Dædalus

Journal of the American Academy of Arts & Sciences

Spring 2023

Delivering Humanitarian Health Services in Violent Conflicts

Jaime Sepúlveda, Jennifer M. Welsh & Paul H. Wise,
guest editors

with Sergiy Maidukov · David Miliband
Ken Sofer · Svitlana Biedarieva
Anastasia Shesterinina · Mark Neville
Lawrence Freedman · Nina Murray
Ana Elisa Barbar · Bina Shah · Keith Stanski
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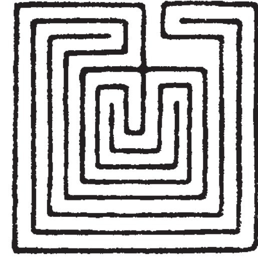

Journal of the American Academy of Arts & Sciences

"Delivering Humanitarian Health Services in Violent Conflicts"
Volume 152, Number 2; Spring 2023

Jaime Sepúlveda, Jennifer M. Welsh & Paul H. Wise, Guest Editors
Phyllis S. Bendell, Managing Editor and Director of Publications
Peter Walton, Associate Editor
Key Bird, Assistant Editor

Financial support for the Academy project on Rethinking the Humanitarian Health Response to Violent Conflict, of which this Dædalus *issue is a part, was provided by Louise Henry Bryson and John E. Bryson, the Malcolm Hewitt Wiener Foundation, and The Rockefeller Foundation.*

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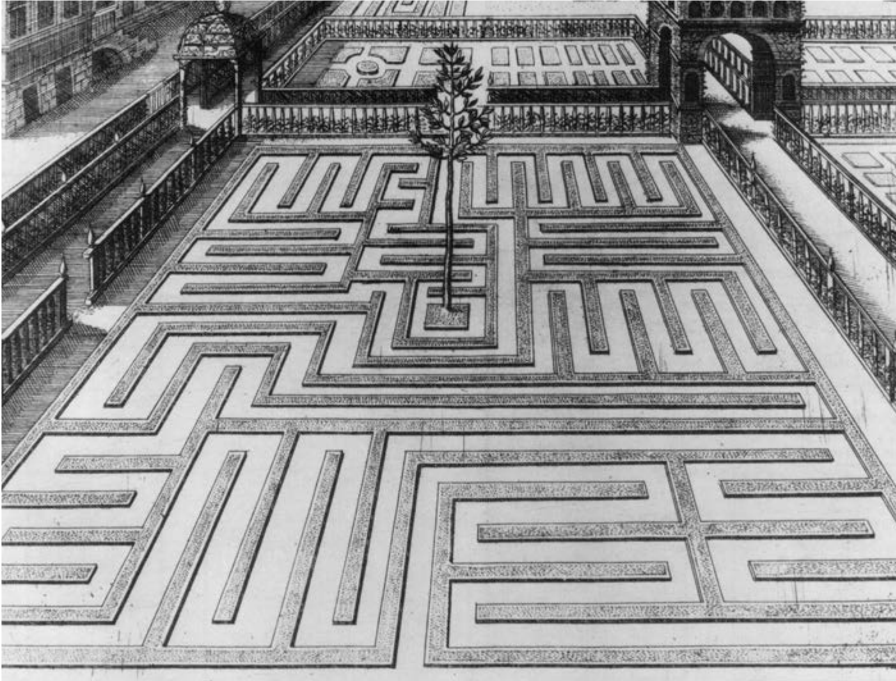

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Dædalus Spring 2023
Issued as Volume 152, Number 2

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Editorial offices: *Dædalus*, American Academy of Arts & Sciences, 136 Irving Street, Cambridge MA 02138. Phone: 617 576 5085. Fax: 617 576 5088. Email: daedalus@amacad.org.

Library of Congress Catalog No. 12-30299.

Dædalus publishes by invitation only and assumes no responsibility for unsolicited manuscripts. The views expressed are those of the author(s) of each essay, and not necessarily of the American Academy of Arts & Sciences.

Dædalus (ISSN 0011-5266; E-ISSN 1548-6192) is published quarterly (winter, spring, summer, fall) by The MIT Press, One Broadway, Floor 12, Cambridge MA 02142-1189, for the American Academy of Arts & Sciences. An electronic full-text version of *Dædalus* is available from amacad.org/daedalus and from The MIT Press.

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Postmaster: Send address changes to *Dædalus*, One Broadway, Floor 12, Cambridge MA 02142-1189. Periodicals postage paid at Boston MA and at additional mailing offices.

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Preface

Jennifer M. Welsh, Paul H. Wise & Jaime Sepúlveda

Russia's invasion of Ukraine last February initiated a brutal conflict between the armed forces of the two countries, with devastating consequences for the Ukrainian population. The numbers are staggering: along with the thousands killed or injured, 5.9 million Ukrainians have been internally displaced, 7.9 million have fled into neighboring countries, and many others have sought refuge by living underground. Relief organizations estimate that 17.7 million people in Ukraine are in urgent need of humanitarian assistance.[1] In the closing months of 2022, Russia began bombarding the country's power grid, water supply, and other key facilities with the aim of turning the cold and dark of winter into another weapon of war. For humanitarian actors on the ground, this was but another grim episode in a conflict that had already witnessed blatant violation of basic principles of international humanitarian law through denial of access to imperiled civilians or indiscriminate attacks on both populations and critical infrastructure, including (at the time of writing) seven hundred attacks on health care.[2]

In truth, however, the massive wave of air and missile attacks launched on Ukrainian cities in late autumn of 2022, along with the continuing systematic assault on health care, was an extension of the war strategy already employed by the Russians and their Syrian allies during Syria's protracted civil war. During the final battle over Syria's second largest city, Aleppo, in the latter half of 2016, more than 31,000 Syrian civilians died through the combined effects of explosions, barrel bombs, field executions, and chemical attacks. As aid convoys were attacked in the Aleppo countryside – denying humanitarian assistance to thousands in need – and hospitals and marketplaces were routinely hit during the siege of the city, former UN Secretary General Ban Ki-Moon declared that Aleppo had become a "synonym for hell."[3]

Moreover, whereas the conflict waged in Ukraine has attracted intense diplomatic and media attention, there are many forgotten crises unfolding outside the glare of the spotlight, where populations suffer systematic violence or are denied life-saving humanitarian assistance. In November 2022, vital medical supplies finally began arriving in Tigray – the first delivery of aid to Ethiopia since

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https://doi.org/10.1162/DAED_e_01988

fighting resumed in late summer between the current Ethiopian federal government and the former ruling party in the country, the Tigray People's Liberation Front. The humanitarian crisis facing the Tigray region is of epic proportions, with five million people currently at imminent risk of starvation. Elsewhere, the sociopolitical and economic crisis in Venezuela continues, as mass migration, hyperinflation, and the impact of COVID-19 have exacerbated the conditions for the most vulnerable, including women and girls. This case, along with other Latin American contexts with high rates of violent death and sexual and gender-based violence, demonstrates that many of the world's deadliest places are not in fact zones of formal armed conflict, as defined by international lawyers. Instead, they are "situations other than war," as the International Committee of the Red Cross refers to them, featuring extreme political and criminal violence that is in many cases both organized and deliberate.[4] These situations pose additional challenges for humanitarian actors, including which international legal frameworks are applicable and what responsibilities should be exercised by international organizations such as the United Nations.

These snapshots of contemporary violent conflict point to the enormous strain being placed on traditional humanitarian strategies and actors, and particularly on the delivery of effective health responses. Much of global humanitarian action has been rooted in international humanitarian law, which contains obligations to distinguish between civilian populations and combatants, and to verify that objects to be attacked are neither civilians nor civilian objects, including sites subject to special protection, such as medical and humanitarian personnel, their means of transport and equipment, and their facilities. Yet today's warring parties – whether nonstate armed groups or state militaries – routinely dismiss or override this normative framework through strategies and day-to-day battlefield decisions that put both civilian populations and humanitarian health workers at risk.

Adding to these pressures are two worrying trends: First, the increasing rollback of political commitments to upholding humanitarian principles by UN member states and signatories of the Geneva Conventions in a context of growing geopolitical rivalry. And second, the ongoing impact of counterterrorism policies developed by governments and international organizations that have inadvertently created new obstacles for humanitarian health by constraining the provision of services in areas controlled by nonstate armed groups. There are also new constraints and challenges more specific to the humanitarian health field that call for further reflection and examination, including the increasing attention on fostering local ownership in humanitarian health delivery, the need to consider the impact of digital technology and data in caring for victims of violent conflict, and the immediate and long-term effects of infectious disease in conflict zones. While pandemics have featured in conflict settings for some time, the global scale

of COVID-19 and its impact on both deeper conflict dynamics and civilian populations (including migrants) are likely to shape broader policy discussions of humanitarian health in the coming decades.

Against this backdrop, we have co-led a multiyear initiative through the American Academy of Arts and Sciences to critically interrogate and creatively reimagine strategies for preventing civilian harm and delivering critical health services in areas plagued by violent conflict.[5] As co-editors with diverse scholarly backgrounds and varied policy experience, our work has been based on a central premise: that innovative approaches are best derived from a deeper, transdisciplinary understanding of the changing political, military, legal, and health dimensions that are dramatically redefining humanitarian action across the globe. Our collaborative work has brought together legal and security experts, health professionals, policy-makers, artists, leaders of humanitarian organizations, and representatives of conflict-affected communities to address a range of pressing challenges. Our in-depth research projects have included examination of the political and security dimensions of pandemic response in areas of weak governance and violent conflict (drawing lessons from the Ebola outbreaks in West Africa and the Democratic Republic of the Congo), as well as the humanitarian health challenges related to major migrant flows, with a particular focus on those seeking relief from criminal and political violence in Mexico and the countries of the Northern Triangle of Central America.[6]

All our activities have been organized around a set of interrelated principles: 1) interdisciplinarity, with an emphasis on integrating long-siloed scholarship and deliberations; 2) ongoing, substantive dialogue with practitioners and victimized communities in the field; and 3) sustained engagement with disciplines that help shape local and global norms, including the arts and other arenas of talent and expertise beyond traditional academic spaces.

In developing this issue of *Dædalus*, we convened authors and relevant experts in small workshops organized around specific themes to both enhance the quality of their essays and generate ideas and momentum for broader policy changes in humanitarian health delivery. The volume reflects the most significant crosscutting issues that have emerged from our collaboration with the contributors, as well as our consultations with humanitarian health practitioners over the last four years. The collection also illustrates our belief in the fundamental role that the arts play in shaping norms and public understanding of humanitarian needs. By leveraging the American Academy's network and connecting with artists in conflict-affected areas, we have included a series of artistic works within the volume.

The essays and artistic expressions that follow are designed to illuminate and examine the key features of the complex challenges facing humanitarian actors today, but also to provide forward-looking ideas for rethinking strategies to deliver humanitarian health assistance in a rapidly changing conflict environment. We

begin with an introduction by International Rescue Committee (IRC) President David Miliband and IRC Director of Policy Communications Ken Sofer, who vividly depict the stark realities that give rise to the widespread need for humanitarian assistance, and particularly health services, in today's zones of conflict.[7] Our contributors to the first half of the volume build on this foundation, with an analysis of how the nature of contemporary civil wars shapes humanitarian needs, responses, and outcomes, and a discussion of how the shift of major powers away from counterinsurgency, and back toward peer or "near-peer" conflict, is likely to affect the context for humanitarian health delivery.

Our authors then revisit the ethical and legal principles that have long guided humanitarian action and deliberate on how the changing character of war – including fast-moving technological developments – is undermining compliance with these traditional norms. At the same time, they ask how a set of prominent justice-related claims, such as the imperative to decolonize humanitarian assistance, demand reconsideration of what it means for humanitarians to act ethically. We round out the first section with a discussion of two particularly challenging contexts for humanitarian health delivery: situations of urban conflict, such as those in Iraq, Syria, and Yemen, where humanitarian missions have struggled to access and meet the needs of civilian populations; and situations of intense political and criminal violence, which create ambiguity regarding the appropriateness of different legal frameworks for regulating efforts to protect and assist populations under threat.

The authors in the second half of this issue apply their deep policy-making and field experience to address a set of specific ethical and operational challenges facing those who seek to provide humanitarian health relief in twenty-first-century conflicts. We begin part two with a discussion of the ongoing dilemmas and obstacles confronting humanitarian health actors in engaging with nonstate armed groups, which leverages the most recent research on both the need for and modalities of working with these actors. The following essay examines both the opportunities and challenges posed by new capacities to gather and use data in humanitarian emergencies, and the tensions that can arise concerning the need to share data between and among humanitarians and with donor governments. Our contributors then focus on the increased risks of violence against humanitarian health workers and facilities and assess the impact of various high-profile diplomatic efforts both to prevent such attacks and to hold perpetrators accountable.

A final set of essays takes up a prominent theme from the 2016 World Humanitarian Summit: namely, the imperative to "localize" humanitarian assistance by empowering and supporting local actors, including in the health care sector. Our first contribution on this theme explores the role of local women's organizations in Jordan as frontline responders with the potential, if harnessed, to improve both health service quality and gender equality, while the second draws on a survey of

international nongovernmental organizations to better understand what efforts they have undertaken to localize health services and build critical capacity in conflict-affected societies.

We conclude the volume with our own reflections on the key messages that emerge from the essays. We also draw out recommendations for how to pursue innovative change in humanitarian health delivery in light of the profound shifts in the nature of conflict itself, and in the normative and operational environment in which humanitarian actors operate. Taken together, the essays we have assembled show that the rich and complex tapestry of norms and practices that shapes humanitarian health delivery is now confronting a historic moment. While the humanitarian mandate remains unchanged, the evolution of organized violence and increasingly unstable geopolitical order have generated challenges so deep and varied that a reconsideration of humanitarian health's most basic tenets and pragmatic practices seems unavoidable. Even the ethical foundation of humanitarian health responses, we argue, will become an essential component of this rethinking, as both scholars and practitioners grapple with not only the growing tensions among core humanitarian principles, but also the competing imperatives that sometimes underpin legitimate calls for reform of today's humanitarian system.

The creation of this volume was a collaborative effort among many individuals and institutions working toward a more robust humanitarian landscape. This *Dædalus* issue originated with the Rethinking the Humanitarian Health Response to Violent Conflict project at the American Academy of Arts and Sciences. We are grateful to the members of the project's advisory group for their advice in shaping the trajectory of this initiative, including Donald Berwick, Elisabeth Decrey Warner, Marian Jacobs, Arthur Kleinman, Joanne Liu, Jane Olson, Deborah Rutter, and Tamara Taraciuk-Broner; the consultants who helped lay out the foundations of this project in the preliminary and exploratory meetings, including Michael Barnett, Jocelyn Kelly, Beatriz Magaloni, J. Stephen Morrison, James Orbinski, David Polatty, Anne Patterson, Leonard Rubenstein, Fernando Travesi, Ronald Waldman, and Elisabeth Wood; and the American Academy of Arts and Sciences' Committee on International Security Studies for their oversight of this volume. We are appreciative of Dirk Druet for his leadership and authorship of our work on pandemic and peace operations, and Ender McDuff and David Fidler for their invaluable assistance on the project's publication on international cooperation in pandemic preparedness and response. We would also like to thank our partners at the University of California campuses in San Francisco and San Diego, and El Colegio de la Frontera Norte for their collaborative work and field research on regional humanitarian responses to pandemics in the context of forced migration. We thank our home institutions McGill University, Stanford University, and the University of California, San Francisco, for support-

ing us. We are grateful to Chris Merrill and James Cuno, whose insights were crucial for the inclusion of the creative writing and visual arts pieces in this volume. We thank the Academy team, especially David Oxtoby, Tania Munz, Peter Robinson, Melissa Chan, Michelle Poulin, Francesca Giovannini, Islam Qasem, Kathryn Moffat, Kathleen Torgesen, Rebecca Tiernan, Jen Smith, Phyllis Bendell, Scott Raymond, Peter Walton, and Key Bird for their support. This venture would not have been possible without the generous support of Louise Henry Bryson and John E. Bryson, the Malcolm Hewitt Wiener Foundation, and The Rockefeller Foundation.

Finally, and most important, we thank each of the writers and artists whose work appears in this volume. This edition of *Dædalus* would not have been possible without your extensive research, revisions, and creative contributions.

ABOUT THE AUTHORS

Jennifer M. Welsh, a Fellow of the American Academy since 2021 and cochair of the Academy's project on Rethinking the Humanitarian Health Response to Violent Conflict, is the Canada 150 Research Chair in Global Governance and Security at McGill University. Her most recent books include *The Return of History: Conflict, Migration and Geopolitics in the 21st Century* (2016) and *The Responsibility to Prevent: Overcoming the Challenges of Atrocity Prevention* (2015).

Paul H. Wise, a Fellow of the American Academy since 2018 and cochair of the Academy's project on Rethinking the Humanitarian Health Response to Violent Conflict, is the Richard E. Behrman, MD, Professor of Child Health and Society, Professor of Pediatrics, Co-Director of the March of Dimes Center for Prematurity Research, and a Senior Fellow at the Freeman Spogli Institute for International Studies at Stanford University. He participated in two other projects at the American Academy: Civil Wars, Violence, and International Responses; and New Dilemmas in Ethics, Technology, and War.

Jaime Sepúlveda, a Fellow of the American Academy since 2014 and cochair of the Academy's project on Rethinking the Humanitarian Health Response to Violent Conflict, is the Haile T. Debas Distinguished Professor of Global Health and the Executive Director of the Institute for Global Health Sciences at the University of California, San Francisco. He is also a member of the U.S. National Academy of Medicine. He has published in journals such as *The Lancet*, *NEJM*, *Vaccine*, *Health Affairs*, *BMJ*, *Science*, and *Nature*.

ENDNOTES

[1] The breakdown of the data as of late 2022 can be found at Relief Web: U.S. Agency for International Development, "Ukraine: Complex Emergency Fact Sheet #5, Fiscal Year (FY) 2023," December 23, 2022, https://reliefweb.int/report/ukraine/ukraine-complex-emergency-fact-sheet-5-fiscal-year-fy-2023.

[2] This estimate comes from the World Health Organization's "Surveillance System for Attacks on Health Care," https://extranet.who.int/ssa/LeftMenu/Index.aspx?utm_source=Stopping%20attacks%20on%20health%20care%20QandA&utm_medium=link&utm_campaign=Link_who (accessed November 23, 2022).

[3] "'Aleppo Now Synonym for Hell,' Ban Warns in Final Press Conference as UN Chief," UN News, December 16, 2016, https://news.un.org/en/story/2016/12/547962#:~:text=%E2%80%9CAleppo%20is%20now%20a%20synonym,to%20the%20UN%20press%20corps.

[4] Quoted in Igarapé Institute, "Humanitarian Action in Situations Other than War," https://igarape.org.br/en/hasow (accessed February 15, 2023).

[5] "Rethinking the Humanitarian Health Response to Violent Conflict," American Academy of Arts and Sciences, https://www.amacad.org/project/humanitarian-health (accessed February 13, 2023).

[6] See the summary of project activities at ibid.

[7] David Miliband and Ken Sofer, "Introduction," *Dædalus* 152 (2) (Spring 2023): 13–21.

Introduction

David Miliband & Ken Sofer

Two hundred seventy-four million people – one in thirty people on the planet – are in humanitarian need as of September 2022.[1] More than one hundred million of these individuals are displaced, usually as a result of crisis: conflict, political upheaval, economic meltdown, or climate shocks.[2] In a humanitarian crisis, health is the most urgent and paramount need. But today the system for preventing and addressing humanitarian crisis is failing, and with it, the health needs of millions of vulnerable people are under threat. From treating childhood acute malnutrition to delivering COVID-19 vaccines to ensuring access to sexual, reproductive, maternal, and newborn health, health care in humanitarian contexts requires a dramatic rethink amid growing challenges to access and service delivery.

Health care in conflict, crisis, and humanitarian settings remains an uphill battle. The essays in this issue of *Dædalus* highlight how modern conflicts and, in particular, civil wars impact humanitarian health, analyzing the unique challenges humanitarian health responders face working in conflict zones and with nonstate actors. Taken together, these essays show that health care for civilians in conflict settings around the world is suffering not just from operational or technical challenges, but from a broader "system failure" globally. With more than fifty active conflicts in the world and a record one hundred million people forced to flee their homes because of conflict and disaster, the system for preventing and addressing humanitarian crisis, built on the twin pillars of, first, state sovereignty and responsibility, and second, international law and rights, is failing. The reasons for that failure speak to the very structure of the international system, and that means things will get worse unless action is taken.

First, states are increasingly failing to fulfill their basic responsibilities toward their citizens. In civil wars, which have come to represent the face of modern conflict, states are attacking their own populations and refusing to allow aid to communities they view as the enemy. As discussed by Anastasia Shesterinina in her essay, the majority of major conflicts today are intrastate conflicts, with Ukraine being the notable exception.[3] This means the provision of health care, operated in most countries by public health systems, is withdrawn for political purposes by the very governments tasked with the responsibility of providing it in the first place. As Ann-Kristin Sjöberg and Mehmet Balci explain in their essay, this of-

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https://doi.org/10.1162/DAED_e_01989

ten means nonstate actors are responsible for the provision of health care in large swaths of conflict-affected countries.[4]

Second, diplomacy has been in retreat for the past ten years, resulting in more armed conflicts that last longer and are never fully resolved. This in turn puts more civilians at risk, increases their health needs, and reduces the capacity of the health systems in these countries to respond to those needs.

Third, respect for international law has been abandoned, putting health workers and civilian infrastructure in the crosshairs of armed actors. Despite well-codified laws protecting civilian infrastructure like hospitals and health clinics from attack, health care has increasingly become a target in conflict, often part of a deliberate military strategy and not simply as collateral damage, as highlighted in the essay by Simon Bagshaw and Emily K. M. Scott.[5] The rules and institutions meant to hold violators accountable have not been successful at stopping this onslaught of impunity.

