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Strengthening Legal Protection for Medical Personnel in Indonesia's Conflict-Affected Areas

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Abstract

Medical personnel serving in conflict-affected areas face risks of violence, security threats, and disruptions to healthcare delivery that may endanger their safety while simultaneously undermining the continued realization of the population's right to health. Indonesia has established a legal basis for protection through national health law and International Humanitarian Law; however, a gap remains between normative guarantees and protection that can be effectively implemented in practice. This study aims to construct an integrated legal protection model for medical personnel in conflict-affected areas of Indonesia. It employs a qualitative approach with a socio-legal research design based on document analysis and online sources. Data were obtained from legislation and regulations, institutional documents, scholarly literature, reports issued by national and international organizations, and credible online news sources, and were subsequently analyzed using qualitative thematic content analysis and source triangulation. The findings indicate that the principal challenge in protecting medical personnel lies not merely in the absence of legal norms, but in the lack of integration among protection mechanisms before, during, and after deployment. This study develops a continuum of legal protection that connects risk assessment, security measures, deployment protocols, reporting and early-warning systems, legal assistance, victim recovery, investigation, and accountability across four dimensions: preventive, operational, remedial, and accountability protection. The model shifts the orientation of protection from a reactive and fragmented approach toward a preventive, continuous, and human-centered system. Strengthening its implementation requires operational regulations and inter-agency coordination to safeguard medical personnel while ensuring the continuity of healthcare services in conflict-affected areas.

Keywords: *Legal Protection, Medical Personnel, Conflict-Affected Areas, Health Law, Continuum of Protection*

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1. Introduction

Healthcare delivery in conflict-affected areas places medical personnel in a position that is simultaneously professional and humanitarian, while also exposing them to significant threats to their safety. Medical personnel are nevertheless expected to remain present and provide assistance even when violence, insecurity, limited access, and intimidation directed at healthcare facilities increase the risks faced by those delivering care (Elnakib et al., 2021; Haar et al., 2024; Riyanto., O2025). The situation in Papua demonstrates that attacks against health workers not only result in deaths and injuries but may also further reduce the availability of medical personnel and disrupt the continuity of healthcare services for the community. These consequences extend beyond the immediate victims, as disruptions to healthcare services diminish public access to essential care and undermine the fulfillment of the right to health (Kostandova et al., 2024; Dafallah et al., 2023; Haar et al., 2024). From a global perspective, violence against and obstruction of healthcare services are likewise regarded as systemic threats to public health and the resilience of health services during crises (Haar et al., 2021; Kostandova et al., 2024; Niba et al., 2022; Vento et al., 2020).

The national legal framework has, in principle, recognized the right of medical personnel to obtain protection in the performance of their professional duties. Law Number 17 of 2023 concerning Health is understood in Indonesian health law literature as providing a legal basis for the protection of physicians and health workers in professional practice, including professional safeguards and safety standards in the delivery of healthcare services (Rosnida et al., 2025; Siahaan et al., 2026; Tamon et al., 2025). Government Regulation Number 28 of 2024, as the implementing regulation of Law Number 17 of 2023, provides more detailed provisions governing the administration and management of the health system (Siahaan et al., 2026).

The particular characteristics of conflict-affected areas present more complex legal and operational challenges because normative guarantees do not automatically determine how risk assessments should be conducted prior to deployment, who bears responsibility for security, how deployment and evacuation protocols should be regulated, or what mechanisms are available when an attack occurs (Kostandova et al., 2024; Cervantes-Pérez, 2020; Tamon et al., 2025). The applicable legal consequences are also influenced by the classification of the situation, because International Humanitarian Law applies when the threshold of an armed conflict has been met, whereas national law and the international human rights law framework remain the principal bases of protection when the violence has not reached that threshold (Haar et al., 2021).

International law provides a strong foundation for the protection of medical personnel, medical units, and medical transport during armed conflicts, including non-international armed conflicts, which are often particularly relevant to situations of internal violence (Mamun, 2024; Habrelian, 2020). Customary international

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humanitarian law affirms that medical personnel must be respected and protected, encompassing both the prohibition against making them the object of attack and the obligation to allow medical functions to be performed without unlawful interference (Mamun, 2024; Habrelian, 2020). United Nations Security Council Resolution 2286 condemns attacks against medical facilities and personnel and calls for measures to strengthen protection and accountability, thereby positioning the protection of healthcare services as an integral component of the civilian protection agenda (Bagshaw & Scott, 2023; Cervantes-Pérez, 2020). The WHO has also formulated protection and accountability mechanisms in its publications concerning the protection of healthcare in conflict, while recent literature emphasizes that the enforcement of these legal obligations remains weak and therefore requires effective institutional arrangements, documentation, accountability mechanisms, and concrete operational measures (Bagshaw & Scott, 2023; Mamun, 2024).

