

“Adding salt to the wound”

The experience of MSF frontline workers providing impartial healthcare in counter-terrorism environments

Introduction: 20 years of the ‘war on terror’

It has been 50 years since Médecins Sans Frontières/Doctors Without Borders (MSF) launched its medical humanitarian work and 20 years since the start of the ‘Global War on Terror’. In those 20 years, counter-terrorism has come to define military operations far beyond those launched by the United States in response to the attacks of 11 September 2001. The US’s ‘war on terror’ paved the way for other states to launch their own battles against domestic and transnational enemies, without the same constraints as in a conventional armed conflict between states. While this may not have fundamentally changed the nature of warfare, it has changed the way it is justified. Today, the conflicts in Ethiopia, Yemen, Syria, Iraq, Nigeria, Mozambique, Mali and countless other places are defined as ‘battles against terrorism’. The trend seems set to continue, as states find comfort in the expansive powers offered by fighting an enemy designated as ‘terrorist’.

How has the ever-expanding global ‘war on terror’ impacted the delivery of impartial healthcare in conflict zones for an organisation like MSF? This public report – *“Adding salt to the wound”* – is based on research conducted with frontline MSF workers, from ambulance drivers to hospital managers, all of whom come from and work in three of the countries most affected by the ‘war on terror’: Afghanistan, Iraq and Nigeria.

This report shows that in counter-terrorism contexts, health workers often fail to provide medical care to those who need it most. This is for three main reasons:

- because they face restrictions in their ability to negotiate their acceptance with all parties to the conflict;
- because they face immense pressure to provide assistance according to military priorities; and
- because they fear speaking out due to the consequences, both for them individually and for the organisations for whom they work.

Those health workers who are able to provide assistance and save lives invariably take significant risks, often with unacceptable consequences. More than half of the MSF frontline workers interviewed for this research have been subject to threats, beatings and violence for allegedly ‘supporting terrorism’ by providing impartial healthcare.

The limitations on health workers – and the heavy-handed way in which they are imposed – are enabled and justified by states through the existence of a ‘terrorist’ enemy.

Despite this situation, reflections and debates about counter-terrorism often neglect the perspective of humanitarian aid workers in those countries most impacted by counter-terrorism operations. As one participant in this research commented: *“We are the most stigmatised when in fact we are the most affected.”*

Debate about counter-terrorism usually focuses on two central issues: the problem of defining who is and is not a ‘terrorist’; and how to find quantitative proof of the potential impact of counter-terrorism on humanitarian access.

However, neither of these issues is reflected in the priorities, experience and knowledge of those on the frontline of efforts to provide impartial healthcare in counter-terrorism conflicts. Speaking from firsthand experience, MSF field workers are emphatic in their conviction that counter-terrorism poses an undeniable challenge to providing healthcare. It hampers their ability to negotiate and it makes the principle of impartiality both more important and more difficult to apply. Counter-terrorism multiplies the barriers that prevent patients from accessing healthcare and that prevent our teams from accessing patients. Working in war is hard and dangerous; working in counter-terrorism wars add “*salt to the wound*”.

Yet two decades into the ‘war on terror’, states continue to question the extent of the adverse or unintended consequences of counter-terrorism legislation and measures on humanitarian assistance in general and on the provision of impartial healthcare in particular.

Instead, the burden of proof is shifted to humanitarian workers. This demonstrates how counter-terrorism contexts are dominated by uncompromising narratives that polarise issues and eradicate nuance, often through the silencing of credible voices, such as those of health workers.

Providing impartial medical care has a specifically protected status under international humanitarian law (IHL). This ensures that the act of providing assistance based on medical needs alone is not criminalised and that medics are not punished for doing their job. Yet when negotiating for humanitarian access and its maintenance, MSF teams face a situation where facts are disputed, as are applicable norms – crucially the IHL provisions for the protection of the medical mission and the right of the sick and wounded, whether civilians or combatants, to receive medical care.

Ever-expanding counter-terrorism regimes, policies and legislation – at both national and international levels¹ – bring uncertainty to the provision of impartial healthcare. We live in an ‘age of exception’,² where extra-legal conditions in the ‘War on Terror’ have created a permanent state of emergency that has become one of the essential practices of contemporary states. One recent example was the ‘COVID ceasefire’ promoted by UN Security Council Resolution 2532 of July 2020,³ which explicitly excluded from the ceasefire all military operations against groups designated as terrorist.

This briefing paper aims to contribute to an improved understanding of the adverse and unintended consequences of counter-terrorism warfare, legislation, policies and measures on the provision of impartial humanitarian assistance, specifically healthcare. It voices a perspective that is too often neglected: that of the frontline workers providing medical care.

