

COUNTERTERRORISM AND SANCTIONS

How counterterrorism throws back wartime medical assistance and care to pre- Solferino times

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Abstract

Domestic counterterrorism (CT) frameworks have been increasingly employed to criminalize impartial medical care to wounded and sick from non-State armed groups labelled as criminal or terrorist in non-international armed conflicts (NIACs). It has also contributed to legitimize attacks and incidental damage on medical facilities in armed conflicts overlooking the international humanitarian law (IHL) protection afforded to the wounded and sick as well as to medical personnel and facilities. This article compares the treatment of the wounded and sick in both international armed conflicts (IACs) and NIACs in the context of the global war on terrorism. It demonstrates the impacts that CT measures have on the IHL protection of the medical mission while demonstrating the increased acceptance that some incidental damages, such as the downgrading of IHL core protections, are tolerated, by some countries in the global fight against terrorism. The article further illustrates how the special criminal status of wounded and sick from non-State armed groups in armed conflicts that are evolving in a CT context can mechanically contaminate the status of impartial humanitarian medical activities, facilities and personnel in such contexts. It also shows how the simultaneous application of CT and IHL in numerous contexts of armed conflict as well as the involvement of State armed forces under those two different bodies of

law contributes to blurring the lines between IHL and CT, between protected or “criminal” humanitarian and medical activities. In contexts of complex military operations, this reality creates a mind-set conducive to legal mistakes and security incidents on the medical mission. Although there is a distinction between the protection from attacks and the protection from prosecution under IHL, in practice, numerous military operations to arrest are launched in ways similar to attacks and can end up with some killings. The article concludes that States could easily limit the impact of CT on IHL by adding an exemption in their CT framework for humanitarian and medical assistance that is compatible with IHL. This is the first necessary condition – even if obviously not a sufficient one – to end the legal ambiguity between IHL and State domestic law as to the criminalization or loss of the IHL protected status for the much necessary needed medical assistance and care activities in times of armed conflict that are evolving in a CT context.

Keywords: protection of the medical mission, global war on terrorism, counterterrorism measures, non-State armed groups, criminalization of humanitarian aid or actors, humanitarian exemption.

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Introduction

Since 2001, the “global war against terrorism” has entered the international vocabulary,¹ and has challenged long-standing rules established by international humanitarian law (IHL).² It should be noted that this concept of a global war

- 1 The Washington Post, “President Bush’s Address to a Joint Session of Congress and the Nation”, 20 September 2001, available at: https://www.washingtonpost.com/wp-srv/nation/specials/attacked/transcripts/bushaddress_092001.html (all internet references were accessed in October 2021); Phoebe Wynn-Pope, Yvette Zegenhagen and Fauve Kurnadi, “Legislating Against Humanitarian Principles: A Case Study on the Humanitarian Implications of Australian Counterterrorism Legislation”, *International Review of the Red Cross*, Vol. 97, No. 897–898, 2015, pp. 235–61; Kathleen Gleeson, *Australia’s “War on Terror” Discourse*, 1st ed., Routledge, London, 2016; Jethro Mullen and Margot Haddad, “‘France is at War,’ President Francois Hollande Says After ISIS attack”, *CNN*, 16 November 2015, available at: <https://edition.cnn.com/2015/11/16/world/paris-attacks/index.html>, quoting the then French President: “We are in a war against terrorism, jihadism, which threatens the whole world. [...] Terrorism will not destroy France, because France will destroy it.” However, from 2009, the then President of the United States, Barack Obama, rebranded the term of global war against terrorism to the one of “Overseas Contingency Operations”. See David R. O’Leary, *The United States’ Overseas Contingency Operations/Global War on Terror: A Military Revolution?*, Master’s Thesis, Homeland Security Digital Library, 21 May 2014, available at: <https://www.hsdl.org/?view&did=760770>; and Scott Wilson and Al Kamen, “‘Global War on Terror’ is Given New Name”, *Washington Post*, 25 March 2009, available at: <https://www.washingtonpost.com/wp-dyn/content/article/2009/03/24/AR2009032402818.html?hpid=topnews>; John Davis, “Assessing Obama’s Efforts to Redefine the War on Terror”, in John Davis (ed.), *The Barack Obama Presidency: A Two Year Assessment*, Palgrave Macmillan, New York, 2011.
- 2 Marko Milanovic, “Lessons for Human Rights and Humanitarian Law in the War on Terror: Comparing Hamdan and the Israeli Targeted Killings Case”, *International Review of the Red Cross*, Vol. 89, No. 866, 2007; Mary Ellen O’Connell, “The Legal Case Against the Global War on Terror”, *Case Western Reserve Journal of International Law*, Vol. 36, No. 2, 2004; Humanitarian Policy Group, “Humanitarian Action and the ‘Global War On Terror’: A Review of Trends and Issues”, *HPG Briefing*, Overseas Development Institute, London, July 2003, available at: <https://cdn.odi.org/media/documents/355.pdf>.

against terrorism had already been invoked in 1999 by the Russian authorities in the context of the second Chechen war.³

The fight against terrorism is largely referred to today to describe the use of armed force against non-State armed groups that are fighting for a new political-religious national order.⁴

Terrorism offences are governed by a specific set of rules in international law⁵ as well as in domestic criminal law. However, they do not belong to a legal

3 Vladimir Putin, “Opinion: Why we Must Act”, *The New York Times*, 14 November 1999, available at: <https://www.nytimes.com/1999/11/14/opinion/why-we-must-act.html>.

4 Ministère de l’Europe et des affaires étrangères, “La force conjointe G5 Sahel et l’Alliance Sahel”, *France Diplomatie*, February 2021, available at: <https://www.diplomatie.gouv.fr/fr/politique-etrangere-de-la-france/securite-desarmement-et-non-proliferation/terrorisme-l-action-internationale-de-la-france/l-action-de-la-france-au-sahel/article/la-force-conjointe-g5-sahel-et-l-alliance-sahel>; U.S. Department of State, “The Global Coalition to Defeat ISIS”, *About Us*, available at: <https://www.state.gov/about-us-the-global-coalition-to-defeat-isis/>; Global Coalition to Defeat Daesh/ISIS, available at: <https://theglobalcoalition.org/en/>. See also for example, the qualification by the governments of Chad, Central African Republic (CAR), Ethiopia, Indonesia and Myanmar of the opposition groups with the “terrorist” label. Ethiopia: On 6 May 2021, the House of Peoples’ Representatives unanimously adopted Resolution No. 10/2021 by majority vote to designate the Tigray People’s Liberation Front (TPLF) and Oromo Liberation Army (OLA)/Shene as terrorists, endorsing the resolution adopted by the Council of Ministers on 1 May 2021; Elisa Meseret, “Ethiopia Charges Prominent Opposition Figure with Terrorism”, *AP News*, 19 September 2020, available at: <https://apnews.com/article/race-and-ethnicity-addis-ababa-abi-yahya-ethiopia-terrorism-c5b1f95bb4eb2258767c2676e665a2dd>. Chad: The Chadian transitional government has purportedly referred in the preamble of its transitional Charter to the Front for Change and Concord in Chad (FACT) rebels as terrorists: see N’Djaména Act, “Charte de Transition de la République du Tchad”, 21 April 2021, available at: <https://www.ndjamenaactu.com/charte-de-transition-de-la-republique-du-tchad/>. However, it seems that the signed version of the Charter changed the term from “terrorists” to “mercenaries”: *Charte de Transition de la République du Tchad*, available at: <https://presidence.td/wp-content/uploads/2021/04/charte-de-transition-tchad.pdf>, but the “terrorist” version of the Charter still remains online. See also, Paul-Simon Handy, *Chad: Democratisation Challenges and Limits of International Intervention (ARJ)*, Real Instituto Elcano, 6 June 2008, available at: http://www.realinstitutoelcano.org/wps/portal/rielcano_en/contenido?WCM_GLOBAL_CONTEXT=/elcano/elcano_in/zonas_in/sub-saharan+africa/ari59-2008: “The increased oil revenues particularly enhanced Deby’s ability to further militarise his regime by (mis)using the terrorist metaphor and attracting international support. By describing his political opponents as terrorists, Deby is not only postponing necessary democratic reforms but he is also trying to secure military support from countries like France and the US.” CAR: In a communiqué released on 20 April 2021 (No. 009/MISP/DIRCAB/SP.21), the Government of CAR declared the armed groups Anti-balaka, Retour, Réclamation et Réhabilitation (3R), Mouvement patriotique pour la Centrafrique (MPC), Unité pour la paix en Centrafrique (UPC), Front populaire pour la renaissance de la Centrafrique (FPRC) and the Coalition of Patriots for Change (CPC) as terrorist groups and no longer as politico-military groups (copy available with the author). Myanmar: The Tatmadaw have labelled the National Unity Government a terrorist group. Reuters, “Myanmar’s Junta Brands Rival Government A Terrorist Group”, 8 May 2021, available at: <https://www.reuters.com/world/asia-pacific/myanmars-junta-brands-rival-government-terrorist-group-2021-05-08/>. Indonesia: Indonesia has designated West Papuan independence fighters as “terrorists”. New Zealand Herald, “Terrorist Tag in West Papua Could Worsen Racism: Rights Group”, 7 May 2021, available at: <https://www.nzherald.co.nz/world/terrorist-tag-in-west-papua-could-worsen-racism-rights-group/G3LB5UWQV5LNT2RMOMBRCFEFOI/>.

5 The 1963 Convention on Offences and Certain Other Acts Committed On Board Aircraft; The 1970 Convention for the Suppression of Unlawful Seizure of Aircraft; The 1971 Convention for the Suppression of Unlawful Acts against the Safety of Civil Aviation; The 1973 Convention on the Prevention and Punishment of Crimes against Internationally Protected Persons, including Diplomatic Agents; The 1979 International Convention against the Taking of Hostages; The 1980 Convention on the Physical Protection of Nuclear Material; The 1988 Protocol for the Suppression of Unlawful Acts of Violence at Airports Serving International Civil Aviation, supplementary to the Convention for the Suppression of Unlawful Acts against the Safety of Civil Aviation; The 1988 Convention for the Suppression of Unlawful Acts against the Safety of Maritime Navigation; The 1988 Protocol for the

category under IHL. The lack of agreement on an international definition for the concept of terrorism⁶ contributes to blurring the right of individuals (labelled as terrorists), who are part of a non-State armed group in a non-international armed conflict (NIAC), to the legal protections afforded by IHL in the course of the conduct of hostilities. Indeed, these individuals will usually fall under domestic terrorism laws, the application of which, in several cases of observed practice, supersedes IHL and subtracts them from a protection that they would normally benefit as a non-State party to a conflict. Conflation of IHL and domestic criminal terminology has become inherent to the effective implementation of IHL in these situations.

This confusion is even more aggravated by the ambiguity created by the choice to use terms such as “war” or “combat” to refer to the fight against individuals and groups labelled as terrorists at the national and international level.⁷ It also contributes to blurring the lines between criminal law and the legal framework applicable to armed conflict. Recent reference to “armed terrorist groups” by State military representatives⁸ further crystalizes this risk. Indeed, in determining if the commission of certain acts meets the threshold of an armed conflict, the labelling of individual or non-State armed groups as being terrorist is irrelevant. What matters is the intensity of the violence used between the opposing State and non-State parties to the conflict – government forces against the non-State armed group.⁹

Terrorism is a broad criminal qualification that materializes in two different and intertwined ways: special criminal procedure in front of tribunals and special military operations in the battlefield. It has also been broadly used by governments in many NIACs to qualify groups and individuals affiliated to non-State armed groups and to deprive them of IHL provisions, notably about

Suppression of Unlawful Acts against the Safety of Fixed Platforms Located on the Continental Shelf; The 1991 Convention on the Marking of Plastic Explosives for the Purpose of Detection; The 1997 International Convention for the Suppression of Terrorist Bombings; The 1999 International Convention for the Suppression of the Financing of Terrorism.

- 6 A draft convention that would include a definition of terrorism in its article 2 has been under negotiation since 1996 (for now twenty-five years) by the United Nations General Assembly (UNGA) (*Draft Comprehensive Convention on International Terrorism*). For more information, see United Nations, *Ad Hoc Committee Established by General Assembly Resolution 51/210 of 17 December 1996*, available at: <https://legal.un.org/committees/terrorism/>.
- 7 States keep their own sovereignty in deciding which groups or individuals shall be considered as terrorist within their domestic jurisdiction without prejudice of other international procedures such as the one under the United Nations Security Council (UNSC).
- 8 See the reference made by the French to “armed terrorist groups” (GAT in French): Ministère des Armées, *Communiqué de presse, Opération Barkhane: Frappe contre un rassemblement de membres d’un groupe armé terroriste dans la région de Douentza*, 7 January 2021, available at: <https://www.defense.gouv.fr/english/salle-de-presse/communiques/communiquede-presse-operation-barkhane-frappe-contre-un-rassemblement-de-membres-d-un-groupe-arme-terroriste-dans-la-region-de-douentza>; Ministère des Armées, *Réaction du ministère des Armées au rapport de la Minusma sur les frappes de janvier au Mali*, 30 March 2021, available at: <https://www.defense.gouv.fr/actualites/articles/reaction-du-ministere-des-armees-au-rapport-de-la-minusma-sur-les-frappes-de-janvier-au-mali>.
- 9 International Criminal Tribunal for the Former Yugoslavia, *The Prosecutor v. Fatmir Limaj et al.*, Judgment (Trial Chamber II), IT-03-66-T, 30 November 2005, paras. 135–70.

detention and interrogation¹⁰ but also in connection with the provision of impartial medical care. Indeed, beyond international designation of terrorist individuals and groups, each country takes its own decision regarding such designation. While attention has been given to attacks on medical care as a generic issue, more elaboration on their typology and triggers is necessary to identify effective leverage. Better acknowledgement of the adverse effects of counterterrorism (CT) measures on the humanitarian action and the way the fight against terrorism is conducted is needed to shield IHL's legitimacy and its legal protection from pervasive CT criminal frameworks.

These practices are a direct challenge to the rules of IHL applicable in situations of NIACs. IHL is meant to apply equally to all Parties to the conflict including non-State parties in today's most common situation of NIACs. IHL also recognizes the status of "Party to the conflict" to non-State armed groups under the condition that they are sufficiently organized and under responsible command capable to carry out sustained and concerted military operations.¹¹ All parties, including non-State armed groups, are thus bound to respect IHL during the conduct of hostilities and to respect the right to medical assistance and care for victims of armed conflict. It should not be forgotten that individuals affiliated with non-State armed groups are liable to prosecution for war crimes under IHL for any acts amounting to it while also being liable to national criminal prosecution for the mere participation in hostilities. Indeed, they do not benefit from the "combatant privilege" that is afforded solely to members of a State armed group according to the Third Geneva Convention. Therefore, non-State armed group members can be so prosecuted, regardless of the labelling of the offence they are accused of committing (terrorism or not). However, any violation of IHL committed by members of non-State armed groups does not deprive these non-State armed groups of their status of Party to the conflict and the ensuing IHL protections, nor do they release States Parties to the conflict

10 *Djamel Ameziane (United States)*, Inter-American Commission on Human Rights, Merits Report No. 29/20, Case 12.865, 22 April 2020, paras. 126–7, 131 and 133.