Indonesian legal scholarship has established an important foundation concerning the normative protection of medical personnel and the general obligations of the state; however, existing studies remain predominantly focused on the existence of legal norms and have not consistently linked those norms to comprehensive operational mechanisms extending from prevention to recovery and accountability (Tamon et al., 2025; Andayani & Kurniawan, 2023; Mashdurohatun et al., 2025). Several studies have highlighted challenges in implementation and law enforcement in the context of Papua, including the impact of violence on the continuity of healthcare services and the fulfillment of the population's rights (Fadhillah, 2025; Abdullah, 2021). Empirical findings have also revealed more concrete operational dimensions, such as limited access to legal and psychological assistance, the predominance of internal dispute resolution, and the need for standard operating procedures, reporting systems, security measures, and more systematic mechanisms for addressing violence (Tamon et al., 2025; Kostandova et al., 2024; Al-Bitar et al., 2025; Rubab et al., 2025; Sing & Lau, 2025). International literature demonstrates a similar pattern: although the normative framework for protection is relatively strong, protection in practice remains inadequate because the translation of legal norms into preventive measures, risk mitigation, documentation, and accountability has yet to be implemented effectively (Haar et al., 2021; Agbo et al., 2024; Habrelian, 2020).

The research gap lies in the absence of an integrated legal protection model for medical personnel in conflict-affected areas of Indonesia that connects all stages of protection within a single continuous framework (Fadhillah, 2025; Tamon et al., 2025; Mashdurohatun et al., 2025; Bogale et al., 2024). Previous studies have examined the normative foundations of protection, the obligation to respect medical personnel, law enforcement challenges, and several forms of security protection and recovery; however, these elements have largely been analyzed separately and therefore have not yet formed a comprehensive protection pathway extending from pre-deployment to the post-

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incident stage (Abdullah, 2021; Habrelian, 2020; Tamon et al., 2025; Kostandova et al., 2024; Kaim, 2025). The gap between legal protection on paper and protection in practice becomes particularly evident when legal protection is not accompanied by pre-deployment risk assessments, security standards during the performance of duties, safe reporting channels, post-incident legal assistance, victim recovery measures, and clear mechanisms for investigation and accountability (Kaim, 2025; Kostandova et al., 2024; Al-Bitar et al., 2025). This gap is theoretically significant because legal protection must move beyond a predominantly normative approach toward an approach that integrates legal norms, institutions, operational safety, recovery, and accountability within a single framework that can be empirically tested and evaluated (Kaim, 2025; Rubab et al., 2025).

This study aims to construct an integrated legal protection model for medical personnel in conflict-affected areas of Indonesia that ensures their safety and recovery through risk assessment, security measures, deployment protocols, reporting systems, legal assistance, victim recovery, investigation, and accountability. The model is structured around four interconnected dimensions: preventive protection, operational protection, remedial protection, and accountability. Accordingly, protection does not remain confined to normative guarantees but is translated into mechanisms that can be implemented before, during, and after violations occur. The theoretical contribution of this study lies in developing the concept of legal protection as a continuum of protection that integrates prevention, safety in the performance of professional duties, victim recovery, and accountability within a single analytical framework. Its regulatory and practical contributions are directed toward the development of more measurable inter-agency protection protocols, while affirming that safeguarding the safety of medical personnel also means preserving healthcare delivery capacity and protecting the communities that depend on such services.

2. Literature Review

Amid the violence and suffering that accompany armed conflict, medical personnel serve as guardians of humanitarian values, continuing to provide assistance even when their own safety and liberty are under threat (Roring et al., 2023). This position places medical personnel as “unarmed knights” who perform humanitarian duties without taking part in hostilities. International Humanitarian Law (IHL) guarantees their protection as neutral persons or non-combatants who must be respected and protected in various conflict situations (Putri & Ruslie, 2024; Roring et al., 2023). This moral and legal foundation is reinforced by Common Article 3 of the 1949 Geneva Conventions and Additional Protocol II of 1977, which prohibit attacks, arrest, detention, and discriminatory treatment against medical personnel as long as they do not directly participate in hostilities (Deta et al., 2025; Putri & Ruslie, 2024). Attacks against medical personnel, ambulances, and healthcare facilities bearing internationally recognized

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protective emblems are regarded as grave breaches and war crimes that may give rise to legal responsibility under both civil law and international criminal law (Wijaya & Hartono, 2025).

