

An environment conducive to mistakes? Lessons learnt from the attack on the Médecins Sans Frontières hospital in Kunduz, Afghanistan

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Abstract

On 3 October 2015, the Médecins Sans Frontières (MSF) Trauma Centre in Kunduz, Afghanistan was bombed during a US–Afghan joint military operation to retake the city. Even before that night, attacks on health-care facilities in war zones were already a worrying trend and a major concern for humanitarian organizations. Such attacks have led both MSF and the International Committee of the Red Cross (ICRC) to launch campaigns¹ addressing the need for greater protection of the medical mission in situations of armed conflict. Nonetheless, the scale and specific context of the attack on the Kunduz Trauma Centre have given rise to various specific investigations² and provoked many more questions that this article will explore. The article will delve into the “many mistakes” scenario that has been presented by the US investigation in order to critically analyze whether these mistakes may originate from either incorrect or biased interpretations or implementation of international humanitarian law.

Keywords: Afghanistan, Kunduz, Médecins Sans Frontières, IHL principles, attacks on health care, international military coalition, counter-terrorism, identification, self-defence, United States.

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The need to strengthen commitments to the protection of the health-care mission is evident in the fact that in 2016 alone, four out of five permanent members of the United Nations (UN) Security Council were involved in military coalitions that conducted air strikes on hospitals in Yemen, Syria and Afghanistan.³

According to the Geneva Conventions, medical personnel and structures, as well as the wounded and sick, are protected and immune from attack and punishment.⁴ It is mandatory to provide medical care to all patients, without any

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1 The ICRC Health Care in Danger campaign was launched in 2011; see: <http://healthcareindanger.org/hcid-project> (all internet references were accessed in December 2018). The MSF Medical Care Under Fire campaign was launched in 2013; see: www.msf.org/en/article/medical-care-under-fire.

2 Following the Kunduz attack, four specific investigations were conducted: two domestic investigations (US and Afghan), a NATO (Resolute Support Combined Assessment Team) investigation and an internal MSF investigation. The results of the US investigation were temporarily made public: US Department of Defense, Army Regulation (AR) 15–6 Investigation, *Concerning a Potential Civilian Casualty Incident in Kunduz*, ordered on 17 October 2015, completed on 11 November 2015 and approved by the appointing authority on 21 November 2015 (AR 15–6 Investigation Report). The Afghan investigation, ordered by Presidential Decree No. 1348, 9 October 2015, was never made public (see Lynne O'Donnell, "Afghan President Orders Investigation into Fall of Kunduz" *AP News*, 10 October 2015, available at: <https://tinyurl.com/yaoo5fsh>); nor was the NATO investigation (see NATO, "Statement on the Kunduz MSF Hospital Investigation", 26 November 2015, available at: <https://rs.nato.int/news-center/press-releases/2015/statement-on-the-kunduz-msf-hospital-investigation.aspx>). The internal MSF investigation was made publicly available; see MSF, *Initial MSF Internal Review: Attack on Kunduz Trauma Centre, Afghanistan*, Geneva, 5 November 2015 (MSF Internal Review), available at: http://kunduz.msf.org/pdf/20151030_kunduz_review_EN.pdf.

3 See Human Rights Watch, "Hospitals, Health Workers Under Attack", 24 May 2017, available at: www.hrw.org/news/2017/05/24/hospitals-health-workers-under-attack; "At Least 11 Dead after Saudi-Led Coalition Bombs Yemen Hospital", *The Guardian*, 15 August 2016, available at: www.theguardian.com/world/2016/aug/15/saudi-led-air-strike-yemen-hospital-kills-at-least-seven; MSF, "MSF President to UN Security Council: 'Stop These Attacks'", 3 May 2016, available at: www.msf.org/en/article/msf-president-un-security-council-stop-these-attacks.

4 Medical personnel: Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950) (GC I), Arts 24–25; Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950) (GC II), Arts 36–37; Protocol Additional (II) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 1125 UNTS 609, 8 June 1977 (entered into force 7 December 1978) (AP II), Arts 15–16; Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law*, Vol. 1: *Rules*, Cambridge University Press, Cambridge, 2005 (ICRC Customary Law Study), Rules 25–26, available at: http://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul. Medical units: GC I, Arts 19–23; Geneva Convention (IV) relative to the Protection of Civilian Persons in Time of War of 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) (GC IV), Art. 18; Protocol Additional (I) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3, 8 June 1977 (entered into force 7 December 1978) (AP I), Arts 8(e), 12–14. Medical transport: GC I, Arts 35–37; GC II, Arts 38–40; GC IV, Arts 21–22; AP I, Arts 8(g), 21–31.

discrimination, to the fullest extent practicable.⁵ However, what the recent attacks on health-care facilities have demonstrated is that implementation of the international humanitarian law (IHL) protective framework has been both directly and indirectly impacted by the approach of the ever-expanding “war on terror” and more specifically by the increased intermingling of IHL and domestic security and anti-terrorist regulations which may not necessarily be in line with international law. It has also been affected by the increasing use of and reliance on aerial warfare by international military coalitions, coupled with the unconventional ground deployment of special forces to supplement, if not substitute, “regular” national armies, notably in Yemen, Syria and Afghanistan.

At a minimum, these mixed regulations create an environment that is conducive to mistakes, as was seen in the case of the bombing of the Médecins Sans Frontières (MSF) Trauma Centre in Afghanistan, which is explored in this paper. They may also result in the criminalization of the delivery of medical care in certain circumstances and allow some doctors and patients to be considered as “criminals” and as a threat to national security under domestic criminal law, in contradiction to IHL provisions forbidding the prosecution of medical personnel.⁶ Such situations are symptomatic of an overarching issue, especially in non-international armed conflicts (NIACs) – namely, the legal uncertainty surrounding the status and protection of non-governmental medical activities in areas controlled by non-State armed actors.

Although attacks on hospitals in Yemen, Syria and Afghanistan have more differences than similarities, there is a common factor in each. The States involved in these air strikes often justify their military actions as part of the fight against those labelled “terrorists”. These conflicts are also characterized by the involvement of international military coalitions comprised of multiple different military and security forces operating in the same territory yet under various command structures and according to different domestic rules incorporating varying interpretations of IHL. The national security imperative of the State is also

5 Respect for and protection of the wounded and sick: GC I and II, Art. 12; GC IV, Art. 3; AP I, Arts 10–11; AP II, Arts 7–8; ICRC Customary Law Study, above note 4, Rule 110.

6 General protection of medical duties – prohibiting, under any circumstances, the punishment of any person for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom: AP I, Art. 16.1; AP II, Art. 10.1. See Caroline Abu Sa’Da, Françoise Duroch and Bertrand Taithe, “Attacks on Medical Missions: Overview of a Polymorphous Reality: The Case of Médecins Sans Frontières”, *International Review of the Red Cross*, Vol. 95, No. 890, 2013, pp 327–329. See also Phoebe Wynn-Pope, Yvette Zegenhagen and Fauve Kurnadi, “Legislating Against Humanitarian Principles: A Case Study on the Humanitarian Implications of Australian Counterterrorism Legislation”, *International Review of the Red Cross*, Vol. 97, Nos 897–898, 2016, p. 246, n. 71, citing US District Court for the Southern District of New York, *United States v. Tarik Ibn Osman Shah, Rafiq Sabir and Mahmud Faruq Brent*, 474 F. Supp. 2d 492, 2007, to show that doctors providing medical support to Al-Qaeda were prosecuted and convicted under US domestic criminal law.

used – in some cases with the backing of the UN Security Council⁷ – to blur the limits of warfare set by IHL through the Geneva Conventions.⁸ Such prioritization of militarized law-and-order operations, often involving security and military actors from various countries, contributes to a blurring of the understanding of and respect for IHL and its relationship with the different legal concepts governing counterterrorism and national security.⁹

Aerial bombardment is not the only way in which the medical mission can come under attack in such an environment. Hospitals risk being part of the battlefield where State law-enforcement is given carte blanche to raid hospitals and “high-value” patients arrested or killed during “search and capture” operations. MSF is not the only medical organization to have experienced the full range of these attacks in Afghanistan or elsewhere.¹⁰ In addition to this, non-State armed actors have also been involved in incidents affecting health-care provision.

After decades of humanitarian practice, these events have raised fundamental questions for medical and humanitarian personnel. Are we running hospitals in war zones based on the same understanding of IHL as the various State armed forces that are waging these wars? What is at stake is the practicability of medical assistance to wounded and sick persons living in areas under the control of non-State armed groups. In other words, how can non-State armed groups maintain protected medical facilities under IHL while simultaneously being criminalized under domestic law?

The questions raised by the Kunduz incident echo far beyond the attack itself as humanitarian workers are increasingly confronted with environments in which States’ view of humanitarian aid (particularly the US view) has arguably shifted from that of contributing to legitimacy in stabilization operations to being seen by counterterrorism forces as an unacceptable benefit to a delegitimized enemy.

- 7 See, e.g., UN Doc. S/RES/1368, 12 September 2001, available at: www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/1368%20%282001%29; UN Doc. S/RES/1465, 13 February 2003, available at: www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/1465%20%282003%29.
- 8 For a primer on the protection of medical services under IHL, see: www.msf.org/article/primer-protection-medical-services-under-international-humanitarian-law. See also the entries on “Medical Personnel” and “Medical Services” in *The Practical Guide to Humanitarian Law* online, available at: <http://guide-humanitarian-law.org/content/article/3/medical-personnel/> and <http://guide-humanitarian-law.org/content/article/3/medical-services/>.
- 9 See, for example, Ellen Policinski, “Terrorism, Counter-Terrorism and IHL: Primer on a Recurring Conversation”, *Humanitarian Law & Policy*, 2 November 2016, available at: <http://blogs.icrc.org/law-and-policy/2016/11/02/terrorism-counter-terrorism-ihl/>; Laurie Blank, “Targeted Strikes: The Consequences of Blurring the Armed Conflict and Self-Defense Justifications”, *William Mitchell Law Review*, Vol. 38, No. 5, 2011; Geoffrey S. Corn, “Self Defense Targeting: Conflict Classification or Willful Blindness?”, *International Law Studies*, Vol. 88, No. 1, 2012.
- 10 See UN Assistance Mission in Afghanistan, *Afghanistan: Annual Report 2015: Protection of Civilians in Armed Conflict*, February 2016, available at: <https://unama.unmissions.org/sites/default/files/poc-annual-report-2015-final-14-feb-2016.pdf>. See also “Israelis in Disguise Raid Hebron Hospital, Seizing Suspect”, *BBC News*, 12 November 2015, available at: <http://www.bbc.com/news/world-middle-east-34801195>; “Three Killed as Afghan Forces Raid Swedish-Run Clinic”, *Al Jazeera*, 19 February 2016, available at: www.aljazeera.com/news/2016/02/killed-afghan-forces-raid-swedish-run-clinic-160219044441899.html.

The impartial delivery of medical treatment – including to those wounded who are considered “terrorist” enemies – is at stake. If impartiality is made impossible by counterterrorism regulations, then so too is principled wartime humanitarian action. Being forced to “choose sides” will come with a different set of risks for both patients and medical service providers.

The events of the night of 3 October 2015 and the immediate reaction from coalition and government representatives raise many questions about the future ability of MSF and other medical humanitarian organizations to continue providing impartial and independent medical care to all wounded people, including those belonging to non-State armed opposition groups, in the midst of an intense battle fought by special forces with such high political stakes. Other contexts such as Syria and Iraq demonstrate that this scenario and its related questions are far from pure fiction.¹¹

The case of Kunduz in Afghanistan, where forty-two MSF staff and patients were killed in a US attack on the trauma hospital, offers a useful case study of the challenges of operating a health facility that treats wounded fighters, notably those belonging to non-State armed opposition groups, in the midst of a high-intensity urban battle. It also exemplifies how IHL principles can be distorted through their translation into rules of engagement referred to and applied in practice by military personnel on the battlefield. In the case of Kunduz, the rules of engagement allowed for the requesting of air strikes in situations of self-defence. The application of a “self-defence” framework tends to weaken the fundamental IHL principle of distinction, increasing the difficulty of appropriately responding to threats. In this case, discussions between the ground forces and the aircrew referred continually to “self-defence” despite argument from the aircrew, who identified that there was no sign of direct hostility or fire coming from the targeted building.¹² Finally, the Kunduz incident concretely demonstrates the challenges facing international independent fact-finding and the activation of accountability mechanisms in such circumstances.

