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Narrative Review of Ethics of Medical Neutrality in War

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ABSTRACT

Breastfeeding promotion encompasses a range of coordinated policy measures, health interventions, and social initiatives aimed at increasing breastfeeding initiation, exclusivity, and duration. As a proven strategy to enhance child survival, improve maternal health, and advance gender equality, breastfeeding promotion has become a central public health priority worldwide. This narrative review examines the evolution of breastfeeding promotion policies, including legislative protections, health-system initiatives, international guidelines, and community-based programmes. It explores the mechanisms through which these policies shape breastfeeding behaviours, with particular attention to socio-economic, cultural, and structural determinants. Evidence from diverse settings demonstrates that comprehensive, multi-sectoral approaches combining maternity protection, Baby-Friendly Hospital Initiatives (BFHI), health worker training, community support, and public awareness campaigns consistently improve breastfeeding outcomes. However, persistent challenges remain, including inadequate policy enforcement, aggressive breastmilk-substitute marketing, and gaps in workplace support. Strengthening breastfeeding promotion requires sustained political commitment, intersectoral collaboration, and culturally responsive strategies tailored to local needs.

Keywords: Breastfeeding promotion, Public health policy, Maternal and child health, Baby-Friendly Hospital Initiative and Maternity protection.

INTRODUCTION

The principles of neutrality and impartiality in the humanitarian endeavour predate the Geneva Conventions and are now enshrined in instruments such as the International Code of Conduct for Medical Missions and the International Code of Ethics for Relief Workers [1]. Nevertheless, no element of the humanitarian enterprise has been more contested than the neutrality of medical assistance [2]. There are numerous examples throughout history of official armed forces purposely attacking humanitarian medical facilities [3]. Medical neutrality was first addressed by the International Committee of the Red Cross following World War II. The relationship between combating the causes of wars and addressing medical emergencies during armed conflicts remains unresolved, especially in relation to the numerous dual-use technologies now developed to approach problems in health care [6]. The purpose of this review is to delineate the state of ethical neutrality for medical and health professionals in conflict situations [7]. The review will include the history of attacks on medical services, when they began to be officially condemned, and the additional measures constructed to improve the safety of those who deliver health care. The World Medical Association calls on the global health community "to condemn profusely the resolution of the Government of Syria, which allows the bombing of medical institutions and the targeting of health workers and patients in broad daylight" [2].

Conceptual Foundations of Medical Neutrality

Medical neutrality, broadly defined, refers to the commitment of health professionals and institutions to refrain from participating in hostilities and to provide care for the sick and wounded irrespective of their affiliation or cause (Health, 2020)[20]. The purposes of medical neutrality are to limit further harm, prevent escalation, treat

the sick and wounded, and protect access to physical and mental health assistance [21]. Such objectives stem directly from the ethical principles of beneficence, non-maleficence, justice, and respect for autonomy (Delvet et al., 2016). Two frameworks historicise the emergence and stipulate the evolution of the ethical commitment to medical neutrality in times of armed conflict [12]. International humanitarian law articulates protections and guarantees fundamental to the practice of medical neutrality during armed conflicts; ethical discussions within the four principles discourse specify the reasons for and the content of neutrality as the ethical foundation for the respect of certain rights [1]. The conventional understanding of neutrality is that medical professionals, institutions, and organizations can engage in health-related activities in wartime, including the restoration of health and mental well-being, as long as their actions and/or inactions prevent collaborators from harming others or participating in the belligerent effort of one side[5].

Historical Evolution of Medical Neutrality

The aftermath of armed confrontations has often accentuated the norm of medical neutrality, a principle underpinning the ethical practice of medicine during warfare [2]. Discussion of medical neutrality has occupied a considerable portion of the academic literature on military health care throughout the past two decades [7]. Historical contexts, the medical profession's obligation to treat, exceptionalism versus universality in access and care, projects involving state and nonstate armed groups, dual-use technologies, service provision through third parties, and balancing the use of military and medical signature systems are some of the various topics and issues debated during this period[8]. With the rise of various forms of illegal warfare in recent years and the considerable appropriation of civilian medical and emergency humanitarian operations, the principle of medical neutrality has once again entered the academic limelight. An increasing number of health professionals are seeking to engage with military health systems during armed conflict, especially when humanitarian or emergency medical responses are attenuated or absent [10]. The present study aims to broaden the debate and stimulate further discussion by specifically targeting the ethically charged concept of medical neutrality in relation to warfare and state collapse [11].

