




The Criminalization of Healthcare

**SAFEGUARDING
HEALTH
IN CONFLICT**


JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Center for Public Health
and Human Rights



University of Essex

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Edited by and human rights section written by Julie Hannah

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1. Forward

Violence against health workers is not a new phenomenon, but has gained increasing visibility in recent years. Two years ago, we celebrated the passage of Security Council Resolution 2286 - a watershed moment for the protection of healthcare.

However, today, through numerous communications, country visits, and newspaper headlines, I continue to be seized of situations where punitive measures are levelled against health workers as a result of their healthcare provision. Without robust national efforts to protect the provision of healthcare, the medical mission remains under threat with harmful implications for the protection of human rights, human dignity, and the ethical framework foundational to the practice of modern medicine.

I welcome this report, which represents an important first effort to understand the chilling effects domestic legal frameworks and policies can have on the delivery of healthcare when not firmly grounded in international law, particularly the right to the highest attainable standard of health. Far removed from the corridors of government and the United Nations, health systems, health professionals, and the lives and dignity of countless individuals remain under threat as a result of punitive domestic laws and practices.

The findings of the study, which covers countries across various political and hemispheric geographies, indicate that the world over, far too many health professionals continue to be punished for carrying out their primary healthcare role. These contemporary situations do not occur in isolation but instead emerge from a normative culture where domestic legal frameworks can be, and often are, used to punish health professionals for carrying out their duties to serve people without discrimination. The 21st century landscape of conflict and national security has rapidly changed, rendering, at times, the exceedingly important protections afforded under the Geneva Conventions insufficient in addressing the protection of health professionals. The importance of embedding human rights, including the right to health in political, legal, and policy discussions related to complex security situations has become more pressing than ever before.

This is an opportunity for both states and the organs of the United Nations to reflect on how each can contribute to advancing the necessary human rights conversation around domestic legislation, public security, and the delivery of healthcare. It is my hope that this report will stimulate further research, documentation, and accountability at domestic levels, and encourage the human rights dimensions of the issue to be brought to the fore.

UN Member States, particularly those committed to the rule of law, must lead by example to safeguard healthcare during complex security situations. Human rights is a tool to support this leadership. I hope this report can help galvanize a new coalition of champions to meet this challenge.

Sincerely,



Dainius Puras
Professor, Vilnius University
Visiting Professor, University of Essex
United Nations Special Rapporteur on the enjoyment of the right to the highest attainable standard of physical and mental health

2. Introduction and executive summary

Long-standing principles of humanity and human dignity embodied in international humanitarian and human rights law entitle all people, regardless of their beliefs, affiliation or status, to have access to healthcare in war and in peacetime. The principle applies to wounded and sick combatants, to civilians in armed conflict, as well as to people living in societies that face threats from terrorism. The ethics of the medical profession mirror these values as practitioners have a duty to provide care without discrimination, including if a person is labeled an enemy or a terrorist. International law recognizes the imperative to enable health providers to carry out these duties without fear of punishment so that all people can receive the care they require.

In recent decades, though, and especially after the attacks of September 11, 2001, contrary to these principles, states have punished the very act of providing or seeking to provide medical care to people who are labeled terrorists or affiliated with terrorist organizations.

On May 3, 2016, the United Nations Security Council (UNSC) adopted resolution 2286,¹ condemning attacks and threats against the wounded and sick, medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities. This resolution, co-sponsored by more than 80 Member States, demanded that all parties to armed conflict comply fully with their obligations under international law, including international human rights law and international humanitarian law. It also urged member states to develop “domestic legal frameworks to ensure respect for their relevant international legal obligations.”²

In his recommendations pertaining to the implementation of this resolution, former United Nations Secretary General Ban Ki Moon noted that healthcare professionals are entitled to provide care “without any distinction other than on medical grounds, in line with their ethical obligations, in all circumstances, without incurring any form of harassment, sanctions or punishment.”³ Regrettably today, more than two years after the adoption of resolution 2286, healthcare professionals continue to be harassed, arrested, and prosecuted for providing care to those in need, in violation of international human rights law, international humanitarian law, or both:

- In some countries, **laws criminalizing support for terrorists** and others opposing the state are “inappropriately applied to the provision of medical care.”⁴ They cast healthcare as a prohibited form of support to the enemy and criminalize those that provide it as a result.
- In other countries, **general laws** are used to punish health providers on grounds unrelated to the provision of care (e.g. illegal assembly, spreading false news), but the underlying reason for the prosecution is the provision of care to people opposing the state, such as political protestors, non-state armed groups, or groups listed as terrorists.
- In yet other contexts, healthcare professionals face **administrative sanctions** (e.g. suspension), harassment, or intimidation for fulfilling their duty of providing medical care.

This report is an initial effort to explore how domestic laws and regulations are used to prosecute and otherwise sanction professionals who provide healthcare, as well as emerging best practices to shield healthcare professionals from harassment and prosecution for the same. It focuses on situations where the provision of healthcare leads to illegitimate prosecution, sanctions, and harassment of healthcare professionals by states. As such, it focuses on domestic laws as opposed to the international counter-terrorism framework. It centers on local providers rather than on the already

1. United Nations Security Council, Res 2286 (3 May 2016) UN Doc S/RES/2286 <<http://unscr.com/en/resolutions/doc/2286>> accessed 29 May 2018

2. United Nations Security Council, Res 2286 (3 May 2016) UN Doc S/RES/2286 <<http://unscr.com/en/resolutions/doc/2286>> accessed 29 May 2018

3. UNSC ‘Recommendations of the Secretary-General, submitted pursuant to paragraph 13 of Security Council resolution 2286 (2016) (SG letter) (18 August 2018) UN Doc S/2016/722 <<http://undocs.org/S/2016/722>> accessed 29 May 2018

4. United Nations General Assembly ‘Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (9 August 2013) UN Doc A/68/297, 7 Session, 9 August 2013, p. 7.

well-documented extent to which counter-terrorism laws might collide or interfere with the work of international non-governmental organizations (NGOs). It does not include situations where healthcare professionals are harassed or targeted by non-state armed groups. And it does not include cases when state forces and their affiliates seek to arrest wounded enemies or individuals deemed terrorists (unless they also take action against health workers), or situations when health providers are arrested for activities entirely unrelated to the provision of medical care.

Of the 16 countries surveyed for this report, practices in at least 10 countries appear to suggest that the authorities interpret support to terrorism to include the provision of healthcare.

Methodology

The present report is the result of desk research and shaped by consultations among a range of knowledgeable stakeholders, including representatives of the human right community, United Nations (UN) agencies, legal experts, as well as members of humanitarian and civil society organizations. It is based on publicly available information and insights from the countries surveyed. Countries were chosen from diverse geographical areas, and represent a mix of countries in conflict, post-conflict, or situations of civil unrest (Afghanistan, Bahrain, Colombia, Egypt, Ethiopia, India, Iraq, Myanmar (Burma), Nigeria, Pakistan, Peru, Syria, and Turkey). The report also includes countries that provide military assistance or are in coalition with other countries in a conflict, as well as those whose counter-terrorism and related laws may affect the ability of health providers to provide healthcare without fear of punishment (Australia, the United Kingdom, and the United States). Also included are possible best practices (the European Commission, Canada, New Zealand, Afghanistan, Colombia, Nigeria). In addition to the summarized information found in this report, a web-based appendix will provide additional country-specific background and details.

To the extent possible, domestic counter-terrorism laws (including relevant criminal laws) were reviewed along with the specific allegations against individuals when publicly available. A desk research of the literature was also conducted, as well as a scan of the grey literature and searches in relevant databases (including those of the United Nations Office on Drugs and Crime (UNODC), the European Court of Human Rights (ECHR), the Office of the United Nations High Commissioner for Human Rights (OHCHR), and the Georgetown University Global Health and Human Rights Database).

Notable limitations include that engagement of local legal experts was not feasible within the context of this research; neither were examination of records of judicial proceedings or interviews with public officials in countries surveyed. Additionally, while translations of relevant laws were obtained whenever possible, the research was primarily conducted in English, French, and Spanish, thus omitting important information which might have been available in other languages.

3. Legal Framework

International humanitarian law and international human rights law in different contexts entitle people in need to obtain healthcare. International humanitarian law requires parties to conflicts to respect and protect people - whether combatants or civilians - who are wounded and sick. The right to health under international human rights law requires states to ensure that healthcare to people within their jurisdiction is available, accessible, acceptable, and of good quality. It also requires states to refrain from interfering with the enjoyment of the right to health, such as by denying care based on a person's status or affiliation. Both bodies of law recognize that fulfillment of these rights is only possible if healthcare professionals can provide care competently and consistent with their ethical obligations. For that reason, these laws demand that parties to a conflict and states refrain from punishing or interfering with health providers' duties to provide ethically appropriate care.

3.1. International human rights law

Safeguarding the provision of healthcare amidst national security challenges or during armed conflict engages a spectrum of indivisible, legally binding human rights obligations. The criminalization of healthcare affects the rights of both healthcare providers as well as the communities and individuals they assist. Four clusters of human rights are especially relevant to the criminalization of healthcare:⁵

- The rights to life, liberty, and freedom from torture or cruel, inhuman and degrading treatment or punishment;
- The rights to free assembly, association, and movement;
- Labor rights - the right to and in work, the rights to organize trade unions and to strike; and
- The right to the enjoyment of the highest attainable standard of physical and mental health.

The domestic contexts studied for this report often involve legal environments that can undermine a range of human rights, all of which are necessary for the full and effective realization of the right to health. However, for the purposes of this report, focus will be on the right to the enjoyment of the highest attainable standard of physical and mental health (right to health) and the cross-cutting human rights principles of non-discrimination and accountability.

The right to health, enshrined in article 12 of the International Covenant on Economic, Social, and Cultural Rights (the Covenant), provides a valuable normative and legally binding framework to examine the global threat to the delivery of healthcare.⁶ It places a legal obligation on states to guarantee the right to health, eliminate discrimination that obstructs the delivery of healthcare, develop suitable laws and policies that safeguard access to healthcare and medical ethics, and ensure accountability. This framework applies domestically, including in the administration of counter-terrorism laws, and remains binding in armed conflict, during which time it is complemented by international humanitarian law provisions laid out in the next chapter.⁷ While human rights treaties do not contain explicit language addressing situations of armed conflict or complex security environments, an authoritative set of interpretative standards have been developed in recent decades to elaborate the human rights obligations of states, including specifically the right to health. These standards are an important tool to analyze the criminalization of healthcare.

5. See framework for understanding the right to health and healthcare professionals established by then UN Special Rapporteur on the right to health, Paul Hunt: UNGA 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (August 2005) UN Doc A/60/348 paras 8-17

6. International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR) art 12

7. ICJ Cases – Legal Consequence of the Construction of a Wall in the Occupied Palestinian Territory. Advisory Opinion, I.C.J. Reports 2004, 136, para 112; Case Concerning the Armed Activities on the Territory of the Congo (*Democratic Republic of the Congo v. Uganda*) I.C.J. Reports 2005, para 216

Obligations and limitations

At all times - including during armed conflict or during efforts to counter terrorism - states have an obligation to respect, protect, and fulfil the full spectrum of human rights, including the right to health.

The obligation to respect requires that states refrain from measures that result in the curtailment of human rights. Respecting the right to health means that states must refrain from discrimination in the access to healthcare services and refrain from compelling health practitioners to deny certain individuals healthcare. This obligation includes eschewing the formulation of policies or practices that directly or indirectly impede access to healthcare for those suspected or involved with opposition, terrorist, protest movements, or other unpopular groups.⁸ Respecting the right to health likewise requires states to refrain “from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.”⁹

The former Special Rapporteur on the right to health recognized that the arrest or prosecution of health workers for providing medical services runs counter to the obligation to respect and has called on states “to avoid formulating laws and policies which criminalize provision of health service by health professionals to people involved in conflict, or repeal them where they exist. States should also refrain from interfering with the duty of health professionals to provide services in an impartial manner.”¹⁰ This approach has been affirmed by the UN High Commissioner for Human Rights.¹¹

Times of armed conflict, insecurity, and resource shortages may make it difficult for states to meet all obligations to provide high quality healthcare to its people, though they remain bound to progressively realize this right. Obligations to respect the right to health by not interfering with medical ethics are not subject to any such obstacles, and cannot excuse non-compliance on resource, security, or other grounds.¹²

Core obligations contained in the International Covenant on Economic, Social, and Cultural Rights, including the right to health, are non-derogable and can only be limited in a manner compatible with the nature of the Covenant and solely for the purpose of promoting the general welfare in a democratic society.¹³ A state that limits the right to health for reasons of national security or the preservation of public order would have to justify that “such serious measures” are consistent with “international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.”¹⁴ Further, the limitations must be the least restrictive means available to achieve the ends sought, be of limited duration, and subject to review.¹⁵ There is no evidence that punishing health professionals for providing care achieves any counter-terrorism objectives, much less is the least restrictive means of achieving them. The permanence of such laws is also inconsistent with the requirement that restrictions be of limited duration.

8. UN CESCR, ‘Report of the Special Rapporteur, Paul Hunt, submitted in accordance with Commission resolution 2002/31’ (13 February 2003) UN Doc E/CN.4/2003/58 para 97

9. UN CESCR ‘General Comment No. 14: The Right to the Highest Attainable level of Health’ (2000) UN Doc ICESCR/E/C.4 para 34

10. UNGA ‘Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (August 2013) UN Doc A/68/297 para 70(c).

11. UNGA Report of the United Nations High Commissioner for Human Rights, protection of economic, social and cultural rights in situations of armed conflict, with a specific focus on the rights to health and to education. (July 2015) UN Doc E/2015/59 http://www.un.org/ga/search/view_doc.asp?symbol=E/2015/59

12. UN CESCR ‘General Comment No 12: The Right to Adequate Food (1999) UN Doc E/C.12/1999/5 para 19; UN CESCR ‘General Comment No. 14 : The Right to the Highest Attainable level of Health’ (2000) UN Doc ICESCR/E/C.4 paras 16, 34; UNGA ‘Report of the Independent Commission on Inquiry on the Syrian Arab Republic’ (23 November 2011) UN Doc A/HRC/S-17/2/Add.1, para 81

13. International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR) art 4; ‘It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable’, UN CESCR ‘General Comment No. 14 : The Right to the Highest Attainable level of Health’ (2000) UN Doc ICESCR/E/C.4 para 47; AComHPR *Amnesty International and Others v Sudan*, Comm No 48/90, 50/91

14. UN CESCR ‘General Comment No. 14 : The Right to the Highest Attainable level of Health’ (2000) UN Doc ICESCR/E/C.4 para 28

15. UN CESCR ‘General Comment No. 14 : The Right to the Highest Attainable level of Health’ (2000) UN Doc ICESCR/E/C.4 para 29; ICESCR, art 5(1)

Importantly, the UN Committee on Economic, Social and Cultural Rights, the most authoritative source for interpreting rights contained in the Covenant, specifically notes the narrow scope for limitations in the Covenant prohibits states from refusing “to allow doctors to treat persons believed to be opposed to the Government.”¹⁶

The strict standards for limiting the right to health precludes punishing health professionals for providing care to an individual labeled a terrorist, affiliated with a terrorist organisation, or otherwise in opposition to the government. Further, states have provided no evidence or justification that criminalizing the provision of healthcare is necessary to protect national security, is proportional to the objective, or is the least restrictive means for achieving such objectives.

