Attacks on medical missions: overview of a polymorphous reality: the case of Médecins Sans Frontières*

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Abstract

The aim of this article is to carry out a preliminary analysis of issues relating to the types of violence that are directed against humanitarian medical missions.

Starting from the observation that violence can cause some degree of disruption for a medical organisation such as Médecins Sans Frontières, despite its wide experience which has brought it much wisdom and generated numerous and sporadic responses to such events, the article offers a more subtle analysis of terms and of situations of violence so as to contribute to the establishment of a research project and, in a second phase, to an awareness-raising campaign focusing on these complex phenomena.

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> *If we are killed, the NGOs will withdraw and there will be no-one left to pay for the protection racket or salaries. They want us alive and scared. So you should be scared and happy because that means you can work.*[1]

The aim of this article is to examine the sources and the limits of analysis of phenomena of violence aimed at humanitarian medical missions. Often presented in an anecdotal manner, as in the above quotation taken from an historical example dating from 1992, the issue of violence against patients and against doctors and health-care personnel working for Médecins Sans Frontières (MSF)[2] has not always been the focus of coherent reflection within the organisation. The issue of attacks against medical activities is doubtless not a new one, but since the initiative taken by the International Committee of the Red Cross (ICRC) titled 'Health care in danger',[3] it has aroused the interest of a community of practitioners and humanitarian workers. This reflection nevertheless needs to be further developed and supported by an analysis of the complexity of such occurrences.

Since its inception in 1971, MSF has been confronted with various forms of violence against its patients, its personnel and its medical facilities and vehicles, as well as against national health systems in general. Nevertheless, these forms of violence, often heterogeneous, have rarely been approached as a matter for deliberation and comprehensive analysis by the organisation. The action taken in those cases has been sporadic and reactive, often spurred by operational urgency and the media climate of the time.

The aim of this article, therefore, is to draw attention to the importance of the matter for MSF by outlining the general framework in which the problem of violence against medical activities arises. It will examine the semantic choices made in relation to such violence, consider the pertinence of the criterion of intentionality in investigations focusing on such attacks and, finally, seek to establish to what extent such instances of violence and the way they are dealt with by the organisation call humanitarian principles into question.

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1   Extract from a discussion between Joni, an MSF volunteer, and James Orbinski in Somalia around 1992. Quoted in James Orbinski, *Le cauchemar humanitaire*, Music & Entertainment Books, Marne-la-Vallée, 2010, p. 99.
2   MSF is termed 'the organisation', 'the movement', or 'MSF' throughout this article.
3   ICRC, *Health care in danger: Making the case*, ICRC, Geneva, 2011.

Subsequently we shall endeavour to classify the different types of attack on medical activities which are directed against MSF in the field. This will point up three ambiguous dimensions of MSF's relationship to violence and insecurity, dimensions which are potential subjects of research: the trivialisation of violence, its internalization and, more insidious, tolerance of such incidents. The article takes up those three points and attempts to bring out their complexity. While remaining at a distance from the anecdotic, it seeks to establish in concrete terms the nature of such violence so as to give it a 'visibility'[4] which may enable us to understand its motivations and its intrinsic dynamics.

Talking about of the trivialisation of violent incidents might lead to recognition of their almost implicit character in the conduct of humanitarian medical activities. Despite extensive risk assessment[5] and personnel management practices, an organisation like MSF nevertheless lacks the cross-sectional and longitudinal data and the meta-analyses that should underpin a global perception of phenomena of violence within the movement[6] or in the situations in which it works. However, such data does exist and is often processed in the framework of operations and of human resources, but with variabilities which may cause uncertainty as to the origins and nature of violence. While violence can never be entirely eliminated, and while insecurity and risk are both inflationary trends, humanitarian workers have perhaps tended to consider them as a constituent part of their way of operating.[7]

In the worst case, therefore, a real climate of tolerance might develop among teams vis-à-vis situations which are nevertheless unacceptable. As humanitarian activities always take place in a balance of power, some degree of ambivalence or even ambiguity may appear. Undoubtedly, from an historical standpoint, such tolerance appears to be on the decrease. It remains, however, deeply entrenched in the culture of the organisation.

More recently there has been a debate throughout the MSF movement focusing on the issue of violence directed against medical activities. In the absence of reliable data and definitions, tension relating to security matters might also be a symptom of what British sociologists call 'moral panic', that is, a moral crisis within the organisation created by a general feeling of anxiety in the face of acts of violence. This feeling is not generally associated with any rational demonstration of an increase in insecurity.[8] The organisation thus seems to be subject to two

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4   Conversation with Jérôme Oberreit, Secretary General of MSF International, 16 May 2013.
5   Used mainly in psychiatry and criminology, the techniques of 'risk assessment' have moved away from their initial usage. See Kevin A. Douglas, David N. Cox and Christopher D. Webster, 'Violence risk assessment: Science and practice', in *Legal and Criminological Psychology*, Vol. 4, 1999, pp. 149–184.
6   The MSF movement comprises five operational sections and 23 associations.
7   See, for example, the memoirs of John Norris, *The Disaster Gypsies: Humanitarian Workers in the World's Deadliest Conflicts*, Praeger Security International, Westport, CT, 2007, pp. 7–8.
8   The concept of 'moral panic' has its origins in the work of Jock Young and Stanley Cohen. It often refers to the impact of the media and other forms of expression of opinion on the development of new social perceptions of danger in response to concern about social changes. The concept is now an integral part of the development of approaches to risk and risk assessment. See Stanley Cohen, *Folk Devils and Moral Panics*, Blackwell, Oxford, 1972; Kenneth Thompson, *Moral Panics*, Routledge, London, 1998. For more recent use, see Sheldon Ungar, 'Moral Panic Versus the Risk Society: The Implications of the Changing Sites of Social Anxiety', in *The British Journal of Sociology*, Vol. 52, No. 2, 2001, pp. 271–291.

contradictory currents, that is, teams that accept or even tolerate violent incidents on a daily basis, and an institutional dynamic which appears increasingly unwilling to accept the taking of risks.[9] It must be admitted, however, that currently there are security issues in medical circles, and in very different contexts; this situation may create the possibility of a new perception of problems which have, nevertheless, existed for a long time.[10] In both cases it would appear justified to focus on this violence as a subject of research.[11]

The theoretical and historical implications of the issue

Discussion of the problem of violent acts against humanitarian medical organisations often takes the form of questions regarding the notion of neutrality of medical activities. While it is not automatically synonymous with a reasoned approach to violence, medical neutrality has been claimed by certain organisations from the origins of the modern humanitarian movement.[12] Without reverting to the numerous attacks perpetrated against doctors and patients during the war of 1870,[13] soon after adoption of the first Geneva Convention, the issue of medical neutrality in conflict situations described as 'insurrectionary or revolutionary' was considered important enough in the 1950s[14] et 1960s to justify the holding of conferences on the subject and the publication of articles in the *Revue internationale de la Croix-Rouge*.[15] The problem is therefore not a new one. Partisan use of medical

9   In this regard, see Michel Tondellier, 'L'action organisée face à la prise de risque: l'héroïsme au travail et son institutionnalisation', Proceedings of the symposium 'Acteur, risque et prise de risque', 25 and 26 November 2004, Centre lillois d'études sociologiques et économiques, UMR 8019 Centre national de la recherche scientifique.

10 The Chinese press, for example, reported 17,000 incidents in 2011: *Wall Street Journal*, 22 October 2012; see Therese Hesketh, Dan Wu, Linan Mao and Nan Ma, 'Violence against Doctors in China', in *BMJ* 2012;345/e.5730. Violence in hospitals is also at the centre of investigations in France and in the United Kingdom. See Ministère du Travail, de l'Emploi et de la Santé (French Ministry of Work, Employment and Health), *Bilan national des remontées des signalements d'actes de violence en milieu hospitalier*, 2011.