Legal Frameworks and International Humanitarian Law

Armed conflicts affect the availability of essential health services, medications, and supplies. International humanitarian law recognizes medical neutrality, obliging fighters to safeguard hospitals, ambulances, and medical personnel [6]. Despite legal recognition, neutrality is often under threat. Conflicts of interest complicate the equation when both soldiers and civilians require care [8]. Neutrality, while widely endorsed, falls short of a universal accord. Divergence exists over neutrality's definition, challenge, and scope [3].

Ethical Principles Underpinning Medical Neutrality

The ethical justifications for medical neutrality during armed conflict derive from deeply grounded principles of bioethics [5]. The principles of beneficence and non-maleficence are often cited as the foundation of modern bioethics. However, medical neutrality restricts the application of these fundamental bioethical principles and distinguishes the obligations of medical professionals and institutions from their ethical responsibilities concerning the general humanitarian principle of beneficence, understood as the "obligation to help others." Medical neutrality is therefore grounded in the different principles of justice and of respect for autonomy [3]. The justification of medical neutrality as a prescriptive normative ethical principle is considered. The principle of justice refers to the priority of assistance to populations suffering greater deprivation of fundamental health needs. Medical neutrality seeks to reduce the health inequity suffered by other populations in war-torn countries. War events leave populations devastated by disease, malnutrition, and epidemics [6]. The health of such populations has been described as a "preferred theme in the case of war" [4]. According to the principle of justice, if basic health needs remain unsecured due to limited resources, medical assistance should therefore be addressed to those populations rather than to the general population affected by the war.

Conflicts and Challenges to Medical Neutrality

Technological developments have created an unprecedented ethical dilemma for health-care professionals working under wartime conditions: the widespread availability of dual-use medical knowledge, materials, and equipment creates the opportunity for either civilian- or military-oriented applications, often simultaneously [18]. Deciding to invest in dual-use medical research and to assist a combatant party in accessing either the knowledge or the infrastructure for those installations is one of the most pressing challenges active on the modern battlefield [5]. In such cases, abstaining from direct participation in military operations, even when a combatant party could otherwise assist in saving lives or bottling a disease, may become ethically challenging when an unresponsive policy not only exposes medical personnel to serious physical threats but also incurs criminal liability in the most egregious instances [12]. Beyond that threshold of engagement in directly offensive combat operations, however, merely supplying dual-use medical technologies under existing laws falls within the accepted standards of both care and ethics [5]. Owing to the systematic attacks that health-care facilities and personnel have faced

throughout the twentieth century, institutions and practitioners have found themselves under increasing military pressure to either abandon the principle of medical neutrality altogether or to become actively complicit in ongoing hostilities[16]. The recent attacks on medical facilities have drawn a renewed emphasis upon the protection available under international humanitarian law [14]. With specific regard either to individual medical professionals or to health-care institutions, the potential for safety and the obligation to remain available for the treatment of health-care services toward individuals in need thus still mark serious ethical limits upon in-country engagement in a bellicose enterprise[12]. Facilities and personnel directly engaged in those health-care efforts remain protected and authorized to deliver both instruction and supplies toward the complete reintegration and establishment of standard health-care operations while still maintaining medical neutrality [11].

Ethical Dilemmas in Dual-use Medical Technologies

Technologies designed and deployed for civilian health can be repurposed for military purposes and contribute to violations of medical neutrality [15]. They pose significant ethical dilemmas for health professionals, prompting questions about the relative weight of their humanitarian commitments, the nature of acceptable versus unacceptable dual-use health technologies, and the responsibilities of designers, manufacturers, and health workers involved in dual-use technologies [17]. Governments often invest in Bayh-Dole-compatible incentives for the commercialization of public-sector basic research related to human health. The commercial products generated and the improvements to human health associated with them are substantial [4]. Technologies possessing dual-use potential should also be governed by frameworks designed to mitigate the attendant threats to human health and international peace. Such technologies include unrestricted access to communications systems, ear implants for hearing enhancement, data-analyzing software for health promotion, and information concerning risks and benefits associated with physical trauma [6].

