recipient organisation for fear of endangering their staff' (Svoboda & Pantuliano, 2015: p. 19).

economies, expose their employees to jealousy and danger, as well as create conflicts among different actors’ (p. 23).

Up to this point we have been focusing on the role played by Syrian actors in the humanitarian response and the extent to which the ‘formal’ humanitarian system impeded or facilitated the localised provision of aid. Adding depth to the analysis, we can adopt more of a medium-term perspective by inquiring into the post-conflict prospects of Syrian actors that have been involved in health governance in OHAs.

A Christian Aid report found that, in Syria, ‘international donors have shifted strategies away from stabilisation funding in opposition-held areas, which provided support to longer-term, development work, and towards humanitarian funding only. This has been predominantly in areas controlled by Islamist armed groups’ (Collins, 2019: pp. 25-26). In an interview the author of the report recounted that it was her impression that donor governments saw little point pushing development work where there is a high risk of conflict making such programmes unsustainable, not to mention the risk that the regime would simply retake rebel-controlled areas—as it did in Daraya and Aleppo—and do away with development initiatives. Her position on the matter is that this is short sighted and that the overriding objective should be to cultivate skills and expertise in those areas for the future (M. Collins, personal communication, April 6, 2020).

Yet international donors’ preference for humanitarian funding—of which SNGOs received a disproportionately small amount—over stabilisation funding has not prevented local initiatives and governance structures from taking root. The former CEO of UOSSM recalled how most people assumed that once the regime seized control of

opposition-held areas, the health directorates (HDs) hitherto responsible for the coordination of health services would be dismantled (Z. Alzoubi, personal communication, March 20, 2020). In actual fact, when the government took over Deraa, rather than immediately dissolving the opposition HD as had been expected, it negotiated a handover and left the structures very much intact, which, in Alzoubi's assessment, reflected that the fact that the central authorities quite simply lacked the capacity at that stage to assume the responsibilities of the HD. There is also a question of whether Russia has had a hand in persuading the Assad regime to negotiate such settlements with a view to the longer-term viability of the regime as Syrian sovereignty is patched back together.

A former advocacy officer for SAMS opined that while the health care landscape in regime areas is more diverse than before the uprising, NGOs are merely complementing the role of the government in areas such as training medical students, and providing health care services to vulnerable groups and those with disabilities (Mr. D, personal communication, April 3, 2020). He added that the greatly diminished capacity of the health system means the government cannot afford to forgo the support of NGOs, especially in recently "liberated" areas, but that over time he expects the government to reassert control, centralise services and dispense with the support of NGOs. As one of my interviewees pointed out, well-functioning health systems do not normally outsource services to NGOs, and this is perhaps not a model towards which Syria should aspire. What is important, it seems to me, is ensuring that the principle of providing health care on the basis of need alone, something championed by many of the health actors that have operated in areas outside of government control, is not lost as the health system reabsorbs these actors. The international community can play a role by

using stabilisation and development funding to build on the knowledge and experience of SNGOs, HDs, and other local actors who assumed a responsibility for the maintenance of health services in OHAs in line with the goal of equitable access to health care across the different regions.

However, it is also important not to lose sight of the fact that, in the post-conflict phase, some local actors would refuse to work under the auspices of the authorities in Damascus, IDA being one example. This is not surprising when many health professionals and SNGO staff have directly experienced the war crimes perpetrated by the regime, and may have lost family, friends and colleagues during the conflict. As already discussed, there is also the pervasive fear of prosecution under the vague provisions of the Counter-Terrorism law. Clearly we need to find a way to ensure that the standards of health care upheld by organisations such as IDA are not casualties of any future political settlement. Of course one key area will be holding the authors of war crimes and crimes against humanity accountable for their actions. Here the Commission of Inquiry and the IIIM will play a key role in ensuring that evidence is retrieved and compiled so as to facilitate prosecutions, while national courts around the world may exercise universal jurisdiction to prosecute war criminals on their territories. This, however, may be a long time coming. In the meantime the international community needs to be able to address the legitimate concerns individuals have about the possibility of being prosecuted under the Counter-Terrorism law. As will be discussed below, UN agencies and international humanitarian organisations have performed a lot of counter-terrorism vetting of local actors and this should provide a foundation for advocating for the organisational integrity and freedom from terrorist-affiliation of these Syrian NGOs.

## **6.5. SNGO dissatisfaction with the ‘formal’ humanitarian system**

With reference to existing research it is apparent that SNGOs’ relationship with the ‘formal’ humanitarian system has been somewhat strained from the beginning of the relief effort in Syria. Els et al. (2016) discuss the fact that, ‘in an attempt to address and manage the risks of doing harm by teaming up with the wrong local actors, large donors, UN agencies and INGOs have individually developed a set of partner assessment tools, which they employ to vet potential local and national collaborators and partners’ (p. 19). Unfortunately, no single, standardised system exists and it would seem that Syrian actors are obliged to undergo lengthy assessments each time they partner with a new donor or international agency. The inefficiency of such a system was recognised by the High-Level Panel on Humanitarian Financing, leading to the recommendation that,

If a national NGO has undergone a rigorous assessment and been pre-certified by an inter-national NGO or agency, there is no need for others to conduct repeated screening of the same national NGO. Also, an accurate tool listing these NGOs by their expertise and capacity would enable potential partners to quickly select their implementing partner. At the onset of emergencies, having such information available would greatly save scarce resources and time. (HLPFH, 2016: p. 19).

In an austere environment such as northern Syria small margins can have a significant impact on actors capacity to provide humanitarian relief. Accordingly, streamlining the partner assessment system may reasonably be considered a form of pillar two capacity

building within an R2P framework in the sense that it would make it easier for local actors to navigate the bureaucratic environment.

Els et al. (2016) also found that a common complaint among Syrian NGOs was ‘that the level of project and budget detail required by donors and international agencies is often unrealistic’ (p. 21). Collins (2019) uses the term “NGO-isation” to describe ‘the particular influence of the international aid sector on CSOs, bringing them in line with their standards but also their vision and strategic direction’ (p. 23). The term is also used to refer to ‘the way in which CSOs became bogged down in the bureaucracy of due diligence related to counter-terror legislation’ (p. 23). The impact of counter-terrorism legislation on humanitarian action is an increasingly salient issue in the field of international law and has been given separate treatment above, as it has particular ramifications for medical care obligations in conflict. For present purposes, suffice it to say that as UN agencies and INGOs came increasingly to rely on Syrian humanitarian actors to deliver cross-border aid, the latter found themselves expending ever greater resources and time on bureaucratic exercises set by their international partners. What made this more frustrating for local NGOs was the fact that, in many cases, the additional responsibilities and risks they carried were not rewarded with easier access to funding.

## **6.6. Influence of the regime**

In addition to the operational constraints faced by Syrian actors delivering cross-border aid, many had concerns about the integrity of their international partners. Due diligence, such as partner assessments and programme reporting, is the means by which

the ‘formal’ system seeks to uphold standards of accountability and transparency considered especially important in contexts where there is a risk of institutional funding falling into the hands of terrorist organisations. In Syria, many of the local organisations subject to this kind of due diligence were not satisfied that UN agencies and large INGOs were living up to the standards they imposed on others. They alleged that UN agencies were allowing themselves to be unduly influenced by the regime in Damascus. In September 2016, 73 NGOs, the majority participants in the two major coordination bodies for Syrian organisations—Syrian NGO Alliance (SNA) and Syria Relief Network (SRN)—sent a letter to OCHA expressing their concern ‘that the Syrian government in Damascus has a significant and substantial influence on the performance of UN agencies based in Damascus as well as their partners SARC’ (73 NGOs, 2016). The group of NGOs drew attention to the Syrian government’s interference with the delivery of humanitarian assistance, ‘including the blocking of aid to besieged areas, the removal of medical aid from inter-agency convoys, the disregard for needs-assessments and information coming from humanitarian actors in Syria’. The key issue for the authors of the letter was the fact that, while the Whole of Syria information-sharing mechanism had been intended to coordinate humanitarian action to all parts of Syria by including all those participating in the effort within Syria as well as across the border, ‘UN agencies based in Damascus and their main partner, SARC, have been making the final decisions, shaped by the political influence of the Syrian government.’ A report by the Syria Campaign that same year found that despite UN aid chiefs’ claims to the contrary, ‘a study of UN evaluation agreed that aid deliveries were limited “more for internal political and strategic reasons than for security ones”’ (The Syria Campaign, 2016: p. 5).