Finally, the humanitarian system is failing to fill the yawning gap between needs and services. Though aid budgets have doubled since the global financial crisis of 2008, the needs have tripled. UN appeals are less than half-funded and humanitarian responses to many of the worst crises around the world are less than 20 percent funded.[6] This shortfall has particularly urgent effects for health needs in conflict settings, not just acute needs like life-saving surgeries, but also noncommunicable diseases, mental health services, maternal health, and community health and hygiene awareness programs, which depend on reliable, robust funding to ensure both the reach and scale required for impact.

The system failure playing out in conflict zones around the world highlights the challenge of delivering health services to people in crisis. Four key areas of need stand out.

Childhood Acute Malnutrition

Each year, more than fifty million children suffer from acute malnutrition, otherwise known as wasting, a scale larger than any single humanitarian crisis on the planet. Malnutrition is an underlying cause in 50 percent of under-five mortality, and in conflict zones where food systems are disrupted, access to potable water is reduced and famines are common, it can kill more children than bombs and guns.[7] The number of children experiencing acute malnutrition is expected to grow by millions more in the immediate term. We know that treatment for wasting is highly effective, however 80 percent of malnourished children currently lack access, and the concern is that rising global food prices will not only increase the prevalence of acute malnutrition, but will also increase the cost of treatment with ready-to-use therapeutic food.[8]

The war in Ukraine has caused additional strains on global food security and, in turn, acute malnutrition among children. Nowhere is the effect being felt more

urgently than in the East African countries of Somalia, Kenya, and Ethiopia, which rely on Russia and Ukraine for nearly 90 percent of their wheat imports.[9] In Somalia, an International Rescue Committee (IRC) clinic has experienced an 818-percent increase in children with wasting from February to June 2022.[10] We need to address the wasting crisis through a public health approach similar to the one that has brought the HIV epidemic to heel. Such an approach would explicitly prioritize scale and coverage by simplifying and decentralizing core interventions. While it would value prevention, it would not shy away from delivering highly effective treatment to those who need it. And while it would continue to require solid evidence and adhere to the principle of "do no harm," it would also adopt a bias to action that reflects the absolute urgency of delivering a simple, proven cure to children who may die without it.

At present, treatment is delivered through a bifurcated system that treats severe and moderate forms with different products, through different supply chains, at different delivery points. In addition, children are admitted and dosed according to complex weight-based calculations, primarily through formal health facilities. This approach is difficult to coordinate and impossible to scale.

A growing body of evidence led by IRC's research shows that simplified approaches – a combined protocol for diagnosing and treating both moderate and severe acute malnutrition, and family diagnosis using a simple, color-coded armband and treatment delivery by community health workers – are equally effective, more cost-effective, and easier to scale than the current, more complex model.[11] To scale this feasible, lifesaving intervention, we need to: 1) adopt these simplified approaches as best practices for broad delivery; 2) support nationally led efforts to treat wasting; 3) hold ourselves accountable for progress; and 4) increase the funding needed to make it happen. UNICEF, the lead UN agency on wasting, has a vital role to play in leading these practice changes.

Last Mile Delivery of Vaccines

The COVID-19 pandemic has highlighted the importance of timely, efficient, and widespread distribution of vaccines, not only to protect individuals but entire communities from viruses. But in the fragile and conflict-affected settings where IRC works, the World Health Organization (WHO) goal of 70 percent vaccine coverage remains far out of reach, with deadly consequences. A recent study in *The Lancet* estimates that 45 percent of COVID-19 related deaths could have been averted in low-income countries had the 20 percent vaccination coverage target originally set by the global vaccine alliance COVAX been met in each country.[12] Despite a supply of doses that has begun to outpace government delivery capacity, frontline responders, including both local civil society and international operational NGOs, remain largely sidelined by distribution channels.

There is significant potential to extend governments' funding and resources, addressing access barriers in the service of universal health care goals. At the White House's Second Global COVID-19 Summit in May 2022, the IRC committed to expanding the capacity of governments around the world to deliver vaccines in humanitarian settings and estimated that with $160 million and sufficient doses, we could reach nearly all eligible people in thirty fragile and conflict-affected countries where the IRC works.[13] But this effort is only possible if donors direct resources to frontline NGOs and civil society, not just to governments and international organizations.

Since the start of the pandemic, we have seen a decline in routine immunization among children who have not received any vaccines: "Global vaccination continues to decline in 2021 with 25 million children missing out on lifesaving vaccines, 2 million more than in 2020, and 6 million more than in 2019."[14] These so-called zero-dose children are more vulnerable to deadly and debilitating infectious diseases, and account for nearly half of all vaccine-preventable deaths. To reverse this backslide and improve immunization coverage, Gavi, the Vaccine Alliance recently launched the Zero-Dose Immunization Program, a $100-million project to vaccinate zero-dose children living in displaced communities and fragile and conflict-affected settings across eleven countries.[15] The IRC is leading a consortium with Gavi in the Horn of Africa and working with partners to extend the reach of health systems into cross-border and hard-to-reach communities, as well as areas controlled by nonstate actors. This innovative, NGO- and community-led approach, a first for Gavi, is designed to complement government services and overcome the barriers of the traditional state-led system, which too often lets children in fragile and conflict-affected communities fall through the cracks.

Sexual, Reproductive, Maternal, and Newborn Health

In nearly every crisis, the most vulnerable suffer the worst consequences. In humanitarian settings, that population often includes women and young children, whose health needs are no exception to the rule.

Ensuring access to adequate maternal and newborn health care is one critical yet often overlooked area of need. In many of the Sub-Saharan African countries the IRC operates in, one in ten children do not live to see their fifth birthday. At the same time, in many of the contexts where the IRC works, women and newborns are dying at increasingly high rates. According to the most recent UN estimates, 55 percent of global maternal mortality, 38 percent of neonatal mortality, and 38 percent of stillbirths occur in the thirty countries with a 2022 UN Humanitarian response plan.[16] Looking more closely at just four crisis-affected countries – Democratic Republic of the Congo, Nigeria, Somalia, and South Sudan – there are 850,000 maternal, neonatal, and fetal deaths occurring each year, the vast majority of which are preventable.

According to the WHO, scaling up known interventions, including pregnancy care, care during labor, and care for small and sick newborns, has the potential to save three million lives every year.[17] IRC is identifying and testing approaches to bring maternal and newborn health care closer to women and babies in conflict-affected communities who are unable to safely reach a health facility.

Closely linked to maternal and newborn health is the urgent need to support the sexual and reproductive health needs of women and girls in humanitarian settings, who often lack access to life-saving care, especially contraception and abortion. Approximately one-third of maternal deaths annually could be prevented by meeting the need for contraception, and nearly all deaths related to unsafe abortion can be prevented by providing access to safe abortion care.[18] Globally, unsafe abortions cause roughly 10 percent of maternal deaths and 596 severe complications per one hundred thousand live births, and fatal complications are likely to be even greater in humanitarian settings and fragile states.[19] The cycle of unintended pregnancy and unsafe abortion is both a cause and result of gender inequality and becomes more severe during crises, leading to excess morbidity and mortality.

The IRC's flagship contraception and abortion care program remains one of the largest privately funded programs the IRC has ever operated, delivering contraception to nearly three hundred thousand women and girls, post-abortion care to over twenty thousand women and girls, and safe abortion care to over four hundred women and girls since its implementation in 2011.[20] In the next five years, the IRC will build on this momentum by designing and implementing innovative approaches, such as self-care, for increasing access to contraception and abortion care in acute and protracted emergencies and fragile settings.

Protecting Health in Conflict Settings

In all three of these areas, more work needs to be done, more services need to be provided, more action must be taken. But the failure of the humanitarian system to make up for the broader failures of the international system on health is not just about a lack of resources. Humanitarians themselves are increasingly being prevented from delivering lifesaving aid to communities in need.

According to ACAPS (Assessment Capabilities Project), nearly two hundred million people in humanitarian need, 70 percent of all people in need, are living in countries with very high or extreme humanitarian access constraints.[21] These access constraints – which range from bureaucratic red tape to armed checkpoints to direct attacks on aid workers – prevent people from being treated by doctors, receiving enough food to protect against malnutrition, and accessing the medicines and insulin required for their health needs.

This is not the collateral damage of conflict. It is not the result of a stray bullet or a military mistake. It is often a deliberate part of the war strategy – one that

directly violates the laws of war. And those who complain, expose, or campaign, whether they be UN officials or NGOs or political opposition, are often targeted for retribution. This is part of the broader "age of impunity" in which we now live.[22] Crimes without punishment. Actions without consequences.

These dangers are most pronounced in the health sector. The Safeguarding Health in Conflict Coalition's most recent annual report documented attacks on over fourteen hundred health workers and four hundred fifty health facilities in 2021.[23] The WHO itself has acknowledged over one hundred attacks on health care workers and facilities in Ukraine alone in the first one hundred days of the war.[24] This is a violation of standards rooted in the Geneva Conventions and international human rights law that severely compromises the safety and effectiveness of humanitarian actors. Moreover, if these attacks are not met with swift accountability, they reinforce a culture of impunity that can only sow chaos and further empower bad actors. At IRC, we aim to work with others to bring to bear all the international system's measures of accountability and censure to better protect health services in conflict settings.

Revitalizing health care for the quarter of a billion people in humanitarian need requires rethinking our approach to how we deliver these services amid conflict and humanitarian access restrictions, vaccine inequity, and unique challenges facing the most vulnerable populations: women and children.

These challenges are obviously interrelated, and they are not exclusive, but they have a common element: the notions of "system strengthening" that have led to such progress in stable settings over the last twenty or thirty years need to be adapted, radically, for places where states, populations, and rebel groups are engaged in conflict. The whole notion of what constitutes "the system" is different: more informal, more contested, more dangerous, less singular, less stable, less planned.

In conflict settings, the system depends on norms and understandings more than rules and laws. It requires countervailing power to the tendencies toward impunity. Above all, it needs to be bottom-up and community-led, rather than top-down, prizing flexibility to deliver sustainability. With respect to these four challenges and many others, the experience of IRC as a solutions-focused NGO shows that community leadership is the key and can be meaningful when it marries local expertise with external support.

While operational and technical solutions by health experts and frontline humanitarian responders will be critical to addressing these gaps, these fixes can only staunch the bleeding. They cannot stop the killing. Addressing the drivers of health needs among displaced and vulnerable communities requires grappling with the political and structural elements of system failure. From raising the cost of the veto in order to break the gridlock in the UN Security Council to taking the

realpolitik out of humanitarian access by establishing an independent monitor that can call out the strangulation and weaponization of aid, the international system requires a system reboot to function properly.[25]

These fixes are the realm of diplomats and political leaders, not doctors and humanitarians. But without action, the demand for health provision in humanitarian settings will continue to outgrow the ability of humanitarians to supply it.

ABOUT THE AUTHORS

David Miliband, a Fellow of the American Academy since 2018, is President and Chief Executive Officer of the International Rescue Committee. He is the author of *Rescue: Refugees and the Political Crisis of Our Time* (2017).

Ken Sofer is the Director for Policy Communications with the Global Advocacy & Influence team at the International Rescue Committee (IRC). He previously worked as the Advisor for Policy & Planning in the IRC's Office of the President.

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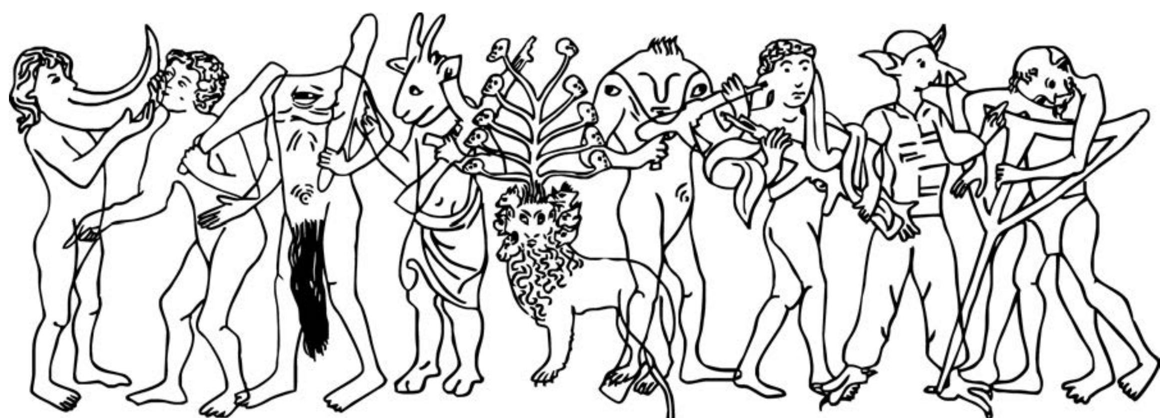

The Morphology of War I

Svitlana Biedarieva

The Morphology of War was conceived in 2017 as a project of large-scale digital murals. It focuses on the idea that each society gives birth to its own monsters. In a time of war and under the influence of propaganda, they procreate. Friends change their form and become enemies – unfamiliar, grotesque, and potentially dangerous. They experience severe morphological changes. This project reflects the ugliness of Russian military aggression and the initial hybrid warfare that distorted the image of the "other." It is also an exploration of how deeply destructive instincts are rooted in visual culture, using images from medieval bestiaries and beyond. The continuous line of monsters is reminiscent of the symbolism of the *danse macabre* taken by Ingmar Bergman for the conclusion of his film *The Seventh Seal*.

ABOUT THE ARTIST

Svitlana Biedarieva is an award-winning art historian, artist, and curator. She has a PhD in History of Art from the Courtauld Institute of Art at the University of London. She is the editor of the book *Contemporary Ukrainian and Baltic Art: Political and Social Perspectives, 1991–2021* (ibidem Press, 2021) and the co-editor of *At the Front Line, Ukrainian Art, 2013–2019* (Editorial 17, 2020).

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https://doi.org/10.1162/DAED_a_02001

Identifying Contemporary Civil Wars' Effects on Humanitarian Needs, Responses & Outcomes

Anastasia Shesterinina

Contemporary civil wars are highly complex processes involving a myriad of non-state, state, civilian, and external actors. These actors develop systems of relationships that evolve during conflict and affect humanitarian needs, responses, and outcomes. This is because humanitarian actors are not isolated from but are part of these social systems. Their activities are constituted by and are constitutive of the interactions between the internal and external actors engaged in civil wars. This essay advances an analytical framework for mapping systems of relationships between the actors at the center of contemporary civil wars to understand how the relationships established by humanitarians transform for reasons outside of their control. This framework highlights the contingency inherent in wartime humanitarian activities in general, and health care provision in particular, and the need for locally informed, adaptive humanitarian practices in changing conflict environments.

The destruction of a maternity hospital in the besieged city of Mariupol on March 9, 2022, drew the world's attention to Russia's increasing attacks on medical facilities, confirmed by the World Health Organization (WHO), since the Russian invasion of Ukraine on February 24, 2022.[1] As "the hospital was clearly identifiable and operational at the time it was hit . . . [and n]o effective warning was given [or] time-limit set," the Organization for Security and Co-operation in Europe (OSCE) determined this attack and others to be in clear violation of international humanitarian law (IHL), despite Russia's claims that Ukraine staged the attack in what was called "fake news" and, later, that the building was used by the Ukrainian far-right Azov battalion.[2] The Russian armed forces also blocked humanitarian aid from the besieged city, obstructing "humanitarian corridors" and seizing food and medical supplies set for Mariupol.[3] Reports from a makeshift hospital in the city's last site of Ukrainian defense, the Azovstal steelworks plant, indicated Russia's continued attacks and the lack of medication to treat the wounded.[4] Because local supply chains were damaged and the war displaced both patients and health care providers, delivery of aid, including emer-

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https://doi.org/10.1162/DAED_a_01990

gency contraception amidst rising reports of sexual violence, not least from Bucha, faced challenges elsewhere in Ukraine.[5] In the meantime, millions of refugees forced to flee Ukraine sought access to health care in the neighboring countries.[6]

Russia's war in Ukraine is an interstate war, a rare event in the landscape of contemporary armed conflict, which has been dominated by intrastate or civil wars since World War II.[7] However, its impact on humanitarian health care provision bears a resemblance to the challenges posed by wars in which "armed combat [takes place] within the boundaries of a recognized sovereign entity between parties subject to a common authority at the outset of the hostilities"[8] but where "other states have [increasingly] intervene[d] militarily on one or both sides."[9] In these contexts, researchers have identified attacks on medical facilities and personnel, impediments to health care reaching patients, and displacement of patients and health care providers as among the challenges also evident in Russia's war in Ukraine.[10] These common challenges manifest differently across specific armed conflict contexts, and change over time.[11] Researchers have also identified similarities in justifications used by perpetrators of violations of IHL – including those related to health care – across inter- and intrastate wars, such as blame-shifting, denial of facts, misinformation, and colonial representations of the enemy, which Russian explanations of the attack on Mariupol's hospital exemplify.[12] Elements of the analytical framework that this essay advances to better understand the effects of contemporary civil wars on humanitarian activities in general, and health care provision in particular, can thus be applicable beyond internal armed conflicts.

How do we make sense of the contemporary violent contexts in which humanitarian actors operate?[13] I argue that civil wars are highly complex, social processes that involve a myriad of actors and their evolving relationships, which humanitarian actors are an integral part of.[14] The evolution of these relationships as a result of the different actors' concurrent activities, their transformation in response to internal and external pressures, and the emergence of new actors all serve to underpin the "changing conflict environment . . . [that] the provision of humanitarian services must continually adapt to."[15] Understanding the effects of civil wars on humanitarian activities therefore requires mapping these relationships and their evolution and drawing the implications of these changes for the operation of humanitarian actors. This mapping entails not simply identifying the different actors and their interests that are central to specific contexts at any given moment in the conflict, but also analyzing what relationships exist *between* conflict actors and charting the dynamics their evolving interactions produce over time. These dynamics range from internal politics within these actors to violent and nonviolent conflict and cooperation between them.

In this essay, I briefly outline the actors involved in civil wars and delve into the social systems that these actors' relations generate. This discussion demonstrates that humanitarian actors are not isolated from but are both constituted by and

constitutive of the interactions between the internal and external actors engaged in contemporary civil wars. Placing humanitarians in the context of these social systems can help us to understand how the relationships they establish evolve – sometimes for reasons outside of their control. Humanitarian health care provision is contingent on this evolution and requires locally informed, adaptive practices in order for humanitarian organizations to be able to negotiate access, protect medical facilities and personnel, and deliver vital assistance in an ongoing way in response to changing circumstances.

While early studies of civil war focused on "dyadic" relationships between states and insurgencies, recent work has sought to disaggregate these actors, recognizing their various origins and multidimensional nature, and to incorporate a broader range of violent and nonviolent actors in the analysis.[16] These actors include civilian populations, traditional leaders, religious groups, rival militias, humanitarian agencies, international organizations, neighboring states, and private corporations, each of which, as civil war scholars have noted, is driven by its own "distinct logic."[17] To this set, we can add "extralegal groups" that, unlike politically driven insurgents, do not seek to take over the state or part of its territory to implement political projects but rather to provide basic "governance functions" to sustain their profit-driven activities.[18] Humanitarians, themselves driven by a distinct technocratic logic defined by neutrality, impartiality, and independence and the guidelines that stem from these principles,[19] have to navigate the terrain where these actors' identities, interests, and activities "coexist and coevolve."[20] For the purposes of this essay, I group these actors into nonstate, state, civilian, and external categories to explore their relationships.

Nonstate armed groups or insurgents that challenge the state's authority and control over territory lie at the center of dynamic systems of relationships that define contemporary civil wars. Insurgents typically mobilize and organize before the war and are therefore embedded in broader populations to a different extent.[21] They emerge from distinct origins in clandestine groups, social movements, and elite splinters within the regime, which condition their relationships with other actors.[22] For example, as political scientist Janet Lewis has shown, clandestine groups made up of a core of dedicated recruits rely on local networks for their survival in their early days due to the asymmetry of power in their relationship to the state.[23] As a result, these groups tend not to engage in indiscriminate violence against the communities that they depend on, at least initially, leaving these communities off the radar for humanitarians until the armed groups become viable and turn against them. This was the case with the Lord's Resistance Army in Uganda. On the other hand, as political scientist Theodore McLauchlin has argued, splinters of existing armies that rebel against

the state emerge from within the regime and rely on intra-regime networks.[24] These groups are not necessarily weaker vis-à-vis the state and do not initially depend on the population to recruit fighters, but their preexisting military capacity means that the wars they initiate are shorter and bloodier and attract humanitarian action early on in the fighting. The First Liberian Civil War is an example.

Regardless of these distinct origins, in order to sustain their opposition to the state, insurgents ultimately need to generate support from civilians and develop concrete organizational forms to work toward their goals.[25] This approach involves the establishment of leadership structures and institutions that can govern behaviors within the organization, thereby socializing members through training, disciplinary practices, and political education.[26] While these efforts are aimed, in part, at fostering cohesion, internal politics and external influence can nonetheless produce divisions within insurgent organizations, leading to fragmentation and infighting between factions competing for leadership and influence.[27] These dynamics reduce the capacity of leaders to control their organizations and multiply the number of actors within a conflict context, with direct implications for humanitarians seeking to engage with nonstate armed groups on the ground.[28] For example, a group that is initially cohesive, with identifiable leaders who can negotiate from a unified position and induce members to deliver on given commitments, can later fragment, renege on prior commitments, and make continued engagement challenging due to internal splits and factional competition. In practice, this means that sustained dialogue with armed groups may not be possible. Humanitarian organizations will thus have to engage multiple groups to obtain the necessary security guarantees for their activities.[29]

But nonstate armed groups' transformations, and the implications that they may have for humanitarian actors and their work, are not simply a feature of internal politics. These groups also have to constantly adapt to other nonstate, state, civilian, and external actors' activities. As a result, we cannot merely analyze nonstate armed groups' organizational dynamics to understand the challenges civil wars pose to humanitarian health care provision. In addition, we should place the evolving relationships they have with other actors at the center of analysis, ranging from competition and alliance formation with other nonstate armed groups to violent and nonviolent conflict and cooperation with the state, the different civilian responses to these groups' activities, as well as varied forms of international intervention. The social systems that emerge from these dynamics are critical for our understanding of the ever-changing environment in which humanitarian actors operate during civil wars.