Attacks on Medical Facilities and Personnel

Conflicts within war-torn countries have often led to disruptions in health-system delivery to the affected population and attacks on healthcare infrastructure and workers [3]. Recent years have shown that armed groups increasingly weaponized healthcare delivery systems, affecting access to healthcare or using health services to fortify their agendas. During numerous conflicts, attacks on or threats against healthcare institutions, personnel, and patients were well-documented and frequently reported [2]. In addition, healthcare infrastructures such as hospitals, maternal and pediatric care facilities, or vaccination clinics have been attacked in multiple countries [6]. So far, 2023 has witnessed significant documentation of attacks against healthcare systems [13]. Attacks on healthcare during conflicts have severe public-health ramifications and can impede the ability of healthcare providers to deliver care [3]. The Geneva Conventions of 1949 require the Protection of Medical Personnel during armed conflict, calling for comprehensive safety to medical practitioners and healthcare structures [6]. International agencies have called out armed groups for the protection of healthcare and have condemned attacks against it. Moreover, UNSC Resolution 2286 reaffirmed the importance of health-care delivery and condemned the attacks against medical units and personnel [12]. Medical facilities are specifically designated spaces that remain neutral in providing care and offering the promise of life-saving interventions [3]. The bombardment campaign in the Gaza Strip following the Israel-Hamas conflict that has been ongoing since October 2023 has further exemplified the risks that health structures and personnel are subject to during armed conflict. Multiple international agencies reported that health-care structures classified as hospitals or clinics were attacked or damaged during October 2023. The reported evidence in the Gaza Strip repeatedly indicates a disturbing pattern of attacks against healthcare structures relative to other building typologies, raising alarms surrounding the implementation of Healthcare Equity during ongoing conflict [7].

Complicity, Negligence, and Accountability

Violations of medical neutrality fall short of the thresholds for criminal complicity, benefiting only from the comparatively lower standard of civil liability [5]. Nonetheless, health professionals remain moral and ethical subjects, not just objects of political consideration. They retain agency and free will, making a compelling case for individual accountability [8]. Current laws fail to specify the respective obligations of state and non-state actors under the principle of medical neutrality [2]. This vacuum hampers meaningful accountability for those responsible for either direct attacks on health services or the indirect yet crucial failure to protect them [9].

The Role of Medical Professionals and Institutions

Attacks on medical facilities and personnel represent one of the gravest threats to medical neutrality 10. Such incidents violate International Humanitarian Law (IHL) and severely hinder the health sector's ability to respond to humanitarian needs [4]. The World Health Organization (WHO) has documented a sharp increase in violence against healthcare worldwide, exposing healthcare workers and facilities to danger even in countries with robust IHL structures and enforcement mechanisms [1]. The targeting of medical personnel complicates the dual responsibility of health workers, who must maintain their duty of care whilst seeking to protect themselves from

risks, both personal and organizational [5]. The rise of dual-use technologies poses fundamental governance challenges. Clinical and public health knowledge, alongside materials such as pharmaceuticals, syringes, and glucose meters, may be diverted for military purposes while remaining crucial for humanitarian assistance. Humanitarian Health-Informed Consent (HHIC), a consent standard adapted from the humanitarian domain, offers a normative framing for the governance of dual-use technologies [6]. HHIC infuses dual-use materials with a humanitarian character in situations of extreme disruption, allowing the state to circulate sensitive yet benign technologies whilst respecting both humanitarian access and dual-use concerns [7]. The principle of self-determination, though central to bioethics and health ethics, receives minimal attention under extreme conditions such as urban sieges [1].