The context: permanent state of emergency undermining international law

Today, numerous wars are being fought in the name of counter-terrorism. This allows a growing number of states and international military coalitions to expand the legitimacy of brutal bombings⁴ and siege routines,

¹ The proliferation and expansion of domestic legislation was noted as early as 2012 by Human Rights Watch. See: “[In the name of security. Counterterrorism Laws Worldwide Since September 11](#)”

² Fassin, D., (2012) “Humanitarian Reason: A Moral History of the Present”, University of California Press. See specifically chapter 7 *Desire for exception*.

³ [UNSC Res. 2532](#) (July 2020) explicitly states: “The Council affirmed that the general and immediate cessation of hostilities and humanitarian pause does not apply to military operations against Islamic State in Iraq and the Levant (ISIL/Da’esh), Al-Qaida and Al-Nusra Front, and all other individuals, groups, undertakings and entities associated with Al-Qaida or ISIL, and other Council-designated terrorist groups.”

⁴ Examples of bombings of MSF facilities include the attack on our hospital in Kunduz, Afghanistan, in October 2015; in the same month 12 MSF-supported hospitals were bombed in Syria, adding to the 94 MSF-supported health facilities in the country bombed during 2015; in Yemen, MSF facilities came under attack on four occasions between October 2015 and January 2016.

often fought from the air⁵ and often in urban settings.⁶ Counter-terrorism is increasingly used to circumvent a state's obligations under IHL.⁷

'Terrorism' has always been a controversial term. There is no consensus on the definition of the word or, crucially, on who is and is not a terrorist. A 2001 study notes: "In 1988 [...] in a survey of the field, Schmid and Jongman identified 109 different definitions of the word terrorism [...] The debate has gone nowhere precisely because defining [who is a] terrorist is an exercise in political classification."⁸

This has not impeded a staggering proliferation of counter-terrorism policies, measures and legislation that clearly work in the interests of states. Counter-terrorism legislation has expanded at a rapid rate over the past two decades. Before 11 September 2001, only 31 out of 193 states (or 16 percent) had counter-terrorism legislation.⁹ But following the Security Council's post-9/11 resolutions, more than 140 countries have enacted or revised one or more counter-terrorism laws.¹⁰

UN Security Council Resolution 1373¹¹ of 28 September 2001, passed in response to the attacks on 9/11 in the USA and established under Chapter VII of the UN Charter, is fundamental to understanding the proliferation of counter-terrorism tools. Firstly, it constitutes "one of the most ground-breaking resolutions in the body's history. It imposed legally binding obligations on all UN member states to, among other things, enhance legislation, strengthen border controls, and increase international cooperation to combat terrorism," according to Sebastian von Einsiedel, author of *Assessing UN efforts to Counter Terrorism*.¹²

Secondly, it opened the door to abusive domestic legislation by omission, as it includes no references either to IHL or international human rights law, an omission that took 15 years to be corrected.¹³ An analysis from

⁵ Hajjar, L., (2015) "Drone Warfare and the Superpower's dilemma" [parts I](#) and [part II](#) and Emmerson, B., (2014) "[Report- focus on use of remotely piloted aircrafts](#)", Hofman, M., (2018) "[Humanitarians in the Age of Counter-Terrorism: Rejected by Rebels, Co-opted by States](#)", *Alternatives Humanitaires*. Whittall, J (2018) "[Starving and bombing civilians in the name of fighting terrorism](#)" <https://www.aljazeera.com/opinions/2018/5/18/starving-bombing-civilians-in-the-name-of-fighting-terrorism>; and Whittall, J (2018). *The Politics of Health in Counterterrorism operations*. MERIP. <https://merip.org/2018/10/the-politics-of-health-in-counterterrorism-operations/>

⁶ See among others, ICRC, (2007) "[IHL and the challenges of contemporary armed conflicts](#)" 2nd thematic report/ International Conference Red Cross Movement- chapter II: IHL and terrorism (October 2007), Graham, S., ed., (2004) "[Cities, War and Terrorism: Towards an Urban Geopolitics](#)"

⁷ See OHCHR, (2007) *Fact Sheet No. 32* "[Human rights, terrorism and counter-terrorism](#)", OHCHR, (2018) "[Report of the Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism on the human rights challenge of states of emergency in the context of countering terrorism](#)", NRC/ Mackintosh, K., & Duplat, P., (2013) "[Study of the Impact of Donor Counter-Terrorism Measures on Principled Humanitarian Action](#)" and IASC, (2020) "[Desk review of relevant literature on the impact of counter-terrorism legislation and measures on principled humanitarian assistance - key recommendations](#)" among others

⁸ See details in David W. Brannan , Philip F. Esler & N. T. Anders Strindberg, "[Talking to "Terrorists": Towards an Independent Analytical Framework for the Study of Violent Substate Activism](#)", *Studies in Conflict and Terrorism*, 24:1, 3-24 (2001)