Given the existence of multiple nonstate armed groups in contemporary violent contexts, humanitarians rarely operate in relation to a single armed group, even that which appears to be the dominant actor in the broader

civil war or any subnational locale.[30] Different armed groups compete for population support and scarce resources and ally for strategic and ideological reasons. These actors can be driven by political goals, even if they engage in criminal activities to finance their operations, or by profit, even if they establish governance structures to protect their business, as conflict scholar Christine Cheng has demonstrated in the case of "extralegal groups," or by a combination of both.[31] Their patterns of relationships as well as their identities and interests therefore vary and can change over time. This in turn shapes how they perceive humanitarian activities.[32] For example, research has shown that groups seeking domestic and international legitimacy are less likely to undermine humanitarian health care provision compared with those that do not seek legitimacy or those whose legitimacy does not depend on the population's support or abiding by international rules that govern humanitarian action.[33] However, their struggles with each other and the state can create challenges for humanitarian actors. Humanitarian health care provision in an area controlled by an armed group can preclude health care providers' access to territory controlled by that group's enemies. Moreover, engagement with some but not other armed groups that share control over an area can compromise health care provision there. Finally, changes in territorial control can undermine previous agreements and require renegotiation. Humanitarian efforts in Syria exemplify each of these challenges.[34] Understanding changing relationships between nonstate armed groups can help "humanitarian actors to keep up with the pace of fragmentation, splitting and alliances that forms the rhythm of the life of armed actors" and thereby adapt to the challenges that result from these dynamics.[35]

Nonstate armed groups' relationships with each other and their effect on humanitarian action cannot be understood outside of the activities of the state. Researchers have found that state counterinsurgency strategies are one of the key determinants of nonstate armed groups' internal cohesion and intergroup relationships.[36] Shifts in state counterinsurgency policy, for example, can interact with different groups' organizational features to make some groups more vulnerable to fragmentation than others, with trickle-down effects on humanitarian activities.[37] These shifts can be motivated by changing political realities, but are rooted in the government's preferences, institutions, and coalitions with various actors that underpin its political vision or, as political scientist Paul Staniland has put it, its "ideological project."[38] Changes in intra- and intergroup dynamics that are generated by state policy are thus a further crucial part of the systems of relationships in which humanitarian actors are embedded. The stable relationships they build with some nonstate armed groups – to facilitate the delivery of humanitarian assistance – can subsequently be impeded by the changing pressures these groups face from the state.

Yet governments engage not only in violent relationships with nonstate armed groups, but also in nonviolent conflict and even forms of cooperation.[39] In fact, relationships between states and nonstate armed groups can be placed on a continuum of "armed orders" that ranges from "total war," characterized by military interactions, to containment, cooperation, and alliance over mutually beneficial goals, such as attacks on shared enemies or population governance.[40] State and nonstate forces can therefore restrain violence to receive medical care alongside each other and make arrangements to enable health care provision to their members and the populations they control. In Nepal, for example, the Communist Party of Nepal-Maoist (CPN-M) relied on access to existing health facilities for treatment of their members and allowed health service delivery to meet civilian needs in the areas under their control, including through humanitarian organizations. As analysts have demonstrated, humanitarians established operating principles and organized IHL training for warring parties to help protect health care provision from the kind of politicization that marked other services, such as education.[41]

Nevertheless, even humanitarian health care provision can be "weaponized" by state and nonstate armed actors, especially when these actors find themselves in a relationship of "total war" and interpret humanitarian health care assistance as advancing the other side's position.[42] Arrest, detention, and in extreme cases execution of health workers for treating wounded enemy combatants is the most basic form of such weaponization, recorded in contexts as diverse as Colombia, Chechnya, and East Timor.[43] State and nonstate armed actors also militarize health facilities – for example, by using these facilities as bases for their operations or places to store arms – and they politicize aid by denying access to certain populations, such as those controlled by their opponents.[44]

Humanitarian actors thus operate in dramatically different contexts within the broad rubric of contemporary civil war that constrain and enable their activities in distinct ways and that can change unpredictably. In some situations, this means that the provision of humanitarian health assistance can backfire in what conflict scholar Reed Wood and statistician Emily Molfino have called "unintended negative externalities," whereby such aid can intensify violence between insurgent and counterinsurgent forces.[45] These negative externalities depend on whether assistance is perceived by the warring parties as advancing one or the other actor's military capabilities or resources (defense infrastructure, for example).[46] Where they are seen to undermine the state's position, such as in the areas outside of its control, especially with regard to nonstate armed groups that are categorized as "terrorist organizations," humanitarian activities can be obstructed by the state. One clear illustration is in the Nigerian government's restrictions on humanitarian health care provision to areas controlled by Boko Haram.[47] Similarly, insurgent retaliation is more likely when humanitarian aid provided by organizations allied with the state is used in an attempt to win the "hearts and minds" of the popula-

tion and facilitate government control over the contested or insurgent-controlled areas, as in the case of Afghanistan.[48] Forms of retaliation range from intentionally targeting humanitarian personnel and civilians receiving assistance, to predation and looting of medical supplies and facilities, to seeking to extend control into the areas where humanitarian assistance is concentrated.

Civilian populations are at the core of this contestation. It is widely accepted that armed actors require civilian support to achieve their wartime objectives.[49] They seek to establish control over territories with not only armed force but also institutions in what is broadly known as rebel governance. These institutions vary widely, even within the same contexts, and structure rebel-civilian relationships in different ways.[50] Provision of health care, among other basic services, is one of the goals that insurgents undertake when they come to control territory.[51] Hindering health care provision, which entails significant human costs that are not comparable to those associated with not providing other services, such as education, can jeopardize insurgents' attempts to secure civilian support in the short term as well as with regard to the longer-term political and social goals that many of these groups have. Interfering with the provision of health services may also jeopardize their efforts to establish themselves as legitimate actors beyond the territories that they control. As a result, while some armed actors weaponize health care, others explicitly decide not to and actively protect health care for various strategic reasons, including to bolster their legitimacy among the civilian populations they govern and more generally. The case of the CPN-M in Nepal is illustrative of this search for legitimacy.

While humanitarian health care provision was relatively unrestricted by the CPN-M, coercion typically plays a role in insurgent relationships with humanitarians, with implications for co-optation of health care activities.[52] Because of the importance of being perceived as health service providers for civilians, insurgents seek to control and manipulate humanitarian actors delivering health care where they have capacity to do so, appropriate medical facilities and supplies, and even attack humanitarian actors and civilians when these services do not advance their social, political, and military goals. As political scientist Zachariah Mampilly has found in South Sudan, insurgents are then able "to siphon material and financial resources that enrich rebel coffers by inserting themselves between international aid efforts and the civilian populations they claim to serve."[53]

Civilian inhabitants of the areas armed groups govern, however, are not simply on the receiving end of the arrangements that these groups make with humanitarian actors and the institutions that they build. Some cooperate with insurgents, whereas others refuse to, with a range of associated responses, from leaving the areas insurgents control to obeying the rules they impose, and from supporting or even enlisting in their organizations to resisting their rule.[54] Equally, civilians

can support humanitarian aid provision, particularly health care, because it is essential to survival in contexts where few medical services and facilities may have existed before the war or where access to existing health care is dangerous or no longer possible, such as in urban areas where medical services and facilities have increasingly come under attack.[55] But they can also reject it, especially when humanitarian assistance in fact puts them at greater risk, for example, by leaving the areas where assistance is concentrated to avoid retaliation from armed actors. Finally, civilians can use humanitarians to navigate complex conflict contexts, for example, by identifying as victims to be eligible for aid or drawing on humanitarian actors' standing and capacity to help lobby on their behalf or protest armed actors' activities.[56] In these and other ways, civilians in contemporary civil wars exercise agency and engage in forms of self-protection that can be missed when focusing solely on nonstate, state, and external actors.[57] Civilian responses to armed actors and humanitarians, among others, are therefore a major part of systems of relationships that emerge in civil wars. Civilians influence the ways in which other actors engage in these contexts by remaining neutral, variously supporting or resisting their activities. The knowledge of these local dynamics is critical for the ability of humanitarian organizations to facilitate rather than hinder civilian efforts to navigate these contexts.

Local actors, such as religious organizations, provide and support the delivery of health care and develop their own relationships with nonstate, state, civilian, and external actors in these contexts. In fact, the distinction between the local and the international is not clear-cut, as demonstrated by the practices of remote management in which international humanitarian organizations rely on local staff and partners for the delivery of health care.[58] However, humanitarians can be broadly seen as part of the category of external actors. They can operate as individual organizations or in collaboration with local and international partners, including private actors. They can also be embedded within broader international coalitions, for example, progovernment forces delivering counterinsurgency aid. Indeed, internationalization is a common feature of contemporary civil wars, and different forms of international intervention have been shown to shift the dynamics of conflict.[59] For example, armed intervention by external states clearly changed the balance of power between state and nonstate forces in Syria.

Humanitarian actors, however, can have important effects of their own, including the negative externalities for insurgent and counterinsurgent violence and beyond. These actors have developed institutional procedures and policies rooted in the humanitarian principles to advocate for unrestricted access to health care to combatants and civilians with varied actual or perceived affiliations, train warring parties in IHL, and negotiate and support the delivery of health care. These advancements have been made despite the constrains on the health systems, re-

stricted access to the populations in need, and other challenges that exist in contexts of civil war.[60]

But these efforts can come into tension with political projects of host states and donors, as exemplified by counterterrorism legislation that complicates engagement with armed groups listed as "terrorist organizations."[61] Politicized funding and aid allocations, poor coordination among humanitarian actors, and misalignment between their different priorities and the needs of the populations can result in insufficiently tailored, short-term responses.[62] These responses can also unintentionally *increase* civilian insecurity, particularly when they do not account for conflict interactions involving armed actors. Political scientists Erin Baines and Emily Paddon, for example, have shown how relocation of civilians to "protected villages" in Uganda limited access to local networks and knowledge central to civilian self-protection strategies, deepened civilian dependence on state protection, and endangered those who moved to the camps as loyal to the state in the eyes of insurgents.[63] Increasing civilian insecurity can also stem from the interaction of humanitarian strategies with the politics of local actors involved in health care provision. As political scientist Sarah Parkinson and anthropologist Orkideh Behrouzan have found, the procedures of refugee registration and insurance contracting that humanitarians established to facilitate care for Syrian and Palestinian refugees in Lebanon hindered access to health care and exposed refugees to structural violence in the exclusionary Lebanese health system.[64] Addressing such unintended consequences of humanitarian activities requires a locally informed – and critical – understanding of the contexts humanitarians operate in.

This discussion has demonstrated that humanitarian actors are involved in complex systems of relationships where nonstate, state, civilian, and external activities, including those of humanitarians, shape health care provision in interaction with one another. Because of its universal and vital quality, health care is strategically important for armed actors whose members and the communities in which they are embedded require such services and whose internal and external legitimacy in part depends on their decisions around health care. Yet health care provision is uniquely drawn into various conflictual and cooperative relationships between nonstate, state, civilian, and external actors, which means that in some circumstances, these actors can consciously obstruct, refuse, and manipulate health care provision. Moreover, their decisions can change as they navigate a complex set of conflict relationships.

These contingent constellations of identities, interests, and activities are context-specific and result in what anthropologist Lisa Dorith Kool and her coauthors have referred to as "humanitarian micro-spaces . . . fluid, dynamic and evolving so fast that practitioners can hardly keep up."[65] By mapping not merely the different actors and their interests at any given time in a conflict but also the evolving re-

lationships that they establish with one another in the course of conflict, humanitarian health providers can better understand and operate within such "microspaces." While the systems of relationships I discuss here have long been a part of civil wars, the proliferation of actors and their activities in contemporary civil wars makes these social systems increasingly complex. To adapt to changing conflict realities, humanitarian actors involved in health care provision must come to terms with this complexity. The framework for analyzing systems of relationships developed in this essay can contribute to this goal, and to the underlying shift in mindset to viewing civil war as a social process that is necessary to make sense of contemporary conflict environments.

AUTHOR'S NOTE

This research is funded by the UK Research and Innovation Future Leaders Fellowship (grant title: "Understanding Civil War from Pre- to Post-War Stages: A Comparative Approach"; Grant Reference: MR/T040653/1; start date January 1, 2021). Data availability statement: no primary data is associated with this article. I would like to thank the editors of this *Dædalus* issue and the participants in the workshop on Understanding 21st Century Violent Conflict's Effects on Humanitarian Health, particularly Zachariah Cherian Mampilly, for their comments.

ABOUT THE AUTHOR

Anastasia Shesterinina is Professor and Chair in Comparative Politics in the Department of Politics at the University of York. She is the author of *Mobilizing in Uncertainty: Collective Identities and War in Abkhazia* (2021), and has published in such journals as *American Political Science Review*, *Journal of Peace Research*, and *European Journal of International Relations*.

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Children from Bogdanovka inside Their Burnt-Out School Bus, Kyiv Region

Mark Neville

When Russia invaded Ukraine in February 2022, Kyiv-based British artist Mark Neville fled to Poland. In March 2022, Mr. Neville briefly returned to Kyiv to retrieve his camera equipment. When he returned to Kyiv once more in April, Neville established Postcode Ukraine, a charity funded by a photography collector who had received a copy of Mr. Neville's first activist book, *Stop Tanks with Books*, and who had immediately offered to help. Through Postcode Ukraine, Neville has provided funding and logistical support to grassroots Ukrainian charities that deliver food and medical supplies to residents of villages devastated by the Russian invasion.

Neville emphasizes the importance of both humanitarian aid and photography in his work. "Our mission has not just been about delivering humanitarian aid," says Neville. "It was essential to make thoughtful images and present them in resonant contexts to compassion-fatigued Western audiences in order to help people reengage with Ukraine. For example, large prints of my Ukraine photographs and copies of my photo book are currently on prominent display at the Foreign, Commonwealth and Development Office in London. The war is not over, there are still many battles to fight, and by helping Ukraine, we help ourselves."

Of his photo *Children from Bogdanovka inside Their Burnt-Out School Bus, Kyiv Region*, Neville recounts, "I pictured these children almost as ghosts, attempting to reclaim the ruins of the school that the Russian army blew up and mined during their retreat."

ABOUT THE ARTIST

Mark Neville is a British artist who has been living and working exclusively in Ukraine since 2020.

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https://doi.org/10.1162/DAED_a_02002

Humanitarian Challenges of Great Power Conflict: Signs from Ukraine

Lawrence Freedman

Until the Russian invasion of Ukraine, there was little evidence of what a conventional war between the regular forces of peer competitors might look like today. After the total war of the twentieth century, the evolution of precision-guided munitions and drones set up the possibility of a new ideal type of conflict, in which U.S.-NATO coalitions could quickly defeat the regular forces of much weaker opponents, largely from a distance, while avoiding excess loss of civilian life. "Smart" weapons created the perception that when civilians were killed, this was an operational failure. Russia's approach to war, however, has not put a high priority on avoiding civilian casualties, but has shown that precise weapons could be used deliberately to target civilian infrastructure in ruthless and coercive air campaigns. In this essay, I suggest that the Russia-Ukraine War provides insight into what a major power war would look like. I contrast the two distinct approaches represented by Ukraine, strengthened by NATO weapons and informed by its concepts, and Russia, with its readiness to attack civil society. I focus on the resulting humanitarian disaster in Ukraine, where more than one-quarter of the population has been displaced and where Ukrainians in Russian-occupied territories have reported thousands of instances of war crimes. I conclude by considering the likelihood and potential consequences of Russia's use of nuclear weapons.

Although there have been numerous wars involving the major powers since World War II, some historians have nonetheless described this period as a "long peace," a term first coined in the 1980s, simply because there has yet to be a World War III.[1] Such a war would be defined less by how much of the world's landmass was engulfed in conflict, for the end of the European empires means that there would be less chance of the conflict spreading across continents, than the danger to humanity posed by the likelihood that this would be a confrontation between nuclear-armed powers. This possibility, and the desire to avoid it, helps explain the long peace.

World War II was a total war, requiring the complete mobilization of all the economic and social resources of the belligerents, which in turn ensured that their

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https://doi.org/10.1162/DAED_a_01991

economies and societies were treated as legitimate targets. Even before the United States detonated atomic bombs above Hiroshima and Nagasaki, attacks on civilian populations during the last year of the war had reached new levels of destructiveness. The Allies' firebombing of Dresden in February 1945 and Tokyo in March 1945 caused unprecedented death tolls. What separated the atomic bombs dropped on Hiroshima and Nagasaki was not the numbers of civilians killed, but the ease with which it was done, along with the insidious new factor of radioactivity. Coupled with the V-2 missile attacks on London, the first successful long-range guided ballistic missile attacks, they warned of how whole cities, even civilizations, could be obliterated, quickly, efficiently, and from a distance, with little hope of protection.

Although the United States and Soviet Union spent the 1950s thinking up ways to win a nuclear war, with either a disarming first strike or with low-yield nuclear weapons designed for the battlefield, by the mid-1960s, both sides understood they could be destroyed by the other in any nuclear confrontation. The idea of a limited nuclear war seemed preposterous. Any employment of those systems designed to replicate conventional munitions, whether mortars, mines, depth charges, or gravity bombs, would most likely trigger a process of escalation. There was no getting away from the proposition that nuclear war would be the ultimate horror, ending in mutual destruction.

This prospect deterred moves that could lead to such a catastrophe. It became U.S. strategy to underline the risk, demonstrating to the Soviet Union that it was irretrievably vulnerable, even while accepting that the same was true for the United States. There were criteria defining what an assured destruction capability required: 50 percent of industrial capacity and one-third of the population.[2] The argument was not that these numbers were necessary for deterrence purposes, let alone desirable. They were calculated in reference to the point at which extra weapons would cease to make much difference to the amount of destruction caused. Whether this would be reflected in actual targeting policy in the event of a war was another matter. Yet even when U.S. administrations asked for options that offered less than full-blown Armageddon, they were continually disappointed by how large the most limited options appeared.

There are a variety of options available to policy-makers for nuclear employment today, but what purposes they could serve remain unclear. In public discourse, it is taken for granted that a war between great powers would soon involve full-scale nuclear exchanges, which is why the nuclear powers sought to avoid even moderate skirmishing with regular forces. Whether in such circumstances the two sides might look for different options was irrelevant; the effect was to create a fear of escalation.

Even the "limited" wars of Korea and Vietnam resulted in tens of thousands of American casualties and millions of local civilian casualties. And in the protracted civil wars of the last three decades, from the Democratic Republic of the Congo to

Syria, deaths have often had less to do with clashes of forces and more to do with the famine, poverty, and disease resulting from social and economic collapse.

The U.S. and NATO-led wars of the digital age have provided a different sort of experience, reflecting efforts to avoid putting regular forces in harm's way and exploiting their advantages in air power to the full. "Smart" weapons have encouraged the view that there is little excuse for widespread casualties and collateral damage. As the "drone wars" have demonstrated, it is now possible to pick very specific targets, even individuals. Against this, it is also apparent (as the Russians demonstrated in Syria) that smart weapons can be used to attack civilians more efficiently. These, however, have been unequal wars, fought by great power forces against much weaker armies and militias.

This leaves much uncertainty about the conduct of a potential war among the great powers: the five permanent members of the UN Security Council, with the United States, China, and, at least until recently, Russia in a higher league than the United Kingdom and France. They all have nuclear capabilities. Of the other nuclear states, India has the weight to be considered a great power. Pakistan, Israel, and North Korea could play influential roles in any major war, as would other nonnuclear powers, such as Germany and the rest of NATO, while countries such as Japan, South Korea, and Australia could influence any Indo-Pacific war. There is a consensus view that a third world war would at least involve the United States and China or Russia. This reflects the assumption that if nuclear weapons were *not* involved, and the fighting were confined to conventional forces, a conflict would not escalate to the level of a world war.

A nonnuclear war between major powers is considered unlikely because of the presumption of almost automatic escalation once these powers entered into direct confrontation. There are many reasons to avoid another war between great powers, but the possibility that it could end with nuclear exchanges ranks high among them. Although it is possible that parties in a major war could find ways to avoid nuclear use, or even keep any nuclear use in some ways limited, common prudence warns against testing this hypothesis.

Our distance from the world wars limits our grasp of the form a modern war between great powers could take, and the levels of casualties it would entail. Would the prospect of such a war still have a deterrent effect if there was confidence that there would be no nuclear escalation? Analyses of the likely loss of life in the event of a revived war on the Korean Peninsula alarmed members of the Trump administration, motivating the president's outreach to Kim Jong Un even as the United States updated its plans for "decapitation strikes" against him.[3] The loss of life would have been far worse than any recent conflict, but not unusual compared with the past world wars. Would a revived Korean War start with efforts to contain the violence (as was the case, to a degree, in 1939)? And how long might any restraint last? Does the disconnect between conventional battles and

nuclear exchanges make escalation less likely? By comparison with the middle of the last century, when large air raids over capital cities were still the norm, would it be possible to generate the intensity and passion among the populace to make nuclear use conceivable?

The humanitarian consequences of a nuclear war would far exceed anything previously experienced in warfare. This needs little elaboration. Though I shall return to the nuclear issue later, for the most part, I wish to concentrate on the form such a war might take without the use of nuclear weapons, or at least before the nuclear threshold has been passed.

I consider two contrasting models of warfighting associated with the United States and the Russian Federation, describing how much they diverge, particularly when it comes to the deliberate targeting of civil society. I then consider the conduct of the Russia-Ukraine War beginning on February 24, 2022. This has been the closest we have recently been, in intensity and the type of forces involved, to a war between major powers. Unlike Russia, Ukraine did not enter this war with all the attributes of a great power. Unlike Russia, it does not have a nuclear arsenal (it gave up the arsenal it inherited from the Soviet Union in 1994) and, unlike Russia, it does not deploy its armed forces beyond its borders in support of clients and allies. It is, however, fighting a war with NATO support and, increasingly, weaponry.