Indonesia ratified the Geneva Conventions through Law Number 59 of 1958, yet this normative commitment has not been fully translated into effective protection for healthcare workers in the field (Wijaya & Hartono, 2025). The gap between legal guarantees and the reality of protection remains evident, particularly when healthcare workers are required to perform their duties in areas characterized by high levels of insecurity and security threats. National regulations, such as Government Regulation Number 67 of 2019, have largely governed the protection of healthcare workers in general terms and have not adequately addressed the tactical requirements and emergency conditions encountered in conflict-prone areas (Tanaem, 2023). Law Number 17 of 2023 concerning Health represents an important development by providing security guarantees and special incentives for healthcare workers serving in conflict and border areas (Tafkurullah, 2024). Challenges nevertheless remain because Indonesia has not ratified Additional Protocol II or the Rome Statute, thereby limiting the incorporation of international norms into domestic law and generally leaving perpetrators of attacks against healthcare workers subject only to the ordinary criminal provisions of the Indonesian Criminal Code, rather than prosecution as perpetrators of war crimes or violations of international humanitarian law.

This protection gap is not merely a normative concern but has generated tangible humanitarian consequences for medical personnel and the communities that depend on their services. The attack on the Kiwirok District Community Health Center in Papua on 13 September 2021 constitutes one of the clearest illustrations of the vulnerability faced by healthcare workers serving in conflict-affected areas (Kahfianto & Setiyono, 2023). The attack carried out by the armed group not only claimed the lives of healthcare workers but also inflicted profound psychological trauma on the victims and damaged healthcare facilities essential to the local population (Kahfianto & Setiyono, 2023). Difficult geographical conditions and the limited availability of security personnel in regions such as Papua further exacerbate this vulnerability because physical protection by central and local governments cannot always be provided promptly and effectively (Ginting, 2023). The consequences become even more extensive when legal proceedings against perpetrators encounter obstacles, as insecurity among healthcare workers and disruptions to healthcare facilities may ultimately restrict the realization of the affected population's fundamental right to health (Mubarok & Sutrisno, 2022). The need for more systematic protection has therefore become increasingly urgent, including through the development of a comprehensive occupational safety blueprint, the establishment of standard operating procedures (SOPs) for responding to attacks in conflict-prone areas, and the conduct of comprehensive investigations to ensure protection, victim recovery, and the realization of humanitarian justice.

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3. Research Method

This study employs a qualitative approach using a socio-legal research design based on document analysis and the examination of online sources (Riyanto, et.al., 2022). This approach is used to investigate the gap between the normative legal protection afforded to medical personnel and its implementation in conflict-affected areas of Indonesia. The analysis encompasses national health law, human rights law, criminal law, and relevant instruments of International Humanitarian Law. All research data are derived from online secondary sources, including legislation and regulations, government documents, reports issued by national and international institutions, scholarly articles, and credible online news reports.

Sources were selected purposively based on their relevance to the safety and protection of medical personnel. The selected data include information concerning threats or attacks against medical personnel, disruptions to healthcare facilities, security arrangements, the deployment of medical personnel, reporting systems, legal assistance, victim recovery, investigations, and accountability. Media reports were used primarily to reconstruct incidents and institutional responses, whereas legal status and protection obligations were determined on the basis of applicable legislation and legal documents. Information obtained from media reports was cross-checked against official sources or other independent news reports to enhance accuracy and reduce the risk of information bias.

The data were analyzed using qualitative thematic content analysis through the identification, coding, categorization, and interpretation of themes. The analysis focused on four dimensions of protection: preventive protection, operational protection, remedial protection, and accountability. These dimensions encompass risk assessment and prevention; security measures and deployment protocols; reporting systems, legal assistance, and victim recovery; as well as investigation, law enforcement, and accountability. Source triangulation was conducted by comparing legal documents, institutional reports, scholarly research, and media reports to ensure the credibility of the findings.