⁹ Elena Pokalova (2015) "Legislative Responses to Terrorism: What Drives States to Adopt New Counterterrorism Legislation?", *Terrorism and Political Violence*, 27:3, 474-496- journal article April 2014

¹⁰ For details see, Human Rights Watch (HRW), "[In the name of security. Counterterrorism Laws Worldwide Since September 11](#)" (report) June 2012

¹¹ See: https://www.unodc.org/pdf/crime/terrorism/res_1373_english.pdf

¹² [Assessing UN efforts to Counter Terrorism](#) (October 2016) Sebastian von Einsiedel, Director, United Nations University, Tokyo, Japan

¹³ It was not until 2016 that [UN General Assembly Resolution 70/291](#) reviewed the language on IHL and stated its recognition that: "when counter-terrorism efforts neglect the rule of law, at the national and international levels, and violate international law, including the Charter of the United Nations, international humanitarian law and refugee law, human rights and fundamental freedoms, they [member states] not only betray the values they seek to uphold, they may also further fuel violent extremism that can be conducive to terrorism." In a parallel development, in 2016 the United Nations General Assembly (UNGA) reviewed the language on IHL in its 5th (bi-annual) Global Counter-terrorism Strategy and further elaborated that CT measures should not impede humanitarian and medical activities or engagement with all relevant actors as foreseen by IHL. But it is not until 2021 that the language in the 7th review of the UN Global Counter-terrorism Strategy becomes explicit on the non-punishment rule under IHL (UNGA A/RES/75/291). In other words, it took them 20 years to incorporate the IHL derived non-punishment rule in the language of the Global Counter-terrorism Strategy, taking this language on non-punishment beyond the existing scope of the 2017 and 2018 UNGA resolutions on Humanitarian Coordination [UNGA A/RES/72/133 (2017) and A/RES/73/139 (2018)].

2014¹⁴ identified 193 states which had submitted 708 reports to the Security Council Counter-Terrorism Committee outlining efforts undertaken in compliance with international counter-terrorism legislation. The UN Counter-Terrorism Executive Directorate (CTED) has only recently started working on a report on the implications of UN counter-terrorism resolutions (resolutions 1373, 1624, 2178 and others) for principled humanitarian action and on their compliance with IHL.

Labelling opposition groups as terrorists gives states a series of advantages. Using this blanket pejorative term creates a hostile narrative which demonises and criminalises entire communities.¹⁵ It also serves to deflect careful scrutiny of governments' domestic and foreign policies, while calling into question the application of internationally agreed norms in the context of counter-terrorism operations, notably – but not exclusively – IHL. Existing counter-terrorism frameworks can blur the lines between armed conflict and terrorism, and worryingly, counter-terrorism policies “can recast medical care as a form of illegitimate support to the enemy.”¹⁶ Under this logic, assaults on civilian populations and healthcare systems become normalised and considered as acceptable.

The context in which these legislative and policy developments have taken place is one of unprecedented levels of humanitarian need. The *Global Burden of Disease Study 2017*,¹⁷ which examines the state of the world's health by estimating average life expectancy as well as the number of deaths, illnesses and injuries from more than 300 causes, found that since 2006, “the number of deaths from conflict and terrorism has risen significantly, reaching 150,500 deaths in 2016 (which is a 143% increase since 2006).”¹⁸ Forced displacement due to armed conflict is at its highest level on record, according to the UN High Commissioner for Refugees.¹⁹ The number of non-international armed conflicts has more than doubled since the early 2000s (from 30 to 70), coupled with an unparalleled proliferation of non-state armed groups. The International Committee of the Red Cross (ICRC) estimated in 2020 that there were some 614 such groups and that between 60 and 80 million people live under the direct state-like governance of armed groups.²⁰ Access constraints for delivering humanitarian aid are on the rise, exacerbated by the COVID-19 pandemic. The World Food Programme (WFP), in a 2018 meta-analysis of its evaluations (2012-2017), noted obstacles to access in 20 out of 22 evaluations, stressing “CT [counter-terrorism] legislation and increasingly sophisticated governmental restrictions have rendered access negotiations more complex.”²¹

A 2018 comprehensive report on the criminalisation of healthcare by John Hopkins and Essex Universities noted that “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.”²²

MSF has witnessed the consequences of counter-terrorism measures in Afghanistan, Gaza, Nigeria, Syria and Yemen, and countless other contexts. People living in areas under control of groups designated as terrorist are often considered hostile and terrorists themselves,²³ depriving them of much-needed assistance. Meanwhile the groups that control these territories may limit people's freedom of movement and impose

¹⁴ Pokalova (2015) *op. cit*

¹⁵ Sluka, J., (2008) *op. cit*.