11 Protocol Additional (II) to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts, 1125 UNTS 609, 8 June 1977 (entered into force 7 December 1978) (AP II), Art. 1(1); International Criminal Tribunal for Rwanda, *The Prosecutor v. Alfred Musema*, Case No. ICTR-96-13-T, Judgment and Sentence (Trial Chamber I), 27 January 2000, para. 257; International Criminal Tribunal for the Former Yugoslavia, *The Prosecutor v. Fatmir Limaj et al.*, Case No. IT-03-66-T, Judgment (Trial Chamber II), 30 November 2005, para. 89; *The Prosecutor v. Ramush Haradinaj et al.*, Case No. IT-04-84-T, Judgment (Trial Chamber I), 3 April 2008, para. 60; *The Prosecutor v. Ljube Boškoski and Johan Tarčulovski*, Case No. IT-04-82-T, Judgment (Trial Chamber II), 10 July 2008, paras. 194–205. Under Article 3 common to the four Geneva Conventions, it would be an even lower threshold. See the International Committee of the Red Cross (ICRC) Commentary of 2021 to Article 3 Common to the Four Geneva Conventions, paras. 463 ff, and its accompanying footnotes. See <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=31FCB9705FF00261C1258585002FB096>. In order for a non-State armed group to be sufficiently organized to become a Party to a NIAC, it must possess organized armed forces. Such forces "have to be under a certain command structure and have the capacity to sustain military operations". (emphasis added).

from their obligations – in case of detention, *hors de combat*, etc. – under IHL in the conduct of their military operations.¹²

Article 3 common to the four Geneva Conventions acknowledges the specificity of NIACs and takes into account the legal asymmetry between the State and the non-State party to such conflicts. It specifies, in sub-article 2, that application of IHL provisions shall not affect the legal status of the Parties to the armed conflict. The primary purpose of that last sentence at the end of common Article 3 was to emphasize that the application of IHL – rights and obligations – to non-State armed groups does not grant them a “legal status” that would shield them from prosecution under domestic law for taking up arms against the *de jure* government.¹³ This concretely means that the legal status of the non-State party to the armed conflict remains defined by domestic law as a criminal one – which has been widened by new CT regulations and practices.

As this article will demonstrate, the layering of IHL and the CT criminal framework in most armed conflicts involving non-State actors has been made at the expense of the integrity of IHL essence and rules, including the most ancient ones regarding medical care to wounded combatants whichever nation they belong to.¹⁴ Two main factors may be identified. The first is the special nature of CT criminal law that challenges the judicial protection system with regard to

12 ICRC Commentary of 2021 to Article 3 Common to the Four Geneva Conventions, paras. 915 and 916. See <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=31FCB9705FF00261C1258585002FB096>. Para. 915: “The recognition that serious violations of common Article 3 amount to war crimes has opened new avenues for both international courts and tribunals and domestic courts to prosecute alleged offenders. *International courts and tribunals, such as the ICTY, the ICTR, the ICC, the SCSL and the Iraqi Special Tribunal, have been set up to prosecute alleged offenders for serious violations of common Article 3, among other international crimes.*” (emphasis added). Para. 916: “Alleged perpetrators can be prosecuted by the courts of the State on whose territory the offences were committed, the State of nationality of the victim, or the State of their own nationality. In non-international armed conflicts, these three possible States will mostly be one and the same, namely the territorial State.”

13 This purpose is clear from the ICRC Commentary of 2016 to GC I on Article 3 Common to the Four Geneva Conventions, paras. 861 and 864. See <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=59F6CDFA490736C1C1257F7D004BA0EC>. Para. 861: “This clause, which affirms that “[t]he application of the preceding provisions shall not affect the legal status of the Parties to the conflict”, is essential. It addresses the fear that the application of the Convention, even to a very limited extent, in cases of non-international armed conflict may interfere with the *de jure* government’s lawful suppression of armed activity. This clause makes absolutely clear that the object of the Convention is purely humanitarian, that it is in no way concerned with the internal affairs of States, and that it merely ensures respect for the essential rules of humanity which all nations consider as valid everywhere, in all circumstances.” Para. 864: “This provision confirms that the application of common Article 3 – or, perhaps more accurately, a State’s acknowledgement that common Article 3 and customary IHL obligations apply to a conflict involving a non-State armed group – does not constitute any recognition by the *de jure* government that the adverse Party has any status or authority of any kind; it does not limit the government’s right to fight a non-State armed group using all lawful means; and it does not affect its right to prosecute, try and sentence its adversaries for their crimes, in accordance with its own laws and commensurate with any other international legal obligations that may apply to such procedures. The same holds true in respect of the conclusion of special agreements. Indeed, the application of common Article 3 to a non-international armed conflict does not confer belligerent status or increased authority on the non-State armed group.” (footnote citation omitted).

14 *Convention de Genève du 22 août 1864 pour l’amélioration du sort des militaires blessés dans les armées en campagne*, Art. 6 (Convention of 1864).

investigation, arrest, detention and prosecution. The second is the absence of explicit reference in domestic law to the medical and humanitarian immunity provided by IHL.¹⁵ This omission exposes humanitarian and impartial medical assistance to the suspicion and threats stemming from the current wide definition¹⁶ (and application)¹⁷ of complicity, association with, and support to terrorism offences.

IHL applies in situations of armed conflict regardless of the criminal classification done by States of the status of individuals or armed groups. Conversely, the qualification of non-State armed group fighters as “terrorists”, including when they are wounded and sick, contaminates the legitimacy of the series of IHL provisions that protects medical and humanitarian assistance in armed conflicts.

Beside the duty to collect and care for wounded and sick without discrimination as provided in common Article 3, the medical mission¹⁸ – broadly speaking – itself is defined and protected as such under IHL since 1864 in international armed conflict (IAC) and since 1977 in NIAC. This protection covers the specific status of wounded and sick, medical personnel as well as medical facilities and transport.¹⁹ It was drawn for military and later extended to civilians.²⁰ In 1977, the Additional Protocols to the Geneva Conventions have merged the protection for the military and civilian categories of the medical mission. However, domestic criminal law still frames and limits the way wounded

15 Protocol Additional (I) to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3, 8 June 1977 (entered into force 7 December 1978) (AP I), Art.16(1); and AP II, Art. 10(4).

16 See, for example, the definition put forward in 18 U.S. Code (United States), Arts 2339A and 2339B; Criminal Code (Canada), Arts 83.03(b) and 83.19; Criminal Code (Niger), Art. 399.1.21; see also UNGA, *Note by the Secretary-General on Extrajudicial, Summary or Arbitrary Executions*, UN Doc. A/73/314, para. 33; Dustin A. Lewis, Naz K. Modirzadeh and Gabriella Blum, *Medical Care in Armed Conflict: International Humanitarian Law and State Responses to Terrorism*, Legal Briefing, Harvard Law School Program on International Law and Armed Conflict, September 2015, pp. 63 and 100.

17 United States District Court for the Southern District of New York, *United States v. Shah*, 474 F. Supp. 2d 494 (S.D.N.Y. 2007); UNGA report, UN Doc. A/73/314, para. 34; P. Wynn-Pope, Y. Zegeghagen and F. Kurnadi, above note 1, p. 247, for the examples of trials in the United States; see also the examples given on Afghanistan at para. 8 and of accusations against the non-governmental organization (Interpal) of having financed terrorism activities for the sole fact of having been present and working only in Palestinian territories at para. 10 in François Lenfant, Lia van Broekhoven and Frank van Lierde, “Les conséquences de la guerre contre le terrorisme sur le monde des ONG”, *Cultures & Conflicts*, Vol. 76, 2009, available at: <https://journals.openedition.org/conflicts/17779>. See Sen Kasturi and Tim Morris, *Civil Society and the War on Terror*, Intrac, Oxford, 2008; Nolan Guigley and Belinda Pratten, *Security and Civil Society: The Impact of Counter-Terrorism Measures on Civil Society Organisations*, National Council for Voluntary Organisations, London, 2007, which both demonstrate that most accusations levelled against non-governmental organizations were unfounded at para. 10.

18 This article uses the term “medical mission” in its broad sense to describe the entire set of medical activities, medical personnel, units, duties, equipment and transports aimed at the civilian population in general, and in particular to all wounded and sick persons, without discrimination, in times of armed conflict.

19 Geneva Convention (IV) relative to the Protection of Civilian Persons in Time of War of 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) (GC IV), Arts 16–22; AP I, Arts 8–31; AP II, Arts 7–12; and Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law*, Vol. 1: *Rules*, Cambridge University Press, Cambridge, 2005 (Customary IHL Rules), available at: <https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1>, Rules 25–30, 109 and 111.

20 *Ibid.*

and sick from non-State armed groups can receive medical care which leads to “mistake” attacks and incidental damage on the medical mission.²¹

At the international level, the scale of the attacks committed against the medical mission in armed conflicts such as those of Afghanistan, Syria and Yemen led the Member States of the United Nations Security Council (UNSC), in 2016, to reaffirm the protection of this mission in the framework of its resolution 2286.²² During this process, it became apparent that the violence perpetrated against the medical mission was systemic and that it significantly involved armed State actors that were carrying action in the course of their global fight against terrorism.²³

The United Nations General Assembly (UNGA) has developed for several years a strategy to fight terrorism that relies on the prerogatives of the UNSC under Chapter VII of the United Nations Charter, adopting international sanctions against specific countries but also against non-State armed groups and individuals listed as terrorists.²⁴ In addition to international treaties prohibiting terrorism, the UNSC passed international sanctions against designated groups and individuals and required all States to adopt criminal measures that demonstrate their good faith commitment to the fight against terrorism.²⁵ For a while, such resolutions only intended to remind States of their obligation, while fighting terrorism, to respect international law, including human rights law, refugee law and IHL.²⁶ However, recent UNSC and UNGA resolutions have scaled up their concerns of ensuring the respect of IHL while combatting terrorism.²⁷ These resolutions call on all States to take into account the impact of their CT legislations on exclusively humanitarian actions, including medical activities carried out by impartial humanitarian organizations in accordance with IHL.²⁸ These renewed concerns from the United Nations have been fuelled by the worrying trends of attacks on the medical mission in numerous situations of armed conflict.

21 Françoise Bouchet-Saulnier and Jonathan Whittall, “An Environment Conducive to Mistakes? Lessons Learnt From the Attack on the Médecins sans Frontières Hospital in Kunduz, Afghanistan”, *International Review of the Red Cross*, Vol. 100, No. 1-2-3, 2018.

22 UNSC Res. 2286, 3 May 2016.

23 Médecins sans Frontières (MSF), “MSF International President to UN Security Council: ‘This Failure Reflects a Lack of Political Will’”, 28 September 2016, available at: <https://www.msf.org/msf-international-president-un-security-council-failure-reflects-lack-political-will>. World Health Organization, Report on Attacks on Health Care in Emergencies, 2016, p. 7, available at: <https://www.who.int/hac/techguidance/attacksreport.pdf>.

24 UNGA Res. 60/288, 20 September 2006. See the updated 2021 strategy: UNGA, *The United Nations Global Counter-Terrorism Strategy: 7th Review: Draft Resolution/Submitted by the President of the General Assembly*, available at <https://digitallibrary.un.org/record/3930201?ln=fr>.

25 UNSC Res. 373, 28 September 2001; and UNSC Res. 1624, 14 September 2005. See the UNSC CT Committee, description available at: <https://www.un.org/securitycouncil/ctc/content/our-mandate-0>.

26 UNSC Res. 1456, 20 January 2003, para. 6; UNSC Res. 1787, 10 December 2007, preamble; UNSC Res. 2129, 17 December 2013, preamble, paras. 18 and 21; UNSC Res. 2220, 22 May 2015, preamble, paras. 2 and 3; UNSC Res. 2354, 24 May 2017, preamble, para. 2(e); UNSC Res. 2396, 12 December 2017, preamble, paras. 22 and 34; UNSC Res. 2427, 9 July 2018, preamble, paras. 12 and 13.

27 See, for example, UNGA Res. 72/133, 16 January 2018, para. 68; UNGA Res. 72/180, 30 January 2018, paras. 1, 5(a), 5(o) and 7; UNGA Res. 72/284, 26 June 2018, para. 79; UNGA Res. 73/139, 17 January 2019, para. 69; and UNGA Res. 73/174, 17 January 2019, paras. 2 and 14.

28 UNSC Res. 2462, 28 March 2019, p. 1 and paras. 5–6, 20 and 24; UNSC Res. 2482, 19 July 2019, p. 2 and para. 16.

It is important to recall that the criminal and terrorist characterization of non-State armed groups active on a territory depends on the policy of each country and the content of its criminal law. This qualification therefore goes far beyond the groups and individuals listed as terrorists by the UNSC resolutions²⁹ and puts humanitarian and medical personnel under additional pressure and criminal threats. At the national level, few States have already taken legal action to rectify this by including specific humanitarian exemptions in their criminal CT regulations. These legislative evolutions reflect lucid and responsible acknowledgement by the concerned States of the current weakening of IHL protections which is due to the criminalization of medical and humanitarian activities under CT criminal law measures.³⁰

This article will examine how the CT criminal framework is virtually destroying the fragile balance between IHL and the already existing criminal status of non-State armed groups under domestic law, notably by obliterating the medical duties in situations of armed conflict toward the wounded and sick affiliated to non-State armed groups as provided by IHL. The success of Henry Dunant after the Solferino battle to ensure that wounded enemies receive impartial medical care in IAC, extended to NIACs in 1949 through common Article 3, needs to be put back on track. Indeed, this should be done so that wounded fighters receive this impartial medical care and also to allow the civilian population living in disputed areas or under the control of non-State armed groups, labelled as terrorist, to benefit from unimpeded humanitarian assistance.

From the historical consensus on medical care to the military wounded and sick on the battlefield

The international consensus surrounding the duty to care for the wounded and sick on the battlefield emerged from the direct witnessing of their fate in Solferino by Henry Dunant, a civilian from a neutral country who published his book “A Memory of Solferino”. In 1864, the very first of the Geneva Conventions established the IHL framework providing impartial medical care for the military wounded and sick and protecting them as well as those assisting them. Wartime impartial medical care is therefore the starting point and at the heart of the oldest protections laid out in contemporary IHL.

