PROTECTING THE WOUNDED, SICK AND SHIPWRECKED UNDER INTERNATIONAL HUMANITARIAN LAW: BETWEEN HUMANITARIAN IDEALS AND WARTIME REALITIES*

Abstract

The protection of the wounded, sick and shipwrecked is one of the most enduring humanitarians guarantees under international humanitarian law (IHL). Rooted in Henry Dunant's vision after the Battle of Solferino in 1859 and first codified in the 1864 Geneva Convention, the framework has evolved into a comprehensive body of treaty and customary rules binding on state and non-state actors alike. At its core, IHL imposes obligations to respect, protect and provide humane treatment and medical care to all wounded, sick and shipwrecked persons without adverse distinction, save on medical grounds. The Geneva Conventions of 1949 and the Additional Protocols of 1977 consolidate these obligations, harmonising earlier distinctions between combatants and civilians, while extending protection to maternity cases, newborns, expectant mothers, parachutists in distress and other vulnerable groups. Despite the clarity of these norms, violations persist in practice, ranging from the civil wars in Liberia and Sierra Leone to recent counter-insurgency operations in Nigeria, exposing the tension between military expediency and humanitarian imperatives. This article critically examines the treaty framework and customary rules, the role of humanitarian actors, and the challenges of enforcement, arguing that the regime's effectiveness lies not merely in codification but in faithful implementation, accountability for breaches and the reinforcement of humanitarian norms in modern warfare.

Keywords: International Humanitarian Law, Geneva Conventions, Wounded, Sick, Shipwrecked, Humanitarian Protection

1. Introduction

The protection of the wounded, sick, and shipwrecked in situations of armed conflict represents one of the oldest and most deeply entrenched guarantees of international humanitarian law (IHL). At its core, this principle reflects the recognition of the inherent dignity of all human beings, irrespective of their status as combatants or civilians. The rule that persons rendered hors de combat, whether through wounds, sickness, or shipwreck, must not be left to die or subjected to inhumane treatment is now universally acknowledged as customary international law.[1] Yet, this principle did not arise in a vacuum. Its development has been shaped by historical experience, codified progressively through international conventions, and refined in response to the challenges of modern warfare. The turning point was Henry Dunant's humanitarian vision after witnessing the horrors of the Battle of Solferino in 1859. His proposals in Un Souvenir de Solferino inspired the creation of the International Committee of the Red Cross (ICRC) in 1863 and led to the adoption of the first Geneva Convention in 1864.[2] That Convention laid down three principles that remain foundational today: the duty to collect and care for the wounded without discrimination, the neutrality of medical services, and the distinctive emblem of the Red Cross.[3] This paper interrogates the historical development and current legal framework of protections under IHL for the wounded, sick, and shipwrecked. It critically analyses the duties imposed on parties to conflict, the role of humanitarian organisations, and the persistent challenges of compliance. It draws principally from the four Geneva Conventions of 1949 and their Additional Protocols of 1977, supplemented by customary law and relevant case studies.

2. Historical Evolution

The 1864 Geneva Convention inaugurated what has become known as 'Geneva Law', that branch of IHL concerned primarily with the protection of persons, in contrast with 'Hague Law,' which regulates the means and methods of warfare.[4] Though limited in scope to land warfare, the Convention was revolutionary: it mandated impartial care for wounded combatants, affirmed the neutrality of medical personnel, and adopted the Red Cross emblem. Subsequent treaties expanded this regime. The 1906 Geneva Convention broadened protection to persons attached to armed forces, while the Hague Conventions of 1899 and 1907 extended protections to naval warfare, covering sailors, medical vessels, and shipwrecked combatants.[5] The 1929 Geneva Convention consolidated rules on the treatment of the wounded and medical units. The landmark 1949 Geneva Conventions further entrenched these protections. Geneva Convention I (GCI) addresses the wounded and sick in armed forces on land; Geneva Convention II (GCII) deals with the wounded, sick, and shipwrecked at sea; Geneva Convention III (GCIII) protects prisoners of war; and Geneva Convention IV (GCIV) extends humanitarian protections to civilians, including the infirm, expectant mothers, and children.[6] The Additional Protocols of 1977 represented the most significant expansion. Additional Protocol I (API) consolidated definitions and extended protection to all wounded, sick, and shipwrecked persons, civilian or combatant, while Additional Protocol II (APII) adapted these guarantees to non-international armed conflicts, reflecting the prevalence of internal wars in the post-colonial era.[7]

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[5] Hague Convention II with Respect to the Laws and Customs of War on Land (1899).