Contrasting Models of Conventional War

Until the Russian invasion of Ukraine, there was remarkably little evidence of what a conventional war between the regular forces of "peer competitors" might look like. Recently, as in Iraq and Afghanistan, Western armies have defeated much weaker opponents in the conventional stages of war, only to then get bogged down in resilient insurgencies and civil wars. Russia has also waged war against weaker opponents: in Chechnya, starting in 1994 and again in 1999, in Georgia in 2008, in Crimea and Eastern Ukraine in 2014, and then in support of the Syrian government from 2015. The most recent example of a conventional war with relatively modern equipment was the short Armenian-Azerbaijan conflict of September 2020. It was evident from this war that drones were making a difference to contemporary tactics, just as the 1991 Gulf War confirmed what had first been seen in 1972 in Vietnam: that precision-guided munitions created new options for conducting war by enabling accurate targeting of enemy systems from a distance.

Looking back over the available experience, and simplifying somewhat, we find two contrasting types of war. The first, a continuation of the total war of World War II that led to the massive air raids of civilian targets and the introduction of nuclear weapons, assumes the military objective of destroying civil society to remove the enemy's will and capacity to fight. In the second, a more classical view, the objective of military action is to eliminate the military capabilities of the

enemy, ensuring that fighting is largely confined to regular forces. Here the quality of the eventual political settlement will reflect the extent of the military victory. These are ideal types in that, though they may shape strategy in practice, they will differ according to the nature of the adversary's strategy, the operational conditions, and the wider political context.

For the United States, the second type represents the ideal type of conventional strategy. In this form, conventional warfare would be conducted separate from civil society, with the belligerents gaining advantage through the speed of their decision-making, the quality of their technology, and the professionalism of their tactics. Those working with this framework have been particularly enamored with operational concepts based on outmaneuvering the enemy in battle, avoiding attritional warfare, trading firepower, and so tending toward a conflict in which all casualties, military and civilian, could be reduced. This form came into fashion after the 1991 Gulf War, under the banner of the next "revolution in military affairs." Western countries concentrated on developing technologies for this form, integrating sensors, command networks, and guidance systems that could achieve pinpoint accuracy at extended ranges.

One problem with this model was that it encouraged a view of warfare as the preserve of military professionals, conducted by armed forces with regard for each other but not the political context within which they operate. This added to the challenge of aligning operational practice with political purposes. In practice, the boundaries between the military and civilian spheres were less than clear cut. Even in the 1991 Gulf War, and certainly in U.S. wars since, it has become apparent that military operations, even with the most accurate weapons, could not avoid civilian targets, especially those connected to the infrastructure supporting the enemy's military operations, notably transportation links, but also energy and administration.

This has certainly been true when combatting insurgencies. Enemy militants are often indistinguishable from civilians, and efforts to make the distinction often fail. Considerations of force protection tend to take precedence over civilian casualty avoidance: that is, militaries are quicker to risk civilian lives than those of their own forces. The effort to reduce humanitarian costs through a sharp focus on defeating enemy combatants created narrative issues with the inevitable noncombatant deaths: they implied that they were the result of problems with the decision-making, technology, or tactics, and not just the inherent uncertainties of wars fought "among the people."

The opposing ideal type of conventional warfare, involving the direct targeting of civil society, is less demanding. It requires directing available firepower – artillery, rockets, missiles, aircraft – at large targets without any requirement for precision, although precision can enable attacks on strategically important targets, such as refineries, power stations, railway hubs, government buildings, hospitals, and

schools. The Russians appear to have embraced this ideal type in recent asymmetrical conflicts as well as against Ukraine today.

In the wars against Chechnya to prevent secession, Russian tactics were often quite brutal, and Russia's air strikes flattened the capital, Grozny. In operations beginning in 2015 to support the Syrian government against rebels, Russia not only provided cover to prevent criticism of the Syrians for their use of chemical weapons and barrel bombs, but also used air power to make life as difficult as possible for civilians, in order to encourage them to leave. This was the other side of the coin of precision guidance: the same systems that could be used to avoid hitting civilians could also be used to target them effectively. In Aleppo, for example, Russian aircraft deliberately struck hospitals, often using coordinates handed to them through the United Nations so they could *avoid* these buildings.

The Russian ideal type is highly political. It is insensitive to civilian (or for that matter, military) casualties, but ruthless in defeating its opponents. Tellingly, Russia has worked hard on the narratives surrounding any military operations, seeking to demonstrate that the victims deserved all they got, and that Russia is only responding to severe provocations. Putin is widely considered responsible for a "false flag" operation in September 1999, using supposed terrorist attacks against residential accommodation as pretext for the Second Chechen War, which he launched immediately thereafter.

In Ukraine, following the 2013–2014 EuroMaidan protests and the ousting of Viktor Yanukovych, Ukraine's pro-Russian president, Putin looked for demonstrations of spontaneous support for action against the new government in Kyiv, which he found in Crimea but was equivocal in the Donbas. With Syria, there was less need for justification because he could claim to be acting in support of an established government. Although Russia presented their entrance into the conflict as an anti-ISIS operation, Russia adopted an expansive definition of ISIS to include any anti-Assad group, as, their logic went, they were all objectively supporting the Islamists. This created its own problems of alignment, since Russia's political narratives created objectives that it could not achieve by available operational means.

In addition to humanitarian impact, this model creates problems on its own terms. If there is a strategic purpose to attacking civil society, it is to influence enemy decision-makers to look for ways out of the war to relieve the pain and punishment. But as with any coercive effort, it cannot dictate the target's reaction. Compliance is one possibility; angry, hardened resistance is another. This sort of strategy therefore does not preclude the need for land operations to take control of disputed territory or even to seize control of the enemy's decision-making center. This then creates questions about the interaction between the two efforts. At its simplest, should firepower be directed against targets that would degrade civilian life or that would support land operations?

Russia under Putin has shown a coercive mindset, particularly when using energy and economic measures to encourage other states to be compliant with its wishes. This was, after all, how the Ukrainian crisis began in 2013, when Putin turned the screws on Yanukovych to dissuade him from signing an association agreement with the European Union. This tactic succeeded, except that Ukrainian popular reaction against this decision set in motion the EuroMaidan movement and all that followed. In Chechnya and Georgia, Putin used military pressure to force political settlements. In Syria, Russia's vicious air campaign sought to drive civilians from rebel areas, though it did not contribute troops to this effort. Putin's approach, including in Ukraine in 2014, combined ruthlessness with limited liabilities. So while the attacks on Grozny or Aleppo might have foreshadowed the attacks on Mariupol, Severodonetsk, and Bakhmut in 2022–2023, they were not full tests of a coercive military strategy.

The Western model sought to limit the humanitarian costs of military operations, but was subverted by interactions with civil society. Expectations of opposing forces in combat well away from populated areas will always be unrealistic. This is even more so with "wars among the people," when regular forces face hostility from sections of the population. Western campaigns have become associated with humanitarian distress, despite the accuracy of the weaponry and the skill with which it is used, because they have occupied territory where their presence is resisted, or they had taken sides in an internal conflict. The Russian model was indifferent to humanitarian costs – in Syria, it pursued them – and had no issue with taking sides. But Putin also sought to limit his exposure. The Syrian Civil War is the deadliest modern conflict the region has known, but Russia confined itself to airpower to avoid getting caught up in any heavy fighting. In Ukraine in 2014, the annexation of Crimea involved little fighting. The situation was different in the Donbas, where Russia sponsored separatist groups, often led by Russians, to undertake a rebellion against a new government in Kyiv.

There will always be limits to how much civilians can be protected from a war being fought where they live, unless of course they flee, which is a natural and frequent response to outbreaks of war. But this does not mean that the differences between the two ideal types are unimportant, most of all in whether civilians would be deliberately targeted in war. The Western model, in line with the Geneva Conventions, attempts to avoid civilian targeting as much as possible; the Russian model agreed in principle but in practice was far more ruthless. It might not matter to those attacked if they were victims of "collateral damage" or deliberate targeting, but the strategic use of firepower to intimidate populations and clear residential areas of hostile populations will inevitably cause much greater humanitarian distress. The Russia-Ukraine War that began in February 2022 provided a striking contrast between the belligerents' military strategies: not so much due to the influence of NATO thinking on Ukrainian practices, but because Ukraine had

every incentive to reduce the harm to their own civilian population, while Russia was inclined to target civilians not only as military strategy but because of its underlying political objectives.

The Course of the War

Moscow's intention – signaled in Putin's invasion speech of February 24, 2022, when he moved away from the purported threat to Russian-language speakers in the Donbas to the need to "de-Nazify and demilitarize" Kyiv – was to install a puppet government and effectively reincorporate Ukraine into a "Greater Russia." Belarus, which was already in the process of being turned into a client state, was part of this project. If the war in Ukraine had gone well for Moscow, it is likely that Moldova would also have been overrun. This was therefore a straightforward war of aggression and conquest.

The delusional and destructive view that Ukraine was not a proper state but really a part of old Russia, seized in an illegitimate putsch, shaped Russia's initial war strategy. Russian forces sought to capture or kill President Zelensky in Kyiv on the first day of the war, using a "thunder run" led by paratroopers and agents already in place. This would have precluded what many analysts had assumed to be the best option for Zelensky: to flee and then form a government in exile to mount an insurgency against the Russian occupation.

But Russia's effort failed and Zelensky was able to lead his people from the national capital. Soon it was apparent that not only had Russia failed to meet its initial objectives, but their forces were in trouble. The Ukrainians were outgunned by the Russians but not outfought. They inflicted heavy losses on Russian forces, leading Moscow to abandon its initial objectives, in particular its attempt to seize the capital, Kyiv, and concentrate instead on seizing the Donbas. It took until June for Russia to take Luhansk, but they were unable to capture Donetsk. Ukraine focused its limited counteroffensives close to Kharkiv, Ukraine's second-largest city.

Once it was evident that Ukraine was succeeding in its defensive operations and was starting to push back Russian forces, Western states stepped up their military assistance to Ukraine, providing high-quality, modern weapons (with the exception, so far, of aircraft) that have made the fight closer to equal. The equipment deliveries began with drones and antitank and air-defense systems, but eventually also included artillery and armored vehicles. In June 2022, NATO states began to deliver more advanced weapons systems, notably, artillery that could fire with high accuracy over long ranges. In contrast to the Russian way of waging war, which used firepower to batter enemy defenses and to attack residential buildings and infrastructure, Ukraine, acting more in line with the Western way, concentrated its firepower on ammunition dumps and command posts to degrade Russian capabilities. As Ukraine turned its attention to the port city of Kherson,

seized by Russian forces early in the war, it concentrated on blocking bridges that might have provided Russia with both lines of supply and escape.

Because of these contrasts, the conduct of the war has increasingly resembled a great power conflict. Some Western commentators have described it as a "proxy war."[4] This chimed with Russian propaganda that presented the war as a defensive and existential conflict with NATO, which was using Ukraine as a puppet. In this way, proxy war is a misleading label, suggesting that Ukraine is fighting to serve a wider Western agenda, and not its own: to survive as a sovereign country.

The conduct of conventional war in Ukraine demonstrated the importance of such factors as logistics and chains of command in determining military effectiveness, as well as terrain, as rivers have affected both offensive and defensive operations. Russia's nuclear status has also limited what NATO countries have been willing to do in their direct support for Ukraine, as well as what Russia might try against NATO countries supporting Ukraine.

The war has been a humanitarian disaster. After six months of fighting, ten million Ukrainians, or one-quarter of the Ukrainian population, were displaced, with more than six million having left the country. Several cities, notably Mariupol and Kharkiv, along with many towns and villages, were battered by Russian firepower. In places occupied by Russian forces, there have been numerous reported instances of torture, incarceration, and murder of individuals alleged to be working against Russian forces, as well as looting, sexual abuse, and wanton violence and destruction.[5] Where Russia claimed land areas that it expected to hold for the long term, it enforced changes to education, currency, and language, replacing Ukrainian with Russian. Accompanying this, Russia has waged an intense propaganda campaign to demonstrate that particular atrocities against Ukrainians were self-inflicted. While this effort has been largely unsuccessful in the West, it has shaped popular attitudes in Russia and limited the impact of any concerns about Russia's conduct among the general population. It became a genocidal war, not in the popularly understood meaning of the term as an attempt to exterminate a whole people, but in terms that met the criteria of the 1948 Genocide Convention: "to destroy, in whole or in part, a national, ethnical, racial or religious group."[6] Russia did not bother to hide this intent, denying the existence of a separate Ukrainian people and, when given a chance, acting upon this denial.

When humanitarian organizations sought to arrange relief convoys to get civilians out of besieged cities – notably Mariupol, which became a battered symbol of Ukraine's resistance – Russia toyed with them and subjected the convoys to shelling, forcing them to turn back toward the city. In response to the more than seventy thousand war crimes that have been reported to Ukrainian authorities, Ukraine appointed a special prosecutor who has vowed to investigate each and prosecute as many as the evidence would support. As of February 2023, twenty-five Russians have been convicted of war crimes in local courts.[7] At the same time,

the United Nations Human Rights Council established an Independent International Commission of Inquiry to support the international investigation of Russia's crimes. All this, of course, after the basic crime of launching an imperialist war against a neighboring sovereign state. Moscow could claim that particular attacks were false flags, though after a point, the pattern of Russian behavior was too consistent for these claims – always implausible – to ring at all true.

In terms of causing harm to Ukraine, the campaign has been a tragic success. Russia has destroyed Ukrainian infrastructure and shrunk its economy by an estimated 45 percent in 2022.[8] Russia has killed or wounded tens of thousands of Ukrainian civilians, displaced millions more, and caused high military casualties on both sides. Yet the Russian effort to eliminate Ukraine as a sovereign nation with a strong identity backfired completely. Russia's attacks on civilian life have brought it no military advantages. Ukraine defended its cities and towns despite the rubble. Russia's claim that it was "liberating" the Donbas became absurd when it was precisely the "most Russian" parts of the country that were harmed the most. After late September, when Putin claimed to have annexed Donetsk, Lugansk, Zaporizhzhia, and Kherson, in addition to Crimea, so that they were now forever Russian, this "prize" was devastated and depopulated, with those left (certainly those who had not been living in the separatist enclaves) full of hatred for Russia.

If Russia's war effort has been coercive in intent, it has failed. Russian brutality did not prompt calls for capitulation but reinforced Ukrainian determination to fight on. Evidence from opinion polls in Ukraine has demonstrated a nation no longer divided by regions or language, but convinced that victory against the occupiers was both possible and necessary. Time will tell whether they are right, but the asymmetry of motivation is clearly in Ukraine's favor. On the Russian side, there is evidence of poor morale. And while the Russian military's crimes against the Ukrainian population may reflect incessant anti-Ukrainian propaganda, it also reflects poor discipline, for example, as valuable space on military vehicles was taken up with looted goods.

Russia's war effort was also counterproductive in that it convinced Western countries that they could not let Russia win and therefore had to provide Ukraine not only with weapons for defense against the Russian offensive, but the heavier weapons needed for counterattacks to push Russian forces out of occupied territory. The terrible revelations about Russian war crimes following Russia's abandonment of territory near Kyiv hardened Western opinion and led to pressure to supply still more and better weapons.

One argument for caution in all of this is that, if the Ukrainian counter-offensive succeeds too well, it could lead a desperate Putin to authorize the use of nuclear weapons, possibly starting with a small-yield weapon against troop concentrations. Because Putin made the foolish decision to invade Ukraine, we cannot rule out that he would make an even more foolish decision to launch a nuclear war.

Still, it would be odd to refuse to turn the limited "special military operation" into a full-scale war, but then suddenly move the conflict to a wholly novel level of catastrophe. Russia was able to intensify its efforts after setbacks in September 2022 by a partial mobilization of some three hundred thousand men and by intensifying its attacks on Ukraine's critical infrastructure, using missiles and drones, without resorting to nuclear weapons. It is not clear what military problem employing nuclear weapons would fix. Further, from the start of the war, Russia has signaled that it would not escalate to a full-scale war with NATO – which could possibly "go nuclear" – unless the forces of NATO countries were directly fighting Russia's. When launching the war on February 24, 2022, Putin said:

> I would now like to say something very important for those who may be tempted to interfere in these developments from the outside. No matter who tries to stand in our way or all the more so create threats for our country and our people, they must know that Russia will respond immediately, and the consequences will be such as you have never seen in your entire history.[9]

NATO has respected this warning and limited its commitments accordingly, even when Kyiv was pleading for NATO to establish a "no-fly zone" to prevent Russian aircrafts from bombing Ukrainian cities.

Some have used this restriction to urge Ukraine to make territorial concessions and focus its defenses on what matters most, despite its success in pushing back the original Russian offensive. But Ukraine was never likely to make such concessions. So if Western countries believe it would be disastrous for European security if Russia gains from its war against Ukraine, not least because of the brutality of its methods, and if Western countries refuse to cross the threshold of sending troops directly into the conflict, then they are obliged to keep supporting Ukraine with weapons and financial support. When a country, even one with nuclear weapons, wages war against a whole people, that choice might be difficult, but in the end it could only go one way.

ABOUT THE AUTHOR

Lawrence Freedman, an International Honorary Member of the American Academy since 2020, is Emeritus Professor of War Studies at King's College London. In June 2009, he was appointed to serve as a member of the official inquiry into Britain and the 2003 Iraq War. He was awarded the Commander of the British Empire in 1996. Among his recent books are *Strategy: A History* (2013), *The Future of War: A History* (2017), *Ukraine and the Art of Strategy* (2019), the fourth edition of *The Evolution of Nuclear Strategy* (with Jeff Michaels, 2019), and *Command: The Politics of Military Operations from Korea to Ukraine* (2022).

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how to write a poem about Bucha

Nina Murray

have the kettle on behind you on a video call. steep the words its rattle and hiss grind up to make a cup tea. let it sit. soak a piece of knitting in it, rib by rib. now put the wool over your eyes and wait until it sucks out of them the sights of dogs shot dead in the street.′ wring it.′ dip daffodils in the resulting ink. wait for a storm. what's left on the petals, rain-torn, will be the poem.

"How to Write a Poem about Bucha" originally appeared in Ukrainian-American Poets Respond, *edited by Olena Jennings and Virlana Tkacz (2022).*

ABOUT THE AUTHOR

Nina Murray is an American poet and translator, born and raised in the western Ukrainian city of Lviv. She is the author of two books of poetry, *Alcestis in the Underworld* (Circling Rivers, 2019) and *Minimize Considered* (Finishing Line Press, 2018), and the translator of Oksana Zabuzhko's *The Museum of Abandoned Secrets* (Amazon Crossing, 2013) and Peter Aleshkovsky's *Fish: A History of One Migration* (Russian Life Books, 2010) and *Stargorod* (Russian Life Books, 2013).

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https://doi.org/10.1162/DAED_a_02003

Challenges for Ethical Humanitarian Health Responses in Contemporary Conflict Settings

Ana Elisa Barbar

This essay examines the pressures and narratives that constrain humanitarian health actors from meeting their commitments to ethical conduct. I focus on critical contemporary issues that exacerbate or generate new ethical concerns for humanitarians, such as the imperatives to be accountable to affected populations, to "decolonize" humanitarianism, and to respect intersectional diversity; and how maleficence should be interpreted in this changing context. I argue that by adopting certain practices – particularly those that create space for new voices and confront entrenched power systems – today's humanitarian health actors can remain true to their core ethical principles.

Humanitarian principles are a set of values designed to guide decision-making in the face of limited resources, competing interests, and ethical dilemmas. Humanitarian actors are expected to both operationalize and embody principles as a kind of moral code to navigate the complexities inherent in mounting an emergency response in areas where one is required. By referring to these principles, humanitarians are validating the sector's ethical boundaries and distinguishing themselves from other interveners who, while providing similar services, may embrace different ethical frameworks. Beyond their moral origins, humanitarian principles can also be instrumental in enhancing the security of humanitarian actors on the ground and ensuring their access to populations in need. Humanitarian principles can thus be seen as key enablers for successful humanitarian operations, serving both as an overarching moral framework for action and a basis for pragmatic responses to humanitarian crises.[1]

Ethical Principles Guiding the Humanitarian Health Response

There are four central principles that underpin contemporary humanitarian action in settings of conflict: humanity, impartiality, neutrality, and independence (see Table 1). Although some humanitarian organizations may add other guiding

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https://doi.org/10.1162/DAED_a_01992

Table 1
Humanitarian Principles

Humanity
This foundational principle endeavors to prevent and alleviate human suffering wherever it might be found. Its purpose is to protect life and health and to ensure respect for the human being.
Impartiality
This foundational principle requires that efforts to protect life and alleviate human suffering should be delivered on the basis of need and individual suffering, with no discrimination as to nationality, race, religious beliefs, social class, or political opinions. It also seeks to give priority to the most urgent cases of distress.
Neutrality
This operational principle requires that humanitarian actors cannot take sides in hostilities or engage at any time in controversies of a political, racial, religious, or ideological nature. This principle helps to ensure that humanitarian actors will have the confidence of all parties and to maintain access to people in need.
Independence
This operational principle requires that humanitarian actors must always maintain their autonomy from states, combatants, and other local or international authorities, so that they can at all times access populations in need and act in accordance with the principles of humanity and impartiality.

Source: Paul H. Wise, Annie Shiel, Nicole Southard, et al., "The Political and Security Dimensions of the Humanitarian Health Response to Violent Conflict," *The Lancet* 397 (10273) (2021): 511–521, https://doi.org/10.1016/S0140-6736(21)00130-6.

principles, these four constitute the core of what has been called the "Dunantist tradition" in Western humanitarianism, named for Henry Dunant, one of the founders of the International Committee of the Red Cross.[2] Given our focus here is on humanitarian *health* responses, there are other principles that are particularly relevant to the delivery of health services, including a respect for the dignity, agency, and autonomy of the individual receiving care, to ensure benefit to those receiving an intervention, to avoid harm (nonmaleficence), and to commit to the just application of resources. More broadly, humanitarian health personnel are expected to respect medical ethics in their daily work.[3]

Even if these additional elements have not been explicitly framed as part of the guiding principles for humanitarian health provision, they have in practice been incorporated into the strategies and normative doctrine of humanitarian health

actors.[4] In this way, the ethical framework guiding humanitarian health responses can be seen as broader than that which shapes other forms of humanitarian assistance.[5] For example, nonmaleficence – which is commonly interpreted as "do no harm" – might not be traditionally labeled as a humanitarian principle, yet there is little doubt that it has a prominent place in the hierarchy of effective concerns shaping humanitarian health. Other important examples include the just distribution of resources and the preservation of confidentiality.