Although this right may be seen as self-evident, it is important to understand the difficulties that had to be overcome in 1864 before it could make

²⁹ See above notes 4 and 26.

³⁰ See UNSC, Letter Dated 3 June 2020 from the Chair of the Security Council Committee Established Pursuant to Resolution 1373 (2001) Concerning Counter-Terrorism and the Chair of the Security Council Committee Pursuant to Resolutions 1267 (1999), 1989 (2011) and 2253 (2015) Concerning Islamic State in Iraq and the Levant (Da’esh), Al-Qaida and Associated Individuals, Groups, Undertakings and Entities Addressed to the President of the Security Council, UN Doc. S/2020/493, 3 June 2020, para. 84; see also UNGA, above note 16, paras. 48–52, 84, 85(a) and (b), 86, 89(d) and (g) and 90(a).

its appearance in the law of IAC. These difficulties can shed light on underlying factors of the multiple violations observed today, particularly in the context of NIACs.

Claiming that providing medical care to wounded and sick from the armed forces was mandatory, military neutral and not a support given to the adverse Party to the armed conflict was a new assumption that required a solid legal framework. From the outset, legal and practical difficulties had to be overcome for the principle, that the wounded and sick must be collected and cared for without discrimination, to be enshrined in IHL.

The first legal difficulty was the legal “neutralization” of the enemy’s wounded and sick—belonging to the armed forces—so that care would not be assimilated with a contribution to the war effort or with any form of participation in the hostilities. The wounded and sick benefit from the protections of IHL, as long as they do not participate to the hostilities.³¹ This status offers a protection that has a dual component which includes the obligation of the Parties to the armed conflict to facilitate medical care, as well as the prohibition on attacking the wounded and sick and the medical facilities, transport and personnel that care for them.

The 1864 Geneva Convention based the protection of the wounded and sick on the fact that they were no longer taking an active part into the hostilities. Therefore, those combatants would be considered as legally protected in the armed conflict and could not be attacked. Indeed, as the wounded and sick combatants no longer pose a military threat, there was no military necessity to attack them. Moreover, from a humanitarian perspective,³² as these persons are suffering, they needed to be treated. Furthermore, States Parties were to collect, treat and care for the wounded and sick combatants without any adverse distinction, i.e. of whichever nation they may belong to.³³ This obviously created an incentive for all parties to the armed conflict, as with it, they were given the same guarantee regarding their own wounded and sick. The protection of medical personnel, facilities and transport was also built on the medical neutrality agreement stipulating that ambulance and military hospitals shall be recognized as neutral and protected against any attacks.³⁴ The personnel performing medical, administrative and transportation duties of those hospitals as well as ambulances were to benefit from the same neutrality.³⁵ It also specified that acting in the

31 See Convention of 1864, above note 14, Art. 6; Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950) (GC I), Art. 12; and Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950) (GC II), Art. 12.

32 The principle of humanity forbids the infliction of all suffering, injury or destruction not necessary for achieving the legitimate purpose of an armed conflict.

33 Convention of 1864, above note 14, Art. 6.

34 In that regard, the 1864 Geneva Convention adopted a distinctive emblem (the Red Cross) at its article 7, to signal the neutral status of medical personnel, facilities and transport. However, no such provision has been provided in AP II regarding the use of the medical protective emblem under the control of non-State parties to the armed conflict.

35 Convention of 1864, above note 14, Arts 1–4.

name of humanity conferred neutrality to the people bringing assistance to the wounded and sick.³⁶ Interestingly, while the issue of capture and arrest of wounded and sick enemy is a contentious practice, the very first Geneva Convention, in 1864, did not mention the right to capture or arrest wounded and sick from the enemy but rather provided that they could be directly rendered at the front line.³⁷

Another practical issue to which health personnel were confronted was the pressures from State security agents and military forces with regard to provision of medical care to some wounded and sick in armed conflict contexts. Therefore, IHL provided a secured and protective legal framework of action to health and relief personnel based on international recognition of medical ethics. IHL enhanced the mandatory respect of medical ethics by medical personnel against other dual security obligations imposed by States Parties to an armed conflict. To fully protect the autonomy of medical personnel and their professional ethics, IHL upholds immunity under domestic law for medical personnel acting according to medical ethics. This was necessary to secure their protection which derived from the neutrality of the medical activities they performed, and which are also in line with medical ethics.

The First Geneva Convention of 1949, for the first time, enshrined a specific IHL obligation that no one, including health personnel, shall be “molested” or “punished”³⁸ for treating the wounded and sick, including enemies, as required by medical ethics.³⁹ Subsequently, IHL in the 1977 Additional Protocols also affirmed that medical ethics is the imperative framework for medical assistance and that it is binding on all parties in situations of armed conflict and that no discrimination can be made between wounded and sick (including enemies) except if done based on medical criteria.⁴⁰

The current IHL framework protecting the medical duties, personnel and facilities is a functional one aimed at ensuring that medical care is provided without discrimination. It is rooted in the 1864 conventional agreement that medical care to wounded and sick enemy is of a neutral nature and that it encompasses the status of hospital and ambulances as well as medical and administrative personnel. Recalling this initial agreement is useful to overcome difficulties of IHL implementation in NIACs that are evolving in contexts of CT. Under IHL, civilians are entitled to the general protection under their civilian status as long as they do not make a direct participation in hostilities (DPH),⁴¹

36 Convention of 1864, above note 14, Arts 2 and 5.

37 Convention of 1864, above note 14, Art. 6.

38 It is interesting to note that GC I, at Article 18, uses the terms “*inquiété*” (worried) and “*condamné*” (convicted) in its French version while its English version uses the terms “molested” and “punished”. However, this difference of language cannot be found in the Additional Protocols. AP I, at Article 16 (1), and AP II, at Article 10(1), use the term “*puni*” in their French version and use its exact equivalent in the English version: “punished”.

39 Convention of 1864, above note 14, Arts 2 and 5; GC I, Art. 18; AP I, Art. 16; and AP II, Art. 10(1).

40 AP I, Art. 16(2); AP II, Art. 10(2); the 1864 Geneva Convention does not contain an explicit mention to medical ethics but only refers to the duty to care humanely and without discrimination.

41 See Nils Melzer, *Interpretive Guidance on the Notion of Direct Participation in Hostilities Under International Humanitarian Law*, ICRC, Geneva, 2009, available at: <https://www.icrc.org/en/doc/assets/files/other/icrc-002-0990.pdf>.

while wounded and sick, medical personnel, facilities and transports as well as medical duties benefit from a distinct and special protection on the basis of ensuring the performance of vital medical functions in their civilian and military components to satisfy the need for medical care.

Who are the protected wounded and sick?

In an IAC there is an obvious distinction between the military and civilian wounded and sick. The first two Geneva Conventions of 1949 developed rules for care and protection of the wounded and sick of the armed forces.⁴² The definition of armed forces was later extended by Additional Protocol I. However, it only covers individuals from a State Party to the armed conflict which encompasses their armed forces or other individuals, groups and units affiliated to it,⁴³ as long as they are under a command responsible for the conduct of its subordinates to a State Party. Although they benefit from the general protection offered by common Article 3, a confusion is created as wounded and sick fighters belonging to non-State armed groups are not explicitly included in the historical core of the protection of the wounded and sick – which used to designate solely combatants from a State armed force. The Fourth Geneva Convention of 1949 extended this protection to wounded and sick civilians, notably in situations of occupation⁴⁴ but made no explicit mention of members of non-State armed groups (or other civilians taking a DPH in the course of a NIAC) who become wounded and sick. They remain only covered by the general protection offered by common Article 3(2).

Additional Protocol I unified the definition of protected wounded and sick persons by specifying that it refers to all military or civilian persons in need of medical care and who refrain from any act of hostility.⁴⁵ It is thus clear that under IHL, impartial medical care should be provided to any wounded or sick person regardless of the label assigned to them as terrorist, or as a member of a non-State armed group – either a fighter or a civilian taking a direct part into hostilities.

The obligation to search, collect, evacuate and care for the wounded and sick without delay and without adverse distinction is a strong rule of customary IHL that clearly prohibits the abandonment of those people who are specifically at risk.⁴⁶ The rule applies to every wounded and sick person – civilian or military – as long as he is not directly participating in the hostilities when receiving the impartial medical care. This formulation allows the inclusion of wounded and sick from non-State armed groups in the protected status without

42 Prisoners of war are also entitled to hygiene and medical attention pursuant to Geneva Convention (III) relative to the Treatment of Prisoners of War of 12 August 1949, 75 UNTS 135 (entered into force 21 October 1950) (GC III), Arts 29–32.

43 GC IV, Art. 4(A)(1)–(3) and (6); and AP I, Art. 43(1).

44 GC IV, Art. 16; GC I, Art. 12; GC II, Art. 12; and GC III, Art. 30.

45 AP I, Art. 8(A).

46 Customary IHL Rules 109–11.

entering into debate about their military or civilian nature. This is in line with the minimum regime established for NIACs by common Article 3. However, if the unified definition allows for the minimum protection of the wounded and sick, it has not abolished the different civilian and military special protection regimes applicable to medical duties, staff and facilities as we will see later.

Protection of medical duties under IHL contains two separate provisions: the right for the wounded to be collected and cared for on the one hand, and on the other hand, for the related protection against an attack. The prohibition of attacks protects persons *hors de combat* in particular because of their wounds and sickness.⁴⁷ Concerning the wounded and sick, while the obligation to collect and care for them is clearly stated, common Article 3 does not explicitly include specific requirements and protection for medical personnel, facilities or transports, or the military or civilian status of the personnel and the medical structures involved in such duty.⁴⁸

Additional Protocol II complemented the sobriety of common Article 3 with a set of provisions very similar to those found in Additional Protocol I for IACs.⁴⁹ The obligation to protect, collect and care covers all wounded, sick and shipwrecked persons whether or not they took part in the armed conflict.⁵⁰ This new formulation therefore imposes an absence of distinction, based on criteria other than medical ones, for the care of these persons⁵¹ as demonstrated by several international instruments⁵² and the practice of many States which included it in their military manuals applicable in NIACs.⁵³

Does it mean that belonging to either the armed forces of a State or to non-State armed groups is no longer relevant with regard to the access to and conditions of medical care? The answer is no for two main reasons, the first one being the variation in the degree of application of the precaution and proportionality duties; the second is related to the loss of protection of wounded and sick fighters.

The extension of protection to civilian wounded and sick and the unification of the terminology contained in the Additional Protocols to the Geneva Conventions have not abolished the specific rules applicable to military or civilian health personnel⁵⁴ as well as military or civilian medical facilities.⁵⁵ It

47 GC IV, Art. 3(1).

48 GC IV, Art. 3(2).

49 AP II, Arts 7–11; and AP I, Arts 10–17.

50 AP II, Art. 7(1).

51 AP II, Art. 7(2); Customary IHL Rule 110.

52 *Cairo Declaration on Human Rights in Islam*, 5 August 1990, Art. 3(a); *Hague Statement on Respect for Humanitarian Principles*, 5 November 1991, paras. 1 and 2; *Memorandum of Understanding on the Application of International Humanitarian Law between Croatia and the Socialist Federal Republic of Yugoslavia*, 27 November 1991, para. 1; *Agreement on the Application of International Humanitarian Law between the Parties to the Conflict in Bosnia and Herzegovina*, 27 November 1991, para. 2.1; *Comprehensive Agreement on Respect for Human Rights and International Humanitarian Law in the Philippines*, Part IV, 16 March 1998, Arts 4(2) and (9).

53 See Customary IHL Rule 110 and the various military manuals cited in its endnote 10.

54 See AP I, Arts 13 and 15, applicable to civilian medical facilities and personnel. These articles complement GC I, Arts 21, 22 and 23–6.

55 GC I, Art. 12; GC II, Art. 12; GC IV, Arts 16 and 27; and common Article 3.

has not abolished as well the original distinction between combatant or civilian wounded and sick and its impact on the protected status of military or civilian medical facilities and personnel.

From a humanitarian point of view, the major differences between the military and civilian protection regimes for the wounded and sick, for medical personnel, facilities and transports relates to the protection against attacks and the right of capture or arrest of any wounded and sick person. The protection against indiscriminate attacks includes, of course, the prohibition to attack intentionally any wounded and sick, medical personnel, facility and transport whether or not they are considered as military or civilian.⁵⁶ The military or civilian categorization of wounded and sick and of medical unit and personnel is irrelevant for direct attacks. However, such categorization matters with regard to the duty of precaution and proportionality regarding incidental damage suffered by wounded and sick, medical personnel facilities and transports in the conduct of hostilities.⁵⁷ In such situations, the assessment of proportionality and precaution is based only or mostly on the civilian nature of the incidental damage.⁵⁸ The military or civilian characterization of such wounded and sick from non-State armed groups as well as the medical personnel and units involved in their care may lead to the exclusion of their loss and casualties from the calculation of the civilian damage. This changes the level of incidental protection that may be expected in cases of a medical facility and its personnel providing medical care without discrimination to wounded and sick from non-State armed groups.

The drafters of Additional Protocol I felt necessary to specify that the presence of the armed forces of a State or other combatant in a civilian medical facility for medical reasons shall not be considered as an act harmful to the enemy (AHTTE) and therefore shall not deprive civilian medical facilities of their IHL protection from attacks.⁵⁹ This clarification, provided only for IAC, shed

56 AP I, Art. 51(4)(a); Customary IHL Rule 12 (regarding the prohibition against indiscriminate attacks in general); GC I, Arts 12–13; GC II, Arts 12–13; GC IV, Art. 16; AP I, Art. 10(1); AP II, Art. 7(1) (regarding protection for the wounded and sick); GC I, Arts 24–6; GC II, Art. 36; GC IV, Art. 20; AP I, Art. 15(1); AP II, Art. 9(1); Customary IHL Rule 25 (regarding protection for medical personnel); GC I, Art. 19; GC IV, Art. 18; AP I, Arts 12 and 52; Customary IHL Rule 28 (regarding protection for medical facilities); GC I, Art. 35; GC IV, Art. 21; AP I, Arts 21 and 52; Customary IHL Rule 29 (regarding protection for medical transports).

57 AP I, Arts. 51(5)(b), 57 and 58; Customary IHL Rules 14, 15 and 21–4.

58 AP I, Arts. 51(5)(b); Customary IHL Rules 14 and 15. However, the position that the principles of proportionality and precaution apply differently (or not at all) to military wounded and sick, and military medical personnel and objects is not universally shared. See Robert Kolb and Fumiko Nakashima, “The Notion of ‘Acts Harmful to the Enemy’ under International Humanitarian Law”, *International Review of the Red Cross*, Vol. 101, No. 912, 2019, p. 1176 and its footnotes 35–9 where the three debated positions are discussed: (i) fully applicable to all; (ii) applicable to wounded and sick military as well as to military personnel and objects but with a more lenient equation for assessing collateral damage than for civilian collateral damage; and (iii) not applicable to military medical personnel and objects or to military wounded and sick as they remain combatants.