The results of the analysis were used to construct an integrated legal protection model for medical personnel in conflict-affected areas of Indonesia. The model connects protection before deployment, during the performance of duties, after an incident occurs, and throughout the accountability process within a single continuum of legal protection. Ethical considerations were addressed by relying exclusively on publicly available information, limiting the use of identifying and sensitive information, and avoiding unnecessary descriptions of violence. This approach is intended to ensure that the protection of medical personnel does not remain confined to normative guarantees but develops into a systematic and effective protection mechanism oriented toward safety and recovery.

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4. Result and Discussion

4.1 Protection of Medical Personnel as a Continuous Process

The findings indicate that the challenges surrounding the protection of medical personnel in conflict-affected areas of Indonesia are not primarily attributable to the absence of a legal basis. A normative framework already exists under both national health law and International Humanitarian Law, yet the various forms of protection have not always been integrated into a comprehensive mechanism operating continuously from the pre-deployment stage through the occurrence of violations. This situation reveals a gap between the protection promised by law and the actual safety experienced by medical personnel working in high-risk environments. Previous studies concerning Papua have shown that inadequate security guarantees may affect the presence and availability of medical personnel and ultimately disrupt the provision of healthcare services to local communities. These findings provide the basis for this study to conceptualize protection not merely as a response initiated after an attack has occurred, but as a continuous process extending from the pre-deployment stage, throughout the performance of duties and the occurrence of violence, to recovery and accountability.

The international legal foundation for such protection has long formed part of Indonesia's legal commitments. Law Number 59 of 1958 formalized Indonesia's adherence to all four Geneva Conventions of 1949. Common Article 3 provides minimum protections in non-international armed conflicts for persons taking no active part in hostilities and requires the humane treatment of the wounded and sick. The First Geneva Convention provides more specific protection for medical services: Article 19 requires fixed establishments and mobile medical units to be respected and protected, while Article 24 requires respect and protection for personnel exclusively engaged in medical functions. More broadly, the First Geneva Convention is designed to protect the wounded and sick, medical personnel, medical units, and medical transport. Article 20 is not relied upon as the principal legal basis for the protection of medical personnel on land because its scope specifically concerns the protection of hospital ships against attacks from land.

The application of International Humanitarian Law nevertheless requires careful legal assessment of the status of a particular situation. The term "conflict-affected areas" as used in this study is not intended to suggest that every security disturbance in Indonesia automatically constitutes an armed conflict within the meaning of International Humanitarian Law. Legal assessment must consider the nature and intensity of the violence and the degree of organization of the parties involved before a situation can be classified as a non-international armed conflict. This distinction is particularly important because Indonesia is not listed by the ICRC as a State Party to Additional Protocol II of 1977. The protection of medical personnel must therefore be constructed through an integrated application of national health law, criminal law,

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human rights law, the Geneva Conventions binding upon Indonesia, and other relevant rules of International Humanitarian Law, according to the legal and factual characteristics of each situation.

The national health law framework has also evolved. Law Number 17 of 2023 concerning Health is currently in force and serves as the principal legal basis for the administration of the national health system. Article 273 of the Health Law provides the legal basis for the right of medical personnel and healthcare workers to obtain legal protection when performing their duties in accordance with professional standards, service standards, standard operating procedures, and professional ethics, as well as protection of their safety and security. Government Regulation Number 28 of 2024 subsequently became the implementing regulation of the Health Law and is likewise currently in force. This regulation also repealed Government Regulation Number 67 of 2019 concerning the Management of Healthcare Workers. Accordingly, Government Regulation Number 67 of 2019 is more appropriately understood as part of the historical development of the regulatory framework rather than as an operational legal basis currently in force.

These regulatory developments further clarify the position of this study. The identified gap no longer concerns the absence of legal recognition that medical personnel must be protected, but rather the insufficient translation of these legal norms into mechanisms that specify what must be undertaken before medical personnel are deployed, how their safety is to be safeguarded while performing their duties, what measures should be taken when threats arise, and how the state and relevant institutions should respond after medical personnel become victims. It is within this gap that the integrated legal protection model developed in this study is constructed.

