Applied Reflection on Humanitarian Practice

The moral relativism of subordinating civilians to terrorists

MSF reflections after a tragic year of hospital bombings

Alejandro Pozo Marín
with the collaboration of Françoise Bouchet-Saulnier

MEDICOS SIN FRONTERAS

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The moral relativism of subordinating civilians to terrorists
MSF reflections after a tragic year of hospital bombings

Alejandro Pozo Marín[1,2]
with the collaboration of Françoise Bouchet-Saulnier[3]

Bombing a hospital from the air is nothing new.[4] Whilst the attack on the hospital in Kunduz (Afghanistan) on 3 October 2015 represented a turning point for Médecins Sans Frontières (MSF) on many levels, it was not the first time that health facilities managed or supported by the organisation had been bombed.[5] There have also been numerous examples of ground attacks on health centres in MSF's more than four decades of existence. Interpretations of international humanitarian law continue to be as perverted today as they have been for

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2 The author acknowledges and thanks the following for their contributions to this text: Mònica de Castellarnau, Hélène Lorinquer, Corinne Baker, Raquel Ayora, Teresa Sancristóval, Pablo Marco, Leandro Sugameli, Alina Haddad and Velina Stoianova. The author would also like to thank Abby Stoddard, partner at Humanitarian Outcomes, for her review of the article and contribution.

3 Legal director of MSF. Author of *The Practical Guide to Humanitarian Law*, Rowman & Littlefield.

4 To give two examples: in Puthukkudiyiruppu (Mullaitivu district), a rebel zone in the northeast of Sri Lanka, a hospital was attacked three times in 24 hours in February 2009, killing nine people among the almost 500 patients at the centre. In 2014, an Israeli attack on a hospital in Gaza killed five people and injured 70. See "Deadly strike on S Lanka hospital" 2009, BBC News, 2 February; and "Gaza conflict: Five dead at hospital hit by Israeli strike" 2014, BBC News, 22 July.

5 Here are three examples. First, in Frandala, South Kordofan (Sudan) an MSF hospital with about 150 patients and workers was attacked with cluster munitions by the Sudanese Air Force on 20 January 2015, leaving two people wounded. The same hospital had been bombed six months previously, resulting in one dead and several injured (see "Sudan: MSF hospital bombed in South Kordofan", MSF press release, 23 January 2015). Second, the attacks by American and Moroccan blue helmets (UN military) on Digfer hospital, in Mogadishu (Somalia), that took place on 17 June 1993. The hospital was supported by an MSF emergency team. See the account of what happened in Tanguy, Joëlle (1993), Statement on the events of 17 June 1993 in Mogadishu, *MSF Speaking Out*, 25 June. Available from: http://speakingout.msf.org/fr/node/125. Third, in Sudan between the beginning of 1999 and February 2000: the Kaju-Kaji hospital, in Equatoria province (today located in South Sudan) was bombed 10 times with a total of 66 bombs, of which 13 hit the hospital structure. See "Living under aerial bombardments: Report of an investigation in the Province of Equatoria, Southern Sudan", 20 February 2000. Available from: http://reliefweb.int/sites/reliefweb.int/files/resources/EBB5D9AE36E196FE852568B80051F909-sdbomrap.pdf

decades.[6] However, the frequency[7], methods and consequences of, and above all the reactions (including those of MSF) to the attacks that have occurred since Kunduz, as well as the justifications for them, have few precedents.

The purpose of this paper is to analyse the context and the circumstances of the wave of bombings of hospitals and other medical services that have made headlines over the past year. Since the tragic attack by US forces on the MSF hospital in Kunduz, at least 81 other medical facilities either directly managed or supported (the vast majority) by MSF have been bombed in Syria and Yemen.[8] Syria has borne the brunt of most of these attacks, but Kunduz represented one of the biggest tragedies in the history of MSF. Five assaults on medical facilities managed or supported by the organisation have occurred in Yemen. The total number of attacks in Syria, Yemen and Afghanistan is likely to be much higher, since MSF only manages or collaborates with a small part of the health systems. These incidents are an indicator of the magnitude of the problem and of the ways in which wars are fought today in these contexts. Some of these 82 attacks (including Kunduz) have been the subject of international attention owing to the media coverage they generated. The vast majority, however, are just statistics: no explanation, no one held responsible, no reparation. Three tragedies that have been deeply shocking for MSF are the bombings of three hospitals, namely the Kunduz trauma centre (Kunduz, Afghanistan), the Al Quds hospital (Aleppo, Syria) and the Abs hospital (in the Yemeni governorate of Hajjah). All three incidents have been

6 Two practices can be drawn from that incident in Digfer in 1993 that are sadly still relevant today, almost a quarter of a century later. The first is the identification of a large inhabited nucleus as a hostile area in its entirety. In fact, there had been a mass evacuation of humanitarian workers and of the UN at the express request of the UN spokesman, who warned that "substantial collateral damage" was expected. In the second, author Alex de Waal tells how a US military lawyer responded to their protests saying that the Geneva Conventions did not apply in the case of intervention forces in Somalia, and that the UN resolution protected any use of force. This author also reports that an arrest warrant was issued against him on charges of collaborating in the propaganda efforts of the party to the conflict that was fighting the UN troops. See De Waal, Alex (2015), "Is it Ever Legal to Bomb a Hospital?" World Peace Foundation, 6 October. Available from: https://sites.tufts.edu/reinventingpeace/2015/10/06/is-it-ever-legal-to-bomb-a-hospital/

7 The ICRC's Health Care in Danger project has collected 2,398 incidences of violence against healthcare in 11 countries between January 2002 and December 2014. The ICRC has reported over 160 attacks against health personnel and structures in less than two years in Yemen, and 349 attacks on health facilities between 2014 and 2016 in Syria. See "Everyone wounded or sick during armed conflict has the right to health care", ICRC, 9 December 2016. Available from: https://www.icrc.org/en/document/everyone-wounded-or-sick-during-armed-conflict-has-right-health-care; Watchlist has reported more than 240 attacks against medical facilities and staff throughout Afghanistan. See Monaghan, Christine (2017), *'Every Clinic is Now on the Frontline'. The impact on children of attacks on health care in Afghanistan*, Watchlist. Available from: http://watchlist.org/about/report/afghanistan/.

8 See Stokes, Christopher (2016), "One year after Kunduz: Battlefields without doctors, in wars without limits", MSF, 3 October. Available from: http://www.msf.org/en/article/one-year-after-kunduz-battlefields-without-doctors-wars-without-limits. In the days following this press release, at least four other hospitals supported by MSF were damaged by bombs in Syria.

investigated internally by MSF and will be used as case studies in this paper.[9]

The MSF hospital in Kunduz was hit by 211 shells over the course of approximately an hour from 2am on 3 October 2015 by a Lockheed AC-130 aircraft designed and built in the US and used by its air force. The US admitted responsibility for the attack, which it called a "mistake". Among the 42 people who died were 14 MSF employees.[10] The attack destroyed the hospital, which was the only one in the region and, since then, the people living in the area have been deprived of the services it had been providing. US president Barack Obama apologised to MSF's international president and announced an internal investigation.[11] NATO decided to conduct an administrative investigation and released it before the US one.[12] No investigation was carried out by the Afghan government.[13] Meanwhile, MSF demanded an independent investigation. Whilst the incident received widespread media coverage and was condemned by various international institutions, the public condemnation of this attack was louder than in the political arena.

Abs hospital (Yemen), which is supported by MSF, was hit by a single strike on 15 August 2016 that killed 19 people in the hospital grounds, including one MSF employee.[14] MSF declared that the organisation was "neither satisfied nor reassured by the Saudi-led coalition's statement that this attack was a mistake."[15]

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9 The methodology also includes interviews with MSF staff and other people external to the organisation, including military experts.

10 More details about the attacks can be found in the MSF internal investigation "Initial MSF internal review: Attack on Kunduz Trauma Centre, Afghanistan', November 2015. Available from: http://www.msf.org/sites/msf.org/files/msf_kunduz_review_041115_for_public_release.pdf. See also the special website related to the attacks: http://kunduz.msf.org/

11 The US government made a redacted part of its investigation public. MSF has not received anything other than what was published.

12 Whilst the NATO investigation was not made public, they released an executive summary which is available at: "Release of the Executive Summary of the Combined Civilian Casualty Team Assessment Report on the Airstrike on Kunduz Hospital", NATO, 27 November 2015. Available from: https://www.shape.nato.int/release-of-the-executive-summary-of-the-combined-civilian-casualty-team-assessment-report-on-the-airstrike-on-kunduz-hospital

13 The Government of Afghanistan never officially proceeded with an investigation of the attack on the hospital. They proceeded with an overall investigation of the fall of Kunduz, not including the attack on the MSF hospital per se.

14 More details about the attacks can be found in the MSF internal investigation "MSF internal investigation of the 15 August attack on Abs hospital, Yemen. Summary of findings", MSF, September 2016. Available from: http://www.msf.org/sites/msf.org/files/yemen_abs_investigation.pdf

15 "MSF forced to evacuate staff from six hospitals in Northern Yemen", MSF press release, 18 August 2016. Available from: http://www.msf.org/en/article/yemen-indiscriminate-bombings-and-unreliable-reassurances-saudi-led-coalition-force-msf

The hospital was inactive for 11 days and was then partially reopened while destroyed parts of the hospital were being rebuilt. The incident was widely condemned and the subsequent MSF evacuation received considerable media coverage.

Unlike in Kunduz, Al Quds hospital in eastern Aleppo is not managed by MSF, nor does it have any local or foreign employees of the organisation among its staff, as is the case in Abs. However, MSF has strongly supported this hospital since January 2013, and maintained close and constant technical cooperation with its medical teams. On 27 April 2016, the hospital was bombed from the air by unknown military forces who did not admit responsibility for the attack. The hospital was inactive for 20 days and then reopened, although only able to provide partial, less consistent services in comparison with the situation prior to the attack.[16] The incident generated significant media coverage, probably because of the high geopolitical component of the Syrian crisis, the magnitude of the tragedy and the visibility of MSF. Furthermore, the timing of the attack coincided with the final deliberations of the UN Security Council that led to the adoption of a resolution condemning attacks on the medical mission.[17]

The patterns and repetition of these attacks, as well as the reactions they provoked in the different warring parties, suggest that the bombing of medical facilities will continue in certain contexts. However, there is not enough evidence to conclude that these bombings will become a new norm or that they will be generalised everywhere. MSF's experience in Afghanistan, Yemen and Syria is the consequence of a combination of factors, such as the growing effort of MSF to work in hospitals and provide live-saving medical services to populations trapped near the frontlines (with full awareness of the balance between the risk assumed and the expected impact) and certain particularities of the aforementioned contexts, such as the strong interest of foreign countries and their military presence, the use of air force and the acceptance of certain abuses that characterise the fight against terrorism. Beyond the enormous suffering they cause, these bombings have added a huge new concern to the already considerable challenges that come with the decision to work in certain armed conflict contexts. Through a comparative analysis of the three cases mentioned, this paper will examine the current options available to an organisation like MSF for dealing with hospital bombings, as well as the challenges that the future holds. The opinions expressed here are those of the author alone and do not necessarily correspond to the position of MSF.