59 AP I, Art. 13 complements GC I, Art. 22. See also Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds), *Commentary on the Additional Protocols*, ICRC, Geneva, 1987 (ICRC Commentary on APs), paras. 571 and 572 on AP I, Art. 13. Para. 571: “In view of the conditions of modern warfare, military and civilian wounded and sick are often found in the same place, and

light on the risks remaining in NIAC concerning the various possible interpretations and legal impacts of the presence of wounded and sick from non-State armed groups in a medical facility either as potential non civilian “acceptable” incidental damage, or as “acceptable” targets under their potential continuous hostile activity or under other AHTTE. Navigating the various IHL criteria related to the loss of protected status for wounded and sick in NIAC requires scrutiny of the various domestic doctrines and practices.⁶⁰ AHTTE differs from acts of hostility and from DPH. Although acts of hostility do not have a clear definition under IHL, they are interpreted by analogy with the rather strict definition of “hostile act”.⁶¹ However, some countries also refer to a hostile intent rather than a hostile act in their determination of DPH, thereby creating more uncertainty as to the effective status of protection of wounded and sick.⁶² The scope of AHTTE is broader than the above-mentioned two concepts as it may encompass indirect effects, attempts, and not only acts deliberately committed to harm the military operation of the adverse party, not intended to support a specific party to the armed conflict (some acts could be committed by inattentiveness or by error). AHTTE are mainly appreciated based on the caused harm and possible contribution to military operations without having to be strictly connected to hostilities (which are defined as all the direct engagements in specific means and methods of injuring the enemy).⁶³ For example, an AHTTE could be the sheltering, inside a civilian medical facility, of fit and healthy non-State armed group fighters or the transportation, in an ambulance, of these same fighters so that they are not attacked due to the special protection afforded to the medical mission. These acts, carried inside protected medical objects, would thus confer a military advantage to one of the parties to the armed conflict as they would be performed by medical personnel outside of their humanitarian duties and outside of the function of medical objects.

Additional precaution is also required when involving the CT legal framework in the equation. Indeed, various militarized security operations taking place in CT contexts risk blurring concepts related to law enforcement and to the law of armed conflict.

consequently they may be collected by the same medical units. Thus it is not possible to complain about the presence of wounded and sick civilians in a military unit, or that of military wounded and sick in a civilian unit, as a reason to terminate the protection to which these units are entitled. The provision quoted above removes any ambiguity on this point, as do the equivalent provisions of Article 22 of the First Convention with regard to military medical units, and of Article 19 of the Fourth Convention for civilian hospitals.” Para. 572: “The expression ‘or other combatants’ was added to the expression ‘members of the armed forces’ to ensure that all combatants within the meaning of Article 43 of the Protocol (*Armed forces*) are included. This addition, which was made during the CDDH, was retained in the end, even though it had become superfluous in view of the final wording of Article 43 (*Armed forces*). As armed forces are defined in a very broad sense in paragraph 1 of that article, there are no combatants who are not members of the armed forces of a Party to the conflict within the meaning of the Protocol.”

60 R. Kolb and F. Nakashima, above note 58, pp. 1171–99.

61 AP I, Arts 41(2)(c), 42(2) and 51(3).

62 United States Department of Defense, *Law of War Manual*, June 2015 (updated December 2016), para. 5.8.3.3: “demonstrated hostile intent may also constitute taking direct part in hostilities”.

63 R. Kolb and F. Nakashima, above note 58, p. 1192. See also N. Melzer, above note 41, p. 1013.

Under IHL, the capture of an enemy, even wounded and sick, is a military operation that cannot amount to an attack on the wounded and sick or on the medical facility and personnel and it must comply with medical duties. It is not subject to formal judicial procedure.⁶⁴ Moreover, the arrest of a wounded and sick alleged criminal must respect official procedure and judicial guarantees.

Losing the wounded and sick protected status?

Under IHL the protected status of wounded and sick covers persons, whether military or civilian, who because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility.⁶⁵ This definition, from the 1977 Additional Protocol I to the Geneva Conventions, complements the protected status of persons *hors de combat*.⁶⁶

The protected status of the wounded and sick and therefore the risk of losing it depends on two basic components: the person's medical condition as well as the person's conduct. However, IHL provides no clear definition of what an act of hostility is⁶⁷ or a hostile act.⁶⁸ Nor does it clarify the difference between those two terms. While good faith interpretation and implementation are expected, the case-by-case determination of wounded and sick status creates uncertainty. The loss of wounded and sick protected status may also weaken the special protection provided by IHL to medical personnel, units and transports.⁶⁹ Indeed, IHL provides that this special protection will cease if, outside its humanitarian function, the personnel commit, or the unit is used to commit AHTTE.⁷⁰ IHL officially excludes four specific situations from the scope of definition of AHTTE,⁷¹ leaving space for broad case-by-case interpretation, challenging the wounded and sick and the medical duties protected status.⁷²

64 However, a military operation only designed to capture wounded and sick from the enemy may be questioned.

65 AP I, Art. 8(a).

66 Common Article 3(1), which is applicable both to State and non-State actors, lays out that in NIACs, fighters who have laid down their arms and those placed "*hors de combat*" are to be treated humanely in all circumstances without distinction. However, common Article 3 offers no definition of the term *hors de combat*. This definition is contained in Customary IHL Rule 47 and AP I, Art. 41(2) which consider a person *hors de combat* if: (1) he is in the power of an adverse Party; (2) he clearly expresses an intention to surrender; or (3) he has been rendered unconscious or is otherwise incapacitated by wounds or sickness, and therefore incapable of defending himself; provided in any of these cases he abstains from any hostile act and does not attempt to escape.

67 AP I, Art. 8(a).

68 AP I, Art. 41(2); AP II, Art. 11(2).

69 GC I, Art. 21; GC IV, Art. 19(1); AP I, Arts 13(1) and 21; AP II, Art. 11(2); Customary IHL Rules 25 and 28. See also R. Kolb and F. Nakashima, above note 58, pp. 1171–99.

70 GC I, Art. 21; AP I, Art. 13(1); Customary IHL Rules 25 and 28.

71 AP I, Art. 13(2).

72 ICRC Commentary of 2016 to Article 3 Common to the Four Geneva Conventions, para. 1840 on GC I, Art. 21; see <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=59F6CDFA490736C1C1257F7D004BA0EC>; ICRC Commentary on APs, above note 59, para. 551 on API, Art. 13.

Without calling into question the customary character of the rules of IHL concerning the protection for the wounded and sick and medical duties in times of armed conflict, it is clear that the distinction between military and civilian wounded and sick remains a structural component of conventional IHL (reflected in numerous domestic military manuals).⁷³ It creates practical interpretation and implementation challenges in NIAC where members of non-State armed groups are considered criminals or terrorists under domestic law.

The protected status of the wounded and sick from non-State armed groups is even more problematic in a NIAC for countries that have not ratified Additional Protocol II.⁷⁴ In such contexts, common Article 3, as well as Customary IHL Rule 110, requires that the sick and wounded shall be collected and cared for without distinction, but it is silent on the actors and the means of such missions.⁷⁵ Some countries have used this silence to insist and put forward a difficult interpretation that the wounded and sick from a non-State armed group be treated only in State hospitals or State military medical units and not in other civilian or humanitarian medical facilities. This pattern was noticed in the wake of civil unrest and demonstrations during the Arab Spring, notably in Bahrain, Turkey and Syria. It has been maintained and reinforced when the situation of violence reached the

73 The United States *Law of War Manual*, for instance, treats separately military medical personnel (see Art. 4.9 and 4.10) and civilian medical personnel (Art. 7.17.4) as well as military hospitals (Art. 7.10.1.1) and civilian hospitals (Art. 7.17.2.1). Conditions related to the loss of protection are specified with regard to military hospitals (Art. 7.8.3): United States Department of Defense, above note 62.

74 For instance, the countries of Syria, Iraq and the United States.

75 Customary IHL Rule 110 states that: “The obligation to protect and care for the wounded, sick and shipwrecked is an obligation of means. Each party to the conflict must use its best efforts to provide protection and care for the wounded, sick and shipwrecked, including permitting humanitarian organizations to provide for their protection and care. Practice shows that humanitarian organizations, including the ICRC, have engaged in the protection and care of the wounded, sick and shipwrecked. It is clear that in practice these organizations need permission from the party in control of a certain area to provide protection and care, but such permission must not be denied arbitrarily (see also commentary to Rule 55). In addition, the possibility of calling on the civilian population to assist in the care of the wounded, sick and shipwrecked is recognized in practice.” See also the ICRC Commentary of 2020 to common Article 3, paras. 792, 793 and 798. See <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Article.xsp?action=openDocument&documentId=E160550475C4B133C12563CD0051AA66>. Para. 792: “Although it is clear that Parties to a non-international armed conflict are responsible for searching for and collecting the wounded and sick, common Article 3 does not specify who it is that has actually to carry out these activities. The typical scenario envisaged in the article involves search, collection and evacuation activities by the Party or Parties to the conflict that have been involved in the engagement and has resulted in wounded persons [...]” Para. 793: “If the resources of a Party to the conflict are not sufficient to carry out search, collection and evacuation activities in order to meet its obligations under common Article 3, that Party may call upon civilians or humanitarian organizations to assist in these efforts [...]” (footnote citation omitted). Para. 798: “The obligation to care for the wounded and sick requires that the Parties to the conflict take active steps to ameliorate their medical condition. Like the other obligations in common Article 3, this obligation applies equally to State and non-State Parties. Some non-State armed groups have the capacity to provide sophisticated medical care, while others have more rudimentary capacities. In any case, non-State armed groups must endeavour to develop their capacities to provide treatment to the best of their abilities and should be permitted to do so. Like State Parties, they should ensure that their forces are trained in first aid. Likewise, they may have recourse, if necessary, to medical aid provided by impartial humanitarian organizations [...]”

threshold of a NIAC.⁷⁶ It is also significant that in the context of the global war against terrorism launched by the United States in 2001, even the application of common Article 3 to non-State armed groups involved in the territories where the United States was militarily engaged has been contested.⁷⁷

The elephant in the (medical emergency) room: the “criminal” wounded and sick from non-State armed groups

As previously presented, the coherence of the international protection of the wounded and sick is historically and legally based on their combatant *versus* civilian status stirring the neutrality challenge of medical duties. Historically, the legal protection for the wounded and sick combatants of State armed forces has been obtained on the battlefield, based on a clear international definition of such combatant, and of their neutralized military status when out of combat due to wounds and sickness.⁷⁸ There is no such clarity regarding the wounded and sick members of non-State armed groups. Under IHL they are excluded from the treaty definition of a combatant. They may only be considered as civilians taking a DPH.⁷⁹ Undeniably, the concept of DPH is highly debated among States and even between States and the International Committee of the Red Cross (ICRC).⁸⁰

The affirmation of the special protected status of wounded and sick from non-State armed groups is tainted by certain ambiguities that work against them when it comes to making case-by-case determination and articulating their medical status with the conditions required for *hors de combat* (implying that they are abstaining from hostile acts) in concrete and real-time field cases. The *hors de combat* notion was designed for the special protection of wounded and sick combatants, and it must be distinguished from the later ones applicable to civilians taking a DPH and their potential continuous combat function⁸¹ and from the concept of AHTTE, which is used for the special protection of the medical mission (personnel, facilities and transports).⁸²

The principle of distinction between civilian and combatant remains the fundamental basis of IHL that cannot survive any third categorization of “unlawful” fighter or “criminal” civilian.

76 See the cases of Iraq, Nigeria, Pakistan, Syria, Turkey, Bahrain and Egypt where State regulation forbids that wounded and sick be treated by civilian or humanitarian doctors or any related medical facility. See the cases presented in Marine Buissonnières, Sarah Woznick and Leonard Rubinstein, *The Criminalization of Health Care*, Safeguarding Health in Conflict, Johns Hopkins University and University of Essex, June 2018, p. 31, available at: <https://www1.essex.ac.uk/hrc/documents/54198-criminalization-of-healthcare-web.pdf>.

77 United States Supreme Court, *Salim Ahmed Hamdan v. Donald H. Rumsfeld et al.*, 548 U.S. 557 (2006), No. 05.184, *Decision on a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit*, 29 June 2006, pp. 67–8.

78 Common Article 3; AP I, Art. 41(1); Customary IHL Rule 47.

79 AP I, Arts 45(1)(3) and 51(3); and AP II, Art. 13(3).

80 See N. Melzer, above note 41, pp. 43–5.

81 N. Melzer, above note 41, pp. 34 and 35.

82 R. Kolb and F. Nakashima, above note 58, pp. 1171–99.

The explicit reference to the *hors de combat* status appears in common Article 3 in the context of a NIAC. This reference grants a protected status to wounded and sick who are affiliated to non-State armed group(s) party to the armed conflict.

It is agreed that civilians lose their protection as civilians for the duration of their DPH.⁸³ This category may efficiently cover occasional civilian participation in hostilities, but it has been expanded by doctrine and jurisprudence of some States⁸⁴ to include a continuous combat function⁸⁵ by members of non-State armed groups.⁸⁶

With regard to the continuous combat function, the interpretive guidance from the ICRC requires the element of a “lasting integration into an organized armed group” which is acting as the armed forces of a non-State party to an armed conflict and it also “involves the preparation, execution, or command of acts or operations amounting to direct participation in hostilities”.⁸⁷ The function assumed must be continuous rather than a spontaneous, sporadic or temporary role assumed for the duration of a particular operation.⁸⁸ However, under IHL and the ICRC interpretive guidance, the protected status of wounded and sick remains an individual one, triggered by the need of medical care at a given moment and the abstention of hostile act at this same time without consideration of previous continuous combat function.

The commentaries to Additional Protocols I and II demonstrate that States did not consider it necessary to define the concept of “hostile acts”.⁸⁹ This allows

83 N. Melzer, above note 41.

84 Supreme Court of Israel, *Iyad v. State of Israel*, CrimA 6659/06, 11 June 2008.

85 The concept of permanent participation in hostilities is not defined by IHL.

86 N. Melzer, above note 41, pp. 33–5 and 72; see ICRC, *Practice Relating to Rule 106. Conditions for Prisoner-of-War Status*, IHL Database, Customary IHL, available at: https://ihl-databases.icrc.org/customary-ihl/eng/docs/v2_rul_rule106.