Drawing from the extensive amount of information and documentation gathered over more than a year spent managing the investigation and following up on the Kunduz incident, this article raises questions that have resurfaced in other subsequent attacks on health-care facilities directly managed by MSF, notably in Yemen and Syria. The partial release of the US investigation’s report on the Kunduz attack confirms the existence of “grey areas” regarding the

11 See, among others, the Safeguarding Health in Conflict Coalition website, available at: www.safeguardinghealth.org/mission; Amnesty International, *Iraq: At Any Cost: The Civilian Catastrophe in West Mosul, Iraq*, 11 July 2017, available at: www.amnesty.org/en/documents/mde14/6610/2017/en/; Human Rights Watch, *All Feasible Precautions? Civilian Casualties in Anti-ISIS Coalition Airstrikes in Syria*, 24 September 2017, available at: www.hrw.org/report/2017/09/24/all-feasible-precautions/civilian-casualties-anti-isis-coalition-airstrikes-syria; Samuel Oakford, “More than 1,800 Civilians Killed Overall in Defeat of ISIS at Raqqa, Say Monitors”, *Airwars*, 19 October 2017, available at: <https://airwars.org/news-and-investigations/raqqa-capture/>; Amnesty International, *Syria: “I Won’t Forget this Carnage”: Civilians Trapped in the Battle for Raqqa*, 24 August 2017, available at: www.amnesty.org/en/documents/mde24/6945/2017/en/.

12 See AR 15–6 Investigation Report, above note 2, p. 75.

interpretation and implementation of IHL that jeopardize the effective protection of wartime medical care, particularly in situations where different military and security bodies act together in international coalition, as was the case in Kunduz. While the partial release of the findings of the US investigation falls short of the MSF request for an international independent investigation into the attack by the International Humanitarian Fact-Finding Commission (IHFFC), even this minimum has not been achieved by other States implicated in other instances of attacks against MSF health-care facilities. Unless interpretations of IHL are directly and systematically challenged through the independent establishment of the facts and circumstances of attacks or purported mistakes on medical facilities and civilians, IHL risks being turned into abstract theory.

Background

The capture of Kunduz City by the Taliban on 28 September 2015 was the first time that the armed opposition had controlled a provincial capital since its fall from power in 2001. International coalition forces pushed back against the Taliban advance, which resulted in a high-intensity urban battle.¹³ The consequences of this all-out battle were seen both in the medical injuries treated by MSF in the last week of September 2015, and in the attack on an MSF trauma centre on 3 October 2015. Not only was this attack one of the biggest losses of life in MSF's history, but it also had consequences which can be seen in the mounting death toll that continues to rise as a result of the closure of a trauma hospital previously conducting life-saving medical treatment for the entire province.

International forces in Afghanistan are organized into two separate operations under the same commander, albeit operating under different legal interpretations and rules of engagement. Resolute Support is a NATO operation to train, advise and assist Afghan forces, while Freedom's Sentinel is a US counterterrorism operation against Al-Qaeda and its affiliates in Afghanistan.¹⁴ On the ground, and in addition to the "regular" armed forces, it is the special forces, both Afghan and foreign, that are increasingly called on to directly intervene in a growing number of areas under armed opposition control. Confusingly, there are portions of the insurgency considered to be legitimate armed opposition (i.e., armed groups allowed to be partners in negotiations) while other insurgents are considered to be "terrorists" and are therefore politically excluded. A battle waged between an army and an armed opposition accepted by the United States and its allies as legitimately taking part in the hostilities is clearly governed by IHL rules. But in NIACs, such as the one taking

13 See Matthieu Aikins, "Doctors with Enemies: Did Afghan Forces Target the M.S.F. Hospital?", *New York Times*, 17 May 2016, available at: www.nytimes.com/2016/05/22/magazine/doctors-with-enemies-did-afghan-forces-target-the-msf-hospital.html.

14 See "Resolute Support (NATO)", *GlobalSecurity.org*, available at: www.globalsecurity.org/military/ops/resolute-support.htm; John F. Campbell, "Operation Freedom's Sentinel and Our Continued Security Investment in Afghanistan", *US Army*, 1 October 2015, available at: www.army.mil/article/156517.

place in Afghanistan, some States claim that military operations against groups considered “terrorist” or criminal fall into a hybrid legal area that mixes IHL with theories of self-defence and the legal regime applicable to law enforcement in the form of militarized counterterrorism operations.¹⁵

Adherence to the limits on the use of force with regards to the IHL principles of distinction, precaution and proportionality have been weakened by the blurring and overlapping of multiple military and security mandates and a vaguely defined enemy. The law itself has not changed when it comes to regulating the use of force between State and non-State parties to a conflict in a NIAC. What has changed, however, is the rise in criminalization of the non-State party and a trend of political expediency in interpreting and implementing IHL – most notably in contexts of counterterrorism. This has led some States to argue that there is greater room for manoeuvre in the way in which armed conflicts are fought.¹⁶

The attack on the Kunduz Trauma Centre was immediately justified by the Afghan authorities on the allegation that the hospital was a “Taliban base” and that “15 terrorists had been killed”.¹⁷ The US Army first said that it had attacked out of “self-defence”. It later claimed that it was requested to attack by its Afghan counterparts, before subsequently taking full responsibility for the attack, saying that it intended to strike a nearby building and hit the hospital by mistake.¹⁸

- 15 This confusion of legal frameworks can be seen in earlier statements by US officials. See, e.g., “Attorney General Eric Holder speaks at Northwestern University School of Law”, 5 March 2012, available at: www.justice.gov/opa/speech/attorney-general-eric-holder-speaks-northwestern-university-school-law; “Remarks of John O. Brennan, ‘Strengthening Our Security by Adhering to Our Values and Laws’”, 16 September 2011, available at: <https://obamawhitehouse.archives.gov/the-press-office/2011/09/16/remarks-john-o-brennan-strengthening-our-security-adhering-our-values-an>; Harold Hongju Koh, “The Obama Administration and International Law”, 25 March 2010, available at: <https://2009-2017.state.gov/s/l/releases/remarks/139119.htm>.
- 16 These claims can be linked to the so-called “erosion” of IHL norms. For more on the debate on the weakening of the norms of law versus the weakening of the application of the law, see Adama Dieng, “We Must Stop the Erosion of International Humanitarian Law”, *Justiceinfo.net*, 15 December 2015, available at: www.justiceinfo.net/en/component/k2/25124-we-must-stop-the-erosion-for-international-humanitarian-law.html; Benjamin Wittes, “Notes on the Erosion of Norms of Armed Conflict”, *Lawfare*, 14 January 2015, available at: www.lawfareblog.com/notes-erosion-norms-armed-conflict. A *contrario*, on lack of respect for the norms, see Marco Sassöli and Yvette Issar, “Challenges to International Humanitarian Law”, in Andreas von Arnould, Nele Matz-Lück and Kerstin Odendahl (eds), *100 Years of Peace Through Law: Past and Future*, Duncker & Humblot, Berlin, 2015; Helen Durham, “Atrocities in Conflict Mean We Need the Geneva Conventions More than Ever”, *The Guardian*, 5 April 2016, available at: www.theguardian.com/global-development/2016/apr/05/atrocities-in-conflict-mean-we-need-the-geneva-conventions-more-than-ever; “We Are Witnessing ... Erosion of the Protection of Civilians”, Opening Remarks by Jonas Gahr Støre to the Second Annual Trygve Lie Symposium, Norwegian Ministry and International Peace Institute, 24 September 2009, available at: www.ipinst.org/2009/09/we-are-witnessing-erosion-of-the-protection-of-civilians.
- 17 See May Jeong, “Death from the Sky: Searching for Ground Truth in the Kunduz Hospital Bombing”, *The Intercept*, 28 April 2016, available at: <https://theintercept.com/2016/04/28/searching-for-ground-truth-in-the-kunduz-hospital-bombing>.
- 18 *Ibid.*

Immediately after the attack, confronted with the contradictory US and Afghan explanations,¹⁹ MSF undertook its own Internal Review of the facts and the reality of the legal frameworks used by the various military forces operating in Afghanistan.²⁰ The intention was twofold: (i) to better learn and adapt medical operations based on the specific risks posed by working in a high-intensity urban battlefield, and (ii) to avoid being victimized again during the second part of the battle concerning the Kunduz attack – the battle for the truth of the faulty legal reasoning behind the bombing. This process is not over. The MSF Internal Review focused on establishing facts from MSF teams on the ground. The review was not intended to be an independent investigation, but rather a compilation of what the organization could determine as fact from its limited perspective as victim of the attack. Most notably, the Internal Review collected all information regarding the functioning of the Kunduz Trauma Centre not only to verify its actual function as a hospital, meaning that its intentional attack would be against IHL rules protecting medical facilities, but also to assess whether parties to the conflict could have had an understanding of those rules different to that of MSF.

Additional information was obtained from a redacted US military investigation,²¹ which has left a number of worrying questions about the way IHL is understood and implemented in contexts of armed conflict that remain haunted by the post-September 11 “with us or against us” counterterrorism military logic.

Negotiating access and the opening of a trauma centre

MSF has been operating in Afghanistan since its return to the country in 2009 through a negotiated agreement reached with all State and non-State parties to the conflict.²² This negotiated access has been based on the fundamentals of IHL, which include the ability to treat all sides to the conflict. MSF negotiated that all wounded would be treated in hospital and that no weapons would be allowed into health facilities. MSF reached agreements that its hospitals and other health facilities would not be targeted under any circumstances. These negotiated elements allowed the major deployment and presence of MSF, with full international teams operating from clearly identified hospitals. In a press release at the time of the opening of the Kunduz Trauma Centre in 2011, MSF stated that “it is the duty of all parties to a conflict to respect the rules of IHL, including those concerning the protection and respect of medical structures, medical personnel and patients”.²³

19 See box, “From Collateral Damage to Tragic Mistake: The United States’ Changing Narrative”, below.

20 MSF Internal Review, above note 2.

21 AR 15–6 Investigation Report, above note 2.

22 See Michiel Hofman and Sophie Delaunay, *Afghanistan: A Return to Humanitarian Action*, MSF USA, 11 March 2010, available at: www.msf.org/sites/msf.org/files/old-cms/fms/article-images/2010-00/return_to_humanitarian_action.pdf.

23 See MSF, “Afghanistan: MSF Opens a Surgical Hospital in Kunduz”, Kabul, 18 October 2011, available at: www.msf.org/afghanistan-msf-opens-surgical-hospital-kunduz.

The Kunduz Trauma Centre, in Kunduz City, was initially a fifty-five-bed privately funded trauma hospital and was the only trauma facility of its kind in northeast Afghanistan. In the run-up to the opening of the hospital, fighting had led to large numbers of people sustaining bomb-blast, shrapnel and gunshot wounds in addition to those in need of specialized surgical care.²⁴

The opening of such a facility was clearly linked to identified needs in northeast Afghanistan. These needs arose in an overall context of chronic systemic failures of the Afghan health-care system to adequately address the needs of a population still largely trapped in conflict, and even more acutely for those living in areas outside government control.²⁵

By 2015, the hospital employed 460 staff and was equipped with an emergency room, operating theatres, an intensive care ward, and X-ray and laboratory facilities.²⁶ From the date of opening, the MSF hospital treated both violent and accidental trauma cases.²⁷ Between January and August 2015, 3,262 surgeries were conducted.²⁸ The hospital had ninety-two beds, which increased to 140 beds in the last week of September 2015 to cope with the unprecedented number of admissions linked to the increase in fighting during that period.²⁹

MSF relied on patients being able to reach the provincial capital of Kunduz from all across northeast Afghanistan. While the hospital contributed to providing high-quality trauma care, it was largely confined to operating in the urban, government-controlled provincial capital. However, a small step was taken in June 2015 to improve access to health care in territories outside governmental control. When MSF opened a clinic in Chardara district, 15 kilometres from Kunduz, this district was largely under the control of the armed opposition. In this clinic, nurses provided immediate care to trauma patients before they were transported to Kunduz City.³⁰ However, such medical transfers depended on the ability of MSF to safely refer patients across the front line to the MSF hospital.

The negotiated access, aimed at securing the neutral, impartial and independent status of MSF medical care, notably enabled MSF to preserve its

24 *Ibid.*

25 See Jonathan Whittall, “The Operation Was Successful, but the Patient Died”, *Huffington Post*, 20 March 2014, available at: www.huffingtonpost.co.uk/jonathan-whittall/afghanistan-humanitarian-aid_b_4993451.html.