[6] Geneva Convention I (12 August 1949) 75 UNTS 31.

[7] Protocol Additional to the Geneva Conventions (Protocol I) (1977) 1125 UNTS 3.

3. Definition of Protected Persons

Understanding the scope of protection requires a clear grasp of the categories of persons entitled to benefit. Initially, the 1864 Geneva Convention applied only to wounded combatants. By 1949, GCI and GCII extended protections to all wounded, sick, and shipwrecked members of armed forces, including those who fall into enemy hands. GCIV further guaranteed medical protection for civilians, including maternity cases.[8] Article 8 of API provides the most comprehensive definitions, covering all persons, military or civilian, requiring medical assistance, including maternity cases, newborns, and the infirm.[9] The Protocol also regulates the treatment of parachutists in distress, stipulating that they must not be attacked during descent or upon landing unless engaging in hostile acts.[10] These definitions demonstrate a shift from nationality and allegiance to humanitarian need as the basis for protection. However, individuals who engage in hostile acts while wounded or sick temporarily forfeit protection until such acts cease.[11]

4. Core Protections

The protective regime rests on the triad of obligations: respect, protect, and treat humanely.[12] Belligerents must refrain from harming incapacitated persons, must actively shield them from further harm, and must provide them with food, shelter, and medical care. Article 12 of GCI provides that the wounded and sick 'shall be respected and protected in all circumstances and shall be treated humanely and cared for without any adverse distinction.'[13] API reinforces this in Article 10, mandating protection for all categories of wounded, sick, and shipwrecked, while APII, Article 7, extends this to non-international conflicts.[14] The principle of impartial treatment ensures that medical need takes precedence over political or military considerations, embodying the humanitarian essence of IHL.

5. Search, Collection, and Evacuation

IHL imposes affirmative duties on belligerents to search for, collect, and evacuate the wounded, sick, and shipwrecked. Article 15 of GCI obliges parties 'at all times, and particularly after an engagement' to take measures to locate and protect casualties.[15] Similar obligations exist under GCII (Article 18) and API (Article 15), which also empower humanitarian bodies such as the ICRC to offer assistance.[16] These obligations underline that humanitarian protection is not merely passive; it requires proactive efforts, even amidst ongoing hostilities.

6. Protection of Medical Personnel and Units

From 1864, the law has recognised the indispensable role of medical personnel. Articles 24-26 of GCI require that they 'shall be respected and protected in all circumstances.'[17] Civilian medical staff are covered under API, which forbids punishment of personnel for treating 'enemy' fighters in accordance with medical ethics.[18] Medical establishments and transport are similarly protected (GCI, Article 19; API, Article 12), with protection only lost if used to commit hostile acts, and even then, only after due warning.[19]

7. Medical Aircraft, Safety Zones and Distinctive Emblems

Modern IHL extends protection to medical aircraft (API, Articles 24–31), hospital zones (GCI, Article 23; GCIV, Article 14), and neutralised zones (GCIV, Article 15).[20] Distinctive emblems, Red Cross, Red Crescent, and Red Crystal, signal neutrality and immunity. Misuse constitutes perfidy and is prohibited under Article 37 API.[21] Hospital and safety zones established under GCIV must be respected by all parties.[22] Neutralised zones can be set up in combat areas to shelter the wounded and non-combatants.[23] Yet, misuse of medical units or emblems to commit hostile acts results in loss of protection, though only after due warning.[24] The distinctive emblems themselves, Red Cross, Red Crescent, Red Crystal, are protected under treaty law, with misuse criminalised.[25] The ICRC has repeatedly stressed that trust in these symbols is essential for humanitarian work.[26] Attacks on emblem-bearing units, when lawfully used, amount to war crimes under the Rome Statute.[27]