4.2 Safety Begins Before Deployment

Effective protection must begin before medical personnel enter areas characterized by heightened security risks. The findings indicate that risk assessment constitutes the initial step that shapes all subsequent forms of protection (Mushasha et al., 2024; Malhouni & Mabrouki, 2023; Levi et al., 2024). Such an assessment cannot be limited to determining whether an area is simply categorized as safe or unsafe; rather, it must consider patterns of violence, threats to healthcare facilities, geographical conditions, transportation access, communication systems, distance from security centers, the availability of evacuation routes, and the capacity of government authorities and healthcare facilities to respond to emergencies (Malhouni & Mabrouki, 2023; Chauhan et al., 2022; González-Villa et al., 2023; Kagai et al., 2024; Levi et al., 2024). This information provides a rational basis for determining whether a particular deployment is appropriate and what forms of protection must be prepared (Levi et al., 2024).

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Risk assessment carries both legal and humanitarian significance. Deploying medical personnel to areas in need of healthcare services is indeed part of the state's obligation to ensure access to healthcare, but the needs of the population cannot justify disregarding the safety of those providing such services (Rubenstein & Haar, 2022). Deployment decisions must balance community healthcare needs against the institutional obligation not to expose medical personnel to risks that can reasonably be anticipated and mitigated (Marou et al., 2024). This approach shifts protection from a reactive model toward prevention, as the state does not wait for casualties to occur before implementing security measures (Mamun, 2024; Bilgrami et al., 2025).

The results of the assessment must then be translated into security measures tailored to the characteristics of the area concerned. Such measures may include inter-institutional coordination, the designation of safe routes, emergency communication systems, transportation preparedness, relocation plans, and evacuation procedures when threat levels change (Malhouni & Mabrouki, 2023; Zimmerman et al., 2025; Chauhan et al., 2022; Kagai et al., 2024; González et al., 2024; Mushasha et al., 2024). Within these mechanisms, the status of medical personnel must continue to be preserved as providers of humanitarian functions rather than as parties involved in hostilities (Vuorio & Bor, 2022; Agbo et al., 2024; Bartles-Smith, 2025). This principle is consistent with the special protection afforded by International Humanitarian Law to medical personnel and medical units for as long as they retain their humanitarian function (Mamun, 2024; Droege, 2025).

Deployment protocols serve as the link between the results of risk assessments and the performance of day-to-day duties. Such protocols should clearly establish the preparedness of medical personnel, the duration of deployment, personnel rotation, communication channels, safe locations, inter-agency coordination, decisions concerning the temporary suspension of services, and evacuation mechanisms when threats escalate (Mushasha et al., 2024; Chauhan et al., 2022; Brown et al., 2021). Such clarity is essential because regulatory guarantees of security lose their practical effectiveness when medical personnel do not know whom to contact or what measures to take when circumstances change rapidly (Ginting, 2023; Brown et al., 2021).

4.3 Ensuring a Sense of Security While Medical Personnel Perform Their Duties

Protection during deployment requires a system capable of rapidly identifying changes in risk so that healthcare workers are not exposed to threats that could have been anticipated from the outset (Rød et al., 2023; Jaime, 2025). Reporting systems should therefore be understood not merely as administrative mechanisms activated after an incident has occurred, but also as instruments of prevention, monitoring, and organizational learning that can continuously strengthen protection (Abreu et al., 2026). Threats, intimidation, disruptions to healthcare facilities, changes in security conditions,

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and barriers to accessing healthcare services must be systematically documented and communicated to those with the authority to take appropriate action. Consistent and comprehensive documentation is essential so that every attack or disruption to healthcare services can serve as a basis for protection, evaluation, and accountability (Vuorio & Bor, 2022; Haar et al., 2021; Meier et al., 2021). The information collected can subsequently be used to update risk assessments, strengthen security measures, adjust deployment arrangements, or make evacuation decisions when circumstances no longer permit healthcare services to be delivered safely (Jaime, 2025).

Previous studies have shown that safe, accessible, and institutionally supported reporting channels constitute an important component of the protection of healthcare workers (Lee et al., 2024; Elsharkawy et al., 2025; Song et al., 2020; O'Brien et al., 2024). A culture of reluctance to report, inadequate institutional support, and uncertainty regarding follow-up actions may allow violence to recur without an adequate response while weakening healthcare workers' confidence in the available protection system (Spencer et al., 2023; Al-Bitar et al., 2025). Evidence from various contexts also demonstrates that when healthcare workers perceive reporting processes as ineffective or unsafe, many incidents ultimately remain absent from formal documentation (Abreu et al., 2026; Makali et al., 2023). Accordingly, within the model developed in this study, the reporting system is more appropriately positioned as part of an early warning mechanism that not only records incidents that have already occurred but also helps identify patterns of threats and prevent risks from escalating into more serious violence (Riyanto. et al., 2023; Shimizu et al., 2025).