26 See MSF Internal Review, above note 2, p. 2.

27 For example, in 2014 alone more than 22,000 patients received care at the hospital and 4,241 surgeries were performed. *Ibid.*, p. 3.

28 *Ibid.*

29 *Ibid.*, p. 2. A June 2015 press release on the Kunduz Trauma Centre stated: “From 20 to 23 June, MSF’s medical teams treated 77 patients directly wounded in the fighting; one-third of these patients were women and children. The majority of wounded patients admitted to the trauma centre came from Chardara district, around ten kilometres from Kunduz city, which has been engulfed by fighting since Saturday 20 June. The bulk of patients had sustained bomb blast or gunshot wounds, with MSF surgeons treating severe abdominal, limb and head injuries.” MSF, “Afghanistan: Scores of Wounded Treated after Heavy Fighting in Kunduz Province”, Press Release, Kabul, 25 June 2015, available at: www.msf.org/en/article/afghanistan-scores-wounded-treated-after-heavy-fighting-kunduz-province.

30 For more information on the background of this medical post, see MSF Press Release, above note 29.

capacity to carry out its medical activities in areas not under governmental control. This was particularly important in a context where humanitarian organizations were being systematically incorporated into military stabilization strategies by the United States, Afghanistan and their allies. The logic of the inclusion of basic services into military stabilization strategies was elaborated in three ways: first, the provision of public services enhances government legitimacy; secondly, carefully targeted services help to reduce grievances; and thirdly, encouraging cooperation in health care can make it possible to also encourage cooperation on other issues.³¹

The enactment of this incorporation of health into stabilization could initially be seen in military personnel directly carrying out medical activities themselves and later in the more indirect building of State legitimacy as a way to undermine support for the opposition. The latter gained prominence as counter-insurgency thinking evolved away from a pure focus on winning hearts and minds to a strategy “that centres on supporting the legitimacy and the development of the core capabilities of the host state”.³²

The need to build the legitimacy of the State as part of a stabilization plan was facilitated by the multi-mandated approach of many NGOs whose aim to engage in longer-term State-building processes converged with the methods used in pursuit of the Afghan government and its allies’ stabilization objectives.³³

By 2015, the vast majority of the aid system in Afghanistan was entirely incorporated into a State-building logic. The health system was subcontracted to NGOs by the State.³⁴ The World Bank, USAID and the European Union provide resources to a trust fund that the Ministry of Health administers.³⁵ NGOs therefore receive direct funding from one of the parties to the conflict in the delivery of health services.

Through its negotiations in Afghanistan, MSF managed to a large extent to obtain an exemption from the incorporation of humanitarian action into the international and national objectives of State-building. However, the reach of the State still extended into MSF medical facilities. This was particularly evident in the extension of security forces operations into the hospital in search of patients considered to be criminals by the State. For example, in July 2015, Afghan Special Forces stormed the MSF Kunduz Trauma Centre. MSF immediately released a statement, which read:

31 See Stuart Gordon, *Winning Hearts and Minds? Examining the Relationship between Aid and Security in Afghanistan’s Helmand Province*, Feinstein International Center, Tufts University, April 2011, available at: <https://tinyurl.com/yd52wej6>.

32 Stuart Gordon, “The United Kingdom’s Stabilisation Model and Afghanistan: The Impact on Humanitarian Actors”, *Disasters*, Vol. 34, No. 3, 2010, p. S370.

33 See Jonathan Whittall, “Is Humanitarian Action Independent from Political Interests?”, *Sur International Journal on Human Rights*, April 2015, available at: <http://sur.conectas.org/en/is-humanitarian-action-independent-political-interests/>.

34 See Markus Michael, Enrico Pavignani and Peter S. Hill, “Too Good to Be True? An Assessment of Health System Progress in Afghanistan, 2002–2012”, *Medicine, Conflict and Survival*, Vol. 29, No. 4, 2013, available at: www.ncbi.nlm.nih.gov/pubmed/24494581.

35 *Ibid.*

On Wednesday 1 July at 14:07, heavily armed men from Afghan Special Forces entered the MSF hospital compound, cordoned off the facility and began shooting in the air. The armed men physically assaulted three MSF staff members and entered the hospital with weapons. They then proceeded to arrest three patients. Hospital staff tried their best to ensure continued medical care for the three patients, and in the process, one MSF staff member was threatened at gunpoint by two armed men. After approximately one hour, the armed men released the three patients and left the hospital compound.³⁶

This operation, carried out in the Trauma Centre by armed personnel, was conducted without a warrant, in contravention of due process as well as in violation of the neutral character of the hospital. The operation was based on false information that a “high-value” individual was being treated in the hospital. It also fuelled some authorities’ misperceptions about MSF’s mandate to treat wounded members of the armed opposition or individuals designated “terrorists”. Those authorities viewed such medical care provided without distinction as helping the “enemy” rather than complementary to their own IHL obligation to provide medical assistance without discrimination.

The July 2015 raid on the hospital may also have signified a shift in the military environment in Kunduz. Coalition troops were drawing down and there was a higher reliance on the use of special forces. Although MSF had negotiated its presence with all parties to the conflict, direct access to special forces remained a challenge.

As international troops withdrew, the armed opposition expanded its presence.³⁷ Military forces from the government may have also seen MSF shift from being a potential benefit in a provincial capital controlled by the government to an unacceptable benefit to the enemy in a context of opposition advancements.

This changing political and military environment raises questions on the extent to which the negotiated presence of MSF in Kunduz remained valid in the eyes of the government and coalition forces prior to the attack on the hospital. Aside from the July military intrusion and prior to the air strikes on the hospital, the agreement certainly *appeared* to remain intact. The rules of the hospital prohibiting bearing arms within the hospital and so on in order to maintain its purely medical function were well understood by all parties to the conflict, and MSF was able to treat the wounded from all sides in the weeks running up to the air strikes. Weapons were kept outside and fighters from each side lay in the same wards.

36 MSF, “Afghanistan: MSF Condemns Violent Armed Intrusion in Hospital in Kunduz”, Kabul, 3 July 2015, available at: www.msf.org/en/article/afghanistan-msf-condemns-violent-armed-intrusion-hospital-kunduz.

37 See UN Assistance Mission in Afghanistan, above note 10.

Shifting front lines

The medical data from the Kunduz Trauma Centre show that there was a cyclical pattern in the violent causes of trauma treated in the hospital that often correlated to the “fighting season”, according to MSF’s Internal Review. The Internal Review notes that “[s]ince the opening of the KTC [Kunduz Trauma Centre] in 2011, more than 15,000 surgeries were conducted and more than 68,000 emergency patients were treated”. The number of patients, particularly those admitted for violent trauma, steadily increased from 2011 to 2015.³⁸ 2015 recorded a notable increase in violent trauma when compared to previous years: between June and August 2015, the number of violent trauma cases averaged 105 cases per month – a 40% year-to-year increase.³⁹

Such data provide clear indicators of continued armed conflict, even if it appeared that the general discourse was shifting towards stabilization and normalization. In such a context, providing impartial medical care to all wounded persons is a duty under IHL.⁴⁰ However, depriving members of armed opposition groups of access to impartial medical care is a State practice often used to deter and weaken those groups.⁴¹ This takes the form of governmental regulations or practice restricting the authorization of humanitarian organizations to providing medical care only in government-controlled medical facilities or territories.⁴² This directly contributes to increasing the pressure and danger on health-care services, personnel and facilities as parties to the conflict vie for access to or control over life-saving resources.⁴³

In September 2015, the violence in Kunduz peaked. As noted above, the capture of Kunduz City by the Taliban on 28 September 2015 marked the first time that the armed opposition had taken control of a provincial capital since its fall from power in 2001. It must be noted that after the Taliban took control of Kunduz, they also came to the MSF hospital to inform the team that they would

38 MSF Internal Review, above note 2, p. 4.

39 Míguel Trelles *et al.*, “Averted Health Burden over 4 Years at Medecins Sans Frontieres (MSF) Trauma Centre in Kunduz, Afghanistan, Prior to Its Closure in 2015”, *Surgery*, Vol. 160, No. 5, 2016, available at: www.surgjournal.com/article/S0039-6060%2816%2930199-4/pdf.

40 GC I–IV, common Art. 3(2); AP I, Arts 10–11; AP II, Arts 7–8; ICRC Customary Law Study, above note 4, Rule 110.

41 See Leonard S. Rubenstein, “Global Health and Security in the Age of Counterterrorism”, *Journal of the Royal Society of Medicine*, Vol. 108, No. 2, 2015, p. 50: “The logic of employing health instrumentally to advance security has also led to practices that deny healthcare as a counterterrorism strategy and punish those who offer it.”

42 Human Rights Watch, *Attacks on Health: Global Report*, May 2015, available at: <https://tinyurl.com/m3cq3tf>; UN Office of the High Commissioner for Human Rights, *Report of the Independent International Commission of Inquiry on the Syrian Arab Republic*, UN Doc. A/HRC/28/69, 5 February 2015, p. 13.

43 See ICRC, *Safeguarding the Provision of Health Care: Operational Practices and Relevant International Humanitarian Law concerning Armed Groups*, Geneva, June 2015, pp. 30–35, available at: <https://shop.icrc.org/les-groupes-armes-et-la-protection-des-soins-de-sante-2106.html>.

not interfere with the hospital, that they respected the MSF rules regarding the neutrality of the hospital and that no weapons were allowed inside the facility. Since the opening of the Trauma Centre in 2011, the vast majority of the wounded fighters treated in the hospital were observed to be government forces and police.⁴⁴ However, the proportion of wounded from both sides varied according to the intensity of the fighting, the position of the front line and the ease of access to the Trauma Centre relative to other medical facilities. In the week starting 28 September 2015, this shifted to primarily wounded Taliban fighters.⁴⁵

By 10pm on the 28th September 2015, MSF's medical teams had treated 137 wounded. This included 26 children. The majority of patients had sustained gunshot wounds, with surgeons treating severe abdominal, limb and head injuries.⁴⁶

An MSF press release was issued stating that “the hospital is inundated with patients” and that

we have quickly increased the number of beds from 92 to 110 to cope with the unprecedented level of admissions, but people keep arriving. We have 130 patients spread throughout the wards, in the corridors and even in offices. With the hospital reaching its limit and fighting continuing, we are worried about being able to cope with any new influxes of wounded.⁴⁷

By Wednesday, 30 September, approximately half of the wounded fighters in the hospital were likely to have belonged to the Taliban forces.⁴⁸

The willingness and duty of MSF to provide medical treatment to all parties to the conflict and without discrimination had been explained not only prior to the opening of the hospital but also at multiple occasions during the week prior to the bombing of the hospital. On Thursday, 1 October,

MSF received a question from a US Government official in Washington, DC, asking whether the hospital or any other of MSF's locations had a large number of Taliban “holed up” and enquired about the safety of our staff. MSF replied that our staff were working at full capacity in Kunduz and that the hospital was full of patients including wounded Taliban combatants, some of whom had been referred to the MSF medical post in Chardara. MSF also expressed that we were very clear with both sides to the conflict about

44 MSF Internal Review, above note 2, p. 4.

45 *Ibid.*

46 *Ibid.*

47 *Ibid.*, p. 5; and quoted initially in MSF, “Afghanistan: MSF Hospital Overwhelmed with Wounded after Heavy Fighting in Kunduz” Press Release, Kabul, 30 September 2015, available at www.msf.org/article/afghanistan-msf-hospital-overwhelmed-wounded-after-heavy-fighting-kunduz.

48 MSF Internal Review, above note 2, p. 5.

the need to respect medical structures as a condition to our ability to continue working.⁴⁹

The attack on the Kunduz Trauma Centre demonstrates how misinterpretation of IHL can affect its implementation. Indeed, from an IHL point of view, a hospital full of wounded fighters is still a protected hospital⁵⁰ and wounded belligerents are themselves protected as persons *hors de combat*.⁵¹ The reason IHL provides protection to health-care facilities, transports and personnel is to guarantee that the sick and wounded will be able to receive treatment. However, from a military intelligence view, a hospital full of wounded fighters could mistakenly be interpreted as no longer being protected under IHL. This is not pure speculation, as the hypothesis that a hospital could be held “hostage” by the enemy was raised during trilateral discussions between MSF and the US and Afghan armies. According to the US and Afghan forces, a hospital could then be perceived as an enemy stronghold, which may affect its protected status either in terms of loss of protection or with regard to its civilian medical status. Such misinterpretation of law opens paths for misapplication of the law. Indeed, in a number of countries, military manuals apply different thresholds for precaution and proportionality when referring to incidental loss and damage affecting a military hospital or hospitals close to military objectives.⁵²

With regard to the armed opposition, when they took control of Kunduz they informed MSF that they would not interfere with the hospital, so it could continue to function as a hospital. They did not enter the hospital to search for wounded enemy forces, nor did they try to enter with weapons when bringing or visiting patients.