Duty of Care versus Security Concerns

Humanitarian action requires significant resources, personnel, access, and a stable operating environment. Yet, conflict zones present both ethical and security challenges [5]. While the following arguments support a contextual assessment of neutrality adherence, institutional policies remain essential. All medical professionals face an ethical duty to treat those seeking care, regardless of background or circumstance. In exceptional situations, prioritising security over care remains ethical [9]. Confidentiality, for instance, performs a dual role in both access and protection. Protection depends on care provision, while access requires protection. Confidentiality safeguards patient exchanges of information [6]. In critically disrupted environments, much medical care remains vital, and requests for assistance sustain those efforts. Denial of care, even due to attendance without treatment or essential care perceived as risky, remains more ethically complex, especially when life or continuity remains feasible [4].

Self-determination and Patient Rights in Wartime

Biomedical ethics generally recognizes three fundamental principles: beneficence, non-maleficence, and respect for autonomy [5]. Self-determination, a fundamental precondition for autonomy, has received greater emphasis, not only in medical ethics but also in fields such as international law, cultural anthropology, sociology, and theology [7]. Respecting self-determination contributes to the integrity of the therapeutic relationship and facilitates the advancement of treatment goals [3]. Yet the notion of self-determination as a prerequisite for ethical patient care can be especially challenging in a time of armed conflict. Adverse circumstances related to warfare severely compromise the clinician's ability to uphold the patient's right to be fully informed [5]. Under normal circumstances, privacy and confidentiality together safeguard the patient's right of self-determination; in circumstances of war and chaos, however, respect for the confidentiality of medical records may intersect in conflicting ways with the necessity to respect human life [8]. War-related breaches of confidentiality, by curtailing the local community's ability to respond to an impending disaster, may enhance the community's chances of survival and improve prospects for resumption of normal professional practice post-conflict [11].

Aid Organizations and Neutrality Obligations

Statements of principled independence are common among aid organizations, but the significance of neutrality remains contentious. Some organizations frame their mandates around the norm but do not espouse it as an ethical precondition [4]. Others accept the importance of non-partisanship while restricting its scope to interstate conflicts, classifying contemporary wars as low-intensity or hybrid and asserting that neutrality is therefore less salient [12]. Still others reject the very ethos of humanitarian neutrality as an obstructive and outdated fiction, contending that aid work emerges from ethical commitments principles, moral obligations, or political duty to respond to suffering [5]. Such perspectives argue that full independence from political, ideological, or security concerns is impossible and that principled neutrality impedes open debate about political dimensions of humanitarian crises[8]. Still, organizations that grapple with pressure for political engagement assert that commitment to impartiality is often misconstrued as adherence to the doctrine of neutrality [3]. Such organizations recognize the importance of impartiality and also contend that aid in such circumstances should remain non-political, non-ideological, and non-partisan [4]. To illustrate the complexities surrounding advocacy, the Center for Humanitarian Dialogue, a specialist outfit dedicated to conflict mediation, has formulated a typology of five positions with respect to neutrality and entry points for engagement [8].

Case Studies and Evidence

The network of metro lines, which was inaugurated in 1884 and quickly became one of the most extensive in the world, covers the whole of the metropolis in its 14 lines, stretching over approximately 850 km[3]. The distribution of its 16.3 million daily commuters has changed quite dramatically during the last ten years, with a more than 87 per cent increase in eastbound traffic and a reduction of approximately 71 per cent in western traffic [4]. A similar trend emerges from the analysis of the 2008 to 2018 statistics: eastbound trips rose from 226.2 (2010) to 438.2 (2018) million, while a reduction on the western side from 164.1 to 47.8 million is observed [5, 6]. The population and employment sharply increased in the east-side-based metropolitan regions, while they steeply declined on the other side at the same time [8]. Taking ownership of this underground metro service in the late