11 A series of semi-structured interviews was carried out in order to substantiate this article. Four members of MSF took part in interviews held to record the issues relating to incidents they had experienced while working for the organisation in the field. The reports were recorded and written up *in extenso*. The questions and all the replies are available on request.

12 Frank T. Carlton, 'Humanitarianism, Past and Present', in *International Journal of Ethics*, Vol. 17, No. 1, 1906, pp. 48–55; John F. Hutchinson, 'Rethinking the Origins of the Red Cross', in *Bulletin of the History of Medicine*, Vol. 63, No. 4, 1989, pp. 557–578; Bertrand Taithe, 'The Red Cross Flag in the Franco-Prussian War: Civilians, Humanitarians and War in the "Modern" Age', in Roger Cooter, Steve Sturdy and Mark Harrison (eds), *War, Medicine and Modernity*, Sutton Publishing, Stroud, 1998, pp. 22–47; John Hutchinson, *Champions of Charity: War and the Rise of the Red Cross*, Westview Press, Oxford, 1996.

13 Charles Duncker, *Les violations de la convention de Genève par les français en 1870–1871*, Berlin, 1871; J. M. Félix Christot, *Le Massacre de l'ambulance de Saône et Loire le 21 janvier 1871; rapport lu au comité médical de secours aux blessés le 7 juillet 1871*, Vingtrinier, Lyon, 1871; Charles Aimé Dauban, *La Guerre comme la font les prussiens*, Plon, Paris, 1871; Bertrand Taithe, *Defeated Flesh: Welfare, Warfare and the Making of Modern France*, Manchester University Press, Manchester, 1999, pp. 169–173.

14 John H. Herz, 'Idealist Internationalism and the Security Dilemma', in *World Politics*, Vol. 2, No. 2, 1950, pp. 157–180.

15 Jean des Cilleuls and Raymond de la Pradelle, 'Medical Neutrality in Subversive Wars', in *International Review of the Red Cross*, Vol. 13, No. 10, 1960, pp. 195–204.

resources,[16] the theft or exclusive appropriation of health services, and violent acts perpetrated against medical personnel with the aim of depriving the adversary of medical treatment are unfortunately all features of warfare examples of which may be found throughout the twentieth century. More recently, ongoing events in Syria are forceful reminders that health systems can be the object of targeted attacks.[17] Medical activities may thus be perverted to serve logistic and belligerent purposes. The issue of access or denial of access to medical care can deprive entire populations of vital assistance.[18] Hence attacks on medical facilities allow the parties to the conflict to assert their power in an effective and symbolic manner.[19]

Violence in war must nevertheless be analysed in its own context. While there is no golden age for humanitarian action in the face of conflict, it should be noted that responsibility for such violence against medical facilities has been claimed only in the context of efforts to rid a country entirely of a foreign presence, and that since the 1870s attacks on health facilities and personnel have always given rise to international controversy.[20]

Nevertheless, beyond their specific contexts, such attacks are heterogeneous. A distinction must therefore be drawn between several elements, and the porous nature of possible analytical categories must be recognized.[21] However, certain common points may be stressed in order to distinguish, perhaps artificially, the causal connections which often overlap:

● The brutal nature of the social relations in which attacks on medical missions generally occur;[22]

16 Laurence Brown, 'The Great Betrayal? European Socialists and Humanitarian Relief during the Spanish Civil War', in *Labour History Review*, Vol. 67, No. 1, 2002, pp. 83–99.

17 Médecins Sans Frontières, 'Syria: All Parties To The Conflict Must Respect Medical Facilities', 26 January 2013, available at: http://www.doctorswithoutborders.org/press/release.cfm?id=6582&cat=press-release (last visited 13 June 2013); Olivier Falhun, 'En Syrie, l'humanitaire confronté à ses limites', CRASH, 12 March 2012, available at: http://www.msf-crash.org/sur-le-vif/2012/03/12/4902/en-syrie-lhumanitaire-confronte-a-ses-limites (last visited 13 June 2013).

18 'A deeply worrisome pattern is emerging, where people and their scarce resources are deliberately targeted by all the armed groups involved in inter-communal violence. Hospitals, health clinics, and water sources are all targets, suggesting a tactic of depriving people of life's basic essentials, precisely when they need them most'. See Médecins Sans Frontières, 'Even Running Away Is Not Enough: Attacks in Jonglei, South Sudan, Perpetuate Extreme Violence', 24 January 2012, available at: http://www.doctorswithoutborders.org/press/release.cfm?id=5740ost (last visited 13 June 2013).

19 'Biopolitics designates the assumption of control by the power of the processes that affect life, from birth to death (disease, age, disability, environmental effects, etc.) and that, while absolutely random on the scale of the individual, have, as a collective phenomenon, decisive economic and political effects' [ICRC translation]. See Marie Cuillerai and Marc Abélès, 'Mondialisation: du géo-culturel au bio-politique', in *Anthropologie et Sociétés*, Vol. 26, No. 1, 2002, p. 22.

20 In this regard, international law governing the use of armed force (*jus ad bellum*) and international humanitarian law governing the use of force (*jus in bello*) coincide. See Martti Koskenniemi, *The Gentle Civilizer of Nations: The Rise and Fall of International Law, 1870–1960*, Cambridge University Press, Cambridge, 2002; Samuel Moyn, *The Last Utopia: Human Rights in History*, Harvard University Press, Belknap, 2010; David. G. Chandler, 'The Road to Military Humanitarianism: How the Human Rights NGOs Shaped a New Humanitarian Agenda', in *Human Rights Quarterly*, Vol. 23, No. 3, 2001, pp. 678–700.

21 An argument to this effect is put forward by Larissa Fast, 'Characteristics, context and risk: NGO insecurity in conflict zones', in *Disasters*, Vol. 31, No. 2, 2007, pp. 130–154.

22 The concept of brutalisation is a reference to the work of George Mosse, *De la Grande Guerre au totalitarisme, la brutalisation des sociétés européennes*, Hachette, Paris, 1999.

- The chronic insecurity of patients and personnel resulting from the fact that hospitals, and health facilities in general, are perceived first and foremost as possible targets for predation, with essentially criminal objectives;
- The strategic or tactical importance of medical facilities in the wider context of urban or psychological warfare or insurgency;
- The perception of health care as being a private asset or resource (of the enemy) rather than being for the common good.

While attacks on medical facilities may be a sign of an escalation in hostilities (for they are aimed at premises usually devoted to preserving vital interests common to the entire population), they usually occur in a context marked by other types of violations of international humanitarian law, such as attacks on civilians – in particular counterinsurgency operations which make the distinction between civilians and combatants (an essential precept of international law) illusory[23] – or acts of torture perpetrated on the civilian population by government forces, a phenomenon which, sadly, may be observed in many situations.[24]

The sequence of such events is also a matter for investigation. In particular, the stage at which these eruptions of violence occur – the moment in time when such acts against medical facilities are most frequent or appear advantageous for those who carry them out – remains a subject for analysis.

Semantic choices

Several studies have demonstrated the importance of the terminology used by humanitarian organisations in their responses to difficult situations.[25] As well as more general discussions on principles, debate centred on the very terms of such discussions takes on an autonomous dimension. For example, MSF very often refers to the notion of 'medical sanctuaries', but without taking into account the metaphysical dimension that this idea may embody. The term 'sanctuary' might also give rise to confusion in that it suggests that medical services belong in an extraterritorial sphere, that is, outside national sovereignty which is itself often at issue in conflicts. By being considered as a refuge, or a safe haven, protected from any national or international interference, a sanctuary may appear to be a non-indigenous structure, in contradiction with the idea of common good which is essential to its safety.[26] The fact that the existence of any 'medical sanctuary' is a myth, albeit an advantageous and necessary one, is not often the subject of internal discussion within MSF and it is perhaps illusory to imagine that such a notion can

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23 Gilles Andréani and Pierre Hassner (eds), *Justifier la guerre? De l'humanitaire au contre-terrorisme*, Presses de la Fondation nationale des sciences politiques, Paris, 2005.