⁴⁹ *Ibid.*

⁵⁰ GC IV, Arts 16, 18–20; Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, Vol. 4: *Geneva Convention relative to the Protection of Civilian Persons in Time of War*, ICRC, Geneva, 1958 (ICRC Commentary on GC IV), pp. 154 (particularly noting the phrase “outside their humanitarian duties” at Art. 19), 40–41; GC I, Arts 21, 22; GC IV, Art. 19; AP I, Art. 13; AP II, Art. 11; ICRC Customary Law Study, above note 4, Rules 28, 31. See also Dustin A. Lewis, Naz K. Modirzadeh and Gabriella Blum, *Medical Care in Armed Conflict: International Humanitarian Law and State Responses to Terrorism*, Harvard Law School Program on International Law and Armed Conflict, September 2015, available at: <https://tinyurl.com/ycmqahv5>.

⁵¹ GC I, Arts 3(1), 12(1); GC II, Arts 3(1), 12(1); Geneva Convention (III) relative to the Treatment of Prisoners of War of 12 August 1949, 75 UNTS 135 (entered into force 21 October 1950), Art. 3(1); GC IV, Arts 3(1), 16(1); AP I, Arts 10(1), 41(1), 85(3)(e); AP II, Arts 4(1), 7; ICRC Customary Law Study, above note 4, Rule 47.

⁵² For further discussion on this, see below. See US Department of Defense, *Law of War Manual*, December 2016 (US LoWM), para. 7.10.1.1, available at: www.hsdl.org/?abstract&did=797480. It is important to emphasize that military hospitals are not legitimate military objectives. Under IHL, military objectives are defined as “objects which by their nature, location, purpose or use make an effective contribution to military action and whose partial or total destruction, capture or neutralization, in the circumstances ruling at the time, offers a definite military advantage”. ICRC Customary Law Study, above note 4, Rule 8. See also Laurent Gisel, “Can the Incidental Killing of Military Doctors Never Be Excessive?”, *International Review of the Red Cross*, Vol. 95, No. 889, 2013, available at: www.icrc.org/eng/assets/files/review/2013/irrc-889-gisel.pdf.

A relentless and brutal attack

The US air strikes started between 2 a.m. and 2:08 a.m. on 3 October 2015. Despite the attack occurring in the middle of the night, the MSF hospital was busy and in full operation. According to the MSF Internal Review, medical staff were making the most of the quiet night to catch up on the backlog of pending surgeries.⁵³

When the aerial attack began, there were 105 patients in the hospital. MSF estimates that three or four of the patients were wounded government forces and approximately twenty were wounded Taliban. 140 MSF national staff and nine MSF international staff were present in the hospital compound at the time of the attack, as well as an International Committee of the Red Cross (ICRC) delegate.⁵⁴ It is estimated that the air strikes lasted approximately one hour.

A series of multiple, precise and sustained air strikes targeted the main hospital building. The GPS coordinates that were given to the parties to the conflict correlated exactly to the building that was struck.⁵⁵ When the first air strikes hit the main hospital building, two of the three operating theatres were in use. Three international and twenty-three national MSF staff were performing surgeries in this same main building, or caring for patients. Within this building, eight patients were in the intensive care unit and six were in the area of the operating theatres.⁵⁶ Many staff described seeing people being shot from the air as they tried to flee the main hospital building that was being hit with each air strike. Some accounts mention shooting that appears to follow the movement of people on the run.⁵⁷ The precision of the air strike and the deliberateness of the destruction stands in contrast with the initial reactions from international forces.

53 MSF Internal Review, above note 2, p. 7.

54 *Ibid.*

55 *Ibid.*, p. 8.

56 *Ibid.*, p. 9.

57 *Ibid.*, p. 10.

From collateral damage to tragic mistake: The United States' changing narrative

The changing narrative in the immediate aftermath of the attack reflects the diverging “raw” justifications presented by the various military bodies involved in the attack. It also becomes difficult to unequivocally reconcile the United States' immediate statements with the narrative presented in the final Investigation Report.

3 October 2015

“US forces conducted an airstrike in Kunduz city at 2:15am (local), Oct. 3, against individuals threatening the force. The strike may have resulted in collateral damage to a nearby medical facility.”

Colonel Brian Tribus, spokesman for US Forces-Afghanistan⁵⁸

4 October 2015

“US forces conducted an airstrike in Kunduz city at 2:15am (local), Oct. 3, against insurgents who were directly firing upon US service members advising and assisting Afghan Security Forces in the city of Kunduz. The strike was conducted in the vicinity of a Doctors Without Borders medical facility.”

Colonel Brian Tribus, spokesman for US Forces-Afghanistan⁵⁹

5 October 2015

“We have now learned that on October 3rd, Afghan forces advised that they were taking fire from enemy positions and asked for air support from US forces. An airstrike was then called to eliminate the Taliban threat and several civilians were accidentally struck. This is different from initial reports which indicated that US forces were threatened and that the airstrike was called on their behalf.”

General John Campbell, commander, US Forces Afghanistan and NATO's Operation Resolute Support⁶⁰

6 October 2015

58 “Kunduz Airstrike Reportedly Kills 19 at Doctors Without Borders Hospital”, *NPR*, 3 October 2015, available at: www.npr.org/sections/thetwo-way/2015/10/03/445435361/after-u-s-airstrike-3-dead-at-doctors-without-borders-hospital.

59 “US Strike on Afghan Kunduz Clinic ‘Killed 42’, MSF Says”, *BBC News*, 12 December 2015, available at: www.bbc.com/news/world-asia-35082350.

60 *Ibid.*

“Even though the Afghans request that support, it still has to go through a rigorous US procedure to enable fires to go on the ground. We had a special operations unit that was in close vicinity that was talking to the aircraft that delivered those fires.”

General John Campbell, commander, US Forces Afghanistan and NATO’s Operation Resolute Support⁶¹

7 October 2015

“President Obama spoke today by phone with [MSF] International President Dr. Joanne Liu to apologize and express his condolences for the MSF staff and patients who were killed and injured when a U.S. military airstrike mistakenly struck an MSF field hospital in Kunduz, Afghanistan. During the call, President Obama expressed regret over the tragic incident and offered his thoughts and prayers on behalf of the American people to the victims, their families, and loved ones. Acknowledging the great respect he has for the important and lifesaving work that MSF does for vulnerable communities in Afghanistan and around the world, the President assured Dr. Liu of his expectation that the Department of Defense investigation currently underway would provide a transparent, thorough, and objective accounting of the facts and circumstances of the incident and pledged full cooperation with the joint investigations being conducted with NATO and the Afghan Government.”

White House spokesperson⁶²

The call for an independent investigation

On 7 October 2015, MSF announced the call for an independent investigation under the IHFFC.⁶³ The IHFFC was established by Additional Protocol I to the Geneva Conventions as the only permanent body set up specifically to investigate violations of IHL.⁶⁴

61 “Doctors Without Borders Airstrike: US Alters Story for Fourth Time in Four Days”, *The Guardian*, 6 October 2015, available at: www.theguardian.com/us-news/2015/oct/06/doctors-without-borders-airstrike-afghanistan-us-account-changes-again.

62 White House Office of the Press Secretary, “Readout of the President’s Call with Doctors Without Borders International President Dr. Joanne Liu”, 7 October 2015, available at: <https://obamawhitehouse.archives.gov/the-press-office/2015/10/07/readout-presidents-call-doctors-without-borders-international-president>.

63 See MSF, *MSF: Even War Has Rules*, Geneva, 7 October 2015, available at: www.doctorswithoutborders.org/what-we-do/news-stories/research/msf-even-war-has-rules.

64 The IHFFC was established under Article 90 of AP I. When parties to a conflict are accused of violating IHL, 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, IHL. For further information, see the IHFFC website at: www.ihffc.org.

Although this body has existed since 1991, it only received its first conventional request to institute an enquiry in May 2017.⁶⁵ It requires one of the seventy-seven signatory States to sponsor an inquiry as well as the consent of the State(s) concerned. It can also work on the basis of good offices toward States that have not ratified it.⁶⁶ The confidentiality of its work and reports was initially intended to build confidence and to extract a situation from war propaganda.

In 2015, MSF called on this mechanism as a way to determine the facts surrounding the attack on the Kunduz Trauma Centre in terms of responsibility of both US and Afghan governments under IHL, and to go beyond apology as a sufficient endpoint. In a speech calling for this investigation, the MSF International president, Dr Joanne Liu, stated:

It is unacceptable that States hide behind ‘gentlemen’s agreements’ and in doing so create a free for all and an environment of impunity. It is unacceptable that the bombing of a hospital and the killing of staff and patients can be dismissed as collateral damage or brushed aside as a mistake.⁶⁷

It must be noted that while this situation was related to a NIAC and that neither the US nor the Afghan government has ratified the permanent competence of the IHFFC, the IHFFC considered that it was competent to offer its good offices to investigate this type of incident. It officially informed the US and Afghan governments of its readiness to proceed upon receiving their agreement.⁶⁸

The parties to the conflict never accepted the good offices offered to them by the IHFFC. Instead, the US military and Afghan government launched two separate investigations while NATO produced the mandatory but confidential report on civilian casualties. The Afghan investigation – which was never made public – concentrated on the fall of Kunduz City, while the US investigation focused on the attack on the Kunduz Trauma Centre and covered only the duration of the attack. The US Investigation Report under Army Regulation (AR) 15–6 was finished in November 2015, but its findings were only presented generally in a press conference by General Campbell and were not made public at that stage.⁶⁹ The 3,000-page report underwent an extensive redaction process and

65 Please refer to IHFFC News Archive, “International Humanitarian Fact-Finding Commission to Lead an Independent Forensic Investigation in Eastern Ukraine (Luhansk Province)”, 19 May 2017, available at: <http://www.ihffc.org/index.asp?Language=EN&page=news&do=-1%27>.

66 AP I, Arts 90(2)(c)(ii), 90(d). See also Ove Bring, “The Kunduz Hospital Attack: The Existence of a Fact-Finding Commission”, *EJIL: Talk!*, 15 October 2015, available at: www.ejiltalk.org/the-kunduz-hospital-attack-the-existence-of-a-fact-finding-commission/; IHFFC, “The IHFFC in a Few Words”, available at: www.ihffc.org/index.asp?page=aboutus_general.

67 See MSF, above note 63.

68 See IHFFC News Archive, “IHFFC Contacted by Médecins Sans Frontières”, 8 October 2015, available at: www.ihffc.org/index.asp?Language=EN&page=home&mode=newsarchive.

69 See US Department of Defense, “Department of Defense Press Briefing by General Campbell via Teleconference from Afghanistan”, 25 November 2015, available at: www.defense.gov/News/Transcripts/Transcript-View/Article/631359/departement-of-defense-press-briefing-by-general-campbell-via-teleconference-fro.

in April 2016, only 721 pages of the report were made available to the public for a short time.⁷⁰

How facts matter in the interpretation and implementation of IHL

Whereas the United States shifted its explanation significantly, some Afghan officials remained consistent, claiming immediately after the attack that the MSF hospital was being used as some kind of command and control centre for the armed opposition. According to a report from *The Intercept*,

Sediq Sediqi, the spokesperson for the Ministry of Interior, said that 10 to 15 terrorists were hiding in the hospital. National security adviser Hanif Atmar said the government would take full responsibility, as “we are without doubt, 100 percent convinced the place was occupied by Taliban.”⁷¹

Reinforcing these claims was an ex-CIA official turned television pundit who claimed that MSF was providing material support to “terrorists” because the hospital treated wounded fighters.⁷²

More worrying than these false allegations and the questioning of MSF’s duty to treat all wounded equally is the insinuation that these circumstances would have made a functioning hospital – medical staff and patients alike – a legitimate target. This often-implied accusation has left the public to wonder whether this unacceptable attack on the hospital could have been permitted under other rules applicable to the conflict, such as counterterrorism laws, or under very permissive interpretations of IHL principles applicable in NIAC that have been adopted by some countries not party to Additional Protocol II (AP II), as explored further below.