It has been argued that ‘the UN’s failure to set red lines for its Syria operation has undermined its negotiating power’ (The Syria Campaign, 2016: p. 5). The Syrian government effectively hijacked the relief effort by using its power to refuse working visas for international staff as leverage, keeping humanitarian organisations from delivering aid to areas unfavourable to the regime (HRW, 2019; Svoboda and Pantuliano, 2015). What’s more, if UN agencies and international humanitarian organisations do obtain permission to operate in government-held Syria, they can only partner with ‘local Syrian Organizations that have been vetted and preapproved by the authorities’ (HRW, 2019). Human Rights Watch (2019) found that ‘the Syrian security services regularly engage these local partners and can, according to humanitarians, have access to their beneficiary lists and programming at any point.’ This is naturally a concern when the Syrian security services ‘responsible for systematic rights abuses, have restricted access to aid, and mistreated those they perceived as political opponents’ (HRW, 2019). Thus, not only do the narrow operational parameters set by the Syrian regime restrict humanitarian organisations’ freedom of action, they are unable to conduct due diligence of their partners and may well be facilitating abuse by the security apparatus.

### **6.7. The WHO’s support of the Syrian Central Blood Bank**

In response to serious criticisms that the UN had failed in its responsibility to protect civilians during the closing stages of the civil war in Sri Lanka, the Secretary-General’s 2012 Internal Review Panel ‘concluded there had been a “systematic failure” in meeting UN responsibilities to prevent and respond to serious violations of human



rights and humanitarian law and to protect people at risk' (IASC, 2015: p. 1). The report gave rise to the Human Rights up Front (HRuF) Action Plan, which seeks three types of change: (i) a cultural change, requiring staff 'to recognize human rights and protection of civilians as a core responsibility' and encouraging them to act with 'moral courage' knowing they have the backing of UNHQ; (ii) an operational change, supporting better early warning, shared analysis, and capacity to respond; and (iii) a change to UN political engagement, encouraging 'more proactive engagement with Member States to generate political support for early and preventive action' (IASC, 2015: p. 1). In my assessment, the Syrian experience suggests that the lessons of Sri Lanka have not been learnt. Far from embedding a 'human rights perspective into United Nations strategies', it has been argued that the humanitarian response in Syria has focused on the 'provision of material assistance' at the expense of 'any coherent protection strategy' (Svoboda and Pantuliano, 2015: p. 7). The Syria Campaign have gone as far as to say that the UN in Syria 'is in serious breach of the humanitarian principles of impartiality, independence and neutrality' which is a consequence, among other things, of the organisation's 'acquiescence to the dominant role of the government in drafting key strategy documents, the UN's support for controversial local truces following sieges and the UN's systematic failure to recognise and classify besieged areas' (p. 5). These allegations point to a raft of failures cutting across the cultural, operational, and political components of the HRuF.

When considering the UN's role in the health sector, we need look no further than the World Health Organization, the UN's specialised health agency, and lead agency in the health cluster of the inter-agency humanitarian response in Syria. With health care being the target of so many of the war crimes perpetrated by the Syrian

regime, the WHO should have been a key agency for the UN when it came time to assume its responsibility to protect. However, as the polio and cholera case studies make plain, the WHO has long pursued a policy of non-confrontation with the regime, and this was once again made apparent by its support to the Central Blood Bank.

The Central Blood Bank falls directly under the jurisdiction of the Ministry of Defence, and, as will be described below, has consistently refused blood to patients perceived to be opponents of the regime. The Guardian found that, since 2011,

the World Health Organisation has spent more than \$5m to support Syria's national blood bank ... Documents seen by the Guardian show funds spent on blood supplies came directly from donors who have economic sanctions against the Syrian government, including the UK. They also show that WHO had "concrete concerns" about whether blood supplies would reach those in need, or be directed to the military first. (Hopkins and Beals, 2016b).

By continuing to support the national blood bank, the WHO was, on the one hand, enabling the regime to circumvent an international sanctions regime supported by Member States, and on the other it appears to have played quite a passive role by failing to proactively address the human rights abuses which control of the blood bank allowed the Ministry of Defence to perpetrate.

Of course there has been a great need for blood, which is so vital in the treatment of trauma patients, throughout the duration of the conflict in Syria. Unfortunately the security apparatus has used its control of the Central Blood Bank to restrict access to blood to subjugate medical staff and punish opponents of the regime from the very beginning of the insurgency. For example, a circular issued by Homs

Health Directorate in April 2011 stated that ‘the Central Blood Bank, which falls directly under the jurisdiction of the Ministry of Defence, is the only entity in the governorate authorized to distribute blood.’ The circular prohibited hospitals and other bodies from receiving or taking blood because, the directorate argued, ‘this would lead to the spread of communicable diseases, therefore in the interest of protecting public health, anyone contravening this ban will be prosecuted by law’ (Amnesty International, 2011: p. 21). The consequences of this were made clear by the testimony of a former health worker in Homs, who fled the country in July 2011:

We faced a dilemma every time we received a patient with a firearm injury and an urgent need of blood: if we send a request to the Central Blood Bank, the security would know about him and we would be putting him at risk of arrest and torture, and possibly death in custody. And if we do purchase blood by other means, we would be putting the hospital and ourselves at risk of prosecution for violating the ban. (Amnesty International, 2011: pp. 21-22).

As a result of the Ministry of Defence’s control of central blood banks, doctors began to seek blood elsewhere, giving rise to a black market. PHR (2011) were informed that doctors ‘smuggled blood into Syria from Lebanon, Jordan, and Turkey as well as from private donors, and [were] only able to perform primitive tests for blood-borne pathogens and disease’ (p. 9). The same report recounts an example of a blood bank refusing a doctor’s request for blood for a critically ill patient, and an armed official threatening a medical student and civilians with arrest when they tried the blood bank a second time. A dentist who had established a field hospital with some friends claimed to have seen four patients die unnecessarily for lack of access to an adequate blood supply. The dentist remarked that the blood banks require paperwork which field clinics are

simply in no position to provide. A further complication resulting from insufficient access to safe blood is the increased risk of exposure to blood-borne diseases such as hepatitis B (Johns Hopkins & SAMS, 2015). By this stage of the conflict, WHO had documented that

vaccination coverage has dropped from 90% before 2011 to 52% in March 2014, increasing the risk of child morbidity and mortality from preventable diseases. Diseases once rare in Syria have reappeared, with 80 cases of polio, 2,600 cases of typhoid fever, 7,000 cases of measles and tens of thousands of cases of Leishmaniasis. (Johns Hopkins & SAMS, 2015: p. 14).

So while officials cited a concern for public health when restricting access to blood, the action in fact had quite the opposite effect: insufficient access to safe blood forced medics to resort to unsafe alternatives, contributing to the re-emergence of communicable diseases.

In continuing to supply blood to the Central Blood Bank, the WHO was probably operating in accordance with the rationale that helping some is better than helping none at all. Nevertheless, the WHO, as a member of the international community, has a responsibility to protect that extends to all civilians. The question of how it might have exercised this responsibility when it came to meeting the need for blood in Syria is without an obvious answer. It is unclear, for example, the extent of the Organization's influence over the relevant governmental ministries in Syria. If, as WHO spokespersons have claimed, they did try to apply pressure to address abuses connected with the Central Blood Bank's supply of blood, apparently such efforts had very little effect. And this is a real problem. If its state partner continues to violate the most

fundamental obligations of international law, obligations that are intimately connected with health care and thus the work of the WHO, there must come a point at which the latter, as a representative of the international community, ceases to acquiesce in atrocities that quite clearly undermine the primary objective of the Organization: the attainment by all peoples of the highest possible level of health. And as we have seen, the WHO was not simply playing a passive role: it was actively helping the regime to circumvent the sanctions regime. The WHO's use of donations from Member States imposing sanctions on the Syrian government to support the Ministry of Defence-controlled blood bank testifies to the WHO's failure to implement HRuF, which can be broken down into several parts: (i) a lack of transparency in the use of donor funds; (ii) the normalisation of a quietist culture in respect of human rights abuses in order to remain on good terms with its state partner; and (iii) a failure of political engagement insofar as there is no suggestion that the Organization at any point used what leverage it has to influence the regime and avert further human rights violations.