Health systems, the right to health, and the criminalization of healthcare

As an “essential element” of the right to health, health facilities, goods and services must be available, accessible, acceptable, and of good quality delivered to everyone without discrimination.¹⁷ Ensuring and safeguarding these minimum standards is essential for the health and dignity of communities, the protection of medical ethics, and the functioning of health systems irrespective of the security environment.

States must ensure the availability of essential levels of healthcare and their accessibility without discrimination, regardless of an individual’s status, including a person labeled a terrorist, affiliated with a terrorist organisation, or otherwise in opposition to the government. Acknowledging the existence of counter-terrorism and other laws that may be “inappropriately applied to the provision of medical care”, the former Special Rapporteur on the right to health highlighted how these laws can affect availability of essential levels of healthcare as they “deter healthcare workers from providing services...due to fear of prosecution”.¹⁸ The former Special Rapporteur has also recognized that arrest or prosecution of health workers for providing healthcare can deter individuals’ access to healthcare for fear of their own arrest should they be reported.¹⁹

General Comment 14 of the Committee of Economic Social and Cultural Rights has interpreted acceptability to mean that “all health facilities, goods and services must be respectful of medical ethics.”²⁰ The former Special Rapporteur has highlighted that “this includes the provision of impartial healthcare and services by health professionals to people affected by conflict.”²¹ The current Special Rapporteur has reinforced the importance of safeguarding ethical care, stating “doctors and other health-care workers must not be arrested, charged or sentenced for acting within their professional duty of ensuring medical impartiality.”²²

Health professionals are foundational to operationalizing the right to health, including during complex security situations or armed conflict. Safeguarding their ability to deliver healthcare is an essential means to secure the right to health.

16. UN CESCR ‘General Comment No. 14 : The Right to the Highest Attainable level of Health’ (2000) UN Doc ICESCR/E/C./4 para 28

17. UN CESCR ‘General Comment No. 14 : The Right to the Highest Attainable level of Health’ (2000) UN Doc ICESCR/E/C./4 para 12(c)

18. UNGA ‘Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (9 August 2013) UN Doc A/68/297, para 21

19. *ibid* para 22

20. UN CESCR ‘General Comment No. 14 : The Right to the Highest Attainable level of Health’ (2000) UN Doc ICESCR/E/C./4 para 12(c)

21. UNGA ‘Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (9 August 2013) UN Doc A/68/297 para 19

22. OHCHR, ‘Letter on Mandates of the Working Group on Arbitrary Detention from the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; the Special Rapporteur on the situation of human rights defenders; the Special Rapporteur on the independence of judges and lawyers; and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment’ (23 June 2017) AL TUR 8/2017<<https://spcommreports.ohchr.org/TMResultsBase/DownloadPublicCommunicationFile?gld=23180>> accessed 20 May 2018

Accountability

The rights and obligations elaborated above require accountability - a central feature of the international human rights system. Accountability is often misunderstood as a narrow, adversarial process for blame and punishment. For more than a decade, accountability within the right to health framework has been significantly broadened and developed as a constructive and cyclical process that includes monitoring, review, and redress.²³ Accountability arrangements for the right to health help to demonstrate the ways in which laws, policies, and institutions are effective or ineffective in relation to health, and in the present context, healthcare provision. The purpose of such arrangements is to improve the full and effective realization of the right to health.

In relation to the criminalization of healthcare, both domestic and international accountability mechanisms are required. National accountability mechanisms such as human rights institutions, ombudspersons, legislative review bodies, and healthcare professional organisations should monitor, document, and review the impact punitive legal frameworks have on the delivery of healthcare in the context of armed conflict or complex security environments. Where human rights violations are identified, these bodies should seek ways to hold states accountable, to ensure violations cannot be repeated, and work to secure redress for the individuals or groups affected.²⁴ International accountability mechanisms, such as human rights treaty bodies, should regularly consider, particularly during periodic reviews of States parties, the human rights impact of the criminalization of healthcare. Likewise, they should provide clear recommendations to states about how to address shortcomings identified, including the reform of domestic legislation.

3.2. International humanitarian law

The Geneva Conventions of 1949

From the original Geneva Convention of 1864, a principal concern of international humanitarian law has been to ensure that “[w]ounded or sick combatants, to whatever nation they may belong, shall be collected and cared for”²⁵ and that their caregivers be immune from punishment or other harm for providing it. The underlying principle is that all wounded and sick must be provided care, based on need alone, without any distinction based on affiliation or enemy status.

The modern Geneva Conventions of 1949 powerfully expand on the original. The First Geneva Convention, applying to wounded and sick combatants in international armed conflicts, requires that the wounded and sick “be respected in all circumstances.”²⁶ It is emphatic that the wounded or sick “shall not willfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.”²⁷ Even a party that is required by circumstances to “abandon wounded or sick to the enemy shall, as far as military considerations permit, leave with them a part of its medical personnel and material to assist in their care.”²⁸

Toward these objectives, medical personnel who transport or care for the wounded and sick “shall be respected and protected in all circumstances.”²⁹

23. Helen Potts, *Accountability and the right to the highest attainable standard of health* (University of Essex, 2008); L.P. Freedman, ‘Human rights, constructive accountability and maternal mortality in the Dominican Republic: a commentary’ (2003) 82 *International Journal of Gynecology and Obstetrics* 114; World Health Organisation, Commission on Information and Accountability for Women’s and Children’s Health ‘Keeping Promises, Measuring Results’, September 2011

24. UN CESCR ‘General Comment No. 14 : The Right to the Highest Attainable level of Health’ (2000) UN Doc ICESCR/E/C./4 para 59

25. International Committee of the Red Cross (ICRC), *Convention for the Amelioration of the Condition of the Wounded in Armies in the Field* (adopted 22 August 1864, entered into force 22 June 1865) art 6

26. ICRC, *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field* (First Geneva Convention) (adopted 12 August 1949, entered into force 21 October 1950) 75 UNTS 31 art 12

27. *ibid*

28. *ibid*

29. See 1949 First Geneva Convention (n 6) art 24

Additionally, the First Geneva Convention requires that military authorities allow the inhabitants of the area where fighting is taking place - which of course includes civilian health providers - to collect and care for the wounded and sick, without interference or punishment. Article 18 provides that "[n]o one may ever be molested or convicted for having nursed the wounded or sick."³⁰ There is no qualification to this protection, no matter the identity, actions, or affiliations of the individual in need of care.

The Fourth Geneva Convention of 1949 extends the obligations of parties to the conflict to wounded and sick civilians. It provides that "[t]he wounded and sick, as well as the infirm, and expectant mothers, shall be the object of particular protection and respect."³¹ As the Commentary to the Fourth Geneva Convention states, the provision "applies to all wounded and sick civilians wherever they may be."³²

The 1949 Conventions address non-international armed conflicts only briefly, but are explicit that the wounded and sick "be collected and cared for."³³

The Additional Protocols of 1977

The 1977 Additional Protocols elaborate on these protections, including the obligation of combatants never to punish people engaged in medical activities in both international and non-international conflicts.

Article 16 of Protocol 1, applicable to international conflicts, provides:

General protection of medical duties

1. Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.
2. Persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other medical rules designed for the benefit of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or from carrying out work required by those rules and provisions.
3. No person engaged in medical activities shall be compelled to give to anyone belonging either to an adverse Party, or to his own Party except as required by the law of the latter Party, any information concerning the wounded and sick who are, or who have been, under his care, if such information would, in his opinion, prove harmful to the patients concerned or to their families. Regulations for the compulsory notification of communicable diseases shall, however, be respected.

Article 10 of Protocol 2, applicable to non-international conflicts, provides:

1. Under no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.

30. See 1949 First Geneva Convention (n 6) art 18

31. ICRC, Geneva Convention Relative to the Protection of Civilian Persons in Time of War (Fourth Geneva Convention) (adopted 12 August 1949, entered into force 21 October 1950) 75 UNTS 287 art 16

32. ICRC, Geneva Convention Relative to the Protection of Civilian Persons in Time of War (Fourth Geneva Convention) (adopted 12 August 1949, entered into force 21 October 1950) 75 UNTS 287, Commentary of 1958, 134

33. ICRC, Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (First Geneva Convention) (adopted 12 August 1949, entered into force 21 October 1950) 75 UNTS 31 art 3; ICRC, Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea (Second Geneva Convention) (adopted 12 August 1949, entered into force 21 October 1950) 75 UNTS 85 art 3; ICRC, Geneva Convention Relative to the Treatment of Prisoners of War (Third Geneva Convention) (adopted 12 August 1949, entered into force 21 October 1950) 75 UNTS 135; ICRC, Geneva Convention Relative to the Protection of Civilian Persons in Time of War (Fourth Geneva Convention) (adopted 12 August 1949, entered into force 21 October 1950) 75 UNTS 287 art 3

2. Persons engaged in medical activities shall neither be compelled to perform acts or to carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and sick, or this Protocol.

3. The professional obligations of persons engaged in medical activities regarding information which they may acquire concerning the wounded and sick under their care shall, subject to national law, be respected.

4. Subject to national law,³⁴ no person engaged in medical activities may be penalized in any way for refusing or failing to give information concerning the wounded and sick who are, or who have been, under his care.

The provisions were thought needed as a result of prosecutions of doctors working in occupied areas in World War II as collaborators,³⁵ and expanded on the First Geneva Convention of 1949, which provided that “[n]o one may ever be molested or convicted for having nursed the wounded or sick.”³⁶ The provisions of Protocol 1 and 2 differ in certain ways, particularly regarding confidentiality of medical information. Additionally, Protocol 1 requires the civilian population to respect the wounded and sick. It also permits the civilian population, on their own initiative, to collect and care for the wounded and sick, even in occupied areas, and states that they may not be harmed, prosecuted, convicted, or punished for these humanitarian acts.³⁷

The sections of greatest relevance to the punishment of health workers are in the first sections of Article 16 of Protocol 1 and Article 10 of Protocol 2, containing almost identical language. The International Committee of the Red Cross (ICRC) has determined that the underlying proscription reflected those sections has become customary international humanitarian law, which applies regardless whether a party to a conflict has ratified or agreed to abide by the Protocols and regardless of the type armed conflict. Rule 26 of the ICRC’s compilation of customary international humanitarian law thus provides: “Punishing a person for performing medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited.”³⁸

The prohibition on punishment for medical activities compatible with medical ethics has wide application and embraces the key ethical duty of impartiality. It has the following key elements:

- *Broad application to all health workers.* Certain provisions of the Geneva Conventions and the 1977 Additional Protocols limit the health workers who are covered by them. These articles of the Protocols, however, apply very broadly to “any person” engaged in medical activities, and is meant to apply to any person, whether or not they qualify as medical personnel.³⁹ The Commentary to Protocol 2, moreover, makes clear that the law applies “not only to doctors, but also to any other persons professionally carrying out medical activities, such as nurses, midwives, pharmacists and medical students who have not yet qualified.”⁴⁰
- *Embrace of protection of the duty to provide care for all.* According to the Commentary to the Protocols, ethical duties are obligations toward patients established by the professions themselves.⁴¹

34. National law could in some circumstances be problematic in deterring individuals from seeking healthcare, but under human rights and humanitarian law standards, there is no limitation on the duty not to punish healthcare providers for offering medical services, no matter what the identity or affiliation of the patient. See ICRC, Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II) (adopted 8 June 1977, entered into force 7 December 1978) 1125 UNTS 609, Commentary of 1987: paras 4680-4684 and paras 4698-4700; ICRC, ‘IHL Database, Customary IHL, Practice relating to Rule 26: Medical Activities’ <https://ihl-databases.icrc.org/customary-ihl/eng/docs/v2_rul_rule26_sectionb> accessed 18 May 2018

35. Sigrid Mehring, *First Do Not Harm: Medical Ethics in International Humanitarian Law* (Leiden: Brill Nijhoff 2015)

36. See 1949 First Geneva Convention (n 6) art 18

37. ICRC, Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I) (adopted 8 June 1977, entered into force 7 December 1979) 1125 UNTS 3 art 17 para 1

38. ICRC, ‘IHL Database, Customary IHL, Rule 26: Medical Activities’ <https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule26> accessed 29 May 2018

39. ICRC, ‘Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949’ <http://www.loc.gov/rr/frd/Military_Law/pdf/Commentary_GC_Protocols.pdf> ¶ 649 accessed 29 May 2018, 649

40. *ibid* ¶ 4686

41. *ibid* ¶ 655

The foundation of the obligation is concern for every human being in need of care. As the Commentary explains:

What is the essential maxim of these principles? It is never to act in conflict with the wounded person's interests, to help him to the fullest extent of the means available, whoever he is (principle of non-discrimination), to be discreet regarding his condition and never to abuse his sense of dependence on the person administering care, particularly not with a view to gaining an advantage from him.⁴²

The reference to "whoever he is" and non-discrimination is elaborated in the Commentary to Protocol 1. It emphasizes that the reference to "regardless of the person benefitting therefrom" in each of the Protocols "reveals the absolute character of the principle, to which no exception can be made. There is a right, and even a duty (in any case for medical personnel) to administer care to the worst enemy of one's own Party to the conflict, if he is wounded, even in the middle of the most cruel battle."⁴³ The Commentary to Protocol 2 similarly states the ethical obligation "[t]o perform medical activities for the benefit of any person, including persons belonging to the adverse party, is not only lawful, but even a duty for those who are professionally bound."⁴⁴ It goes on to say that "the meaning of paragraph 1 is clear: it encourages concern for the wounded, provided this concern remains pure and impartial."⁴⁵

The World Medical Association (WMA), a global consortium of national medical associations, has established standards of conduct for physicians in times of armed conflict, which, while not legally binding as such, are recognized by the Commentary to the Protocols as central in establishing the scope and meaning of medical ethics. The WMA identifies an obligation requiring physicians "in all circumstances" to provide effective and impartial care to the wounded and sick (without reference to any ground of unfair discrimination, including whether they are the 'enemy');⁴⁶

In recent years other professional associations have joined the WMA in emphasizing the duty to care for all in conflict and other emergencies. In 2015, the ICRC released *Common ethical principles of healthcare in conflict and other emergencies* ("Common ethical principles"),⁴⁷ endorsed by the WMA, the International Council of Nurses, the International Council on Military Medicine, and other international professional organizations. The Common ethical principles provide "the primary task of health-care personnel is to preserve human physical and mental health and to alleviate suffering. They shall provide the necessary care with humanity, while respecting the dignity of the person concerned, with no discrimination of any kind, whether in times of peace or of armed conflict or other emergencies." They further state that "no distinction is made between patients, except in respect of decisions based on clinical need and available resources".⁴⁸

- *No exceptions to the obligation to respect health workers' duty to care for all.* It is noteworthy that paragraph 3 of Article 16 of Protocol and paragraphs 3 and 4 of Article 10 of Protocol 2 create a limited exception for the duty of medical confidentiality, by permitting disclosure of patient information in certain circumstances as required by law. But other duties, described in commentaries to the Protocols as "moral duties incumbent upon the medical profession," such as to use independent medical judgment, to act in the best interests of the patients, and to act impartially, contain no exceptions, no matter what national law provide. The commentaries make the absence of exceptions clear as well.
- *Application to authorities beyond military forces.* The provisions apply not only to forces engaged in combat operations, but to "all authorities in a position to administer punishment, from the immediate superior in the hierarchy of the person concerned who is entitled to do so, to the Supreme Court of the State."⁴⁹ This includes

42. *ibid* ¶658

43. *ibid* ¶4686

44. *ibid* ¶4687

45. *ibid* ¶659

46. World Medical Association, 'Regulations in Times of Armed Conflict and Other Situations of Violence' (WMA, rev. 2012) <<https://www.wma.net/policies-post/wma-regulations-in-times-of-armed-conflict-and-other-situations-of-violence/>> accessed 18 May 2018

47. ICRC, 'Common Ethical Principles of healthcare in Conflict and other Emergencies'(ICRC, 30 June 2015)<<https://www.icrc.org/en/document/common-ethical-principles-health-care-conflict-and-other-emergencies>> accessed 20 May 2018

48. ICRC, 'Common Ethical Principles of healthcare in Conflict and other Emergencies'(ICRC, 30 June 2015) <<https://www.icrc.org/en/document/common-ethical-principles-health-care-conflict-and-other-emergencies>> accessed 20 May 2018

49. International Committee of the Red Cross 'Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949' <http://www.loc.gov/rr/frd/Military_Law/pdf/Commentary_GC_Protocols.pdf> ¶651 accessed 29 May 2018, ¶651

“all authorities capable of meting out punishment.”⁵⁰ The requirement thus applies to non-military forces such as prosecutors and police. As the commentaries explain, “[t]his is important because there could be a great temptation for a State to punish its own nationals who have administered care to the wounded.”⁵¹

- *Applies to all forms of sanctions.* The provisions of the Protocols do not limit the forms of punishments they prohibit, from arrest, prosecution and imprisonment to administrative measures.⁵² These could include suspension or removal of license to practice.