This episode has been an alert to the practical consequences of the current blurring of the lines between IHL and the doctrine of counterterrorism. Some legal attention has been paid to analyzing the impact of counterterrorism regulations on

70 AR 15–6 Investigation Report, above note 2. The report was made available to MSF as well as publicly available on 29 April 2016 but is no longer publicly accessible. See also MSF, “Kunduz Hospital Attack: Initial Reaction to Public Release of U.S. Military Investigative Report on the Attack on MSF Trauma Hospital”, New York, 29 April 2016, available at: www.msf.org/kunduz-initial-reaction-public-release-us-military-investigative-report-attack-msf-trauma-hospital; MSF, “Kunduz Hospital Attack: Some of MSF’s Questions in Response to the U.S. Military Investigation into Their Attack on the Hospital”, New York, 29 April 2016, available at: www.msf.org/kunduz-some-msfs-questions-response-us-military-investigation-their-attack-hospital.

71 M. Jeong, above note 17.

72 Former CIA covert operations officer Joshua Katz appeared on a Fox News Channel segment entitled “Shepard Smith Reporting” on 5 November 2015, available at: <http://video.foxnews.com/v/4598798043001/?#sp=show-clips>.

human rights, as well as to the criminalization of humanitarian action,⁷³ but a lot more is still needed to determine how the protections afforded to medical care, the oldest of fundamental IHL principles, might be jeopardized by confusion between the legal frameworks of IHL and counterterrorism.

Among the potential confusions is the fundamental status of the wounded and sick as *hors de combat* (“out of combat”) under IHL. While persons *hors de combat* cannot be targeted under IHL, their protection from militarized law enforcement operations is weakened in the counterterrorism framework and the related targeted killing doctrine,⁷⁴ in which a number of human rights are implicated – notably to the right to life, judicial guarantees and due process.

MSF has witnessed how such confusion surrounding the protected status of patients *hors de combat* can adversely affect the medical facility in which they are supposedly located. In various contexts of armed conflict, MSF has been confronted with military operations where States claim that they do not target the hospital itself but then enact searches or strike legitimate objects inside the hospital. Such practice has grave consequences for the safety and the neutrality of the health-care facility, personnel and patients.⁷⁵

Protection and loss of protection of medical units

The gravity of the attack and the controversial explanations offered by US and Afghan officials point to the need for MSF to review the various scenarios in which its hospitals could be perceived to have lost their legal protection and be attacked.

The IHL rules regarding protection and loss of protection of medical units are clear, and their main principles are well known. Yet behind the broad consensus on these principles lie a diversity of “hidden details” in State interpretation of the

73 See Kate Mackintosh and Patrick Duplat, *Study of the Impact of Donor Counter-Terrorism Measures on Principled Humanitarian Action*, July 2013, available at: www.nrc.no/globalassets/pdf/reports/study-of-the-impact-of-donor-counterterrorism-measures-on-principled-humanitarian-action.pdf. See also D. A. Lewis, N. K. Modirzadeh and G. Blum, above note 50; Jessica S. Burniske and Naz K. Modirzadeh, *Pilot Empirical Survey Study on the Impact of Counterterrorism Measures on Humanitarian Action*, Harvard Law School Program on International Law and Armed Conflict, Counterterrorism and Humanitarian Engagement Project, March 2017, available at: <http://blogs.harvard.edu/pilac/files/2017/02/Pilot-Empirical-Survey-Study-and-Comment-2017.pdf>; Naz K. Modirzadeh, *Comment on Pilot Empirical Survey Study on the Impact of Counterterrorism Measures on Humanitarian Action*, Harvard Law School Program on International Law and Armed Conflict, Counterterrorism and Humanitarian Engagement Project, March 2017, available at: <http://blogs.harvard.edu/pilac/files/2017/02/Pilot-Empirical-Survey-Study-and-Comment-2017.pdf>; and the Harvard Law School Counterterrorism and Humanitarian Engagement Project website, available at: <https://pilac.law.harvard.edu/counterterrorism-and-humanitarian-engagement-project/>. And see Marine Buissonniere, Sarah Woznick, Leonard Rubenstein and Julie Hannah, *The Criminalization of Healthcare*, June 2018, available at: www1.essex.ac.uk/hrc/documents/54198-criminalization-of-healthcare-web.pdf.

74 See, e.g., Nils Melzer, *Targeted Killing in International Law*, Oxford University Press, Oxford, 2008.

75 *Ibid.* See discussion below. See also the Françoise Bouchet-Saulnier, “IHL and Counter-Terrorism: Tensions and Challenges for Medical Humanitarian Organizations”, speech given to the UN Security Council Counter-Terrorism Committee, New York, 2 June 2016, available at: <http://msf-analysis.org/ihl-counter-terrorism-tensions-challenges-medical-humanitarian-organizations/>.

law regarding not only the applicability but also the interpretation of each rule in a given situation. The MSF Internal Review was thus needed to delve into those details.

Indeed, a number of IHL provisions regarding the protection of medical duties have been implemented differently in international armed conflict (IAC) and in NIAC.⁷⁶ In addition, in the Afghan case, while the Afghan government has ratified AP II applicable to NIAC, the United States has not.⁷⁷ Defining the precise IHL legal framework effectively applicable to the situation is therefore not a simple question of determining the relevant treaty and customary rules of IHL. Much more is needed in order to ascertain the content of the rules that soldiers are trained on and theoretically operating under in Kunduz, including reference to domestic legal frameworks and military doctrine such as the US domestic *Law of War Manual* (LoWM).

The comparison of the US LoWM with conventional and customary IHL conducted by MSF during the Kunduz attack review raised a number of questions as to the precise content of the US rules meant to implement the IHL provisions protecting the medical mission, each of which will be outlined below. As discussed above, IHL clearly states that medical units and transports shall be respected and protected at all times and shall not be the object of attack. IHL further states that medical units and personnel may only lose their protected status if they are used to commit – outside their humanitarian function – hostile acts⁷⁸ or acts harmful to the enemy.⁷⁹ “Hostile act” is the term used by conventional IHL in NIAC, while reference to “acts harmful to the enemy” is used for IAC as well as in customary law. What might constitute a “hostile act” in NIAC is not expressly defined but seems to entail an active role and observable activities. IHL does not give a definition or a list of what could amount to an “act harmful to the enemy”;⁸⁰ on the contrary, it provides examples of what will clearly *not* amount to an “act harmful to the enemy”. This includes the fact 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; the fact that the unit is guarded by a picket, sentries or escort; the fact that small arms and ammunition taken from the wounded and sick, and not yet handed to the proper service, are found in the units; and the fact that members of the armed forces or other fighters are in the unit for medical reasons.⁸¹ For years, MSF has translated

76 This is true for instance, in the treaty provisions regarding the principles of proportionality and precautions in attack, and regarding the definition of military and civilian medical units. Additionally, under customary international law there is arguably no requirement of advance warning in order for a medical unit to lose its protected status.

77 A list of States that have ratified AP II is available at: <https://tinyurl.com/y77xzvdf>.

78 AP II, Art. 11(2).

79 GC I, Art. 21; GC IV, Art. 29; AP I, Art. 13; ICRC Customary Law Study, above note 4, Rules 27, 29.

80 But there is some agreement on what constitutes a “hostile act” and “acts harmful to the enemy”. Please see Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, Vol. 1: *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, ICRC, Geneva, 1952, Art. 21, available at: <https://ihl-databases.icrc.org/ihl/COM/365-570026?OpenDocument>.

81 AP I, Art. 13(2).

these rules into its operational practice, including through a strict “no weapons policy” in order to guarantee the safety of its medical activities.

The MSF Internal Review showed that on the night of the attack on the Kunduz Trauma Centre, no fighting had taken place inside the hospital or close to it. It was also clear that no weapons were inside the hospital except for those collected by MSF from the wounded and stored under its control.

The LoWM takes a very permissive interpretation of IHL, providing a list of examples that would entail a loss of protection. One of the most problematic examples for health-care providers is that of a hospital used as a “center for liaison with combat forces”.⁸² While MSF strictly monitors the absence of weapons inside its hospitals as well as the absence of any visible hostile activity within its medical facilities, it has no possibility of verifying more invisible and ill-defined activities. In a period characterized by a concentrated presence of cell phones and extensive intelligence interception, it becomes almost impossible for a humanitarian organization to identify and challenge the reality of such harmful acts. Such criteria as enunciated by the LoWM have compelled MSF to query whether a permissive reading of the LoWM could conclude – based on possible phone intercepts from inside the compound – that the Kunduz hospital had become a command and control centre. Based on the specific wording of the LoWM, it was unclear whether a hospital full of wounded Taliban would still be protected as a hospital. These questions and concerns were again fuelled by the multiple references to a hospital and to a Taliban command and control centre (“TB C2 node”) which were identified as key targets in the US AR 15–6 Investigation Report.⁸³

82 This is an example given for the rules of IAC in both US LoWM, above note 52, para. 7.17.1.1; ICRC Commentary on GC IV, above note 50, p. 154.

83 AR 15–6 Investigation Report, above note 2, p. 80: “Prior to the engagement, the [redacted] reporting confirmed that as many as 65 Taliban had recently received care at the facility, and that unarmed Taliban were present at the time of the strike. [Redacted] confirmed that two senior Taliban officials had recently visited the hospital. No foreign persons of interest were observed at the trauma center”; pp 84–85: “Intelligence assessed that insurgent and potentially high value individuals were or had visited the MSF trauma center. There are no specific intelligence reports that confirm insurgents were using the MSF trauma center as an operational C2 node, weapons cache or base of operations”; p. 217: “our initial objective for the night of 29/30 September was the actual Kunduz city hospital (also known as the PRT) in Kunduz city ... as it had been taken by the Taliban. The mission was approved”; p. 271: “The plan was for [redacted] ... to clear a hospital in the south edge of the city. The hospital was reportedly held by the Taliban The hospital was one of the three that we knew about in addition to the MSF facility and an Afghan hospital on the west side of Kunduz city, in the same area as the MSF trauma hospital. With three hospitals and the language barrier, it was often difficult to determine which hospital was discussed in conversations”; p. 424: “It should be noted that the initial [operational plan] approved at the [Resolute Support] level on 29 sept had the Kunduz hospital as the clear [objective].” Nevertheless, the precise description of the MSF Trauma Centre was transmitted by the force on the ground to locate and target a Taliban command and control centre; pp. 241–242: “I had them describe the compound[, and] [redacted] said that it was a large T shaped structure with several smaller structures around it. I advised the [ground force commander] and he advised the [redacted] the description of the TBC2 compound and the [redacted] confirmed this was the structure. [Redacted] also advised that there was an arching gate on the compound which was also relayed to our [redacted] who confirmed this to be the TB C2 node.”

Another concern could be whether the presence of high-value individuals among the wounded would justify a strike on these individuals under the US LoWM even while they are inside the hospital. This question was motivated by the fact that the building hosting surgical wards and emergency rooms was the only one destroyed systematically by the attack, while all other buildings in the hospital compound full of patients were left untouched.

Finally, in the event that an act harmful to the enemy is being committed, IHL requires that a warning must be given allowing reasonable delay to remedy the situation or to allow the evacuation of the medical personnel and the wounded and sick. Without such a warning there will not be a loss of specific protection.⁸⁴ However, this conventional requirement does not appear as clearly in international humanitarian customary rules, creating some risk of permissive interpretation of IHL obligations by military commanders from countries such as the United States that have not ratified AP II.⁸⁵ This risk is further aggravated by the way in which relevant IHL provisions are translated into some States' domestic law, as seen for example in the US LoWM.

While IHL contains no exception to the warning requirement, the US LoWM limits this obligation by providing an explicit exception to the warning in cases of self-defence.⁸⁶ This reference to self-defence creates great security concerns for medical facilities. Self-defence remains a poorly defined concept more related to the *jus ad bellum* or domestic security law than to the *jus in bello*. Its extensive use to qualify or justify military action in situations of conflict raises additional concerns as to how reference to self-defence may also jeopardize and weaken the IHL obligations under the principles of precautions and proportionality.⁸⁷ It is interesting to note that these issues are not limited to a single domestic law of war manual but appear in many domestic military translations of IHL provisions.⁸⁸

Similar questions have been raised by MSF regarding the Saudi-led coalition in relation to the bombing of hospitals in Yemen in 2016.⁸⁹ In one case,

84 GC I, Art. 21; GC II, Art. 34 for hospital ships; GC IV, Art. 19; AP I, Art. 13(1); AP II, Art. 11(2).

85 ICRC Customary Law Study, above note 4, Rule 28. This rule, related to protection of medical units, does not explicitly mention (save in the Commentaries) the warning requirement. The requirement of warning is included in Rule 20, regarding attacks which may affect the civilian population.