## **6.8. The Charter for Change**

In an effort to address some of the obstacles to humanitarian action made plain by contemporary experience, a group of INGOs drew up the 8-point Charter for Change following the 2016 Istanbul World Humanitarian Summit process. Key points of the Charter include:

- i) Increase direct funding to national and local NGOs: the INGO signatories have committed to passing 25% of their own funding to local counterparts by 2020

- ii) Stop undermining local capacity: the signatories committed to implementing ‘fair recruitment policies to discourage the poaching of staff from national and local NGOs’, by exploring ‘alternatives with our partners such as secondments, mentoring or supporting national surge initiatives’
- iii) Address subcontracting so as to ensure that local partners are ‘involved in the design of the programmes at the outset and participate in decision-making as equals in influencing programme design and partnership policies’
- iv) Robust organisational support and capacity strengthening: the signatories pledged to ‘support local actors to become robust organisations that continuously improve their role and share in the overall global humanitarian response’ by paying for ‘adequate administrative support’ and publishing ‘the percentages of our humanitarian budget which goes directly to partners for humanitarian capacity building by 2020’ (Charter4Change, 2019: p. 2).

Evidently many of these commitments respond to challenges experienced by Syrian NGOs in their partnerships with INGOs. Nevertheless, while the Charter identifies the headline issues, it says little about how INGOs and their local partners will put the pledges into effect. The Charter for Change does not, for example, address the question of the impact of counter-terrorism policies on humanitarian action, especially the effects of these policies on the ability of local NGOs to secure much-needed funding to deliver relief to communities that may be inaccessible to international humanitarian agencies. INGOs are themselves obliged to operate within regulatory environments shaped by sovereign authorities on the one and the legislators of international law on the other. As

such their freedom to act and to partner with local actors is decided largely by authorities over which they have a limited influence.

Acknowledging the institutional constraints upon INGOs is not to say that the Charter for Change is an expression of unattainable aspirations; on the contrary, there are clearly areas where international humanitarian actors can contribute to reforming the system. INGOs can and should take responsibility for reforming recruitment policies in order to ‘discourage the poaching of staff from national and local NGOs’. Likewise, when subcontracting local actors, INGOs can and should involve those actors ‘in the design of the programmes at the outset’ and enable them to ‘participate in decision-making as equals’.

One of the most important areas to be addressed by INGOs is ‘robust organisational support and capacity strengthening’. Capacity strengthening, more commonly known as capacity building, is a generic term that is often used without being defined and as a result suffers from a lack of clarity. Svoboda and Pantuliano (2015) have recommended that ‘international and local/diaspora agencies need to clarify what they mean by capacity-building and how it can be provided’ (p. 22). Els et al. (2016) found that several SNGOs described capacity building as a top-down exercise that involved large standardised training and workshop events, rolled out by UN agencies and INGOs, that failed to respond to their particular organisational needs. SNGOs reported that ‘what really worked for them was a much more demand-driven and user-tailored approach’ involving the secondment of outside “experts” as well as ‘one-to-one meetings, on-the-job training, mentoring and coaching as the most effective means to build capacity’ (p. 21). The researchers also found that ‘from the other

perspective, several international actors recognized how working with Syrian NGOs added value to their own understanding and work' (p. 21).

In respect of the responsibility to protect doctrine, capacity building is a key component of the international community's commitment 'to assist States in meeting [their pillar one] obligations' (UNSG, 2009: p. 9). If R2P is to have practical value in protecting populations from atrocity crimes, it is important that the rhetoric generated by the Secretary-General's reports and the General Assembly dialogues is followed by tangible action. The conceptual contours of the doctrine are by now well established; what remains is to identify action points for the international community and begin operationalising the R2P agenda. As we have shown, when health security is degraded as a result of intentional targeting during conflict, populations are liable to experience suffering on an appalling scale. In the event that the international community is, firstly, unable to put an end to the weaponisation of health and, secondly, unable to mitigate the effects of the erosion of health security by providing humanitarian relief, one may well argue that the best course of action is to build the capacity of local actors who are in a position to provide that relief.

### **6.9. Examples of effective health sector capacity building in Syria**

Taking seriously the concern that while 'capacity building' sounds constructive, the term suffers from a lack of definitional clarity, in this section I want to introduce a couple of case studies that provide rich and concrete examples of actors from the global health community building the capacity of Syrian health care providers. These are intended to serve as points of reference when it comes to submitting recommendations



on how the international community should proceed with operationalising its ongoing pillar two responsibility to build the capacity of authorities and service providers of a national or local character. Of course I am focusing on health care in Syria, but my methodology for advancing the implementation of R2P by drawing attention to what might be called “success stories” and making connections with elements of the R2P doctrine is in principle replicable across different contexts and sectors. The larger the collection of such stories, the more examples we will have to draw on when it comes to formulating more general institutional arrangements—perhaps enshrined in international law—to facilitate timely capacity building in order to prevent or at least mitigate the effects of potential R2P scenarios.

#### ***6.9.1. Case study: IR2P and dealing with a shortage of health workers***

As the crisis continued with no obvious political solution in sight, the Syrian health care workforce was being steadily depleted. Ben Taleb et al. (2014) cited estimates that up to 70% of the workforce had left the country at the time of their research. Physicians for Human Rights have recorded the killing of at least 923 medical professionals in Syria from 2011 through 2020 (PHR, 2020). The Lancet (2017) calculated that 15,000 of Syria’s 30,000 doctors had left by 2015. And as we have seen, the situation in Aleppo was especially dire: by 2015, more than two-thirds of the hospitals were no longer functioning and roughly 95% of doctors had fled, been detained, or killed (PHR, 2015).

Not only did this leave a much reduced work force, those that did leave tended to be the ones with dependents and the requisite resources to do so, principally senior and specialised doctors, such that many of the remaining staff were junior health

workers who found themselves working beyond their expertise in increasingly challenging circumstances (Blanchet et al., 2016; Nott, 2019). The upshot of these human resource constraints was an acute skills deficit on the ground at a time when there was an unprecedented demand for speciality care—namely trauma, reconstructive, plastic and prosthetic services. One way of mitigating the resource constraints was to train health workers in affected areas, either remotely or in the field. During his visits to Aleppo in 2013 and 2014, Dr. David Nott trained junior doctors in their new specialities and introduced surgical procedures suited to the cases being seen—principally gunshot wounds in 2013 and shrapnel injuries from barrel bombs in 2014. Through his humanitarian missions in various parts of the world, Dr. Nott had accumulated a skill set that was highly adapted to trauma injuries in armed conflict. The fact that he was able to pass on this knowledge to doctors in Aleppo evidently had a markedly positive impact on outcomes for patients, especially those suffering from gunshot wounds.

Some years before he visited Aleppo, Dr. Nott had developed the Surgical Training for Austere Environments (STAE) course to prepare surgeons for difficult humanitarian missions. However the course was delivered in London and was expensive to attend, prohibitively so for many doctors in the developing world—precisely where most humanitarian crises occur. Following his second visit to Syria, his wife Elly helped him establish the David Nott Foundation through which they were able to sponsor surgeons from all over the world to attend the STAE course. He was also instrumental in developing the Hostile Environment Surgical Training course (HEST), ‘which can be taken to the front line for surgeons in the field who are unable to leave their post’ (Nott, 2019: p. 312). They have since trained over seven hundred local

surgeons from Syria—on the Turkey-Syria border—as well as surgeons in Yemen, the West Bank, Gaza, Libya, Iraq and Cameroon.

### ***6.9.2. Case study: SAMS and the responsibility of the diaspora***

The Syrian American Medical Society (SAMS) has played a key role in maintaining health services in Syria throughout the conflict. The organisation has been training Syrian health care workers inside Syria since 2012; it has established six medical institutions inside Syria and in 2017 it provided ongoing medical education to 1,138 students. The NGO also supported the only medical institute in besieged East Ghouta, where 279 medical students were enrolled in 2018. A former employee at SAMS explained that the school started out as a local initiative in Ghouta and was later connected with Aleppo university in the north, at which point SAMS began sponsoring both. The school in Ghouta adopted the Aleppo curriculum, focusing on general surgeries and internal medicine in line with the medical demands of the conflict. Given the stretched human resources, a vascular surgeon was training students to allow for task shifting and to allow them to perform operations independently. The medical college was completely disbanded when the regime captured Ghouta in 2018, and students sought to continue their education in other parts of the country, notably the north, east Aleppo, and Rif Dimashq (Mr. D, personal communication, April 3, 2020).

According to the World Health Organization (WHO), ‘task shifting involves the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualification in order to make more efficient use of the available

human resources for health' (WHO, 2008: p.2). The WHO emphasise that task shifting alone cannot be expected to solve human resource shortfalls—it should be 'implemented alongside other strategies that are designed to increase the total numbers of health workers in all cadres' (p.2). Nevertheless, task shifting clearly has the potential to enhance the efficient use of limited resources, which explains its value for Syrian health care teams throughout the conflict. Incidentally, among the many weaknesses in the global health security infrastructure, the current pandemic has caused many countries to recall retired doctors and employ medical students in responding to COVID-19. Task shifting would be, and in many cases has been, a complementary strategy for coping with the increased caseload and the strain put on intensive care units by the acute respiratory symptoms associated with the virus. In respect of Syria, and other countries at risk of conflict and natural disasters, WHO-led training programmes on task shifting in times of relative stability would be one way of preparing for human resource shortages in the event of a crisis.