16 More details about the attacks can be found in the MSF internal investigation "Review of Attack on Al Quds hospital in Aleppo City", MSF, September 2016. Available from: https://www.msf.es/sites/default/files/attachments/alquds_public_report_-_280916_-_final.pdf

17 Resolution 2286 (2016) of 3 May. See "Security Council Adopts Resolution 2286 (2016), Strongly Condemning Attacks against Medical Facilities, Personnel in Conflict Situations". Available from: http://www.un.org/press/en/2016/sc12347.doc.htm

Comparative analysis of the attacks

Summary of the variables considered in this article and their application in the three case studies

	Kunduz (Afghanistan)	Abs (Yemen)	Al Quds (Syria)
General data			
Date of air attacks	3 October 2015	15 August 2016	27 April 2016
Date MSF started working at the hospital	August 2011	June 2015	January 2013
No. of strikes in each incident	211 shells	1	2 direct & 2 related
No. of previous bombings of the hospital	0	0	2
Total no. of workers in the hospital	460 MSF employees	176 MSF and 29 non-MSF	Approx. 74 (none from MSF)
No. of workers present during the attack	140	54 MSF + 26 non-MSF	Approx. 70
No. of MSF international staff present during the attack	9	3	0
No. of patients present during the attack	105	At least 73[18]	Unknown[19]
Estimated no. of wounded combatants (patients) treated at the hospital at the time of the attack	3 or 4 government soldiers + approx. 20 wounded Taliban	Probably just 1	None reported
Consequences of the attacks			
No. of deaths directly caused by the attacks	42 (MSF confirmed)	19 (MSF confirmed)	55 (non-MSF data)
No. of hospital workers killed	14 MSF employees	1 MSF employee	6
No. of health workers killed	3 doctors, 5 nurses, 1 pharma	0[20] (waiting area)	2 doctors, 2 nurses, 1 technician
No. of injured (total)	37	24 (4 health workers)	Approx. 80 (incl. 8 staff)
Did the attacks end operations in the hospital?	Yes, still today[21]	Yes, partial reopening after 11 days	Yes, partial reopening after 20 days
Previous contacts and context			
Precedents in the country	None (recent bombing attacks) related to MSF	Numerous (4 recent cases related to MSF)[22]	Numerous (including many MSF-supported hospitals)
Extreme counter-terrorism context	Yes	Yes (with nuances – see later)	Yes
GPS coordinates provided to parties	Yes, to all parties	Yes, to all parties	No
Identification of the hospital	Yes	Yes	No
Negotiation/contact with the parties	Full	Full	Partial
Who controlled the hospital zone?	Opposition (Taliban)	Opposition (Houthis)	Opposition (rebels)[23]

Facts and interpretation of the attacks			
Acknowledgement of the attack	Yes (USA)	Yes (Saudi Arabia)	No
Perpetrators named by MSF	Yes (USA)	Yes (Saudi Arabia)	Yes (Syria or Russia)[24]
Designation of hostile area	Yes (USA/Afghanistan)	No, but bordering a designated area[25]	Not explicitly[26]
Intentional damage/collateral damage	Intentional (they targeted the wrong building)[27]	Intentional (vehicle)[28]	To be determined
Justified as a mistake by the perpetrators	Yes	Yes[29]	No
Military activity/weapons in the hospital	No	No	No
Warning prior to the attacks	No	No	No
Self-defence (real)	No	No	No
Self-defence (rhetorical)	Yes	No	No
Loss of protection status (author's analysis)	No	No	No
Precautions in the attack (author's analysis)	No	No	No
MSF reaction			
MSF internal investigation	Yes	Yes	Yes
Known independent investigations	None	None	None
Investigations by the parties to the conflict	Yes (US, NATO)	Yes (JIAT)[30]	Unknown
Findings of investigation by the parties shared with MSF	Yes, partial public release of US and NATO investigations[31]	Yes, some findings made public[32]	No
Request for independent investigation	Yes, formal request to IHFCC	Yes, but not formally	No
End of MSF operations	Yes (Kunduz city) No (Kunduz province, small health post); No (Afghanistan)	No (temporary suspension in Abs); No (Yemen)	No (Al Quds), support only; No (Syria)

Table 1. Summary of parameters of the three case studies. Produced by the author.

18 23 patients in surgery, 25 on the maternity ward, 12 in paediatrics and 13 newborns.

19 However, the number of patients was higher than usual because five bombings were recorded that day in the district (Al Sukkari), and because of the number of patients who went to the hospital after the first bombing outside the facility.

20 The strike affected the waiting area and the health workers were in the medical rooms.

21 MSF continues operations in a health post in a district outside Kunduz city.

22 The other four attacks on services supported by MSF were on: Haydan hospital (Sa'ada governorate) on 26 October 2015; a mobile clinic in the district of al-Houban (Taizz) on 2 December 2015; Shiara hospital in Razeh (Sa'ada) on 10 January 2016; and an ambulance from Al Jamhoory hospital (Sa'ada city) on 22 January 2016.

23 The specific group is unclear.

24 Without making a categorical accusation, MSF expressed that Russian or Syrian forces were highly likely to be responsible for the attacks.

25 The coalition officially declared the Sa'ada governorate as hostile, but not neighbouring Hajjah, where Abs is located.

26 At the time of the incident (27 April 2016). However, that was the interpretation made in subsequent attacks. Eastern Aleppo was identified as territory in the hands of "terrorists" by the Syrian government and its allies.

27 According to the statement given on 25 November 2015 by General John F. Campbell, commander of the Resolute Support mission and US forces in Afghanistan: "the U.S. forces directly involved in this incident did not know the targeted compound was the MSF Trauma Center. The medical facility was misidentified as a target by U.S. personnel who believed they were striking a different building several hundred meters away where there were reports of combatants", reference USFOR-A PUBLIC AFFAIRS 2015-11-25-US-01.

28 The hospital itself was reportedly not targeted, and the target was the vehicle inside the IHL-protected hospital compound.

29 It was claimed that it was unknown that the vehicle was within a hospital compound. "Official Spokesman of Joint Incidents Assessment Team (JIAT) Issues Statement", Saudi Press Agency, 6 December 2016. Available from: http://spa.gov.sa/1567351?lang=en&newsid=1567351

30 Joint Incident Assessment Team (JIAT), non-independent mechanism part of the coalition led by Saudi Arabia.

31 MSF got access to the findings made public by the US (approximately 600 pages out of around 3,000); NATO published the 2-page findings and recommendations of their investigations, but the report was never shared with MSF.

32 However, MSF openly disagreed with the public declaration by the JIAT and declared that it "does not reflect the conversations MSF had in Saudi Arabia with the JIAT and military forces after the attack." See "Yemen: Saudi-led airstrike on Abs hospital cannot be justified as 'unintentional error' ", MSF press release, 9 December 2016. Available from: http://www.msf.org/en/article/yemen-saudi-led-airstrike-abs-hospital-cannot-be-justified-unintentional-error

The counter-terrorism framework

The three contexts analysed – Afghanistan, Yemen and Syria – fall under the overall framework of the fight against terrorism, and several of the most important military powers in the world are involved in all three cases, either through direct participation or as allies of one of the main warring parties. They correspond to three situations of extreme violence and polarisation, and in all three cases there are groups officially designated as terrorists by certain warring parties.[33]

However, the counter-terrorism framework is more extensive. It is well known that the 11 September 2001 attacks in the United States were a turning point in international relations in terms of understanding security threats and methods to combat them. Whilst it used to be unacceptable to publicly defy International Humanitarian Law (IHL), today a degree of flexibility seems to be politically allowed when facing the so-called supreme challenge of terrorism.[34] MSF was recently told by a high-ranking official of a UN Security Council permanent member that "neutrality does not apply in the case of terrorists". People branded as "terrorists" have ceased to be considered combatants subject to rights and obligations and, in many places, have become a dehumanised object dispossessed of any rights, as well as a prized objective whose "neutralisation" justifies all means.[35] Today, the red lines on who deserves medical humanitarian treatment, while fixed by international law, are challenged in practice by the parties to a conflict and the doctrine of counter-terrorism. However, a consequence of the counter-terrorist initiatives is the extension of the very same treatment to insurgents who would not previously have been labelled terrorists. In fact, being branded a terrorist now depends not only on the actions and methods used – the means – but also on the objectives and the ways of thinking – the ends. Thus, the concept of terrorist is easily (ab)used to designate the enemy, who in

33 For example, the following are designated as terrorist groups, among others: al-Qaeda, by the EU, Iran, the US and the UK; al-Qaeda in the Arabian Peninsula, by the US, Saudi Arabia and the United Arab Emirates; the Al-Nusra Front (now called *Jabhat Fateh al-Sham*), by the Russian Federation, Saudi Arabia and the US; the Houthis, by Saudi Arabia and the United Arab Emirates; Islamic State, by the EU, the US, Saudi Arabia, the Russian Federation, Iran, Turkey and the United Arab Emirates; and the Pakistani Taliban (Tehrik-e-Taliban Pakistan) by the US and the UK. The Afghan Taliban is designated as a terrorist group by Canada and the Russian Federation, but those countries are no longer warring parties in Afghanistan.

34 Naz K. Modirzadeh argues that "neither IHL nor IHRL are the disciplines that they were in 2001", and that interpretations of international law "may be shaped by a coming legal elite forged in the battles of the last twelve years, perhaps defined more by responding to the demands of policy than by fealty to international law. The extent to which international law can meaningfully constrain authority during the tumult of armed conflict and other situations of lethal force may be at stake." Modirzadeh, Naz K. (2014), "Folk International Law: 9/11 Lawyering and the Transformation of the Law of Armed Conflict to Human Rights Policy and Human Rights Law to War Governance", *Harvard National Security Journal*, Vol. 5, No. 1, p. 304.

35 For example, George H. Aldrich concludes, in the case of Afghanistan that "(...) Members of al Qaeda are not entitled to be combatants under international law and are subject to trial and punishment under national laws for their crimes." Aldrich, George H. (2002), "The Taliban, Al Qaeda, and the Determination of Illegal Combatants", *The American Journal of International Law*, Vol. 96, No. 4, October, p. 898.

turn is no longer perceived as deserving the right to the minimum guarantees provided by IHL. In the three contexts chosen as case studies, there are armed groups that are widely labelled as terrorists – such as IS or al-Qaeda – but also others that are identified in this way by just one or few actors – such as the Yemeni Houthi (by Saudi Arabia and the Emirates) and opposition groups in Syria (by the al-Assad government).

Irrespective of whether one or more parties to a conflict are indeed terrorist groups or insurgents receiving equivalent treatment, the fight against terrorism or its derivatives represents an obstacle for principled humanitarian action, for at least the following six reasons:

1. *Difficult engagement with the parties in conflict.* Under certain national legislations, any exchange with, or payment or even involuntary diversion of goods or funds to groups designated as terrorists is understood to be a breach of the law, and humanitarian workers can be prosecuted for it.[36] However, MSF needs to ensure solid communication with the parties to a conflict and with all those groups that could represent a limitation in terms of access and security. In Afghanistan and Yemen, MSF had constant and fluid interaction with almost all parties, including the respective governments, the opposition (whether designated as terrorist or not) and the foreign forces. All parties expressed their acceptance of MSF operations. In the case of Syria, anti-terrorism laws issued on 2 July 2012 effectively criminalised medical aid to the opposition, contravening customary international humanitarian law.[37] MSF has sought the acceptance of the government authorities since the beginning of the conflict, but the organisation has never received their authorisation to work in Syria and, as a consequence, MSF has not been able to work in the zone controlled by the Syrian government, despite wanting to do so. Communication has, however, been fluid with the active armed actors in opposition-controlled areas, with the exception of the Islamic State.

2. *Limited access*. A country's government may not let humanitarians work in areas it controls if it believes that enemy groups might benefit. Moreover, some of the groups designated as terrorists will be unwilling to accept the presence of a foreign organisation or workers from the same countries that have included them on the aforementioned lists; and some others will see foreign organisations as legitimate targets of violence in their own campaigns. Security will be compromised in the "all's fair in the fight against terrorism" environment.

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36 Humanitarian workers can even be requested by the judiciary to disclose information. It is not only the transfer of funds that is part of material support but also transfer of knowledge and all kind of material support.

37 See "Assault on medical care in Syria", Human Rights Council, twenty-fourth session, agenda item 4, reference A/HRC/24/CRP.2, 13 September 2013. Available from: www.ohchr.org/EN/HRBodies/HRC/.../A-HRC-24-CRP-2.doc, p.5.