86 US LoWM, above note 52, para. 7.17.1.2.

87 Geoffrey S. Corn, "Self-Defense Targeting: Blurring the Line between the Jus ad Bellum and the Jus in Bello", *International Law Studies*, Vol. 88, No. 1, 2012, available at: <https://papers.ssrn.com/sol3/papers.cfm?abstract-id=1947838>; Jasmine Moussa, "Can Jus ad Bellum Override Jus in Bello? Reaffirming the Separation of the Two Bodies of Law", *International Review of the Red Cross*, Vol. 90, No. 872, 2008, available at: www.icrc.org/eng/assets/files/other/irrc-872-moussa.pdf.

88 ICRC, *Commentary on the First Geneva Convention: Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, 2nd ed., Geneva, 2016 (2016 Commentary on GC I), para. 1848 (particularly n. 22).

89 See MSF, "Yemen: Saudi-Led Airstrike on Abs Hospital Cannot Be Justified as 'Unintentional Error'", 9 December 2016, available at: www.msf.org/en/article/yemen-saudi-led-airstrike-abs-hospital-cannot-be-justified-unintentional-error; MSF, "Yemen: MSF Releases Detailed Documentation of Attacks on Two Medical Facilities Ahead of UNSC Closed Session on Protection of Medical Mission", 27 September 2016, available at: www.msf.org/en/article/yemen-msf-releases-detailed-documentation-attacks-two-medical-facilities-ahead-un-security.

MSF decided to impose a “no cell phone” policy inside its hospital. In another instance, MSF faced the issue of a car being targeted inside the hospital compound while transporting at least one wounded person to the hospital because it was considered by the military coalition as a legitimate military target. This incident raises once again not only the principles of distinction, precaution and proportionality, but also the issue of targeting high-value individuals inside hospitals.⁹⁰ There have been two other instances in which the issue of warning has been at stake. In the first instance the coalition acknowledged that the MSF hospital was considered to have lost its protected status and deplored having omitted to issue a warning before the strike.⁹¹ In the second instance the warning was issued in advance, allowing MSF to remedy the harmful act and to maintain the protected status of its hospital.⁹²

Distinction, precaution and proportionality

Direct attacks on health-care facilities are rarely claimed by any party to a conflict. There are political incentives for parties only to acknowledge mistakes in having attacked an erroneous target or to claim that they did not know the target was a health-care facility due to various technical problems of identification.⁹³

IHL prohibits deliberate attacks on medical units. It also contains broader obligations concerning indiscriminate attacks and collateral civilian damage in the conduct of hostilities. The duty of military commanders includes obligations of distinction, precaution and proportionality in attacks in order to avoid and limit indirect civilian loss and damage linked to attacks against legitimate military objectives.⁹⁴ However, these apparently clear IHL principles are met with complex debate when confronted with their translation and interpretation in domestic law of war manuals, military rules and doctrines.

One example of such debate became apparent during the MSF Internal Review, which found that the IHL obligations of precaution and proportionality

90 See for example Saudi Press Agency, “Official Spokesman of Joint Incidents Assessment Team (JIAT) Issues Statement”, Riyadh, 6 December 2016, available at: www.spa.gov.sa/viewstory.php?lang=en&newsid=1567351. The language used by the Joint Incident Assessment Team, “Houthi armed leaders” and “targeted the location of that gathering”, suggests that there was a subjective belief that there were high-value individuals involved in this incident.

91 This refers to the aerial bombardment of Haydan Hospital in Saada governorate. See Saudi Press Agency, “Joint Incidents Assessment Team (JIAT) on Yemen Responds to Claims on Coalition Forces’ Violations in Decisive Storm Operations”, Riyadh, 5 August 2016, available at: www.spa.gov.sa/viewstory.php?lang=en&newsid=1524799.

92 In this case, MSF was able to identify the presence of a military objective located next to the GPS coordinate provided for the hospital, and was able to request that it be moved away.

93 This argument is central in the attack on the Kunduz Trauma Centre. It was also presented by the Saudi-led coalition regarding the attack on the Abs Hospital in Yemen on 6 December 2016: see Saudi Press Agency, above note 90; Saudi Press Agency, “Joint Incidents Assessment Team (JIAT) Response to Doctors Without Borders, Amnesty International”, Riyadh, 6 December 2016, available at: www.saudiembassy.net/news/joint-incidents-assessment-team-jiat-response-doctors-without-borders-amnesty-international. Regarding the attack on the Haydan Hospital in Saada governorate in Yemen on 26 January 2015, see Saudi Press Agency, above note 91.

94 The words “collateral damage”, “incidental damage” and “unintended damage” are also frequently used.

were interpreted quite restrictively in their implementation in the US LoWM. For instance, the LoWM provides a distinction between civilian and military medical facilities and personnel that is not founded in IHL. Under IHL, the rules related to the loss of protection are the same for both civilian and military medical facilities and personnel, though the rules arguably differ when it comes to protection from collateral damage.⁹⁵ Indeed, some US LoWM provisions purport to weaken the principles of precaution and proportionality regarding incidental damage to military medical units and personnel when they are located close to a military objective.⁹⁶ They even go so far as to reverse the obligation by instead placing the duty on medical units and personnel to either distance themselves from military objectives or to accept the consequences, rather than on the armed forces to locate their military objectives away from medical units and personnel.⁹⁷

In light of the US view that incidental harm to *military* medical units is not prohibited, to determine whether US forces violated their own domestic law in the attack on the Kunduz Trauma Centre, it is therefore necessary to first determine the status – civil or military – of the MSF hospital and its medical personnel under the US LoWM.⁹⁸ This question becomes more complex as the LoWM does not aid in clarifying the status of a wounded combatant from a non-State armed group, and even more so given that these patients were being treated in a private hospital run by a medical humanitarian organization. The question therefore becomes whether, under the US LoWM, the presence of the wounded Taliban in the Kunduz Trauma Centre on the night of the attack may have adversely affected its civilian status under US military doctrine and thereby deprived it of the highest level of protection.

More generally, if under the US LoWM being situated in the proximity of a legitimate military objective supersedes the special protection of health-care facilities, notably when targeting mobile military objectives, it would be contrary to one of the main pillars of IHL. This is of very grave concern for humanitarian organizations whose presence in areas of conflict is fundamental and essential to providing vital medical care to the victims of the conflict. While a number of military objectives are by nature very mobile, it is unacceptable that the burden of

95 But see L. Gisel, above note 52.

96 US LoWM, above note 52, para. 7.8.2.1: “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. 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”; para. 7.10.1.1: “The incidental harm to medical units or facilities, 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.”; para. 7.12.2.5 (acceptance of the risk from proximity to combat operations).

97 *Ibid.*, paras 7.10.1.1, 7.8.2.1, 4.10.1.

98 *Ibid.*, paras 5.12.3.2, 7.8.2.1, 7.10.1.1, 4.10.1, 17.15.1.1.

risk and the responsibility to maintain distance from military objectives be simply transferred to humanitarian medical facilities and personnel.⁹⁹

The application of such provisions would render IHL protection of medical units useless, particularly in a context like that of Kunduz, where the hospital was a protected medical unit yet located in a city turned battlefield. Such an interpretation would be writing a blank cheque to authorize attacks in contexts where a mobile military objective is in close proximity to a medical facility, or is even found inside the medical unit. This has been experienced and documented in Yemen with the Saudi-led coalition,¹⁰⁰ and it corresponds with current military targeting practices that are reliant on electronic intelligence and phone intercepts to locate and launch aerial attacks on mobile military objectives, including on so-called high-value individuals. In the aftermath of the Kunduz attack, this has been raised by MSF and more widely, including by specialized US lawyers involved in the drafting of the 2015 US LoWM.¹⁰¹

Identification of medical units, transport and personnel

Effectively implementing the IHL prohibition on attacking medical units, transport and personnel requires that such units are effectively known as being medical by the parties to the conflict. Ensuring that this crucial information is effectively communicated to the armed forces and non-State armed groups, as well as to the appropriate level within the chain of command, is an essential operationalization of this special IHL protection. The displaying of the protective emblems of the red cross, red crescent and red crystal is a well-regulated option in IAC but is legally and practically more complex in NIAC, notably with regard to medical facilities operating in territories beyond State control.¹⁰² However, it is worth mentioning that under IHL, identification can be effectuated not only with the emblems but also by other means agreed by the belligerents at the beginning of

99 This view is echoed by the Saudi-led coalition in a statement by the Joint Incidents Assessment Team regarding the bombing by coalition forces in Taiz province, Yemen, on 2 December 2015: “It is necessary to keep the [MSF] mobile clinic away from military targets so as to not be subjected to any incidental effects.” See Saudi Press Agency, above note 91.

100 See, for example, UN Panel of Experts on Yemen, *Final Report*, 27 January 2017, notably para. 128 and Appendix C to Annex 49 on the attack on Abs Hospital in Yemen, available at: www.un.org/ga/search/view_doc.asp?symbol=S/2017/81; Saudi Press Agency, “JIAT Response to Doctors Without Borders”, above note 93; Saudi Press Agency, above note 90.

101 Amongst these are Oona Hathaway, “The Law of War Manual’s Threat to the Principle of Proportionality”, 23 June 2016, available at: www.justsecurity.org/31631/lowm-threat-principle-proportionality; Geoffrey S. Corn and Andrew Culliver, “Wounded Combatants, Military Medical Personnel, and the Dilemma of Collateral Risk”, 13 December 2016, available at: <https://ssrn.com/abstract=2884854>; Jens D. Ohlin, “Was the Kunduz Hospital Attack a War Crime?”, 1 May 2016, available at: <http://opiniojuris.org/2016/05/01/was-the-kunduz-hospital-attack-a-war-crime/>.

102 See GC I, Arts 35–38; GC II, Arts 41–45; GC IV, Art. 18; AP I, Art 18; AP II, Art 12; AP I, Annex I, Arts 1–14. In NIAC the “competent authority” authorizing the use of the protective emblem may not allow its use by medical facilities in territories under the control of non-State opposition groups. See also Gérald C. Cauderay, “Les moyens d’identification des transports sanitaires protégés”, *International Review of the Red Cross*, Vol. 76, No. 807, 1994, available at: <https://doi.org/10.1017/S0035336100009734>.

or during the conflict.¹⁰³ In practice, humanitarian organizations largely comply with whatever means of identification are requested of them.

The debate on the identification of health-care facilities that have been the victim of attack in Afghanistan as well as in Yemen has focused not on the use of the emblems but rather on new means of identification such as electronic GPS identification that is foreseen by conventional IHL rules.¹⁰⁴ The practice of sharing GPS identification¹⁰⁵ has largely replaced the emphasis placed on displaying the protective emblems in the context of contemporary aerial warfare. GPS coordinates of health-care facilities are transmitted to the parties to the conflict, to be included on their no-strike lists. However, it must be noted that while the identification of humanitarian and medical facilities by displaying the protective IHL emblems remains essential, their usage is subject to specific authorization under *State* regulations, which may impact their use in NIAC, notably in areas under the control of non-State armed groups.¹⁰⁶

It must be recalled that hospitals benefit in theory from protection whether or not they use the emblems, and, furthermore, under the IHL general principles of distinction, precaution and proportionality, health-care facilities remain protected as civilian objects even if they do not display the protective emblems in any case.¹⁰⁷ In practice, however, the special protection of a medical facility is bound to the knowledge of its medical status by the belligerent. In the case of Kunduz, the presence of the MSF Trauma Centre had been negotiated with and agreed

103 AP I, Annex I, Art 1.4.

104 *Ibid.*

105 For more information regarding MSF's recent practice of sharing GPS identification, see Alejandro Pozo Marin and Françoise Bouchet-Saulnier, *The Moral Relativism of Subordinating Civilians to Terrorists*, MSF Centre for Applied Reflection on Humanitarian Practice, June 2017, p. 15, available at <https://arhp.msf.es/attacks-against-medical-mission/moral-relativism-subordinating-civilians-terrorists>. See also Michiel Hofman, "The UN Security Council Must Do More to Protect Syrian Civilians", *The Guardian*, 21 February 2016, available at: www.theguardian.com/commentisfree/2016/feb/21/medecins-sans-frontieres-plea-for-civilian-bombings-syria-stop. For more information regarding the general practice of sharing GPS identification, see Global Shelter Cluster, *Guidance for Submitting Humanitarian Location Information in Syria and Iraq*, rev. 21 January, 2015, available at: www.sheltercluster.org/sites/default/files/docs/deconfliction_of_movements_in_iraq_guide_for_ingos_ocha.pdf; UN Office for the Coordination of Humanitarian Affairs (OCHA), *Deconfliction Mechanisms of Humanitarian Organisations Operating in Yemen (Mission Movements and Static Locations)*, last update 29 March 2018, available at: <https://reliefweb.int/report/yemen/deconfliction-mechanism-humanitarian-organisations-operating-yemen-mission-movements>; OCHA, *No Strike List Guidelines*, 4 February 2018, available at: <https://reliefweb.int/report/yemen/no-strike-list-guidelines>.