¹⁶ Lewis, D. A., Modirzadeh N. K., and Gabriella Blum, “[Medical Care in Armed Conflict: International Humanitarian Law and State Responses to Terrorism](#),” *Legal Briefing*, Harvard Law School Program on International Law and Armed Conflict (PILAC), September 2015

¹⁷ See: http://www.healthdata.org/sites/default/files/files/policy_report/2019/GBD_2017_Booklet.pdf

¹⁸ See details in Simeon, J., (2017) “[A New Protection Orientation and Framework for Refugees and Other Forced Migrants](#)” MDPI

¹⁹ See: <https://www.unhcr.org/globaltrends2018/>

²⁰ ICRC, (2021) “[ICRC Engagement with Non-State Armed Groups: Why, how, for what purpose, and other salient issues](#)” Position Paper(March 2021)

²¹ WFP, (2018) GPPI & Humanitarian Outcomes/ Steets, J., Meier, C., Harmer, A., Stoddard, A., and Spannagel, J: “[Evaluation of WFP Policies on Humanitarian Principles and Access in Humanitarian Contexts](#)”

²² Buissonniere, M., Woznick, S. and Rubeinstein, L., (2018) M., John Hopkins/Essex University “[Criminalisation of Healthcare](#)”

²³ MSF internal documents, examples from Kasai, Democratic Republic of Congo; Afghanistan; Syria; Nigeria; and Gaza

social restrictions which are often enforced through violence. People wounded in counter-terrorism operations, whether combatant or not, are often trapped out of reach of medics and left without care, sometimes dissuaded from moving to receive care because of the fear of heavy-handed military 'screening' activities at checkpoints.²⁴ Those who manage to reach health facilities may find themselves reported to the intelligence services. Currently, MSF finds itself too often restricted to one side of a frontline, with a counter-terrorism force that wants to take advantage of the provision of humanitarian aid, and an opposition force that will not talk to us or is hostile to us. MSF has been accused of supporting terrorists and even of being a terrorist organisation itself.²⁵

Findings: the experience of MSF frontline workers

Research methodology

The research project whose findings are presented here was intended not only to retrace MSF's efforts over many years in navigating counter-terrorism environments, but also, crucially, to allow MSF frontline workers to share their experiences from some of the countries most impacted by counter-terrorism operations: Afghanistan, Iraq and Nigeria.²⁶ The researchers actively asked for evidence of what has worked when providing healthcare in these environments, thereby addressing an identified gap in existing public knowledge.

The methodology for this research aimed to understand the extent of counter-terrorism's effects on the provision of impartial humanitarian healthcare from the firsthand experiences of MSF frontline workers. It was designed on the basis of an extensive literature review and interviews with key informants. 111 external documents were reviewed (along with a similar volume of internal MSF documentation) which was thematically coded for comparison purposes. Additionally, some 44 key informant interviews (approximately 50% with MSF staff) were conducted and thematically coded for emerging themes and patterns.

Qualitative data was then collected through online and live in-depth interviews with 26 MSF locally-hired staff in three countries. All 26 of these staff members worked directly in environments where they were exposed to counter-terrorism measures and operations. In all cases, their agreement to participate in the research was based on strict confidentiality due to the risks associated with this topic.

To select the countries, we analysed a range of 42 potentially affected countries where MSF currently works. We observed that eight of these countries had the clearest and most illustrative counter-terrorism measures and regimes. Of those eight countries, Afghanistan, Iraq and Nigeria are to date the countries most affected by the perceived threat of terrorism, and where its impacts have influenced legislative developments and military operations.²⁷ A significant amount of MSF's operational volume is concentrated in these three

²⁴ MSF internal documents, examples from Gaza, Occupied Palestinian Territories; and Mosul, Iraq. See <https://msf-analysis.org/medical-humanitarian-needs-changing-political-aid-environment/>

²⁵ [Security Council 8236th Meeting Notes](#), 17 April 2018, MSF referred to as 'terrorists without borders' by Syrian ambassador to the UN. For more recent examples in Cameroon and Ethiopia, see [The New Humanitarian](#), '[Expelled aid workers, COVID lockouts, and climate change casualties](#)' August 2021

²⁶ Institute for Economics & Peace, (2020) "[Global Terrorism Index: measuring the impact of terrorism](#)"

²⁷ In domestic legislative terms; Afghan New Criminal Procedure Code and Anti-terrorism and Anti-laundry legislation (significant changes in legislation date between 2013 and 2014), Iraqi national legislation extension of the Iraqi Penal Code (2005) and Kurdish Parliament CT legislation (2006) and Nigerian Penal and Criminal Law extended CT crimes in the Terrorism Prevention Act (2011, amended in 2013). Additionally, all three countries have had international/regional military interventions under CT arguments, as well as extensive sanctions regimes (Afghanistan, EU and UK; Iraq, Australia, Canada, EU, UK and UN; and Nigeria, UK). Finally all three countries present a record of attacks on the medical mission, often taking place under CT arguments. Another particularly significant example of CT legislative development is Syria. Syria ranks in fourth place of countries impacted by terrorism, immediately

countries, which are distributed across three geopolitical areas, enabling operational and geographical representativeness.