3. *Limited funds for international humanitarian actors (and therefore reduced presence).* MSF does not accept any public institutional funding to work in armed conflicts settings with an anti-terrorist component. Owing to its independence, MSF may be in a much better position to engage with armed actors and gain access to certain areas compared to other NGOs that are dependent on funding from parties to "the war on terror". For some of the biggest donors, the diversion of any resources to certain groups including designated terrorists is unacceptable. However, while humanitarian organisations must minimise this risk as much as possible, they cannot guarantee that humanitarian resources will not benefit an armed actor in some way or another, and some level of diversion is to be expected. This is an inherent and unavoidable reality when working in conflict-affected zones. Thus, the only way to ensure that these diversions do not happen is by not working in areas controlled by such groups. This of course means that certain communities will not receive humanitarian assistance.[38]

4. *Blanket declaration of an inhabited area as hostile*. A large part of the world perceives terrorism as an extreme and imminent threat. Under such pressure, collateral damage is more palatable as a lesser evil for public opinion. In the eyes of the attacker, everything and everybody may become a legitimate target in a hostile territory, including an MSF hospital. Examples of this declaratory practice will be addressed later in the paper (see Table 2 below).

5. *Legitimisation of targeted killings.*[39] Justification of targeted killings is increasingly common in the context of fighting terrorism (and other groups receiving similar treatment), both in times of war and of peace, even though these acts may mean the denial of the right to presumed innocence or to a fair trial.[40] Such killings are very rarely condemned or prosecuted by states and international organisations. In international humanitarian law and in medical ethics – and, therefore, for MSF – a patient is a patient regardless of their military rank or relevance. Attacks on hospitals are prohibited, but in the current climate, if a hospital admits as a patient a leader of a group that is designated by others as terrorist the consequences could be disastrous.

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38 See Keen, David (2013), "When Do No Harm Hurts", *The New York Times*, 6 November.

39 According to a UN special report, a targeted killing is "the intentional, premeditated and deliberate use of lethal force, by States or their agents acting under colour of law, or by an organized armed group in armed conflict, against a specific individual who is not in the physical custody of the perpetrator. In recent years, a few States have adopted policies, either openly or implicitly, of using targeted killings, including in the territories of other States", UN General Assembly (2010), "Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Philip Alston. Addendum - Study on targeted killings", Human Rights Council, Fourteenth session, 28 May, reference A/HRC/14/24/Add.6. Available from: http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.24.Add6.pdf

40 For instance, targeted killings have become a central component of US counter-terrorism operations around the globe. See Masters, Jonathan (2013), "Targeted Killings", Council on Foreign Relations, 23 May. Available from: http://www.cfr.org/counterterrorism/targeted-killings/p9627

In fact, armed groups themselves have refrained from taking their leaders to MSF hospitals as they were afraid that this could trigger an attack against the facility.

6. *Ill-treatment of patients and health workers within medical facilities*. In many contexts, patients and health professionals have been interrogated or arrested within hospitals and other facilities under the justification of law enforcement. In some cases, they have been tortured, disappeared or even killed. In Afghanistan, patients designated as "criminals" under domestic law have been arrested, eroding the neutrality of health facilities.[41] In Syria, patients and medical personnel providing treatment to perceived opposition supporters have been interrogated, arrested, tortured, disappeared and killed.[42]

	Afghanistan	Yemen	Syria
Engagement/negotiation with the parties	Yes, with all, but accusations of Taliban using the hospital and hiding there [43]	Yes, with all, but warnings about proximity to terrorists	Not with all. Accusations of collaboration with terrorists
Limited access	In theory, no problems (determined by security)	In theory, no problems (determined by security)	No permission and no operations in the government-controlled areas; no operations in the IS-controlled areas because of risk of kidnapping
Reduced presence of international humanitarian groups	Extensive presence in Kabul and certain urban areas, but very limited beyond	Very limited outside Sana'a	International NGOs without direct presence (security reasons). Problems in Islamic State areas
Blanket declaration of an inhabited area as hostile	Yes, officially acknowledged in the partial release of the US internal investigation	Yes, in the governorate of Sa'ada (declared military objective); not explicitly in Hajjah province (Abs)	Not at the time of the attacks. Subsequently, the UN criticised Syria and the Russian Federation for using terrorism as an excuse to destroy the area
Legitimisation of targeted killings	Unknown	Abs: vehicle designated as a target	Numerous reports (non-MSF)
Arrest of patients and health workers	Cases reported (outside MSF facilities)	No cases reported recently, but patients have been arrested in Yemen in the past years	Many cases reported, including disappearances

Table 2. Adaptation of the limitations for MSF in the fight against terrorism in the three case studies. Prepared by the author.[44]

What determines the protection of hospitals?

International law is clear: "Civilian hospitals organised to give care to the wounded and sick, the infirm and maternity cases may in no circumstances be

41 Whittall, Jonathan (2016), "Targeting terrorists", MSF Analysis, 5 August. Available from: http://msf-analysis.org/new-treating-terrorists/

42 "Assault on medical care in Syria", *Op. Cit.*

43 See footnote 56 for details.

44 See the references used later in this article.

the object of attack, but shall at all times be respected and protected by the Parties to the conflict."[45] It uses the phrase "in no circumstances", although international humanitarian law also notes that protected status may be withdrawn in certain situations: when hospitals are used to commit acts that, outside their humanitarian duties, are "harmful to the enemy". In those cases, protection may be withdrawn, but only if proper warning has been provided and if, after a reasonable amount of time has passed, that warning has been ignored.[46] While acknowledging the subjectivity associated with the assessment of what is "harmful to the enemy", it should be stated that MSF has rarely received a formal warning announcing the loss of protection.

International humanitarian law sets out some (but not all) situations that should not be considered as harmful to the enemy and therefore would not result in the loss of protection of a medical facility.[47]

> "2. The following shall not be considered as acts harmful to the enemy:
>
> (a) that the personnel of the unit are equipped with light individual weapons for their own defence or for that of the wounded and sick in their charge;
> (b) that the unit is guarded by a picket or by sentries or by an escort;
> (c) that small arms and ammunition taken from the wounded and sick, and not yet handed to the proper service, are found in the units;
> (d) that members of the armed forces or other combatants are in the unit for medical reasons."

Yet, five additional variables seem to be taken into consideration today when trying to establish if a medical facility could have lost its protected status. Each of these variables is discussed below, both generally and specifically in relation to the cases examined in this paper.

1. *Identification of hospitals*. Under international humanitarian law, civilian hospitals must be notified to the parties to the conflict and identified.[48]

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45 Article 18 of IV Geneva Convention (IVGC). Also related are the following, among others: articles 19 to 23, 33 to 35 and Annex 1 of IGC; articles 14, 56 and 57 and Annex 1 of the IVGC; articles 8 to 31 of Additional Protocol I (API); articles 7 to 12 of APII; and rule 35 of customary international humanitarian law.

46 Article 19 of IVGC; article 11 of APII; article 13 of API.

47 Article 13.2 of API.

48 According to Article 18 of IVGC: "States which are Parties to a conflict shall provide all civilian hospitals with certificates showing that they are civilian hospitals and that the buildings which they occupy are not used for any purpose which would deprive these hospitals of protection in accordance with Article 19. Civilian hospitals shall be marked by means of the emblem provided for in Article 38 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949, but only if so authorized by the State. The Parties to the conflict shall, in so far as military considerations permit, take the necessary steps to make the distinctive emblems indicating civilian hospitals clearly visible to the enemy land, air and naval forces in order to obviate the possibility of any hostile action."

In some places, MSF shares the GPS coordinates of its facilities with the parties to the conflict. While it does not always do so, it is a common practice of the organisation with armed groups with military air capability that use weapons with detection systems. MSF regularly provided the coordinates of the hospital it operated in Kunduz to all armed groups in the region, and its teams in Kabul and New York made sure to make the relevant contacts.[49] MSF also made sure the hospital complied with the requirements of identification agreed with the parties to the conflict, and that it was known and was clearly identified as an MSF hospital. In Yemen, MSF also transmitted every three months from July 2015 its GPS coordinates to the Saudi Arabia-led coalition through its Evacuation and Humanitarian Operations Cell (EHOC).[50] As for identification, while the JIAT investigation said that the buildings "had no signs of a hospital", the question remains as to the size of any visual identification required for visual aerial identification. Indeed, Abs hospital's enclosed complex had a large logo (2m x 5m) painted on its roof, and its location and GPS coordinates were known to be those of a functional hospital.[51] By contrast, in Syria, the Al Quds hospital did not provide its GPS coordinates to the warring parties. MSF does not manage this centre, it only supports it, and the decision to identify it or not is to be made by the hospital management. In fact, all the hospitals supported by MSF in Syria have decided against sharing their GPS coordinates with the parties to the conflict. It is locally perceived that in this context identification increases the risk of attacks rather than prevents it. However, the MSF internal investigation concluded that it was more than likely that the hospital was known to the parties to the conflict, particularly those with intelligence services, given that it was a fully functioning hospital which had been in constant use for three-and-a-half years, and had an estimated 5,000 patients a month and a regular ambulance service. MSF believes that the location of the hospital was well known, but obviously cannot confirm that it was known to whoever bombed it from the air.

2. *The nature of the hospital's activities*. In addition to the medical nature of the building, the protection of hospitals under international humanitarian law is

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49 In fact, on 29 September 2015, just four days before the attack, MSF sent a reminder email with the GPS coordinates of the main building and the administrative building of the hospital, to the US Department of Defence, the US military in Kabul, the Afghan ministries of the interior and defence and the UN. US interlocutors confirmed receipt and the Afghan Ministry of the Interior did so verbally. The US reported that they shared the coordinates with the parties to the conflict and the UN intermediary confirmed onward transmission to the NATO Resolute Support operation.

50 The last general communication of these coordinates was on 10 August, just five days before the attack, and the next day contact was made once again in order to add the location of a water tank.

51 "Yemen: Saudi-led airstrike on Abs hospital cannot be justified as 'unintentional error' ", *Op. Cit.*; see the conclusions by the JIAT at "Official Spokesman of Joint Incidents Assessment Team (JIAT) Issues Statement", *Op. Cit.*

also related to the civilian or military character of their activities. Frequently, in territories designated as "hostile", the civilian character of hospitals Wand their activities are questioned. In all three case studies, however, the hospitals were functioning as civilian medical facilities, as indicated in the following table:

	Number of beds	Consultations	% under 5s	Injured in violence[52]
Kunduz (Afghanistan)	92 (140 end-September wartime exceptional)	22,000 (4,241 surgeries) in 2014	7% (inpatient care) in 2011-2015	47.6% (surgery) in 2015; 12.5% in emergency room in 2015[53]
Abs (Yemen)	38	12,000 in a year	22% (emergency room)	161 in 6 months
Al Quds (Syria)[54]	34	Approx. 5,000 per month	Almost 8%	282 (Feb 2016), 3%

Table 3. Medical statistics at the time of the attacks. Prepared by the author.

3. *Treatment and volume of ex-combatants*. International humanitarian law clearly recognises that combatants lose their status once they become patients, and expressly declares that "members of the armed forces or other combatants [that] are in the unit for medical reasons" – regardless of their number and relevance – shall not be considered as "acts harmful to the enemy". MSF must prioritise its patients according to their medical needs, regardless of considerations of ideology or identity. In this regard, medical ethics and IHL are aligned. In war zones, one of MSF's added values is precisely that it treats all those wounded, whether they are combatants or not. In two of the scenarios (Yemen and Syria), patients injured by weapons were the rare exceptions and not the rule (3% in Al Quds and slightly less in Abs).[55] In contrast, the percentage was much higher in Kunduz, owing to armed clashes in the city and the lack of treatment alternatives. Some Afghan officials and spokespersons defended the attack on the hospital a posteriori, claiming that the hospital was "full of Taliban", thereby suggesting that if this were

52 Injured by violence includes, for example, gunshots, bombings and stabbings. It does not include traffic accidents, falls or burns.

53 Surgery (OT): 47.6% violent trauma, 52.4% accidental trauma; emergency room: 12.5% violent trauma, 87.5% accidental trauma.