3.3. Affirmation of these duties by the UN General Assembly and the Security Council

Both the United Nations General Assembly and Security Council have affirmed the centrality of respect for health providers’ offering care no matter who is the beneficiary, including in armed conflict and domestic emergencies. In a resolution on Global Health and Foreign Policy, the UN General Assembly:

Noting that attacking, threatening or otherwise preventing medical and health personnel from fulfilling their medical duties undermines their physical safety and the integrity of their professional codes of ethics, and that this impedes the attainment of the right to the enjoyment of the highest attainable standard of health, as well as being a barrier to universal access to health services,

in an operative paragraph of the resolution, the General Assembly:

13. Urges Member States, in cooperation, as appropriate, with relevant international organizations and relevant non-State actors, to develop effective preventive measures to enhance and promote the safety and protection of medical and health personnel, as well as respect for their respective professional codes of ethics.⁵³

Security Council Resolution 2286 affirmed, too, that both international human rights and humanitarian law preclude punishment of persons engaged in medical care for treating the wounded and sick. Thus, the resolution,

Recalling that under international humanitarian law, persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other medical rules designed for the benefit of the wounded and the sick.

and

Noting that medical personnel, and humanitarian personnel exclusively engaged in medical duties, in an armed conflict situation, continue to be under a duty to provide competent medical service in full professional and moral independence, with compassion and respect for human dignity, and always to bear in mind human life and to act in the patient’s best interest and stressing the need to uphold their respective professional codes of ethics, and *further noting* the applicable rules of international humanitarian law relating to the non-punishment of any person for carrying out medical activities compatible with medical ethics.

In an operative paragraph of the resolution, the Security Council:

2. *Demands* that all parties to armed conflicts fully comply with their obligations under international law, including international human rights law, as applicable, and international humanitarian law, in particular their obligations under the Geneva Conventions of 1949 and the obligations applicable to them under the Additional Protocols thereto of 1977 and 2005, to ensure the respect and protection of all medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities.⁵⁴

50. *ibid* ¶4690

51. *ibid* ¶651

52. *ibid* ¶4691

53. UNGA ‘Global Health and Foreign Policy’ (9 January 2015) UN Doc A/RES/69/132

54. United Nations Security Council Res 2286 (3 May 2016) UN Doc S/RES/2286 <<http://unscr.com/en/resolutions/doc/2286>> accessed 29 May 2018

Despite annual resolutions from the Human Rights Council related to the protection of human rights and fundamental freedoms while countering terrorism, the importance of safeguarding the provision of healthcare in the context of armed conflict or other complex security environments has not yet been addressed.

3.4. Law and the United Nations counter-terrorism frameworks

In the past generation, the UN Security Council has adopted a series of resolutions urging states to take steps toward preventing terrorism including through law enforcement and criminal justice. Its most recent resolution, 2396, adopted in 2017, reiterated previous pronouncements that terrorism is a threat to international peace and security and urged strong steps to prevent and counter it, including by strengthening national law.⁵⁵ Though the resolution contained general language that acts taken to combat terrorism must be taken in accordance with international human rights law and humanitarian law, like prior resolutions it contains no language reconciling its call for curbing material support of terrorism with protections of medical care under international law. While this gap is problematic, international human rights and humanitarian law as set forth above protects healthcare in all relevant circumstances and must be respected by states, whether they conduct hostilities or are engaged in law enforcement activities. Further, Security Council resolution 2286, adopted in 2016, on the protection of healthcare in conflict, reinforced the prohibitions in international law of punishment of persons for carrying out medical duties in accordance with medical ethics, and contained no suggestion that the duty was limited by counter-terrorism frameworks.

55. United Nations Security Council Res 2396 (2017) UN Doc S/RES/2396

4. Anti-insurgency and counter-terrorism laws

4.1. From guerillas to contemporary terrorism

As examples from the Latin American or South Asian contexts attest to, the prosecution of healthcare professionals for providing medical care to individuals listed as terrorists or insurgents is not a recent phenomenon. From the 1960s onwards, guerilla movements fighting governments were active throughout Latin America and South Asia. The question of how to deal with medical professionals who might have provided care to wounded guerilla members was the subject of many political debates and legal deliberations.⁵⁶ In Peru, some physicians were prosecuted on terrorism-related charges for supporting the Maoist-inspired Shining Path, “at least in part through medically related activities.”⁵⁷ In 1996, Dr. María De La Cruz-Flores was charged with the “*crime of collaboration with terrorists*” and sentenced to 20 years in prison. In an order issued in 1995 to open the pre-trial investigation, the criminal court stated that the defendant and others were “members of the Peruvian Communist Party (Sendero Luminoso), and had provided medical attention, treatment and operations, supply of medicines and medical instruments for the care of criminal terrorist[;] acts [that] constitute the crime established and penalized in Article 4 of Decree Law No. 25,475.”⁵⁸ Ultimately, Dr. De La Cruz-Flores was not convicted for membership in a terrorist organization, but for the crime of unlawful collaboration with terrorists (1996) and unlawful association with terrorists (1999, annulled in 2000).⁵⁹

In Colombia, physicians were prosecuted because of services they provided to militants.⁶⁰ Legal jeopardy for Dr. Luis Alfredo Moreno García began in 2003, when an anesthesiologist friend, Dr. Moreno Alejandro Rico, invited him to participate in a medical mission in the department of Meta.⁶¹ The orthopedic surgeon agreed to join but was taken to a guerilla camp, where he felt that he had no other choice but to care for militants. He was subsequently forced to return one more time and threatened with reprisals against his family if he refused. In 2008, the Colombian authorities arrested Dr. Moreno García, accusing him of being part of an outlawed group, charging him with “rebellion”. The physician spent 14 months in jail awaiting trial.⁶² He based his defense on the Hippocratic oath and the pledge he had made to serve people, regardless of whom or where.⁶³ In another case in May 2009, the Criminal Cassation Chamber of the Supreme Court of Justice upheld the conviction of Dr. Jorge Luis Quintero Milanes, who, in addition to having provided medical and surgical services to members of the FARC, had also managed referrals to Bogota and to specialized clinics that he thought medically necessary.⁶⁴ The Court “reasoned that those referral services fell outside of the scope of medical activities protected by IHL (as incorporated into Colombian law) and into the crime of rebellion”.⁶⁵ The Court also considered that the

56. Carlos Francisco Fernández and Sonia Perilla S, ‘Se reabre debate sobre si asistir médicamente a una persona al margen de la ley es delito’ (*El Tiempo*, 2008) <<http://www.eltiempo.com/archivo/documento/CMS-4542240>> accessed 30 May 2018

57. 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 (HLS PILAC)*, 8 September 2015) <<https://ssrn.com/abstract=2657036>> accessed 30 May 2018, 117

58. Case of De la Cruz Flores v Peru, Merits, reparations and costs, IACHR Series C no 115, [2004] IACHR 11, IHR 1498 <http://www.corteidh.or.cr/docs/casos/articulos/seriec_115_ing.pdf> accessed 30 May 2018 para 73(20)

59. HLS PILAC ‘5 State responses to terrorism’ (Harvard Law School Program on International Law and Armed Conflict) <<https://pilac.law.harvard.edu/mcac-report//5-state-responses-to-terrorism/>> accessed 30 May 2018

60. Hernando Salazar, ‘Colombia: investigan médicos’ (*BBC Mundo*, 2008) <http://news.bbc.co.uk/hi/spanish/latin_america/newsid_7635000/7635739.stm> accessed 30 May 2018; Carlos Francisco Fernández and Sonia Perilla S ‘Se reabre debate sobre si asistir médicamente a una persona al margen de la ley es delito’ (*El Tiempo*, 2008) <<http://www.eltiempo.com/archivo/documento/CMS-4542240>> accessed 30 May 2018; Laura Pedraza Rodríguez, ‘Uno a nadie le puede negar la salud’ (*Cerosetenta*, 2015)

61. Laura Pedraza Rodríguez, ‘Uno a nadie le puede negar la salud’ (*Cerosetenta*, 2015) <<https://cerosetenta.uniandes.edu.co/uno-a-nadie-le-puede-negar-la-salud/>> accessed 30 May 2018; Hernando Salazar, ‘Colombia: investigan médicos’ (*BBC Mundo*, 2008) <http://news.bbc.co.uk/hi/spanish/latin_america/newsid_7635000/7635739.stm> accessed 30 May 2018

62. Semana, ‘Doctors working for FARC: Medical mix-up?’ (*Semana*, 2009) <<http://www.semana.com/international/print-edition/articulo/doctors-working-for-farc-medical-mix-up/100099-3>> accessed 30 May 2018

63. Laura Pedraza Rodríguez, ‘Uno a nadie le puede negar la salud’ (*Cerosetenta*, 2015) <<https://cerosetenta.uniandes.edu.co/uno-a-nadie-le-puede-negar-la-salud/>> accessed 30 May 2018

64. <https://corte-suprema-justicia.vlex.com.co/vid/sentencia-suprema-justicia-sala-penal-69223885>

65. HLS PILAC ‘5 State responses to terrorism’ (Harvard Law School Program on International Law and Armed Conflict) <<https://pilac.law.harvard.edu/mcac-report//5-state-responses-to-terrorism/>> accessed 30 May 2018

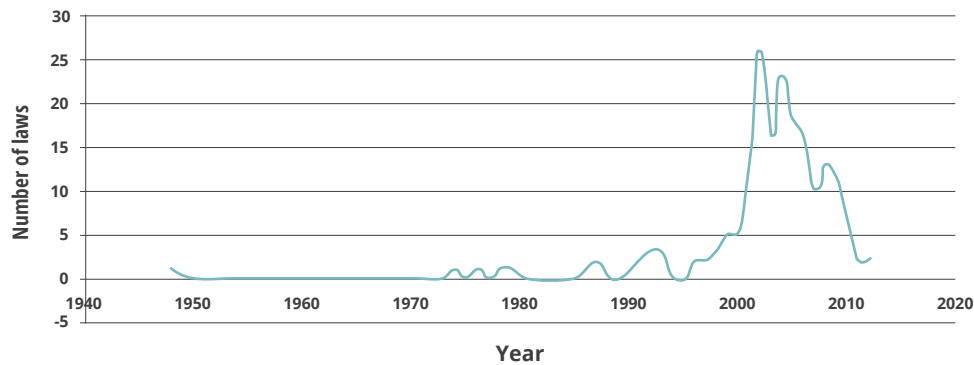
medical activities performed by the accused “strengthened the guerilla group since healed members of the group would subsequently return to fight”.⁶⁶

In South Asia, where Maoist movements have also been active,⁶⁷ doctors working in affected areas in the central and eastern parts of India have faced legal issues. One high-profile case is that of Dr. Binayak Sen,⁶⁸ an Indian pediatrician who devoted his life to “improving the health and welfare of some of the most marginalised and poverty-stricken people in India”⁶⁹ and was running mobile clinics in Chhattisgarh, one of the states most affected by the insurgency.⁷⁰ Dr. Sen had also been documenting alleged human rights violations carried out during “anti-Naxalite” operations. He was detained on May 14, 2007, under the Chhattisgarh Special Public Security Act. Authorities initially detained him on grounds that he was acting as a courier between the jailed Maoist leader Narayan Sanyal and an alleged supporter. Dr. Sen had been visiting the 70-year-old leader to provide medical and legal assistance under the supervision of prison authorities, who were authorized to search him. After Dr. Sen’s arrest, his house was subsequently searched and documents collected allegedly showed his links with Maoists. Dr. Sen was convicted of sedition in December 2010 and sentenced to life in prison.⁷¹ In April 2011, the Indian Supreme Court observed that there was actually no evidence of sedition and granted him bail.⁷² At this time, the two judges observed: “The worst that can be said is that he was found in possession of general documents (sympathetic to Naxalism), but how can it be said that such possession would attract the charge of sedition?”⁷³

Elsewhere, in the years before the adoption of new counter-terrorism frameworks following the attacks of September 11, doctors were prosecuted for offering medical care to people deemed to be terrorists. In Kosovo, Serb authorities brought criminal charges against Kosovar Albanian physicians for allegedly providing care to members of the Kosovo Liberation Army.⁷⁴ In Turkey, doctors who provided rehabilitation services to victims of torture were prosecuted and imprisoned.⁷⁵

While the examples above show that prosecution of impartial care predated the rise of contemporary forms of counter-terrorism frameworks, the overall terrain has dramatically evolved in the last two decades.⁷⁶ In the wake of September 11 and under the rubric of counter-terrorism, new treaties, legislation, decrees, agencies, and doctrines have emerged, with the intent to prevent terrorist attacks, minimize their impact if they occur, and take into account their transnational dimensions.⁷⁷ Before September 11, only 31 states had specific counter-terrorism legislation; that number rose to 109 by 2014.⁷⁸