24 Médecins Sans Frontières, 'Libya: Detainees Tortured and Denied Medical Care, MSF Suspends Work in Detention Centers in Misrata', 26 January 2012, available at: http://www.doctorswithoutborders.org/press/release.cfm?id=5744 (last visited 13 June 2013).

25 With regard to the terminology used by humanitarian agencies, see Caroline Abu Sa'Da, *Dans l'œil des autres: Perception de l'action humanitaire et de MSF*, Editions Antipodes, Lausanne, 2011, pp. 43–50.

26 Sarah Kenyon Lischer, *Dangerous Sanctuaries: Refugee Camps, Civil War, and the Dilemmas of Humanitarian Aid*, Cornell University Press, Ithaca, 2005.

have any meaning or indeed, a priori, any useful purpose.[27] Several other examples could be cited, but suffice it to note here the critical importance of terminology in all approaches and responses to violence.

Pertinence of the parameter of intentionality

While it is often difficult to analyse the causes of attacks on medical activities, their consequences are essentially difficulties in the delivery of care or in accessibility by patients to health services. Lack of security resulting from unpredictable acts of violence also has secondary effects. Fiona Terry, referring to her long experience with MSF and in humanitarian activities in general, points out:

> The most widespread consequence of violence against health-care is its absence or inaccessibility when needed most. Violence causes health structures to close and staff to flee, leaving no one to treat patients. Resupplying health centres with drugs, materials and equipment is a major problem in insecure contexts such as Somalia today. People in the south and central regions are deprived of health-care because resupply trucks cannot get through.[28]

Trying to distinguish between criminal violence and tactical violence, whether on a battleground or more sporadically in street fighting, or even during strategic combat in which deprivation of medical care is a war objective, is thus hardly pertinent from the viewpoint of the primary victims. In many cases such distinctions emerge only after the event, from historical or legal analysis.

In fact, light can be shed on the issue of intentional deprivation of medical care by means of political analysis which is often carried out after the event. Neglecting to perform such analysis sometimes leads to deferring the issue of responsibility to a later date and focusing attention on the medical consequences. Analysis of a situation from the angle of deprivation of medical care ignores the various forms of violence to concentrate only on their effects. This approach may be necessary during local negotiations, but it might seem to set such practices apart from the political responsibilities with which they must be linked, and to amalgamate events that are highly diverse. From the opposite viewpoint, an approach focusing on an analysis of intentionality might be distorted by a biased or ill-informed perception of highly complex situations. In either case, a non-governmental medical organisation (NGO) is hardly qualified to carry out a comprehensive analysis of the situations of insecurity in which it attempts to

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27 In fact, the term 'sanctuary' implies the capacity of society to remove individuals from a situation of danger and to produce a situation in violation of the usual rules; in the North American context the concept of sanctuary refers to local and exceptional campaigns run by churches or other religions relying on 'pastoral power' in aid of a few refugees. As this concept has no implications for the majority of other refugees, it is not a universally recognized principle, but merely a locally negotiated balance of power. See Randy Lippert, 'Sanctuary Practices, Rationalities, and Sovereignties', in *Alternatives: Global, Local, Political*, Vol. 29, No. 5, 2004, pp. 535–555.

28 Interview with Fiona Terry, Geneva, 14 May 2013.

operate, often because of its fragmentary view of the causal links and the motivations underlying such phenomena.

Challenging principles

It is partly to transcend these analytical limits that recalling the fundamental concepts of humanitarianism might be a possible solution. In fact, attacks on medical missions are attacks on the principles of humanitarian action as set out in the MSF Charter and constitute a grave violation of international humanitarian law.[29] While the neutrality of MSF is called into question by the very existence of its operational and medical choices, which remain a political decision on the part of the organisation, this principle is at the heart of reflection regarding attacks on medical activities.[30] The interpretation of neutrality as a condition for negotiations or as a fundamental principle is often placed in an historical perspective. In this connection, Fiona Terry remarks:

> When the founder of the Red Cross Movement, Henri Dunant, proposed that medical personnel and volunteers agree to be neutral in time of war, it was with the quite clear objective of avoiding attacks on them. Medical staff and their assistants were not allowed to take part in fighting and their status had to be clearly indicated by a distinctive sign. But, like all good ideas, the neutrality of humanitarian workers in times of war has given rise to many dilemmas, both practical and philosophical.[31][ICRC translation]

Moreover, as pointed out by Hugo Slim, neutrality and impartiality are the main points of tension in both law and practice.[32] Article 23 of the Fourth Geneva Convention states clearly that aid may be suspended if there is any evidence that thanks to that aid 'a definite advantage may accrue to the military efforts or economy of the enemy.'[33] In this legal perspective, therefore, aid is not intended to help or develop the capacity of the parties to the conflict. It may be difficult to claim that medical assistance is entirely impartial if it is seen not as a common asset but as a private resource or an advantage for one of the parties to the conflict.

29 Certain public statements made by MSF concerning security incidents explicitly mention the attack on the fundamental principles of medical humanitarian aid. For example: 'The attack on our team in Kismayo has been an attack on the very idea of humanitarianism and our ability to alleviate the suffering in Somalia', available at: http://www.msf.org/article/attack-our-team-kismayo-has-been-attack-very-idea-humanitarianism-and-our-ability-alleviate (last visited 13 June 2013).

30 For two historical examples at critical moments, see Max Huber, 'Croix-Rouge et neutralité', in *Revue internationale de la Croix-Rouge*, Vol. 18, No. 209, 1936, pp. 353–363; Carola Weil, 'The Protection-Neutrality Dilemma in Humanitarian Emergencies: Why the Need for Military Intervention?', in *International Migration Review*, Vol. 35, No. 1, 2001, pp. 79–116.

31 Interview with Fiona Terry, Geneva, 14 May 2013; Jean Pictet, *The Fundamental Principles of the Red Cross*, Henry Dunant Institute, Geneva, 1979.

32 Hugo Slim and Miriam Bradley, 'Principled Humanitarian Action and Ethical Tensions in Multi-Mandate Organizations in Armed Conflict, Observations from a Rapid Literature Review', in *World Vision*, March 2013, p. 13.

33 *Ibid*. See also Barbara Ann Rieffer-Flanagan, 'Is Neutral Humanitarianism Dead? Red Cross Neutrality Walking the Tightrope of Neutral Humanitarianism', in *Human Rights Quarterly*, Vol. 31, No. 4, 2009, pp. 888–915.

While neutrality is an historical concept, the history of its application is rife with tension and temptation. Indeed, humanitarian medical staff have often been active in favour of one or other party to the conflict. From the Vietnam War to the conflicts in Afghanistan against the Soviet invaders,[34] humanitarian involvement in the Cold War did not always abide by the principles of neutrality and impartiality. Instead, humanitarian personnel acted in accordance with other, more partisan considerations, often focusing on identifying victims of oppressive regimes, which led them to concentrate their efforts on a particular cause and group. In the operational history of MSF, such choices clearly demonstrate that there is a degree of ambivalence regarding principles when it comes to practice.[35]

Certain dynamics of war – which could be termed totalizing, for they consist in the gradual invasion of all public and private places in pursuance of the political and military aims of the conflict – sometimes appear inconceivable for an organisation such as MSF. Yet here we have to analyse such phenomena in contrast to what is termed the 'total' warfare of the past, during which the nature of medical neutrality and the protection of medical facilities were more or less established, although recent historiography reveals many breaches of the generally accepted rules.[36] On the other hand, civil wars offer numerous examples of violence against the wounded and medical personnel.