106 The Afghan law regulating the use of the protective emblem was adopted on 8 October 2016, one year after the attack on Kunduz. It served to fill the legal gap regarding the designation of a domestic authority competent to authorize usage of the emblems. The law delegates this power to the Afghan Red Crescent Society. ARCS Regulative Law 1395/7/17 on Regulation Affairs of the Red Crescent Society, 8 October 2016, Part 2. See, generally, ICRC Customary Law Study, above note 4, Rules 1–10; ICRC, *Study on the Use of the Emblems: Operational and Commercial and Other Non-Operational Issues*, Geneva, 2011, available at: www.icrc.org/eng/assets/files/publications/icrc-001-4057.pdf; D. A. Lewis, N. K. Modirzadeh and G. Blum, above note 50, pp. 37–66.

107 AP I, Appendix I, Art. 1.2: "These rules do not in and of themselves establish the right to protection. This right is governed by the relevant articles in the Conventions and the Protocol." See also GC I, Chap. 7, especially Arts 38, 42; 2016 Commentary on GC I, above note 88, para. 2540; Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds), *Commentary on the Additional Protocols*, ICRC, Geneva, 1987, paras 732–733.

upon by the Afghan authorities, who did not at any stage require that a red cross or red crescent emblem be displayed on the hospital. The nearby Kunduz Provincial Hospital, run by the Afghan Ministry of Health, was not marked by any IHL protective emblem either. The US investigation of the Kunduz attack never challenged the fact that the Trauma Centre was, at the moment of its attack, marked with the MSF logo on its roof rather than with the red cross or red crescent emblems. It simply concluded that the plane did not see the MSF logo and was also unable to access the no-strike list on which the GPS coordinates of the Trauma Centre had been recorded. It is thus the targeting process that failed in this instance rather than the identification process. Nevertheless, it is interesting to note that in some contexts of armed conflict, parties to the conflict have changed their practice after having “learnt lessons” from erroneous attacks on health-care facilities. Rather than one simple GPS coordinate, they now require the transmission of several coordinates indicating the perimeter of health-care facilities in order to better assess the consequences of targeting military objectives in their proximity.¹⁰⁸

Mistakes or systemic failure?

The legal “details” and discrepancies in implementation of the law identified through the comparison of IHL provisions and domestic military codes, especially the US LoWM, should not be underestimated as a major source of insecurity on the battlefield. This is significantly aggravated by the large number of foreign and national military and security forces who concurrently abide by different domestic legal frameworks and military doctrines on some of the contemporary battlefields occurring under a counterterrorism framework.

In the Kunduz case, the validity of these concerns has been made clear by the contradictory explanations given at the various levels of interaction between MSF and the various allied military forces involved in the Battle of Kunduz. Beyond the initial US assessment stating that the attack was due to a series of human and technical errors, the reading and analysis of the 721 declassified pages of the US AR 15–6 Investigation Report shows that a lot of so-called “errors” are in fact incorrect understanding and implementation of IHL and the military doctrine applicable to forces both on the ground and in the air. The analysis of the Kunduz attack made possible by the Investigation Report shows that the rules and procedures were not at all clear enough amongst the military forces. The first and most direct victims of this lack of clarity were the patients and staff of the Trauma Centre.

According to the United States’ own investigative findings, the Afghan forces on the ground in Kunduz on the night of the attack sought to target a

108 In a meeting between MSF and the Royal Court of the Kingdom of Saudi Arabia on 30 August 2016, this request was made directly to MSF. The minutes of this meeting state: “The Coalition would like that GPS are send [*sic*] with different points delimitating the perimeter to be protected.”

National Directorate of Security building taken over by the Taliban.¹⁰⁹ The AC-130 aircraft that was dispatched to target the building was diverted to Kunduz without receiving a briefing or the no-strike list. The United States claims that during the flight, “the electronic systems onboard the aircraft malfunctioned ..., eliminating the ability of [the] aircraft to transmit video, send and receive e-mail or send and receive electronic messages”.¹¹⁰ When the AC-130 arrived in Kunduz, General Campbell stated that the crew “believed it was targeted by a missile”.¹¹¹ The gunship then increased its altitude, which “degraded the accuracy of certain targeting systems”.¹¹² Although it looked entirely different, the United States claims that the intended target “roughly matched” the MSF Trauma Centre “as seen by the aircrew”.¹¹³ This is on top of the fact that when the crew entered the coordinates of the intended target into their grid location system, the coordinates correlated to an open field. When the AC-130 returned to its optimal altitude the system apparently corrected the coordinates to match with a different building, but “the crew remain[ed] fixated on the physical description of the facility”.¹¹⁴

The United States admitted through its own investigation that the force commander “was unable to adequately distinguish” between the building that the AC-130 intended to target and the MSF Trauma Centre.¹¹⁵ They also admitted that the AC-130 did transmit the exact coordinates of the MSF hospital back to Bagram Airbase before firing on the facility. Bagram Airbase did have access to the no-strike list but did not check whether the AC-130 was about to strike a protected facility. According to a response by the Afghanistan operations deputy chief of staff for communications, General Wilson Shoffner, during the question-and-answer session following General Campbell’s statement, “the investigation found that the actions of the air crew and the special operations commander were not appropriate to the threats that they faced”.¹¹⁶

Analysis of the AR 15–6 Investigation Report clearly shows that military personnel at all levels of the US chain of command – ground force commander, aircrew, headquarters, and the investigating officer – displayed a lack of knowledge or a misunderstanding of the scope and requirements of IHL. The Report shows a failure to implement fundamental aspects of IHL regarding the protection of medical facilities and civilians in Kunduz.

At a minimum, this failure can be explained by inappropriate or unclear writing, understanding and application of rules and procedures pertaining to the conduct of hostilities contained in the US LoWM as well as the Rules of Engagement and Standard Operating Procedures used by the troops on the

109 See US Department of Defense, above note 69.

110 *Ibid.*

111 *Ibid.*

112 *Ibid.*

113 *Ibid.*

114 *Ibid.*

115 *Ibid.*

116 *Ibid.*

ground.¹¹⁷ The absence of the no-strike list on board the aircraft undertaking the attack and the fact that the GPS coordinates of the intended attack were not verified against the coordinates provided for the no-strike list at command level point to a clear default in regards to the duty of distinction and precaution. This seems to be confirmed by the decision of General Campbell to issue a revised Tactical Directive and Targeting Standard Operating Procedure for the US Forces in Afghanistan. These documents emphasize tactical procedures to minimize the risk to civilians and civilian sites.¹¹⁸ However, this hypothesis cannot be verified since most of those documents, including the Rules of Engagement, are classified. A less charitable explanation would be to say that the decision reflects a reckless approach to the protection of civilians in conflict zones prior to the incident.

There are three areas of particular concern arising from the analysis of the AR 15–6 Investigation Report that have implications for the safety of hospitals in war zones. Firstly, the Report makes multiple explicit references to the fact that another hospital had been designated by the United States as a planned target of an operation during the week of 28 September 2015.¹¹⁹ Nowhere in the Report is it indicated that a specific procedure was activated with regard to this hospital within the US chain of command. On the contrary, the report indicates that the US operational plan in which the Kunduz Provincial Hospital was designated as a target (although eventually never actually attacked)¹²⁰ was reviewed by two levels of higher command and an operational law military attorney. The Investigation Report gives no indication as to how the Provincial Hospital may have lost its protected status and therefore became a lawful military target. And while it is mandatory under IHL to issue a warning in order to allow for evacuation or for any military use of the hospital to be ceased, there is no indication that any such warning was given or was going to be given to the hospital.

Secondly, the AR 15–6 Investigation Report admits that in the operation to retake Kunduz from the Taliban, US personnel considered entire swathes of the city to have been taken over by the Taliban and therefore void of civilians and designated as hostile.¹²¹ During the week preceding the attack on the Kunduz Trauma Centre, a US commander explained to their forces that the Taliban controlled the entire west of Kunduz city, and that therefore, everyone west of the city was considered

117 AR 15–6 Investigation Report, above note 2, p 72: “Throughout the investigation, it became clear that many commands have difficulty articulating an understanding of the Tactical Guidance, [Resolute Support] and [Operation Freedom Sentinel] ROE and the basic fundamentals regarding the use of force.”

118 See US Central Command, “April 29: CENTCOM Releases Investigation into Airstrike on Doctors Without Borders Trauma Center”, 29 April 2016, available at: <http://www.centcom.mil/MEDIA/PRESS-RELEASES/Press-Release-View/Article/904574/april-29-centcom-releases-investigation-into-airstrike-on-doctors-without-borde/>; US Department of Defense, “Department of Defense Press Briefing by Army General Joseph Votel”, 29 April 2016, available at: <https://www.defense.gov/News/Transcripts/Transcript-View/Article/746686/department-of-defense-press-briefing-by-army-general-joseph-votel-commander-us>.

119 AR 15–6 Investigation Report, above note 2, pp. 45, 270–271, 423–424, 429, 622.

120 *Ibid.*, p. 622, point 21.

121 *Ibid.*, p. 596: When asked about the purpose of the AC-130 fire, “he stated that the purpose was the ‘overall self-defense of our perimeter’ and that everything west of [redacted] was full of insurgents.”

hostile.¹²² In a briefing from the US ground force commander prior to the battle for Kunduz, he stated that “all civilians have fled and only Taliban remain in the city”, and that “everything is a threat”.¹²³ The assumption that there were no civilians left in Kunduz appeared to give the troops on the ground the mistaken belief that they were not required to follow the basic obligations of distinction, precaution and proportionality under IHL. For example, one of the basic ways forces can distinguish between military and civilian sites is to consult a no-strike list. What is particularly alarming is that the no-strike list – on which the Kunduz Trauma Centre and other protected sites were marked¹²⁴ – was either not available or not consulted by anyone at any level of the US chain of command in the hours leading up to the attack or during the attack itself.¹²⁵

The designation of the entirety of Kunduz City as “hostile” is also reflected in the exchanges between ground forces and the aircrew of the AC-130. The AR 15–6 Investigation Report found that there was no consideration for the possibility that there could be civilians in the compound that was targeted.¹²⁶ It states that the aircrew arbitrarily chose the building that they engaged and that the ground force commander authorized striking the building without confirming the lack of civilian presence. This is worrying considering that, according to the Investigation Report, the Kunduz Trauma Centre was observed and discussed by US forces for an hour and eight minutes before the strike without identifying any “hostile act or demonstrating a hostile intent”.¹²⁷

Thirdly, the AR 15–6 Investigation Report demonstrates that there is a systemic misunderstanding and abuse by US personnel of the rationale of self-defence. Under the controversial US theory of “self-defence targeting”, the targetability of individuals is determined by necessity and proportionality as understood in the *jus ad bellum*, rather than under the IHL principles applicable to the conduct of hostilities.¹²⁸ In accordance with IHL, the obligations of precaution and proportionality still apply in situations of self-defence, which entails limiting the means of warfare to what is necessary to eliminate the threat that troops are facing. However, both the US LoWM and Rules of Engagement applicable to these operations referred to self-defence authority in a way that was misapplied by troops in the field.¹²⁹ In an environment where “everything was considered as a threat”, US forces erroneously applied the logic of self-defence in the *jus ad bellum* sense to their operations. US forces were employing force in a manner much more aligned with the offensive conduct of hostilities while

122 *Ibid.*, p. 254.

123 *Ibid.*, p. 256.

124 *Ibid.*, pp. 32, 77–79.

125 *Ibid.*, pp. 52, 81–82, 424, 620.

126 *Ibid.*, p. 89.

127 *Ibid.*, p. 75.