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66. Ekaterina Ortiz Linares and Marisela Silva Chau ‘Reflections on the Colombian case law on the protection of medical personnel against punishment’ (2013) 95 (890) *International Review of the Red Cross* <<https://www.icrc.org/en/download/file/11108/irrc-890-ortiz-linares-chau.pdf>> accessed 25 May 2018; Case No 27227 of 21 May 2009, Supreme Court of Justice of Colombia
67. Alpa Shah and Judith Pettigrew ‘Windows into a revolution: ethnographies of Maoism in South Asia’ (2009) (3/4) *Dialectical Anthropology* <<https://link.springer.com/content/pdf/10.1007/s10624-009-9142-5.pdf>> accessed 22 May 2018
68. Human Rights Watch ‘Between Two Sets of Gun: Attacks on Civil Society Activists in India’s Maoist Conflict’ (2012) Human Rights Watch <<https://www.hrw.org/report/2012/07/30/between-two-sets-guns/attacks-civil-society-activists-indias-maoist-conflict>> accessed 21 May 2018; Independent, ‘Outcry over ‘saintly’ doctor jailed for aiding Maoist rebels’ (Independent, 7 February 2011) <<http://www.independent.co.uk/news/world/asia/outcry-over-saintly-doctor-jailed-for-aiding-maoist-rebels-2206373.html>> accessed 21 May 2018
69. The Lancet ‘Binayak Sen’s conviction: a mockery of justice’ (2011) 377 (9760) *The Lancet* <[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)60003-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60003-2/fulltext)> accessed 22 May 2018
70. Malavika Vyawahare ‘A Conversation With: Human Rights Activist Binayak Sen’ (2012) *New York Times* <<https://india.blogs.nytimes.com/2012/12/10/a-conversation-with-human-rights-activist-dr-binayak-sen/>> accessed 22 May 2018
71. Human Rights Watch ‘Between Two Sets of Gun: Attacks on Civil Society Activists in India’s Maoist Conflict’ (2012) Human Rights Watch <<https://www.hrw.org/report/2012/07/30/between-two-sets-guns/attacks-civil-society-activists-indias-maoist-conflict>> accessed 21 May 2018
72. Dhananjay Mahapatra and Supriya Sharma ‘SC grants bail to Binayak Sen, says no case for sedition charge’ (2011) *The Times of India* <<https://timesofindia.indiatimes.com/india/SC-grants-bail-to-Binayak-Sen-says-no-case-for-sedition-charge/articleshow/7987813.cms>> accessed 21 May 2018
73. Samanth Subramanian ‘Rights activist granted bail’ (2011) *The National* <<https://www.thenational.ae/world/asia/rights-activist-granted-bail-1.431348>> accessed 21 May 2018
74. Physicians for Human Rights ‘Perilous Medicine: The Legacy of Oppression and Conflict on Health in Kosovo’ (2009) <https://s3.amazonaws.com/PHR_Reports/perilous-medicineKosovo-legacy.pdf> accessed 21 May 2018
75. Global Torture Fighters ‘In prison for protecting torture victims in Turkey’ (2010) <<https://irct.org/media-and-resources/latest-news/article/572>> accessed 20 May 2018
76. While some tactics may be similar, the definitions of insurgencies and guerrillas are doctrinally different from terrorism. Guerilla wars are often seen as a subcomponent of insurgencies, whose work center on attacking regimes and their goals. Terrorists, by comparison, focus on broader ideological intentions. At least in some contexts, however, the definitions are considered to overlap, for example with respect to the FARC who were designated an insurgent entity by the Government of Colombia and as a terrorist entity by the United States.
77. Institut de Relations Internationales et Stratégiques (IRIS) ‘How will the international counterterrorism architecture evolve in the next 5 years and in what way does it affect humanitarian action?’ (2016) <<http://www.iris-france.org/wp-content/uploads/2016/11/ENG-Observatoire-Prospective-Huma-CounterTerrorism-October-2016.pdf>> accessed 20 May 2018
78. Elena Pokalova ‘Legislative Responses to Terrorism: What Drives States to Adopt New Counterterrorism Legislation?’ (2015), 27(3) *Terrorism and Political Violence* 474, 477



Trends counterterrorism legislation

Elena Pokalova (2015) *Legislative Responses to Terrorism: What Drives States to Adopt New Counterterrorism Legislation?*, *Terrorism and Political Violence*, 27:3, 474-496, pg. 477

Powerful governments led a determined and robust response to terrorism, emboldened by widely shared views that decision makers needed to be “tough on terrorism”.⁷⁹ The UN Security Council adopted a number of anti-terrorism resolutions, binding for all member states.⁸⁰ They were complemented by General Assembly resolutions, anti-terrorism conventions, and specialized agencies’ counter-terrorism-related policies, standards, and programming initiatives.⁸¹ Governments of affected countries (or of those in their vicinities) or enmeshed in armed conflict adopted wide-ranging laws and penalties against terrorism.⁸² States passed laws that generally sought to broaden the definition of the crime of terrorism; to prohibit financial transactions with terrorist organizations, the provision of (or the attempt to provide) diverse forms of support and resources to terrorists, as well as association with terrorist organizations, and to prosecute terror offences and establish penalties. Some states also addressed terrorism concerns through asylum regulations, barring alleged supporters of terrorism from asylum claims.⁸³ The approaches deployed were expansive, and in the view of some “potentially abusive.”⁸⁴ Fionnuala Ni Aolain, Special Rapporteur on the promotion and protection of human rights while countering terrorism noted at the occasion of the presentation of her 2018 report to the Human Rights Council that “a vague and overly broad definition of terrorism” had been used “to target civil society, human rights defenders, bloggers and activists, which in effect had been abuse of the law.”⁸⁵ The Committee on Economic, Social and Cultural Rights also

79. David S. Broder and Dan Balz ‘How Common Ground of 9/11 Gave Way to Partisan Split’ (16 July 2006) http://www.washingtonpost.com/wp-dyn/content/article/2006/07/15/AR2006071500610_pf.html “When he resumed campaign planning in the spring of 2002, Edwards had concluded that voters would have a new set of criteria for evaluating candidates: How tough are you? Are you tough on terrorism? Are you tough in what you’re willing to do? Are you tough in your ability and willingness to use military force?” ; Bruce Ackerman, *Terrorism and the Constitutional Order*, 75 *Fordham L. Rev.* 475 (2006). Available at: <http://ir.lawnet.fordham.edu/flr/vol75/iss2/2/>: “The “war on terror”... invites an aroused public to support the President in an endless struggle against an amorphous enemy”

80. United Nations Office of Counter Terrorism, Counter-Terrorism Implementation Task Force (CTITF) ‘UN Global Counter-Terrorism Strategy’ <<https://www.un.org/counterterrorism/ctitf/en/un-global-counter-terrorism-strategy>> accessed 21 May 2018

81. Alice Debarre, ‘The Tensions between Counterterrorism Approaches and International Humanitarian Law/Principled Humanitarian Action’ Background Paper (International Peace Institute, 2018) https://www.ipinst.org/wp-content/uploads/2018/05/IPI_April-26-workshop_Background-paper-2.pdf

82. 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 (HLS PILAC), 8 September 2015 <<https://ssrn.com/abstract=2657036>> accessed 30 May 2018, 4

83. The US Immigration and Nationality Act (INA) section 212(a)(3)(B) renders inadmissible an alien who provides material support, including the provision of medical care, to a terrorist organization or to an individual the alien knows, or reasonably should know, has committed or plans to commit a terrorist activity. Policy memorandum PM-602-0052, 20 November 2011 introduced limited exception concerning certain forms of medically related material support to terrorism

84. Institut de Relations Internationales et Stratégiques (IRIS) ‘How will the international counterterrorism architecture evolve in the next 5 years and in what way does it affect humanitarian action?’ (2016) <<http://www.iris-france.org/wp-content/uploads/2016/11/ENG-Observatoire-Prospective-Huma-CounterTerrorism-October-2016.pdf>> accessed 20 May 2018

85. United Nations Human Rights Council ‘Human Rights Council discusses the protection of human rights while countering terrorism, and cultural rights’ (1 March 2018) <<http://www.ohchr.org/EN/HRBodies/HRC/Pages/NewsDetail.aspx?NewsID=22742&LangID=E>> accessed 20 May 2018

expressed, on multiple occasions, its concerns about State parties' broadly formulated definitions of terrorism.⁸⁶

None of the new counter-terrorism laws and regulations in the countries surveyed in this report explicitly refer to the provision of medical care as forbidden and/or considered as material support for terrorism. Nor do these laws explicitly allow the provision of medical care to banned groups, though a small number of the surveyed countries carve out exceptions for acts defined as purely "humanitarian" in nature or for the provision of medicines for instance. But overall, and this is a central matter, counter-terrorism laws have tended to contain broad definitions of terrorism and what is meant by support for terrorists.⁸⁷ As a result, such laws leave broad space for interpretation and may result in criminalization of non-violent activities, including medical care.⁸⁸ The provision of healthcare to groups or individuals listed as terrorists has, in some cases, been construed as an illegitimate form of support for terrorism. These interpretations have had a significant impact on the provision of medical care.

Having (or being suspected of having) provided medical care to those labeled terrorists or enemies, health professionals find themselves caught between domestic criminal laws to combat terrorism that criminalize their behavior and their ethical duties to impartially treat all on the basis of medical need, a duty recognized under international human rights and humanitarian law, as noted above. The profusion of counter-terrorism laws established a backdrop conducive to recasting medical care "as a form of illegitimate support to the enemy"⁸⁹. And when ethics, human rights and humanitarian legal frameworks are not clearly prioritized and maintained, "both those seeking and providing medical care inevitably become criminalized".⁹⁰

4.2. Counter-terrorism laws and the criminalization of healthcare

Following the recent proliferation of counter-terrorism legislation, instances of health professionals prosecuted for providing care have been recorded from Syria to Pakistan, Nigeria to Turkey, Iraq to the United States. The scope concerning whom or what activities are deemed illegitimate and the consequences have varied among jurisdictions.⁹¹ The result, however, is that in more and more jurisdictions, the provision of medical care is being considered an unlawful form of support for terrorism. "Doctors and other health-care workers have been arrested, charged and sentenced for acting within their professional duty of ensuring medical impartiality" as noted by the Special Rapporteur on the right to health.⁹² Such cases are increasingly apparent as governments committed to countering terrorist threats deploy more robust responses. **Of the 16 countries surveyed for this report, practices in at least 10 countries appear to suggest that the authorities interpret support to terrorism to include the provision of healthcare.**

As the discussion about pre September 11 cases shows, what is new is not the criminalization of healthcare per se, but how the counter-terrorism framework has purportedly strengthened the legal and moral basis to justify such actions.⁹³ Below are a few examples illustrating how health professionals have found or could find themselves accused of supporting

86. UN CCPR 'Concluding observations on the seventh periodic report of the United Kingdom of Great Britain and Northern

Ireland',** (17 August 2015) UN Doc CCPR/C/GBR/CO/7 <<http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsg%2F0K3H8qae8NhIdi53Mecj8Es8jxwwaL1HQ8hgVMkgor%2Ba2BnDTW%2FHC6BlyM8TPJNF%2F6qe%2Bcdb0NBnXp%2BA57rBA17cvjmBwuiVD2gq5FYEj>> accessed 20 May 2018; UN CCPR 'Concluding observations on the sixth periodic report of Canada'

(13 August 2015) UN Doc CCPR/C/CAN/CO/6 <<http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhskswUHe1nBHTSwwEsgdxQHJBoKwgsS0jmHCTV%2FFsa70KzYyna940OqLeAawpMzCD5oTanJ2C2rbU%2F0kxds%2BXCyn40Fm3xDYg3CouE4uXS>> accessed 20 May 2018

87. There is no universally agreed upon definition of terrorism

88. Human Rights Watch "'Foreign Terrorist Fighter' Laws: Human Rights Rollbacks Under UN Security Council Resolution 2178' (2016) <https://www.hrw.org/sites/default/files/news_attachments/ftf_essay_03feb2017_final.pdf> accessed 18 May 2018

89. 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 (HLS PILAC)*, 8 September 2015 <<https://ssrn.com/abstract=2657036>> accessed 30 May 2018,

90. Dr. Françoise Bouchet-Saulnier 'IHL & Counter-Terrorism: Tensions and Challenges for Medical Humanitarian Organizations' (*Médecins sans Frontières Analysis*, 2 June 2016) <<https://msf-analysis.org/ihl-counter-terrorism-tensions-challenges-medical-humanitarian-organizations/>> accessed 18 May 2018

91. 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 (HLS PILAC)*, 8 September 2015 <<https://ssrn.com/abstract=2657036>> accessed 30 May 2018,

92. UNGA 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (9 August 2013) UN Doc A/68/297

93. Jonathan Whittall 'Treating Terrorists' (*Médecins sans Frontières Analysis*, 2015) <<https://msf-analysis.org/new-treating-terrorists/>> accessed 18 May 2018

terrorism for providing care to individuals belonging to groups labeled terrorists or enemies:

Iraq - Since the battle against the Islamic State of Iraq and Syria (ISIS) largely came to an end, Iraqi forces have been screening, charging, and convicting thousands of people for ties to ISIS. The Iraqi law on combating terrorism (13/2005)⁹⁴ allows judges to bring charges against a wide range of suspects, “including some who are not implicated in specific violent acts but are deemed to have assisted ISIS”.⁹⁵ This has in practice included doctors who continued working in hospitals under ISIS-held territories.⁹⁶ Senior counter-terrorism judges were reportedly considering terrorism charges against doctors, who continued providing medical care in Mosul under ISIS.⁹⁷

Nigeria has complex challenges with its counter-terror legislation, which includes the Terrorism (Prevention) (Amendment) Act of 2013.⁹⁸ Cases of doctors arrested for providing care to Boko Haram members have been reported, including that of Dr. Muhammad Marri Abba, who was detained on October 22, 2012. Dr. Abba was said to be “coming from a WHO program at Nangere LG area of Yobe state on October 22, 2012 when he was allegedly arrested by a combined team of army and police personal.”⁹⁹ The physician was suspected of supporting Boko Haram and, though not charged, was kept incommunicado. In May 2016, he sued the federal government and demanded that the Federal High Court in Abuja declare his 4-year detention illegal, unlawful, unconstitutional, and an infringement on his fundamental right to liberty.¹⁰⁰

Pakistan, which has been grappling with terrorism at least for the past two decades, has promulgated a number of laws, including the Anti-Terrorism Act (ATA) of 1997, the 2014 Protection of Pakistan Act, and subsequent Constitutional Amendment Acts. The ATA contains a broad definition of terrorist acts, which creates ambiguity as to what exactly constitutes a terrorist act (Section 6, subsection 1).¹⁰¹ Some doctors have been arrested as a result of providing care to suspected terrorists. On October 5, 2015, the Counter Terrorism Department (CTD) raided the Zubaida Medical Center in Bahadurabad. It reportedly arrested two suspected militants under treatment as well as three doctors for treating the suspects. The Karachi police chief confirmed the raid at the health facility¹⁰² and that those arrested were charged with treating militants from the outlawed Tehreek-i-Taliban Pakistan, without informing the authorities.¹⁰³ Though the CTD released the three doctors on November 17, 2015, it was only because “they did not know that the wounded they were treating were militants”.¹⁰⁴

Syria - Anti-terrorism laws were issued in July 2012, with Law 19/2012 defining terrorism, stating criminalized acts and related punishment.¹⁰⁵ The law is vague, allowing state officials to arrest and prosecute a person for any act considered a disturbance “to public security” committed “by means of any tools”.¹⁰⁶ Financing terrorism is defined as “any direct or indirect raising or supplying of money, arms, munitions, explosives, telecommunications means, information or any