In focusing on this broader set of principles and the contemporary context for their application, this essay takes a practice-facing rather than conceptual approach. More specifically, it highlights some of the emerging issues that are currently circulating in settings of humanitarian health response. These include "accountability to the affected population," "decolonization" of humanitarianism, "intersectional diversity," and the evolving interpretation of maleficence. The essay concludes by pointing to some new practices that can ensure that humanitarian health responders remain true to both humanitarian and medical ethics, especially in highly dynamic political and security environments.

Emerging Challenges to Traditional Humanitarian Principles

In recent decades, humanitarian organizations have had to confront pressures generated by a rapidly changing operational and political context that demands that they commit to taking concrete steps to strengthen accountability.[6] Although some of these pressures may not be entirely new, their effects on humanitarian health responders have become more consequential in recent years.[7]

For example, the growth of digital media and their utility in conflicts and crises have increased the scrutiny of humanitarian decision-making. Humanitarian funding has increased globally, creating new actors and expanding response capacity. New technologies and digital tools are developed and implemented at full-speed, as the humanitarian sector struggles to keep up with the inclusion of protective digital safeguards. A further example is the proliferation of conflict actors and the intensification of asymmetric warfare, which have contributed to a far more complex humanitarian landscape in which command and attribution have become more difficult to discern. Moreover, the protracted nature of conflict and the contemporary emphasis on a "humanitarian-development nexus" implies a continuity of response that can challenge the traditional boundaries between neutral and independent humanitarian action and non-neutral development partnerships, often with the engagement of states.[8] Finally, the urgent consequences of climate change and growing concerns around sustainability now frame the daily dynamics of humanitarian health responses.

There is also a set of justice-related challenges that calls upon humanitarian health actors to rethink the way they operate. New commitments to equity, diver-

sity, and inclusion – which previously garnered little attention in humanitarian action – are now raising questions about the colonial roots of global humanitarian structures and how power is exercised through humanitarian interventions. These concerns have grown in demands for "localization," which emphasizes the importance of bottom-up and participative approaches in humanitarian activities and primary accountability to local populations, as opposed to donors. More broadly, a greater appreciation of planetary health has also raised important questions about traditional humanitarian health ethics and practices. The preservation of natural ecosystems and the well-being and recovery of the environment must also be incorporated into the fabric of humanitarian practice.[9]

The core humanitarian principles of humanity and impartiality compel the relief of suffering based on need, and yet there is a growing imbalance between "forgotten" or "invisible" crises and those that are elevated by donor preferences and Western media. Moreover, targeted legislation or sanctions as well as the shifting priorities of the UN Security Council can enhance or diminish humanitarian action in specific settings around the world. The prioritization of certain health needs and the neglect of others may also reflect external pressures rather than the careful application of traditional humanitarian principles.

The principle of independence can also be challenged by external pressures. While this humanitarian principle calls for autonomous decision-making by humanitarian organizations, specific, earmarked funding or the preferences of host states can impose targeted uses of resources that does not always correspond to observed needs or gaps in service provision.[10] Ethical decision-making entails efforts to ensure that local communities and civil society have opportunities for shaping the local humanitarian agenda. However, this may chafe against the need to remain independent, particularly when local communities are closely affiliated with a particularly political or combatant group.[11] At the same time, any stakeholders' interests must always be weighed against the imperative for health care providers to be first and foremost responsive to the wishes and needs of the person receiving health care. Given the complexities inherent in navigating this array of influences, humanitarian organizations may rely on transparency in operational decision-making to convey how they attend to the requirements of ethical humanitarian principles.

Respect for Local Voices

The imperative for humanitarian actors to acknowledge the voices and priorities of communities has ascended to an increasingly prominent place in the contemporary humanitarian agenda. While this practice can sometimes create ethical dilemmas, particularly in remaining independent and neutral, it can also be viewed as a way of strengthening ethical decision-making. Diverse communication chan-

nels, including traditional community gatherings as well as social media engagement, can expose humanitarians to community views and facilitate joint delineation of the priorities for the humanitarian health response. While there is often a mismatch between the community's ask and the proposed response from humanitarian health actors, this can lead to essential conversations and help ensure that humanitarians act as true "responders" and not as "interventionists."[12]

Although this dynamic is often depicted as humanitarian actors enhancing their "accountability to the affected population," this expression can unwittingly create the impression of an us-versus-them dynamic that overlooks the possibility of local communities and humanitarian organizations codesigning humanitarian health responses. This latter practice, if fully incorporated into humanitarian work, could potentially have a profound impact on strategic and operational decision-making. More specifically, it could shape new ethical approaches to humanitarian health in which neutrality and impartiality are in large part defined by communities that, in their empowered role, seek to defend their interests beyond the limits of what may have traditionally been deemed acceptable by humanitarian organizations.

At the same time, greater care and attention need to be paid to the potentially counterproductive role that social media can play in ongoing exchanges between local communities and humanitarian organizations. The proliferation of misinformation or disinformation calls for transparent and frank dialogue between humanitarians and other stakeholders, especially those who represent the communities that humanitarian organizations wish to serve.[13] Humanitarian principles themselves should form a core foundation for this dialogue, a commitment that requires a willingness from all parties to collaboratively explore the ethical standards that humanitarian organizations are seeking to operationalize. While, under some circumstances, this dialogue can expose difficult tensions between humanitarian organizations and community members, the transparent exploration of these issues can identify conflicting, even abusive attitudes regarding impartiality, independence, and neutrality. It can also provide a conducive platform to foster trust and ultimately joint compliance with a common set of ethical protocols and procedures.

Humanitarian Ethics and the Exercise of Power

Beyond the demand for greater attention to diverse voices, discussions about the decolonization of humanitarian health responses have had to confront the implications for the principle of nonmaleficence, the obligation not to inflict harm while providing care. This justice-related claim contests the *status quo* distribution of power and speaks directly to how humanitarian health responses are designed, delivered, managed, and evaluated. From an ethical point of view, calls to decolonize humanitarian health responses raise the fundamental question of what val-

ues and purposes humanitarian principles serve if they are not confronting the inequitable distribution of power, knowledge, and resources in the humanitarian space.[14]

The humanitarian sector seems to be alarmed by the prospect that their practices might, in fact, be strongly rooted in colonialism. From an ethical standpoint, acknowledging these colonial origins means more than debating constructs that relate to compliance with traditional humanitarian principles. It also entails deeper questions about the future of a sector that was established, governed, and driven by Western, and largely white, institutions.[15]

The issues around inequality and power imbalances reflect a lack of diverse representation in strategic decisions, recruitment strategies, the establishment of salary grades, the management of discrimination and abuse, and the targeting of specific health problems and populations. Of particular concern to humanitarian health, power imbalances can distort therapeutic choices, the types and origins of employed drugs and medical devices, and supply channels for a variety of essential humanitarian materials. These issues may raise questions beyond humanity, impartiality, neutrality, and independence. But can humanitarian provision be truly ethical if these problems are not addressed?

While localization has been embraced as a remedy to counter some of these power imbalances, its comprehensive implementation remains rare. In addition, the full utility and limits of localization will vary in different social and political settings.[16] While the goals of many humanitarian organizations might aspire to meaningful inclusiveness and diversity, achieving these goals will likely require a deeper revision of long-standing values and a willingness to challenge practices established in a colonial past.

Even the language of humanitarian health requires ethical reassessment. Affected communities are often described as "beneficiaries," "recipients," or "victims," which tends to diminish community strengths and, more profoundly, community power. Language is a battlefield of ethical reality and should also be the subject of collaborative reflection and revision.[17] Public communication and "marketing" shaped by the interests of the organizations can prove disrespectful of communities and their dignity, and instrumentalize human suffering. Humanitarian organizations are often engaged in intense data collection protocols, yet the discussion of consent regarding the use and storage of data, particularly using digital technologies, may not meet ethical or humane standards.

Most important, humanitarian principles, particularly the principle of neutrality, should not be used as a shield to community engagement or to avoid unpleasant conversations about inequalities and the abuse of power. Rather, ethical considerations should support the thoughtful yet forceful protection of communities and actively work to use humanitarians' own base of power to challenge inequalities, give space to diverse voices, and actively promote change.[18]

Identity and Intersectionality in Humanitarian Health Responses

Humanitarian actors today face new demands to ensure that the identities of individuals and groups are respected in the design and delivery of humanitarian health responses. Intersectionality is "a way of thinking about identity and its relationship to power," and emphasizes that people's lives are shaped not by a single factor but by a variety of personal, political, and social dimensions.[19] It thus seeks to identify the many ways and forms in which a person can be or become powerful and be or become susceptible to abuse or invisibility. Intersectionality reminds humanitarian health workers that the traditional mindset of "risk groups" might be imperfect or simply too reductive to facilitate just humanitarian action. Embedding intersectionality within the guiding ethical principles for humanitarian action would therefore mean, first and foremost, that the humanitarian sector must identify its own limitations and biases that necessarily frame its approach to each context.[20] Humanitarian actors are often unaware of, or understate, the impact that operational mandates, international guidelines, or legal frameworks have on their understanding of and response to the challenges in distinct humanitarian settings.[21]

There is still much to be done to expand new practices that respond to justice-related claims. There is a need to embed them more firmly within both the humanitarian sector's conception of ethical action and its everyday implementation on the ground. This will surely require ongoing critical dialogue, and the humanitarian health community must reassess its ethical foundations that, while controversial, could provide guidance for a range of ethical realignments in the humanitarian response and patient-centered care.

Ethical principles exist because reality can be messy, confusing, and contradictory. Solutions to such challenges will always be less than ideal, and it is unsurprising that the just application of ethical principles would be similarly complex. However, complexity should not be used as an excuse for inaction. In this context, it should be remembered that the ethical principles of humanitarian health are principles of action intended to motivate and facilitate deeds in the real world.[22]

There is also a constant need for reassessing the translation of ethical principles into action, particularly in an area as dynamic as humanitarian health. There is a requirement for listening and responding and not the veiled imposition of unilateral declarations or positions. Enacting principles in a complex, fast-evolving environment means that humanitarian health workers should be capable of critically reflecting on their practices and ensure that their choices are relevant to and respectful of the communities to be engaged. Principles in action are people-centric; they should first and foremost respond to the benefit of those whom the humanitarian sector intends to support.

Throughout this essay, I have emphasized the need to create and strengthen participatory and representative platforms of conversation as a way to keep humanitarian principles alive, relevant, and actionable. Many humanitarian health organizations are actively engaged in seeking new ways to address these challenges through reflection, facilitated engagement, and action. I have also advanced the argument that humanitarian health workers who directly deliver services to communities in the field are essential guides to the deliberation of ethical frameworks. Finally, I have underscored the necessity that humanitarian organizations invest in attitudes and practices that open space for the voices of all those engaged in health responses and to actively break down power structures that stress or create vulnerability and impotence. This more expansive commitment will best ensure a constructive rethinking of the ethical basis of humanitarian health, and ultimately prove sufficiently insightful, actionable, and humane to meet the rapidly changing reality of humanitarian health in the real world.

AUTHOR'S NOTE

This essay does not represent the views of the International Committee of the Red Cross, where the author currently works. The author wishes to thank Lina Echeverri, Mutsa Mugangavari, Maria Guevara, and Berhanu Endeshaw, who generously offered feedback on earlier drafts.

ABOUT THE AUTHOR

Ana Elisa Barbar is an Advisor at the International Committee of the Red Cross.

ENDNOTES

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A Bird with One Wing

Bina Shah

When the wedding was over, Zarghuna climbed aboard the bus, leaving the evening's cool breeze for the pungent, stuffy air of the women's section. All in all, there were about forty of them – men, women, and children – returning home from the celebrations in a neighbouring village. The women sat at the front, swathed in burqas hiding wedding finery underneath, their faces made up in carefully hoarded foundation, bright red lipstick, eyes rimmed with kajal. Earrings and necklaces clinked as they laughed and talked and gossiped, while children lay bundled up around them, tired and sleepy in the dark. Further back, their husbands sat together in the men's section, rubbing stomachs full from the six rice dishes served at the feast.

It had been Zarghuna's cousin's daughter's wedding; the other women had teased her cousin, asking if she was ready to become a grandmother. She was only thirty-five.

"May you be the grandmother of seven grandsons," they called out to her raucously making her laugh and the bride cover her face in embarrassment, clearly smiling through her hennaed fingers. Everyone knew you needed sons for inheritance, for land, and for feuding. That is to say, for war. Each house had its own graveyard, at the front of which the bodies of recent casualties were buried, each grave marked only by a small, modest stone. The more stones, the more honour for the family.

As she reached the top of the steps, Zarghuna wondered to her husband which seat was a better bet in case of a crash. Her husband conveyed this question to the bus driver, who said a crash would be very inconvenient for his schedule, and both men laughed while Zarghuna chewed on the end of her burqa, embarrassed. The bus driver was her father's cousin's son, a boy she'd known since she was small. He exchanged a few pleasantries with her husband, a little friendly greeting – *May you not get tired* – and the response – *May you never know poverty* – falling easily from their lips, with smiles and enquiries about aged parents and young children. It was improper to address another man's wife directly even if she was standing in front of you, so her cousin did not speak to her, showing her husband the respect he deserved. But he gestured silently behind him to a pair of seats in a better condition than the rest.

As she sat down, her husband moved on to the back, entrusting her to her cousin's silent care. The young man had already pushed the rear-view mirror up to face

the ceiling so that his glance would not fall on any woman's face. The woman next to her, Shugla, smiled and offered her a piece of mithai from the wedding feast.

"Sit next to the window," Shugla said. "I know you get carsick." She got up and offered Zarghuna the window seat; Zarghuna accepted both the seat and the sweet, popping the coconut barfi into her mouth and chewing it slowly so that it lasted a long time.

It was only a two-hour drive from the neighbouring village to their hamlet, in a small enclave of North Waziristan not far from Shewa. There had been some discussion about which route to take: whether the old, winding, single-lane mountain road or the Shewa-Miranshah paved road would get them to the wedding faster. The mountain road was treacherous, the scene of many accidents, but the paved road had more checkpoints, and nobody wanted to shepherd their women on and off the bus to be glared at by the Pakistani soldiers. The decision was made: to take the back road. They would take the same road now, on the return journey, at three in the morning, and would be home hopefully before dawn.

As a girl, she'd dreamed of being married to a soldier. Zarghuna and her sisters used to watch them from a distance, spinning around in their army trucks, tall and authoritative in their uniforms. But there was no question of marriage with a man from the army. They were the occupiers, and she could only ever be married to a relative, or at best a kinsman.

At fourteen, Zarghuna married the cousin she was promised to when she had been ten. She'd accepted her fate as she'd accepted most of the realities of her life: the many children she was expected to bear, the hard scrabble of living on the mountain, taking care of the house and goats, cooking and cleaning, serving her in-laws. Her husband was better than most; he'd finished high school, and he didn't hit her, even though her sisters whispered to her that a man who hit you was better than a man who didn't care.

And life had its bright spots, like the wedding parties they attended several times a year. This was the first time Zarghuna had traveled so far outside the village since giving birth to her son. But it was a special occasion, the first wedding since the truce had been declared between the two warring sides of the family, who had each sworn allegiance to a different warlord in the fighting that was going on around them, here and across that invisible line the Pakistani Army called a border. The presence of the womenfolk was a parley, a promise that trust, like a toppled tree, could take root again and grow in a different direction. The men had still worn their rifles and kept their guns in their pockets, but the bullets were stored separately, as a gesture of goodwill. It had all gone well, and when the bride had been carried in her palanquin to her husband's home, everyone allowed themselves to relax and enjoy the rest of the night.

The bus chugged on, climbing steadily towards home. Zarghuna whispered a prayer as they rounded a hairpin curve; the steep mountain bends made her feel nauseous. Her husband had instructed her not to look down, but to focus on a

point far away, out the window. It was not yet dawn, but Zarghuna sought out the white thread at the horizon that indicated the end of the long night. She wanted to see her son, who was back in the village, spending the evening with her mother, who had stayed home to look after him.

They made it past the turn and were on a straight stretch of road now. She could see Sahar Sthoray, the morning star, glittering in the night sky.[1] Zarghuna cheered up when she spotted it, forgetting her queasiness. She recited to herself, *Which of the favours of your Lord will you deny?* Then a humming sound caught Zarghuna's attention. She didn't have time to register whether it was a military helicopter or just the wings of a giant bird. Just as she turned her head to search for it, there was a loud noise: *dum dum*. And then a flash, and the entire bus shook and everything turned brilliant white to signal the end of Zarghuna's world.

At first, there was nothing. Then slowly sound came back. Zarghuna was standing in the women's public call office and the telephone bell was ringing above her head. She shook her chin from side to side; the clamour didn't stop.

It wasn't dark any more; the weak light of the winter sun, an hour after dawn, pressed painfully against her eyelids. When they finally opened, she saw that she was still in her seat, a bar from the seat next to hers pressing into her waist, right above the scar from her C-section. Then she remembered: the wedding, the bus, the winding road. The heat, the light, the impact. She opened her mouth to scream but summoned no one with her cries.

A drone, she thought to herself suddenly. The word, sharp and pointed, quivering with significance, an odd intrusion into the dullness of her brain. *A drone*, she thought again, and wondered if she'd gotten it right. Why was it so important that she had?

Zarghuna checked her own arms and legs to see if they were still there, and her fingers moved of their own volition to push the bar away from her stomach. Something hurt inside her belly, but not enough to keep her from trying to wobble to her feet. As soon as she was upright, vertigo hit her with the strength of a hammer, and she reeled, left to right, bobbing up and down helplessly. Spinning and ringing, ringing and spinning. She held the seat in front of her to steady herself.

Her fingers touched her hair, and then stickiness. The bus driver, her kinsman, didn't move when Zarghuna prodded his shoulder. Now her hand was on her cousin's forehead, and his skin was still warm. But he was gone, already far away from where she was, moving in a different direction. Her hand, when she removed it from his forehead, was red with his blood, mingling with the floral designs painted on her palms. What about his wife and children, sitting just behind her in the women's section? Had he left them behind or were they travelling to the next world with him?

She looked around but could make no sense of the twisted metal, the shards of glass, and the charred bodies slumped in their seats. Nothing moved; there was only the ticking sound of metal cooling down and the hiss of acrid smoke curling into her nostrils. She would suffocate if she didn't find her way outside quickly.

Zarghuna couldn't tell whether the bus was lying straight or lopsided; only that it was roughly the right side up. She looked for the front door of the bus, but it was welded shut from the heat of the explosion. A cold wind was knifing in through the shattered front windows; too much jagged metal blocking the frames for her to try and hoist herself through. The side windows were nothing more than small squares, lined with iron bars. Zarghuna decided to head backwards, into the bowels of the bus, with the vague thought of finding one of the men of her family still alive. The men would tell her what to do, whether it was safe to go and wait at the side of the road for help from the very military men they'd been trying to avoid.

Clawing, stumbling, her hands pulled her body in the right direction. She held onto burst seat backs for balance, their plastic and stuffing melted into clumps. It was difficult to see the floor with so much debris blocking the way: bags fallen from the overhead rack, shawls, shoes, a Quran. And more women's bodies, or the fragments of them; whatever was left after the drone had found its target, and released its rockets.

Zarghuna passed all the men, dead in their seats, or thrown onto the floor. Broken glass crunched under her feet as she walked by the remains of her husband, her brother-in-law, her cousins. Some were intact, lolling backwards, others were taken apart, like butchered goats. There were empty seats, too, which meant that some had been thrown clear of the bus, a gaping hole in its ceiling. That's where the rocket had struck, blowing out the top of the bus. But it was as if the dead were the living, and Zarghuna, the ghost moving amongst them.

And then the image of her child came to her, the infant who had emerged from her body a wriggling, struggling lump, all elbows and knees and large hands and feet and head. She had been lucky to be taken to the THQ hospital in Shewa for his birth; her husband had wanted his firstborn son to be perfect, and for Zarghuna, his young wife, to survive the birth. She had been attended by a midwife – an unheard of luxury for the women from the more remote villages, most of whom laboured and gave birth in their homes, sometimes dying there in the process.

The moment her son had emerged from the slit in her stomach, everything was wrong and right at the same time. Zarghuna had known it before they'd even told her. Her husband had taken another wife after the child had been born, wanting healthy children that Zarghuna would obviously never be able to give him. She remembered just then that Shugla, her co-wife, was sitting at the front of the bus with her head and limbs blown off. If they had not exchanged seats at the beginning of the journey, Zarghuna would be dead.

Zarghuna's son had been afflicted with mild Down's Syndrome, a diagnosis she had not understood when they told her, and only understood it a little better now. They watched her carefully for weeks after the birth, worried that the news of her afflicted child and the second wife would make her suicidal. They had misunderstood her completely. She had been terrified her child would spend his life crawling on the floor, unable to sit up by himself, talk, or feed himself. The child she got instead was sweet and pliable, sharply intelligent, humorous and loving. He couldn't speak clearly and walked with difficulty, but she loved him all the same, perhaps more, in place of her unreliable husband. Her son was her bird with one wing; she whispered the endearment as she bathed him, rocked him to sleep, nursed him. *Fabi ayyi ala i rabbikuma tukazzibaan . . .* [2]

It was for her son that she forced herself to take step after painful step, pushing herself along the bus's blasted insides. This was how he felt when he walked. She could do the same for him.