In French history, the insurrectionary régime of the Paris Commune in April 1871 was not legally competent to sign the Geneva Convention, so could claim adherence to it only implicitly:

> The *International Aid Society for Nursing of the War Wounded* having protested to the Versailles government about the atrocious violations of the Geneva Convention committed daily by the monarchy's troops, Thiers gave this heinous reply:
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> 'As the Commune has not adhered to the Geneva Convention, the Versailles government is under no obligation to comply with it.'
>
> The Commune has done better to date than to adhere to the Geneva Convention.
>
> It has scrupulously respected all the laws of humanity in the face of the most barbarous acts, the most bloodthirsty challenges to civilization and to modern law: our wounded finished off on the battlefield, our hospitals shelled, our ambulances riddled with bullets, our doctors and nurses even having their throats cut in the performance of their duties.[37][ICRC translation]

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34 Scott Flipse, 'The Latest Casualty of War: Catholic Relief Services, Humanitarianism and the War in Vietnam, 1967–1968', in *Peace and Change*, Vol. 27, No. 2, 2002, pp. 245–70; Christopher Kauffman, 'Politics, Programs and Protests: Catholic Relief Services in Vietnam, 1954–1975', in *Catholic Historical Review*, Vol. 91, No. 2, 2005, pp. 223–250.

35 Fabrice Weissman (ed.), *In the Shadow of Just Wars: Violence, Politics and Humanitarian Action*, Hurst & Co, Paris & New York, 2004; Claire Magone, Michaël Neuman and Fabrice Weissmann (eds), *Agir à tout Prix? Négociations humanitaires: l'expérience de Médecins Sans Frontières*, La Découverte, Paris, 2011.

36 Annette Becker, *Oubliés de la grande guerre: humanitaire et culture de guerre, 1914–1918. Populations occupées, déportés civils, prisonniers de guerre*, Editions Noêsis, Paris, 1998.

37 *Journal Officiel de la Commune de Paris*, 12 May 1871.

Only to recognize it officially on 16 May according to a narrow interpretation:

> The only aim and effect of the Geneva Convention is to guarantee the neutrality of the buildings and the personnel of military ambulances. The Commune's adherence is limited to recognition of this neutrality.[38][ICRC translation]

In practice, the facilities of the Aid Society were harassed by the Commune and its leaders were forced to flee after 15 April 1871.[39] While the first victim of the retaking of Paris by the Versailles government was a Dr Pasquier, killed by communards while wearing a Red Cross armband, violence against the Commune did not spare medical facilities. After the Commune de Paris insurgency, wounded persons identified by doctors as communards were executed by French army forces.[40] Be it the Commune de Paris, the Spanish Civil War or the wars in Indochina, all civil conflicts are, sadly, replete with examples of atrocities committed against medical services. We should, however, approach these distinctions between 'conventional' (or international) wars and 'civil' wars with caution, because in practice medical services were not spared to any greater extent during 'conventional' wars. Since the Peninsular War fought by Napoléon I, conflicts described as 'conventional' have often had a counter-insurrectional element which could easily be mistaken for what is usually called 'civil war'.[41] The primary aim of conflicts fought for national independence, such as the war in Algeria,[42] was to support the population. However, they led to the use for political ends of doctors and medical treatment; a trend which prompted the holding of three congresses between 1959 and 1968 on the neutrality of medical care.[43]

Since the end of the Cold War, the proliferation of local conflicts has led to a perception of so-called 'new' wars, according to the studies of Mary Kaldor.[44] These conflicts, described as 'asymmetrical'[45] and taking place in what are

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38 Journal Officiel de la Commune de Paris, 15 May 1871 (Paschal Grousset's declaration being postdated).

39 Eugène Delessert, *Épisodes pendant la Commune*, Charles Noblat, Paris, 1872, pp. 60–64; B. Taithe, above note 13, p. 146; Bertrand Taithe, *Citizenship and Wars, France in Turmoil, 1870–1871*, Routledge, 2001, p. 137.

40 For example, the hospital of the rue d'Allemagne, Dr Dolbeau's patients at the Beaujon hospital and the execution of Drs Faneau and Moilin are all well documented: see *ibid.*, p. 148.

41 Helen Yanacopulos and Joseph Hanlon (eds), *Civil War, Civil Peace*, Open University, Oxford, James Currey, 2006.

42 Axelle Brodiez, 'Le Secours populaire français dans la guerre d'Algérie: Mobilisation communiste et tournant identitaire d'une organisation de masse', in *Vingtième siècle. Revue d'histoire*, No. 90, 2006, pp. 47–59; Raphaëlle Branche, 'Entre droit humanitaire et intérêts politiques: les missions algériennes du CICR', dans *Revue historique*, Vol. 301, No. 1(609), 1999, pp. 101–125; Maurice Faivre, *La Croix-Rouge pendant la guerre d'Algérie: un éclairage nouveau sur les victimes et les internés*, Lavauzelle, Panazol, 2007.

43 'Third Congress of the Neutrality of Medicine', in *International Review of the Red Cross*, Vol. 13, No. 87, No. 594, June 1968, pp. 418–424.

44 Mary Kaldor, *New and Old Wars*, Polity, Oxford, 1998–2006.

45 For analysis of the term 'asymmetrical warfare' see Robin Geiß, 'Asymmetric conflict structures', in *International Review of the Red Cross*, Vol. 88, No. 864, 2006, p. 759 : 'Neither the term "asymmetric warfare" nor the sometimes synonymously employed terms "fourth-generation warfare" or "non-linear war" have thus far been concordantly defined. … Analysis shows, however, that there is a noticeable tendency in contemporary conflicts towards an increasing inequality between belligerents in terms of weaponry.'

considered to be middle-income countries,[46] seem to give rise to particularly extreme forms of violence against health systems, as these can become important stakes in the dynamics of war. Doctors and hospitals may sometimes be regarded as a dyad to be destroyed, as they represent the possible preservation of the enemy's human resources. For example, one doctor[47] working for MSF in Syria reported that he had been advised to describe himself as a journalist rather than as a health professional. In some 'civil' wars,[48] suspicion regarding health services and insurgents may be connected with a long tradition of distrust towards the medical domain, which would indicate that this phenomenon is far from new. The hiding of weapons in hospitals and firing emanating from health-care establishments have on occasion justified the massacre of medical personnel and sometimes of their patients.[49] In all these historical cases, medical 'sanctuary' certainly seems to be tainted by partiality and class or political solidarity.

To a certain extent hospitals, like all the other services of a sovereign State, remain associated with the previous political régime. Medical care given to insurgents that appears to amount to aid, even when dispensed impartially, becomes a justification for violence against health personnel. In a situation of total war, whether ideological or societal, there is little room left for political ideals relating to the common good.[50] This is sadly not a recent phenomenon, and the 1864 Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field hardly broached the issue of the total politicisation of everyday activities such as health care. In certain contemporary conflicts, the population has been fearful about the setting-up of medical centres because they might attract aerial bombing.[51] Shelling of medical facilities bearing the logos of international organisations or the Red Cross emblem is also not a new phenomenon, for it has been denounced by the French authorities since the siege of Paris in January 1871. In response to that infringement of the law, the French authorities also violated the Geneva principles, using enemy prisoners as human shields by placing them in hospitals to better

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46 Income groups: economies are classified by gross national income (GNI) per capita for the year 2011, calculated according to the World Bank Atlas method. The groups are: low income, $1,025 or less; lower middle income, $1,026–$4,035; upper middle income, $4,036–$12,475; and high-income, $12,476 or more. Available at: http://data.worldbank.org/about/country-classifications (last visited 13 June 2013). See Mark R. Duffield, *Global governance and the new wars: the merging of development and security*, Zed Books, London, 2001; Edward Newman, 'The "New Wars" Debate: A Historical Perspective is Needed', in *Security Dialogue*, Vol. 35, No. 2, 2004, pp. 173–189.