94. Anti-Terrorism Law 13/2005, available here: gipi.org/wp-content/uploads/anti-terrorism-law-iraqi-no-13-2005.doc

95. Human Rights Watch ‘Flawed Justice: Accountability for ISIS Crimes in Iraq’ (HRW, 5 December 2017) <<https://www.hrw.org/report/2017/12/05/flawed-justice/accountability-isis-crimes-iraq>> accessed 18 May 2018

96. *ibid*

97. See also, *ibid*

98. Federal Republic of Nigeria Official Gazette, ‘Terrorism (Prevention) (Amendment) Act’ (2013) 100 (25) Federal Republic of Nigeria Official Gazette A27 <<http://placng.org/wp/wp-content/uploads/2018/02/Terrorism-Prevention-Amendment-Act-2013.pdf>> accessed 5 June 2018

99. Unini Chioma, ‘Medical doctor detained since 2012 drags FG to court, demands N500m damages’ (The Nigeria Lawyer, 16 May 2016) <<http://thenigerialawyer.com/medical-doctor-detained-since-2012-drags-fg-to-court-demands-n500m-damages/>> accessed 18 May 2018 <https://www.adhrb.org/2017/03/dr-ali-al-ekri-completes-sentence-released-prison/>

100. Unini Chioma ‘Medical doctor detained since 2012 drags FG to court, demands N500m damages’ (The Nigeria Lawyer, 16 May 2016) <<http://thenigerialawyer.com/medical-doctor-detained-since-2012-drags-fg-to-court-demands-n500m-damages/>> accessed 18 May 2018

101. Public Procurement Regulatory Authority (Pakistan) ‘The Anti Terrorism Act (ATA), 1997’ <<http://www.ppra.org.pk/doc/anti-t-act.pdf>> accessed 20 May 2017 - With the ATA defining terrorism as “the use or threat of action where the use or threat is designed to coerce and intimidate or overawe the Government or the public”

102. Dawn ‘Doctor, wounded militants held in raids on three Karachi hospitals’ (Dawn, 5 October 2015) <<https://www.dawn.com/news/1210908>> accessed 18 May 2018

103. Shiite NEWS ‘Doctors arrested for Assisting Taliban Released’ (Shiite NEWS, 18 November 2015) <<http://www.shiiteneews.org/index.php/pakistan/item/19603-doctors-arrested-for-assisting-taliban-released/19603-doctors-arrested-for-assisting-taliban-released>> accessed 18 May 2018

104. Ishaq Tanoli ‘Three doctors held for treating ‘militants’ released’ (Dawn, 18 November 2015) <<https://www.dawn.com/news/1220375/three-doctors-held-for-treating-militants-released>> accessed 17 May 2018

105. Violations Documentation Center in Syria - VDC, ‘Special Report on Counter-Terrorism Law No. 19 and the Counter-Terrorism Court in Syria’ (April 2015) <<http://www.vdc-sy.info/pdf/reports/1430186775-English.pdf>> accessed 20 May 2018, Laws 19, 20, 21 and 22 of 2012

106. *ibid*, Law 19/2012, art 1

other object to be used in a terrorist act perpetrated by a terrorist individual or terrorist organization". "Any other object" renders the definition of support so broad that it could include healthcare, for which there is no exemption clause. The Independent International Committee of Inquiry on the Syrian Arab Republic noted that the laws had "effectively made it a crime to provide medical care to anyone suspected of supporting the rebels. Laws 19, 20 and 21 contravene the customary international humanitarian law rule that under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom."¹⁰⁷ It also reported the government had invoked anti-terrorism laws to curtail medical support to opposition factions and their purported supporters.¹⁰⁸ One of many such cases was that of Dr. Abbas Khan, who provided medical care to wounded opposition fighters designated as terrorists and was arrested in Aleppo in November 2012. He was detained, tortured, and died in government detention, a day before he was to appear before a terrorism court.¹⁰⁹ He told his family that he was accused of treating dying women and children, which had been classified as an act of terrorism.¹¹⁰

Turkey – In recent years, the Turkish authorities have arrested, detained, and prosecuted individuals suspected of belonging to groups listed as terrorist organizations. At least 50,000 people have been remanded on pretrial detention and more have been prosecuted since the 2016 failed coup, including journalists, civil servants, teachers, and politicians, as well as police officers and military personnel.¹¹¹ Physicians, including Dr. Serdar Küni, were also arrested. Dr Küni was apprehended on October 19, 2016, and accused of providing medical treatment to members of the Kurdistan Workers' Party (PKK) - listed as a terrorist organization by Turkey - during clashes in the city of Cizre in 2015 and 2016. On April 24, 2017, a court in Şırnak sentenced Dr. Küni to four years and two months in prison. He was charged under Article 220(7) of the Turkish Penal Code pertaining to aiding and abetting a terrorist organization.¹¹² In June 2017, the Working Group on Arbitrary Detention, the Special Rapporteur on the right to health, the Special Rapporteur on the situation of human rights defenders, the Special Rapporteur on the independence of judges and lawyers and the Special Rapporteur on torture and other forms of cruel, inhuman or degrading treatment or punishment addressed a communication to the Turkish Authorities concerning "the alleged arbitrary detention and conviction of Dr. Serdar Küni for actions that pertain to his duty as a doctor to provide equal and appropriate medical treatment to everyone".¹¹³ In its response, the Turkish authorities emphasized the severe threats terrorist organization represented for the country and that article 220/7 rendered persons knowingly aiding a criminal organization liable to punishment.¹¹⁴

United States of America - In the United States, support for terrorism constitutes prohibited activities as codified in title 18 of the U.S. Code, Section 2339A¹¹⁵ on providing material support to terrorists and Section 2339B¹¹⁶ on providing material support of resources to designated foreign terrorist organizations. The law exempts the provision of medicine¹¹⁷ and religious materials from this prohibition, and the material-support statute allows for the Secretary of State, together with the Attorney General, to approve the provision of "personnel," "training," and "expert advice and assistance" that might

107. UNSC 'Report of the independent international committee of inquiry on the Syrian Arab Republic' (12 February 2014) UN Doc A/ HRC/25/65 para 111; Annex VII 'Assaults on Medical Care' para 21

108. UNSC 'Report of the independent international committee of inquiry on the Syrian Arab Republic' (12 February 2014) UN Doc A/HRC/25/65 para 111

109. Abul Taher 'Family of British surgeon killed in Syria say he was drugged and hanged by his captors then his body flushed with fluids to ruin a post-mortem' (*Daily Mail*, 28 December 2013) <<http://www.dailymail.co.uk/news/article-2530457/Family-British-surgeon-killed-Syria-say-drugged-hanged-captors-body-flushed-fluids-ruin-post-mortem.html>> accessed 18 May 2018

110. Lizzie Dearden 'Dr Abbas Khan was unlawfully killed in Syrian prison despite 'suicide' claims, inquest finds' (*The Independent*, 27 October 2017) <<https://www.independent.co.uk/news/uk/crime/dr-abbas-khan-was-unlawfully-killed-in-syrian-prison-despite-suicide-claims-inquest-finds-9821316.html>> accessed 16 May 2018

111. Human Rights Watch 'Turkey: Events of 2017' (2017) <<https://www.hrw.org/world-report/2018/country-chapters/turkey>> accessed 17 May 2018

112. Worldwide Movement for Human Rights 'Turkey: Conviction and sentence against Dr. Serdar Küni (TIHV)' (26 April 2017) <<https://www.fidh.org/en/issues/human-rights-defenders/turkey-conviction-and-sentence-against-dr-serdar-kuni-tihv>> accessed 20 May 2018

113. OHCHR, 'Letter on Mandates of the Working Group on Arbitrary Detention from the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; the Special Rapporteur on the situation of human rights defenders; the Special Rapporteur on the independence of judges and lawyers; and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment' (23 June 2017) AL TUR 8/2017<<https://spcommreports.ohchr.org/TMResultsBase/DownloadPublicCommunicationFile?glid=23180>> accessed 20 May 2018

114. Note replies received from Turkey (22 August 2017) available here: <https://spcommreports.ohchr.org/TmSearch/Results>

115. 18 U.S. Code § 2339A <<https://www.law.cornell.edu/uscode/text/18/2339A>> accessed 18 May 2018

116. 18 U.S. Code § 2339B <<https://www.law.cornell.edu/uscode/text/18/2339B>> accessed 18 May 2018

117. The jurisprudence has indicated that 'any assistance to a designated terrorist group – apart from the statutorily exempt medicine and religious materials – will be seen as furthering that group's terrorist activities, relying on the notion of fungibility of resources' and the exemption for 'medicine' does not appear to extend beyond medicine itself, thus excluding such activities as medical treatment, training or the provision of other medical equipment.

otherwise qualify as material support.¹¹⁸ The U.S. instituted legal proceedings against physicians for supporting terrorists through medical activities in relation to armed conflicts. Dr. Rafiq Sabir, a New York licensed physician trained at Columbia University, was arrested on May 28, 2005, and indicted in the Southern District of New York on charges that between October 2003 and May 2005 he had conspired to provide material support or resources to the terrorist organization al Qaeda, under its direction and control, and provided or attempted to provide such support.¹¹⁹ Dr. Sabir had sworn an oath of allegiance to al Qaeda and offered to be on call to treat wounded jihadis in Saudi Arabia. He was convicted by a jury of conspiring to provide and actually providing or attempting to provide material support under the direction or control of a terrorist organization in violation of 18 U.S.C. § 2339B and sentenced to a 300-month term of incarceration. In dismissing Dr. Sabir's challenge to the constitutionality of his indictment, a judge emphasized that Dr. Sabir was not charged for being a doctor or for performing medical activities but because he had volunteered as a medic in the al Qaeda military structure, putting himself at their service to attend to the wounds of injured fighters. The rationale underlying Dr. Sabir's conviction was that it was "impermissible to provide medical support (except medicine itself) to wounded jihadis knowing that they have engaged in terrorist activity".¹²⁰ Because the offense required that the person act under the direction and control of a terrorist organization, the court indicated that a different conclusion might have been reached in the case of independent humanitarian workers "act[ing] entirely independently of [a] foreign terrorist organization."¹²¹

Australia - Since the terrorist attacks of September 11, the Australian government has introduced more than 40 new counter-terrorism laws.¹²² According to the Australian Human Rights Commission, these laws "have created new criminal offences related to terrorism, new detention and questioning powers for police and security agencies, new powers for the Attorney-General to 'list' (ban) terrorist organizations, and new ways to control people's movement and activities without criminal convictions".¹²³ In the absence of an international definition of terrorism, the Australian definition of the crime drew heavily on the UK Terrorism Act of 2000.¹²⁴ The anti-terrorism laws are inconsistent in their protection of Australian medics. Some offences such as "association" with a terrorist organization,¹²⁵ entry into a "declared area"¹²⁶ or providing resources to a foreign fighter¹²⁷ contain humanitarian exemptions. However, those seeking an exemption bear the evidential burden should the matter proceed to court. This has been criticized by the Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism as "such legislative techniques may conflict with the right to a fair trial, in particular the respect for the presumption of innocence under article 14 of the International Covenant on Civil and Political Rights, which is a non-derogable right."¹²⁸ Other offences proscribe conduct connected to terrorist activity and do not provide humanitarian exemptions, for example, the provision of "support or resources" that would "help" an organization engage in terrorist acts.¹²⁹ According to media reports, an Australian medic is currently facing charges under this section by "making himself available to the organization by undertaking guard duty and providing medical services."¹³⁰ There are several offences which criminalize conduct regardless of its connection to violence and regardless of the independence of the actors involved. The offence of providing "training" to a terrorist organization bans

118. Katie King, Naz K. Modirzadeh and Dustin A. Lewis, 'Understanding Humanitarian Exceptions: U.N. Security Council Sanctions and Principled Humanitarian Action' (*Harvard Law School Program on International Law and Armed Conflict (HLS PILAC)*, April 2016) <http://blogs.harvard.edu/pilac/files/2016/04/Understanding_Humanitarian_Exemptions_April_2016.pdf> accessed 17 April 2018, 12; Holder v. Humanitarian Law Project, 561 U.S. 1, 16-17 (2010)

119. *United States v Farhane* 634 F.3d 127, 132 (2d Cir, 2011) <<https://caselaw.findlaw.com/us-2nd-circuit/1554703.html>> accessed 20 May 2018

120. HLS PILAC '5 State responses to terrorism' (Harvard Law School Program on International Law and Armed Conflict) <<https://pilac.law.harvard.edu/mcac-report//5-state-responses-to-terrorism>> accessed 30 May 2018

121. *United States v Shah*, 474 F. Supp. 2d 492 (S.D.N.Y.2007) <<https://www.courtlistener.com/opinion/2579725/united-states-v-shah/>> accessed 20 May 2018

122. Australian Human Rights Commission 'A Human Rights Guide To Australia's Counter-Terrorism Laws' (2008) <<https://www.humanrights.gov.au/human-rights-guide-australias-counter-terrorism-laws>> accessed 20 May 2018, section 2.1; George Williams, 'A Decade of Australian anti-Terror Laws' (2011) 35(3) *Melbourne University Law Review* 1136 <<http://search.informit.com.au/documentSummary;dn=520408496475278;res=IELHSS>> accessed 18 April 2018

123. Australian Human Rights Commission 'A Human Rights Guide To Australia's Counter-Terrorism Laws' (2008) <<https://www.humanrights.gov.au/human-rights-guide-australias-counter-terrorism-laws>> accessed 20 May 2018, section 2.1

124. George Williams, 'A Decade of Australian anti-Terror Laws' (2011) 35(3) *Melbourne University Law Review* 1136 <<http://search.informit.com.au/documentSummary;dn=520408496475278;res=IELHSS>> accessed 18 April 2018; CSIS Human Rights Initiative, 'Counterterrorism measures and civil society: Changing the will, finding the way' (*Center for Strategic and International Studies*, 2018) <<https://www.csis.org/analysis/counterterrorism-measures-and-civil-society>> accessed 22 March 2018

125. Australian Criminal Code 1995(Cth), Section 102.7

126. Australian Criminal Code 1995(Cth), Section 119.2

127. Australian Criminal Code 1995(Cth),Section 119.4(7)

128. Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism (2016) UN Doc A/71/384 para 50. <http://ap.ohchr.org/documents/dpage_e.aspx?si=A/71/384> last accessed 11 June 2018

129. Australia Federal Register of Legislation, Criminal Code of 1995 as amended <<https://www.legislation.gov.au/Details/C2015C00254>> accessed 20 May 2018

medical or international humanitarian law compliance training by groups such as the ICRC and Geneva Call.¹³¹ Similarly, the provision of finances or assets to a terrorist organization is prohibited, regardless of their intended use.¹³² Both the offence of providing “training” and finances or assets arguably extend beyond listed terrorist organizations to any armed actor in a conflict zone.¹³³ The Australian Independent National Security Legislation Monitor and several academics have expressed concern about the breadth of these laws.¹³⁴