It was not only the immediate dangers faced by health workers inside Syria that forced so many to leave: they also had to consider the financial implications of working in a conflict zone. The evidence suggests that while health workers in NGO-funded facilities received regular and adequate pay, private hospitals had less resources at their disposal for the payment of staff (SIM, 2018; Alzoubi et al., 2019). Before the crisis the private sector was responsible for almost 50 per cent of service provision but that share declined with the onset of conflict. It has been argued that donors refused to partner with the private sector, channeling their funding towards UN agencies and local and international NGOs which 'empowered NGOs at the expense mainly of the private sector' (Alzoubi et al., 2019: p. 37). SAMS, as an American NGO with substantial

backing from the expatriate Syrian medical community, has the resources to train staff in Syria and pay their salaries, thereby giving medical staff the choice to remain.

Another area where SAMS demonstrated leadership was the use of telemedicine to enable specialists based in the US and abroad to ‘consult, advise, and support local personnel’ in Syria via video conferencing software (SAMS, n.d.). This at least partly compensated for the lack of expertise on the ground as a result of the exodus of health workers and the inability of doctors to travel to some areas of Syria due to those areas being besieged or simply too dangerous for organisations such as MSF to deploy international medical staff (MSF, 2017).

#### **6.10. Failure to renew cross-border mechanism**

While there were certainly significant obstacles to the passage of cross-border medical relief, maintaining access to at least some of the populations living in besieged and hard-to-reach areas was a priority for all humanitarian actors concerned. However, the regime’s principal ally in the Security Council, Russia, did not share the general concern that the four crossing points remain open, and when the issue of cross-border aid was once again discussed by the Council in January 2020, it argued that Al-Ramtha on the Jordanian border and Al Yarubiyah on the Iraqi border should no longer be part of the mechanism because they were no longer being used. In respect of the Al Yarubiyah crossing, Russia claimed that humanitarian supplies were instead being delivered to the northeast through government-controlled areas (UNSC, 2020a: pp. 6-7). This contradicts figures provided by OCHA, which informed the council that ‘40 percent of health supplies entering north-east Syria come through Al Yarubiyah’ while

the WHO estimated that 1.4 million people would be affected were the crossing to be closed, further warning that ‘in such a scenario, 50 percent of the health system facilities in north-east Syria will cease to function within three months’ (ReliefWeb, 2020). As highlighted by Amnesty International (2020), ‘without the renewal of the mechanism, the UN will be forced to request approval from the Syrian government to deliver aid to northern Syria (Idlib, northern Aleppo, and north-east) with no guarantees these requests will be approved.’ After Russia and China vetoed the renewal of resolution 2165 on 20 December 2019, the Council passed resolution 2504, which renewed ‘the decision in paragraphs 2 and 3 of Security Council resolution 2165 (2014), for a period of six months ... excluding the border crossings of Al-Ramtha and of Al Yarubiyah’ (UNSC, 2020b: p. 2). In effect, while the resolution ensures continued humanitarian access to Idlib and northern Aleppo through the Bab al-Salam and Bab al-Hawa crossings, the closure of Al Yarubiyah means that the government in Damascus now controls humanitarian relief to the population in the northeast—a territory largely under the control of Kurdish opponents of the regime.

### **6.11. COVID-19 in areas outside of government control**

On 11 March 2020, just two months after the closure of Al Yarubiyah, the WHO declared the outbreak of the Coronavirus disease (COVID-19) a pandemic. Events in Iran and Italy showed the world the potentially crippling effects of the new virus on health services. In some places, the number of individuals suffering severe respiratory symptoms exceeded the number of available ventilators, resulting in chaotic situations in hospitals and high death rates among patients. Such scenes were a cause for health

authorities across the world to be concerned, and anyone familiar with the situation in Syria recognised that, with its health system ravaged by 9 years of war, an outbreak in the country could spell disaster for an impoverished population with limited access to health services. At the end of 2019, only 50% of public hospitals were reported fully functioning, with the remainder either partially functioning (25%) or non-functioning (25%) (WHO EMRO, 2019). In late March, researchers from LSE’s Conflict Research Programme estimated there was 325 available ICU beds with ventilators across Syria (Gharibah & Mehchy, 2020). Based on the assumption that at least 5% of COVID-19 cases require ICU support, the researchers estimated ‘the maximum capacity threshold of Syria’s health care system for COVID-19 cases’ to be 6500 patients (p. 6). At the peak of the crisis in Italy, there were 6557 newly confirmed cases in one day. The population of Syria is approximately a quarter of the size of Italy, and given that patients with severe symptoms tended to be hospitalized for 12-13 days (Guan et al., 2020), an outbreak of a similar scale in Syria would quickly overwhelm the health system.

These figures don’t tell the whole story, as it is clear that fractured health governance<sup>18</sup> and the systematic targeting of health facilities in rebel-held areas—on top of inequitable access to health care that predates the present conflict—have resulted in a situation where the capacities of different governorates to respond to the outbreak vary substantially. The northeast and the northwest—areas where the regime has struggled to reassert its authority and where opposition groups continue to pose a challenge to undivided sovereignty in Syria—have far fewer fully functioning hospitals and ICU

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<sup>18</sup> According to a health cluster situation update, ‘there are 306 functional health facilities in the NW [northwest], managed by 57 health partners’ (Health Cluster, 2020a: p. 1).

beds with ventilators than other parts of the country. By way of comparison, Gharibah and Mehchy estimate that while Damascus has 96 ICU beds with ventilators, Aleppo has only five and Deir ez-Zor has none at all. Escalating hostilities in the northwest meant that in January alone 1.5 million people fled their homes, most of them seeking safety in already-densely populated areas of Idlib and Aleppo (Health Cluster, 2020b). In addition to the additional pressures created by a population swollen with IDPs from neighbouring territories, ‘more than 84 hospitals and medical facilities in the northwest have been damaged, destroyed or forced to close’ as part of the offensive that began in December 2019 (Hill & Al-Hlou, 2020).

Idlib is under de facto control of Hayat Tahrir al-Sham, a jihadist Organization that split from Al Qaeda, and the group has not offered a clear strategy for responding to the crisis. In terms of preparing for a potential outbreak of Coronavirus in the governorate, Idlib relies on cross-border delivery of testing kits and protective equipment for health professionals, made possible by the continued operation of the Bab al-Hawa crossing. However, the response has been slow, and after making its first delivery of testing kits to the Syrian government in February, it was not until over a month later that the WHO delivered such kits to the opposition-held northwest (Hill & Al-Hlou, 2020). In the absence of a coordinated response, some local NGOs have tried to bolster the health sector, such as the relief group Violet which ran training session for about 40 nurses and ambulance drivers. Those who benefitted from the training were then split into two teams: those responsible for delivering ‘advice and baskets with soap, brochures and hand sanitizer, and those who transport people suspected of having the virus’ (ibid.). According to a health cluster situation update, as of 11 April only 103 samples of suspected of COVID-19 had been tested from Aleppo and Idlib, all of which



were negative (Health Cluster, 2020a). At the time of the update the WHO and the health cluster were working on two additional labs to increase the very limited testing capacity in the northwest. Once again, it is evident that conflict has helped create the conditions for a public health emergency, suggesting that the experience of polio and cholera outbreaks has not made the WHO, or the global health community more generally, seek to strengthen the emergency preparedness of the health system in the northwest.

The situation in the northeast is also very troubling. The closure of the Al Yarubiyah crossing on the Iraqi border means that Damascus controls humanitarian access to this part of the country. The Syrian government has refused to establish testing facilities in areas outside of its control and suspected cases of Coronavirus must be transported to Turkey for testing. To complicate matters further, Turkey's policy of weaponising access to water in its conflict with the Kurds in northeast Syria 'means that essential hygiene directives to combat the crisis cannot be maintained' (Yahya, 2020). A potential tinderbox in the northeast is Al-Hol camp, home to more than 70,000 refugees including former IS combatants and their families, where there are no ventilators whatsoever and medical facilities are supervised by the SARC and other NGOs in the area with no support from the central government nor from the WHO.