She was breathing hard, sweating with effort. The sickening odour of smoldering steel, chemicals, gasoline, and electrical wiring assaulted her senses. And other, worse smells: charred flesh, burnt hair. But there seemed to be no immediate danger of fire; what flames had burned the bus were already dead. Still, another explosion could come at any moment; drones would often circle back and strike again at the same target. She had to keep going. Onwards she pressed, until she reached the end of the bus. Her husband and his brother had taken the seats at the back, wanting to laugh over silly WhatsApp videos on each other's phones, away from prying eyes.

She could see as soon as she reached them that they were both dead. Her husband's legs were blown off; his brother was leaning forward with his forehead torn open. To the side, the gaping hole in the ceiling reached all the way down to include their window. Cold air whistled in, invigorating her. All she had to do was climb up on top of them, push herself out through the hole, and she would be free.

But she hesitated. Maybe she should stay here until someone came to get her out. Surely it was the safest thing to do. The drone might be lurking around, waiting for signs of life, to strike again – to finish the job. Suddenly she realised that it wasn't inevitable she would get out alive.

For a moment, she considered huddling in the corner of the bus, or crawling under the bodies of her husband and his brother and staying there until death came for her too. The relief that such a decision offered her for those few moments was more powerful than any sedative. The struggle would be over: all the striving and back-breaking housework, the scrimping and saving, the endless need to be cheerful for everyone else's sake. What a pointless charade, just for others to look at – her life with her husband, his second wife, and her disabled child – and still feel superior about. For sure, they would continue to whine about the imperfections and frustrations of their everyday lives, but secretly they were all grateful for

their better fortune. If she gave up now, she could stop being everyone else's cautionary tale.

But just as Zarghuna was about to sink down, she heard a second explosion in the distance – the drone had found its true target: maybe a house in which a militant lived. There were a few in their village, though none belonged to Zarghuna's family or kin.

She stood stock-still. The voices came to her gradually, at first as a wall of sound, then slowly as individual strands of words.

"Allah! God have mercy!"

"Another one! God curse America!"

"Is anyone still alive?"

Zarghuna wanted to call out to them, but fear put its hand over her mouth. Fear of those birds that brought death, that kept them hiding in their houses, that stopped their children from playing outside. Her family had thought it safe to go to the wedding, since it had been a long while since the last drone strike. That calculation had been their last mistake. And now forty of them had met God, but not her. And not her son, her bird with one wing.

Soon there would be the growl of the military cars coming to check on the strike and eventually the wailing ambulances arriving from Shewa Hospital. All that fuss for only one survivor.

Zarghuna whispered to herself: *Which of the favours of your Lord will you deny?*

She put one unsteady foot into her husband's seat, where his legs had once been, then the other, balancing herself against the skeleton of the bombed-out bus. She glanced down to check the steadiness of her position: her toes were blue and cold in her wedding sandals, her nails painted pink a million years ago for the occasion. She climbed carefully out through the window, pushing her head and shoulders out of the broken pane of glass.

The villagers on the road, milling around the bus, spotted her and began to shout encouragement. "Subhanallah! A survivor, praise God!"

"Khoray, that's right, come on, you can do it!"[3]

"We'll take revenge, Khoray, if it takes a hundred years!"

She knew their vows served no purpose. They could not stop the drones from coming. All they could do, after it was over, was sort through the bodies, and protest with raised fists against the killer in the skies.

The villagers kept cheering her onwards. Strong arms reached for her, to help her climb down. The black burqa flapped around her as she emerged, like the wings of a butterfly emerging from a chrysalis. She tried to keep it wrapped around her head and mouth, conscious of her honour. If she died, they would tell her son that she'd behaved like a proper Pashtun woman even in the face of death.

When she felt her feet touch the icy ground, she collapsed, trembling, onto her side. Dust filled her nostrils, and she coughed hard, her lungs seared with the heat

and smoke from the burning trees that had caught fire from the explosion. The ambulances and fire tenders were already there, rescue workers and policemen swarming all over the road. Zarghuna closed her eyes and waited for one of them to notice her. Now her job was done, and it would be up to all the others to bring her back to life.

If she listened very carefully, the voices of the shouting villagers started to blur into the sound of a muted trumpet – Jibrael's on the day of Qiyamat. Tomorrow the mourning would start, and perhaps in a hundred years there would be revenge. But Qiyamat was a long way off, and her son was waiting for her to return. She closed her burning eyelids and saw her son's face, his smile, and she stretched her arms and legs out, to swim like a dolphin in the epicanthic folds of his eyes.

"A Bird with One Wing" by Bina Shah was first commissioned for and published in The American Way: Stories of Invasion, *edited by Orsola Casagrande and Ra Page (Comma Press, 2021).*

ABOUT THE AUTHOR

Bina Shah is a journalist and author of five novels and two collections of short stories. Her latest novels are a feminist dystopia, *Before She Sleeps* (Delphinium Books, 2018), and its sequel, *The Monsoon War* (Delphinium Books, 2023). In 2022, she was awarded the rank of Chevalier in the Order of Arts and Letters by the government of France.

ENDNOTES

[1] Sahar Sthoray is the Pashto name for Venus.

[2] Arabic, from *The Quran*, Surah Rahman: *Which of the favours of your Lord will you deny?*

[3] Khoray is the Pashto word for *sister*.

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https://doi.org/10.1162/DAED_a_02004

Humanitarian Health Responses in Urban Conflict Zones

Keith Stanski

War has long tested the design, capacity, and protected status of health care personnel and systems. In recent years, however, urban conflict zones have come to exemplify many of the most intractable humanitarian dilemmas around the delivery of medical care. In this essay, I examine several recurring dilemmas concerning operational independence and physical safety, as encountered in Syria and Yemen. I argue that, as a generative force, war has the potential to make (and remake) social, economic, and political life in urban settings in ways that accentuate essential challenges facing the safe and principled delivery of health care. These far-reaching effects leave humanitarians and their supporters to adapt existing strategies, many developed in more rural contexts, to shifting urban environments. In such contexts, the establishment of "hospital" or "relief zones" may offer a pragmatic and principled strategy to mitigate many of the dilemmas surrounding the protection of medical facilities and personnel in urban conflict settings.

War has long tested the design, capacity, and protected status of health care personnel and systems. In recent years, however, urban conflicts have come to exemplify many of the most intractable humanitarian dilemmas facing the delivery of medical care. This is apparent across the Middle East, where shifting frontlines around Al-Hudaydah, East Aleppo, and Mosul have turned health providers into victims, their facilities into targets, and their patients into collateral damage.

What is the significance of these urban areas for the delivery of health care amid armed conflict? What explains their relative prominence in global debates? Prevailing accounts stress the degree of human suffering in Syria and Yemen.[1] Interdependent infrastructure and essential services have compounded the effects of direct or indirect targeting, and interrupted water, sanitation, and electricity services have placed greater pressure on already limited health assistance.[2] Scholars have cited the intensity of urban fighting.[3] Others point to wider changes in the character of war and the strategies and tactics of contemporary belligerents, many of which contravene international humanitarian law (IHL) and may constitute war crimes.[4]

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https://doi.org/10.1162/DAED_a_01993

Beyond such explanations, these conflict zones also illustrate the potential for war to make (and remake) social, economic, and political life in ways that accentuate essential challenges facing the principled delivery of health care. War is more than just a destructive force: it can recast defining features of conflict areas where humanitarian health providers operate, altering population distributions, shifting legal frameworks, and replacing long-standing governance systems with rival authority claims.[5] These effects are pronounced in urban areas of the Middle East, where populations, geostrategic interests, and symbolic importance are concentrated.

Such effects have immediate consequences for strategies to ensure the operational independence and physical safety of humanitarian medical operations. Humanitarian health providers and their supporters are often left to adapt existing strategies, many developed in more rural contexts, often with mixed results. A global strategy to mitigate these dilemmas may prove difficult, especially given the local particularities of urban conflict zones. One option rooted in IHL may be to increase advocacy for the establishment of "hospital" or "relief zones." Consensual agreements among combatants and humanitarian actors about such areas may create a more predictable and permissive operating environment for the delivery of health assistance in urban conflict zones.

Armed conflicts in Syria and Yemen have challenged all facets of humanitarian medical operations. Few are more essential than operational independence. This challenge derives, at least in part, from regional legacies. As scholars note, health systems in the Middle East have never been characterized by independence.[6] On the contrary, health and health care have long been central to securing social and political legitimacy in the postcolonial state. The construction of hospitals, accreditation of physicians, and prerogative to deny or provide treatment have thus been essential to states' claims to and exercises of sovereign authority.

Amid recent armed conflicts, as sovereign authorities have faced new challenges, especially from emerging nonstate actors, many states have claimed even greater authority over the provision of health, including in areas outside their control. In Syria, in 2012, the parliament effectively criminalized the provision of medical assistance and other humanitarian activities outside government-approved structures.[7] In Yemen, health providers and other humanitarian actors are generally prohibited from working across the entire country; registration with either the internationally recognized government based in Aden or de facto authorities in Sana'a precludes recognition from its rival.

Nascent governance structures further illustrate this legacy. Health provision was essential to the earliest attempts by the Islamic State of Iraq (ISI) to govern Iraqi territory before and during its self-declared caliphate that extended into much of Syria. In April 2007, for example, a minister of health was appointed to

ISI's first cabinet, along with ministers for war, public security, and martyrs and prisoners.[8] The ministry of health consolidated and expanded its authority in subsequent years, even as other administrative branches (such as "Al-Hesba" or the morality police) exercised considerable influence over hospitals and clinics, with grave consequences for the quality of care.[9]

Amid such sweeping exercises of political power, urban medical providers are often implicated in more localized contests over political authority. As seen in various contexts, including beyond the Middle East, war can turn cities into epicenters of competing authorities, particularly where emerging rivals struggle over potential revenues, strategic advantages, and political standing. The ensuing operating environment for medical providers can vary, ranging from lawlessness in urban battlegrounds to cities with nascent administrations, with both extremes posing serious dilemmas for health operations.

The challenges medical providers face amid competing authorities are apparent at Al-Thawra General Hospital in Taiz, Yemen. With support from international donors, most notably Médecins Sans Frontières (MSF), the hospital has operated for years in a violent urban environment. Located in a nominally pro-government area known as the "enclave," the hospital has been surrounded in recent years by a fractured collection of armed groups, all nominally united in a fight against pro-Ansarallah forces. In reality, however, these new and established groups are locked in their own contest over power, control, and territory with the support of various Yemeni and regional powers.[10]

This dynamic poses several chronic challenges for the medical operation. Fighting and indiscriminate shelling endanger the facility, assets, staff, and patients. Roadblocks restrict staff movements and essential supplies, especially from Ansarallah-controlled areas. Conditions do not permit medical assessments in the surrounding areas: patients that manage to reach the hospital are often the most reliable indication about the prevailing needs.[11] These conditions have deterred most other international nongovernmental organizations from operating in the urban warzone, leaving MSF as one – if not the only – international presence in the city center providing significant medical humanitarian support.[12]

Although related to this pervasive insecurity, a more intractable dilemma has been preserving medical providers' ability to operate without interference. The concentration of armed actors in a small, contested urban geography deeply constrains health care delivery. Staff warn about fighters' interference in hospital administration and decision-making.[13] More violent acts, however, are among the most flagrant challenges to the hospital's operational independence. Militias are often stationed in the hospital and the surrounding compound. Fighters have forced surgeons to operate at gunpoint.[14] Government-affiliated fighters have assaulted doctors and nurses over the treatment of enemy and allied soldiers. In 2020, in one of several press statements, an MSF manager in Taiz warned, "Our

humanitarian space is threatened by repeated violations committed by the different warring parties in Taiz."[15]

Recurring interference at Al-Thawra General Hospital illustrates urban medical providers' limited recourse to assert the principled nature of their operations. Management and staff have periodically reduced or suspended operations in protest, relying on national and international media coverage to highlight their difficult situation. Public attention complements private advocacy with commanders, armed groups, and other influential actors to increase acceptance of the hospital and MSF as a neutral and impartial medical humanitarian organization. But the contested urban enclave also serves to constrain such an advocacy strategy: the multiplicity of armed actors, changing leadership, and shifting alliances complicate MSF efforts to ensure these principles are respected.

Strong considerations may deter more severe responses. Closure of the facility, for example, would have outsized consequences for the surrounding population, which totals more than one million people, as Al-Thawra is the largest medical facility in the region. The remaining facilities in the area are insufficient to absorb the resulting unmet caseload. Relocation may only compound civilians' difficulties in accessing adequate medical treatments, particularly in the absence of other humanitarian medical workers.

In contrast to the lawlessness of Taiz, Yemen, select health workers in Northwest Syria navigate a more consolidated, albeit still emergent, political order. In 2017, Hayat Tahrir Al-Sham (HTS), an internationally designated terrorist entity, began to impose itself over rival factions across opposition-held areas of Idleb governorate. HTS used its growing military hegemony to force rival armed groups and a patchwork of courts, local councils, and independent authorities to submit to the new technocratic authority based in Idleb City, the Syrian Salvation Government (SSG).[16]

Under the SSG, humanitarian medical workers are an essential part of the provision of basic health services in Idleb. As with the wider humanitarian sector, the SSG does not have the personnel, financial resources, or technical expertise to support the millions of people in need of assistance across its territories. Instead, international humanitarian organizations and their local partners have largely taken over a deficient health sector, leaving a fragmented response with many basic and chronic needs going unmet.

The Syrian Arab Red Crescent (SARC), the internationally recognized Red Cross/Red Crescent Movement national society, occupies a precarious place in the wider humanitarian medical response in Idleb. SARC-Idleb is one of the oldest medical providers in Northwest Syria: its operations date back decades, long before HTS and the SSG emerged. SARC personnel have remained active amid repeated kidnappings, attacks, and casualties during the ongoing armed conflict. Despite this established presence, SARC's activities in Idleb have decreased in re-

cent years, focusing mostly on first aid and primary health services. As of 2019, SARC only maintained two urban medical facilities in Idleb City and Ariha, providing some sixty-eight thousand people with medical assistance during the first half of the year.[17] This reduction made SARC a relatively small part of humanitarian medical response activities, especially compared with cross-border NGO actors operating from Türkiye.

More important, SARC-Idleb is the only Syrian health actor to operate in HTS-controlled territory with governance and financial structures headquartered in government-controlled areas. Historic ties between SARC and the Syrian government implicate the Idleb branch in wider debates, accusations, and conspiracies about the organization's operational independence.[18] In 2019, local councils, medical professional societies, and other stakeholders in Northwest Syria began to refuse to cooperate with SARC, with some calling them an extension of the government, not an independent humanitarian health provider.

This precarious status escalated in 2020. The SSG attorney general's office responded to growing accusations about SARC by closing its offices in Idleb City and Ariha and seizing assets, citing charges of corruption. Staff and volunteers were temporarily detained. Several SARC leaders later fled to other parts of Northwest Syria after the SSG opened criminal cases against them. SARC headquarters condemned the "assault and intrusion," questioning the legality of both the court order and the SSG.[19] The International Committee for the Red Cross raised concerns about the closure, citing the need to respect and protect the humanitarian relief personnel and objects for humanitarian relief.[20]

More than two years since the raid, SARC offices in Idleb are still closed and court cases are still pending, even as health needs in Northwest Syria continue to increase. The SSG's position on the situation remains unchanged, despite public and private calls for greater acceptance of SARC in Northwest Syria. Its relative absence from other health-related matters only affirms the SSG's nascent political-legal authority and the wider transformation of governance in HTS-controlled areas.

The Idleb case illustrates how this transformation is most pronounced in urban areas. The SSG's presence in Idleb City and, to a lesser extent, in Ariha enables it to exercise a degree of authority that would be untenable in wider, more rural parts of Idleb. The SSG lacks the means and will to fully regulate the social, economic, and political life in HTS-controlled territory, particularly outside urban areas. As an administrative and legal matter, SARC and its supporters must manage not only the highly politicized medical humanitarian response in HTS territory, but also the often arbitrary legal and procedural stipulations of the SSG order.

Beyond preserving operational independence, the protection of staff, patients, and medical facilities is a recognized challenge across conflict settings worldwide. As World Health Organization Director-General Dr.

Margaret Chan warned in 2014, violence is occurring "with growing frequency in all regions of the world, and in all contexts, during peacetime as well as armed conflict and other humanitarian crises."[21] The scope of such violence has not been reliably calculated.[22] Its cumulative effects are even less understood.

In Syria, the protracted war has transformed health care provision throughout the country.[23] As Dr. Aula Abbara and colleagues have argued, since the outbreak of the armed conflict, geopolitical, fiscal, and humanitarian factors have fragmented and politicized the Syrian health system, creating distinct systems across the country, including in the HTS-controlled Northwest.[24] Overt challenges to the protected status of wartime medical units have arguably been the most far-reaching factors in fragmenting and politicizing the Syrian health system. As many scholars have noted, parties to the conflict have recast patients, medical providers, and their facilities as strategic targets, intrinsic to the enemy war efforts and warranting attacks.[25] The resulting protection challenges extend throughout the country, particularly in opposition-held areas, even as researchers acknowledge systematic underreporting.

Safety risks have forced medical service providers in Syria and their supporters to devise elaborate responses. The "hardening" of medical facilities, particularly in underground sites, became one of the most notable strategies in areas outside government control across North, Northwest, and, to a lesser extent, South Syria.[26] Beginning in June 2011, hundreds of medical facilities were established, consolidated, and concealed behind and beneath reinforced structures.[27] Several specialized facilities were later built inside caves, perhaps most notably Al-Maghara (Dr. Hassan Al Araj) Central Hospital outside Kfar Zeita, Hama, which was constructed below meters of rock. In 2018, a survey of health workers in Syria commissioned by the UK Department for International Development found that, among various protection measures and strategies, underground facilities and fortified sites were the "most commonly used protection tool[s]."[28]

Space, structural, and cost constraints have prevented the construction of fully underground facilities in urban settings. Instead, two related approaches have become more commonplace, especially in North and Northwest Syria. First, beginning in 2011–2012, medical providers and their donors have established facilities in "unconventional places," including private homes, cellars, mosques, and churches.[29] Although the quality of care varies, these smaller medical points and "field hospitals" have helped extend service delivery, including to areas that lacked adequate facilities, materials, and professional staff. Moreover, hospitals have been divided into smaller sites across several locations, with networks of connecting tunnels, to lower the risk posed to health workers and assets. This footprint has decreased the potential for large queues of patients around facilities, with a view toward reducing the chance of detection by surveillance aircraft and civilian casualties during an attack.[30]

Second, existing buildings have been retrofitted and reinforced. Such an approach was common in hospital facilities, including Idleb National Hospital in Idleb City and Al-Sakhour Hospital in East Aleppo, which were too large and often too well-known to conceal. Emergency rooms, intensive care units, and other service areas were relocated to lower floors for protection. In addition, vacant buildings with basements were rehabilitated and turned into hospitals, using the existing structure as a base. Upper levels were abandoned given their exposure to shelling, missiles, and airstrikes. If budgets permitted, these areas were often reinforced with sandbags, concrete, and other construction materials to provide additional protection for the floors below.

Principle and pragmatism underpinned the rationale for constructing underground medical facilities. Health providers and their supporters continued to insist that IHL afforded a protected status to medical operations in all areas outside government control. This argument was apparent in May 2017, when a consortium of medical providers and advocates appealed for more international support to construct fortified and underground hospitals. As they explained, "We have called for the protection of hospitals and health workers from the beginning of the conflict."[31] Yet, after five years of conflict, appeals to IHL had proven insufficient. Amid increasing attacks, medical providers had taken it upon themselves to protect their staff, patients, and facilities in both urban and rural areas. "While the international community fails to protect Syrian medics from systematic aerial attacks on their hospitals," the consortium explained, "Syrians have developed an entire underground system to help protect patients and medical colleagues as best they can."[32] A strategy of self-protection was borne out of necessity; it was a practical recourse given the limits of principle-based protection. "We are forced," the consortium concluded, "to fortify our hospitals and rebuild them underground for our own safety. This is not development – this is protection."[33]

In subsequent years, efforts to disperse, conceal, and fortify urban medical sites helped save lives and enabled medical operations in opposition-controlled areas, even following attacks.[34] At the same time, as peace efforts stalled and frontlines encroached, urban conflict zones in East Ghouta, Idleb, and Aleppo revealed the limits of self-protection strategies: hidden and reinforced medical facilities could not evade intensifying attacks, safeguard staff and patients, or compel greater respect for IHL.

Medical providers' public resolve for self-protection strategies diminished amid the realities of escalating violence and bombardment. Concealment strategies in urban areas were relinquished in favor of other approaches, including greater public advocacy. By mid-2018, with escalating fighting outside Damascus and in Northwest Syria, many medical providers and supporters became more outspoken about the inherent risks of delivering medical services, especially in urban contexts. This was evident in the advocacy of two of the largest internation-

al medical providers, the Syrian American Medical Society (SAMS) and Union of Medical Care and Relief Organizations (USSOM): in 2019, the two networks published more than forty press releases in English about incidents affecting their urban operations.[35] Essential details about location names, years of international support, and status of operations were disclosed in repeated calls for fighting to stop and IHL to be respected. Graphic photos revealed the structural damage and loss of life.

After years of advocating for concealment and fortification strategies, SAMS began to acknowledge that such approaches could not overcome a lack of respect for the protected status of medical staff and facilities under IHL. "The symbolic Red Cross or Red Crescent markings," they explained, "have been removed from most hospitals in Syria as they are now a literal target."[36] Moreover, the physical limitations of self-protection strategies became evident. Repurposed and reinforced structures could not withstand repeated attacks, especially with the deployment of larger artillery and more sophisticated missiles. SAMS lamented the situation, warning, "Bunker buster bombs have been used to cut through concrete and decimate basements and underground hospitals."[37]

Humanitarian medical workers have been left with few options. In Idleb and North Aleppo, some medical providers relocated larger hospitals away from urban areas, opting to reopen closer to the Syrian-Turkish border, where hundreds of thousands of displaced families had settled. The remaining humanitarian health operators continue to deliver assistance in uncertain conditions.