47 Discussion with MSF physician, March 2013.

48 Christopher Cramer, *Civil War is Not a Stupid Thing: Accounting for Violence in Developing Countries*, Hurst, 2006, p. 33.

49 Laurence Brown, '"Pour Aider Nos Frères d'Espagne": Humanitarian Aid, French Women, and Popular Mobilization during the Front Populaire', in *French Politics, Culture and Society*, Vol. 25, No. 1, 2007, pp. 30–48.

50 This politicisation reappears quite markedly during the Second World War: Paul Benkimoun, A. Bergogne and C. Coumau, 'Les médecins et Vichy: Résistants, collaborateurs . . .', in *Impact médecin hebdo*, No. 380, 1997, pp. 6–19.

51 Interview with MSF chief of emergency operations, March 2013.

protect such premises.[52] Such practices were observed in 1877–78 and in many later conflicts.[53]

In fact, a war hospital is a structure sheltering a concentrated mass of exceptionally static and vulnerable wounded combatants who are tempting prey in the effort to destroy the enemy. It is therefore a favoured target in a context of total war. In such cases the vulnerability of a wounded soldier may no longer evoke the urgency of medical care but rather an opportunity for attack. Thus the principle of humanity is completely disregarded, or perverted solely for exploitation in the dynamics of war.

In other cases, as we shall see later, the purpose of the belligerents may be to use medical services to consolidate their control over a given community.[54] Furthermore, the possession of medical facilities is a matter associated with the principle of sovereignty,[55] and an affirmation of power as well as a source of political legitimacy. Their loss or destruction thus becomes a vital issue in protracted conflicts involving local and international alliances. Presenting itself as the essential role of protector and provider of health care creates and consolidates a power in place. This political use of health economics has in the past been exploited by humanitarian organisations themselves in order to gain access to patients. Negotiations with various warlords in Afghanistan, for example, are a good historical demonstration of this.[56]

That being the case, what can be done to counter such practices, apart from invoking the principle of universality to promote acceptance of the fact that health facilities benefit everyone, and that ensuring their security is based on well-understood mutual interest? What difference is there between health care in time of war and such activity in peacetime? As doctors have a dual role in wartime – that of treating victims and, in the case of military medical officers and others in a similar category, sometimes that of accompanying the fighting forces – it is evident that some ambiguity may arise.[57] Sometimes in the past humanitarian aid has even been seen as a form of support for the war effort: the early Quaker pacifists saw it as a way of internationalizing conflicts, and even of mobilizing women and children.[58] In fact, it cannot be denied that humanitarian assistance in time of war does allow mobilization of an international environment and thus contributes to accounts of

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52 Charles Laurent, 'Histoire de deux prisonniers allemands à Paris', in *Annales Politiques et Littéraires*, 1911, pp. 304–306, 338–339, 358–359, 378 and 404–406.

53 *Report and Record of the Operations of the Stafford House Committee for the Relief of Sick and Wounded Turkish Soldiers: Russo Turkish War, 1877-1878*, pp. 119–120.

54 Xavier Crombé, 'Afghanistan retour négocié?', in C. Magone, M. Neuman and F. Weissmann, above note 35, pp. 65–91.

55 Antony Anghie, *Imperialism, Sovereignty and the Making of International Law*, Cambridge University Press, Cambridge, 2005.

56 Archives MSF France, Afghanistan Ghazni, 1986–1989; see also the archives of MSF France, Thailand 1989, on the situation of latent violence in Site II of the Cambodian camps.

57 John T. Greenwood and F. Clifton Berry Jr, *Medics at War: Military Medicine from Colonial Times to the 21st Century*, Naval Institute Press, Annapolis, MD, 2005.

58 B. Taithe, above note 12, pp. 22–47.

the causes of conflicts.[59] Is it not the case that NGO reports and victims' stories are often referred to by the press and by States party to the conflict as sometimes being used for political ends?[60] Indeed, being in control of medical care might also be a means of controlling the narrative of the war:[61] Biafra is a significant example of this.[62] It therefore represents a resource and a symbolic asset whose usefulness in generating political propaganda remains immense.[63]

To conclude this first part, it must be said that the debate concerning attacks on MSF's medical activities often comes down to calling into question, by the teams, of the pertinence, the advantage gained by the populations concerned and the added medical and operational value should MSF decide to remain in a context in which it has come under attack. In such cases the continuity of operations sometimes prevails over contingencies connected with violent phenomena. Invocation of the concept of neutrality has rarely prevented attacks on medical activities; medical missions have often been exploited for political purposes. In approaching this subject it is essential not only to be prudent in the choice of terms used, but also to place the events concerned in context.

An attempt to draw up a typology of attacks on medical missions and attitudes to such attacks

It should be noted that in the history of the organisation, these acts of violence have been recurrent (spasmodic or chronic, often a combination of both) and have several categories of effects on access to and delivery of medical care:

- A general restriction on access to care, either because the infrastructure has become inoperative or for lack of competent health personnel, for example when they have been directly or indirectly targeted by attacks.
- Withdrawal from certain medical zones, or even certain types of medical care, as a result of direct and indirect attacks against health personnel and patients.
- The impossibility of providing primary health care, in particular under the Expanded Programme on Immunization, due mainly to obstruction of medical

59 Heather Jones, 'International or Transnational? Humanitarian Action During the First World War', in *European Review of History*, Vol. 16, No. 5, 2009, pp. 697–713.
60 Luc Boltanski, *La souffrance à distance: morale humanitaire, médias et politique*, Métailié, Paris, 1993; Rony Brauman, *Dangerous Liaisons: Bearing Witness and Political Propaganda. Biafra and Cambodia – the Founding Myths of Médecins Sans Frontières*, Centre de réflexion sur l'action et les savoirs humanitaires, Paris, 2006.
61 Jonathan Benthall, *Disasters, Relief and the Media*, Tauris, London, 1993.
62 Henryka Schabowska, *Africa Reports on the Nigerian Crisis: News, Attitudes and Background Information. A Study of Press Performance, Government Attitude to Biafra and Ethnopolitical Integration*, Scandinavian Institute of African Studies, Uppsala, 1978; Donald Rothchild, 'Unofficial Mediation and the Nigeria-Biafra war', in *Nationalism and Ethnic Politics*, No. 3, 1997, pp. 37–65; Enda Staunton, 'The Case of Biafra: Ireland and the Nigerian Civil War', in *Historical Studies*, Vol. 31, No. 124, 1999, pp. 513–534; Daniel Bach, 'Le Général de Gaulle et la guerre civile au Nigeria', in *Canadian Journal of African Studies/Revue Canadienne des Etudes Africaines*, Vol. 14, No. 2, 1980, pp. 259–272; John J. Stremlau, *The International Politics of the Nigerian Civil War*, Princeton University Press, Princeton, NJ, 1977.
63 J. Benthall, above note 61.

activities, looting of medical supplies or the inability of medical personnel to travel because of poor security conditions.

- Constriction of the humanitarian organisations' working space when violent incidents result, in some serious cases, to a diminution in the aid dispensed and in the geographical area covered.
- Triage of patients according to non-medical criteria (for example gender, age or ethnicity).[64]
- Selection[65] of certain staff members on the basis of gender, religion or culture, which violates the principles governing MSF's working practices and the principles set out in its charter.

A whole range of problems arise as a corollary of the consequences set out above. They create tensions (functional, ethical, or even identity-related), not only within MSF but also among international organisations in general, especially in the event of very serious incidents[66] likely to call individual and institutional responsibilities into question.