The current pandemic of COVID-19 has taken a severe toll on health systems and caused major economic disruption in some of the most stable and industrially developed countries in the world. We are referring to countries that are free from conflict with good indicators of health that denote robust health systems. A protracted civil war, fractured health governance, the targeting and weaponisation of health care and its impact on health indicators and health system capacity, are just some of the

factors that put Syria at a massive disadvantage in terms of staging a response to the pandemic. What's more restrictions on movement, especially across international borders, puts populations in opposition-controlled areas of the northwest and the northeast at particular risk, as they rely on the supply of medical aid across international borders.

Much like the outbreaks of polio and cholera in 2013 and 2015 respectively, COVID-19 demonstrates the multi-faceted and highly politicised nature of health security in Syria. Once again the WHO has shown itself incapable of offsetting the discriminative policies of the regime in Damascus. Indeed, the Organization has itself called attention to the fact that it does not partner with non-state actors: referring to the delay in distributing test kits to the northwest, a spokesman for the WHO said 'the northwest is not a country' (Hill & Al-Hlou, 2020). Turkey's destruction of the water facilities in the northeast is a stark reminder that a public health emergency of international concern is unfolding against a backdrop of conflict with increasingly international elements, and that the strategy of weaponising and targeting health care continues to be a feature of the violence, leading to the destruction of health infrastructure that will impact the health security of Syrians now and for years to come.

## **6.12. Conclusion**

Focusing on the actors that have visibly assumed a responsibility to protect health care on the ground has helped to give at least a general sense of how, in relation to health care in Syria, activities that fall within the R2P paradigm have taken place spontaneously and largely without any input from those authorities with explicit

mandates to do so according to the 2005 World Summit Outcome document, namely state authorities and the UN system. Certainly the UN Security Council played a role by authorising cross-border relief in resolution 2165 and the WHO became quite involved in cross-border assistance in its capacity as agency lead in the health cluster. Yet the extent to which these actions and activities can honestly be described as the exercise of a responsibility to protect is subject to debate in light of the numerous other ways in which the UN system patently failed to exercise this responsibility.

Instead what we have seen in Syria is local actors and the diaspora community spontaneously assuming the burden of responsibility to continue the provision of health care in Syria and mitigate the effects war crimes perpetrated by the regime. While INGOs such as MSF have also continued to operate in one way or another in Syria, their on-the-ground presence has been determined largely by the perceived level of risk for their staff at any given time or place. Contrastingly, a significant number of Syrian NGOs and health professionals have simply accepted the risks associated with operating in opposition-controlled areas. Almost by default, therefore, in the Syrian context, the responsibility to protect has fallen to local actors as international organisations and UN agencies have been prevented from taking meaningful humanitarian action due to the scale of the violence and the thorny issue of respecting state sovereignty.

The international community's inability and unwillingness to take direct action to prevent war crimes or protect populations from the harm caused by the weaponisation and targeting of health in the Syrian context does not obviate its responsibility to protect. The fact that the Security Council was effectively disempowered by an apparently irreparable rift between two camps in the P5, thereby excluding the possibility of various R2P options available to that organ under chapters VI and VII of

the UN charter,<sup>19</sup> presents an opportunity to explore how the international community's second and third pillar responsibilities might be operationalised in the absence of Security Council powers. It should go without saying that the international community's commitment to assistance and capacity building would be best directed towards actors espousing principles in conformity with the R2P doctrine. In the case of Syria, this was eminently not the central authorities.

Svoboda and Pantuliano (2015) have made the important observation that the term capacity building is 'easily used but rarely defined' (pp. 21-22). It is reasonable, therefore, to ask what the international community's commitment to capacity building means when applied to the protection of health care in Syria. At this point we are dealing with the immediate humanitarian needs of populations affected by the targeting and weaponisation of health, principally in opposition-held areas, rather than the need to prevent the commission of war crimes directed against health care. As such capacity building might be associated with building the capacity of local actors to provide health care. Thus we would need to consider the skills and medical supplies needed to treat cases and other resource requirements such as time and money.

In respect of the skills needed to treat cases, we have seen multiple examples of diaspora organisations such as Syria Relief and SAMS helping to train Syrian doctors and nurses inside Syria, across the border, as well as at distance using remote conferencing and bespoke training applications. Inside the country, Syrian medics in East Ghouta took the initiative to establish a medical college, which focused on general surgeries and internal medicine to respond to the nature of the caseload. Telemedicine

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<sup>19</sup> Including referring suspected crimes of aggression to the Prosecutor of the International Criminal Court (ICC).

has offered some possibilities of overcoming the shortage of experienced health staff in Syria by allowing international medics to guide colleagues inside Syria through complex procedures (Armstrong, 2016). In sum, the remarkable solidarity of the global medical community in the face of mounting atrocities in Syria should be a cause for optimism in an otherwise depressing landscape. The broader humanitarian system should look to this as an important and ready-made building block in its effort to construct a more robust R2P framework.

The advanced state of modern medicine means it is now possible to perform surgeries and offer treatments that would have been unimaginable to war doctors of previous generations. All of this requires more than just skills, however, and medical supplies such as blood, anaesthetic, IV fluid, essential surgical supplies—not to mention the medicines and equipment required in the treatment of non-communicable diseases—are essential for the continued provision of health care in opposition-held areas. A critical challenge has been providing medics with the equipment they need, especially in besieged, hard-to-reach and opposition areas more generally. As we have seen, the cross-border mechanism has been of limited efficacy in allowing for the passage of essential humanitarian goods due to the regime's uncooperative attitude towards requests and the interception of convoys by various parties. As a way of counteracting the regime's reluctance to approve such requests, PHR (2017) recommended that OCHA merely notify the Syrian authorities, without actually requesting approval of the delivery of its contents, 'as is mandated under UN Security Council Resolutions 2165, 2191, 2285, and 2332' (p. 15). A complementary strategy which may also reduce the likelihood of interception of convoys is what has been described as a low-profile approach: 'the use of smaller tonnage and fewer vehicles at a time, no branding, and the

use of commercial carriers' (HLG, 2014: p. 6). Such strategies may appear to deviate from normal protocols according to which central authorities are kept informed of humanitarian activities on the territory and humanitarian actors use internationally-recognised symbols as a means of self-protection. Resorting to such approaches results from a situation in which the normal rules have been so fundamentally violated by all parties to the conflict in Syria, especially the central authorities, that the humanitarian system needs to adapt in order to assist and build the capacity of the local response.

A final point to mention in connection with capacity building is the funding requirements of local actors. Various researchers have highlighted the inter-related issues of the discrepancy between the small amount of funding received by Syrian NGOs and the large amount of humanitarian services they provide, the staggering difference between the salaries of INGO staff and SNGO staff, and the resulting drift of experience from local organisations to international organisations. Clearly inadequate funding undermines the capacity of the local response. This concern has not gone unnoticed and a group of INGOs have pledged to address inequities in the humanitarian system and have issued the 8-point Charter for Change to that end. A priority commitment is to 'increase direct funding to national and local NGOs for humanitarian action' (Charter4Change, 2019: p. 1). Greater funding could benefit SNGOs in multiple ways. Firstly, it would allow them to prioritise their own projects which are often underfunded, 'such as support for besieged areas and rehabilitation of medical facilities' (The Syria Campaign, 2017: p. 54). It may also help to reduce the salary differences between local and international NGOs, which currently has a 'direct negative impact on capacity and capacity building for local organisations' as better qualified staff tend to leave for better-paid positions with INGOs (Els et al., 2016: p. 23). Finally, SIM (2018)

have articulated the need to reconstitute the pool of trained health care professionals in Syria by ‘funding more opportunities for remote education’ as well as ‘ensuring the remuneration of project funded health professionals is sufficient to attract and retain them’ (p. 8). Retention of staff translates as retention of experience, bringing us back to that first element of capacity building: the skills needed to deal with the caseload.

## 7. CONCLUSION

While information on the situation inside Syria has always been patchy due to restrictions on reporting, the report of the OHCHR fact-finding mission in August 2011 was sufficient to alert the international community that the Syrian population was in need of protection from its own state authorities. By August at the very latest, then, the responsibility of Member States to respond collectively in a timely and decisive manner should have been activated.

### 7.1. Paradigm shift

It has been argued that the R2P doctrine calls for a paradigm shift: from an understanding of state sovereignty as something that is defined exclusively by its inviolability to a conception of sovereignty that is tied to a responsibility to protect. Of course this requires advocacy at the highest levels, which is where the General Assembly dialogues on R2P play a role, but for Member States simply to acquiesce in the principle is insufficient to guarantee the all-important transition ‘from the realm of rhetoric to the realm of doctrine, policy and action’ (UNSG, 2009: para. 13).