Humanitarian medical professionals face near intractable dilemmas in urban conflict zones in the Middle East. These settings illustrate more than just the depraved nature of contemporary warfare; they also demonstrate the potential for war to recast essential features of conflict zones, often in ways that undermine the safe and principled delivery of health assistance. These effects can be especially pronounced in urban environments, where social, political, and economic life are concentrated. Humanitarian medical workers are liable to be directly implicated in violent contests, including among emerging nonstate entities, over authority, legitimacy, and service provision. Nascent political orders may encroach on humanitarian health operations, exercising a level of authority otherwise limited beyond their de facto capitals. Escalating targeting can outstrip concerted efforts to conceal medical operations, fortify structures, and compel great respect for their protected status under IHL.

Immediate solutions to such challenges may prove difficult. The violent, shifting, and often very particular urban environments likely preclude a global approach. It may be opportune, however, to increase advocacy for the establishment of designated localities for the provision of humanitarian health assistance. As outlined in the Geneva Conventions, "hospital zones" or "relief zones" can be or-

ganized on the territory of a party to the conflict or occupied territories to protect the sick, wounded, and assigned medical personnel from the effects of war.[38] Such zones can include, but are not limited to, established medical facilities; temporary and unconventional medical sites can also be accommodated. More notable, these distinct zones are founded on a consensual agreement among relevant parties about their protected status, physical delineation, and duration. This agreement distinguishes such zones from other kinds of protected areas (such as "safe havens") that may be organized on a unilateral basis and lack a grounding in IHL.[39]

Hospital zones have supported various medical and humanitarian operations. Nonetheless, several operational realities may limit their viability in urban conflict zones, including in Syria and Yemen. A consensual agreement, for instance, may prove difficult to achieve in settings like Taiz City, where the number of belligerents is high, overall levels of trust are low, and strategic interests are entrenched following years of conflict. Moreover, in such contested settings, any agreement is liable to be tested: a single spoiler can jeopardize a negotiated arrangement, particularly in the absence of monitoring or enforcement mechanisms. Perhaps most important, hospital zones have the potential to attract large numbers of civilians, as physical safety and humanitarian assistance are strong pull factors.[40] Other kinds of protected areas are also likely to be combined, potentially complicating the agreed purpose of the designated areas.[41] Such possibilities pose serious protection risks for affected populations, but also for patients and humanitarian medical personnel.

With these realities in mind, greater advocacy for the establishment of hospital zones may help humanitarian medical providers and their supporters navigate several of the challenges identified in urban conflict zones: First, hospital zones can support humanitarian medical providers in establishing – and possibly preserving – their operational independence in urban conflict settings. From the outset, minimum operating requirements can be part of the consensual agreement to create a hospital zone. Such an understanding could afford humanitarian medical providers and their supporters greater leverage with parties to the conflict, particularly if these agreements encourage compliance (such as reliable medical treatment for war-wounded) and raise the potential costs (that is, reduced or suspended medical operations) of their interference.

Second, hospital zones could reduce the security risk humanitarian medical providers face in urban conflict environments. In principle, the consensual agreement would further deter direct attacks against humanitarian medical operations, since the potential political, strategic, and legal consequences of such an act would be greater. In practice, their effects may be more varied. Parties to the conflict, for instance, may only agree for zones to be created in safer areas, away from current or prospective fighting. Furthermore, humanitarian actors electing to work within the zone may reorganize their individual medical operations (such as consol-

idated facilities, standard demarcations, and collective civil-military liaison) to reduce their collective security exposure. In any case, the creation of consensual humanitarian zones may help medical operators better manage the inherent and shifting physical dangers of urban warzones. Such possibilities warrant further consideration given the inherent challenges facing humanitarian health responses in urban conflict zones.

AUTHOR'S NOTE

This essay has been written in a personal capacity. The views expressed herein are those of the author and do not necessarily reflect the views of the United Nations. Thanks to Larry Lawrence, Leonard Rubenstein, Zachariah Mampilly, George Khoury, Nathalie Weismann, Alex Dunne, Victoria Stanski, and the editors of this *Dædalus* volume for earlier comments. Any mistakes are solely the responsibility of the author.

ABOUT THE AUTHOR

Keith Stanski is a humanitarian professional with experience in Afghanistan, Colombia, Lebanon, Syria, and Yemen. He is the editor of *Orientalism and War* (with Tarak Barkawi, 2012).

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Excerpt from *The Committed*

Viet Thanh Nguyen

PROLOGUE
We

We were the unwanted, the unneeded, and the unseen, invisible to all but ourselves. Less than nothing, we also saw nothing as we crouched blindly in the unlit belly of our ark, 150 of us sweating in a space not meant for us mammals but for the fish of the sea. With the waves driving us from side to side, we spoke in our native tongues. For some, this meant prayer; for others, curses. When a change in the motion of the waves shuttled our vessel more forcefully, one of the few sailors among us whispered, *We're on the ocean now*. After hours winding through river, estuary, and canal, we had departed our motherland.

The navigator opened the hatch and called us onto the deck of our ark, which the uncaring world denigrated as merely a boat. By the lopsided smile of the crescent moon, we saw ourselves alone on the surface of this watery world. For a moment we were giddy with delight, until the rippling ocean made us giddy in another way. All over the deck, and all over one another, we turned ourselves inside out, and even after nothing remained we continued to heave and gasp, wretched in our retching. In this manner we passed our first night on the sea, shivering with the ocean breezes.

Dawn broke, and in every direction we saw only the infinitely receding horizon. The day was hot, with no shade and no respite, with nothing to eat but a mouthful and nothing to drink but a spoonful, the length of our journey unknown and our rations limited. But even eating so little, we still left our human traces all over the deck and in the hold, and were by evening awash in our own filth. When we spotted a ship near the horizon at twilight, we screamed ourselves hoarse. But the ship kept its distance.

On the third day, we came across a freighter breaking through the vast desert of the sea, a dromedary with its bridge rising over its stern, sailors on deck. We screamed, waved, jumped up and down. But the freighter sailed on, touching us only with its wake. On the fourth and fifth days, two more cargo ships appeared, each closer than the one before, each under a different flag. The sailors pointed

at us, but no matter how much we begged, pleaded, and held up our children, the ships neither swerved nor slowed.

On the fifth day, the first of the children died, and before we offered her body to the sea, the priest said a prayer. On the sixth day, a boy died. Some prayed even more fervently to God; some began doubting His existence; some who did not believe in Him began to; and some who did not believe disbelieved all the more strongly. The father of one of the dead children cried, My God, why are You doing this to us?

And it struck us all then, the answer to humanity's eternal question of *Why?*

It was, and is, simply this: *Why not?*

Strangers to one another before we clambered aboard our ark, we were now more intimate than lovers, wallowing in our own waste, our faces green, our skin blistered by salt and baked into the same shade by the sun. Most of us had fled our motherland because the communists in charge had labeled us puppets, or pseudo-pacifists, or bourgeois nationalists, or decadent reactionaries, or intellectuals of the false conscience, or because we were related to one of these. There was also a fortune teller, a geomancer, a monk, the priest, and at least one prostitute, whose Chinese neighbor spat on her and said, Why is this whore with us? Even among the unwanted there were unwanted, and at that some of us could only laugh.

The prostitute scowled at us and said, What do *you* want?

We, the unwanted, wanted so much. We wanted food, water, and parasols, although umbrellas would be fine. We wanted clean clothes, baths, and toilets, even of the squatting kind, since squatting on land was safer and less embarrassing than clinging to the bulwark of a rolling boat with one's posterior hanging over the edge. We wanted rain, clouds, and dolphins. We wanted it to be cooler during the hot day and warmer during the freezing night. We wanted an estimated time of arrival. We wanted not to be dead on arrival. We wanted to be rescued from being barbecued by the unrelenting sun. We wanted television, movies, music, anything with which to pass the time. We wanted love, peace, and justice, except for our enemies, whom we wanted to burn in Hell, preferably for eternity. We wanted independence and freedom, except for the communists, who should all be sent to reeducation, preferably for life. We wanted benevolent leaders who represented the people, by which we meant us and not them, whoever they were. We wanted to live in a society of equality, although if we had to settle for owning more than our neighbor, that would be fine. We wanted a revolution that would overturn the revolution we had just lived through. In sum, we wanted to want for nothing!

What we most certainly did not want was a storm, and yet that was what we got on the seventh day. The faithful once more cried out, *God, help us!* The non-faithful cried out, *God, You bastard!* Faithful or unfaithful, there was no way to avoid the storm, dominating the horizon and surging closer and closer. Whipped into a frenzy, the wind gained momentum, and as the waves grew, our ark gained

speed and altitude. Lightning illuminated the dark furrows of the storm clouds, and thunder overwhelmed our collective groan. A torrent of rain exploded on us, and as the waves propelled our vessel ever higher the faithful prayed and the unfaithful cursed, but both wept. Then our ark reached its peak and, for an eternal moment, perched on the snow-capped crest of a watery precipice. Looking down on that deep, wine-colored valley awaiting us, we were certain of two things. The first was that we were absolutely going to die! And the second was that we would almost certainly live!

Yes, we were sure of it. *We – will – live!*

And then we plunged, howling, into the abyss.

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ABOUT THE AUTHOR

Viet Thanh Nguyen, a Fellow of the American Academy since 2018, is a *New York Times* bestselling author and Pulitzer Prize–winner for Fiction. He is also a University Professor, the Aerol Arnold Chair of English, and a Professor of English, American Studies and Ethnicity, and Comparative Literature at the University of Southern California. His most recent book is *The Committed*, the sequel to *The Sympathizer*, for which he is the recipient of fellowships from the Guggenheim and MacArthur Foundations, and Le Prix du Meilleur Livre Étranger (Best Foreign Book in France).

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https://doi.org/10.1162/DAED_a_02010

The Great Evasion: Human Mobility & Organized Crime in Mexico & Its Borders

Sergio Aguayo

Translated from Spanish by Sandra Sepúlveda

Mexico finds itself at the epicenter of unprecedented migration flows. Governments, international organizations, and civil society institutions, however, choose to ignore the current weight of organized crime in the matter. I shape the central thesis of this essay through an account of the phenomenon's evolution, starting in the 1970s. I conclude by analyzing the ongoing migration issue along Mexico's borders with Central America and the United States, while offering recommendations to improve conditions of a migratory problematic made worse by the denial of its existence.

In June 2022, leaders from twenty countries in attendance at the Summit of the Americas in Los Angeles endorsed a "Declaration on Migration and Protection." In this document, they pledged to fight for the "safe" and "dignified" transit of migrants, and promised to combat "those who abuse" them and "violate [their] human rights."[1]

Despite their good intentions, they failed to address a central topic: the importance of organized crime in the reality of human mobility. Organized crime is only mentioned twice, in passing, in the Declaration. In stark contrast, the 2021 Global Organized Crime Index, funded by the United States and the European Union, concluded that human trafficking is the most lucrative activity for organized crime in the world. After comparing 193 countries, this index ranked Mexico fourth in levels of criminal presence worldwide.[2]

Therefore, I argue that governments, international organizations, and civil society organizations (CSOs) are only focusing on the symptoms of this problem: Governments believe they control their borders, international organizations apply criteria of international human rights law, and CSOs help people on the move and denounce the abuses they are subjected to. But they forget about the impact of organized crime on the equation.

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https://doi.org/10.1162/DAED_a_01994

Expanding on this statement, I first summarize some important events in North and Central America between 1979 and 2000. Then, I turn the focus to circumstances along the two Mexican borders during the twenty-first century in more detail, in order to recommend how we might address and improve the conditions of those locations in particular.

Migration in the Twentieth Century

Along both the northern and southern borders of Mexico, policies have been modified in response to profound shifts in the political systems and institutional framework of the territories between Panama and the United States. I mention some of the main changes in the region between 1979 and 2000 below.

In 1979, the Sandinista Revolution triumphed in Nicaragua, and the resulting turmoil spread to the rest of Central America. Although Mexico was supportive of the winds of change, Washington tried to stifle them in the belief that the international communist movement, represented by Cuba and the Soviet Union, lurked behind the insurgencies. The conflict was regionalized and bogged down for a decade.

In Mexico, the murder of U.S. Drug Enforcement Administration agent Enrique Camarena in 1985 led to the dissolution of Mexico's Federal Security Directorate in 1986. Its absence contributed to the empowerment of the drug cartels in the country. The political system was weakened further in 1994. In January of that year, the indigenous Zapatistas began their rebellion in Chiapas. In March, Luis Donaldo Colosio, the PRI (Institutional Revolutionary Party) candidate for the presidency, was assassinated. And in December, a terrible financial crisis devastated the Mexican economy.

Meanwhile, cocaine's popularity in the United States had increased exponentially. While President Richard Nixon declared the War on Drugs in 1971, President Ronald Reagan made it a centerpiece of his administration in the 1980s. Domestically, Reagan prioritized criminalization and punitiveness. In Latin America, Reagan focused primarily on the powerful Colombian cartels, which suffered a severe setback when, in December 1993, Pablo Escobar Gaviria, the leader of the Medellin Cartel, was executed on a rooftop in Medellin.

In 1989, the Berlin Wall was torn down, symbolically ending the Cold War. No longer worried about intercontinental missiles coming from the Soviet Union, the Pentagon reoriented its ROTHR (Relocatable Over-the-Horizon Radar); they were now charged with stopping Colombian cocaine coming through the Caribbean Basin. But consumers in North America would not settle for a disruption in their supply of cocaine, and the flow was redirected through Central America and Mexico, further strengthening the Mexican cartels.

In 1994, a new era began in the region with the North American Free Trade Agreement (NAFTA), which opened the borders to the exchange of goods. Car-

los Salinas, president of Mexico at the time, predicted that Mexico would export goods, not people. The country, however, began shipping out both. Exports from Mexico to the United States went from $51 billion in 1994 to $384 billion in 2021.[3] Between 1990 and 2009, the number of people born in Mexico residing in the United States almost tripled, from 4.5 million to 12.6 million.

A demographic revolution was brewing. In the 1980s, two events marked a radical change in the United States' admissions policy for countries in the Caribbean Basin. In 1980, Cuban President Fidel Castro played on a unique immigration policy resulting from the U.S. Cuban Adjustment Act of 1966 and shipped 125,000 Cuban people to the United States through the port of Mariel. And throughout that decade, the Central American revolutions displaced between two million and three million people, many of whom made their way to the United States through Mexican soil.

Human mobility is a part of Mexican identity. Currently, the Mexican diaspora in the United States is around thirty-six million first- and second-generation Mexicans, accounting for approximately 10.8 percent of the total U.S. population. These affluences created strong social and institutional fabrics to help migrants cross the border and defend their rights, as well as political and social infrastructure aimed at facilitating, promoting, and investing their "remesas" (remittances) into their communities of origin. People from Central America trying to reach the United States took advantage of these migratory networks built by Mexicans over decades.

The voyage was simpler then. Until the early 1990s, the border was not a real obstacle for those with relatively modest amounts of money. There was room for innovation, too. For example, one contribution of the Central American wars was the creation of an "underground railway" that carried politically persecuted people from Central America to a network of churches in the United States providing sanctuary for migrants and refugees.

But the age of open borders was coming to an end. In the 1990s, the United States began erecting physical, as well as bureaucratic, barriers on its southern border in an attempt to stop the flow of migrants and drugs coming into the country. At the same time, however, NAFTA continued to increase the flow of people and goods between countries.

Migration in the Twenty-First Century

At the dawn of the new century, the Mexican cartels had extended their power and attached themselves inextricably to state and social bodies in Central and North America. All the pieces were in place for them to take over segments of the Mexican borders.

Rodolfo Casillas, a researcher at the Latin American Faculty of Social Sciences in Mexico, did pioneering research on how the cartels began to control human

mobility in the country. The Zetas, a cartel created in the early 2000s by deserters of elite troops based in Tamaulipas, were the first to tap into it. Enforcing their military logic that territories should be controlled integrally, in 2004, they began to charge migrants who passed through their territory a fee. They – and their counterparts in other states – had discovered a gold mine.

That same year, the U.S. government declined to renew the ten-year ban on the sale of assault weapons signed into law by Bill Clinton in 1994. Hundreds of thousands of these military-grade weapons began to flow illegally into Mexico from the United States. In 2022, the Mexican Foreign Ministry estimated that 500,000 to 850,000 weapons are sent from the United States to Mexico every year. These weapons are used to arm the legions of "sicarios" – hired assassins – fighting each other for territories, called "plazas." Deaths and forced disappearances swelled in the country, as well as the risks for people on the move.

Between 2010 and 2012, the San Fernando and Cadereyta massacres took place in Mexico. Dozens of migrants, most of them Central Americans, but also from South American countries, were kidnapped and murdered at the hands of organized crime in the north. These massacres, widely reported by the media, finally put the issue of human mobility on the public agenda and raised awareness about the dangerous travel conditions of people crossing Mexico. Three key events took place in 2014, 2019, and 2020.

2014: Unaccompanied Minors

In 2014, President Barack Obama called the arrival at the U.S. border of tens of thousands of unaccompanied children and adolescents a "humanitarian crisis."[4] The infrastructure for housing families, children, and adolescents detained near the border with Mexico all but collapsed. The real crisis, however, was not in the north, but in Central America, where violence and inequalities were forcing people to emigrate. The United Nations High Commissioner for Refugees (UNHCR) and some academics and journalists documented this crisis with studies published in 2013 and 2014.[5]

The United States and Mexico focused on controlling and stopping migration by detaining migrants along their journey, and then deporting them back to their countries of origin. However, this strategy ignored the fact that large numbers of people on the move from Central America have international protection needs, which means that deportation to their home country would put their lives in danger. At the same time, both countries tried to dissuade these people from leaving their countries of origin in the first place by allocating some resources to address the economic causes of migration. But these efforts failed. Between 2014 and 2019, there was a steady increase in the number of immigrant detentions in Mexico, while asylum applications have grown apace.

The share of people in need of international protection within the mixed movements has also diversified. This led to the creation of support networks: churches, mainly Catholic; civil society organizations specialized in legal assistance; and international organizations such as the UNHCR, United Nations International Children's Emergency Fund (UNICEF), and International Organization for Migration (IOM), as well as some Mexican agencies such as the Mexican Commission for Refugee Assistance.

2019: Migrant "Caravans" and the Mexican Response

The obstacles put in place by Mexico and the United States did little to deter migrants from their purpose. Starting in 2018, they organized so-called caravans made up of thousands of people traveling from Central America to the United States. This attracted the attention of the media, and though the newly inaugurated President of Mexico, Andrés Manuel López Obrador, claimed a commitment to human rights, it put the new administration in a bind.

At the beginning, the López Obrador administration adopted a more humane policy: it granted visitor cards for humanitarian reasons that allowed foreigners to regularize their situation in Mexico, find a job, and travel through Mexican territory without being detained. But in 2019, the Trump administration gave Mexico a peremptory deadline to start detaining migrants, or else the U.S. federal government would impose tariffs on Mexican exports to the United States. Mexico was forced to give in and accept Trump's request to deploy 28,000 members of its National Guard to stop migrants from traveling to its northern neighbor.

Since then, Mexico has tightened its border policies and created various new obstacles to deter people from trying to get into the country. As the Mexican government's attitude toward migrants changed, the media began to broadcast images of Mexican police and military chasing down and throwing tear gas at men, women, and children attempting to cross the border.

2020: The COVID-19 Pause

The COVID-19 pandemic momentarily reduced population movements along the migratory networks created throughout Central America, Mexico, and the United States. At the same time, however, the pandemic aggravated already frail conditions in migrants' and refugees' countries of origin. Thus, when the most acute phase of the pandemic passed, these population movements surged again.

In 2021, Mexico reached a historic figure: It was host to more than one hundred thirty thousand asylum seekers, becoming one of the three countries with the most asylum requests in the world (the others were Germany and the United States). That same year, more than three hundred thousand people were detained

and deported from Mexico. Human mobility returned to prepandemic levels with an upward trend.[6]

The Standpoint of the Key Players in 2023

Mexico and its borders have become a territory of uncertainty and hope, a country trapped between two tsunamis. On one hand, domestic and international forces are advocating for greater migratory control, and on the other, there are demands for the humane treatment of migrants in accordance with international human rights standards. The positions adopted by the key players are described below.

People on the Move

Migrants and refugees will continue to arrive at the Mexican border because they suffer from criminal and political violence, persecution, poverty, inequalities, unemployment, and the devastating consequences of climate change in their countries of origin.[7] Their influx will continue to grow and diversify. A clear indicator of this is the increase in the number of people from different nationalities arriving to the Mexican southern border. In addition to migrants and refugees from traditional countries of origin – Honduras, El Salvador, and Guatemala – they are now coming from Haiti, Cuba, Nicaragua, and, more recently, Venezuela and some African countries.

Their desired destination, however, has changed. While it is true that most migrants and refugees continue to dream of reaching the United States, Mexico has now become an attractive country of destination, too. The reasons behind this shift are manifold: the strengthening of the asylum system in Mexico, more opportunities of integration in cities in the center and north of the country, the difficulties and dangers of reaching the United States, the high cost of guides and extortions along the journey, and the strengthening of the social networks of refugees and migrants who have established themselves in Mexico, and now call to their family and friends to join them.

Governments

Reacting to Washington's pressures, the Mexican government seeks to stop these migratory populations using a range of deterrents and detention and deportation measures. The Mexican southern border is a gigantic bottleneck. There are large concentrations of people in Chiapas and Tabasco waiting for administrative procedures of various kinds: visitor cards for humanitarian reasons, refugee status determination processes, and other alternatives for migratory regularization. According to official sources, 78 percent of asylum applications in Mexico in 2021 were made in those two states.[8]

The Mexican law on refugees, protection, and political asylum requires asylum seekers not to leave the state where they began their asylum procedures. If they do, their procedures will be considered abandoned and, therefore, they may be detained by the immigration authorities and put at risk of being deported.

Administrative procedures take a long time, and there is no clear criterion on the application of Article 52 of the Migration Law, which benefits bona fide asylum seekers because it grants the Ministry of the Interior power to authorize work permits.[9] However, people are obliged to wait for several months in southern cities, the most impoverished region of Mexico, before obtaining a resolution.