Threats, pressure, violence: visible and invisible forms

In terms of security analysis, the most acute forms of violence are also the most visible, in particular the killing of health personnel and patients,[67] sometimes even inside health centres or ambulances. Such events may have a range of effects which are sometimes difficult to grasp. Thus the migration of qualified medical personnel from public services to the private sector (a phenomenon noted in particular in Central America, where violence perpetrated by organized crime rings[68] against health professionals is well documented[69]) not only results in staff shortages in those structures but also makes the delivery of health care more complex. Indeed, doctors working in Mexico State, Mexico, report that they have to avoid certain territories in the hands of cartels in order to be able to function.[70] In situations of latent war, tactical acts of violence may combine cynicism and terror. For example, a senior

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64 MSF France Archives, Afghanistan 1996, 1997 and 1998, in particular on the conflicts with the Taliban over access to health care for women.
65 Pierre Micheletti discusses 'affectabilité' in 'Les humanitaires français à l'épreuve de la Syrie', *Le Monde*, 28 February 2012, available at: http://www.lemonde.fr/idees/article/2012/02/28/les-humanitaires-francais-a-l-epreuve-de-la-syrie_1649002_3232.html (last visited 13 June 2013).
66 For example, see: Médecins Sans Frontières, 'Afghanistan – L'humanitaire "assassiné"', 5 July 2004, available at: http://www.msf.fr/actualite/articles/afghanistan-humanitaire-assassine (last visited 13 June 2013).
67 A patient executed in a Honduran Red Cross ambulance: 'Acribillan a un hombre dentro de ambulancia en Honduras', in *La Prensa*, 20 March 2013, available at: http://www.laprensa.hn/csp/mediapool/sites/LaPrensa/Sucesos/Policiales/story.csp?cid=365888&sid=951&fid=98 (last visited 29 August 2013).
68 A health centre was closed in Tegucigalpa because of constant threats and extortion on the part of the Maras: 'Mareros le sacan carrera a personal de centro de salud', in *La Tribuna*, 8 December 2012, available at: http://www.latribuna.hn/2012/12/08/mareros-le-sacan-carrera-a-personal-de-centro-de-salud/ (last visited 13 June 2013).
69 For example in Ciudad Juarez and Tamaulipas State: 'Médicos huyen por violencia', in *El Universal*, 5 October 2010, available at: http://www.eluniversal.com.mx/primera/35648.html (last visited 13 June 2013).
70 Private communication, MSF adviser, Mexico, 2013.

member of MSF working in Iraq describes the feeling of helplessness among teams faced with particularly violent attacks directly targeting medical vehicles and hospitals:

> One *modus operandi* is regularly used in Iraq, and consists of multiple attacks: a first explosion – sometimes relatively small – claims a few victims so as to attract a group of emergency personnel, security forces and bystanders to the site of the blast. Then there is a second explosion, often more violent, which results in many more casualties because of all the people who have rushed to the spot to bring aid to the victims of the first one. Sometimes this is followed by a third explosion, targeting the hospital where the wounded have been taken. A similar type of scenario was played out three times in 2011 in Kirkuk, interrupting *de facto* the aid chain, and more generally the operation of the reference hospital, which led to the evacuation or 'bunkerisation' of the teams and thus the suspension of medical care in the wards where MSF was working. This diffuse but constant threat materialized on 21 December 2011, when the vehicle transporting the victims of an initial, targeted attack, was itself booby-trapped and exploded in the compound of the Jumhouri Hospital, wounding an Iraqi doctor.[71]

Several senior MSF officials explain that in situations of extreme violence, operational possibilities (not including public statements) for responding to such events are finally quite limited. In comparable if not similar circumstances, MSF has either temporarily or permanently reduced the number of expatriate, regional or national teams present, or suspended its activities, or else opted for temporary or permanent suspension of medical programmes of whatever description. In many cases, definitive withdrawal from the country is a possibility contemplated only when the degree of risk is weighed against the medical impact that MSF can have on the spot. However, threatening the authorities with temporary or permanent withdrawal would appear to be an effective means of restoring security only where there is a political economy of health whereby the sovereign authority has the means to put an end to violence and needs the continued presence of medical aid.

These two conditions, however, are rather uncertain and the indicisiveness of the Taliban régime in the 1990s about the acceptability of the presence of female medical staff is a clear indication that health policies are often the subject of internal debates which find an echo within MSF.[72] In such a tense context, complex military and political situations sometimes generate conflicting attitudes vis-à-vis the setting-up of autonomous medical aid and the compromises that the organisation might be willing to accept. Finally, a 'vocational crisis'[73] also seems to be emerging.[74] As the practice of medicine exposes practitioners to significant

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71 Discussion with François Delfosse, Head of MSF mission, Geneva, 12 April 2013.
72 Archives MSF France Afghanistan 1996, 1997, 1998.
73 Private communication, teaching staff, University of Mexico Faculty of Medicine, Mexico City, 6 April 2011.
74 There are no doctors in the country's 74 municipalities, which have a population of some 500,000. A large number of complaints have been addressed to the Health Secretary about the lack of treatment available:

risks in certain contexts, health professionals sometimes prefer to emigrate in order to exercise their profession in more serene conditions. In many areas, analysis of violent events tends to demonstrate the extraordinary complexity of both their motivations and in their consequences, and many difficulties arise when steps are taken to prevent and interpret them, especially when the daily threat of violence blurs all sense of normality for the teams.

The nature of activities and specific forms of violence

The nature of medical activities carried out may also be a catalyst for tension, or even for specific forms of violence. This is particularly the case for war surgery,[75] in that it brings together in a single space different types of belligerents, and that this medical activity may be seen as ostensibly sustaining the military forces of the enemy or of the adverse community. For example, when there was fighting between two communities in the Democratic Republic of the Congo in 2003, in the town of Bunia in Ituri district, MSF had to set up ambulance services to transport the wounded belonging to one ethnic group which no longer had access to medical centres run by the other group:

> We negotiated with both sides, in fact, with both the Hema and the Lendu, in the attempt to treat the wounded and sick. At one point MSF was suspected by both sides of no longer being impartial, and one expatriate was kidnapped and held for several days. As a result the organisation hardly left the town of Bunia for almost two years. We no longer responded to outbreaks of disease in the district, for example.[76][ICRC translation]

Even before medical attention is dispensed, the priority accorded in hospital emergency departments to patients in line with their medical condition also gives rise to many disputes: 'The common denominator in the simultaneous management of a large number of victims – whether sick or wounded – is medical triage. When aid activities are initially unable to cope with the scale of an event, the first thing to do is to sort the victims into categories so as to treat them in order of medical priority. Triage allows the emergence of the singular from the collective and the individual from the crowd. It thus moves away from political considerations to focus on ethical ones.'[77][ICRC translation] As it creates both symbolically and

'No hay médicos en 74 municipios del país', in *La Prensa*, 2 April 2011, available at: http://archivo. laprensa.hn/content/view/full/488396 (last visited on 13 June 2013).

75 'Médecins Sans Frontières expresses its serious concern for the security of its surgical centre in Aden, following the irruption into the hospital of a group of armed men during the night of 18 to 19 June. These men tried to carry away a patient who was receiving treatment in the emergency room' [ICRC translation]. See Médecins Sans Frontières, 'Yémen: MSF appelle au respect de la neutralité des hôpitaux', 21 June 2012, available at: http://www.msf.fr/actualite/articles/yemen-msf-appelle-au-respect-neutralite-hopitaux (last visited 13 June 2013).

76 Interview with Laurent Ligozat, Deputy Director of Operations, MSF Switzerland, Geneva, 13 May 2013.

77 Pierre Valette, *Du tri à l'Autre: Éthique et médecine d'urgence,* Thesis presented and defended at the Université Paris-Est Marne-la-Vallée, 1 December 2011, p. 181.

in reality a form of competition among the victims, medical triage becomes a social and political issue and the source of a number of incidents reported in the field. In many cases patients and their families or associates try to relegate medical imperatives to second place so as to obtain immediate assistance for a particular individual or group. This direct interference in the provision of medical care reflects the fact that medical services prior to the arrival of humanitarian aid are not always seen as neutral or impartial, or may simply be dispensed according to personal interest.