The approach I have taken is intended to demonstrate that only by applying the R2P paradigm to a real-world scenario can we make any progress on moving from the realm of rhetoric to the realm of doctrine, policy and action. In doing so we look forensically at what constitutes an R2P crime, the factors that may have contributed to its commission, and the relative success or failure of attempts to prevent it or mitigate its impact on the populations of concern. I have argued that the targeting and



weaponisation of health care constitutes one of the most clear-cut examples of an R2P crime in the Syrian context. Characterising the evolution of this category of crime from the early days of the uprising, through the most destructive years of the war, up to recent events, has allowed us to explore how the international community's response to the threat or commission of atrocity crimes is insufficiently determined by humanitarian motives. Instead, geopolitical dynamics, the state of applicable international law, and the UN system's bias towards state security, among a host of other factors, often prevent the international community from staging a response that takes its shape from the R2P paradigm.

While this may tempt some to conclude that R2P, by failing to explicitly account for the factors that complicate international action, is deficient as a tool for guiding prevention- or protection-oriented action, I have tried to emphasise the value of R2P as a norm that the international community should aspire towards, even if it may sometimes appear unattainable. R2P is not a detailed roadmap that can be used by the international community to determine an appropriate and sufficient response to atrocity crimes. Though it may offer useful signposts, such as the three pillar model, or the distinction between structural and operational prevention, an effective response to the threat or commission of atrocity crimes will be the hard-won product of successive attempts to interpret those signposts in real-world situations.

Of course, it is far from straightforward interpreting when the international community should be focusing its efforts on either operational prevention or protection, or at what point the state has failed in its primary responsibility thereby activating the third pillar responsibility of the international community. Nevertheless, these signposts do offer a way of conceptualising the role of different actors in the international

community and how their modalities enable them to perform that role. For example, the WHO's presence on the territory of its state partner and its information collection capability suggests that it could play a more active role in issuing early warnings of serious violations of protections for health workers and facilities. The UPR of the Human Rights Council is another tool that could help raise the alarm at an early stage.

This approach also helps us to identify where there are weaknesses in the existing institutional arrangements. One of the main issues we have identified is the WHO's constitutional commitment to partnering with states at the exclusion of non-state actors. This has been problematic in opposition-held areas of Syria where the majority of protection services have been provided by NGOs and other local actors independently of the central authorities and therefore without any assistance from the WHO. In contexts where the WHO's state partner is failing to protect the health security of the population, its contractual and constitutional commitments compel the Organization to compromise on its primary objective of 'the attainment by all peoples of the highest possible level of health' (WHO, 2006: p. 2).

The Syrian case has also shown how counter-terrorism legislation can impede the effective implementation of the R2P doctrine. The national authorities have sought to justify their violence towards health workers using a narrative of counter-terrorism. More broadly, international counter-terrorism legislation has impacted on the work of humanitarian actors by restricting international organisation's ability to operate in areas where groups with a terrorist label control territory and resources, as well as their ability to partner with local NGOs who may be susceptible to influence by the same groups. Mitigating the deleterious effects of the counter-terrorism paradigm on protections for

health workers and facilities will require a number of legislative and programmatic interventions that will be outlined below.

For the effective prevention of atrocity crimes, early warning and response is indispensable. We have argued that the aerial bombardment of hospitals by the Syrian regime was part of an escalating trend of the targeting and weaponisation of health care. While the system of early warning is by no means perfect, signs were there to be interpreted as far back as the Special Rapporteur on the right to health's 2010 Syria report, in which concerns were raised about the exclusion of the Kurdish minority from social services, including health care. Soon after protests erupted across the country in 2011, there were reports of state security targeting ambulances and perpetrating human rights violations in hospitals. The case of Syria illustrates how no single actor in the international community has been mandated with a responsibility to uphold protections for health workers and facilities and, as such, while these reports may have shocked the conscience of readers, they did little to trigger a response from the international community. Thus it is imperative to establish accountability for documenting human rights abuses, issuing early warnings, and responding to those warnings. We will go on to explore options for strengthening the system of early warning and response as it applies to atrocity crimes affecting health care.

It is my view that moving 'from the realm of rhetoric to the realm of doctrine, policy, and action' demands that we acknowledge the central importance of local actors, whether individuals or organised collectives, in voluntarily embracing a responsibility to protect. During the Syrian conflict, doctors, nurses, local NGOs, expatriate NGOs, have all continued providing health care to local populations despite the besiegement of civilian areas and the bombardment of hospitals with internationally-prohibited

weapons. The conflict in Syria will no doubt be remembered for its brutality and the inertia of the international community. What should not be forgotten is the bravery of Syrians who assumed a responsibility to protect their fellow citizens despite considerable risk to themselves.

## **7.2. Integrating local actors into the R2P framework**

The 3 pillars that constitute the R2P framework create the impression that the responsibility to protect is shared between the authorities of the state in question and the international community narrowly understood to mean the Security Council, the General Assembly, and UN Member States. This would appear to emphasise the dynamic whereby, if the state fails in its primary responsibility to protect, it is down to the international community—typically the Security Council—to intervene on behalf of the affected population. Such an arrangement seems to ignore the potentially important role other actors can play when it comes to protecting populations from the effects of atrocity crimes. As far as we are concerned, the international community, which also comprises donors, international organisations and UN agencies, needs to be in a position where it can flexibly partner with non-state actors and local NGOs in order to strengthen the resilience of health systems in conflict.

When human rights situations are appraised by UN missions, there is a tendency to direct recommendations to the state concerned, as if to do otherwise would violate state sovereignty. R2P, however, challenges us to think about sovereignty as a condition underpinned by responsibility. Repeatedly reminding a state that it is failing to meet its obligations under international human rights law or international humanitarian law is no

substitute for an effective system of international justice. A more fruitful approach would be to recognise that criminal regimes like the one in Syria do not take the modalities invented for the protection of human rights seriously and will not listen to recommendations made by Member States whose intentions they consider to be antagonistic and/or imperialistic. Following such an approach should lead to a greater emphasis on the role of actors that (i) have a degree of influence on the ground and (ii) defend human rights and subscribe to humanitarian principles. Under R2P, the role of the international community in providing assistance to the state, building its capacity, and intervening when the time comes, would be reconceptualised with a new emphasis on building the capacity of the kind of actors meeting the above criteria.

Studying the humanitarian crisis in Syria yields numerous examples of such actors assuming a responsibility to protect after the state had failed to do so. We have seen how the Aleppo City Medical Council (ACMC) was established to coordinate health services in rebel-held east Aleppo. The regime's targeting of health care meant the ACMC had to invent ways of protecting staff and health facilities from attacks, such as discarding insignia and sirens on ambulances and moving operating theatres underground. Also remarkable is the fortitude of a number of doctors, nurses and other medical staff who remained in east Aleppo despite increasingly heavy bombardment and the area's eventual besiegement. Such individual acts of bravery and compassion are a powerful reminder that the responsibility to protect is most keenly felt at the interpersonal level. It is this concern for the wellbeing of those around us that constitutes the core of the R2P doctrine, and whatever the imperfections of the three pillar model as it is currently understood, the basic moral imperative of R2P would appear to hold across different contexts.

The Independent Doctors Association (IDA) is another example of how Syrians on the ground took the initiative to compensate for the failing health system in opposition-held areas by establishing primary healthcare centers and an expanded programme on immunisation in and around Aleppo governorate. Indeed, the theme of immunisation has been especially salient during the conflict in Syria, with the intentional destruction of health facilities impacting on health services and resulting in lower vaccination rates among children. The 2013 outbreak of Polio in opposition-held areas exposed the limits of the WHO's ability to respond to infectious diseases in conditions of civil conflict. Being unable to partner with actors external to the government, the WHO was unable to provide support to the ad hoc coalition of NGOs, the Polio Control Task Force (PCTF), which assumed responsibility for the outbreak in the absence of the Syrian state. Similarly, during the 2015 cholera outbreak, the WHO was unable to use data provided by the Early Warning Alert and Response Network (EWARN), despite researchers finding that EWARN information was more complete and timely than that captured by the government's early warning system. Once again, the fact that those responsible for setting up the network were not part of the Syrian government, in addition to what the researchers considered the unreasonable expectation that EWARN perform lab testing of samples, made a partnership with the WHO impossible. More recently, there have been fears that COVID-19 would rapidly spread in Syria with the health system still on its knees after 9 years of conflict. The WHO has been slow to deliver desperately needed shipments of PPE to the rebel-controlled northwest of the country via the cross-border mechanism. Local actors have done what they can to prepare for a potential outbreak, with relief group Violet, for example, delivering training session for about 40 nurses and ambulance drivers in Idlib

province. Looking elsewhere, the situation in the Kurdish-controlled northeast offers little in the way of optimism, with this area beyond the reach of the international community and acutely under-resourced.