The selection criteria for participants included: being a frontline MSF worker from one of the three countries; having a work role that was potentially directly impacted by counter-terrorism practices;²⁸ and a willingness to take part in the research by freely expressing their informed consent.

Interpretation and analysis of results: the 26 in-depth interviews (which lasted for more than 17 hours in total) were transcribed (224 pages of transcripts) and thematically coded. These codes were analysed, comparing results between the three countries, between responses by medical and non-medical staff, and against the thematically coded desk literature review and the thematically coded key informant interviews.

The research protocol passed a rigorous ethical review board approval.²⁹

The findings of this research are presented thematically in order to avoid references to specific countries or testimonies that could identify particular staff members. Only those findings that are common to all three contexts are included in this briefing paper.

1. **Counter-terrorism inhibits humanitarian workers from providing impartial healthcare and brings real and personal risks**

Humanitarian organisations have documented the ‘chilling effect’ of counter-terrorism legislation on their work.³⁰ This happens when needs-based and lifesaving humanitarian assistance is paralysed or delayed due to the perceived risks associated with counter-terrorism laws and policies that are overly restrictive, vague and far-reaching. As one key informant for this research commented: “*Self-censoring by humanitarians is based on risk aversion [related to counter-terrorism restrictions].*” Another key informant noted: “[*When implementing due diligence, humanitarians tend to self-limit in counter-terrorism contexts.*” This has direct implications for the timeliness of aid and the ability to target aid based on people’s needs.

However, our research shows that the impact of counter-terrorism measures extends far beyond the so-called chilling effect and includes directly targeted and outrageous acts of intimidation and violence perpetrated against MSF health workers.

Across all three countries included in this research, interviewees reported incidents involving threats and violence against MSF frontline staff. As one MSF colleague commented, it is common for teams to “*be*

after Afghanistan, Iraq and Nigeria, according to the Global Terrorism Index 2020. The country introduced CT domestic legislation in 2012. For an analysis of its impacts and scope, see TIMEP (2019) ‘[Brief: Law No19 of 2012: Counter-terrorism Law](#)’, including a link to the Arabic text of the law, Violations Documentation Centre in Syria (VDC, 2015) ‘[Special Report on Counter-Terrorism Law No. 19 and the Counter-Terrorism Court in Syria](#)’ and Syrian Network for Human Rights (SNHR, 2020) ‘[At Least 10,0767 Persons Still Face Trial in Counter-Terrorism Court, nearly 91,000 Cases heard by the Court- A Political/ Security Court Which Aims at Eliminating Those Calling for Political Change for Democracy and Human Rights](#)’

²⁸ MSF staff whose job involves direct exposure to identified risks associated to CT legislation and measures, given tasks associated to negotiation and maintenance of access and humanitarian space, medically assisting patients injured in the frame of CT operations including during transfer of patients

²⁹ This qualitative operational research was approved by MSF-Ethical Review Board (ID 2119) on May 2021

³⁰ See among others; NRC/ Mackintosh, K., & Duplat, P., (2013) “[Study of the Impact of Donor Counter-Terrorism Measures on Principled Humanitarian Action](#)” and NRC follow up reports in 2016 and 2019, Burniske, J. S., and Modirzadeh, N. K., (2017) *op. cit.*, CHR&GJ, (2011) Huckerby, J., Fakh, L. “[A Decade Lost: Locating Gender in U.S. Counter-Terrorism](#)”, Scheinin, M., (2009) “[Protection of human rights and fundamental freedoms while countering terrorism](#)”, Graduate Institute Geneva, (2020) Mallard, G., Moret, E., “When Money Can’t Buy Food and Medicine: Banking Challenges in the International Trade of Vital Goods and their Humanitarian Impact in Sanctioned Jurisdictions”, El Taraboulsi-McCarthy, S., Gordon S., (2018) “[Counter-terrorism, bank de-risking and humanitarian response: a path forward](#)”. London: ODI, Adamczyk, S., (2019) “[Counter-terrorism, derisking and the humanitarian response](#)” Muslim Charities Forum No.1

subjected to violence like cursing, punishing and beating as result of working on the frontline". A shocking 17 out of 26 interviewees said they had been subject to violence and intimidation as a direct result of providing treatment to patients considered to be terrorists. These included accusations of supporting terrorists, as well as curses, insults, beatings and, in some cases, forced entry to health facilities by armed forces. MSF frontline workers also reported frequent attempted or actual arrests of patients suspected of being terrorists inside MSF health facilities. These incidents included armed intrusions into health facilities and physical and verbal aggression toward health workers. The research findings clearly demonstrate how armed forces have attempted to prevent MSF frontline workers from treating patients based on medical need and according to medical ethics, by means of violence at the gates of health facilities, inside hospital wards and in ambulances on the road.