87 N. Melzer, above note 41, p. 34.

88 *Ibid.*, pp. 34 and 72.

89 See ICRC Commentary on APs, above note 59, paras. 549–53, 555 and 557 on AP I, Art. 13; AP I, Art. 13 (1); ICRC Commentary on APs, above note 59, paras. 4636–9 and 4642 on AP II, Art. 7; AP II, Art. 11(1). Para. 4636: “What is meant by the phrase ‘wounded, sick and shipwrecked’? Protection of the wounded, sick and shipwrecked responds to a fundamental humanitarian requirement and was not cast into doubt in the context of drawing up rules to govern non-international armed conflicts; this is why it is possible to use the same definition of the wounded, sick and shipwrecked as the point of departure in the two Protocols. In the light of the negotiations it can be noted that the basic terminology is uniform.” Para. 4637: “In the absence of a provision of definitions, which was finally not adopted for Protocol II, we refer to Article 8 (*Terminology*), sub-paragraph (a), of Protocol I, which defines the wounded and sick as follows: [p.1409] “Wounded” and “sick” mean persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility. These terms also cover maternity cases, new-born babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility.” Para. 4638: “The definition of the wounded and sick protected by this Part is based on two criteria: 1) requiring medical care; 2) refraining from any act of hostility.” Para. 4639: “Any person, military or civilian, fulfilling these two conditions is included amongst the wounded or sick; maternity cases, new-born babies, the infirm and expectant mothers are examples thereof, but this is not an exhaustive list. Thus this definition differs from the usual meaning of the terms ‘wounded’ and ‘sick’. In fact, a wounded or sick person who continued to fight would not be considered as such under the terms of the Protocol, and would consequently not be entitled to protection under this article.” (footnote citation omitted). Para. 4642: “In a situation of non-international armed conflict people cannot acquire a different status to the same extent as in an international conflict, since there are not, strictly speaking, different categories of

arguing on a case-by-case basis the potential loss of protection of a given person. However, discussions around so-called continuous combat functions can trigger the loss of the special protected status for wounded and sick affiliated to non-State armed groups. Some States' doctrines have also started to challenge the *hors de combat* and non-hostile status of alleged terrorists or of "unlawful" criminal fighters when they are wounded and sick. Indeed, these States developed a broad interpretation of the continuous combat function in connection with the concept of AHTTE.⁹⁰ Rather than demonstrating the occurrence of effective hostile acts as required by IHL, they rely on hostile intent⁹¹ or on a presumed permanent hostile function or nature of such wounded and sick. These States claim a case-by-case determination of the wounded and sick remaining capacities interfering with the autonomy of medical duties. Thus, the mere ability to think ("plan") or to communicate ("command") may preclude the protective status to be afforded to those wounded and sick. Such loss of special protection is not only detrimental for the wounded and sick, it also leads to military interference with the work of medical services and suspends the military duty to protect and respect the medical mission.⁹² For "wounded and sick" fighters of a non-State armed group a "lasting disengagement from combat functions" cannot be the legal criterion imposed, as being a wounded and sick fighter does not mean that the individual needs to become a civilian in order to benefit from IHL protections. However, it can and often will be a temporary/transitory status which is triggered by *de facto* refraining from any act of hostility, for as long as the individual will be specifically protected as a wounded and sick person.

The good faith case-by-case determination of wounded and sick which provides them a protected status is a fundamental element of a correct interpretation of IHL where medical personnel should not be excluded. This is even more important because the standard regarding the nature of hostile acts and evidence required are not clear in practice, notably toward wounded and sick having a so-called continuous combat function or having remaining physical capacity to carry out hostile acts—even though they are not in fact performing hostile acts. When such determination is based on a State's military and security

protected persons: 'all persons who do not take a direct part or who have ceased to take part in hostilities' are protected. Nevertheless, after the end of the rescue operation the shipwrecked are no longer considered as such, and, depending on the circumstances, will be protected under one or other of the rules of the Protocol. As the case may be, they will be wounded or sick within the meaning of this article, if their state of health requires care; they will fall in the category of those detained or interned, if they have been captured by the adverse party, or they may simply be civilians. Protection is due to all the wounded, sick and shipwrecked, 'whether or not they have taken part in the armed conflict'. No distinction is made between members of the armed forces and civilians or according to whether they belong to the one party or the other concerned; the obligation to respect and protect is general and absolute.'" (footnote citations omitted).

90 Art. 5.8.3.3 of the *Law of War Manual* states "demonstrated hostile intent may also constitute taking direct part in hostilities": United States Department of Defense, above note 62.

91 *Ibid.*, Art. 7.10.3.6.

92 ICRC Commentary of 2016 to GC I on Article 3 Common to the Four Geneva Conventions, para. 1854 on GC I, Art. 21; and para. 2008 on GC I, Art. 24. See <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=59F6CDFA490736C1C1257F7D004BA0EC>.

intelligence, which is classified information, it is almost impossible for humanitarian and medical personnel to foresee at the time of the incident and to challenge it afterwards. It creates a loss of objective predictability regarding the protected status for wounded and sick as well as to medical and humanitarian personnel and facilities involved in their medical care. This unsafe legal environment is conducive at least to mistakes, if not, to intentional abuse of IHL.⁹³

Furthermore, the good faith interpretation of the various IHL concepts allowing the granting or the loss of the protected status to wounded and sick may easily be defeated and somehow substituted by the straight and self-executing domestic criminal framework. Indeed, the national criminal status of non-State armed group fighters threatens a fair determination of their international special protection when wounded and sick as well as their potential loss of protection with regard to committing hostile acts while being wounded and sick.⁹⁴

Under IHL, an injury or illness halts the targetability of a person out of combat, providing that this person abstains from committing any hostile act. This last condition is a standard one regulating the loss of the special protection of medical duties provided by IHL. Therefore, there is no justification to take away the protection from a wounded member of a non-State armed group on the basis of his alleged terrorist or criminal activities committed in the course of an armed conflict. However, under domestic criminal law, members of non-State armed groups fall under multiple criminal offences such as crimes against national security and safety as well as terrorism acts. These crimes are, by definition, hostile acts against the State. Wounds and sickness do not alter or stop their criminal status. However, the hostile component of their criminal status may be confused with the criteria leading to the loss of IHL special protection.

As previously mentioned, wounded and sick enemy fighters are not immune from arrest for their criminal acts. However, while they are wounded and sick, their capture, arrest, transfer, and detention by judicial authorities or security forces should be done in conformity with the continuity of their care and in respect of the protected status of medical personnel, facilities and transport. In numerous instances, civilian medical and humanitarian personnel have experienced special military operations to capture, arrest or kill, inside medical facilities or transports, wounded or sick enemy fighters labelled as terrorist. The military tactic was presented by the authorities as a “militarized” law enforcement operation against a patient and not as an attack on the medical facility itself.⁹⁵

93 F. Bouchet-Saulnier and J. Whittall, above note 21.

94 Conventional and customary IHL rules provide for loss of protection for the sick and wounded if they perform hostile acts. See common Article 3(1) and the ICRC 2016 Commentary to the GC I on Article 3 Common to the Four Geneva Conventions of the GC I at para. 737 and Article 12 at para. 1341. See <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=59F6CDFA490736C1C1257F7D004BA0EC>. See also AP I, Art. 8(a); ICRC Commentary on APs, above note 59, para. 306 on AP I, Art. 8; and Customary IHL Rule 109.

95 See, for instance, Reuters, “Undercover Israeli Troops Raid Hospital, Kill Palestinian”, 12 November 2015, available at: <https://www.reuters.com/article/us-israel-palestinians-violence-idUSKCN0T10JX20151112>; for the video of the operation, see Euronews, “Palestinian Killed as Israeli Forces Mount Undercover Raid Hebron Hospital”, 12 November 2015, available at: <https://www.youtube.com/watch?v=>

Such practices and argument illustrate the thin line existing in practice between the use of armed force under IHL or under law enforcement. This narrow division is made even more porous by CT special criminal law that departs from usual judicial guarantees and involves armed forces in militarized law enforcement operations.⁹⁶ State lawfulness arguments cannot silence the practical reality: the use of armed force inside medical facilities and against wounded and sick individuals labelled as terrorists is close to an abolition of the IHL protections. In such a context, the IHL special protection for medical duties associated with wounded and sick is put at odds and corrupted by the far-reaching impact of a patient's criminal status under criminal and CT legislation.

From protected medical duties to support of terrorism

The absence of an international definition of terrorism does not preclude each country from including these offences in the definition of crimes over which their courts have jurisdiction. It is therefore a matter of sovereignty for each country to determine which individuals and groups fall into this category.

Starting from 2001, terrorism has been qualified as a threat to international peace and security by many UNSC resolutions passed under chapter VII of the United Nations Charter. They requested all countries to contribute to the international fight against terrorism and to adopt domestic criminal law for the effective prosecution of terrorism activities.⁹⁷ These UNSC resolutions are also considered suitable for many countries as they represent an opportunity to provide a consensual security instrument that they might use against domestic political and armed opposition groups.⁹⁸ As CT is attached to national security,

Lj4PYh1zrvU. See also the Afghan special forces raiding an hospital in Afghanistan in 2016: Mujib Mashal, "Hospital Raid by Afghan Forces is Said to Kill at Least 3", *New York Times*, 18 February 2016, available at: <https://www.nytimes.com/2016/02/19/world/asia/hospital-raid-afghan-forces-nato-wardak-province.html>.

- 96 Dominique Linhardt and Cédric Moreau de Bellaing, "La doctrine du droit pénal de l'ennemi et l'idée de l'antiterrorisme. Genèse et circulation d'une entreprise de dogmatique juridique", *Droit et Société*, Vol. 97, No. 3, 2017, available at: <https://www.cairn.info/revue-droit-et-societe-2017-3-page-615.htm>; Geneviève Giudicelli-Delage, "Droit pénal de la dangerosité – Droit pénal de l'ennemi", *Revue de science criminelle et de droit pénal comparé*, Vol. 1, No. 1, 2010; Jean-François Dreuille, "Le droit pénal de l'ennemi: Éléments pour une discussion", in *Jurisprudence: Revue critique*, Université de Savoie, 2012, available at: <https://hal.archives-ouvertes.fr/hal-01479079/document>.
- 97 UNSC Res. 1373, 28 September 2001; UNSC Res. 1456, 20 January 2003; UNSC Res. 1535, 26 March 2004; UNSC Res. 1566, 8 October 2004; UNSC Res. 1624, 14 September 2005; UNSC Res. 1787, 10 December 2007; UNSC Res. 1805, 20 March 2008; UNSC Res. 1963, 20 December 2010; UNSC Res. 2129, 17 December 2013; UNSC Res. 2133, 27 January 2014; UNSC Res. 2170, 15 August 2014; UNSC Res. 2178, 24 September 2014; UNSC Res. 2199, 12 February 2015; UNSC Res. 2220, 22 May 2015; UNSC Res. 2242, 13 October 2015; UNSC Res. 2249, 20 November 2015; UNSC Res. 2253, 17 December 2015; UNSC Res. 2255, 21 December 2015; UNSC Res. 2309, 22 September 2016; UNSC Res. 2322, 12 December 2016; UNSC Res. 2341, 13 February 2017; UNSC Res. 2354, 24 May 2017; UNSC Res. 2368, 20 July 2017; UNSC Res. 2370, 2 August 2017; UNSC Res. 2395, 21 December 2017; UNSC Res. 2396, 12 December 2017; UNSC Res. 2427, 9 July 2018.
- 98 For example, in the first six months of 2021, the countries of Chad, CAR, Indonesia and Myanmar have applied the "terrorist" label to opposition groups outside the international designation process. For information, see above note 4.

international law allows restrictions to some human rights. The imperative to deter such acts and facilitate their prosecution have created at national and international level a special CT criminal framework that derogates from the usual criminal system.⁹⁹

The first specificity of CT criminal law is the broad range and many definitions of the various terrorism offences in most national criminal codes.¹⁰⁰ Historically, the international focus has been put on limiting the financing of terrorism. However, in domestic criminal law, this is more widely defined to include all forms of direct or indirect material support and assistance. Aiding and abetting terrorists as well as associating with terrorists are usual CT offences that may include almost all kind of factual interaction, contact and communication. Other offences have been added more recently to complement the legal arsenal against terrorism such as entering a territory under terrorists' control. The second specificity is that the proof of criminal intent is widely replaced by the plain knowledge of the criminal nature of certain individuals or groups involved.¹⁰¹ Such wide criminal definitions lead to wide criminal accusations impacting the legitimacy of humanitarian actors and activities during long periods of time. This specificity brings medical and humanitarian activities from impartial humanitarian organizations *de jure* into the criminal arena. This issue has raised criticism that such legislative techniques may conflict with the right to a fair trial, in particular the respect for the presumption of innocence which is a non-derogable human right.¹⁰² Due to these derogations from the usual due

99 See also Fionnuala D. Ní Aoláin, UN Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism, "Human Rights and Counterterrorism: a Sisyphian Tale", 16 June 2021, available at: https://theglobalobservatory.org/2021/06/human-rights-and-counterterrorism-a-sisyphian-tale/?utm_source=mailchimp&utm_medium=organic_email&utm_campaign=US_GO_publications_analysis&utm_content=link.

100 *Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism*, United States Patriot Act of 2001, Public Law 107–56, 26 October 2001, available at: <https://www.govinfo.gov/content/pkg/PLAW-107publ56/pdf/PLAW-107publ56.pdf>. Until 2018, the provision contained in the Afghan CT law had the potential to encompass medical care within the ambit of punishable offences. See *Law on Combat against Terrorist Offences*, 2008, available at: http://www.vertic.org/media/National%20Legislation/Afghanistan/AF_Law_on_Combat_against_Terrorist_Offences.pdf.

101 See Criminal Code (Canada), Arts 83.03(b) and 83.19; Penal Code (Niger), Arts 200, 206, 399.1.18, 399.1.19 *nouveau (bis)* and *(ter)* and 399.1.23(c); 18 U.S. Code (United States), Arts 2339A and 2339B; see also the CT Law of Mali No. 2008-025, Art. 6, as well as the Malian Penal code, Art. 24 (broad criminal complicity). See also Chad Penal Code, Art. 118 (a broadening complicity to all those who provide without being forced to, and knowing their criminal intention, means of existence, shelter, refuge or meeting place to individuals threatening State safety and integrity), as well as Art. 109 (criminalizing all kind of material support and communication with armed and other rebel criminal groups). In 2020, Chad included a humanitarian exemption in its new CT legislation clarifying that humanitarian assistance is outside of the scope of such criminal offences. See Law No. 003/PR/2020, Arts 1(3) and (4) on the suppression of terrorist acts in the Republic of Chad of 28 April 2020 (Chad CT Law); see UNGA, above note 16, para. 33; D. A. Lewis, N. K. Modirzadeh and G. Blum, above note 16, pp. 63 and 100.