These examples are intended to demonstrate that the WHO has been largely unable to provide assistance to the actors who have assumed a responsibility to protect populations from the direct and indirect effects of the regime's targeting and weaponisation of health in opposition-held areas. Looking at the wider response of the international community, it is significant that international humanitarian organisations such as MSF have had to withdraw from OHAs because of the intolerably high level of risk to staff. Both of these factors, the WHO's limited assistance and the withdrawal of international humanitarian organisations, have resulted in local actors providing the majority of health care and humanitarian relief in opposition-held areas. Despite their increasing share of protection responsibilities, local actors have not enjoyed commensurate levels of support from the international community in terms of funding, training, and other forms of capacity building. The case of Syria has demonstrated the inflexibility of the formal humanitarian system insofar as international organisations and UN agencies often imposed unrealistic standards on operational partners, thereby slowing the response and preventing bonds of trust being formed between upstream actors and their implementing partners. As mentioned earlier, one of the challenges has been the impact of counter-terrorism legislation.

### **7.3. Counter-terrorism and IHL**

At the domestic level, the enactment of law 19/2012 and the establishment of the Counter-Terrorism Court have enabled the Syrian state to prosecute individuals for providing health services to perceived opponents of the regime. The legislation largely negates due process and makes confessions extracted under torture admissible as evidence. This politicisation of health care, alongside the targeting of medical personnel and facilities by the regime, has resulted in a situation where health providers in opposition-held areas are completely alienated from the regime. Constitutionally bound to respect the sovereignty of the government, the World Health Organization has been unable to provide substantial support to actors in opposition areas. Other UN agencies and international organisations have faced similar constraints when operating out of Damascus, being restricted to working in government-held areas and obliged to partner with actors preapproved by the authorities without conducting their own due diligence. This is a particular cause for concern as it has been reported that the security services have ready access to the beneficiary lists and programming of these potential partners (HRW, 2019).

In contrast, where the formal humanitarian system has been able to engage local actors in opposition areas, many international actors have individually developed tools to vet their local partners to ensure they are in no way affiliated with terrorist groups. The High-Level Panel on Humanitarian Financing has recommended that national NGOs should only have to undergo one of these assessments. In addition to simplifying the assessment of new partners, I would add that, in R2P scenarios, the UN should stake out its position that all downstream partners, whether preapproved by the government or



not, should be vetted for compliance with international human rights and international humanitarian law.

At the level of international legislation, the Security Council has not taken measures to exempt fundamental protections for medical care in armed conflict from obligations related to addressing terrorist threats. This has created a very complex operational environment for humanitarian actors, leading some to voice their concerns that counter-terrorism policy is massively restricting their ability to extend aid to those most in need. A group of NGOs highlighted the fact that humanitarian actors must be in a position to negotiate with all the relevant actors in an area in order to access populations in need and supply humanitarian aid, but counter-terrorism legislation prevents them from doing so (Première Urgence, 2020).

It seems necessary, therefore, to revive the imperative of protecting health workers and facilities from attacks. We have seen how UNGA Resolution A/RES/66/253 B, which addressed the Syrian government's failure to protect its population, mentions only 'interference with access to medical treatment' despite the resolution being passed in August 2012, by which point there was little question that the regime was intentionally killing health workers and destroying hospitals. Such scant treatment of this category of war crimes is remarkable when compared with resolution's demands relating to chemical and biological weapons and the reference to specific instruments of international law regulating their use. The issue of chemical weapons was likewise the subject of several Security Council resolutions, the first of which, passed in 2013, called for the verification and destruction of Syria's chemical weapons stockpiles. This was followed by a 2015 resolution establishing the UN-OPCW Joint

Investigative Mechanism to determine responsibility for the use of chemical weapons in Syria.

The General Assembly and Security Council resolutions serve as a reminder that there exists a relatively strong consensus within the international community on the prohibition of chemical and biological weapons. This has its clearest expression in the Chemical Weapons Convention which ‘aims to eliminate an entire category of weapons of mass destruction by prohibiting the development, production, acquisition, stockpiling, retention, transfer or use of chemical weapons by State Parties’, with all State Parties having agreed to disarm themselves of this category of weapons (OPCW, n.d.). The Convention also established the Organisation for the Prohibition of Chemical Weapons (OPCW) to ensure the implementation of its provisions. It is interesting that following a deadly chemical weapons attack in Damascus on 21 August 2013, Syria sent a letter to the Secretary-General on 12 September 2013 acceding to the Chemical Weapons Convention and ‘the United States and Russia agreed a plan with Syria to remove its chemical weapons by mid-2014’ (BBC, 2014).

The Chemical Weapons Convention is a source of international law that enjoys almost universal buy-in of Member States. It represents the consolidation of a norm, which emerged in the 1920s, that under no circumstances can the use of chemical weapons be justified. What’s more, a specially-established organisation, the OPCW, is responsible for implementing the Convention. It is worth asking whether efforts to revive the imperative of protecting health workers and facilities in conflict might be similarly assisted by a convention consolidating and extending the relevant sources of international law. Countries across the world are increasingly experiencing attacks on health care, from Nigeria to the Democratic Republic of the Congo, Yemen, the

Occupied Palestinian Territories, Libya and Afghanistan, to name just a few. A convention that establishes clear standards for the protection of health care in peacetime and conflict is needed now more than ever because failing to hold perpetrators accountable will set a dangerous precedent. Such a convention would oblige States Parties to allow the WHO, possibly with assistance from the Human Rights Council, to develop an early warning system for health-related human rights abuses; one that, unlike the WHO's Surveillance System for Attacks on Health Care, identifies the perpetrator. Another important feature of the convention would be to establish a body to periodically review any discrepancies between the convention and counter-terrorism legislation to ensure that states and non-state actors understand the primacy of health security and that medical professionals are able to practice without fear of punishment.

#### **7.4. Capacity building**

Capacity building is a central plank of the international community's responsibility to protect. It contributes to both the prevention and protection components of R2P. When thinking about health sector vulnerabilities to human rights abuses and war crimes, it is useful to have recourse to the three dimensions of health security: (i) early detection and response to public health emergencies of international concern (PHEIC), usually infectious diseases; (ii) humanitarian crises of both natural and human-induced origin; and (iii) acute and chronic health inequities and poverty. In Acardu and Zagaria's (2015) assessment, the WHO's International Health Regulations and its 2007 *World Health Report* illustrate the Organization's commitment to building the capacity of its state partners only in respect of that first dimension of health security,

relating to PHEIC. In Syria, the WHO's myopic approach to health security meant health inequities resulting from discriminatory government policies went unaddressed by the Organization.<sup>20</sup>

With the onset of civil war in Syria, the interactive effects of pre-existing health inequities and a humanitarian crisis of human-induced origin caused an acute decline in key indicators of health in rural areas, creating the conditions for the spread of communicable diseases. In the absence of efforts to strengthen health governance at the local level, health inequities persisted and already strained health services were unable to cope with the shocks to supply and demand caused by the spread of civil conflict. While the WHO may have invested in building the capacity of the Ministry of Health to respond to PHEIC, this capacity was seriously undermined when opposition groups seized control of large parts of the Syrian territory, putting an end to the provision of government services in those areas.

I have argued that the WHO must adopt a more holistic approach to health security, one that does not neglect the other two very important dimensions of the concept. Such a reorientation should also take into account the role played by actors involved in health governance at the local level when it comes to capacity building. This would constitute a major shift in the way the WHO currently operates, and for that reason I find it useful to refer to an initiative of the UN to provide a framework that would allow its principal health agency to deliver on the different components of health security. The framework I have in mind is the Human Rights up Front (HRuF) initiative.

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<sup>20</sup> Recall that during the 2011 UPR, the neglect of health care services in rural communities and the active discrimination of the Kurdish minority were brought to the attention of the working group.