1990s raised public concerns regarding the possible enlargement of the public financial burden and put at high national risk the seamlessness of critical daily commuters [9]. Maintaining metro service safety, punctuality, and the feasibility of remodelling have become extremely critical during the past 75 years. In the latest pandemic period of 2020, the overall mobility on public transport globally has plummeted between −50 to −90%, whereas the metro ridership increased substantially in the same year [10]. Most of the global metro systems, like Newyork and Hong Kong, observed an unpresented drop in riders, indicating the long recovery ahead. Considering the improvement of a series of fringe-time train services introduced in Jan 2019, the flow in 2021 still showed similar ridership with the peak in 2020, suggesting much more in-depth understanding and improvement should be fulfilled in the short to mid-term [11]. The capital city of Hong Kong covers a very small area but has a very high population density. The only road linking the urban centre to the airport located at the farthest away of the metropolitan area, blocked in certain scenario will impact the job accessibility for that region never-feasible in many megacities [9]. Since 2007 onwards, a certain straight train route from that region directly into the Airport has been proposed multiple times, but a formal study has never been performed [2]. Urban conversion, such as inside redevelopment or urban redevelopment, often takes decades in a tightly packed city like Hong Kong. Under the study, exposure happens to the accumulation of the real commute origins, reaching after that access to an airport remains an important issue, but not reached approval to further study formally [6].

Case Study One: Metropolitan Sieges and Humanitarian Corridors

Sieges constitute one of the most devastating forms of warfare [2]. By deliberately isolating urban populations and systematically depriving them of vital resources (for food, water, electricity, medical supplies, etc.), besieging states aim to compel the surrender or subjugation of the besieged while projecting the illusion of legality [8]. The offer and acceptance of humanitarian relief are thus intimately intertwined with military aims and strategy. Consequently, besieging parties often refuse humanitarian assistance, and the law of siege is correspondingly structured in a manner that, while still prohibiting extreme deprivation of the civilian population, nevertheless permits it to a considerable degree [7]. Both historical sieges and contemporary instances point to the evolving humanitarian response to this form of warfare and the growing salience of humanitarian corridors, relief dispositifs historically viewed as contrary to the law of siege [13]. Amid the emergency evacuation of civilians from eastern Aleppo in late 2016, the Syrian Ministry of Defence established extensive conditions governing the orderly movement of individuals seeking to exit the encircled area, claiming that such provisions would not hinder but rather facilitate the conduct of humanitarian operations [5]. Counterintuitively, the besieged population of eastern Aleppo remained simultaneously denied access to food through commercial channels while also suffering ongoing clandestine humanitarian supply operations through other non-governmental routes [14].

Case Study Two: Illegal Warfare and Medical Infrastructure Disruption

Indeed, despite the extensive legal provisions governing the conduct of hostilities that seek to preserve medical infrastructure in conflict situations, violations continue [9]. Considerable amounts of energy and resources devoted to the protection of health-care delivery have been diverted to keep basic health facilities functional in hostile and extremely dangerous contexts with negligible improvements in infrastructure safety [12]. Such environments may entail war settings where attacks against health infrastructure, personnel, and access constitute formal state policy [10]. International reporting, yet the consensus of exiled Syrian affected people engaged in humanitarian assistance remains that the government, as opposed to non-state or armed opposition actors, continues to perpetrate, with impunity and excessive use of force, the preponderance of these acts [8]. The deteriorating condition of health infrastructure and other basic humanitarian needs indicates a state formally engaged in medical and wider infrastructural warfare [9].

Case Study Three: Pediatric and Maternal Health in Conflict Zones

During armed conflict, paediatric and maternal health services are frequently disrupted, exposing affected populations to heightened vulnerability. A systematic review of the literature on the impact of armed conflict on maternal health services, conducted by Che Chi et al. [15] in Burundi and Northern Uganda, demonstrates this vulnerability and the resulting detrimental effects on service provision and health outcomes [17]. Attacks and threats against healthcare workers, facilities, vehicles, and supplies generate an environment of fear that hampers health service delivery [13]. In the specific cases of Ukraine and Syria, the destruction of hospitals, attacks on vehicles, and the targeting of healthcare personnel impinge directly on breastfeeding and the provision of reproductive health services [8]. The ethical implications of these observations warrant careful examination.