The violence directed toward health workers for doing their job comes on top of the consequences of counter-terrorism wars on their families and communities. Nineteen of the 26 interviewees reported personal experience of the impacts of counter-terrorism wars, ranging from their homes being destroyed to friends and family members being killed.

This correlates with MSF's accumulated experience. Working in conflicts with a counter-terrorism approach, we have seen an effort to control humanitarian activities and to limit the ability of medical workers to 'treat terrorists' and therefore benefit the enemy, despite the specific legal protection afforded to humanitarian and medical activities provided by IHL. The IHL-protected status of the wounded and sick, both civilians and combatants, is contested regularly at the gates of our health facilities.

MSF frontline staff also reported being exposed to violence in counter-terrorism wars, in the form of bullets, mortars and bombings, due to an apparent lack of restraint by armed forces or to a lack of distinction made between combatants and civilians, including medical facilities and ambulances.

In 23 of the 26 interviews, participants reported a clear awareness of the risks associated with the frontline provision of healthcare in counter-terrorism environments, including exposure to violence directed at them. *"We are aware of the risks of being in the frontline, despite negotiations to create awareness of the medical nature of our work,"* said one staff member. Another commented: *"[As a doctor I am] spending energy and resources to save lives while being endangered by violence."*

These risks are posed both by states engaged in counter-terrorism wars and by armed opposition groups. Counter-terrorism conflicts were regarded by the interviewees as *"dirty wars"* where *"no one is safe"*. One interviewee commented: *"The difficulties are both from the [armed opposition group] and also fear from the government. [When] there is conflict or military operations... we contact both sides to move but you don't know what's going on. If you are just stuck in the middle of them, they are firing at each other [and] you, the patients might get hurt. These fears affect everyone."*

Another interviewee said: *"The government and the army tell us we cannot treat the armed opposition group [...] they shouldn't be part of our criteria."* In another country, a staff member reported that restrictions imposed by the army resulted in medical teams *"finding more difficulties to access health facilities under armed opposition groups' control."*

While the findings of this research shed light on the risks faced by MSF frontline workers, many interviewees referred to the way in which entire communities were indiscriminately attacked in counter-terrorism operations. *"Maybe I was expecting CT war to be different, but indiscriminate bombing without a target, arrests and executions in large numbers: that is not normal,"* said one. Another interviewee reported: *"[Daily we witness the] direct loss of lives as a result of bombardments, or wounded in need of immediate treatment out of reach."* Another said: *"[We saw] the levelling of the entire city by aerial bombings."* A fourth reported:

“We saw them bombing the hospital like it is a military base,” and a fifth interviewee said: *“We saw them bombing the city full of civilians, families in their houses.”*

With whole communities besieged, screened, indiscriminately attacked, traumatised and denied access to lifesaving healthcare, the simple act of MSF being there to provide medical treatment is perceived as a threat, if not directly criminalised as ‘material support to terrorism’, by parties to the conflict. The punishment for such perceived crimes is often meted out on the spot, with intimidation and violence intended to deter MSF frontline workers from doing their jobs. From the perspective of frontline workers, it becomes increasingly difficult to distinguish between the tactics of so-called terrorists and those countering them.

2. Counter-terrorism inhibits access to healthcare for people in need

Counter-terrorism measures and legislation marginalise, stigmatise and discriminate against individuals and entire communities. What one MSF frontline worker described as the *“exclusion of people labelled as ‘terrorist’ from receiving care”* significantly impacts their wellbeing and their access to humanitarian assistance and lifesaving healthcare.

An interviewee from another country reported: *“Working during the counter-terrorist military operation, we were facing restricted areas [by the military]: where to work, where was forbidden to go due to insecurity... but there were entire families there; we could not access them and they could not reach us.”*

Even when MSF teams receive permission from states to reach restricted areas, armed opposition groups impose their own constraints. One interviewee reported: *“So it’s a hard time for us; we know that even in areas where we cannot go there are people under armed opposition group control. They have medical needs, but you know we cannot go there because of two things: government will not allow us to go there, and secondly even the AOGs [armed opposition groups] have cut all international NGOs as their target because they say that we are promoting westernisation.”*

As well as the obstructions preventing frontline health workers from reaching those most in need, there were also numerous reported cases of patients being blocked from reaching healthcare during counter-terrorism operations. One interviewee said: *“Accessing medical care was hard, [there were] patients who told us that they were forced to leave wounded family members behind.”* Another interviewee reported that women were particularly vulnerable: *“Not all people who were under the oppression of terrorist groups are affiliated to them; women were the most marginalised group during dominance [of the designated terrorist groups].”* Several interviewees reported that their own family members had been prevented from reaching healthcare due to obstructions during counter-terrorism operations.