United Kingdom - In the past two decades, the United Kingdom has passed several pieces of counter-terrorism legislation, including its landmark 2000 Terrorism Act.¹³⁵ In the Act, offences are framed around providing money or property. Section 15, labeled “fundraising”, provides that “[a] person commits an offence if he (a) provides money or other property, and (b) knows or has reasonable cause to suspect that it will or may be used for the purposes of terrorism.” While there has not to date been any prosecution under Section 15 of healthcare workers for providing care, medicines and medical equipment would fall under the definition of property. Furthermore, though the actual act of providing medical care would not itself be prohibited, it would almost certainly involve “making available” of property to a terrorist. Thus, providing medicines or medical equipment to a terrorist when a provider had reasonable cause to suspect s/he would go on to commit terrorism would be prohibited, and since it is not possible to provide medical care without making available some sort of property, the prohibition of provision of medical care in such a situation would be a corollary of the Section 15 offence. There is no exception for medical provision or humanitarian action in the Terrorism Act. In 2015, a parliamentary committee recommended that the government consider introducing exceptions to counterterrorism legislation for humanitarian activities.¹³⁶ The Home Office and Treasury Office of Financial Sanctions Implementation responded: “We assess that introducing a specific exemption for humanitarian and/or conflict resolution work would create a loophole that could be exploited by unscrupulous individuals and leave NGOs vulnerable to abuse”.¹³⁷

These examples illustrate how domestic laws and policies intended to fight terrorism can be applied to prosecute health professionals seeking to discharge, and/or discharging healthcare including in conformity with their professional duties. Arguably, the situations are often complex and there are a number of cases where charges brought against physicians and other medical professionals include but are not limited to the provision of healthcare to terrorists or insurgents. Forceful responses to terrorism appear to be eroding the notion that wounded enemy fighters are entitled to care. Broad definitions and expansive interpretations of counter-terrorism laws contribute to casting doctors providing care to terrorists/enemies as enemies themselves, exposing significant weaknesses in domestic implementation of international humanitarian and human rights law medical care protections.¹³⁸

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130. Jacqueline Le, ‘Melbourne nurse faces trial accused of working in Syria with IS, Chechen rebels’ (*The Age*, 1 February 2018) <<https://www.theage.com.au/national/victoria/melbourne-nurse-faces-trial-accused-of-working-in-syria-with-is-chechen-rebels-20180201-h0rxii2.html>> accessed 18 April 2018
131. Australian Criminal Code 1995(Cth), Section 102.5
132. Australian Criminal Code 1995(Cth), Section 102.6: ‘the provision of aid of a ‘humanitarian character’ was considered in relation to the LTTE during its period of control in north Sri Lanka’, see *R v Vinayagamoorthy & Ors* [2010] VSC 148
133. Australian Criminal Code 1995(Cth), section 102.1(1)(a) and (b) - See definition of terrorist organisation
134. Bret Walker, ‘Annual report 7th November 2013’ (*Australian Government: Independent National Security Legislation Monitor* 2013) <<https://www.inslm.gov.au/sites/default/files/publications/inslm-annual-report-2013.pdf>> accessed 4 June 2018; Ben Saul, ‘Submission to the council of Australian governments’ review of counter-terrorism legislation (*The University of Sydney, updated* 2012) <<https://www.ag.gov.au/Consultations/Documents/COAGCTReview/Professor%20Ben%20Saul.PDF>> accessed 4 June 2018
135. UK Parliament, ‘Terrorism act 2000’ (updated 2000) <<https://www.legislation.gov.uk/ukpga/2000/11/section/1/>> accessed 28 May 2018
136. Emanuela-Chiara Gillard, ‘Recommendations for Reducing Tensions in the Interplay Between Sanctions, Counterterrorism Measures and Humanitarian Action’ (Chatham House: The Royal Institute of International Affairs, 23 August 2017) <<https://www.chathamhouse.org/sites/default/files/publications/research/2017-08-23-sanctions-counterterrorism-humanitarian-action-gillard-final.pdf>> accessed 17 April 2018
137. Kate Jones ‘Humanitarian Action and Non-state Armed Groups: The UK Regulatory Environment’ (Chatham House: The Royal Institute of International Affairs, 17 February 2017) <<https://www.chathamhouse.org/sites/default/files/publications/research/2017-02-17-humanitarian-action-non-state-armed-groups-uk-jones.pdf>> accessed 17 April 2018 13; Joint Committee on the Draft Protection of Charities Bill, *Draft Protection of Charities Bill*, HL Paper 108, HC 103, February 2015, para 186
138. It should be noted that to date, no member of Western medical non-governmental organizations has been prosecuted for providing impartial care. The concern this may raise is that of selective prosecution, which itself contravenes IHRL standards

5. Other legislation and tools that can hamper healthcare

While the examples above illustrate how counter-terrorism legislation can lead to the prosecution of physicians and other individuals providing healthcare, there are numerous other ways by which the provision of healthcare can be domestically inhibited. In many contexts, general criminal laws, administrative sanctions, and intimidation tactics have been used to punish or deter health professionals from assisting patients alleged to be enemies of the state, terrorists, or criminals. Such practices appear to be enabled by a punitive counter-terrorism climate, where the very notion of ethical healthcare is overridden by state security interests, and where international obligations appear to take second place to domestic political objectives.

5.1. Laws used to press charges against health professionals

Observers and publicly available sources have pointed to circumstances where, in recent years, charges were lodged against health professionals without specific reference to healthcare, but where the underlying circumstances suggested that the charges actually stemmed from the provision of healthcare. In such cases, while the charges did not explicitly invoke medical support to banned groups, physicians have been prosecuted for other alleged illegal actions, often in conjunction with unauthorized demonstrations and protests, or other types of anti-government activities. General laws invoked include membership in a banned group (sometimes based on posts on social media), illegal association, unlawful assembly (at times for being present or near anti-government demonstrations), spreading of false information, anti-government propaganda, or intentions to overthrow the state. Turkey stands out for having included a health-related provision pertaining to the establishment of and “illicit, unauthorized and unsupervised provision” of healthcare services in its 2014 health bill.¹³⁹ Examples of cases where charges (non-terrorism related) have been brought against doctors are below.

Bahrain - In the wake of the 2011-2012 Bahraini uprising, 48 doctors, nurses, and other health professionals who cared for those wounded in political protests and documented the injuries they sustained, faced charges for their actions, and over 200 healthcare personnel were dismissed from their jobs.¹⁴⁰ Of the healthcare workers arrested, 20 were convicted of felonies by a military court and the remaining 28 of misdemeanors.¹⁴¹ Charges brought against them included participating in illegal assembly, calling for demonstrations, occupying a hospital or a public space, possession and concealment of weapons, stealing medication, discriminating against patients, withholding treatment of Sunnis, distributing false information to the media, inciting sectarian hatred, and promoting the overthrow of the state. The 20 health workers facing felony charges were found guilty and sentenced on September 29, 2011 by the military National Safety Court of First Instance. Thirteen received sentences of 15-year imprisonment, five were sentenced to five years and two were sentenced to 10 years. Retrials by a civilian court were announced the following month and began in March 2012. Nine of the defendants were acquitted while nine others had their sentences reduced. In March 2017, Dr. al-Ekri, a pediatric surgeon who had been in the operating room taking care of a teenage boy when security forces came to arrest him, completed his 5-year prison sentence.¹⁴²

Turkey - In addition to its counter-terrorism laws, Turkey's parliament passed a bill (part of a larger package of health bills) under which, medical professionals who provide health services without authorization in emergency situations could face up to three years' imprisonment or a fine of two million Turkish Lira (\$920 000). Bill 6514/46, which became effective on January 8, 2014, targets “engagement in activities out of their original mission by establishing illicit, unauthorized and

139. The World Medical Association, 'Turkish Medical Association: Pressure on Physicians and Medical Neutrality in Turkey' (17 October 2014) <<https://www.wma.net/wp-content/uploads/2016/11/GA-2014-Open-session-Turkey.pdf>> accessed 20 April 2018

140. See Related Special Procedures Communications <<https://spcommreports.ohchr.org/TmSearch/Results?page=2>> accessed 20 May 2018

141. Bahrain Independent Commission of Inquiry 'Report of the Bahrain Independent Commission of Inquiry' (2011) <http://www.bici.org.bh/BICIreportEN.pdf> accessed 20 May 2018, 178, 211-12

142. Americans for Democracy and Human Rights in Bahrain, 'Dr. Ali al-Ekri completes sentence, released from prison' (*Americans for Democracy and Human Rights in Bahrain*, 10 March 2017) <<https://www.adhrb.org/2017/03/dr-ali-al-ekri-completes-sentence-released-prison/>> accessed 17 April 2018

unsupervised healthcare service units under the name of ‘infirmary’.¹⁴³ On January 27, 2014, the Ministry of Health filed a lawsuit against the Ankara Chamber of Medicine using bill 6514/46. The suit demanded the removal of members of the governing and discipline board, alleging they had illegally delivered emergency services to demonstrators protesting in Gezi Park. After the judge heard several witnesses, he dismissed the case on February 20, 2015.¹⁴⁴ Other types of charges have been brought against Turkish medical professionals using general laws, including denigrating a mosque, assisting criminals, being part of an illegal organization, or taking part in protests.¹⁴⁵ Two such examples are Dr. Yasemin Erenç and Dr. Seren Yüksel, who provided first aid services to people wounded during the Gezi protest. They were put on trial for “protecting offenders” and “denigrating a Mosque” as they took care of the wounded inside Dolmabahçe Bezmî Alem Valide Sultan Mosque. On October 23, they were convicted of “denigrating a mosque” and sentenced to 10 months’ imprisonment. In another case, Dr. Selim Maktap and other members of the Hatay Chamber of Medicine were accused of “standing as a party and intervening in social protests” after they publicly communicated the results of the autopsy of on Ahmet Atakan, who died after falling from a building during protests.¹⁴⁶

Egypt - On January 14, 2016, Dr. Taher Mokhtar and his roommates were arrested after state security officers raided the doctor’s residence in central Cairo. The National Security Agency accused them of involvement in the preparation of protests to incite action against the state and its institutions, and to encourage people to spread chaos on January 25. Dr. Mokhtar was a member of the Freedoms Committee at the Egyptian Doctors Syndicate, an organization known for its long standing proximity to the Muslim Brotherhood, which was banned by an Egyptian court in 2013.¹⁴⁷ He played a “a key role in defending doctors’ and patients’ rights in Egypt”¹⁴⁸ and was a founding member of the campaign “Medical Neglect in Places of Detention is a Crime”.¹⁴⁹ At his home, security officials found papers from the campaign, and in particular leaflets criticizing medical condition in prisons.¹⁵⁰ Dr. Mokhtar was accused of attempts to overthrow the regime and kept in pretrial detention for seven months.¹⁵¹ On August 3, 2016, the South Giza Criminal Court ordered Dr. Mokhtar to be released on bail¹⁵² after lawyers filed a motion to protest his continued detention beyond the legal pretrial limit. Expecting to be arrested again, he fled the country in early 2017.¹⁵³

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143. The World Medical Association, ‘Turkish Medical Association: Pressure on Physicians and Medical Neutrality in Turkey’ (17 October 2014) <<https://www.wma.net/wp-content/uploads/2016/11/GA-2014-Open-session-Turkey.pdf>> accessed 20 April 2018
144. See https://s3.amazonaws.com/PHR_other/tma-amicus-brief-2014.pdf; Australian Medical Association ‘Charges Against Turkish Doctors Dropped’ (27 February 2015) <<https://ama.com.au/media/charges-against-turkish-doctors-dropped>> accessed 20 April 2018; Standing Committee of European Doctors, ‘Ankara Chamber of Medicine (ATO) case dismissed’ <<https://www.cpme.eu/ankara-chamber-of-medicine-ato-case-dismissed/>> accessed 20 April 2018; <http://physiciansforhumanrights.org/press/press-releases/judge-dismisses-case-against-turkish-medical-association.html>
145. See Istanbul Tabip Odasi ‘Physicians are in the Mosque; on the Street; in the hospital: wherever they are needed’ (*Istanbul Tabip Odasi*) <<http://www.istabip.org.tr/icerik/dolmabahcebrosuren.pdf>> accessed 17 April 2018; British Medical Journal (BMJ), ‘Two Turkish doctors who went to aid of protesters are sentenced to prison’ (BMJ), 2 November 2015 <<http://www.bmj.com/content/351/bmj.h5869>> accessed 17 April 2018; British Medical Association (BMA) ‘Drop charges against protester-helping doctors, says BMA’ (BMA, 30 June 2016) <<https://www.bma.org.uk/news/2014/october/drop-charges-against-protester-helping-doctors-says-bma/>> accessed 17 April 2018
146. The World Medical Association, ‘Turkish Medical Association: Pressure on Physicians and Medical Neutrality in Turkey’ (17 October 2014) <<https://www.wma.net/wp-content/uploads/2016/11/GA-2014-Open-session-Turkey.pdf>> accessed 20 April 2018
147. Patrick Kingsley, ‘Muslim Brotherhood banned by Egyptian Court’ (*The Guardian*, 23 September 2013) <<https://www.theguardian.com/world/2013/sep/23/muslim-brotherhood-egyptian-court>> accessed 17 April 2018
148. Egypt Solidarity, ‘Doctors delegation takes protest letter to Egypt embassy’ (*Egypt Solidarity*, 29 January 2016) <<https://egyptsolidarityinitiative.org/2016/01/29/doctors-delegation-takes-protest-letter-to-egypt-embassy/>> accessed 17 April 2018
149. Human Rights Watch ‘Egypt: Detained for Protesting Jail Conditions’ (*HRW*, 3 May 2016) <<https://www.hrw.org/news/2016/05/03/egypt-detained-protesting-jail-conditions>> accessed 17 April 2018
150. Erin Cunningham, ‘Egyptian writer caught up in government’s expanding crackdown’ (*The Washington Post*, 2 February 2016) <https://www.washingtonpost.com/world/middle_east/egyptian-writer-caught-up-in-governments-expanding-crackdown/2016/02/02/9277f8c4-c5f4-11e5-b933-31c93021392a_story.html?utm_term=.b13123e0597c> accessed 17 April 2018
151. Aswat Masriya, ‘Health activist Taher Mokhtar, 2 students released after 7 months in jail’ (*Egypt Independent*, 3 August 2016) <<http://www.egyptindependent.com/health-activist-taher-mokhtar-2-students-released-after-7-months-jail/>> accessed 17 April 2018
152. ‘Good news! Three Activists Released on Bail’ (Amnesty USA, 29 August 2016) <<https://www.amnestyusa.org/victories/good-news-three-activists-released-on-bail-egypt-ua-1516/>> accessed 8 June 2018
153. Marie-Stéphane Guy, ‘Egypt: a physician, committed to helping prisoners, imprisoned himself’ (Prison Insider, 19 April 2017) <<https://www.prison-insider.com/en/testimonials/egypte-un-medecin-engage-en-faveur-des-prisonniers-incarcere>> accessed 08 June 2018

5.2. Beyond criminalization: administrative sanctions, harassment, disappearance, illegal detention and extrajudicial killings

Criminal proceedings of the types described above, both in conjunction with counter-terrorism charges and general laws, are one of the many ways by which health professionals' ability to provide care can be hampered. While this report primarily focuses on criminalization and related measures deployed by governments which may hamper the delivery of care, administrative sanctions, harassment, disappearance, illegal detention, and extrajudicial killings warrant mentioning and a few illustrative examples are provided below.