102 UNGA Report on Promotion and Protection of Human Rights and Fundamental Freedoms while Countering Terrorism, UN Doc. A/71/384, 13 September 2016, para. 50, available at: <https://undocs.org/pdf?symbol=en/A/71/384>.

process, CT has been described as a new form of criminal law called the “criminal law of the enemy”.¹⁰³

The negative impact of CT on impartial humanitarian actors raises major legal and humanitarian concerns.¹⁰⁴ Indeed, medical and humanitarian personnel face certain recurring accusations in armed conflicts involving non-State armed groups. A non-exhaustive list of the most common accusations includes facilitating communication, facilitating the transport or escape of criminals, concealing criminal information, hiding, and providing support to criminals by various ways including by providing food, drugs, shelter and medical care. The payment of salaries to medical and humanitarian personnel in territories controlled by armed opposition groups adds to the list of potential material support or financing of terrorism.

This impact has recently been acknowledged by the UNSC resolution 2462 passed under chapter VII of the United Nations Charter which urges States, when designing and applying measures to counter the financing of terrorism, to “*take into account the potential effect of those measures on exclusively humanitarian activities, including medical activities, that are carried out by impartial humanitarian actors in a manner consistent with international humanitarian law*”.¹⁰⁵ However, little has been done at State level to ensure compatibility of CT with IHL rules, notably by enacting proper humanitarian exemptions.¹⁰⁶ This was done under the pressure of the UNSC resolutions, which required all countries to actively contribute to the international fight against terrorism. Furthermore, these offences are defined in many countries without the requirement of a specific intent.

103 See above note 97.

104 ICRC, “The Conflation of IHL and the Legal Framework Governing Terrorism”, in *International Humanitarian Law and the Challenges of Contemporary Armed Conflicts*, 31st International Conference of the Red Cross and Red Crescent, Geneva, Switzerland, 28 November to 1 December 2011, pp. 48–53; United Nations Office for the Coordination of Humanitarian Affairs and Norwegian Refugee Council, *Study of the Impact of Donor Counterterrorism Measures on Principled Humanitarian Action*, July 2013, pp. 71–111. In 2016, MSF raised the issue at the CT committee of the UNSC asking them to issue State guidance regarding humanitarian exemption to ensure that IHL provisions are not undermined by CT measures. For the text of the intervention, see Françoise Bouchet-Saulnier, “IHL & Counter-Terrorism: Tensions and Challenges for Medical Humanitarian Organizations”, MSF Statement to the UN Security Council Counter-Terrorism Committee, 2 June 2016, available at: <https://msf-analysis.org/ihl-counter-terrorism-tensions-challenges-medical-humanitarian-organizations>; *Terrorism, Counter-Terrorism and International Humanitarian Law*, Proceedings of the Bruges Colloquium, 17th Bruges Colloquium, 20–21 October 2016, pp. 25 and 135–51; D. A. Lewis, N. K. Modirzadeh and G. Blum, above note 16; Inter-Agency Standing Committee, Concept Note – IASC Counterterrorism Database: *Principled Humanitarian Action and Counter-Terror Measures: Documenting Impact Collectively Across the Humanitarian Community*; see also InterAction, *Detrimental Impacts: How Counter-Terror Measures Impede Humanitarian Action: A Review of Available Evidence*, April 2021, available at: <https://www.interaction.org/wp-content/uploads/2021/04/Detrimental-Impacts-CT-Measures-Humanitarian-Action-InterAction-April-2021.pdf>, and see at p. 2, the “Impact Catalogue” put together by InterAction.

105 UNSC Res. 2462, 28 March 2019, para. 24 (emphasis added). See also UNSC Res. 2482, 19 July 2019, para. 16.

106 UNSC, above note 30, paras. 83 and 84: “*Only a few States have developed a specific response to the potential impact of the counter-financing of terrorism on exclusively humanitarian activities [...]. At least three responding States have introduced humanitarian exemptions into their counter-financing of terrorism legislation [...]. However, most participating States (58 per cent) did not answer this question.*” (emphasis added).

As already mentioned, in numerous criminal codes, what is required to incur criminal responsibility in relation to a terrorist offence is a proof of a material and moral element. As for the material element, it consists of all kinds of direct or indirect material assistance, contact or association. Regarding the moral element, what is required is either the intention to commit the crime or the mere knowledge of the terrorist nature of an individual or group, and of their actions. Humanitarian and medical actors engaged in situations of armed conflict according to IHL can hardly be accused of criminal intention but their knowledge of the terrorist context, and the medical and humanitarian assistance they provide to all wounded and sick and population living in areas under the control of non-State armed groups are sufficient to incur criminal responsibility for contact and direct or indirect assistance.¹⁰⁷ The vagueness and wideness of these criteria lay grounds for criminal accusations against humanitarian and medical personnel. An exhaustive review is not available, but cases have been documented in Iraq, Nigeria, Pakistan, Syria, Colombia, Turkey, the United States and also Australia and the United Kingdom.¹⁰⁸ The negative impact of CT legislation from Western donor countries on humanitarian assistance abroad has also been established.¹⁰⁹

In Syria, the CT laws issued in July 2012 refer to a wide definition of terrorism and allow any State officials to arrest and prosecute a person for any act considered as a disturbance to public security committed by any means.¹¹⁰ According to the Independent International Commission of Enquiry on the Syrian Arab Republic, these laws have effectively made it a crime to provide medical care to anyone suspected of supporting the rebels.¹¹¹

The Iraqi law on combatting terrorism (13/2005) allows judges to bring charges against a wide range of suspects, including in practice against doctors who continued working in hospitals in Islamic State in Iraq and Syria (ISIS)-held territories.¹¹² In Nigeria, cases of doctors arrested for providing medical care to Boko Haram wounded and sick members have also been documented. Their arrest was possible due to the broad definitions of terrorism offences in Nigerian law. The ensuing release of these doctors was possible based on the fact that they did not know that the wounded they were treating were militants.¹¹³ The trend was also made clear in Pakistan where doctors have been arrested as the result of providing medical care to suspected terrorists without informing authorities.

107 See above note 102.

108 M. Buissonnières, S. Woznick and L. Rubinstein, above note 76, p. 31.

109 United Nations Office for the Coordination of Humanitarian Affairs and Norwegian Refugee Council, above note 104.

110 See the Syrian Laws No. 19, 20, 21 and 22 of 2012. See also, Violations Documentation Center in Syria, (VDC), *Special Report on Counter-Terrorism Law No. 19 and the Counter-Terrorism Court in Syria*, April 2015, available at: <http://www.vdc-sy.info/pdf/reports/1430186775-English.pdf>.

111 UNGA Report of the Independent International Committee of Inquiry on the Syria Arab Republic, UN Doc. A/HCR/25/65, 12 February 2014, para. 111 and Annex VII (Assaults on Medical Care), para. 21.

112 Human Rights Watch, *Flawed Justice: Accountability for ISIS Crimes in Iraq*, 5 December 2017, available at: <https://www.hrw.org/report/2017/12/05/flawed-justice/accountability-isis-crimes-iraq>.

113 See Ishaq Tanoli, "Three Doctors Held for Treating 'Militant' Released", *DAWN*, 18 November 2015, available at: <https://www.dawn.com/news/1220375/three-doctors-held-for-treating-militants-released>.

However, as previously mentioned, in many domestic criminal laws or practices, it is accepted that the simple proof of knowledge of the criminal nature of a group or an individual can be inferred from the material circumstances. Therefore, situations where medical personnel provide impartial medical care to a gunshot- or other violence-related wounded person may arguably trigger criminal charges but also heavy risks of harassment, administrative sanctions, disappearances, illegal detention and extrajudicial killings.¹¹⁴

The removal of subjective elements of criminal intent leaves little legal protection to humanitarian and medical personnel as they must have contact with such individuals and groups in order to provide humanitarian assistance to populations in disputed areas or areas under their control. With regard to medical assistance to any wounded and sick, humanitarian and medical personnel dealing with a gunshot-wounded patient are legally considered as presenting flagrant evidence of criminal activities incurring accusation of complicity and facilitation of terrorism activities if the patient is not immediately reported to the authorities.

Medical and humanitarian personnel from Médecins sans Frontières (MSF; Doctors without Borders) – exclusively engaged in medical and relief activities to populations in territories under the control of non-State armed groups – have faced official accusations and investigations in northern Nigeria, northern Syria but also in Cameroon, Turkey and in the Democratic Republic of the Congo. Accusations range from communication and facilitation of communication with terrorists, material and financial support to terrorism, association with terrorists, complicity, facilitation of transport and sheltering of terrorist individuals when wounded and sick.¹¹⁵

At field level there is a frequent overlapping between the characterization of domestic terrorism offences and that of the participation in a NIAC. Nevertheless, it remains that the simultaneous application of the two distinct *lex specialis* of IHL and criminal law leads to a deadlock for medical assistance and relief activities.

Medical activities and personnel as well as facilities and transports are caught in the domestic legal network of wide criminal offences such as association, complicity and support to terrorists and other criminals.¹¹⁶ These criminal suspicions against them have an impact on the entire medical relief chain, even though it is protected by IHL.

A humanitarian and medical actor such as MSF is witnessing an increase in accusations by the authorities, as well as military and security investigations, into its activities. Even if these investigations rarely result in trials and convictions, they may last for many years without any official decision on the closure of the case being made. During that time, they weaken or halt relief efforts by creating a dangerous

114 Such cases have been documented in Afghanistan, Bahrein, Egypt, Ethiopia, India, Iraq, Nigeria, Pakistan, Syria, Turkey and the United States. See M. Buissonnières, S. Woznick and L. Rubinstein, above note 76, p. 31.

115 These are situations that have directly affected MSF staff and activities over more than ten years, from 2010 to 2021.

116 There is a variety of criminal qualifications applicable to members of non-State armed groups such as rebels, insurgents, terrorists and it incurs criminal offences against State security and terrorism.

medium to long-term suspected status for impartial humanitarian personnel and activities stigmatizing individuals for, at times, many years.

From medical care to wounded and sick to accusations of material support to terrorists

Even if under IHL medical care to all wounded and sick without discrimination is a legal imperative, in practice, this obligation is challenged when the wounded and sick fall within the category of alleged criminals and terrorists, as this section will show.

The offence of material support to terrorism is so widely defined in its redaction that the provision of medical care as well as the provision of medical supplies become constitutive of such support to terrorism in most domestic legislation. A survey conducted on the question of criminalization of medical assistance suggested that authorities interpret support to terrorism to include the provision of health care in ten out of the sixteen countries surveyed.¹¹⁷ This tendency was made explicit in a court ruling on the grounds of “provision or attempt to provide material support to terrorists in the form of medical support to wounded jihadists”.¹¹⁸ Humanitarian organizations have since raised this concern in various fora to obtain humanitarian exemptions in international resolutions and domestic terrorism legislation.¹¹⁹

It is interesting to note that the United States court ruling mentioned above found that medical care given on an individual basis should be criminalized as material support to wounded Al-Qaeda terrorists. The judge found that the same medical care would not be criminalized if provided by an impartial humanitarian organization such as MSF since it was clear that such an organization was not

117 M. Buissonnières, S. Woznick and L. Rubinstein, above note 76, p. 31.

118 See 18 U.S. Code (United States), para. 2339B; *United States v. Shah*, above note 17, p. 499; and United States Court of Appeals, Second Circuit, *United States v. Farhane*, 634 F. 2d 127 (2d Cir. 2011), 4 February 2011, p. 134; D. A. Lewis, N. K. Modirzadeh and G. Blum, above note 16, p. 124.

119 The ICRC has identified this as an issue as early as 2011. See the ICRC Report, “International Humanitarian Law and the Challenges of Contemporary Armed Conflicts”, Official Working Document of the 31st International Conference of the Red Cross and Red Crescent, Geneva, 28 November to 1 December 2011, 31IC/11/5.1.2, 31 October 2011, p. 52, available at: <https://www.icrc.org/en/doc/assets/files/red-cross-crescent-movement/31st-international-conference/31-int-conference-ihl-challenges-report-11-5-1-2-en.pdf>; F. Bouchet-Saulnier, above note 104; Norwegian Refugee Council, “Principles Under Pressure: The Impact of Counterterrorism Measures and Preventing/Countering Violent Extremism on Principled Humanitarian Action”, 12 June 2018, pp. 11, 15, 29 and 34, available at: <https://www.nrc.no/resources/reports/principles-under-pressure>; Fionnuala Ní Aoláin, “Promotion and Protection of Human Rights and Fundamental Freedoms while Countering Terrorism”, Report of the Special Rapporteur to the Seventy-Fifth Session of the UNGA, 3 September 2020, UN Doc. A/75/337, paras. 34, 35, 45(b) and 48; Françoise Bouchet-Saulnier and Mego Terzian, “Comment les États peuvent contribuer à la protection de l’action humanitaire”, 8 September 2020, *Le Monde*, available at: https://www.lemonde.fr/idees/article/2020/09/08/comment-les-etats-peuvent-contribuer-a-la-protection-de-l-action-humanitaire_6051356_3232.html; Françoise Bouchet-Saulnier, “Where Counterterrorism Measures Impede Humanitarian Action, Domestic Law Is Key”, *IPI Global Observatory*, 17 June 2021, available at: <https://theglobalobservatory.org/2021/06/where-counterterrorism-measures-impede-humanitarian-action-domestic-law-is-key>.

acting under the control or direction of a designated foreign terrorist organization with the knowledge that the organization was engaged in terrorism activities.¹²⁰ The thin line drawn by the judge does not solve and rather exacerbates the issue of medical care by agreeing that provision of medical care to the wounded is not a mandatory duty but can amount to criminal material support. Furthermore, consolidated case law is not available in most war-affected countries where humanitarian and medical personnel remain under constant threats of accusations pursuant to national criminal law as interpreted by security and military forces before a potential court ruling.

In these contexts, the mere fact that some people have gunshot wounds is considered as an objective proof of their criminal activities. Therefore, their medical treatment by medical and humanitarian personnel is often construed by authorities as a direct support to criminal militants or terrorists.¹²¹ If it is agreed that wounded and sick enemies shall be treated, the question of where and by whom is not solved.¹²²

Under IHL, medical care to any wounded and sick, including member of non-State armed groups labelled as terrorist, is mandatory for all parties to the conflict and is part of the medical duties of impartial humanitarian and medical personnel.

