Evolving Challenges for Health Care Delivery in Conflict Zones

Perspectives of an MSF Surgeon

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Who Am I

• Vascular surgeon here at CU

Overseas experience

• Belladere, Haiti 12 months 2005-06  
• Kerenik, West Darfur, Sudan 6 weeks 2008  
• Khanh Hoa, Vietnam 4 weeks 2008  
• Betou, Republic of Congo 6 weeks 2012  
• Rutshuru, DR Congo 6 weeks 2014  
• Bentiu POC, South Sudan 6 weeks 2015  

• Two years studying international relations
New Challenges to Care in War Zones

• Security context in flux
• Old paradigms for assuring staff security may no longer hold in all situations

• Where is the seeming insecurity stemming from?
• Is it real?
• What are the underlying causes for it?
• What solutions have been tried to maintain / maximize access?
• Solutions on the horizon?
“Men in rage strike those that wish them best.”
- William Shakespeare, *Othello*

• The history of the **modern humanitarian movement** has been intimately associated with the **history of modern warfare**

  • ICRC founded by Henry Dunant and Gustave Moynier in response to the death of 40,000 soldiers at the Battle of Solferino, 24 June 1859, Austro-Sardinian War
  • Medecins Sans Frontieres founded by Bernard Kouchner in response to the Biafran secession and conflict 1967-70
  • International Rescue Committee founded in the US, at the request of Albert Einstein, in response to European refugees fleeing Nazi and Stalinist oppression
  • UN High Commissioner for Refugees appointed in 1950 to deal with the refugee aftermath of World War II
Foundations of Security – MSF

Organisation Principles

1. Security management on mission is an integral part of MSF OCP’s operational management and therefore a responsibility delegated by the MSF-France Board of Directors and General Director to the Director of Operations – and not to a separate department.

2. Security is first and foremost managed on the ground by the people directly involved in the relief work, interacting with their environment and exposed to its threats.

3. The MSF management line (Project Coordinator, Head of Mission, Program/Cell Manager, Director of Operations, General Director, President and Board) is responsible for:
   - a) Ensuring that all MSF employees are aware of the risks and dangers of the mission they undertake and have the right to withdraw, without it jeopardizing their MSF career.
   - b) Ensuring that the field teams have the necessary tools to reduce and manage risks, such as; risk analysis reports, mitigation procedures, contingency plans and incident reviews.
   - c) Helping the field teams develop and use these tools, including by playing the role of "mirror"/"coach", without substituting for the teams who remain responsible for the daily management of their exposure to danger.
   - d) Informing every MSF employee that she/he is responsible for her/his own safety and that of other employees by contributing to risk analyses as well as to the implementation and improvement of security measures.
   - e) Ordering the withdrawal of individuals or teams engaged in reckless risk taking.

Core Benchmarks

4. The staff protection that MSF strives for in the name of universal medical ethics and the right to humanitarian assistance is not bullet proof: zero risk does not exist.

5. MSF intervenes by choice, not by mandate: risk-taking must be justified in terms of achieved or expected operational results.

6. MSF refuses to intervene in high security risk areas where there is an absence of authorities with which to negotiate our safety and / or when it is impossible to protect ourselves from groups demonstrating radical hostility against us.

7. MSF believes risk reduction should be achieved primarily through political negotiation with all protagonists (military and civilian, local and international) and secondly by measures of protection or deterrence.
   - In this respect, our security depends heavily on the quality of our context analysis, our contacts, adjusting our operations (selection, quality, perception), our behaviour and lifestyle.
   - The use of ‘Bunkerisation’ and armed close protection can only be justified in exceptional circumstances.

8. In high-risk areas, MSF will ensure the continuous presence of experienced team leaders and minimize the number of people exposed to danger, making compromises on the choice of medical activities if required.

9. MSF recognizes that security threats on its members may vary according to their gender, nationality or morphology and that, under exceptional circumstances, MSF may profile its team composition according to such criteria.

10. In the event of kidnapping, MSF itself will manage the crisis and favours release by political means. Nevertheless, MSF will do everything in its power to secure the safe and timely release of its staff.
Foundations of Security – MSF

• Security achieved through wide stakeholder engagement
• High quality programs that help communities improve project security
• Trust individuals over processes; leave key security decisions to field managers
• Armed security / protection more or less forbidden
• Be willing to leave

** - Silence despite injustice is NOT one of our tenets
The people of Chechnya — and the people of Burundi and Rwanda — are paying an intolerable price for security, and the International Community should therefore take steps to ensure that the peace process does not end in failure. The case of the people of Chechnya — and the people of Burundi and Rwanda — is but one of the many examples of how the international community has failed to live up to its obligations. The case of the people of Chechnya — and the people of Burundi and Rwanda — is but one of the many examples of how the international community has failed to live up to its obligations. The case of the people of Chechnya — and the people of Burundi and Rwanda — is but one of the many examples of how the international community has failed to live up to its obligations.
The Blurring of Lines

• Militaries co-opting humanitarian groups
• Engaging in “humanitarian missions”
• Provincial Reconstruction Teams
  • Mid 2000’s: 25 in Iraq, 25 in Afghanistan
Concerns about humanitarian space continue to fuel NGO skepticism. NGOs question military involvement in reconstruction activities because of fears about the shrinkage of “humanitarian space” when PRT areas of operation overlap with their own. These complaints have persisted despite improvements since the clumsy initial forays of PRTs into the development sphere in Afghanistan. While reliant on international military forces to provide a secure environment in which they can operate, NGOs consistently express worries that CIMIC projects implemented by PRTs place their personnel at risk by blurring the distinction between combatants and civilians. PRTs have responded by arguing that simply receiving money from international sources makes NGOs a target by those seeking to disrupt the current order. International NGOs generally assert their independence from PRTs and minimize their direct interaction with military forces.
Confusion and Disdain on the Ground