Administrative sanctions, including pay cuts, suspension, dismissal, or even revocation of professional licenses have been used to crack down on medical professionals suspected of affiliation with or having provided support to government opponents or banned groups. With less demanding procedural requirements and a lower profile than criminal proceedings, such sanctions can affect large groups of professionals over sustained periods of time and have long-lasting effects on the operability of health systems in a country. In **Turkey**, in addition to the criminal charges brought against doctors described above, it is estimated that over 20,000 doctors¹⁵⁴ and medical professionals have been administratively dismissed since 2013 for alleged links with banned/terror groups, speaking out against government policies, or using the Kurdish language¹⁵⁵ in their medical practice.¹⁵⁶ These dismissals have depleted the health system (particularly in the South East) of significant human resources.¹⁵⁷ In **Bahrain**, although the last remaining doctor jailed in conjunction with the 2011 protests was released in 2017, many healthcare professionals have remained dismissed, suspended, or barred from practicing in the public and/or private sector.¹⁵⁸

In a number of cases, military and police security forces do not depend on the rule of law or formal procedures to harass medical providers. Intimidation of medical professionals, disappearance, beatings, illegal detention, torture, and killings all constitute pernicious extra-judicial methods that inhibit the provision of healthcare. Cases of harassment of medical personnel by authorities, compromising the delivery of healthcare, have been reported in numerous contexts including Afghanistan and India. The last United Nations Assisted Mission in Afghanistan Report on Protection of Civilians in **Afghanistan** describes a 2017 incident where local police reportedly entered a Kunduz hospital searching for a member of the Taliban.¹⁵⁹ When told he had already been transferred by police, the authorities harassed the medical staff. In another incident from February 2016, Afghan National Army forces reportedly raided a health center run by the Swedish Committee for Afghanistan, assaulting and handcuffing all the hospital staff members¹⁶⁰ before finding the patients they were looking for and killing them.¹⁶¹

In **India**, during times of political unrest the work of medical staff is often impeded.¹⁶² During the protests in Kashmir from July to November 2016, doctors were prevented from reaching the hospitals where they worked via imposition of days-long curfews. "Moving around, including trying to get to the hospital, has become so difficult. Despite all our identity cards, white coats, and stethoscopes, it is hard to get past the Indian security forces," reported a physician at Shri Maharaja Hari

154. Stockholm Center for Freedom, 'Turkey cracks down on healthcare Professionals' (*Stockholm Center for Freedom*, December 2017) <https://stockholmcf.org/wp-content/uploads/2017/12/Turkey-Cracks-Down-On-Health-Care-Professionals_report_06.12.2017.pdf> accessed 17 April 2018

155. The Kurdish language is used by some of the groups which oppose the current government.

156. Physicians for Human Rights 'Southeastern Turkey: healthcare Under Siege' (August 2016) <<https://static1.squarespace.com/static/58c0271fd1758e5d0c64a756/t/59399ddb3db2b7352d7ffe9/1496948192161/southeastern-turkey-health-care-under-siege.pdf>> accessed 17 April 2018, 20 (See Case of Abdullah Köçeroğlu, a 24-year-old general practitioner who faced punitive treatment for "his use of Kurdish language when speaking to patients").

157. Physicians for Human Rights 'Southeastern Turkey: healthcare Under Siege' (August 2016) <<https://static1.squarespace.com/static/58c0271fd1758e5d0c64a756/t/59399ddb3db2b7352d7ffe9/1496948192161/southeastern-turkey-health-care-under-siege.pdf>> accessed 17 April 2018, 20

158. Physicians for Human Rights, 'Doctors in Bahrain: In Their Own Words' (PHR) <<http://physiciansforhumanrights.org/library/multimedia/doctors-in-bahrain-in-their-own-words.html>> accessed 21 April 2018

159. United Nations Assisted Mission in Afghanistan 'Reports on the Protection of Civilians in Armed Conflict' <<https://unama.unmissions.org/protection-of-civilians-reports>> accessed 21 April 2018

160. Mujib Mashal, 'Hospital Raid by Afghan Forces Is Said to Kill at Least 3' (*The New York Times*, 18 February 2016) <<https://www.nytimes.com/2016/02/19/world/asia/hospital-raid-afghan-forces-nato-wardak-province.html>> accessed 21 April 2018

161. Tim Craig, 'Three killed, including 15-year-old, in Afghan security raid on health clinic' (*The Washington Post*, 18 February 2016) <https://www.washingtonpost.com/world/three-die-including-15-year-old-in-afghan-security-raid-of-health-clinic/2016/02/18/8a46eea4-d647-11e5-be55-2cc3c1e4b76b_story.html> accessed 21 April 2018

162. Physicians for Human Rights 'Blind to Justice: Excessive Use of Force and Attacks on healthcare in Jammu and Kashmir, India' (December 2016) <https://s3.amazonaws.com/PHR_Reports/Kashmir-Report-Dec-2016.pdf> accessed 21 April 2018

Singh Hospital in Srinagar.¹⁶³ Harsh harassment from forces at security checkpoints was also reported, along with assaults on ambulances attempting to provide care and unnecessary restriction of movement.¹⁶⁴ Mohammad Sofi, an ambulance driver, described how security forces fired at his ambulance as he transported two patients to a hospital on August 18 after they were injured during protests.¹⁶⁵

Forced disappearances, torture, and extrajudicial killings for treating protesters have also been documented. In **Ethiopia**, during the 2016 Oromia protests, many doctors refused to carry out orders to refrain from treating injured protesters and to allow the military into hospitals. Health workers in Nekemte town in the East Wollega zone and in West Arsi zone were arrested as a result. In each case they were accused of treating injured students and of encouraging students to protest further. Five of them said that colleagues went missing in the days after the protests and were feared “disappeared”.¹⁶⁶ In **Syria**, as documented by the Commission of Inquiry for Syria and examined at the 24th session of the Human Rights Council on the Assault on Medical Care in Syria, “intelligence and law enforcement agencies have forcibly disappeared medical personnel providing treatment to perceived opposition supporters [...] During 2012, Government forces conducted a wave of arrests and extra-judicial executions of medical personnel working at Aleppo’s opposition affiliated Al Zarzou Hospital. In June 2012, Air Force Intelligence arrested three medical professionals at the hospital. Their burned bodies were found three days later”.¹⁶⁷ In such cases, forced disappearance, detention, and killings have been carried out by entities who do not abide by due process and appear to enjoy impunity.

6. Exceptions and good practices

6.1. Exceptions build into counter-terrorism laws

In their approach to fighting terrorism and the development of related legal frameworks, a handful of countries have carved out exceptions to the prohibition on providing material support. While terrorism definitions tend to be very broad, the grounds for granting exemptions are often very narrow (such as the United States’ narrowly interpreted exemption on “medicine”). Some exemptions are sectorial (e.g. humanitarian), others limited to a particular type of goods or activities. While a few years ago some expressed the views that exemptions could be counterproductive, the argument seems to have lost potency in the face of increasing restrictions.¹⁶⁸ Overall, exceptions remain rare and often inadequate.¹⁶⁹ Examples of exceptions, some more promising than others, are presented below:

New Zealand stands out as it broadly exempts assistance to designated individuals and their dependents when it is solely meant to meet “essential human needs”. According to the Terrorism Suppression Act 2002 subsection 10(3), the prohibition on making property, or financial or related services, available to designated terrorist entity is drafted to exclude support that “does no more than satisfy essential human needs” and is only committed when property is made available “without reasonable excuse.” An example of making property available with a reasonable excuse “is where the property (for

163. PHR interview with SMHS doctor (name withheld for security reasons) on September 9, 2016 in Srinagar. <https://s3.amazonaws.com/PHR_Reports/Kashmir-Report-Dec-2016.pdf> accessed 21 April 2018

164. Physicians for Human Rights ‘Blind to Justice: Excessive Use of Force and Attacks on healthcare in Jammu and Kashmir, India (December 2016) <https://s3.amazonaws.com/PHR_Reports/Kashmir-Report-Dec-2016.pdf> accessed 21 April 2018

165. PHR interview with Ghulam Mohammad Sofi on September 3, 2016 in Srinagar. <https://s3.amazonaws.com/PHR_Reports/Kashmir-Report-Dec-2016.pdf> accessed 21 April 2018

166. Human Rights Watch “Such a Brutal Crackdown”: Killings and Arrests in Response to Ethiopia’s Oromo Protests’ (HRW, 15 June 2016) <<https://www.hrw.org/report/2016/06/15/such-brutal-crackdown/killings-and-arrests-response-ethiopia-oromo-protests>> accessed 21 April 2018

167. Report of the Commission of Inquiry on Syria to the Human Rights Council, ‘Assault on medical care in Syria’ (13 September 2013) UN Doc A/HRC/24/CRP.2 <<http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session24/Pages/ListReports.aspx>> accessed 24 April 2018

168. Some concerns have been voiced that the inclusion of exemption clauses may actually “limit rather than expand” impartial actors’ capacity to operate and be interpreted as prohibiting the activities of organizations and individuals “that do not fall within their scope.” Emanuela-Chiara Gillard, ‘Recommendations for Reducing Tensions in the Interplay Between Sanctions, Counterterrorism Measures and Humanitarian Action’ (Chatham House: The Royal Institute of International Affairs, 23 August 2017) <<https://www.chathamhouse.org/sites/files/chathamhouse/publications/research/2017-08-23-sanctions-counterterrorism-humanitarian-action-gillard-final.pdf>> accessed 18 April 2018; Katie King, Naz K. Modirzadeh and Dustin A. Lewis, ‘Understanding Humanitarian Exceptions: U.N. Security Council Sanctions and Principled Humanitarian Action’ (Harvard Law School Program on International Law and Armed Conflict (HLS PILAC), April 2016) <http://blogs.harvard.edu/pilac/files/2016/04/Understanding_Humanitarian_Exemptions_April_2016.pdf> accessed 17 April 2018

169. A 2015 report by the Harvard Law School Program on International Law and Armed Conflict found that even these countries’ exclusionary language was inadequate – cf. Jessica Burniske and Dustin A. Lewis, with Naz K. Modirzadeh, ‘Suppressing Foreign Terrorist Fighters and Supporting Principled Humanitarian Action: A Provisional Framework for Analyzing State Practice’ (Harvard Law School Program on International Law and Armed Conflict, October 2015) <<https://pilac.law.harvard.edu/briefing-report-suppressing-ffs-and-supporting-pha>> accessed 17 April 2018, 31-33

example, items of food, clothing, or medicine) is made available in an act that does no more than satisfy essential human needs of (or of a dependent of) an individual designated under this Act".¹⁷⁰

In **Canada**, the law criminalizes support (providing, making available, etc., property or services for terrorist purposes) when given to an identified terrorist organization and if that support would help it engage in terrorist activity.¹⁷¹ However, Canada's Criminal Code,¹⁷² R.S.C. 1985, c. C-46, § 83.01(1) specifies that the definition of "terrorist activity" expressly "does not include an act or omission that is committed during an armed conflict"¹⁷³ and that, at the time and in the place of its commission, is in accordance with customary international law or conventional international law applicable to the conflict, or the activities undertaken by military forces of a state in the exercise of their official duties, to the extent that those activities are governed by other rules of international law."¹⁷⁴

In March 2017, the **European Commission** adopted a new directive to combat terrorism, aimed at updating the current European Union framework on criminalizing terrorist offences (Directive (EU) 2017/541 of the European Parliament and of the Council of 15 March 2017 on combating terrorism and replacing Council Framework Decision 2002/475/JHA and amending Council Decision 2005/671/JH).¹⁷⁵ European Member States are required to transpose the new directive into national law by September 8, 2018.¹⁷⁶ The proposal extends the list of existing offences to include receiving terrorist training, traveling and attempting to travel abroad for terrorism, and funding or facilitating such travel. It also includes provisions on the protection of victims. It explicitly states, however, that "the Directive should not have the effect of altering the rights, obligations and responsibilities of the Member States under international law, including under international humanitarian law"¹⁷⁷ and that "the provision of humanitarian activities by impartial humanitarian organizations recognized by international law, including international humanitarian law, do not fall within the scope of this Directive, while taking into account the case-law of the Court of Justice of the European Union."^{178 179} Whether this new directive goes far enough (e.g. it does not address the situation of domestic health workers) or has the intended effect remains to be tested.

6.2. Potentially promising practices: incorporating international obligations in domestic laws

In the face of challenges associated with the provision of healthcare to all, some countries have also taken steps to implement international obligations in their domestic legal frameworks. There are different ways of incorporating a definition of the rights and responsibilities of healthcare personnel into domestic legislation.¹⁸⁰ **Afghanistan, Colombia** and **Nigeria** have, for instance, taken some potentially promising steps to protect healthcare delivery and access.

170. Parliamentary Council Office 'Terrorism Suppression Act 2002' <<http://www.legislation.govt.nz/act/public/2002/0034/34.0/whole.html#DLM152716>> accessed 17 April 2018

171. Canada Criminal Code, R.S.C. 1985, C-46, §83.03: "Everyone who, directly or indirectly, collects property, provides or invites a person to provide, or makes available property or financial or other related services (a) intending that they be used, or knowing that they will be used, in whole or in part, for the purpose of facilitating or carrying out any terrorist activity, or for the purpose of benefiting any person who is facilitating or carrying out such an activity, or (b) knowing that, in whole or part, they will be used by or will benefit a terrorist group, is guilty of an indictable offence and is liable to imprisonment for a term of not more than 10 years".