The interconnectedness of risk assessment, security measures, deployment protocols, and reporting demonstrates that protection during deployment cannot be left entirely to the individual vigilance of medical personnel. Primary responsibility must rest with the system and institutions that deploy and assign them. Medical personnel should not be forced to choose on their own between continuing to provide care and protecting themselves when no clear procedures are available. Legal protection becomes meaningful when legal norms can be translated into practical decisions that can be applied in real-world situations.

4.4 Victim Recovery as an Integral Component of Legal Protection

The consequences of attacks against medical personnel do not end when the physical violence ceases. Psychological trauma, fear, loss of a sense of security, physical injury, disruption to professional life, and prolonged legal proceedings may continue to affect victims long after the incident. The findings indicate that post-incident protection must treat legal assistance and recovery as interconnected and inseparable components of a single protection process. This approach is essential to ensure that medical personnel are

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not treated merely as complainants or witnesses in legal proceedings, but continue to be recognized as individuals entitled to recovery.

Legal assistance is necessary from the initial reporting stage through judicial proceedings. Victims require information regarding their rights, legal assistance when providing statements, support in accessing protection mechanisms, and assistance when facing pressure during law enforcement proceedings. Previous studies have identified inadequate legal assistance as one of the significant obstacles to resolving cases of violence against healthcare workers. Incorporating legal assistance into the protection framework also demonstrates that institutional responsibility does not end once medical personnel have been successfully evacuated from the scene of an incident.

Recovery must extend beyond the treatment of physical injuries. Violence may cause anxiety, depression, trauma, post-traumatic stress disorder, and a loss of confidence in returning to work. Research on violence against healthcare workers demonstrates that psychological support plays an important role in preventing long-term consequences for victims. Adequate recovery therefore encompasses healthcare services, psychological support, protection throughout legal proceedings, professional rehabilitation, and any other assistance necessary to enable victims to resume their lives with dignity.

This approach introduces a human-centered dimension to legal protection. The effectiveness of protection cannot be measured solely by the number of reports processed or perpetrators punished. An equally important measure is whether medical personnel who have become victims are able to regain a sense of security, obtain access to the assistance they need, and are not left to cope alone after carrying out their duty to serve the community.

4.5 Investigation and Accountability as Safeguards of Justice

Investigation constitutes an essential component of protection because every act of violence against medical personnel requires clarity as to what occurred, who bears responsibility, and why the protection system failed to prevent the incident. The investigative process should identify the chronology of events, patterns of attack, perpetrators, available evidence, institutional responses, and potential weaknesses in security arrangements and deployment procedures. A thorough investigation is important not only for determining individual responsibility but also for identifying institutional failures that require corrective action.

The legal characterization of an attack must be undertaken with due care. The mere fact that medical personnel are victims does not automatically render an incident a war crime or a gross human rights violation. Law Number 26 of 2000 limits the jurisdiction of the Human Rights Court to gross violations of human rights in the form of genocide and crimes against humanity. Crimes against humanity require, among other elements, that the relevant acts form part of a widespread or systematic attack directed against a civilian

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population. Determining the appropriate legal basis must therefore consider the context, pattern of attacks, status of the parties involved, and the constituent elements of the offense that can actually be established through evidence.

The status of international legal instruments must likewise be assessed proportionately. Indonesia is not listed among the States Parties to Additional Protocol II of 1977 published by the ICRC, while the list of participants in the Rome Statute maintained by the United Nations Treaty Collection also does not identify Indonesia as a State Party. This situation cannot be reduced to the conclusion that every attack against medical personnel may only be prosecuted under the Indonesian Criminal Code. The applicable legal avenue must instead be determined according to the nature of the conduct, applicable national law, human rights law, the Geneva Conventions binding upon Indonesia, and relevant rules of International Humanitarian Law where the threshold for their application is met.

Accountability serves a broader function than punishment alone. Effective legal proceedings provide justice for victims, prevent impunity, and generate institutional learning concerning aspects of the protection system that require improvement. Previous studies indicate that shortcomings in the protection of medical personnel frequently arise from non-compliance with, or weak implementation of, existing legal norms rather than merely from the absence of such norms. The findings of investigations should therefore be communicated back to healthcare institutions and government authorities as a basis for improving risk assessments, security measures, deployment procedures, and responses to future threats.