Syrian authorities decided to impose that the wounded and sick from opposition groups should only be treated in governmental military hospitals. They thus criminalized any other form of medical care to wounded and sick from the armed opposition groups labelled as terrorist by the government.¹²³ They considered, along with other war-affected countries, that medical care and supplies in areas outside of government control were material support to terrorists.¹²⁴

120 *United States v. Shah*, above note 17, p. 499.

121 In Nigeria the magnitude of this problem among medical personnel has led to a necessary review of the law in 2017 supported by the ICRC. The new “gunshot law” has clarified that medical care is not *per se* a support to criminals. It clearly acknowledges that doctors are obliged to provide medical treatment to gunshot wounded. To secure that medical treatment is provided without discrimination, the law allows delaying notification to the police for up to two hours without incurring criminal charges. See the Nigerian Law: *Compulsory Treatment and Care for Victims of Gunshots Act, 2017*, available at: <https://laws.lawnigeria.com/2018/04/20/lfn-compulsory-treatment-and-care-for-victims-of-gunshots-act-2017/>.

122 The ICRC Commentary of 2016 to GC I on to Article 3 Common to the Four Geneva Conventions acknowledges at para. 768 the responsibility of parties to the conflict to treat wounded and sick. The role of impartial humanitarian organizations is only subsidiary. See <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=59F6CDFA490736C1C1257F7D004BA0EC>.

123 An official instruction from the Homs Directorate of Health from 12 April 2011 ordered the transfer of all wounded patients in relation to the events to the military hospital (copy with the author). See Amnesty International, “Health Crisis: Syrian Government Targets the Wounded and Health Workers”, 25 October 2011, available at: <https://www.amnesty.org/en/documents/MDE24/059/2011/en/>.

124 In 2021, in the North-West Region of Cameroon, MSF has had its activities suspended for over six months and has been denied the resumption of its medical and humanitarian activities following accusations that it was supporting “terrorists”. See, for example, MSF, “Cameroon: People in Northwest Seek Healthcare as MSF Denied Providing Medical Services”, Press Release, 22 June 2021, available at: <https://www.msf.org/msf-denied-providing-badly-needed-healthcare-northwest-cameroon/>; La VOA, “L’aide humanitaire prise

Without going to such extremes, delineating the material support from the legitimate medical duties requires renewed IHL dialogue with all stakeholders of the State and non-State Parties to the armed conflict. Since criminal and CT specialists are not the same person as those who master the technicalities of IHL, there is a need to turn back to the very essence of the IHL message, which is: The wounded enemy is no longer a threat. The Doctor of my enemy is not my enemy.¹²⁵ This giant step of IHL remains a permanent challenge for those confronted with domestic criminal law while providing impartial humanitarian and medical assistance in situations of armed conflict.¹²⁶ The criminal status of fighters of non-State armed groups under domestic law has a spill-over effect that contaminates the protected status of medical activities carried out by impartial humanitarian and medical personnel for such wounded and sick.¹²⁷ Official accusations against humanitarian and medical impartial organizations for providing medical care to members of non-State armed groups labelled as criminal can force the closure of medical activities or initiate criminal proceedings. Accusations brought by governmental authorities may explicitly refer to the provision of medical care to fighters.¹²⁸ This creates a mindset where tacit deprivation of access to impartial medical care to the wounded belonging to non-State armed groups would appear as acceptable. This is in itself a slippery slope that may end up with recent trends of attacks on medical facilities providing medical care to non-State wounded enemies that have occurred in Syria, Yemen and Afghanistan over the last years.¹²⁹

From protected medical facilities to shelter of criminals: A legitimate military target

The fact that some of the wounded and sick are considered potential criminals puts pressure on the protective status of the medical facilities that treat them in accordance with IHL. Providing medical care to gunshot-wounded patients always goes with several legal and practical discussions at field level (see above). What is new is that terrorist crimes are defined so broadly in the criminal law of

entre deux feux au Cameroun anglophone”, 27 February 2020, available at: <https://www.voafrique.com/a/cameroun-l-aide-humanitaire-prise-entre-deux-feux-au-cameroun-anglophone/5306621.html>.

125 MSF, above note 23.

126 Jonathan Whittall, “Treating Terrorists”, MSF Analysis: Reflections on Humanitarian Action, 2015, available at: <https://msf-analysis.org/new-treating-terrorists>.

127 See the UNGA Report of the Special Rapporteur of the Human Rights Council on Extrajudicial, Summary or Arbitrary Executions – Saving Lives is not a Crime, UN Doc. A/73/314, 7 August 2018, paras. 10–11, 33 and 37; D. A. Lewis, N. K. Modirzadeh and G. Blum, above note 16, pp. i–iii and 9–11 (see specifically footnotes 16 and 22 for examples); Alice S. Debarre, “Countering Terrorism and Violent Extremism: The Risks for Humanitarian Action”, in Alain Tschudin, Craig Moffat, Stephen Buchanan-Clarke, Susan Russell and Lloyd Coultts (eds), *Extremisms in Africa*, Vol. 2, Tracey McDonald Publishers, Bryanston, SA, 2019, pp. 208–9; see also the conviction entered in *United States v. Shah*, above note 17.

128 Emile Zola Ndé Tchoussi, “Cameroun: Médecins sans frontières de nouveau accusé de soutenir les séparatistes dans le Nord-Ouest”, 17 December 2020, available at: <https://www.journalducameroun.com/cameroun-medecins-sans-frontieres-de-nouveau-accuse-de-soutenir-les-separatistes-dans-le-nord-ouest-cameroun/>.

129 MSF, above note 23.

most countries that usual humanitarian and medical activities are falling within these definitions, which can lead to accusations such as concealing or providing assistance, transport, shelter or haven to terrorists. Based on these definitions, it is not necessary to prove a specific criminal intention; the simple knowledge of the criminal activities of those wounded and sick suffices to trigger complicity. In some criminal procedures this knowledge can also be derived from the facts.

In most national jurisdictions, these criminal qualifications are not mitigated by any medical exemption and immunity such as the ones drawn by IHL.¹³⁰

In such circumstances, medical activities by impartial humanitarian and medical organizations such as MSF can easily fall under such widely defined crime such as the one of complicity. The mere fact of giving medical care to patient victims and/or authors of violence becomes a factual knowledge of their criminal activities. The nature of the wounds of some patients is often considered as sufficient evidence of their criminal status which triggers criminal responsibility to those providing them with medical care according to medical ethics. This criminal responsibility is framed under different possible offences such as: assistance, complicity, and concealment of crime. In addition, the mandatory reporting of crimes, put in place under the CT regime, goes far beyond the protective provisions of IHL and medical ethics (see above).

Collecting such wounded persons and transporting them to medical facilities is mandatory under IHL and must be facilitated by all parties to the armed conflict. However, under the strict lens of CT offences, medical transports and medical transfers can as well carry criminal implications such as transportation of terrorists, facilitation of movement, concealment or complicity to escape.¹³¹ Such interpretation is obviously contrary to the essence and interpretation of IHL rules regarding protection of medical care and ethics. It reveals the difficulty of reconciling general principles agreement and concrete case implementation. The contentious interpretation of the real scope of legitimate medical care has been raised in Columbia around the prosecution of physicians because of the medical services they provided to militants. In the *Quintero* case,¹³² the Court considered that medical activities performed by the

130 AP I, Art. 16(1); and AP II, Art. 10(1).

131 The broad definition of the various terrorist offences can lead to a severe application of the law and criminalize the action of humanitarian actors. These legal risks have been documented for major donor countries for a long time (see above note 119). They are also found in domestic criminal and CT laws of various countries affected by an armed conflict and where humanitarian action is taking place. For example, see the Penal Code of Niger, Arts 200, 206, 399.1.18, 399.1.19 *nouveau (bis)* and *(ter)* and 399.1.23(c); see also the CT Law of Mali No. 2008-025, Art. 6, as well as the Malian Penal code, Art. 24 (broad criminal complicity). See also the Chad Penal code, Art. 118 (a broadening complicity to all those who provide without being forced to, and knowing their criminal intention, means of existence, shelter, refuge or meeting place to individuals threatening State safety and integrity), as well as Art. 109 (criminalizing all kind of material support and communication with armed and other rebel criminal groups). In 2020, Chad included a humanitarian exemption in its new CT legislation clarifying that humanitarian assistance is outside of the scope of such criminal offences. See Chad CT Law, above note 101, Arts 1(3) and (4).

132 Ekaterina Ortiz Linares and Marisela Silva Chau, "Reflections on the Colombian Case Law on the Protection of Medical Personnel Against Punishment", *International Review of the Red Cross*, Vol. 95, No. 890, 2013; Supreme Court of Justice of Colombia, Criminal Cassation Chamber, Case No. 27227 of 21 May 2009.

accused strengthened the guerrilla group since healed members of the group would subsequently return to fight. It also considered that referral services to specialized care fell outside of the scope of medical activities protected by IHL. This is a debatable legal decision in most contexts of armed conflict where medical personnel, bound by the non-discrimination imperative, transfer wounded and sick to the medical place that is best equipped to deal with their medical condition. This customary practice—based on medical needs—is routinely carried out cross-line or cross-border. The potential criminal status requires legal predictability and compliance with the medical non-discrimination imperative.

The management of the wounded and sick under judicial investigation, arrest or detention follows well-established procedures under IHL and domestic criminal law. However, CT frameworks work under exceptional criminal rules and procedures. Operations are carried out without warrant in flagrant mode by special security agents or military forces. While not strictly falling under the legal definition of attacks on a medical facility, they are carried out in a very similar form of military commando raiding a medical facility to arrest or kill a presumed terrorist patient present inside medical facilities. Several documented incidents¹³³ have shown that medical personnel have no room to argue about IHL rules and the medical condition of the person targeted by such operations which often result in deaths instead of the plain arrest of a patient, due to the use of violence inside the medical facility.

After the 2015 attack on MSF's hospital in Kunduz, Afghanistan, discussions between the military authorities of the United States and MSF highlighted concrete legal ambiguities. Indeed, the military authorities disputed the protected status of the MSF trauma centre as well as its civilian nature, due to the presence of large numbers of wounded and sick Taliban fighters in it.¹³⁴

The United States military authorities challenged the fact that those wounded and sick members of armed opposition groups could be all considered as *hors de combat*. They claimed that the medical state of those wounded fighters would still permit some of them to run some kind of command or combat functions. It also appears that these legal arguments would have made incidental harm on the hospital and medical personnel acceptable as they are supposed to accept the risk due to their presence among or in proximity to combatants or combat operation. Under the same United States *Law of War Manual*, such proximity gives no cause for complaint in cases of incidental harm. Therefore, the death of medical personnel would not be counted in a proportionality analysis nor would the death among the wounded and sick as, according to their

133 See above note 114.

134 The United States are not a party to AP I. Article 13 of AP I is thus not part of their military doctrine. This article states that the protection to which civilian units are entitled to shall not cease if members of armed forces or other combatants are present inside the medical unit for health-related reasons. Such presence should not be considered as an AHTTE. See also F. Bouchet-Saulnier and J. Whittall, above note 21.

interpretation, the precaution and proportionality principles apply to civilian losses only while those wounded enemy fighters are not “innocent” civilians.¹³⁵

These types of incidents are a clear indicator of the dangerous blending between the law applicable to the use of armed forces in armed conflict situations (IHL) and the use of armed force in a CT criminal context for militarized law enforcement operations—human rights.¹³⁶ In this last case, law enforcement “attacks” are becoming a practical substitute for the judicial sanction. The protections afforded by IHL to the wounded and sick are undermined because they remain considered as criminal enemies. At the same time, due process and judicial guarantees, such as fair trial rights, are also being pushed aside under the prism of the global war against terror and new derogative criminal law.¹³⁷

From protected neutral medical personnel to criminal accomplices

Medical personnel engaged pursuant to IHL in the care of all wounded and sick persons without discrimination are also *de facto* involved in the care of those who may be considered criminals or terrorists by the concerned State. This *de facto* assistance may have *de jure* adverse consequences. Criminal association in relation to terrorist undertaking is the legal gateway to most terrorism charges against individuals¹³⁸ including medical and humanitarian personnel. It also comes easily through the channel of material support and complicity that broaden the possibility of criminal charges against medical personnel having attended wounded and sick suspected of any terrorist offences. These specific criminal offences of complicity or association also encompass humanitarian dialogue with alleged criminal groups or individuals in view of providing medical and humanitarian assistance to populations in areas under their control. Here again, the knowledge of the terrorist context can replace the requirement of a criminal intent in supporting accusations of material assistance to terrorism against medical and humanitarian actors to incur criminal responsibility.¹³⁹ In

135 See the United States *Law of War Manual* at Art. 5.12.3.2 (harm to certain individuals who may be employed in or on military objectives), Arts 7.8.2.1 and 7.10.1.1 (incidental harm not prohibited), Arts 4.10.1, 7.10.1.1 and 7.12.3.2 (acceptance or the risk from proximity to combat operations): United States Department of Defense, above note 62. See also Oona Hathaway, “The Law of War Manual’s Threat to the Principle of Proportionality”, *Just Security*, 23 June 2016, available at: <https://www.justsecurity.org/31631/lowm-threat-principle-proportionality>.

136 International Court of Justice, *Armed Activities on the Territory of the Congo (Democratic Republic of the Congo v. Uganda)*, 19 December 2005, para. 216; Gloria Gaggioli, *Expert Meeting: The Use of Force in Armed Conflicts. Interplay Between the Conduct of Hostilities and Law Enforcement Paradigms*, ICRC, November 2013, pp. 14, 19 and 76, available at: <https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4171.pdf>.

137 See above note 131.

138 Human Rights Watch, *Preempting Justice: Counterterrorism Laws and Procedures in France*, 1 July 2008, available at: <https://www.hrw.org/report/2008/07/01/preempting-justice/counterterrorism-laws-and-procedures-france>.

139 See above note 132.

most countries where humanitarian and medical assistance and relief have not been explicitly excluded from the material support to terrorists, the humanitarian and medical personnel present in areas of armed conflict remain vulnerable to such charges due to their activities performed pursuant to IHL in relation to members of non-State armed groups, considered to be terrorist – and criminal. It must be noted that some countries affected by armed conflict have recently amended their domestic law to remedy the negative impact on impartial medical care.¹⁴⁰ In 2019, Afghanistan included an explicit medical exemption in its domestic criminal law to regain coherence with the protected status of medical care under IHL.¹⁴¹ Trying to mitigate the same concern, Colombia adopted in 2013 an explicit immunity for medical personnel that mirrors the ones provided by IHL. However, this immunity was not embodied in Columbia criminal law (that would give it its full force) but in a Medical Service Manual adopted by the Ministry of Health and Social Protection.¹⁴²

From medical confidentiality and ethics to criminal concealment

Accusations against medical and humanitarian personnel face yet another specific difficulty concerning the respect of medical confidentiality under IHL and the obligation to denounce crimes which are imposed and reinforced by criminal law and CT measures. The framework of the medical mission in situations of armed conflict as defined by IHL and, in particular, the two Additional Protocols to the Geneva Conventions upholds the importance of respecting medical ethics.¹⁴³ This is particularly crucial in situations where medical personnel are confronted with patients who are victims of intentional violence in situations of armed conflict and other situations of violence where the respect for the rule of law is no longer guaranteed.