- Humanitarians viewed in some contexts as “tools of the West”
- Particularly acute in Jihadi controlled areas
Medical Care Under Fire

• Ongoing MSF visibility project

• Attacks on healthcare facilities /workers are as old as the organization – Somalia, Chechnya, Yugoslavia

• There is a sense that there is a worrisome new trend involving motivation / ideals-based attacks against foreign healthcare workers
  • Still the minority of incidents, and highly geography restricted

• Perception and expectations may also be partly to blame for this sense of narrowing humanitarian space
  • “Professionalization”; guidelines, security consultants and specialists
  • Centralization of security management, fortification of compounds
Medical Humanitarians

• Intentional Targeting, or Negligent (possibly criminal)
  • Yemen - Over 130 health facilities struck over past year, most by Saudi Coalition force airstrikes
  • Syria – Physicians for Human Rights report
    • 240 health clinics struck, 700 medical staff killed by end of 2015
    • 90% of attacks by the Syrian regime
    • Maarat al-Numan hospital struck, likely by the Russians, in February; 7 dead, 8 missing
Kunduz

• 3 October 2015 – US AC-130 gunship, on orders from ground controllers, strafed Kunduz Trauma Centre
• 30 dead, including 13 MSF staff (3 doctors)
• Calls for an independent investigation
In the case of Kunduz, it is not our responsibility to prove that the United States military violated the laws of war or its own rules of engagement. It is the responsibility of the party that destroyed a fully functioning hospital, with some 200 staff members and patients inside, to prove that it did not.

We know our call may not be heeded, but the United States and other nations should see it as an opportunity. By consenting to an independent investigation, President Obama could reaffirm America’s commitment to international humanitarian law, restore its credibility when it comes to denouncing violations by other states, and help reinforce the protected status of medical facilities in conflict zones.
Money’s Not Everything

• Money not the issue
  • Last year, MSF-USA took in $332 million in private donations
  • Movement wide, $1.3 billion
  • Program/social mission expenditures $858 million
  • Despite major programs in 22 countries, MSF ran a surplus >$250 million
  • MSF mandate to accrue no more than 10 months operating expenses on reserve

• Access
  • How to utilize these funds while remaining effective in an evolving, ever more dangerous space?
  • How to counteract instinctual “institutional preservation” mentality?
  • How to “safely” reach those in greatest need i.e. those in greatest danger?
Institutional Risk

- Duty of Care
- Humanitarian “movement” turning into humanitarian “profession”
- Norwegian Refugee Council and the case of Steve Dennis
- No such thing as “risk free war zone”

The verdict of the case, which found the NRC liable for physical and psychological injuries and awarded compensation for gross negligence that totalled 4.4m krone (£350,000), broke through the numbness that had set in for Dennis after almost two years of what he saw as failed attempts to negotiate. “Hearing it all presented in the verdict from someone anew... wow, it sounded horrible,” he says.
Remote Control and Bunkerization

• Remote Control
  • Abandoning the principle of international staffing of projects
  • Weakening of the “temoignage” mission
  • Inappropriate elevation of the project risk tolerance

• Bunkerization
  • Adherence to extreme security protocols involving separation/isolation from normal external contact
  • Potentially elevates the mission risk profile due to lack of community engagement, “neo-colonial” appearances
Volunteer “Profiling”

• Team composition that is intentionally discriminatory
  • Gender mix in conservative Muslim communities
  • American, British expats in Jihadi controlled regions

• “Do you happen to have a second passport?”

• Alternative:
  • Potential loss of project access
  • Increased project risk profile / institutional risk associated with staff abduction or killing
10 miles or 10,000 miles: A Case study of Unity State, South Sudan

• The world’s newest country, formed 2011
• Devolved immediately into an ethnic civil war
• Prize jewel is Unity State
Dinka vs Nuer

• Dinka have slowly won the upper hand militarily
• A war of attrition
• 100,000 Nuer fled to the UN Peacekeeper base begging for protection
Food Insecurity

40,000 at risk of death
A Rare Compromise (for MSF)
Geographically Close ≠ Access

• Inadvertent “bunkerization” effect
• Nuer dodging Dinka patrols under cover of night to reach MSF hospital
• Provincial governors vs central governors vs military forces – no chain of command for authorization
Images of severe injuries, including gunshot wounds and other types of trauma, are shown. The images depict detailed close-ups of the wounds, highlighting the extent of the damage and the medical attention required for recovery.
Calls for Organizational Change

• The majority of in-country medical NGOs focus on hospital-based infrastructure and standard bottom-up “medical system replacement” in crisis response.

“...I have read one statement by MSF International President Joanne Liu declaring that the MSF Kunduz hospital provided “state of the art” trauma care, but I would argue that, in 2015, battlefield trauma care is not “state of the art” unless it is mobile.”

David Elliott, MD
Colonel (Retired), US Army Medical Corps
MSF-USA Surgeon
Possible Next Steps

• Helicopter airlift capacity
• Scoop and run methodology
• Forward mobile surgical bases

• Reticence on the part of NGOs to pseudo-militarize
South Sudan: Preliminary UN probe shows helicopter was shot down
It’s a Dangerous World

• Humanitarian medical actors privileged status in war zones appears to be weakening
  • Unintentional and intentional victims of armed groups and militia, government militaries
  • Numerous contributing factors, including military co-opting of humanitarianism, “clash of civilizations” effect
• The illusion of safety in a war zone is just that
• Attempts to increase safety (for expats...) inevitably degrade quality of access – our primary mission
• Solving this dilemma will require cost-heavy investments into novel care delivery methods
  • Only a small number of NGOs will be able to afford this
Thank You