Recently vaccination campaigns have also been the scene of repeated attacks against health workers, perpetrated in particular by population groups that reject[78] such campaigns, seeing them as a form of health imperialism.[79]

This often violent opposition to medical activities calls for an analysis of the circumstances, and also for examination of the underlying historical, political and social context of such occurrences. A population always has its own particular perception of and customs relating to medical treatment, arising from its interaction with health systems or with professionals who may be perceived as in the pay of a dominant power, or simply motivated by commercial or even corrupt interests. Medical care is rarely seen as neutral, and a hospital is not an insular structure whose work is guided by metaphysical principles.

The type of activities carried out, the history of the medical profession in a given country and the triage policies which *de facto* create a hierarchy among victims are all factors that tend to exacerbate pre-existing social and political tensions in countries receiving medical aid. Opting for the 'vertical' type of treatment in which resources are used exclusively for a health campaign focusing implicitly or explicitly on a single disease, for example polio or tuberculosis, at the expense of a more 'horizontal' approach, or concentrating on the eradication of one disease while others remain untreated, often appears to be seen by the population as the preferred policy of authoritarian attitudes to health care.[80] These campaigns launched to eradicate major endemic diseases call to mind other, earlier, campaigns, some of which might have appeared experimental while nevertheless justified

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78 'While security concerns persist in Nigeria – amplified by the August bombing of UN headquarters in Abuja – a quarter of the children not vaccinated in the July 2011 immunization campaign were due to refusals – with greater than 80% of refusals in the northern States of Kano, Sokoto and Jigawa', in Heidi J. Larson and Pauline Paterson, 'Eradicating polio: persisting challenges beyond endemic countries', in *Expert Review of Vaccines*, 2011, pp. 1635–1636.

79 'The body and the population resist systematic biomedical practices; they resist in an organic manner in the sense that illness allows a definition of the self and the non-self, of the self and the other, of the pathological and the normal. But bodies and populations also resist in accordance with social contexts and particular policies', in Julie Laplante and Julie Bruneau, 'Aperçu d'une anthropologie du vaccin: regards sur l'éthique d'une pratique humanitaire', in *História, Ciências, Saúde - Manguinhos*. Vol. 10, Suppl. 2, 2003, pp. 519–536, available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-59702003000500005&lng=en&nrm=iso > (last visited 13 June 2013).

80 Maryinez Lyons, *The Colonial Disease: A History of Sleeping Sickness in Northern Zaire, 1900–1940*, Cambridge University Press, Cambridge, 1992; Poonam Bala (ed.), *Biomedicine as a contested site: some revelations in imperial contexts*, Lexington Books, Lanham, MD, 2009; Lea Berrang-Ford, Martin Odiit, Faustin Maiso, David Waltner-Toews and John McDermott, 'Sleeping sickness in Uganda: revisiting current and historical distributions', in *African Health Sciences*, Vol. 6, No. 4, 2006, pp. 223–231.

by ethical considerations.[81] Even today, tensions and misunderstandings relating to that pioneering period persist. Such tensions resurface when specific campaigns overlook the real or perceived needs of the populations concerned.[82] Finding effective levers of power capable of allaying such tensions and organizing a secure space for medical activity often depends on a targeted operational approach which incorporates all these dimensions. Also, serious studies must therefore be initiated to examine the practices which have allowed medical aid to be dispensed in an effective manner.

From tolerated violence to internalised violence?

There is perhaps no clear boundary between tolerance and internalisation of violent phenomena. These two mechanisms often echo feelings of personal insecurity, but may arise from, and be justified by, a substantiated analysis of local micro-politics.[83] Humanitarian activities take place in difficult contexts, and medical teams do not have the authority to solve the prevailing social and political problems.[84] In practice, the teams often experience some difficulty in grasping the overall trends that give rise to attacks, in particular because the issue of intentionality underlying them is extremely difficult to define and understand. The result is a sort of permissiveness in the face of the daily harassment or pressure sometimes experienced by teams on the ground. Only the most brutal attacks on MSF medical missions are reported or denounced. These include attacks on health facilities aimed at identifying opponents of the governing régime,[85] the theft of confidential medical records,[86] and the killing or abduction of patients or personnel.[87] Presented on each occasion as a special case, such problems have served locally as decisive elements in negotiations on the management of resources and relations with local political figures.

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81 Benjamin N. Azikiwe, 'Ethics of Colonial Imperialism', in *The Journal of Negro History*, Vol. 16, No. 3, 1931, pp. 287–308.

82 David Arnold (ed.), *Imperial Medicine and Indigenous Societies*, Manchester University Press, Manchester, 1988; Laëtitia Atlani-Duault and Jean-Pierre Dozon, 'Colonisation, développement, aide humanitaire. Pour une anthropologie de l'aide internationale', in *Ethnologie française*, Vol. 41, No. 3, 2011, pp. 393–404.

83 A field in which MSF teams have often shown great sensitivity, which has sometimes influenced international opinion. Archives MSF France, *Comité Solidarité étranger* (Afghanistan, 1985–1987).

84 For views on the difficulty experienced by medical teams in analysing violent phenomena, see Françoise Duroch, 'Le viol, arme de guerre: l'humanitaire en désarroi', in *Les Temps Modernes*, No. 627, 2004, pp. 138–147.

85 Médecins Sans Frontières, 'MSF Calls for End to Bahrain Military Crackdown on Patients', 7 April 2011, available at: http://www.doctorswithoutborders.org/press/release.cfm?id=5170&cat=press-release (last visited 13 June 2013).

86 'MSF is gravely concerned for the safety of our staff and patients following a serious incident occurring in an MSF medical facility in Dinsor (Bay region, Somalia) on December 27. After taking control of Dinsor, representatives of military forces entered the MSF medical facility, pressured the Somali medical staff employed by MSF, and confiscated all inpatient confidential medical files', in Médecins Sans Frontières, 'After a Week of Intense Fighting in Somalia, MSF Extremely Concerned about the Security of Medical Staff and Safety of Patients', 28 December 2006, available at: http://www.doctorswithoutborders.org/press/release.cfm?id=1916&cat=press-release (last visited 13 June 2013).

87 For example in Somalia, where two MSF colleagues were killed in Mogadishu in December 2011.

Some forms of internalisation[88] have been observed when it comes to certain types of violence[89] experienced repeatedly by MSF teams and patients, who are sometimes forced to endure harassment, threats and blackmail on a daily basis. As a result, a significant number of incidents are reported only in a fragmentary manner.[90] This trivialisation of violence might seem to create the risk of a tacit, or even permissive, culture of an organisation that feeds on individual responses and depends, in practice, on its members' capacity for negotiation. For humanitarian actors and for militants, internalizing acts of violence would amount to making such occurrences a matter that goes unmentioned, an everyday normality that is exhausting and potentially traumatic. As a result, an organisation could become incapable of assessing the real dangers. In fact, this type of internalisation might be seen as giving carte blanche for repetition of such events. Moreover, the tacit acceptance by MSF teams of 'rules' that have to be observed – regarding the recruitment of staff or the conduct of projects, or even for operational choices – and that are constantly being changed by certain elements involved in the conflict, may eventually become a form of submission. The definition of 'red lines' that must not be crossed to avoid passing from accommodation to compromise has been dealt with elsewhere,[91] but still remains a topical issue for the organisation.

Criminalisation of medical activities?