140 Exemptions and good practices are noted in M. Buissonnières, S. Woznick and L. Rubinstein, above note 76, p. 31.

141 Art. 119 of the Afghan Penal Code from 2019 stipulates that no necessary medical procedures are to be considered crimes if they are carried out within the technical principles of the medical profession and the patient's family, or legal representative, has given consent. Surgical procedures performed in emergencies according to medical principles are also not to be labelled as crimes.

142 Ministry of Health and Social Protection, Office of Territorial Management, Emergencies and Disasters, Colombia, *Manual de Misión Médica*, 2013, available at: <https://repositorio.gestiondelriesgo.gov.co/bitstream/handle/20.500.11762/20719/Manual%20de%20Mision%20Medica.pdf?sequence=1&isAllowed=y>.

143 See ICRC Commentary on APs, above note 59, paras. 4692 and 4693 on AP II, Art. 10, which may be of use. Para. 4692: "Paragraph 2 establishes the principle of the free exercise of medical activities, i.e., medical personnel should be able to work without compulsion, guided only by professional ethics. Thus it is specifically prohibited to compel those carrying out medical activities to commit any act or to refrain from acting in a way which would be contrary to 'the rules of medical ethics or other rules designed for the benefit of the wounded and sick, or this Protocol'." Para. 4693: "It should be noted that in addition to the mention of medical ethics reference is made to 'other rules'. This is, in particular, because of the fact that in some countries medical ethics prohibit doctors from co-operating in medical procedures undertaken by personnel which are not officially qualified. This would apply for example to a medical student. The article refers to the rules of medical ethics which protect the wounded and sick, as opposed to those which are concerned only with the interests of the medical profession; it also refers to other rules designed for the same purpose, and applicable in specific cases." (footnote citation omitted).

IHL clearly states that in all type of armed conflict no distinction can be made among the wounded and the sick on any grounds except medical ones.¹⁴⁴ However, one should notice the sensitive character of medical treatment for the wounded and sick in NIAC by the fact that intentional deprivation of medical care is explicitly enunciated as being a grave breach of IHL in the context of an IAC¹⁴⁵ while in a NIAC, the same conduct is not as explicit but may amount to inhumane treatment as a serious violation of common Article 3.

The duty to report some type of disease and injuries to national authorities is a common pattern in domestic law applicable in times of peace. It is based on legitimate concerns of public health or public security, and it is always combined with other provisions allowing medical personnel to refer to medical ethics in making their own decision. In situations of armed conflict, this reporting procedure may be instrumentalized in the course of the conduct of hostilities to restrict access to wounded and sick enemies to medical facilities. It may also create additional pressure or threats on medical personnel that will *de facto* deprive access to impartial medical care for some wounded and sick including victims of sexual and other organized forms of violence. A recent survey has concluded that mandatory reporting is potentially incompatible with international law and medical ethics as it can obstruct access to health care for victims of armed conflict and other emergencies and may expose victims and health-care personnel to further harm.¹⁴⁶

As a body of law that anticipates the complex context of armed conflict, IHL has provided a set of important provisions to allow for medical ethics to prevail over formal compliance with mandatory reporting systems provided by domestic law.

The Additional Protocols to the Geneva Conventions have adopted two specific provisions protecting the legitimate and ethical concerns of confidential medical information.¹⁴⁷

The first provision applies to the protection of medical ethics against mandatory reporting. Its drafting differs slightly in IAC and NIAC but carries the same logic.

In situations of IACs, IHL sets, as an absolute principle, the confidentiality of medical information *vis-a-vis* the opposing Party to the conflict. It also sets a

144 Customary IHL Rule 110; GC I, Arts 12(2) and 15(1); GC II, Arts 12(2) and 18(1); GC IV, Art. 16(1); AP I, Art. 10; common Article 3; and AP II, Arts 7–8.

145 AP I, Art. 11(4).

146 This issue will not be treated in this article as it is not within its scope. However, most public health considerations are compatible with general aggregated data respecting the confidentiality or requiring obtaining the formal consent of the patient. Regarding reporting crimes to authorities, these provisions rarely entail sanction for medical personnel when they have acted in conformity with medical ethics. They instead allow, in limited circumstances, the reporting of cases when it is in the patient's best interest. These practices cannot contradict fundamental principles of medical ethics: access to medical care must not be jeopardized or delayed by such obligation. Patient consent and patient's best interest are the only valid criteria to take into consideration when making a medical decision. See also Swiss Institute of Comparative Law, *Legal Opinion on the Obligation of Health Care Professionals to Report Gunshot Wounds*, 30 June 2019, available at: <https://www.isdc.ch/media/1834/17-120-final-nov19.pdf>.

147 AP I, Art. 16(1)–(3); and AP II, Art. 10(1)–(4).

medical ethic criterion to support the medical personnel's autonomy of decision. "No person carrying out medical activities can be compelled to give out any information concerning the wounded and sick who are, or have been, under his or her care, as long as the medical person considers that such information might prove harmful to the patients concerned or to their families." This applies whether the person requesting the information belongs to the adverse Party to the conflict or to the medical person's own Party, except in cases foreseen by the person's domestic laws. However, even in this limited scenario, only one exception is carved by IHL for such compulsory reporting: regulations concerning the compulsory notification of communicable diseases must be respected.¹⁴⁸

In situations of NIACs, the non-State Party to the armed conflict is not entitled to the same rights as the State. IHL recalls that restriction to confidential medical information can only be carved out by the law in opposition to any other type of executive order or security practices. Additional Protocol II¹⁴⁹ specifies that: "[t]he professional obligations of persons engaged in medical activities regarding information which they may acquire concerning the wounded and sick under their care shall, subject to national law, be respected".¹⁵⁰

The second IHL specific provision aims at shielding medical personnel from the sanction of failure to comply with a domestic mandatory reporting system, notably in NIAC.

In such a context, IHL affirms that: "[s]ubject to national law, no person engaged in medical activities may be penalized in any way for refusing or failing to give information concerning the wounded and sick who are, or who have been, under his care".¹⁵¹ These detailed provisions and their cross-reference to domestic law create an enormous pressure when it comes to their effective and ethical articulation with domestic law provisions regarding mandatory reporting. However, this reference to national law is not a full licence left for compliance when domestic mandatory reporting may contradict the principles of medical ethics and prove harmful to the patients concerned or to their families.

A last provision applicable in both IAC and NIAC provides clear criminal immunity for persons engaged in impartial and ethical medical activities. Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefitting therefrom.¹⁵² The wording of this immunity is carefully chosen to cover all persons who have carried out a medical activity in accordance with professional ethics, regardless of the circumstances or the beneficiaries.¹⁵³ This immunity therefore applies to all persons engaged in these medical assistance and care activities and not only to

148 AP I, Art. 16(3).

149 See ICRC Commentary on APs, above note 59, on AP II, Art. 10(1)–(4).

150 AP II, Art. 10(3).

151 AP II, Art. 10(4).

152 AP I, Art. 16(1); and AP II, Art. 10(1).

153 *Ibid*; Customary IHL Rule 26 uses similar wording: "punishing a person for performing medical duties compatible with medical ethics [...] is prohibited".

the military or civilian assigned medical personnel¹⁵⁴ to this mission by the Parties to the armed conflict nor only to those exclusively engaged in these medical activities.¹⁵⁵ This is confirmed by customary IHL Rule 26 which states that: “[p]unishing a person for performing medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited”. Medical ethics must therefore be remembered as the only mandatory legal framework under which sanction towards the medical personnel could be taken.

However, despite its importance, this immunity clause does not appear in a systematic and consistent way in military manuals or domestic criminal law. Considering the differences in legal systems between monist and dualist countries, the implementation of international treaties may not always require a direct incorporation into domestic legislation. However criminal matters and immunity benefit from solid domestic anchoring. This is even more worrying that in addition to legal concerns raised by mandatory reporting and potential sanction related to the breach of such obligations, CT has created a new layer of obligations and criminal offences challenging medical confidentiality. Where breach of mandatory reporting can lead to limited sanctions, concealment of terrorist information is a fully fledged crime¹⁵⁶ that may be applied to medical and humanitarian personnel in the absence of any explicit exemption and in the context of existing public accusation in some sensitive areas.

Conclusion

The review of the legal context of medical care in mixed situations of CT and armed conflict involving non-State armed groups shows that we are back to pre-Solferino times. CT criminal legal framework is *de facto* denying wounded and sick from non-State armed groups an impartial access to medical care. Like in Solferino, impartial medical and humanitarian personnel and facilities are experiencing this reality on the front line.

Deprivation of impartial medical care to non-State armed group fighters is a tacit component of a State deterring power over armed opposition groups labelled as criminal or terrorist. In situations of armed conflict, it is weaponizing medical care in a way that destroys the neutrality and respect of medical duties built by IHL over the long history of conflict.

It is agreed that human rights (including the right to security) and IHL apply simultaneously in situations of armed conflict. However, this simultaneous application has always acknowledged the primacy of IHL as *lex specialis* in situations of conflict.¹⁵⁷ This primacy has been put in danger by CT criminal law emerging as another competing *lex specialis* in those situations.

154 AP I, Art. 8(c).

155 Customary IHL Rule 25; and GC I, Arts 24–7.

156 See, for instance, Mali, Law No. 2008-025, Art. 7.

157 International Court of Justice, above note 136, para. 216; Gloria Gaggioli, above note 136, pp. 14, 19 and 76.

In this context, the undefined status of members of non-State armed groups under IHL is wiped off by their criminal and terrorist status under national law. The criminal status that authorities assigned them has a contagious effect and turns into accomplices all those who enter in contact with members of non-State armed groups considered as terrorists including through the provision of medical assistance and relief. This article could not touch on other problematics linked to the contagious impact of the CT framework on IHL. Among them, the global right to humanitarian assistance and protection provided by IHL to population victims of armed conflict, living in areas disputed or controlled by non-State armed groups labelled as criminal or terrorist, should never be forgotten.

The relative downgrading of IHL in favour of general criminal law also stems from the fact that CT criminal law is autonomously incorporated into the national law of the different countries and without any reference to the special rights to humanitarian and medical assistance granted by IHL in situations of armed conflict. CT constitutes the strongest body of positive law directly applicable by all States' bodies in a mix of law enforcement and security–military defence order. In situations of armed conflict, CT terminology is undermining the fundamental right of assistance and protection provided by IHL categories of protection and assistance. Where the IHL framework protects “victims” of armed conflict,¹⁵⁸ the newly introduced reference to “innocent civilians”¹⁵⁹ is a soft language that is in fact hiding the tacit agreement to exclude the “suspected” individuals and populations from their right of survival in the contemporary situation of armed conflict tainted by the fight against terrorism.

What matters today is to get States' answer as to whether or not this legal and practical reality is an intended or unintended result of their CT agenda. As the context of CT and armed conflict continues to spread around the world, the historical challenges and dilemmas of IHL must be spoken loudly to the deaf ears of our generation regarding the global struggle against terrorism. The body and essence of IHL can still guide us through the pitfalls of the dehumanization of the enemy in armed violence.

The protection of the medical mission against current trends of attacks and abuses depends on the concrete steps taken by States in restoring the safe and fair coexistence of IHL and CT legislation. In the absence of such clarification, the temptation to weaken the non-State enemy by deprivation of medical care will become an acceptable trend. This requires restoring the primacy of IHL over CT domestic legislation to effectively protect the humanitarian and medical mission for the victims of contemporary armed conflicts.

The multiple ramifications and legal complexities embedded in national and international law leaves only one viable option open to reconcile CT legal framework with IHL duties.

158 AP I and AP II refer to the protection of victims of armed conflict to harmonize the different categories of protection provided in the four Geneva Conventions from 1949.

159 UN Office of the Coordination of Humanitarian Affairs, “Scores of Innocent Civilians Wounded and Killed in Attacks in Hajjah Governorate”, News and Press Release, 11 March 2019, available at: <https://reliefweb.int/report/yemen/scores-innocent-civilians-wounded-and-killed-attacks-hajjah-governorate-enar>.

Carving in the definition of CT offences an exemption¹⁶⁰ for medical and humanitarian activities carried out by impartial humanitarian organizations in accordance with IHL is the safest and easiest way to exclude activities authorized by IHL from the scope of criminal law. It is also a reliable option to go beyond usual lip service and demonstrates States' good faith in their commitment to respect IHL. Unfortunately, in the vast majority of countries, the medical mission as described in IHL remains threatened by CT laws and practices. Official discourse downplays this situation as a non-intentional consequence of the most needed fight against terrorism that must show no weakness. However, acknowledging incidental damage of CT on IHL cannot end with its acceptance.

Aside from international debate on humanitarian exemption, a handful of States have already included such provisions in their CT laws to ensure the non-criminalization and respect for humanitarian and medical activities in accordance with IHL.¹⁶¹ Their decision draws viable solutions to face the legal conundrum of safeguarding the integrity of both IHL and CT. They also show that it is not legitimate to maintain national legal insecurity around activities authorized by IHL. Among them, Chad CT law adopted in 2020¹⁶² dares to give legal strength to nice words. It made clear that activities that are exclusively humanitarian and impartial carried out by humanitarian and neutral organizations are excluded from CT offences. This demonstrates that it is not only necessary but also possible to preserve the principle of humanity in all situations even when confronted with a global phenomenon as tragic as the one of terrorism.

160 An exemption means that the exclusion, non-application of the measure is automatic (like an immunity) and permanent. It does not require any procedure or request for authorization to benefit from it. See also Rebecca Brubaker and Sophie Huvé, *UN Sanctions and Humanitarian Action: Review of Past Research and Proposals for Future Investigation*, United Nations University, New York, 2021, p. 12 and endnote 29, available at: http://collections.unu.edu/eserv/UNU:7895/UNSHA_ScopingPaper_FINAL_WEB.pdf.

161 ICRC, "Counter-Terrorism Measures Must Not Restrict Impartial Humanitarian Organizations From Delivering Aid", ICRC Statement to UNSC Debate, 12 January 2021, available at: <https://www.icrc.org/en/document/counter-terrorism-measures-must-not-restrict-impartial-humanitarian-organizations>; UNSC, above note 30, para. 84.

162 Chad CT Law, above note 101, Arts 1(3) and (4).