54 Data from February 2016. Unfortunately, there are no statistics for April 2016 (when the attacks happened).

55 In eastern Aleppo, most people injured by weapons did not go to Al Quds but, owing to its proximity, to Al Zarzour hospital, the largest referral hospital for surgery, located in the same district as Al Quds (Sukkari/Ansari). In the case of Abs, the low proportion of people injured by weapons reflects the civilian character of the population and the relative security in the zone, far from the war front.

the case, it could justify the hospital being perceived as an enemy base.[56] It is important to underline that a hospital would not lose its protection even in the hypothetical case that it was only treating former combatants. However, MSF has been expressly asked by military authorities whether the organisation treated "significant" numbers of ex-combatants, and it is clear that the warring parties disagree with such action and challenge the provisions of international humanitarian law. That said, it should be noted that, from a legal perspective, admitting to an attack on a hospital and justifying it on the grounds of the presence of wounded enemy fighters would amount to admitting to a war crime.

4. *Military activity, use of mobile phones, presence of weapons*. Military activity at a hospital may be considered by some as "harmful to the enemy" but, even if this observation were true,[57] it would not entitle the belligerent groups to an immediate aggression. MSF does not tolerate military activity or the presence of weapons within its health facilities, even though the latter is permitted in the protection parameters stipulated under international humanitarian law. This strict approach is meant to mitigate security risks inside the medical facilities, as well as to protect the organisation's perceived neutrality by the parties to the conflict and other local groups. At hospital entrances, searches are performed and people carrying weapons are not permitted entry. Sometimes, spaces are provided outside where such weapons can be deposited. In the three cases studied, registration and/or custody of weapons procedures were fully operational. Subsequent investigations confirmed that there were no weapons inside the hospitals. Furthermore, MSF has banned the use of mobile phones in some of the centres in which it operates, such as in Abs, in order to prevent inpatients from remaining active in military operations from within the facility.

5. *Strategic military value of targeted killings*. This refers not to a reaction to an act seen as "harmful to the enemy", but rather to an opportunity to inflict

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56 For example, the spokesman for the Afghan Ministry of the Interior said that: "According to our information, the Taliban were hiding in the hospital building and the area around it while attacking our forces." See "Air strike kills MSF medical staff in Afghanistan", *Al Jazeera*, 3 October 2015. The Afghan minister of defence, Masoom Stanekzai, also said that: "The compound was being used by people who were fighting there, whether it was Taliban or ISI or whoever they were" (ISI refers to the Pakistani intelligence services, accused of supporting the Taliban). "If the fighting was not coming from there, that kind of a mistake will never happen." See O'Donnell, Lynne (2015), "Afghan defense minister says Taliban hid in bombed hospital", AP, 19 October. Hamdullah Danishi, the interim governor of Kunduz said: "The hospital campus was 100% used by the Taliban. The hospital has a vast garden, and the Taliban were there. We tolerated their firing for some time." Pengelly, Martin (2015), "Afghanistan airstrike hospital: Pentagon pledges full investigation", *The Guardian*, 4 October.

57 In certain contexts, the warring parties have shown disrespect for the medical mission and endangered its protection by occupying health facilities or positioning military personnel, snipers and military vehicles including tanks within the hospital grounds or its surroundings. In the case of Syria, see "Assault on medical care in Syria", *Op. Cit*.

a heavy loss. International humanitarian law prohibits the use of weapons and methods that cause excessive damage to civilians and their property in relation to the concrete and direct military "advantage" anticipated. However, the interpretation of when that advantage can justify the harm done to "protected" civilians is very subjective and depends on the interests and perception of whoever is making the assessment. That said, attacks on hospitals are prohibited, regardless of potential military advantage. At Abs, the investigation conducted by the JIAT concluded that the target was a car that entered the hospital grounds. The strike hit the vehicle and completely destroyed it. As stated in MSF's response to the JIAT conclusions, "the car – carrying at least one injured patient – had travelled through unpopulated areas for more than 10 kilometres before arriving at the hospital, where it was parked at the entrance of the emergency room for several minutes before being targeted. So there is no possibility that the car was 'shelled immediately' after" targeting the location where the Houthi armed leaders gathered, as was claimed in the public declaration.[58,59] If the pilot decided to launch the attack with full knowledge that the target was within a hospital compound, this would constitute an example of the protected nature of the health facility being subordinated to the military advantage of the objective. It seems impossible to justify the compliance of such "surgical strikes" inside a hospital with IHL requirements.

Hospitals bombed: a target, a mistake, collateral damage or subordinated to military gain

There are at least four options for determining the rationale behind the bombing of a hospital: (a) a deliberate attack on a medical facility; (b) an indiscriminate attack on an area where military and civilian populations are mixed together; (c) a mistake, and (d) "collateral damage" on the hospital due to an attack on a military objective located in an area that includes the hospital (and other civilian assets). The first two are prohibited under IHL, but they are very difficult to determine, since the intent of the perpetrator must be known and it would be rare for that to be disclosed. In fact, it is hard to imagine someone admitting to a deliberate attack on a hospital unless it is an exercise of atonement. There are things that even the most merciless cannot openly say. There is no shortage of examples of indiscriminate attacks throughout the last century.[60] Some episodes, such as the Second World War allied bombings of Dresden, Hamburg, Tokyo, Hiroshima and

58 "Yemen: Saudi-led airstrike on Abs hospital cannot be justified as 'unintentional error' ", *Op. Cit.*

59 "Official Spokesman of Joint Incidents Assessment Team (JIAT) Issues Statement", *Op. Cit.*

60 Before 1949 they were authorised by IHL and largely used as a method of war. There has been a difference since 1949 and 1977, when the IV Geneva Convention and the additional protocols where respectively established.

Nagasaki, the Nazi bombings of London or Liverpool, or of Gernika and Barcelona during the Spanish Civil War, are among the worst horrors that we humans have ever inflicted on one another. While acknowledging that no fair comparison can be made with the said examples, recent wars have also been characterised by indiscriminate bombings disguised as occupational hazards.[61] In Afghanistan, Syria and Yemen it is not only hospitals that have been bombed. Extrapolating what happened in the medical field to all civil sectors in these three countries provides a rough idea of the horrors of war, and the hypocrisy of the rhetoric of mistake or the lesser evil of collateral damage. There are several indications to suggest that some of the incidents suffered by MSF in the last year bore signs of some kind of intentionality. In relation to the three case studies, it cannot be ruled out.

The third scenario is that of a mistake. It is clear that the mistake narrative risks becoming a subterfuge for avoiding criminal and political responsibilities. However, even in the absence of criminal intent a negligent attack on a medical facility implies that responsibility. Extrapolating the case to domestic criminal law, negligent or involuntary homicide usually results in a lesser penalty than for murder (carried out with malice aforethought and viciousness), but the perpetrator is still called to account in the hope that this will prevent a repetition of the action. One could hardly imagine, should the US or Saudi Arabia suffer a similar attack, that government officials would accept the same excuses they presented for their attacks on Kunduz or Abs hospitals, respectively.[62] Meanwhile, three British ministers have declared that the United Kingdom, an ally of Saudi Arabia and collaborator in its military operation in Yemen, has concluded that no violations of international humanitarian law in that war context were committed by the Riyadh-led coalition,[63] in what appear to be efforts to exclude intentionality and privilege the mistake or collateral damage narrative. The normalisation of the rhetoric of mistake is not acceptable, nor is hiding behind slip-ups in order to avoid being held criminally and politically accountable. In all three cases analysed in this article, as well as in others, there is sufficient evidence to conclude that the perpetrators of the attacks did not take the precautions to which they are duty

61 For example, in the Federal Republic of Yugoslavia, ambulances and around 20 hospitals were bombed between 24 March and 1 May 1999. But so too were electric, hydroelectric and chemical plants; more than 3,500 industrial and commercial facilities; 18 refineries and large warehouses; 32 bridges and 16 railway lines or stations; 5 bus stations; 8 civilian airports; a passenger train (full); 51 historical monuments and 18 monasteries, churches or cemeteries; more than 200 schools, faculties or student facilities, and, in Belgrade, the Chinese embassy, among many others. According to the complaint filed at The Hague on 12 May 1999 before the prosecutor of the International Criminal Tribunal for the former Yugoslavia by the Greek jurist Alexander Lycouredsos (source of the above list of bombings), the political and military leaders of NATO, as well as specific high-level personnel, were accused of having committed war crimes. In Iraq, Chechnya and many other places, the lists have also been long and tragic.

62 It should be noted that both the US and Saudi Arabia have taken responsibility for the attacks, while in Syria nobody has claimed any responsibility even as a mistake.

63 The British government later had to retract numerous oral and written statements in parliament and admit that Britain had not made any assessment of the actions of the Saudis. Wintour, Patrick (2016), "Foreign Office retracts statements to MPs on Saudi campaign in Yemen", *The Guardian*, 21 July.

bound. In no way should a declaration of mistake be the endpoint. In the best case scenario, we would be dealing with gross negligence constituting a violation of international humanitarian law.

Lastly, in the case of collateral damage it is difficult to challenge how duty of precaution and proportionality toward civilians were applied in their calculation of the military advantage of the attack. Collateral damage occurs to a person or civilian asset in the immediate vicinity of a military target. That is, the target is legitimate under international humanitarian law, and that person or civilian asset is simply in the wrong place at the wrong time, becoming part of a group identified as military. However, bombing cities is a war crime when civilians and combatants cannot be differentiated from each other, as is often the case. Indeed, rebel bases are not usually located in isolated places and, in the contexts we are concerned with, many insurgents live and operate in densely populated neighbourhoods. It is not about *civilians in military environments* but, at best, about *combatants in civilian environments*. Moreover, in the case of hospitals it would be, if there were any, *wounded (former) combatants in civilian environments*.

A possible justification for collateral damage that could also resolve the issue of intentionality is that the harm to civilians is subordinated to the military advantage. It is not without precedent.[64] An explanation, halfway between collateral damage and intentionality, would argue that, in the medium term, making living conditions unbearable for people would reduce popular support for the rebels and survival of the fittest would be adopted as a lesser evil. This practice is not new either.[65] Today, there is no shortage of strategists and military analysts who attribute similar strategies to the parties in the wars we are concerned with, although they are careful not to express these views publicly. Another argument that blurs the boundaries between the intention and the lesser evil would argue that, in the short term, the strategic military value of targeted killings is worth the death of many innocents or the violation of the protection status of a hospital. The opportunity to strike the enemy's vehicle in Abs would have been the justification that made, in the eyes of the pilot or whoever ordered the attack, the loss of 19 lives justifiable.[66]

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64 For example, during the Iraq invasion, the authorisation of the US secretary of defence, Donald L. Rumsfeld, was required by US air force commanders whenever an air raid would cause the deaths of more than 30 civilians. More than 50 attacks were proposed, and all were approved. Gordon, Michael R. (2003), "After The War: Preliminaries; US Air Raids in '02 Prepared for War in Iraq", *The New York Times*, 20 July.

65 For example, in May 1999, lieutenant general (three stars) Michael Short, head of the NATO air force in Kosovo, acknowledged that the suffering of the civilian population was a target of the bombing, and said: "I think no power to your refrigerator, no gas to your stove, you can't get to work because the bridge is down – the bridge on which you held your rock concerts – and you all stood with targets on your heads. That needs to disappear at 3 o'clock in the morning." Gordon, Michael R. (1999), "Allied Air Chief stresses Hitting Belgrade Sites", *The New York Times*, 13 May.

66 However, the JIAT's internal investigation claims that the pilot did not know that the compound bombed was a functioning hospital, despite the fact that MSF had shared GPS coordinates and the hospital was visibly identified.