Finally, the question of the criminalisation of medical activities must also be examined. This matter has arisen in the Gaza Strip and also in Somalia, following new legislation put in place in connection with the 'war on terror' and adopted by a group of countries. The issue considered was to what extent providing medical assistance to individuals or groups considered to be terrorists amounted to 'material support for terrorism', as defined by the USA Patriot Act, adopted following 11 September 2001:[92]

> . . . [I]n two criminal cases concerning individual doctors ideologically affiliated with Al-Qaeda, rather than humanitarian organisations, the doctors were

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88 The National Report on the increase in reports of acts of violence in the hospital setting records a similar trend and notes that a policy encouraging reporting of such incidents may result in their increase, while tolerance with regard to violent episodes depends largely on the persons who fall victim to them. 'The establishments do not all report the events that occur in the same manner, for a subjective analysis of the event partly remains, and the threshold of tolerance to agression is very different from one set of personnel to another, from one structure to another, from one establishment to another'. [ICRC translation] See French Ministry of Work, Employment and Health, above note 10, p. 6.

89 'It should be remembered finally that the problem of violence within health facilities requires prudence and prior definitions because violence is protean and subjective. Everyone who encounters this notion gives his or her own definition, a fact that must imperatively be taken into account before any attempt at analysis is made, so as to define a common language from which everyone can draw the elements of communication and information that he or she is seeking.' [ICRC translation] See French Ministry of Work, Employment and Health, above note 10, p. 4.

90 Private communication, senior field staff member, MSF Yemen, March 2013.

91 C. Magone, M. Neuman and F. Weissmann, above note 35.

92 The title of the PATRIOT Act is 'Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism'.

convicted of supporting terrorism by providing medical treatment to members of a proscribed group (the cases are US v. Shah and US v. Farhane). The humanitarian exception was interpreted narrowly in these cases as including the provision of medicine only, and not the provision of medical treatment, which draws upon medical expertise. However, a significant factor in each case was the stated commitment of the defendants to the goals of Al-Qaeda, and the judgments suggest that a different conclusion could be reached in the case of independent humanitarian organisations not acting under the 'direction or control of a designated foreign terrorist organisation.'[93]

In several cases, the manipulation of medical aid for political ends has also led medical organisations such as MSF to withdraw completely from certain contexts. In 1994, for example, MSF withdrew from Rwandan refugee camps so as to cease contributing to the exploitation of humanitarian aid by genocidal factions:

Although the impact of MSF's medical services was marginal compared with that of organisations distributing food . . . our participation in the aid system implicated us in all its outcomes. . . . Everything from our presence in the camps to the resources we lost from theft made us direct accomplices in whatever harmful acts ensued.[94]

There had already been a precedent to this situation in Ethiopia in the 1980s, as reported by Rony Brauman, the then President of MSF France:

The routine of humanitarian activity was beginning to mask participation in the mass violence that was now the primary cause of mortality in the country. Just imagine: I got up, I checked my medical equipment, I went to the dispensary to carry out consultations, I took part in a meeting with the regional coordinating committee, I submitted a request to my headquarters for medical supplies, I paid a visit to the hospital. This daily activity, motivated by the conviction that I was participating in a rescue operation, can be completely turned on its head, seen on the contrary as part of a strategy of oppression, reversed against the intentions pursued, with no break in its routine. . . . We gradually found ourselves in an 'Eichmann-like' process of suspension of critical thinking, in a way delegating our responsibility to higher authorities . . . while carrying out routine tasks ennobled by the underlying intention to bring aid.[95][ICRC translation]

Reverting to the issue of the internalisation of everyday violence and the lack of a critical framework that can result, R. Brauman clearly demonstrates how

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93 Sara Pantuliano, Kate Mackintosh and Samir Elhawary with Victoria Metcalfe, 'Counter-Terrorism and Humanitarian Action, Tensions, Impact and Ways Forward', in *HPN Policy Brief* No. 43, October 2011, pp. 4–5.

94 Fiona Terry, *Condemned to Repeat? The Paradox of Humanitarian Action*, Cornell University Press, Ithaca and London, 2002, p. 3.

95 Rony Brauman, 'La routine du travail humanitaire en venait à dissimuler la participation à des violences de masse', in *Philosophie Magazine*, available at: http://www.philomag.com/les-idees/dossiers/rony-brauman-la-routine-du-travail-humanitaire-en-venait-a-dissimuler-la (last visited 13 June 2013).

internalized violence can become a pernicious dimension of humanitarian work as a whole, undermining the very principles of philanthropy. Forms of mass violence such as the everyday harassment or extreme risks to which MSF medical personnel and patients are exposed by war are interlinked challenges, both individual and institutional, at the heart of current issues.

Conclusion: the MSF 'Medical care under fire' campaign

We have seen how, whatever the form taken by an attack on medical activities, the primary consequence remains the temporary or permanent blocking of access to health care for all or part of the population. In this context, should we see as an indirect threat to medical missions the creation of 'administrative' health wastelands when the authorities deliberately refuse to supply the necessary financial and human resources for certain zones or certain categories of the population?

It appears that the issue of intentionality is finally one of the most sensitive and difficult to grasp and that the pertinence of this factor as an element in analysing field conditions is questionable, despite the fact that its political and historical significance remains indisputable.

In response to all these issues, in 2013 MSF decided to launch a project throughout the MSF movement with the objective of setting up a research programme to document the consequences in medical and humanitarian terms of attacks on patients, health personnel, and health facilities and vehicles. It is intended that the project will focus on improving patients' access to health care and on ensuring the safety of personnel in the exercise, in the broad sense, of their activities. Another aim of the project is to try to determine the consequences in epidemiological terms of the interruption in medical care following an attack. In order to distinguish the real risk from the perceived risk, even if only to dismiss the idea of 'moral panic', it is intended that the project will expand the collection of current and historical data on the basis of shared definitions and methodologies. As suggested by a senior MSF executive, this project could also lead to better understanding of violent phenomena hitherto overlooked, in particular those to which national teams are subjected.[96]

MSF is currently troubled about the absence of data, both narrative and statistical, concerning attacks on medical missions, which seems to highlight a prevailing deficiency and also represents a real challenge for the organisation to produce a coherent analysis of the risks it incurs. Some would like to see these issues of violence analysed more systematically by MSF in order to identify a global trend and a better understanding of the nature of the problem. In practical terms, that may involve use of a database common to all the different sections of MSF – this is still in an experimental phase – coupled with a study of the issues and risks that may be involved in the use of statistical tools, which are time-consuming for the teams and whose pertinence is often called into question.

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96   Discussion with Laurent Ligozat, Deputy Director of Operations, MSF Switzerland, Geneva, 13 May 2013.

Nevertheless, above and beyond the introduction of common and shared procedures allowing the best possible use to be made of the cross-sectional data of the MSF movement and, potentially, ensuring a common understanding of these problems, there remains the basic challenge of conducting a critical study on phenomena of insecurity[97] in the context of humanitarian operations.

Starting from the premise that security incidents result from a combination of elements that may or may not allow the occurrence of such events, the responsibility of humanitarian organisations in relation to the drawing up of operational policies, the quality of the aid delivered and the selection and recruitment of personnel cannot be dismissed out of hand in the process of research. It is therefore not sufficient to be content with assuming the posture of victims or merely denunciators while medical humanitarian aid remains a stakeholder in the conflicts in which it becomes involved and, furthermore, such involvement has to be managed in the most lucid manner possible. There must be detailed analysis of the chain of events leading to the occurrence of these security incidents, and in particular closer assessment of the part played by individuals, groups and random/arbitrary factors. Such investigations should enable the organisation to devise compelling messages that can be brought before the decision-makers: the human cost of operations first of all, the 'knock-on effect' (the immediate, middle-term and long-term effect on health systems), and the implications for patients. Establishment of a data-collection methodology common to the different sections of the MSF movement, and current and retrospective analysis of these violent events will make it possible to track the incidence of such phenomena over time, a process which appears difficult at present.

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97 Elsa Rambaud, 'L'organisation sociale de la critique à Médecins sans frontières', in *Revue française de science politique*, Vol. 59, No. 4, 2009, pp. 723–756.