128 See, for example, G. S. Corn, above note 9, p. 58.

129 US LoWM, above note 52, para. 5.8.3.3.

invoking “self-defence” as a justification.¹³⁰ For example, the Investigation Report shows that in the week preceding the attack on the Trauma Centre, both air and ground forces invoked and applied force under “self-defence” for pre-emptive attacks, notably including deploying close air support from an AC-130 against non-hostile targets of opportunity.¹³¹

This tactical shift from a defensive use-of-force authority to more of an offensive mindset (but still with the justification of self-defence) culminated in the pre-attack process for the strike on the Kunduz Trauma Centre. The attack against the Trauma Centre was justified by the US ground force commander through the invocation of Rules of Engagement pertaining to a self-defence situation, but was conducted in a manner entirely inconsistent with the measured and strictly necessary use of force authorized when acting in self-defence.¹³²

Crucially, although there were significant doubts raised by the aircrew of the AC-130 about the legality of the target they were about to strike due to the fact that no hostile act was observed coming from the Trauma Centre compound, these were ultimately overridden by the fact that the ground force commander invoked self-defence justifications for the attack.¹³³

Furthermore, during the exchanges between the ground and AC-130 aircrew in the minutes before the Kunduz Trauma Centre attack, the US ground force commander referred to “targets of opportunity”, a concept that in this context is legally ambiguous and can be inferred to mean a premeditated strategy to allow for opportune targeting that otherwise falls outside the scope of self-defence authority or approved military targets. This translated into the aircrew confirming the absence of hostile fire coming from the hospital yet ultimately reflecting the ground force commander’s perspective: “I mean when I’m hearing target of opportunity like that I’m thinking you’re going out and you find bad things and you shoot them.”¹³⁴

This may be explained by the ground force commander’s assertion in the AR 15–6 Investigation Report that he believed the National Directorate of Security compound – the supposed intended target that night – was within what he called his “integrated defense bubble”.¹³⁵ In other words, he authorized an attack on a non-

130 AR 15-6 Investigation Report, above note 2, p. 86: “Specific finding. [Redacted] willfully violated the ROE and tactical guidance by improperly authorizing offensive operations. The GFC [ground force commander] understood he had the operational authority to employ fire in self-defense of the [pre-deployment site survey] element against a hostile act under Resolute Support ROE and abused that authority to engage the [ground assault force] target objective with pre-assault fires”; p. 92: “The aircrew was told by the GFC that the building was under Taliban control. They were provided a self-defense authority by the GFC, which was inconsistent with their own observations. They were told to soften the target, suggesting pre-assault fires, but provided a self-defense authority. They were told to strike without any positive identification of a threat.”

131 *Ibid.*, pp. 59–61.

132 *Ibid.*, p. 29.

133 *Ibid.*, pp. 29–30. In response to concerns about the legality of the requested fire, the aircraft commander requested confirmation of the applicable Rules of Engagement; the response given was “collective self-defense ROE”.

134 *Ibid.*, p. 61.

135 *Ibid.*, p. 596. When asked about the purpose of the AC-130 fire, he stated that the purpose was the “overall self-defense of our perimeter”.

hostile target because it was located within this unspecified area that he subjectively considered to be his “bubble” (i.e., perimeter).

Such extensive reference to self-defence to cover an entire military operation indicates a systemic failure to adhere to the framework of IHL.¹³⁶ It ignores the IHL principles of distinction, precaution and proportionality, and the specific IHL framework regulating the protection and the loss of protection of health-care facilities. It raises serious questions about how IHL and the self-defence authority is understood and misused within the US and other forces involved in counter-insurgency and counterterrorism activities in the numerous contexts of international military coalitions. The complexity and uncertainty of the legal framework of such military operations played a central role in the tragedy of Kunduz. On the night of the attack, the US forces were operating with seven different partnered forces from different national contingents.¹³⁷ This complexity is acknowledged in the general findings of the US Investigation Report:

Throughout the investigation, it became clear that many commands have difficulty articulating an understanding of the Tactical Guidance, Resolute Support and Operation Freedom Sentinel Rules Of Engagement, and basic fundamentals regarding the use of force. ... Each unit provided training products which attempted to simplify what is recognized as an exceptionally complex authorities environment. However the investigation also discovered multiple instances of lack of understanding of the authorities. The most acute example was the fact that the tactical commander was unsure of the authorities he was operating under on the night of 3 October.¹³⁸

This was further aggravated by unclear communications between the different forces involved and their failure to refer to a common IHL language.¹³⁹

Conclusion

The attack on the MSF hospital in Kunduz did not happen in a legal vacuum but rather in a complex context of international military and security coalitions in which multiple legal regimes are concurrently applied by the various international and domestic actors. Overlapping areas of responsibility within military coalitions fuel such unregulated overlapping of applicable rules and practices, which is conducive to “mistakes”. This is not specific to the conduct of hostilities in

136 *Ibid.*, p. 93: “The use of military force failed to comply with the plain language of the applicable NATO/USFOR-A tactical guidance, was a departure from the [Resolute Support commander]’s intent, and did not comply with either the governing NATO or [Operation Freedom Sentinel] ROE or [Resolute Support] SOP. [Ground force commander] and aircrew failed to comply with [the law of armed conflict]” (citing AP I, Art. 57(2)(a)(ii)).

137 *Ibid.*, p. 374.

138 *Ibid.*, p. 72.

139 *Ibid.*, pp. 93, 84.

Afghanistan but is a pattern encountered in many other contemporary contexts of armed conflict.

The case of Kunduz illustrates the emergence of a conduct of hostilities that is at odds with the protection of the medical mission. Following the events in Kunduz, MSF engaged in substantial negotiations with Afghan government authorities and US military and civilian authorities as well as the armed opposition in Afghanistan. The questions raised in this article have also been directly discussed with the Afghan and US armies, as well as the armed opposition, in over eighty meetings, including high-level meetings held in 2016. The goal of these meetings was to clarify and reach a common humanitarian and military understanding of these key IHL principles, and more importantly on their practical translation into real wartime contexts and activities. The outcome of these negotiations was the signing of a Humanitarian Special Agreement with the government of Afghanistan and a statement of principles by the US Department of Defense, in which the fundamental tenants of IHL are reasserted in relation to the protection of impartial humanitarian assistance.¹⁴⁰ This has been a critical step, but there remains more to be done.

However, while the case of Kunduz can be seen as the catalyst for such debate, it is important to recognize that there have been numerous other contexts in which attacks on hospitals have not attracted as much attention and subsequent action.

MSF and the ICRC have raised these concerns to the UN Security Council both before and after the adoption of its Resolution 2286¹⁴¹ reaffirming the imperative protection of health-care facilities, staff and patients in contexts of armed conflict. Resolution 2286, unanimously adopted by the Security Council, expressed an international consensus that has not yet changed State practice, with attacks on hospitals continuing unabated. The resolution instructed the UN Secretary-General to make recommendations to operationalize its content. This is in itself a very important step, acknowledging that besides broad consensus and eloquent declarations of principles, specific details with practical effects must be elaborated on. Among those details requiring renewed attention, the Secretary-General identified¹⁴² some inglorious but stubborn facts already experienced by MSF in real-life situations of hospital attacks. The weak incorporation of IHL

¹⁴⁰ Islamic Republic of Afghanistan, Presidential Decree 2774, 10 December 2017, approving the “Host Country Agreement (HCA) signed between Médecins Sans Frontières (MSF) and the Government of the Islamic Republic of Afghanistan”, of which the mentioned Annex refers to the “Memorandum of Understanding between Islamic Republic of Afghanistan and Medecins Sans Frontières for Protection of MSF Operation in Afghanistan” signed on 17 July 2017; US Secretary of Defense, “Principles related to the Protection of Medical Care Provided by Impartial Humanitarian Organizations during Armed Conflict: Memorandum for Secretaries of the Military Departments”, 3 October 2016, available at: www.hsdl.org/?abstract&did=796930.

¹⁴¹ UNSC Res. 2286, 3 May 2016. See also UN, “Security Council Adopts Resolution 2286 (2016), Strongly Condemning Attacks Against Medical Facilities, Personnel in Conflict Situations”, 3 May 2016, available at: www.un.org/press/en/2016/sc12347.doc.htm.

¹⁴² Letter from the Secretary-General addressed to the President of the Security Council, “Recommendations of the Secretary-General, Submitted Pursuant to Paragraph 13 of Security Council Resolution 2286”, UN Doc. S/2016/722, 18 August 2016, available at: www.un.org/ga/search/view_doc.asp?symbol=S/2016/722.

provisions into domestic law and rules of engagement has been explicitly listed in the recommendations of the Secretary-General on the implementation of Resolution 2286.¹⁴³ This document requests member States to undertake comprehensive reviews of their domestic law and adopt any necessary reforms to ensure that they fully incorporate international legal obligations relevant to the protection of medical care in armed conflict. The resolution also recommends that parties to armed conflicts review their rules of engagement, military manuals, tactical directives, standard operating procedures and other similar operational rules or guidelines, and take necessary steps to ensure that such material clearly and adequately prohibits the targeting of protected medical staff, facilities and transport, including the taking of precautionary measures in the planning and conduct of military operations.

Recommendations toward the international investigation of incidents and accountability mechanisms have also been made by the Secretary-General.¹⁴⁴ States have shown a great consensus on this point but it is unfortunately a consensus against the activation of any such mechanisms. MSF has made special and repeated calls for independent investigations by the IHFFC or another independent body regarding the subsequent attacks on its medical facilities in Yemen and Syria in 2016. State reactions have thus far been divided by a simple line: on one side, some States admit their mistakes and claim to undertake their own internal investigations, the reports of which are only partially available;¹⁴⁵ and on the other, there are States that do not openly acknowledge mistakes or engage in internal investigations.¹⁴⁶ Rather than improving the protection of health-care facilities, this situation tends to feed the “propaganda war” regarding responsibility for violations that continue to prevail amongst parties to conflict.

The word “mistake” has appeared recently in the vocabulary of armed conflict. Referring to mistakes requires deeper attention to what makes such mistakes possible and to the role played by humans, but also to procedural and legal errors. The “mistake” argument is not reassuring for humanitarian workers and their organizations. It demonstrates all the more clearly just how vital it is for military alliances and humanitarian actors to reach a clear, simple and unambiguous understanding of the rules applicable to the battlefield, on paper and in praxis. IHL is easily accessible, while rules of engagement that are (besides

143 *Ibid.*, paras 8–9, 19–23.

144 *Ibid.*, paras 6, 28–31.

145 For example, the Joint Incidents Assessment Team responses regarding its investigations of Saudi coalition forces’ violations in Yemen: see Saudi Press Agency, above notes 90, 91 and 93.

146 For example, both the Russian and Syrian governments continued denying allegations of having intentionally targeted medical facilities in Syria in 2015–16, without ever engaging in official reviews of such attacks and sharing their conclusions. Despite the UN Independent International Commission’s recent findings that “Syrian and/or Russian forces continued to target hospitals and medical personnel”, neither the Russian nor Syrian governments have acknowledged responsibility or error. See *Report of the Independent International Commission of Inquiry on the Syrian Arab Republic*, UN Doc. A/HRC/36/55, 6 September 2017, Summary and p. 13 available at: www.ohchr.org/EN/HRBodies/HRC/IIICISyria/Pages/Documentation.aspx; “Russia Has Denied Carrying Out Air Strikes that Killed Dozens of Civilians in Syria”, *Time*, 28 November 2017, available at: <http://time.com/5038762/russia-denies-airstrike-syria/>.

providing tactical and strategic instructions) supposed to simply translate IHL, domestic military manuals and military doctrines into practical procedures remain confidential. There must be a middle ground on secrecy to ensure that such vital rules are understood in an unequivocal and equal way by all military and civilian actors.

What was at stake in Kunduz goes far beyond Afghanistan. The interoperability of different military and security components requires a clear and simple common understanding of IHL rules governing the protection and loss of protection of medical facilities. Addressing this issue will determine the future ability of MSF and other medical humanitarian organizations to continue providing treatment to all wounded persons in the midst of intense, high-stakes special forces battles. This includes clarification over what kind of identification is sufficient, the warnings to be expected in the event that health-care facilities are considered to have lost their protected status, and the conditions under which protected status of the medical facility, staff and patients could be lost. Now more than ever, medical personnel operating in situations of conflict require a reassertion that medical care provided in accordance with medical ethics is explicitly excluded from any form of prosecution (e.g., for material support to terrorism), and that the IHL framework of protection in relation to medical activities will always prevail, regardless of whether the situation amounts to an IAC, a NIAC, or a counterterrorism or security operation in the context of armed conflict.