International humanitarian law justifies, to some extent, this subordination, provided that *proportionality* and *precaution* are respected in the attack. The problem is that the criteria for evaluating them or for identifying targets is confusing and, ultimately, falls on the technical judgement of the experts, that is, the military strategists[67] – judges of their own potential violations, and therefore hardly perceived as impartial. An army will rarely recognise an excess, and will never publicly admit that civilians are a war target. Bombing a city and its hospitals is rarely a "mistake", but rather a premeditated action, and no matter what precautions are taken, it is doubtful that objectives can be attained without indiscriminate damage. In addition, some of the technological precision about which the military boasts is a chimera. Many products are advertised competitively and are tested without taking into account personal factors (such as motivation, stress or fatigue) and environmental factors (such as weather, wind or crowded environments) which make up the reality of armed conflict.[68,69] In addition, in the wars in Syria, Yemen and Afghanistan, a number of organisations have reported the use of weapons that cannot differentiate between civilians and combatants (including incendiary bombs or cluster munitions, among others).[70] When using these weapons, there is clearly no intention (or capacity) to be accurate.

Uses and abuses of the rules and laws of war (justification of attacks)

The two pillars of international humanitarian law are the differentiation between civilians and combatants and proportionality in attacks. In addition, the principles of necessity and precaution in attacks are complementary to these pillars. Today, there are at least three elements that are being used to dilute and relativise the importance of adhering to these principles: the first, the designation of a wide area as hostile, by purposely underestimating or denying the presence of civilians,

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67 Gordillo, José Luis (2008), *Nostalgia de Otro Futuro. La lucha por la paz en la posguerra fría*, Trotta: Madrid, p. 130.

68 By way of example, the manufacturers of the M85 cluster munitions (equipped with a high-tech self-destruct mechanism) insisted at the time that they guaranteed a margin of error for their bomblets (that is, the likelihood of not exploding and remaining active with an impact similar to anti-personnel mines) of below 1%, and even in some cases of 0.06%. However, studies in southern Lebanon showed that the margin of error for the M85 used by Israel was, in reality, around 10%. King, Colin (2007), "M85. An analysis of reliability", Norwegian People's Aid.

69 It should be remembered that all assessments made in the article are the author's own. MSF takes no position on these issues.

70 For instance, according to Human Rights Watch, incendiary weapons have recently been used in Syria, Yemen and Iraq. According to the Cluster Munition Coalition, cluster munitions have recently been used in Syria and Yemen, while they affirm the US used them in Afghanistan in 2001-02. See, respectively, "Time to Act against Incendiary Weapons", Human Rights Watch, 12 December 2012 (available from: https://www.hrw.org/news/2016/12/12/time-act-against-incendiary-weapons) and "Use of cluster bombs", Cluster Munition Coalition (available from: http://www.stopclustermunitions.org/en-gb/cluster-bombs/use-of-cluster-bombs/a-timeline-of-cluster-bomb-use.aspx).

or labelling them as "terrorists" or "hostiles"; the second, the abuse of the concept of self-defence on the part of whoever carries out an offensive; and the third, resorting to special forces with broad powers to fulfil the objectives entrusted.

The partial release of the non-independent investigation by the US regarding its attack on the Kunduz hospital revealed that US ground troops assumed that "all civilians have fled and only Taliban remain in the city" and that "everything is a threat".[71] Under these circumstances, it is obvious that someone could interpret it is not necessary to differentiate civilians that do not exist, increasing the relevance of the need for the attacks or greatly affecting the assessment of proportionality. However, in Kunduz, many civilians remained in the city. Kunduz is the seventh largest city in Afghanistan in terms of population, and in 2014-15 it had between 224,078 and 268,893 inhabitants.[72] It is difficult to find examples of cities that have been completely abandoned by the civilian population, and even more so for cities of more than a quarter of a million inhabitants. Nevertheless, this assessment was not questioned by the US military high command nor was it deemed necessary to double-check if the population had indeed fled. Although MSF repeatedly communicated its activities at the hospital in Kunduz, neither its workers nor its patients (obviously all with protected status) were apparently considered. In Afghanistan, it is easy to conclude after reading the US army's own partially released report that the United States did not take the necessary precautionary measures to which it is duty bound.

In Syria, UN special envoy Staffan de Mistura said that history would judge Syria and the Russian Federation if they used the presence of some 900 ex-combatants of the former Nusra Front group (now called Jabhat Fateh al-Sham) as an "easy alibi" for destroying an area in which 275,000 people were surrounded, including 100,000 children.[73] Much like Kunduz, it appears that eastern Aleppo had also been identified as hostile in its entirety.[74] Even though the Syrian-led coalition had not explicitly declared the area a hostile zone in public, many statements and actions seem to suggest that this was the way the coalition dealt with the besieged

71 On page 256 of the US report.

72 Government of the Islamic Republic of Afghanistan (2015), *State of Afghan Cities 2015*, GoIRA: Kabul, p. 12.

73 "U.N. envoy offers to escort rebels out of Aleppo", Reuters, 6 October 2016.

74 Russia has justified its military campaign in Syria in terms of fighting terrorism. At its onset on 30 September 2015, Sergei Ivanov, Russia's then chief of staff of the Presidential Administration and previously minister of defence and first deputy prime minister, stated that Russia's military involvement in Syria "is not about reaching for some foreign policy goals, satisfying ambitions, which our Western partners regularly accuse us of. It's only about the national interest of the Russian Federation" (...) "the military goal of the operation is strictly to provide air support for the [Syrian] government forces in their fight against Islamic State". See "Russian parliament unanimously approves use of military in Syria to fight ISIS", *Russia Today*, 30 September 2015. Available from: https://www.rt.com/news/317013-parliament-authorization-troops-abroad/.

part of the city (maybe not in April 2016, when Al Quds hospital was attacked, but more so after the siege became effective in July 2016). Nonetheless, one of the surest ways to avoid killing civilians and obtain carte blanche for the methods used to combat the enemy is to force people to leave the city, although this measure clearly contravenes international law.[75] Thus, in Syria, President Assad declared that his armed forces warned civilians of attacks "so that they can get out of there".[76] In Yemen, the military coalition led by Saudi Arabia made a leaflet drop, giving civilians just a few hours to leave Sa'ada after it had declared the entire province a military target. Sa'ada governorate borders with Saudi Arabia and is a bastion of the Houthis, a group designated as terrorist by Riyadh.[77] MSF responded with a public statement saying that the bombing of civilian targets, with or without prior notice, constituted a serious violation of international humanitarian law. In addition, it warned that it was not possible for all people to leave the province in just a few hours: many had no means of transport or fuel owing to the coalition blockade, and many others had not heard about the warning because the telephone network was not working well.[78] It is paradigmatic that three of the five attacks on medical services supported by MSF in Yemen took place in Sa'ada, a governorate expressly categorised as a military target in its entirety. Months earlier, on 5 February 2016, the Saudi embassy in London had already advised the UN and other aid organisations to move their offices and personnel outside the "regions where the Houthi militias and their supporters are active and in areas where there are military operations" in order to "protect the international organisations and their employees".[79] Although these are by no means new practices,[80] the silence and the absence of condemnation that go hand in hand with these initiatives contravening the rules of war are deafening.

Regarding self-defence, the right to defend oneself is in general a recognised right that is limited by the UN Charter.[81] However, the concept is often used and abused claiming that the mere possibility that someone has a motivation and a desire to fight you can be interpreted as an imminent armed attack. Fifteen years ago, the

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75 While evacuation of a besieged city is authorised by IHL, forced displacement is forbidden.

76 "Syria's Assad says to keep fighting until rebels leave Aleppo", BBC Monitoring Middle East, 6 October 2016.

77 "Arab coalition warns Yemenis to leave Saada province", *Al Jazeera*, 9 May 2015.

78 "MSF Statement in Response to Latest Yemen Offensive", MSF, 8 May 2015. Available from: http://www.doctorswithoutborders.org/article/msf-statement-response-latest-yemen-offensive

79 Human Rights Watch (2016), "Yemen: Saudi Warnings No Free Pass to Attack", 17 February. Available from: https://www.hrw.org/news/2016/02/17/yemen-saudi-warnings-no-free-pass-attack

80 Let us recall the context of the Digfer hospital bombing in Mogadishu in 1993. In the Somali capital, there had been a mass evacuation of humanitarian workers and of the UN at the express request of the UN spokesman who warned that substantial collateral damage was expected. Tanguy, Joëlle (1993), *Op. Cit.*

81 The right of defence is recognised when the attack has already occurred and there is evidence of a recurrence or when there is evidence that this attack is imminent.

then US president George W. Bush used the notion of *preventive defence* to justify military aggression against Afghanistan,[82] according to an interpretation of *jus ad bellum* that was both unique and controversial – and illegal according to some authors.[83,84] Today, that same interpretation is being used to limit application of *jus in bello*, or international humanitarian law, with the difference that now some claim that the defence is taking place *while* carrying out an offensive, and that the obligations of precaution and proportionality are not properly observed. That is to say, an invocation of the right to defend oneself from an attack from others who in turn appeal to their own right to self-defence after a pre-emptive attack launched by the former. That way, the party will always be able to defend itself *preventively* from an attack that might happen in the future. This is not the right of defence, but typical war dynamics. In this vicious circle, in the case of Kunduz, it was understood that what mattered was not that there was no hostility coming from the MSF hospital, but that it could happen in an environment labelled in its entirety as hostile. Since the hostility was asserted, the warning of loss of protection status was not effected. Thus, the attack on the MSF hospital was justified by a US commander on the ground by invoking self-defence.[85] When the AC-130 crew raised doubts about the target and requested confirmation for the shot, the answer they received was "self-defence".[86]

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82 As stated by the US permanent representative to the UN John D. Negroponte in his letter dated the same day of the US attacks, addressed to the president of the Security Council, "US armed forces have initiated actions designed *to prevent* and deter further attacks on the US" (emphasis added), UN document S/2001/946, 7 October 2001.

83 Including well-known legal experts such as jurist Baltasar Garzón and Professor Marjorie Cohn. See Garzón, Baltasar (2001), "La respuesta", *El País*, 2 October; and Cohn, Marjorie (2001), "Bombing of Afghanistan Is Illegal and Must Be Stopped"*, Int'l Rev. Contemporary* L. 51. See also Williams, Ryan T. (2012), "Dangerous Precedent: America's Illegal War in Afghanistan", *University of Pennsylvania Journal of International Law*, Vol. 33, No. 2; and Bhagwat, Niloufer et al (2002), *Military Intervention in Afghanistan*, special edition, International Association of Democratic Lawyers, http://www.iadllaw.org/en/node/168. However, many other authors defend the legality of the war on Afghanistan.

84 A military operation against another state can only be legal if it is expressly authorised by the UN Security Council (UNSC) or it is an act of legitimate defence. Authors with a critical approach to Operation Enduring Freedom claim that no UNSC resolution was issued and that, while Article 51 of the Charter of the UN was invoked, certain self-defence principles where not met, such as: a) necessity (danger of further attacks), as the US response took place 26 days after the original attack, which in their opinion would make it more an act of reprisal than of defence; b) provisionality (when the UNSC takes measures, the right to a unilateral defence ceases), as there were resolutions passed soon afterwards that constituted action by the UNSC (including the authorisation for ISAF) and the US could not continue arguing that it was still defending itself after several years; and c) proportionality (defensive attacks launched against those carrying out the original attacks), as even if the connection between the 9/11 attacks, Bin Laden and the Taliban were clearly proven, providing support or sanctuary is not the equivalent of an armed attack, according to the 1986 finding by the International Court of Justice, which stated that US support for *the Contra* rebels was not the equivalent of an armed attack against Nicaragua.