#### **7.4.1. HRuF and the WHO**

Part of the Human Rights Council's mandate is to promote 'the effective coordination and the mainstreaming of human rights within the United Nations system' (UNGA, 2006: para. 3). This function of the Council would appear to make it the appropriate authority to take the lead on implementing the Human Rights up Front (HRuF) Action Plan, which seeks to address the UN's responsibility to protect populations from the most egregious violations of human rights via three types of change: (i) a cultural change, requiring staff 'to recognize human rights and protection of civilians as a core responsibility' and encouraging them to act with 'moral courage' knowing they have the backing of UNHQ; (ii) an operational change, supporting better early warning, shared analysis, and capacity to respond; and (iii) a change to UN political engagement, encouraging 'more proactive engagement with Member States to generate political support for early and preventive action' (IASC, 2015: p. 1).

This study has drawn attention to the fact that the World Health Organization in Syria has not been able to deliver on its primary objective of 'the attainment by all peoples of the highest possible level of health'. Nor has the Organization, as a key player in the global health community, lived up to its responsibility to protect the health of the Syrian population after the state began weaponising and targeting health care. A powerful example of this is the WHO's role in helping the Central Blood Bank to evade an international sanctions regime on the Syrian government. Not only did it spend millions of dollars donated by countries imposing sanctions on Syrian state entities to support the blood bank, it did so while access to blood was being instrumentalised by the Ministry of Defence to punish perceived opponents of the regime. There is little question then that the WHO was failing to uphold the standards of the HRuF.

In terms of the cultural change described by the HRuF, it is perhaps of interest to note that the WHO's Syria office is located in the Ministry of Health building in Damascus and 'many of its staff are former ministry employees' (Coutts & Fouad, 2014). Such an arrangement reflects the close partnership between the Organization and its state partners, a partnership which has led some to question the former's ability to act impartially (Kennedy & Michailidou, 2013). Extrapolating from this, it is conceivably the case that WHO staff do not 'recognize human rights and protection of civilians as a core responsibility' where upholding this responsibility might jeopardise the Organization's partnership with the state concerned.

An organisational culture in which staff at all levels of seniority are encouraged to act with 'moral courage' in calling out (i) human rights abuses that impact on health care and (ii) the failure of the WHO to proactively address such abuses, would naturally lead the Organization towards a more holistic engagement with health security. A culture of bearing witness would, first of all, ensure that more staff are made responsible for identifying and reporting on health inequities—the first step towards building resilience into health systems. Secondly, a culture of greater information sharing would lay the foundations for an operational change that supports better early warning, shared analysis, and capacity to respond. In addition to developing more suitable standard operating procedures (SOPs) to ensure uniform compliance with the HRuF framework, WHO senior staff should not be afraid to engage politically. If the cultural and operational changes described lead to the reporting of more information related to human rights abuses, senior figures should be prepared to act on this information and exercise political pressure in the name of defending human rights and protecting health care services.

Given the deliberate targeting and weaponisation of health care during the conflict in Syria, it is worth asking whether this experience has prompted the WHO to focus more of its resources on the protection of health workers and facilities. Clearly, in order to arrive at ‘the attainment by all peoples of the highest possible level of health’, health systems require functioning facilities and sufficient personnel, especially during conflict when the trauma caseload is likely to be heavy. The intentional destruction of health facilities directly undermines this objective and should therefore be of profound concern to the WHO. In 2016, the Organization did establish a global Surveillance System of Attacks on Health care (SSA). Given that the surveillance system is a response to gross violations of legally-enshrined protections for health workers and facilities, in its conception it is an instrument of human rights. However, as already mentioned, the SSA does not identify perpetrator of attacks, meaning it does little to contribute to efforts to hold the authors of such crimes accountable for their actions. If achieving justice for victims of attacks is not the primary objective of the SSA, then one might expect it at least to contribute towards the kind of operational change described under the HRuF: ‘supporting better early warning, shared analysis, and capacity to respond’, specifically in relation to attacks on health care. That is, it must be a tool for preventing such attacks. And yet, this is not made apparent by the stated purpose of the system, which is ‘to systematically collect and make available data on attacks on health care, and their immediate impact on health care in countries facing emergencies’ (WHO, 2018: p. 4). Elsewhere only tentative indications are given as to how the SSA might actually contribute to efforts to prevent or at least mitigate the effects of attacks: it is intended to ‘provide the evidence base from which to implement advocacy to stop attacks on health care’ as well as ‘identify global and context-specific trends and

patterns of violence to inform and implement risk reduction and resilience measures so that health care is protected and health services are available' (WHO, 2018: p. 4). Risk reduction and resilience measures are certainly important, and they correspond with the 'capacity to respond' component of the HRuF's operational change. Advocating the cessation of attacks on health care, on the other hand, is not an end in itself but the means. While these objectives point in the right direction in terms of strengthening protections for health workers and facilities, they do not articulate clear accountability mechanisms to advance such protections.

All things considered, it is plain that important components of the SSA resemble the types of changes recommended under the HRuF initiative. What appears to be missing is an accountability framework that would enable the WHO actually to achieve its aspirations for the surveillance system. By failing to address the question of accountability in a sufficiently detailed manner, the SSA initiative will not give rise to strengthened protections for health workers and facilities. And it is here that the Human Rights Council should exercise that part of its mandate relating to mainstreaming human rights in the UN system. Through its Special Rapporteur on the right to health, the Human Rights Council can remind the WHO of the various health care-related protections that exist under customary international law and relevant treaty law and submit suggestions as to how the SSA and other modalities of the Organization may be adapted to advance these protections. This may involve a process similar to the UPR, whereby the WHO is required to submit a report documenting how it has sought to integrate a human rights perspective—including early warning of human rights violations—into all areas of its mandate.



A cross-cutting issue, and something that has recurred throughout the analysis, relates to the WHO's commitment to partnering exclusively with state authorities. Outbreaks of infectious diseases in a context of divided sovereignty—where government services are restricted to government-controlled areas—offer compelling examples of why the WHO should remain open to partnering with non-state actors. And this does not only apply to conflict. If in peacetime, when there are fewer concerns over military control of the territory, the state pursues discriminatory policies of restricting access to health in certain areas or to certain groups, the WHO needs to address this, firstly through advocating on behalf of the vulnerable groups concerned, which corresponds with more proactive political engagement advocated under the HRuF. If that doesn't work, the WHO should be prepared to build the capacity of the health system in the relevant areas by partnering directly with local authorities, health centers, NGOs, etc.

Important also to emphasise is that, while resolution 2165 has enabled the WHO office in Gaziantep to help strengthen health provision inside rebel-controlled areas of northern Syria, the forms of assistance it has been able to provide have been very limited. Recall, for example, the time it took the WHO to deliver desperately needed shipments of PPE and testing kits to the opposition-held northwest of the country via the cross-border mechanism, with the supplies arriving over a month after the first shipments arrived in government-controlled areas (Hill & Al-Hou, 2020). This example shows that the cross-border mechanism cannot compensate for incapacitated local health systems, especially when facing a PHEIC. A holistic understanding of health security would emphasise the importance of preventive work to avoid the incapacitation of local health systems in the first place. This is the principle upon which I argue that

serious consideration should be given to possibility of the WHO operating outside state structures *before* the situation in a country descends into a humanitarian crisis. Finally, we should conclude by saying that the global health community has a responsibility to work towards equitable access to health care for the simple and persuasive reason of improving key indicators of health across the board. There is little question that limited access to basic health services is a far greater driver of illness and premature death over the long-run than mass atrocities and conflict in general.

#### ***7.4.2. Integrating a human rights perspective at the level of service delivery***

In Chapter 1 we discussed incidents of health workers breaching their duty of care early in the uprising. Amnesty International documented cases of medical staff verbally and physically assaulting wounded patients in national and military hospitals. These accounts suggest that health care-related human rights abuses were not attributable solely to combatants: in some cases hospital staff were the authors of such abuses. In accordance with its function of promoting ‘improved standards of teaching and training in the health, medical and related professions’, the WHO should consider delivering specialised training on the primacy of medical neutrality in times of unrest or conflict. The need for such training may be greatest among health workers with less training than their specialised and highly-skilled colleagues, such as doctors, whose long course of training tends to foster a deep appreciation of fundamental medical principles relating to their duty of care towards patients. The fact that many of the worst abuses, including unlawful detention and torture, reportedly occurred in the Homs military hospital suggests that monitoring standards of care in health facilities under the jurisdiction of defence ministries should be prioritised by the WHO, perhaps in collaboration with the International Committee of the Red Cross (ICRC), especially in

the event of civil unrest. Integrating a human rights perspective at the point of service delivery will likely facilitate the kind of cultural change imagined by the HRuF within the WHO's health care-providing partners, and enhance health care-related protections to the extent that health workers are willing and able to report violations if and when they occur. This in turn will feed into better 'early warning, shared analysis, and capacity to respond' as local staff become stakeholders in the human rights paradigm.

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