4.6 Legal Guarantees and Protection for Medical Personnel in Conflict-Affected Areas

The principal finding of this study lies in the interconnectedness of all components of protection. Risk assessment determines the security measures required and the manner in which medical personnel are deployed. Reporting systems provide information concerning changes in threats during the delivery of healthcare services. Legal assistance and recovery mechanisms ensure that medical personnel who become victims do not lose protection once an incident has ended. Investigation and accountability generate lessons that must subsequently be used to improve risk assessments for future deployments. These interconnected elements form a continuous cycle that evolves and improves on the basis of previous experience.

This model is not intended to create new rights for medical personnel. Law Number 17 of 2023 and Government Regulation Number 28 of 2024 have established a stronger legal foundation for health protection, and both are currently recorded as being in force in the Legal Documentation and Information Network of the Ministry of Health. Rather, the contribution of this study lies in integrating dispersed obligations and mechanisms

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into a continuous protection framework extending from risk assessment, security measures, deployment, and reporting to legal assistance, victim recovery, investigation, and accountability.

This framework addresses the gap between protection guaranteed by law and protection experienced in practice. Legal guarantees become effective when they are capable of addressing concrete questions: who assesses risks before deployment, who bears responsibility for security, when medical personnel should be evacuated, how threats are to be reported, who provides assistance to victims, how recovery is delivered, and how violations are investigated and accountability established. These questions demonstrate that legal protection cannot end with the formal recognition of rights but must be supported by a clear pathway for implementation.

The findings also demonstrate the close relationship between the safety of medical personnel and the continued realization of the population's right to health. Attacks against medical personnel may reduce the number of professionals willing to work in high-risk areas, interrupt healthcare services, damage healthcare facilities, and deprive communities of access to assistance precisely when it is most urgently needed during conflict. Research concerning Papua indicates that insecurity affecting healthcare workers may reduce the availability of medical personnel and disrupt the provision of healthcare services to the population. Protecting medical personnel therefore serves two interconnected interests: safeguarding the safety and dignity of those who provide care while preserving the public's right to continued access to healthcare services.

The most significant implication of this integrated protection model lies in changing the way the law conceptualizes the safety of medical personnel. Protection should neither begin only after victims have already suffered harm nor end once perpetrators have been punished. It begins when risks are identified, continues while medical personnel perform their duties, remains in place when they become victims, and extends throughout recovery and accountability processes. This framework positions the safety of medical personnel as a responsibility of the health system and the state rather than as a personal risk that medical personnel must bear alone. From a human-centered health law perspective, protecting medical personnel ultimately means safeguarding those who preserve human life while also protecting the communities that depend on their services.

5. Conclusion

This study demonstrates that strengthening the legal protection of medical personnel in conflict-affected areas of Indonesia depends not primarily on introducing new legal norms, but on the capacity of the state and healthcare institutions to translate existing legal guarantees into integrated and operational protection mechanisms. The protection model constructed in this study places risk assessment, security measures, deployment protocols, reporting systems, legal assistance, victim recovery, investigation, and

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accountability within a single interconnected framework. Together, these elements form a continuum of legal protection that operates before medical personnel are deployed, throughout the performance of their duties, after an incident occurs, and during the processes of recovery and accountability. This approach addresses the gap between protection guaranteed by law and protection experienced in practice by emphasizing that effective legal protection must be preventive, operational, remedial, and accountable. The theoretical contribution of this study lies in extending the concept of legal protection beyond a predominantly reactive and fragmented approach toward a continuous framework centered on the safety, dignity, and recovery of medical personnel.

The practical implications of this study call for stronger operational regulations and inter-agency coordination so that the responsibility to protect does not remain confined to normative declarations. Central and local governments, healthcare facilities, security authorities, professional organizations, victim protection institutions, and law enforcement agencies need to establish coordinated mechanisms encompassing pre-deployment risk assessment, security and evacuation standards, reporting and early-warning systems, legal assistance, physical and psychological recovery, independent investigation, and effective accountability. The findings of investigations and accountability processes should also serve as a basis for evaluating and improving protection in subsequent deployments, thereby creating a continuous cycle of institutional learning. Ultimately, protecting medical personnel not only safeguards the rights and safety of those who provide care, but also preserves the continuity of healthcare services and the right of communities in conflict-affected areas to receive care when they need it most.

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