85 The US claims that neither the aircrew nor the ground forces knew that the target was in fact a hospital.

86 According to the part of the US internal investigation that has been made public.

The third factor is related to the participation of special forces with broad powers. Some of the attacks against MSF-run or MSF-supported hospitals have reportedly been conducted by intelligence-driven units.[87] Some of these elite military groups share at least four characteristics, all derived from the "unconventional" nature of their techniques and modes of employment. Firstly, air force pilots can make difficult decisions without requiring confirmation by higher ranks. Secondly, special operations are secret, and are not subjected to parliamentary control. This means that no real accountability is possible. Thirdly, they are often provided with immunity from foreign legal prosecution for the military actions carried out abroad[88] and some kind of de facto domestic immunity, as pilots are favoured by the said secret nature of their missions. Consulted military experts claim that the details of any aerial incursion can be immediately known, as everything is computerised. However, internal investigations often intentionally take several months to be completed, rarely with significant consequences for the perpetrators.[89] Finally, these elite bodies are often subject to the pressure of fulfilling the mission that has been entrusted to them. These operations can have a predetermined objective or may allow a pilot to pursue a target dynamically (in other words, a decision emerges as a reaction to a specific situation encountered, and might be at the discretion of the pilot). The difference between the two is obvious, a planned operation allows for more deliberation time as well as the verification of coordinates of protected places (such as hospitals).[90,91] Returning from a special mission empty-handed (for example, after having aborted it as a precautionary measure) may be perceived as a failure both by those who set the objective and those who carried out the mission. The fog of war and the rush of adrenaline can obscure the conditions of decision-making, in particular when combined with factors such as stress or tension. This pressure to meet the designated objectives is of special concern, particularly when considered alongside the first three characteristics above and the designation of hostile zones, as they enhance the "everything goes" logic. Special operations are increasingly conducted by autonomous robots or remote-controlled mobile robots, such as unmanned aerial vehicles or drones which are already used in various activities in intelligence,

87 Special operations are generally backed by aerial forces. NATO defines special operations as (emphasis added): "military activities conducted by specially designated, organized, selected, trained and equipped forces *using unconventional techniques and modes of employment*". Other organisations and countries use similar definitions. See North Atlantic Treaty Organization (2014), "NATO Glossary of Terms and Definitions (English and French)", reference AAP-06 (Edition 2014). Brussels, NATO Standardization Agency (NSA). Available from: http://wcnjk.wp.mil.pl/plik/file/N_20130808_AAP6EN.pdf

88 This measure may also apply to *regular* forces – not just *special* ones – deployed in foreign countries.

89 This was the opinion of experts interviewed for this article, including a 4-star air force general and a combat aircraft pilot.

90 However, there are mechanisms other than GPS coordinates for determining the nature of objectives. Among others, high-tech precision cameras that enable the identification of individuals from high altitude.

91 GPS coordinates can also be requested and provided while in air.

surveillance and military strikes. The electronic and unmanned involvement in the targeting process entails a number of failures for which today there is a complete vacuum of legal responsibility. In future wars, the use of these machines will be extensive, bringing a wide variety of additional concerns.

The own interpretation of the laws of war

In June 2015 the US Department of Defense published its *Laws of War Manual,* a handbook of more than 1,200 pages.[92] Some of its content has been interpreted as controversial and eventually putting the lives of medical personnel unnecessarily at risk.[93] It is worth highlighting certain extracts of interest in the context of this article and providing an interpretation.[94] Other domestic manuals from other countries also include content deemed worrying from a humanitarian perspective, but there are two reasons why this particular manual has been used here: a) it is a manual made public and commented upon by law experts, all easily available online, and b) because the US has "so much practical experience in warfighting" and other countries may "find it to be the most influential document of its genre".[95] And also because other states may be licensed by the US interpretation of the guiding law.[96] The section and pages in the manual are indicated in each verbatim text and emphasis in italics is added by the author.[97,98]

92 Updates of the manual were published in May 2016 and December 2016.

93 See Hathaway, Oona (2016), "The Law of War Manual's Threat to the Principle of Proportionality", Just Security, 23 June. Available from: https://www.justsecurity.org/31631/lowm-threat-principle-proportionality/

94 The very same text may be interpreted in different ways, even amongst legal experts. For instance, the manual clearly states that "in some cases, the United States and other States have not accepted the ICRC's proposals or interpretations and instead expressed opposing views" (pp. 179 and 1175-1176). This is usual wording and state practice regarding international customary norms, in order to ensure that they cannot become legally binding on them. They are therefore judges of their international legal commitments and their own violation of such commitments. In certain cases, this means interpretation of the law as per own interest. All in all, interpretation by the ICRC is not imperative.

95 Dunlap Jr, Charles J. (2016), "The DoD *Law of War Manual* and its Critics: Some Observations", *International Law Studies*, Vol. 92, pp. 117-118. Available from: http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=6261&context=faculty_scholarship

96 Hathaway, Oona (2016), *Op. Cit.*

97 All page numbers referred in Table 4 correspond to the manual: Office of General Counsel, Department of Defense (2015), *Department of Defense Law of War Manual*, June, Washington DC, US Department of Defense. Available from: http://www.defense.gov/Portals/1/Documents/pubs/Law-of-War-Manual-June-2015.pdf

98 In all cases except in the first point, the text in the updated versions of the manual coincides with the original text, whilst in certain cases the number of the section differs and very slight changes have been made that do not affect the logic.

Section from Manual, verbatim quotes and pages	Interpretation by the author
7.8.2.1 *Incidental Harm Not Prohibited.* The incidental killing or wounding of such [medical and religious] personnel, due to their presence among or in proximity to combatant elements actually engaged by fire directed at the latter, *gives no just cause for complaint.* Because medical and religious personnel are deemed to have accepted the risk of death or further injury due to proximity to military operations, they need not be considered as incidental harm in assessing proportionality in conducting attacks. (p. 436) [The section was modified in subsequent updated versions of the manual after having received strong criticism][99]	This section has been criticised by certain legal experts.[100] Oona Hathaway concluded that it "is not well supported and, indeed, it may put the lives of medical and religious personnel — like those of the MSF doctors I spoke to — unnecessarily at risk. Indeed, taken to its logical conclusion, it threatens to eradicate proportionality as a condition of lawful military targeting altogether (...) So if the 'assumption of risk' is sufficient to disqualify a civilian from consideration in a proportionality analysis, then *any civilian in the vicinity of a military object no longer counts for purposes of a proportionality analysis.*"[101]
5.3.3.2 *What Precautions Are Feasible.* The standard for what precautions must be taken is one of due regard or diligence, *not an absolute requirement to do everything possible.* (...) These circumstances may include: • the effect of taking the precaution on mission accomplishment; • whether taking the precaution poses a risk to one's own forces or presents other security risks; • the likelihood and degree of humanitarian benefit from taking the precaution; • the cost of taking the precaution, in terms of time, resources, or money; or • whether taking the precaution forecloses alternative courses of action.[102] (pp. 189-191)	While the USA has accepted the principle that all practicable precautions must be taken to minimise incidental harm, the considerations described "will have the practical effect of allowing U.S. commanders to regularly decide that precautions are unnecessary, since any significant measure to protect civilians is likely to require acceptance of some increased risk of mission failure or harm to friendly forces."[103]
7.3.3.2 *Search and Other Security Measures Not Prohibited.* 7.3.3.3 *Capture of Wounded, Sick, and Shipwrecked Not Prohibited.* (...) It is not prohibited to capture the wounded and sick, even if they are in the care of military medical units or facilities, or civilian hospitals. (p. 419) 7.8.2.2 *Search and Other Security Measures Not Prohibited.* Medical and religious personnel are not immune from search or other necessary security measures by the enemy. (...) 7.8.2.3 *Capture Not Prohibited.* The respect and protection afforded medical and religious personnel do not immunize them from detention.[104] (p. 436)	These initiatives may deter people from seeking care at medical facilities, as well as pose a threat to their perception as being neutral (and protected). They may be contrary to IHL, as it clearly recognises the protection of the wounded and sick. Whilst the US has not signed the additional protocols to the Geneva Conventions, the search and capture initiatives may jeopardise humanitarian action.
5.5.3.2 *AP I Presumptions in Favor of Civilian Status in Conducting Attacks.* (...) Under customary international law, no legal presumption of civilian status exists for persons or objects, nor is there any rule inhibiting commanders or other military personnel from acting based on the information available to him or her in doubtful cases. (p. 197)	This section expressly denies API Article 50(1).[105] According to certain authors[106] and also acknowledged by the US in their investigation into the airstrikes on MSF's hospital in Kunduz[107], the people responsible for the attack should have presumed the MSF Trauma Centre to be a civilian compound, but they did not.
5.7.7.3 *Definite Military Advantage* (...) The military advantage expected to be gained from an attack might not be readily apparent to the enemy or to outside observers because, for example, the expected military advantage might depend on the commander's strategy or assessments of classified information. (p. 213)	The assessment of proportionality and precaution is made by the military, but it is only at the stage of investigation that these elements can be disclosed. As this element in investigations is rarely made public, independent scrutiny is made impossible.

99 The new text for this section: "the incidental killing or wounding of such personnel, due to their presence among or in proximity to combatant elements actually engaged by fire directed at the latter, gives no just cause for complaint. Medical and religious personnel are deemed to have accepted the risk of death or injury due to their proximity to military operations. Although the presence of medical and religious personnel does not serve to exempt nearby military objectives from attack due to the risk that military medical and religious personnel would be incidentally harmed, feasible precautions must be taken to reduce the risk of harm to military medical and religious personnel". Office of General Counsel, Department of Defense (2016), *Department of Defense Law of War Manual, June 2015 (Updated December 2016)*, Washington DC, US Department of Defense, pp. 458-459.

100 Professor Oona Hathaway argues, with regard to this section, that there is "exactly *one* source in the Manual for the extraordinary proposition that medical and religious personnel need not be considered for purposes of proportionality analysis. That source was, like the Manual, authored by the US military, and it discusses the topic for two sentences without any citation". See Hathaway, Oona (2016), *Op. Cit.*

101 Hathaway, Oona (2016), *Op. Cit.*

102 "For example, if a commander determines that taking a precaution would result in operational risk (i.e., a risk of failing to accomplish the mission) or an increased risk of harm to their own forces, then the precaution would not be feasible and would not be required." (p. 191).

103 Glazier, David; Colakovic, Zora; Gonzalez, Alexandra and Zacharias Tripodes (2016), "A critical assessment of the new department of defense law of war manual", Loyola Law School, Legal Studies Paper No. 2016-35. Available from: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2868016

104 The section also adds that "however, certain classes of medical and religious personnel are, under other rules, exempt from detention or capture". However, MSF and other international humanitarian organizations are not exempted in the Manual from detention or capture. See the criteria used in section 7.9.1.1 Medical and Religious Personnel Who Are Exempt From Capture and Detention.

105 Art. 50 (1): "A civilian is any person who does not belong to one of the categories of persons referred to in Article 4A 1), 2), 3) and 6) of III GC and in Article 43 of AP I. In case of doubt whether a person is a civilian, that person shall be considered to be a civilian."