In general, violence during counter-terrorism military operations was reported to be indiscriminate and to affect everyone – men, women and children: *“During the bombings we saw traumatic amputations in men, women, children... all in need,”* said another interviewee.

In 23 of the 26 interviews across the three contexts, MSF frontline workers reported that medical projects did not necessarily target those most in need, but instead those who could be reached within an acceptable risk threshold. This results in a situation whereby *“aid is not reaching no-go areas”* and the most vulnerable people remain out of reach. *“Targeting based on risk [thresholds], not needs,”* as one interviewee described it, is a direct result of parties to the conflict failing to ensure the protection of medical workers close to the frontlines of counter-terrorism conflicts. Another interviewee reported that MSF teams *“needed security forces’ approval to access areas, being banned from ‘non-liberated’ areas”*. Another reported that *“people are being excluded from [receiving] aid; it is not their fault, but because of the [counter-terrorism] law of the country it makes it difficult to reach them.”*

Restrictions requiring MSF teams to stay in areas that the government deems safe to operate in results in *“armed opposition groups’ perceiving INGOs as partners of government,”* according to one interviewee. This perceived ‘partnership’ is sustained by the constant risk – perceived or real – of international NGOs having their work suspended or being kicked out of the country.

When MSF has a degree of access to frontline conflict areas, our teams can treat the wounded and run medical activities for the direct victims of violence, such as trauma care. Conversely, when MSF is unable to access areas near the frontlines of conflicts, our teams are limited to treating the indirect consequences of violence, particularly forced displacement, malnutrition and psychological trauma.

3. Counter-terrorism hampers negotiated access by inhibiting or criminalising engagement with all parties to the conflict

When MSF experiences difficulties reaching victims of violence, these are usually overcome by negotiating access. As one interviewee commented: *“Negotiation for access is key.”* However, in 20 of the 26 interviews, MSF frontline workers reported that negotiations, access and engagement with armed groups designated as terrorists was hampered, criminalised or forbidden by governments. As a result, negotiations for our teams to be safe, accepted and able to provide treatment based on medical needs alone entails a significant level of risk, which is assumed individually, operationally and at an institutional level.

In nearly half of the 26 interviews, MSF frontline workers spoke of the importance of engagement and networking to mitigate against the risks of working in counter-terrorism environments. Interviewees further qualified that the engagement needs to be *“consistent,” “done in a transparent manner,” “rooted in humanitarian principles”* and done *“in depth”*.

As one interviewee commented: *“Being an independent, impartial and neutral organisation is a departure point for networking, making it clear to everyone.”* Another interviewee said it was essential to *“contact everyone, doesn’t matter religious, government or armed opposition group,”* without which *“it would be difficult to run projects in a conflict country”*.

4. Counter-terrorism inhibits speaking out and increases fear of reprisals

Nearly half of the interviewees reported that the ability to speak out was impacted by counter-terrorism legislation and measures, raising fears of reprisals at an individual and institutional level.

“[As a citizen of my country], daily life, it’s very difficult. For example, in my daily life, as a medic, as a human, I do have the right to express my feelings and opinion on the current situation in [my country], no? Because somewhere, I have lost my brother, I have lost my friend, I have lost my colleagues [...] but [...] the next minute you change your mind, and say, look, I have commented on social platforms and this might endanger my life.”

In counter-terrorism environments, fear of reprisals can also inhibit MSF frontline medical staff from publicly advocating on behalf of their patients. One interviewee raised the concern of MSF being expelled: *“We have seen cases of wives and children of suspected terrorists, and we don’t deny them medical care. But I also see that maybe if the government or the military knows about this it may also be a problem to us and we may also be kicked out of the country, because we are [accused of] ‘supporting terrorism’.”*

Another interviewee reported: *“Seeing the suffering... someone soaked in blood crying, or you see a mother losing her baby in front of you, then as a human being you definitely raise your voice, while working for MSF makes you be silent [publicly].”* Another interviewee stated: *“[We are] fearing being kicked out by the government if MSF even speaks out about working on the other side.”* Another reported: *“Talking with [groups designated as terrorist] is forbidden, trying to talk with them or even speak out about it would*

jeopardise all operations.” These considerations lead MSF frontline workers in counter-terrorism environments to be acutely aware of how the visibility of their actions could conflict with the government’s expectations.

5. Humanitarian principles are key when working in counter-terrorism environments

Twenty-five out of 26 MSF frontline workers interviewed stressed the centrality of humanitarian principles – particularly impartiality – in addressing humanitarian needs in counter-terrorism environments.