172. Canada Criminal Code, R.S.C. 1985, c. C-46 <<http://laws-lois.justice.gc.ca/PDF/C-46.pdf>> accessed 18 April 2018

173. Canadian courts have offered a partial response to the question of individuals accused of terrorism outside of armed conflicts. In 2008, in a case involving a Canadian-born computer programmer, convicted of financing and facilitating terrorism, the Ontario Superior Court of Justice, concluded that whether or not the events in Afghanistan constitute an "armed conflict" ... Mr. Khawaja and his UK counterparts were not physically located in that armed conflict, hence the exception did not apply. In 2012, the Canadian Supreme Court upheld this analysis. See Craig Forcese, 'Khawaja trial decision: the scope of the armed conflict exception' (*Craig Forcese Blog*, 13 November 2013) <<http://craigforcese.squarespace.com/national-security-law-blog/2008/11/13/khawaja-trial-decision-the-scope-of-the-armed-conflict-excep.html>> accessed 20 April 2018; CBC, 'Supreme Court upholds anti-terrorism law' (CBC, 14 December 2012) <<http://www.cbc.ca/news/canada/supreme-court-upholds-anti-terrorism-law-1.1154251>> accessed 18 April 2018

174. Canada Criminal Code, R.S.C. 1985, c. C-46, §83.01 <<http://laws-lois.justice.gc.ca/eng/acts/C-46/FullText.html>> accessed 20 April 2018

175. European Parliament and Council Directive 2017/541/EC of 15 March 2017 on combating terrorism and replacing Council Framework Decision 2002/475/JHA and amending Council Decision 2005/671/JHA (2017) L 88/6 <<https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32017L0541>> accessed 17 April 2018

176. Sofija Voronova, 'Combating Terrorism [EU Legislation In Progress]' (European Parliamentary Research Blog, September 2017) <<https://epthinktank.eu/2017/09/12/combating-terrorism-eu-legislation-in-progress/>> accessed 17 April 2018

177. European Parliament and Council Directive 2017/541/EC of 15 March 2017 on combating terrorism and replacing Council Framework Decision 2002/475/JHA and amending Council Decision 2005/671/JHA (2017) L 88/6, article 37 <<https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32017L0541>> accessed 8 June 2018

178. *ibid*, article 38

179. European Parliament and Council Directive 2017/541/EC of 15 March 2017 on combating terrorism and replacing Council Framework Decision 2002/475/JHA and amending Council Decision 2005/671/JHA (2017) L 88/6 <<https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32017L0541>> accessed 17 April 2018

180. ICRC, 'Domestic Normative Frameworks for the Protection of healthcare' (*ICRC*, 1 September 2015) <<https://www.icrc.org/en/publication/4215-domestic-normative-frameworks-protection-health-care>> accessed 15 April 2018

The 2017 Penal Code of **Afghanistan**, which entered into force February 2018,¹⁸¹ significantly changed the legal framework for criminal and terrorism charges, combining multiple previous statutes including terrorist offenses. Until 2018, the provisions contained in the Afghan counter-terrorism law had the potential to encompass medical care within the ambit of punishable offenses.¹⁸² The new Code¹⁸³ includes promising advances in protections for and duties of medical practice. Article 119 states that no “necessary medical procedures” are to be considered crimes if they are carried out within the “technical principles of the medical profession” and the patient, family, or legal representative has given consent. Surgical procedures performed in emergencies according to medical principles are also not to be labeled as crimes. The duty to provide medical care is addressed in article 888, which states that any health personnel refusing care to a patient may be punished if the refusal results in physical or mental harm. How these new laws will be applied will determine the extent to which health workers are protected in practice from harassment and prosecution.

In **Colombia**, in December 2012, the Ministry of Health and Social Protection issued decision 4481 adopting the Medical Services Manual applicable to its medical mission.¹⁸⁴ Produced with the support of the ICRC, the Colombian Red Cross, the Presidency, and the Ministry of Employment, the manual defines medical duties in both armed conflicts and other situations of violence, sets out the acts that constitute violations towards the medical mission, and establishes regulations on the use of the emblem.¹⁸⁵ Of particular relevance, it sets out the rights of healthcare personnel including the right “not to be sanctioned or prosecuted for the exercise of medical activities”; “not to be forced to act contrary to the principles of medical ethics.”¹⁸⁶ In addition, the code of medical ethics provides that “the doctor will abide by ... the recommendations of the World Medical Association” which implies that the regulations of the WMA are incorporated into the national legal system.¹⁸⁷ It is not known whether the police and prosecutors are bound to follow the manual.

In **Nigeria**, a country which has been grappling with terrorism, reports of intimidation of medical doctors, including arrest and harassment¹⁸⁸ by the security apparatus for taking care of gunshot victims, have been particularly common in the Niger Delta. Hospitals often refuse to treat people with gunshot wounds because of fear of interference by police. In a 2016 report documenting the killings and injuries sustained by supporters of the pro-Biafran organization IPOB (Indigenous People of Biafra), Amnesty International identified a consistent pattern of hospitals facing pressure from the security forces to refuse to treat people with gunshot wounds.¹⁸⁹ The tensions among medical professionals, armed groups, security forces, and communities resulted in healthcare being provided on an increasingly discriminatory basis.¹⁹⁰ In 2016, the Rivers State Ministry of Health supported the creation of a working group, which “developed a protocol and advocacy tool that sets out the rights and responsibilities of healthcare professionals when treating patients during emergencies.”¹⁹¹ As reported by Dr. Theophilus M-Iyenebari Odagme, commissioner of the Rivers State Ministry of Health from 2015 to 2017, the Ministry also decided to engage with the Nigerian police force at the federal level in order to develop a written memorandum concerning the Inspector General of Police's directive on the treatment of those with gunshot wounds.¹⁹² In December 2017, the President signed these new practices into law, allowing health personnel to treat gunshot victims without waiting for a police report and protecting them from harassment for doing so.¹⁹³

181. Penal code, 2017. Afghanistan. 2017.

182. Law on combat against terrorist offences. 2008. http://www.vertic.org/media/National%20Legislation/Afghanistan/AF_Law_on_Combat_against_Terrorist_Offences.pdf. Accessed Apr 14, 2018.

183. Penal code, 2017. Afghanistan. 2017.

184. ICRC, ‘Colombia: Poor access to healthcare and violations against medical personnel and services’ (*ICRC*, 10 July 2013) <<https://www.icrc.org/eng/resources/documents/feature/2013/07-10-colombia-report-health-hcid.htm>> accessed 15 April 2018

185. ICRC, healthcare in Danger (HCID), ‘The Implementation of Rules protecting the provision of healthcare in armed conflicts and other emergencies: a guidance tool’ <<http://healthcareindanger.org/wp-content/uploads/2017/05/hcid-guiding-tool-icrc-eng.pdf>> accessed 17 April 2018, 354

186. ICRC, healthcare in Danger (HCID) ‘Domestic Normative Frameworks for the Protection of healthcare’ (ICRC, May 2015) Annex, p77 <[icrc-002-4215-domestic-normative-frameworks-for-the-protection-health-care.pdf](https://www.icrc.org/eng/resources/documents/feature/2015/05-domestic-normative-frameworks-for-the-protection-health-care.pdf)> accessed 19 May 2018

187. *ibid*

188. Amnesty International, ‘Nigeria: Bullets were raining everywhere: Deadly Repression of Pro-Biafra Activists’ (*Amnesty International*, 2016) <<https://reliefweb.int/sites/reliefweb.int/files/resources/AFR4452112016ENGLISH.pdf>> accessed 15 May 2018

189. Omololu Ogunmade, ‘Buhari Signs Mandatory Treatment of Gun Shot Victims’ Bill into Law’ (*This Day Newspaper*, 30 December 2017) <<https://reliefweb.int/sites/reliefweb.int/files/resources/AFR4452112016ENGLISH.pdf>> accessed 15 May 2018

190. ICRC, ‘Working towards safer access to healthcare in Rivers state’ (*ICRC*, 24 November 2016) <<https://www.icrc.org/en/document/working-towards-safer-access-health-care-rivers-state>> accessed 15 May 2018

191. *ibid*

192. *ibid*

193. Omololu Ogunmade, ‘Buhari Signs Mandatory Treatment of Gun Shot Victims’ Bill into Law’ (*This Day Newspaper*, 30 December 2017) <<https://www.thisdaylive.com/index.php/2017/12/30/buhari-signs-mandatory-treatment-of-gun-shot-victims-bill-into-law/>> accessed 15 May 2018

7. Conclusion

The obligation to provide healthcare to all wounded and sick people and to protect healthcare workers from harassment and prosecution for caring for them without regard to the patient's status or designation, such as enemy or terrorist, is neither uncommon nor recent. It can be found in general medical ethical norms, in international human rights law, and goes back to the earliest of modern international humanitarian law instruments, which have progressively developed since 1864. More recently, the writers of the Geneva Conventions and the International Bill of Rights had fresh in their memory the harassment experienced by those medical doctors who had treated enemies during World War II.¹⁹⁴ The need is as pressing today, as contemporary forms of violence challenge us to think beyond the figure of the terrorist, to be reminded that people are entitled to care by virtue of being human. Counter-terrorism frameworks cannot be permitted to cast aside the principle of humanity by excluding people labeled terrorists from the wounded enemy's entitlement to receive care, and undermining the ethical duty of the healthcare professional to provide it.

Recent cases in which health professionals have been arrested, prosecuted, or otherwise harassed for providing healthcare to members of terrorist, anti-government, insurgent or non-state armed groups, stand in contradiction with some of the most basic principles of international law and medical ethics. Some domestic courts have found health personnel following their ethical precepts guilty of committing acts of terrorism or rebellion, of providing support for terrorism, or of other illegal acts. Some have been jailed or sanctioned. Most often, available records suggest that no international humanitarian or human rights law considerations were taken into account during these domestic proceedings.

As a result, today vague and broad anti-terror laws send a signal of hostility towards access to healthcare for all wounded and sick and constitute a threat to health practitioners obliged to provide it. This dimension of counter-terrorism policy and practice erodes the principle that, allies or foes, wounded are entitled to care. It creates an atmosphere that deters the provision of essential healthcare services and opens the door for harassment and prosecution, both within and outside of the rule of law. These consequences are not only detrimental to the alleged terrorists targeted by such legislation, but to all those in need of healthcare.

As set out in the recommendations of the UN Secretary General to implement resolution 2286, states should ensure coherence and consistency of domestic legislation applying to healthcare personnel, including counter-terror and criminal laws, with international human rights and humanitarian law. They should protect access of all people to healthcare and prohibit the punishment of health professionals for providing it. All counter-terrorism regulations and domestic laws must acknowledge these rights, whatever the circumstance or criminal or terrorist status of the persons benefiting from it.

Domestic laws and regulations also ought to contain explicit provisions affording healthcare professionals immunity from prosecution, sanction, or punishment for the mere fact of acting impartially in providing care. Healthcare professionals must not be hindered in the performance of their exclusively medical tasks. They should not be harassed for assisting the wounded and sick or prosecuted for carrying out acts compatible with medical ethics. Failure to guarantee this risks leading to permissiveness in prosecution as the norm, and where, for our collective loss, the once radical belief that wounded enemies are entitled to care is a distant memory.

194. As did the writers of 1977 additional protocols which subsequently elaborated upon these issues.

8. Recommendations

To states:

1. Review and amend counter-terrorism and other laws to state explicitly that no wounded or sick individual may be excluded from access to healthcare on account of the person's designation as an alleged enemy or terrorist, or as a person associated with or supporting individuals or groups with such a designation.
2. Review and amend counter-terrorism and other laws to state explicitly that the provision of medical services, or acts in support of such services, to wounded and sick individuals may not be subject to criminal or other sanctions on the basis of the designation of the wounded and sick individual as an alleged enemy or terrorist, or a person who is a member of, associated with, or supportive of a terrorist organization.
3. Instruct militaries, police and security forces that medical care for anyone, including an alleged enemy or terrorist, or a person who is a member of, associated with, or supportive of a terrorist organization, should never be denied on the basis of that designation or affiliation, and that individuals providing care to such individuals should never be the subject of arrest, harassment, or intimidation.
4. Engage with fellow member states during the interactive dialogue of the Universal Periodic Review process to ensure that countries under review enable access to medical care for all, regardless of national security concerns, and that they prohibit punishment of individuals for providing health services to a person who is an alleged enemy or terrorist, or a person who is a member of, associated with, or supportive of a terrorist organization.

To the UN Security Council:

1. Provide in resolutions on counter-terrorism that access to medical care by an alleged terrorist or a person who is a member of, associated with, or supportive of a terrorist organization should never be denied on the basis of such designation, and that no person providing health services to a person should be punished on account of providing health services to an alleged terrorist or a person who is a member of, associated with, or supportive of a terrorist organization.

To the UN General Assembly:

1. Include explicit language around the protection of the medical mission and the delivery of healthcare in the bi-annual resolution on the *protection of human rights while countering terrorism*.

To the UN Human Rights Council:

1. Include explicit language around the protection of the medical mission and the delivery of healthcare in the annual resolution on the *protection of human rights while countering terrorism*.
2. Consider the development of a procedural resolution calling for a thematic panel discussion at the Council on the human rights implications of the criminalization of healthcare in the context of counter-terrorism and other public security efforts, with a view towards a comprehensive study of the issue by the Office of the High Commissioner of Human Rights and/or the special procedures.
3. Work towards the development of a substantive resolution that explicitly recognizes that access to medical care by an alleged terrorist or a person who is a member of, associated with, or supportive of a terrorist organization should never be denied on the basis of such designation, and that no person providing health services to a person should be punished on account of providing health services to an alleged terrorist or a person who is a member of, associated with, or supportive of a terrorist organization.
4. Encourage relevant treaty bodies and special procedures to include in their periodic reviews and country missions the following: if the member state ensures access to medical care for all, regardless of whether a person is an alleged terrorist or a person who is a member of, associated with, or supportive of a terrorist organization; and whether the state prohibits punishment of individuals for providing or seeking to provide health services to a person who is an alleged terrorist or a person who is a member of, associated with, or supportive of a terrorist organization.

9. Annex

Treaty Ratification Table Report Specific Country Overview

	International Covenant on Civil and Political Rights 1976	International Covenant on Economic Social and Cultural Rights 1976	Geneva Conventions I through IV 1948 *	Additional Protocol I 1977 *	Additional Protocol II 1977 *	Constitutional Recognition of the Right to Health?
Afghanistan	24-Jan-83	24-Jan-83	26-Sep-56	10-Nov-09	10-Nov-09	Yes
Australia	13-Aug-80	10-Dec-75	14-Oct-58	21-Jun-91	21-Jun-91	No
Bahrain	20-Sep-06	27-Sep-07	30-Nov-71	30-Oct-86	30-Oct-86	No
Colombia	29-Oct-69	29-Oct-69	8-Nov-61	1-Sep-93	14-Aug-95	Yes
Egypt	14-Jan-82	14-Jan-82	10-Nov-52	9-Oct-92	9-Oct-92	Yes
Ethiopia	11-Jun-93	11-Jun-93	2-Oct-69	8-Apr-94	8-Apr-94	Yes
India	10-Apr-79	10-Apr-79	9-Nov-50	N/A	N/A	No
Iraq	25-Jan-71	25-Jan-71	14-Feb-56	1-Apr-10	N/A	Yes
Myanmar (Burma)	N/A	6-Oct-17	25-Aug-92	N/A	N/A	Yes
Nigeria	29-Jul-93	29-Jul-93	20-Jun-61	10-Oct-88	10-Oct-88	No
Pakistan	23-Jun-10	17-Apr-08	12-Jun-51	12-Dec-77 <i>(signed, not ratified)</i>	12-Dec-77 <i>(signed, not ratified)</i>	No
Peru	28-Apr-78	28-Apr-78	15-Feb-56	14-Jul-89	14-Jul-89	Yes
Syria	21-Apr-69	21-Apr-69	2-Nov-53	14-Nov-83	N/A	Yes
Turkey	23-Sep-03	23-Sep-03	10-Feb-54	N/A	N/A	Yes
UK	20-May-76	20-May-76	23-Sep-57	28-Jan-98	28-Jan-98	No
US	8-Jun-92	10-May-77 <i>(signed, not ratified)</i>	2-Aug-65	12-Dec-77 <i>(signed, not ratified)</i>	12-Dec-77 <i>(signed, not ratified)</i>	No

* State Parties as of 22 May 2018 (source: <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/vwTreaties1949.xsp>)

** Ratification / Accession as of 23 May 2018 (source: <http://indicators.ohchr.org>)

*** <https://worldpolicycenter.org/policies/does-the-constitution-guarantee-citizens-health-rights/does-the-constitution-guarantee-citizens-the-right-to-health>