106 See, for instance, Glazier, David et al. (2016), *Op. Cit.*; also Hathaway, Oona, Lederman, Marty and Michael Schmitt (2016), "Two lingering concerns about the forthcoming Law of War Manual amendments", Just Security, November 30. Available from: https://www.justsecurity.org/35025/lingering-concerns-forthcoming-law-war-manual-amendments/

107 "(...) The GFC [Ground Force Commander] and the Aircraft Commander failed to identify the MSF Trauma Center as a lawful target. Therefore, it should have been presumed to be a civilian compound. The GFC never positively identified that the intended target building did not contain civilians, and that the persons identified or the targeted building were committing a hostile act or demonstrating hostile intent. The aircrew never had positive identification." Commander, US Forces Afghanistan, "Investigation Report of the Airstrike on the Médecins Sans Frontières/Doctors Without Borders Trauma Center in Kunduz, Afghanistan on 3 October 2015", p. 59, point 113 g(2). Available from: http://fpp.cc/wp-content/uploads/01.-AR-15-6-Inv-Rpt-Doctors-Without-Borders-3-Oct-15_CLEAR.pdf

5.7.3 *Objects That Are Military Objectives* (…) The term 'military objective' means combatants and those objects during hostilities which, by their nature, location, purpose, or use, effectively contribute to the war-fighting or war-sustaining capability of an opposing force. (footnote 144, p. 206) 5.7.6.1 *Nature, Location, Purpose, or Use.* (…)The location of an object may provide an effective contribution to military action. For example, during military operations in urban areas, a house or other structure that would ordinarily be a civilian object may be located such that it provides cover to enemy forces or would provide a vantage point from which attacks could be launched or directed. (p. 209) Purpose means the future intended use of an object while 'use' means its present function. (note 157, p. 209)	According to a review by the Loyola Law School of Los Angeles (USA), "an otherwise civilian object can become a legitimate object of attack if put to actual military use" (…), but "the manual goes much further, suggesting that (…) a civilian object located so that it '*would provide* a vantage point *from which attacks could* be launched or directed' might be attacked, without any explicit requirement for a showing that the enemy is actually making, or at least preparing to make, such use". The purpose definition "dramatically expands this notion from 'intended' to 'possible use in the future'." They conclude that "almost any object could be articulated to have *some* possible future military use, very little – if anything – would be 'off limits' to attack under the manual's approach."[108]
5.20 Starvation is a legitimate method of warfare. (p. 291) 5.20.2 (…) Military action intended to starve enemy forces, however, must not be taken where it is expected to result in incidental harm to the civilian population *that is excessive in relation to the military advantage anticipated* to be gained. (p. 292) This rule [article 54 (2) of API][109] would not apply to attacks that are carried out for specific purposes other than to deny sustenance. For example, this rule would not prohibit destroying a field of crops to prevent it from being used as concealment by the enemy or destroying a supply route that is used to move military supplies *but is also used to supply the civilian population with food.* (p. 292)	Starvation is an authorised method of warfare against combatants, but IHL prohibits it against civilians in international (API Art. 54) and non-international (APII Art. 14) armed conflicts, and it is considered a war crime in international armed conflicts. IHL prohibits attacking or destroying food products, agricultural areas intended for the production of foodstuffs, crops, livestock, drinking water installations and supplies, as well as irrigation works, as they are indispensable to the survival of the civilian population (API Art. 54.2 and 54.4; APII Art. 14).[110] The manual prohibits starvation against civilians, but it opens the door to this option when justified by the "military advantage".
5.19.2 (…) A commander of an encircling force is not required to agree to the passage of medical or religious personnel, supplies, and equipment if he or she has legitimate military reasons denying such requests (e.g., *if denying passage may increase the likelihood of surrender of enemy forces in the encircled area)*. (p. 289)	The survival of a large number of civilians is subordinated to the military advantage. The warring parties are obliged to accept impartial humanitarian action,[111] also in besieged or encircled areas.[112] This section would represent a negative for MSF and other aid actors to provide humanitarian supplies.
17.8.1 State Consent for Humanitarian Organizations. The activities of relief organizations are subject to the consent of the State concerned. States may withhold consent for, *inter alia, legitimate military reasons,* but should not arbitrarily withhold consent. The safety of personnel of humanitarian organizations is a legitimate consideration for a government in consenting to their operations. (p. 1035)[113]	Humanitarian work cannot be blocked for no reason and indefinitely, but this is conditioned here by "legitimate military reasons". The absence of consent can block humanitarian organisations (even for their "own good") and allows for the criminalisation of their work. MSF may work without the authorisation of governments. For instance, the Syrian government has never authorised MSF to operate in the country and has criminalised in domestic legislation the provision of medical care to combatants and civilians in opposition-controlled areas.

Table 4. Sections from the US Laws of War Manual. Compiled by the author.

108 Glazier, David et al (2016), *Op. Cit.*

109 Under article 54 (2) of AP I, "it is prohibited to attack, destroy, remove or render useless objects indispensable to the survival of the civilian population, such as foodstuffs, agricultural areas for the production of foodstuffs, crops, livestock, drinking water installations and supplies and irrigation works, for the specific purpose of denying them for their sustenance value to the civilian population or to the adverse Party, whatever the motive, whether in order to starve out civilians, to cause them to move away, or for any other motive."

110 See Bouchet-Saulnier, Françoise (2002), *The Practical Guide to Humanitarian Law*, Rowman & Littlefield, 1st English edition, p. 103.

111 Articles 38 and 59 of the IVGC; article 70 in API; article 18 in APII.

112 The safe passage of medical personnel and material within, and on their way, to besieged and encircled areas is included in IGC (article 15), IIGC (article 18) and IVGC (article 17). See Bouchet-Saulnier, Françoise (2002), *Op. Cit.*, p. 374.

113 "In the past, armed groups have sometimes attempted to use humanitarian organizations as cover for participation in hostilities. In addition to legitimate military considerations, other considerations may also limit access by impartial humanitarian organizations to military operations." (pp. 177-178)

Reaction options

Should I stay or should I go?

In war contexts, security incidents related to crime or pillaging attacks are generally considered to be occupational hazards for an organisation like MSF that prioritises operations in some of the most violent parts of the world, given that suffering is particularly acute in those contexts. However, MSF cannot afford to take risks when it detects a repeated pattern concerning security incidents or threats. In this case, the organisation has no choice but to stop or adapt its operations. In Afghanistan, at the time of writing MSF is not working at the hospital in Kunduz – now destroyed – which was the only centre of its kind in the region. MSF maintains a presence in a district outside Kunduz city with a small team at a small clinic, monitoring the consequences of the attack on the hospital on the population and discussing with local authorities and the community the future for the organisation's activities in Kunduz. MSF also continues to work in other areas of the country (Kabul, Lashkar Gah and the province of Khost). In Yemen, the attack on Abs hospital was the fifth incident in almost a year and the deadliest, and led MSF to announce the withdrawal of its teams from the north of the country, where four of those attacks had occurred. MSF always intends to return to places with critical needs from which it has withdrawn and, following a reduction in the intensity of the offensive in northern Yemen, it returned to Abs in November 2016. In Syria, MSF is no longer working with its own teams in many places, such as in Aleppo.

MSF's internal investigations

When MSF suffers a serious security incident that affects its medical and humanitarian work, the organisation has a responsibility to determine internally the circumstances surrounding those events. Moreover, MSF denounces attacks on medical services and tries to draw attention to their impact on the population. In certain cases, MSF also feels that responsibility not only towards its own facilities (as in Kunduz) but also towards the hospitals it supports (such as Abs and Al Quds). In the latter case, MSF can feel legitimately entitled to publicly denounce the events and demand accountability when it has its own teams in the field (as in Abs) or when its own teams are not on the ground but a close, strong relationship has been cultivated with the staff of the supported hospital, and it knows the details of the hospital's activities. Since Kunduz, MSF has conducted internal investigations into all bombings of health centres directly managed by the organisation where it had teams on the ground. However, in other circumstances internal investigations have been rare. Al Quds was the exception. All three attacks analysed in this paper were followed by an internal investigation and the findings were made public.

Requesting independent investigations

For the first time, MSF turned to the International Humanitarian Fact-Finding Commission (IHFFC)[114] after the attack on the hospital in Kunduz. This mechanism had never been activated before MSF's request.[115] At the time of writing, there are three requests listed on its website. One for Afghanistan (Kunduz, attack of 3 October 2015), one for Yemen (Shiara hospital, Razeh district in Sa'ada governorate, attack of 10 January 2016, a different case to the one on Abs) and one for Syria (Ma'arat Al-Numan, Idlib province, attack of 15 February 2016). While the first two were requested by MSF, the third, concerning Syria, was proposed by the IHFFC itself.

MSF is very much aware that the IHFFC would not be able, even if it so wished, to respond to its request for clarification of the facts. The reluctance of governments to submit the conduct of their armies to external investigations is well known. The IHFFC can only work under the authorisation of the states involved and, in the case of Kunduz, MSF has not received an official response from the governments of the US or Afghanistan. Through unofficial channels, however, it has been hinted that the US would not submit to independent investigations and that its own internal inquiries were sufficient.[116] No official response has been received from Saudi Arabia either in relation to the request for an investigation of the attack on Shiara hospital in the Yemeni district of Razeh (Sa'ada). In the case of Al Quds, no one has publicly acknowledged the facts and none of the states whose actions may eventually be investigated will accept any attempt at clarification. Some attacks in Yemen have been investigated by the Joint Incident Assessment Team (JIAT), a mechanism of the Saudi Arabia-led coalition and, therefore, not independent.

However, although MSF values the publication of internal investigations by the parties concerned and also conducts its own inquiries, the organisation considers it essential to have an independent, thorough, credible and prompt investigation, not one in which the presumed perpetrators try to establish their own innocence.

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114 The IHFFC was established under article 90 of API, adopted in 1977. When parties to a conflict are accused of violating international humanitarian law, experts from the commission may investigate the allegations. Unlike a court, the IHFFC's remit is limited to establishing the facts: it does not issue verdicts. The commission informs the relevant parties of the results of its investigation and makes recommendations for improving compliance with, and implementation of, international humanitarian law.

115 At least, there is no record of any other request in the news archive of the IHFFC website. See: http://www.ihffc.org/index.asp?page=home&mode=newsarchive&start=0. It should however be noted that confidential requests can be made to the commission, so it could be that non-visible requests have been made.

116 Afghanistan's minister of defence, Masoom Stanekzai, has stated that his country would not support the type of investigation requested by MSF, saying that: "If you increase the number of commissions and investigating teams, that will make it more complicated instead of getting into the facts. Already there are three investigations; how many more do you need?" O'Donnell, Lynne (2015), "Afghan defense minister says Taliban hid in bombed hospital", AP, 19 October.

MSF has not received any official response since the cases of Kunduz and Shiara (Razeh) were referred to the IHFFC. Nor it is ever likely to receive one. The IHFFC has proven to be a toothless mechanism. By requiring the express approval of the investigated parties, it is fundamentally flawed, yet it is quite likely that this instrument would never have been allowed to be set up, had it not included this provision. As MSF's international president stated to the UN, another resource is needed and MSF called on parties to "immediately endorse and implement the Secretary-General's recommendations – in particular the call for dedicated mechanisms for independent, prompt and effective investigations into attacks on civilians and medical care."[117] This is exactly the need that MSF highlighted one year before by turning to the IHFFC after the attack in Kunduz. This formal request to the IHFFC increased the visibility of MSF's protest and put the parties responsible in a position where they had to respond to an international institution. In other words, even though MSF was always aware that the chances of an international investigation were slim, referring the cases to the IHFFC created a dynamic of accountability between MSF and the warring parties. Was it useful? The answer would depend on one's viewpoint and expectations. The IHFFC stated that the best thing that humanitarian organisations could do was to continue to record the incidents and request IHFFC investigations, and that the fact that investigations had not taken place did not mean that the IHFFC had not contacted the parties to the conflict and conveyed their concerns.[118] However, the author's feeling is that, at worst, requesting investigations from the IHFFC is useless. At best, these requests can serve to draw attention to the incidents and, perhaps, to take advantage of the IHFFC's political advocacy powers, whatever they might be. However, this is something that, owing to the confidential nature of the contacts, we will never know. MSF considered contacting the IHFFC after the attack on Abs hospital, but decided not to formally submit a request for investigation as it was understood from previous exchanges with the IHFFC that the incident could be included under the umbrella of the first request (Shiara hospital). Further, discussions with the Saudi-led coalition were in progress and it was deemed unnecessary to add additional public pressure. In the case of Al Quds, MSF offered to mediate with the international institution, but the hospital itself decided not to pursue the issue as it was not seen as something that would yield immediate results.