Counter-terrorism military operations are subject to sectarian, tribal or religious divides and tensions in all three countries where this research was conducted. With military forces from one group operating in areas of another group, sect or religion, interviewees reported stigma and violence between armed groups, even when fighting on the same side. When international troops were also involved, other tensions came into play. One interviewee commented: *“All foreigners are here to get our [names a resource]. They are all perceived as USA or as enemies.”* The impartiality of MSF’s provision of healthcare was seen by interviewees as helping set MSF apart from these perceptions. One said: *“MSF treats every person, irrespective of who you are, your social class, where you come from. So we don’t think or ask, we go straight to treat, as our primary aim is to save life.”*

Half of the interviewees highlight the importance of explaining how humanitarian principles can be of concrete value to the communities MSF supports and the armed groups with which MSF engages. In all three contexts, interviewees stressed the importance of MSF’s financial independence; its medical triage based on people’s needs; and its ‘no guns inside health facilities’ policy. MSF frontline workers explained how ‘policing patients’ was not part of providing healthcare: *“It never happened that on the door of the facility someone asked the patient what is your religion, your ideology, who are you affiliated to. This is a very important lesson.”*

Interviewees reported that humanitarian principles helped justify why MSF was in contact with all parties to the conflict: *“Years of fighting, of course, has had some impact on all humanitarian organisations but, as you know, we have principles, like neutrality, impartiality and independence, and we [gain] respect with those principles. This is how we implement our project in this conflict situation [...] this is clear for the authorities, this is clear for the armed opposition groups, this is clear for everybody. Therefore we are contacting everyone.”*

Another interviewee reported that the principle of medical impartiality explained how MSF managed to build acceptance: *“The rumour was very strong, that we were treating the armed opposition group. We made them understand that we treat every person, irrespective of who you are, your social class, where you come from, and as much as you fall within the [medical] criteria of [the hospital], we cannot abandon you. [...] They are like: ‘Then the government is trying to go after those people and why are you treating them? Why don’t you allow them to just die off and go?’ I remember, our response to them was: ‘No, every human being has equal rights to live, so we have to treat’ [...] Then an incident happened, there was now a military personnel who was also injured, and they were amazed how we accepted the person in the facility. We accepted them [...] From there, they started understanding MSF, [...]. We told them: ‘Yes our goal, our main aim is to save life, everybody,’ and it went smoothly, I remember this.”*

“[We have to] show we are impartial with consistent action and engagement; [...] people don’t respect humanitarian law from when they were born, [they] don’t know what is medical ethics [...] you need to show them what we do, how we treat patients and save lives.”

Conclusions

There are no silver bullet approaches to providing impartial health care in counter-terrorism environments. Counter-terrorism multiplies the barriers for frontline workers trying to provide healthcare and for communities trying to access healthcare, increasing the challenges and the risks to both. Counter-terrorism adds “salt to the wounds” of the already difficult and dangerous job of providing medical care in conflict zones.

One of the key difficulties of quantifying the impact of counter-terrorism on the provision of medical humanitarian aid is its unpredictable nature, which can make it impossible to attribute a consistent causal chain between the two.

Yet the MSF frontline workers interviewed for this research reported a great many first-hand experiences of the impacts of counter-terrorism wars on individuals, families and communities. MSF staff have been subject to harassment, abuse and violence for allegedly ‘supporting terrorists’. On a daily basis, they have witnessed attempts to prevent ‘terrorists’ and the communities in which they are located from receiving healthcare. This happens at the gates of our hospitals, in ambulances on the road, and by designating entire areas as no-go zones. Our teams’ ability to work safely is hampered by restrictions on negotiating with groups labelled as ‘terrorist’. This reinforces perceptions by these groups that healthcare providers are working hand-in-hand with government-led counter-terrorism operations.

While many of these constraints might not be unique to counter-terrorism wars, MSF frontline workers see the way in which counter-terrorism operations embolden militaries in their efforts to control humanitarian aid. From the checkpoints through which MSF ambulance drivers pass, to the halls of the UN Security Council, the ‘war on terror’ has bolstered the power of armies, while exposing frontline health workers to harassment and violence and restricting their ability to reach the most vulnerable people.

It is imperative that states take urgent measures to ensure that frontline health workers and their medical activities are protected. The medical humanitarian act in conflict needs to be exempted from being targeted by the legal regimes and military tactics that have come to define the War on Terror. Frontline workers should be enabled to work according to medical ethics, not according to who is deemed a criminal, a terrorist, a soldier or a politician. Our teams should be able to treat patients based on needs alone, without the fear of repercussions. Health facilities should not be regarded as military targets. MSF should be able to engage with whichever groups have the capacity either to harm us or to facilitate our access to the most vulnerable people. Our frontline workers should be able to do their jobs without being accused of supporting terrorism.

Twenty years after 9/11, following the staggering proliferation of counter-terrorism legislation and policies, the challenges to providing impartial healthcare are mounting. At the same time, the sick and wounded people deprived of lifesaving healthcare are paying the ultimate price.

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