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[8] Geneva Convention IV (12 August 1949) 75 UNTS 287.
[9] Protocol I, art 8.
[10] Protocol I, art 42.
[11] Sassòli M, *International Humanitarian Law: Rules, Controversies and Solutions* (2nd edn, Edward Elgar 2023) 98.
[12] Scobbie I, 'Principle of Humanity in IHL' in Clapham A (ed), *Oxford Handbook of International Human Rights Law* (OUP 2014).
[13] Geneva Convention I, art 12.
[14] Protocol II, art 7.
[15] Geneva Convention I, art 15.
[16] Geneva Convention II, art 18; Protocol I, art 15.
[17] Geneva Convention I, arts 24–26.
[18] Protocol I, art 9.
[19] Protocol I, art 12.
[20] Protocol I, art 24.
[21] Geneva Convention IV, art 15.
[22] Protocol I, art 21.
[23] Akande D and Gillard E, 'The Protection of Medical Personnel in Armed Conflict' (2016) 97 *IRRC* 1.
[24] Prosecutor v Galić (ICTY, 2006).
[25] UNGA Res 60/147 (16 December 2005).
[26] Geneva Conventions Act, Cap G3 Laws of the Federation of Nigeria 2004.
[27] Nigerian Red Cross Act, Cap N130 LFN 2004.

8. Dead and Missing Persons

The duty to respect human dignity extends beyond death. GCI (Article 15) and GCII (Article 20) require parties to collect and bury the dead with dignity. GCIII (Article 120) and GCIV (Article 130) impose obligations regarding deceased prisoners and civilians.[28] API (Articles 33–34) strengthens the right of families to know the fate of their relatives and to maintain gravesites.[29] Historical precedents, such as the Pohl case at Nuremberg, demonstrate that despoliation of bodies can constitute a war crime.[30]

9. Prohibitions

The regime is reinforced by express prohibitions: i) Reprisals against wounded, sick, and medical personnel are forbidden (GCI, Article 46);[31] ii) Perfidy, including misuse of emblems, is prohibited (API, Article 37).[32] Inconsistent medical practices, such as biological experiments, are outlawed (API, Article 11).[33] Pillage and looting of wounded or dead is prohibited (GCI, Article 15).[34]

10. Case Studies: Compliance Challenges

Despite codification, compliance remains problematic. Nigeria's Niger Delta (2009): Military operations by the Joint Task Force resulted in indiscriminate attacks, denial of medical care, and destruction of civilian property, contravening GCI Articles 12 and 15.[35] Liberia and Sierra Leone: Civil wars saw widespread targeting of medical personnel, looting of hospitals, and denial of care to wounded civilians.[36] Such conduct violated GCIV protections and API prohibitions. Global Trends: International tribunals, such as ICTY in Tadić, have affirmed that many of these rules bind parties in non-international conflicts. Customary IHL also reinforces duties toward medical personnel.

11. Conclusion and Recommendations

The protection of the wounded, sick, and shipwrecked is one of IHL's most enduring achievements. Yet, persistent violations, from Nigeria to Sierra Leone, demonstrate that codification alone is insufficient. The followings are the recommendations:

Dissemination and Training: States must integrate IHL rules into military training and non-state armed group engagement.[37]

Accountability and Enforcement: Violations must be punished through domestic courts, international tribunals, and the ICC.[38] ICTY jurisprudence, such as Galić, reinforces accountability. Victims also have a right to remedies recognised in UN GA Res 60/147.[39]

Domestic Implementation: Nigeria's Geneva Conventions Act provides domestic incorporation.[40] The Nigerian Red Cross Act protects the emblem and supports humanitarian action.[41] At the regional level, the AU Malabo Protocol envisages accountability for IHL violations.[42]

Humanitarian Access: Humanitarian actors, including the ICRC, must have unimpeded access.[43] The ICRC's Health Care in Danger project highlights challenges.[44] WHO data confirms that health facilities are increasingly targeted.[45] UN SC Resolution 2286 reaffirms the consensus against such attacks.

Emerging Challenges: IHL must adapt to new realities such as cyberattacks and drones.[46] Watkin stresses the misuse of hospitals and human shields as growing concerns. The International Law Association highlights proportionality challenges. Scobbie emphasises the centrality of the principle of humanity.[47] UN OCHA calls for political pressure on states and armed groups to safeguard humanitarian space.

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[28] AU Protocol on Amendments to the Protocol on the Statute of the African Court of Justice and Human Rights (Malabo Protocol 2014).
[29] NRC, Operational Access Report (2019).
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[31] WHO, Attacks on Health Care in Emergencies: Report 2016–2023 (2024).
[32] UNSC Res 2286 (3 May 2016).
[33] Sassòli (n 11) 512.
[34] Watkin K, 'Use of Human Shields and Hospitals' (2016) 47 *Israel YHR* 85.
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[36] Scobbie (n 12) 221.
[37] Sassòli (n 11) 415.
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[47] Scobbie (n 12) 221.