One of the lessons learned by MSF regarding requests for independent investigations is that the different actors and mechanisms do not work at the same tempo. When MSF asks for clarification of the facts, it does not seek justice but rather concrete improvements from an operational standpoint. The organisation needs to know what the dysfunctions were and what commitments the warring

117 "Dr Joanne Liu Address to United Nations Security Council Regarding Hospital Attacks", MSF, 28 September 2016. Available from: http://www.doctorswithoutborders.org/article/dr-joanne-liu-address-united-nations-security-council-regarding-hospital-attacks

118 As explained by the then IHFCC's first vice-president, Thilo Marauhn, at the Humanitarian Congress Berlin in October 2016. Interview with an MSF staff member who attended the event.

parties will make in order to correct them. Even if governments and armies were to consent to independent investigations, the international mechanisms are often designed to obtain results that, at best, may only lead to a change in military behaviour in the long term. In this sense it may, perhaps, be useful for future wars. However, MSF needs quick and reactive investigations that produce results in real time, and that allow the continuation of medical and humanitarian activities. It is for this reason that the organisation is calling for an effective and prompt mechanism. Yet it is not for MSF to determine whether that should involve the remodelling of the IHFFC or setting up an alternative. What is clear is that for anything to have a real impact, strong political commitment would be necessary, and this is not something that seems very likely in the current climate.

Renegotiation of the protection of medical services

International humanitarian law is very explicit regarding the protection of medical personnel and units. However, MSF has reached the conclusion that in some scenarios the laws of war, clear as they may be, do not protect the organisation and MSF must assume a *de facto* disregard of its protected status. MSF believes that, in some places, the fundamental principle of protection for medical personnel and services is blatantly disrespected, and the treatment of wounded combatants arouses feelings of suspicion in the other side. The effective protection of medical facilities therefore requires explicit and contextualised negotiations. This is what MSF does in many places, in constant dialogue with all actors over the rationale behind respecting not only hospitals, but medical services as a whole.

MSF continues to implement its policy of keeping hospitals free of weapons,[119] to ensure that there are no meeting places for armed groups in their immediate vicinity and to prevent combatants from using medical facilities as refuges for temporary rest. Whilst not an MSF policy but a measure taken in certain locations, MSF has also banned the use of mobile phones for wounded combatants, thereby preventing them from continuing to operate from the hospital. In addition, MSF has made sure it secures regular contact with armed parties and has strengthened the communication of information regarding the activities it carries out and the identification and location of medical facilities. Negotiating the humanitarian space is a continuous process and not just a one-off deal. Taking the example of Yemen, the Saudi-led coalition was quick to demonstrate its willingness to discuss the circumstances surrounding the attack on Abs hospital, whereas in the past it would have been very difficult for the

119 International humanitarian law requires that hospitals are free from all weapons carried by the wounded, the sick and their carers. It only allows medical staff to carry personnel small weapons for their self-defence, but this is not MSF practice.

organisation to have this contact.[120] With the Houthis, there has been sustained communication regarding the need to ensure that the protected status of medical facilities is not jeopardised. In addition, MSF also contacted close allies of the Kingdom of Saudi Arabia (the UK and the US) in relation to the attack on Abs. In Afghanistan, MSF has renegotiated its humanitarian space with the Afghan and US governments.[121]

Future challenges

Security conditions for humanitarian action have worsened in contexts where the fight against terrorism is a defining element of the conflict (Syria, Yemen, Afghanistan, Somalia, Iraq, Nigeria, Mali, etc.). In such areas, the risk of death or kidnapping for MSF employees is now much higher than it was just a few years ago, particularly for those whose nationality offers greater political opportunities. Therefore, MSF is increasingly forced to make painful choices. For the organisation, the proximity of its employees and the use of staff external to the conflict are important components of its work. In some of these scenarios, such as in Syria, security conditions are so extreme that MSF cannot even work with its own personnel in many locations and the few hospitals it can still run through national staff close to the Turkish border are not accessible to international staff.[122] The options are often reduced to working through partnerships with other medical actors.

The fact that the organisation is not physically present significantly challenges two of the organisation's main pillars. One is adherence to humanitarian principles. In war contexts, some local medical workers may struggle to embrace the principles of neutrality (by benefiting one of the parties), impartiality (by favouring or refusing to treat certain patients) and independence. This may be intentional (because of the grievances and traumas experienced, or out of sympathy for one of the parties) or coerced (because of pressure from armed groups and other power groups). It is well known that the protection of medical services is determined less by the text of international humanitarian law and more by the perception of the parties in conflict, and failure to adhere to the principles may lead to a *de facto* rejection of the protected status of medical personnel and units. It is crucial to explain and convince health workers of the positive impact

120 It took MSF nearly six months to secure meetings with the government of Saudi Arabia to discuss the attack on Shiara hospital in Razeh. However, the Abs incident was discussed within a month and the attitude of the Saudi authorities was noticeably different.

121 MSF has had discussions with the authorities of both countries at all levels (military, civil, political). In total, more than 80 meetings have taken place in Kunduz, Kabul and the US.

122 Syria is the most extreme case: the bulk of MSF's operations there are to support hospitals, without the organisation's physical presence, in up to 26 medical facilities in Aleppo and in more than 150 across the country.

and benefits of being consistent with those principles. The other pillar relates to *advocacy* and witnessing activities. MSF feels it can legitimately raise its voice (publicly or privately) about what its teams have witnessed. Without a presence on the ground, internal debates proliferate about MSF's responsibility to speak out and who deserves to be trusted. When an MSF-supported hospital where there are no MSF workers is bombed, MSF can neither directly confirm the details nor the consequences of the attack, thereby making advocacy difficult.

MSF has learned how to face major challenges with its own national and international staff, but when it has no direct presence, these challenges may significantly increase. This absence can be lessened through relationships cultivated over the years with local professionals and the ongoing monitoring of their activities. The case of al Quds is an example of an effective partnership based on long-term contact and trust. However, it should be recognised that when a relationship is newly established, determining the credibility of partners can become acts of faith. That said, the lack of alternatives for MSF to act otherwise and the imposition of measures aimed at minimising the risk of diversion of resources make the work viable.

The other big challenge is the impunity and increasing vulnerability of medical services in a context where the fight against terrorism may prioritise military advantage over protecting civilian populations. None of the hospital attacks that have occurred over the past year and a half have been investigated by an independent and impartial body. Examples where the self-confessed perpetrator has presented (only partially) the results of its inquiry are the exception. The norm is that the perpetrators will neither admit nor defend their own actions. In the case of Kunduz, the US investigation established an amalgam of technical and procedural errors and concluded that no one was deemed criminally responsible. In Yemen, the protected nature of an identified hospital was not sufficient reason for the attackers to take the precaution to which they are obliged and that could have avoided the death of civilians.

All in all, we should remember that it is not only for MSF to provide assurances so that a hospital is protected. That responsibility lies mainly with the parties to the conflict. If they believe that a facility has lost its protection, they should provide warning thereof. Even if belligerent parties consider that the conditions for that protection have been compromised, IHL stipulates that, beyond a warning, belligerent parties need to continue to observe the principles of differentiation between civilians and combatants, and proportionality and necessity. However, in the context of the fight against terrorism and in view of the statements that have proliferated throughout the recent wave of hospital bombings, it seems that hospitals themselves must take on the responsibility for ensuring their own protection. Not only must they be sensitive to the conditions of protection, but they must also be seen to be so, in contexts where perceptions are often as polarised as the people are.

In response to growing concerns over the wave of attacks on hospitals, the UN Security Council adopted a specific resolution in May 2016. Resolution 2286 strongly condemns attacks on medical personnel and services and calls on the parties to armed conflicts to comply with their obligations under international humanitarian law. The paradox was that some of those who committed to that resolution were the same states who either had attacked hospitals themselves or were militarily supporting unquestioningly certain allies who had done so. The lofty words used in the resolution have so far not been accompanied by concrete measures to reinforce the protection of medical facilities. The resolution entrusted the UN secretary general to recommend such measures to operationalise the resolution, but states have failed to endorse these practical recommendations.[123] This new resolution has so far been symbolic and rhetorical rather than effective for the protection of patients and humanitarians. Abs hospital, for instance, was bombed three months after the resolution was approved.

A total of 116 people died in the three attacks highlighted in this text. A larger number of people were injured and an indeterminate – but very high – number of people were deprived of access to health services in contexts where the medical needs were already massive and urgent. None of these people or their families were able to take legal action against the self-confessed or suspected parties responsible for their suffering, nor are they entitled to compensation for the damage caused, with Kunduz being a limited exception to the general practice.[124]

Conclusions

The main lesson learned by MSF is that dialogue with all the warring parties is essential in order to detect what elements may, in their opinion, lead to a perceived loss of the protected status of medical facilities. Many parties have shown a disregard for the provisions of international humanitarian law or interpret it in their own way. Certain actors see no contradiction in openly defending acts that would have been condemned without reservation until recently by public opinion. In terms of security for MSF, what the laws of war say is in practice less important than what the armed parties themselves think. Certainly, it has always been advisable not to take for granted the protection afforded by the legal frameworks. But having to envisage the option that a medical facility might be designated as a military target is an increasing concern for MSF.

123 In the session of the UN Security Council on 28 September 2016 regarding the recommendations of the Secretary-General on the implementation of resolution 2286, specific measures were proposed but not approved. The likelihood that they will be adopted in the future is slim.

124 In the case of Kunduz, the US military has made "condolence payments" to the families of the dead and to others who were in the hospital at the time of the attacks.

The wilful intent to attack a hospital is difficult to prove and we cannot know the motivations of those who pressed the button or gave the order. There are two possible conclusions after analysing the recent trends. The first recognises that hospitals have always been attacked during war, just like everything else. Before, however, people considered them to be among the safest places, but today, in Syria and Yemen, they identify them as targets. There is a tendency to justify these attacks, to consider them inherent to war with the purpose of diminishing responsibility. If in recent decades recourse to "collateral damage" has been normalised, now the mistake rhetoric has been added as a smokescreen for deliberate acts or negligence, violating international law and without the slightest compassion for people's misfortunes. But the normalisation of an action should not mean that it is excused or that it has lost its savagery. The second conclusion is that, in the context of the fight against terrorism, the warring parties are assessing the military advantage of their actions with a new scale that de facto diminishes the value of the protection of civilians. These days, the same attacks on hospitals that are explained away publicly as mistakes or collateral damage are regarded among belligerent parties as a justified lesser evil, because of the threat that they are fighting, and public opinion accepts it. The anti-terrorist doctrine thus generates a publicly accepted moral relativism and consequentialism that has no qualms about sacrificing civilians when targeting designated terrorists or, simply, the enemy. A crude reality that neither the belligerent parties nor those who arm, finance and support them have the courage to admit.

The outlook in the short term is daunting and the challenges are great. On the one hand, the rights and obligations of the parties to a conflict are increasingly flexible and dependent on their own point of view and interests. Interested interpretations of the provisions of international humanitarian law abound, and there is a worrying trend for practices such as designating entire populations as hostile, forcing evacuations of civilians to facilitate *total war* or claiming the right to self-defence *while* launching an offensive. On the other hand, the security challenges are growing in scenarios characterised by both terrorism and the fight against terrorism. In fact, the increasingly used rhetoric that "neutrality does not apply to terrorists" is more and more used to refer to "the enemy". MSF operations have been seriously affected and options to work with its own international (or even locally hired) personnel have been reduced, forcing the organisation to develop alternative and uncomfortable models of intervention that differ from its operational model. The exceptions will not become the rule, but will increasingly produce recurrent dilemmas for MSF and other humanitarian organisations. In addition, it is to be expected that the trend of impunity will continue in the areas where the mere mention of terrorism is a trump card over the rights of the people and the obligations of the warring parties. MSF will continue to insist on the need for independent, prompt and effective mechanisms to clarify the facts, and will persevere in maintaining the right to treat anybody who needs medical care, regardless of their identity or political or military affiliation. For MSF, investigations are a tool for facilitating discussions about what does not work in

order to correct it; they are not goals in themselves. In short, what interests MSF and other organisations is a real change in the attitude of warring parties that allows them to continue their work.

MSF has repeated to the point of exhaustion that "a war without limits leads to a battlefield without doctors."[125] The limits have proven to be flexible and changeable depending on the interests of the parties. The question is how much flexibility doctors can afford.

125 Stokes, Christopher (2016), *Op. Cit.*


MEDICOS
SIN FRONTERAS