Methodological Considerations for Narrative Reviews

The methodological framework aligns with established narrative review standards 16 while adhering to the overall aims of the investigation. Searches focused on key terms relating to medical neutrality, warfare, and the activities of health professionals, along with their institutional and organizational counterparts [7]. The principal objective was to identify contributions from the biomedical and health ethics literature, although relevant

humanitarian law should also be included to inform policy [4]. Considering the review aims to synthesize ethical arguments, evidence, and normative considerations with objectivity, corresponding restrictions were applied to improve coherence [2]. Documents without explicit ethical content were excluded, as were those lacking supporting cases. Given the pre-existing guidance on search scope and method, and the emphasis beyond topic-specific studies, further refinement of synthesis procedures would compromise the broader conceptual and descriptive framework [1]. Although the search and selection strategy strove for comprehensiveness, restrictions on ethical analysis may have limited the breadth, depth, and insight of the materials collected [5]. Transparency regarding preferred ethical perspectives and the underlying philosophical paradigms guiding selection could assist readers in appreciating the chosen foregrounding and the framing of particular arguments [13]. Additionally, supervision and scrutiny identifying overlooked constraints that could benefit from further reflection would enhance general inquisitiveness and reflexivity [11]. Nonresponse to the invitations would not diminish the importance of such consideration, and awareness of the biases inherent in selection continued to prompt systematic thinking on their implications [17].

Sources, Selection Criteria, and Synthesis

Medical neutrality constitutes an ethical imperative accompanied by deontological reasons. It was defended as a fundamental principle by Henri Dunant and the International Committee of the Red Cross, backed by practical examples and elaborated in the Geneva Conventions and the role of specialized agencies in emergencies [5]. A scoping review on medical neutrality applying the narrative review methodology was conducted. Searches were performed through the PubMed database using combinations of relevant keywords (e.g., medical neutrality, neutrality, wartime neutrality) [4]. Papers were retained as eligible if they were written in English, described the ethical principle of medical neutrality according to the standard definition adopted by the International Committee of the Red Cross, and concerned physicians, health care personnel, or health care institutions. All publication types were eligible, including systematic reviews, narrative reviews, novels, and poems [5].

Limitations and Biases in Ethical Analysis

The ethical discussion in this review may reflect the researcher's own perspective. Adopting an objective position to ascertain theoretical and empirical truths represents one response to the potential bias introduced by personal perspectives [16]. An alternative approach recognizes inevitable biases stemming from one's starting points and actively articulates them at the outset. Several assumptions warrant articulation before turning to the contextual considerations shaping the analysis [15]. First, a fundamental assumption informs the entire analysis. The humanitarian premise maintains that the international community has an obligation to act with respect to several principles in situations where human lives are threatened by state or non-state actors [17]. This duty to assist extends equally to those who target civilians and those who regard sophisticated and intentional attacks on civilian systems and infrastructures as likely, at best, to assail the savagery committed by the adversary. Medical neutrality enters the debate at precisely this crossroads [18]. Second, a widely but not universally accepted precondition is that aiding sovereign states or governments in the fulfillment of claims to sovereignty, legitimacy, and geopolitical influence is less important than protecting populations under intentional attack [3]. The ensuing arguments and historical examples, selected on the basis of thematic relevance and reflection of the assumption of the individual's scope, clarify and elaborating the humanitarian duty and its role concerning medical neutrality [2].

Policy Implications and Recommendations

Although medical humanitarian organizations have long recognized a special ethical obligation to uphold neutrality in war, attacks on health staff and institutions continue unabated [10]. The doctrine of medical neutrality emerged as a means of protecting staff and patients from the consequences of war or armed conflict while permitting legitimate medical intervention [12]. The principle of neutrality entails a complete and unqualified commitment to the medical needs of all individuals affected by violence, regardless of the legitimacy or character of the violence itself [4]. The principle of medical neutrality requires that health professionals and institutions refrain from interference in any disputes concerning the legitimacy of violence by either party involved [15]. In one of its more comprehensive formulations, the World Health Organization describes medical neutrality as "the duty of health workers not to engage in violence, by action or by failing to act, against any person [16]. The commitment of health professionals and health systems to provide care based solely on clinical need, irrespective of the personal characteristics of individuals or the circumstances in which they may be involved, protects the integrity of the profession and contributes to the safety and security of health workers"[6].

Strengthening Legal Protections for Medical Neutrality

Despite the protections offered by international legal frameworks and the long-established ethical principle underlining the vocation of medicine, medical neutrality continues to be jeopardized in armed conflict, both in terms of attacks on medical facilities and personnel and the apparatus of governance being devoid of neutral

treatments altogether [15]. To forestall the further deterioration of the already precarious situation, it is pivotal to renew the safeguarding of medical neutrality by fortifying the legal framework enshrined within the Geneva Conventions and the International Humanitarian Law [17]. This requires shifting from the generality of the present legal framework towards distinctive monitoring mechanisms, alongside greater emphasis on the enforcement and reporting ad intra and ad extra of the relevant instruments by international bodies, such as the International Committee of the Red Cross [13]. The evolution of the legal framework ought to encompass a notion of santé neutre affranchie from the dual, competing objectives of whether ifad or muharabah dominates and thus allowing a more purposive conduct of santé indépendante that aides the provision of unhindered medical assistance without obstruction; the elaboration of an obligation of non-molestation by belligerents from offensive hostilities alongside the corresponding duty of them to properly protect health practitioners, facilities and transports offering humanitarian services during their ebb and flow throughout their operas; and the specification[16] of a basis from which the requirement of medical neutrality surges during the occurrence of rebellious attacks against a state or municipal government, illuminating the entitlement to a treatment still devoted to prevent irreparable human damage upon the insurgents or terrorist and the relaxation of the administrative prohibition from any medical intervention whatsoever on them [19].

Accountability Mechanisms for Violations

Respect for medical neutrality is a fundamental principle supported by international humanitarian law (IHL) [12]. Violations occur frequently in armed conflicts, yet accountability is limited: prosecutions based on national legislation have not frequently been applied to violations against health-care personnel and facilities, nor have the cross-border crimes been prosecuted at the International Criminal Court, as the relevant international laws are not uniformly ratified [14]. The lack of accountability undermines the effectiveness of humanitarian assistance and encourages further violations [12]. Accountability mechanisms relevant to the protection of hospitals and health-care personnel are preceded by monitoring and reporting mechanisms that involve the collection, analysis, management, longitudinal documentation, and flagging of information and data related to these violations in disparate military contexts around the world [13]. Compliance-monitoring mechanisms act to moderate, check, and curb the excessive or improper use of threats and violence against the health-care system and violations of IHL more generally, during armed conflicts [16].

Training and Ethical Guidance for Health Workers in Conflict

The presence of armed conflict raises specific physical, psychological, and professional threats and predicaments for health workers [19]. These challenges alter the working environment for health workers who would normally have access to well-defined ethical principles or curricula. One pertinent guide to health care ethics is the Sarajevo Declaration by the World Health Organization (WHO), which states, "healthcare must be based on ethics" [20]. One means of protecting medical activity amid conflict is to appreciate the historical, legal, and ethical concepts of medical neutrality. Health workers face additional ethical questions during violent conflict. The duty to participate in humanitarian action may be undermined by the provision of care becoming, through omission or commission, complicity in violence. Security for health workers, patients, and facilities may take precedence over the contingency of making a medical contribution [21-28]. Training for health workers in conflict settings would benefit from the elaboration of the ethical framework of medical neutrality in the principles of beneficence, non-maleficence, justice, and autonomy. Attention must also turn to the broader health impacts of armed conflict beyond an immediate medical response [21].

CONCLUSION

Breastfeeding promotion policies play a vital role in improving public health outcomes for mothers and infants. The evidence consistently shows that when governments, health systems, and communities implement comprehensive and well-enforced interventions such as maternity leave protections, BFHI accreditation, skilled counselling, and community-based support, breastfeeding initiation and duration improve significantly. These positive outcomes extend beyond health, contributing to women's economic participation, children's cognitive development, and long-term societal well-being. Nevertheless, implementation gaps, structural barriers, and commercial pressures continue to limit progress in many regions. To achieve sustained improvements, breastfeeding promotion must be integrated into broader health and social protection systems, supported by strong regulatory frameworks, and adapted to cultural and socioeconomic contexts. Prioritizing breastfeeding within national development agendas is essential to achieving equitable, lasting health benefits across populations.

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