During these long wait times, they require humanitarian attention at various levels, which has generated pressure on the services provided by local governments and, above all, by the humanitarian actors, mainly civil society organizations, faith-based shelters, and international organizations.

The demographic pressure exerted by the presence of thousands of people waiting for their administrative resolutions to be able to travel to other states of the country has generated tensions in the host communities, which are of particular concern due to the outbreaks of xenophobia, racism, and discrimination in southern cities such as Palenque, Tenosique, and Tapachula.[10]

The situation on the northern border is similar, although some of the actors and laws are different. Until very recently, asylum seekers and migrants were trapped in a legal limbo created by restrictive immigration measures such as the Migrant Protection Protocols (MPP) and the implementation of Title 42, a policy the U.S. government established to limit the access of people by land by invoking the health emergency caused by the pandemic.[11]

These measures generated significant demographic pressure in some northern towns, because people who wanted to apply for asylum in the United States had to wait in Mexico for their status to be resolved. Some estimates state that, since the establishment of these procedures, more than seventy thousand people have waited in Mexico in a legal limbo. According to different organizations, this policy is contrary to international human rights and refugee law, because thousands of people are forced to live in contexts of violence and insecurity for an indefinite period of time.[12]

Moreover, migrants and asylum seekers at the Mexican northern border were forced to wait in a difficult situation. There is no adequate supply of health care for medical conditions or psychosocial care, no adequate referral to address cases of gender-based violence, no adequate assistance for unaccompanied children, and no adequate integration opportunities for the population. Furthermore, northern cities such as Matamoros, Tijuana, and Ciudad Juárez are rife with violence and insecurity. The constant influx of vulnerable people in irregular situations made for an explosive cocktail with disproportionate impacts on the protection of migrants, refugees, and asylum seekers with specific needs, such as children and adolescents, the elderly, and people with disabilities or chronic illnesses.

The Mexican government set up some shelters in these cities. However, as with the southern border, the bulk of the humanitarian services mentioned above is borne by civil society organizations, faith-based institutions, and international organizations.

In 2019, the change in administration in the United States brought with it an attempt to eliminate the MPP. It was reinstated by court order in December 2021 after the state of Texas sued the Biden administration, but in August 2022, the U.S. Supreme Court finally shut it down, putting an end to an unlawful practice that affected thousands of asylum seekers.

Criminals

Governments have prioritized migrant control, while minimizing the effect of criminal groups that have proliferated in Mexico, even though they have a constant and pervasive presence in the migration process.

This oversight results in tragedies, primarily caused by the inhumane conditions smuggling networks cause.[13] In 2021, more than fifty Central American migrants lost their lives after the overcrowded trailer in which they were traveling suffered an accident in Chiapas, Mexico. In June 2022, U.S. authorities discovered an abandoned trailer with the packed bodies of fifty-three migrants in San Antonio. According to Mexico's Immigration Commissioner, those migrants boarded the trailer in U.S. territory. If so, it would confirm that criminal gangs also operate in the United States. In any case, tragedies like these abound.[14]

Nonetheless, there has not been a significant number of arrests of people involved in human trafficking, nor is there comprehensive intelligence work to deal with this scourge. Although it is true that, in recent years, there have been joint pronouncements and regional commitments to attack human smuggling, the truth is that, at implementation levels, criminal networks continue to operate freely all over Mexico.

Without a doubt, people on the move are a gold mine for criminal bands. Some reports estimate that, depending on where their trip begins, each person pays on average more than USD 7,000 to try to reach the border with the United States.[15] While it is impossible to establish exactly how many people employ smugglers for their journey, there are some indicators, like the number of people detained on the southern border of the United States or throughout Mexico.

In 2021, there were more than 1,300,000 southwest land border encounters by the U.S. Border Patrol.[16] In Mexico, during the same period, the National Migration Institute detained 300,000 people. This means that more than one million people managed to slip through Mexican filters. According to the United Nations Office on Drugs and Crime, "it is estimated that two of the principal smuggling routes – leading from East, North, and West Africa to Europe and from South

America to North America – generate about $6.75 billion a year for criminals. The global figure is likely to be much higher."[17] It goes without saying that Mexico's porosity requires the complacency of Mexican authorities of different levels.

International Organizations and Organized Society

International officials and members of CSOs focus on humanitarian attention, but are unable to offer structural solutions. Theirs is a fundamental work on immediate attention, but they have a meager capacity to influence government policies or contain criminal activities.

Despite their limitations, the humanitarian operations of nonstate actors (nongovernmental and international organizations mainly) play a key role in migrant and refugee protection. They fill in many of the gaps left in place by the state, making it possible for refugees, migrants, and displaced persons to access services such as water, food, and shelter. Their presence also limits the exploitation and hardships imposed on them by criminals and corrupt officials throughout their journey. Moreover, they provide support in their dealings with Mexican authorities. In the United States, some international organizations also provide them with counseling.

In addition, these organizations transmit information to the international community. Thanks to them, we are becoming increasingly aware of a situation stated tactfully by the UNHCR: "given an increasing number of obstacles to access safety, asylum-seekers are often compelled to resort to smugglers."[18]

Recommendations for the Future

In the way of a preamble, I mention some of the factors I believe will remain stable in the coming years.

A perfect storm is brewing at the Mexican borders. On one hand, conditions in countries of origin – Venezuela, Nicaragua, Cuba, Haiti – are erupting in violence, crime, and the degradation of the environment. On the other hand, sociologists studying human mobility to the United States and Mexico found that social networks and the presence of civil society organizations and international organizations give those in transit hope that they will find safe haven. In short, Mexico will continue to be a magnet for migrants and refugees trying to reach the United States, or Mexico itself.

Conditions in the United States make it impossible to return to the open-borders era. Migrants and refugees are "pawns" in societies devastated and polarized by the culture wars. The Mexican government has chosen to collaborate with Washington in stopping migrants before they reach the United States.

Criminal networks will continue to profit from human mobility. The United Nations Office on Drugs and Crime is extensively reporting on the issue, because

human smuggling in Mexico is growing rapidly. In other words, more people with international protection needs mean more money to criminal structures. Expanding on this thinking, I believe this suggests that criminal groups are not only increasingly benefiting from migratory movements, but are also driving them.

Based on these constants, what would be the most viable policies to reduce the human costs paid by migrants, refugees, and asylum seekers? Mexico and the United States have the resources to enact a more humanitarian policy. With this in mind, the challenge is to make thoughtful recommendations for the 2024 presidential campaigns in Mexico and the United States. This is a propitious moment to propose major adjustments to these countries' migratory and asylum policies.

Recommendation 1

Those of us who wish to alleviate this humanitarian tragedy believe that insecurity caused by criminal gangs is a point of consensus between the right and the left in the United States and Mexico. This understanding must become the lever to prioritize the fight against criminals who benefit from exploiting people on the move. Liberating migrants from organized criminal enterprises would fulfill the goal of respecting human rights while attacking the power of illegal gangs.

Recommendation 2

In recent years, the Mexican Commission for Refugee Assistance has increased and improved its processing capacity in localities in the south of the country, especially in Chiapas. However, other migration regularization alternatives should be explored for all people who do not necessarily have international protection needs, yet want to remain in Mexico. Toward the end of 2021, after his visit to Mexico, the United Nations High Commissioner for Refugees, Filippo Grandi, "stressed the importance of finding migratory alternatives for people who do not require international protection."[19] Therefore, comprehensive solutions must take into account the current regulatory frameworks and operational capacities of a large number of state institutions and humanitarian actors on the ground.

The backlog in the issuance of migratory documentation must be reduced so that migrants, refugees, and asylum seekers can leave the southern states of Mexico quickly without fear of detention and deportation. Otherwise, they will continue to use smuggling networks or venture to move around the Mexican territory without valid documentation. In other words, I propose administrative reforms to allow people both to start their procedures in southern cities and conclude these procedures in the center and north of the country, which are the main objective points of the vast majority of people who access Mexico by land and envision this country as their final destination.

This would depressurize the region in demographic and socioeconomic terms, and alleviate the tension of frontline humanitarian services. Likewise, it could ease the integration of refugees and asylum seekers in Mexico, lessening the profits for smuggling networks.

Recommendation 3

Acknowledging that Mexico is and will be a country of destination highlights the need to know how many migrants Mexico is prepared to welcome, and what resources it will need to do so. In other words, we need to know where the country's receiving capacity stands.

Recommendation 4

Knowledge about the role of organized crime must be incorporated in the study of the migratory phenomenon in the twenty-first century. For example, a risk map with the protection of migrants and refugees in mind would be very useful, considering the presence of cartels along migratory corridors. We must use humanitarian intelligence to better inform and guide populations in mobility as they travel, especially related to the threats of organized crime.

Recommendation 5

Mexico and the United States have the capacity to initiate the intellectual and institutional efforts to update the agenda around the migratory phenomenon in the Caribbean Basin. Evading the presence and impact of organized crime within the phenomenon is useless. In order to neutralize a threat, we have to understand it.

In short, international experience suggests that a balance could be found, on one hand, by respecting and strengthening border security, and on the other, by respecting the human rights of people on the move, in particular, by deploying large-scale humanitarian responses that can alleviate the suffering of thousands of people who leave their country of origin in search of a better future.

AUTHOR'S NOTE

I appreciate the comments and suggestions made by Emilio González González to this text. His participation was indispensable. The opinions, statements, and conclusions are of my authorship. This essay was originally written in Spanish. I thank Sandra Sepúlveda for translating this essay into English.

ABOUT THE AUTHOR AND TRANSLATOR

Sergio Aguayo is a Professor at the Centro de Estudios Internacionale, El Colegio de México, and a Visiting Scholar at the FXB Center for Health and Human Rights in the Harvard T.H. Chan School of Public Health. He is the author of numerous books, academic essays, and journalistic op-eds on political and criminal violence, democracy, human rights, and refugees.

Sandra Sepúlveda is a Classical Philologist with an MBA in Cultural Institutions Management from Universidad Complutense de Madrid. She is a freelance editor, publisher, and multilingual translator. She has translated over one hundred books and articles. She currently lives in Mexico City with her husband, eight-year-old son, three dogs, and a cat.

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Aleppo Diary

Fouad M. Fouad

Translated from Arabic by the author and Norbert Hirschhorn

1.

Writing hurts.

The blood dripping down the TV screen
poisons the air,
stains the couch with what looks like
dried coffee. We touch, trembling,
afraid of infection.

Our backs bent as if descending to hell,
red and brown rust spots
reflect on our faces.

We rub our heads, turn away,
and lick the salt from tears.

They who crawl from street to screen
leave green traces on the tarmac,
which burst into bushes of basil.
They throw us a flower and die quickly
to spare us from shame.

Take off your shoes, walk on broken glass,
for now you are in a sacred valley.

2.

I sit on my balcony. Aleppo, spread before me, black and deserted. A clatter of dishes in the dark means life does go on. No other sound save sporadic gunfire somewhere distant until a peculiar whistle before the shell explodes. Someone leaves this earth with a dry throat. Aleppo before me

remains black, and still. Those huge shadows might be trees, or childhood goblins or black vapours exhaled by women waiting for their children, they already numbers in a news bulletin.

3.

Perhaps a time to water plants growing
by a fallen wall, a shattered alley
in the black-and-white city named Aleppo.

In the gap between two houses, a sparrow
trembles in a child's hand, and a sniper
combs his pomaded hair behind a stack

of books shielding against death from the sky.
Inside the church an angel, wings outstretched,
pierced by tears and bullets, and a boy

smutched with dust, laughing. The sniper sucks
seeds from a pomegranate, lets his rifle
rest against a wall. In Aleppo.

In Aleppo, Death grows in alleys like a
rotted plant, pours from the sky:
nuts, bolts, TNT and chlorine.

Death stares into the mirror
for one moment, turns, sights,
pulls the trigger.

People on bread lines know all this.
Also children reciting in school.
And a hunchbacked old man.

"Aleppo Diary" was published by The Hippocrates Press as part of Dr. Fouad's poetry collection, Once Upon a Time in Aleppo *(2020). For permission to reprint Fouad M. Fouad's "Aleppo Diary," grateful acknowledgement is made to The Hippocrates Press, London, UK. The poem has also appeared in* ArabLit Quarterly *and the anthology* The Hundred Years' War *(Bloodaxe Books, 2014). Dr. Fouad would like to extend his appreciation to his friend and co-translator, Dr. Norbert Hirschhorn, for "masterfully translating his original Arabic poems to make them read as if they were originally written in English."*

ABOUT THE AUTHOR AND TRANSLATORS

Fouad M. Fouad is Associate Professor of Public Health Practice at the Faculty of Health and Sciences at American University of Beirut and Co-Director of the Refugee Health Program at the Global Health Institute. His research focuses on the forced displaced population with a special interest in the Syrian refugee crisis, as well as the impact of this crisis on the health and the well-being of the Syrian population. He is the author of *Once Upon a Time in Aleppo* (2020).

Norbert Hirschhorn (co-translator) is a physician specializing in the public health of women, children, and communities in the United States and developing countries. He is the author of several collections of poems, most recently *Stone. Bread. Salt.* (2018), and the co-translator of Fouad M. Fouad's collection *Once Upon a Time in Aleppo* (2020).

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https://doi.org/10.1162/DAED_a_02005

In Their Shoes: Health Care in Armed Conflict from the Perspective of a Non-State Armed Actor

Ann-Kristin Sjöberg & Mehmet Balci

The protection of health care in armed conflict dates to the 1864 Geneva Convention. Yet violations of international humanitarian law related to the protection of health care occur on a near daily basis, and conflict actors continue to obstruct health care actors from assisting people in need in conflict areas. An estimated one-third of the recorded threats affecting health care are attributed to non-state armed actors (NSAAs). Yet given that many NSAAs themselves do in fact provide and facilitate health care, this essay considers NSAAs not just as threats but, in line with international human rights law, also as potential facilitators, providers, and promoters of health care. We discuss the specific case of Northeast Syria, where one NSAA has de facto control of the territory, and examine the level of involvement of NSAAs in the respect, protection, and provision of health care. We also explore some opportunities and challenges in engagement between humanitarian actors and NSAAs on health care provision, with an emphasis on seeing health care from the perspective of the NSAAs themselves.

In addition to the devastating casualties caused worldwide in armed conflicts every year, a broader set of negative health effects plagues the populations in conflict areas. These include "long-term physical disabilities and mental health problems, increasing rates of epidemic diseases, substantial reductions of public health budgets, the departure of trained medical professionals, and the interruption of medical and food supplies."[1] The right to heath care in conflict areas and the protection of health care facilities and providers in armed conflict date back to the very first Geneva Convention of 1864. Yet we read about violations of international humanitarian law (IHL) – including access to health care – on a near daily basis.

An estimated one-third of the recorded threats affecting health care are attributed to non-state armed actors (NSAAs).[2] In order to address the impact of these NSAAs on civilians in conflict, an entire "engagement" or "negotiation" industry has developed, dedicated to improving the efforts of the international community to influence these conflict actors, to reduce abuses, and to advance

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https://doi.org/10.1162/DAED_a_01995

protection. This essay investigates whether turning the equation around and seeing health care provision from the perspective of the NSAAs themselves can assist in improving the provision of health care in conflict settings. NSAAs do provide and facilitate health care, but what are *their* challenges, opportunities, and interests when doing so?

In addressing this question, we join a growing effort to consider NSAAs not just as a threat to health care delivery, but also as facilitators, providers, and promoters of health care, with their own objectives, strengths, challenges, and weaknesses.[3] We also acknowledge that contemporary NSAAs are operating within a context of multiple actors and situations of nonrespect of IHL and standards related to health care provision.[4] By consulting both academic and policy literature on NSAAs, and based on our own direct experience as founding directors of Fight for Humanity, we aim to contribute to more effective engagement with NSAAs on health care provision, particularly in places where an NSAA has stable control of territories (full or partial). More specifically, we draw on Fight for Humanity's work in Northeast Syria (NES) on child protection, where we were asked by the Syrian Democratic Forces (SDF) to support the development of their own policies for the protection of health care, as well as to improve their understanding of the broader humanitarian context, including interactions with humanitarian organizations.[5] Given the situation of de facto control, the focus in this essay is on health care provision in an emergency and conflict situation, but where the main problems are linked to administrative, legal, and political issues, rather than the armed conflict itself or military attacks on health care by NSAAs.[6] In short, the NSAA is controlling (most of) the health care facilities, and as such, there would be little incentive for them to attack them.

To better understand challenges to health care provision from the perspective of an NSAA, we consulted with the civilian wing of the Autonomous Administration of North and East Syria (AANES) and the SDF, its military wing. In the analysis, we draw upon written questionnaires and messages exchanged with both the AANES and the SDF.

Academic literature and institutional practice have increasingly accepted that NSAAs have human rights responsibilities, at least when they control territory or exercise some form of governmental authority.[7] Our own position, argued elsewhere, is that there can be no gap in people's rights, and that therefore if the state is not able or willing to provide for the rights of a population, NSAAs controlling territory can and should do their utmost to do so, directly or indirectly.[8] As a conceptual framework for identifying NSAAs obligations in the domain of health care provision, we employ human-rights activist and academic Daragh Murray's "respect, protect and fulfil[l] framework."[9] Murray sees these three levels of obligations as interdependent, as shown in Table 1.

Table 1
Levels of Human Rights Obligations

Level	Description	Application
Respect	A negative obligation, under which the NSAA needs to refrain from activities that result in violations of international human rights law (IHRL). *Example:* NSAAs should not attack medical staff, vehicles, and facilities.	To all NSAAs. These obligations are equivalent to IHL obligations.
Protect	A positive obligation, which requires that third parties (both individuals and collectives) do not violate individuals' human rights. This is both a preventive obligation, such as in establishing a legal framework or rules, and at times a "remedial" obligation, when a violation has occurred. *Example:* NSAAs should make sure that certain groups, such as minorities or women, are not hindered from accessing health care facilities.	To some NSAAs. This obligation increases to the extent that an NSAA displaces the state authority and takes control of a territory.
Fulfill	A positive obligation to undertake measures to secure the realization of human rights standards. This is a higher level of obligation that can be understood through three elements: *fulfilling as facilitating*, positive measures to assist individuals and communities to enjoy the right to health care; *fulfilling as providing*, directly ensure the provision of the right to health care; and *fulfilling as promoting*, such as health campaigns.	To some NSAAs. Like the obligation to protect, the obligation to fulfill increases as the NSAA displaces the state authority. The level of obligation entailed in fulfilling human rights will also depend on the resources available.

Source: Authors' compilation of data, based on Daragh Murray's research. Daragh Murray, *Human Rights Obligations of Non-State Armed Groups* (Oxford: Hart Publishing, 2016), 181, 182, 189.

Notably, this disaggregation of obligations helps Murray to develop a "division of responsibility" between the state and the NSAA, with the state retaining "the overall responsibility for securing human rights obligations within the national territory."[10] In the cases in which the state cannot fulfill by providing, it should fulfill by facilitating. Thus, the state can never claim that full responsibility for meeting human rights obligations can transfer to an armed group. In line with Murray, we start from the assumption that the responsibility for health care provision lies primarily with the state, but can also be borne by an NSAA.

Here, a link can be made to the concept of "rebel governance," which in international law and human rights scholar Katharine Fortin's words refers to "the provision of public goods and the establishment of norms and rules regulating daily life in territory controlled by armed groups fighting in opposition to the government."[11] In terms of health care, the "public good" includes a spectrum of services: from military medics providing emergency care to the war-wounded, to the provision or facilitation of a variety of services such as maternity and neonatal care, regular check-ups, and surgeries. The public good can also be provided to a range of beneficiaries, including wounded armed actors and police forces; "regular" civilians including minorities, such as women, children, and people with disabilities; refugees and internally displaced people (IDPs); and detainees.

Murray considers health care as an example of a generally "resource intensive service" that may require interactions with the territorial state or other third parties for which "significant resources are required" to train and employ health care professionals, to maintain and operate equipment, machinery, and facilities, and to provide health education.[12] Indeed, political scientists Reyko Huang and Patricia L. Sullivan find that NSAAs that receive external funding, weapons, or training are significantly more likely to provide education and health services to civilians.[13]

The obligation to respect, by contrast, is more dependent upon conduct than upon resources or capacity.[14] In fact, the human rights obligation to respect health care does not go much beyond IHL obligations, notably the prohibitions against attacks on health facilities, vehicles, and personnel; sparing and aiding the wounded; allowing health personnel to operate independently according to the principles of IHL; and not disrupting supplies and services for health facilities. There are some existing tools for NSAAs to commit to the protection of health care, which are discussed elsewhere in this volume.[15]

The obligation to protect requires some capacity and resources – as well as territorial control – in the sense that NSAAs should, following Murray, assure that the health workers in the territories they control meet professional standards (in terms of education, skills, and conduct), and that third parties and harmful practices do not limit access to health care services (by providing and enforcing a regulatory framework on health care).[16]

At the end of the spectrum, fulfillment by provision can entail an NSAA assuming a state-like level of responsibility in relation to fulfillment of the overall right to health. One advantage with this, as Murray argues, could be the continuation and further development of the existing health system, rather than the establishment of a parallel system by humanitarian actors.[17] There are also many examples of NSAAs that have been providing health care services to the populations when controlling or partially controlling territory.[18]

Yet there are also less resource-demanding ways for NSAAs to fulfill obligations in the health domain. Fulfillment by facilitation can be achieved through sharing information about health needs, coordinating action, or simply allowing access and operations. With respect to the latter form of fulfillment, NSAAs have allowed humanitarian access all over the globe, in contexts as diverse as Myanmar, Sri Lanka, Sudan, the Philippines, Mozambique, Somalia, Sierra Leone, Yemen, and the former Yugoslavia.[19] NSAAs can also fulfill obligations by promotion, for example, through public health campaigns. While this aspect is not well documented in existing literature, examples have been plentiful during the COVID-19 pandemic and have been recorded in Geneva Call's COVID Response Monitor and by the International Committee of the Red Cross (ICRC).[20]

The Taliban (until August 2021) is a case in point of fulfillment by facilitation. As argued by political scientists Ashley Jackson and Rahmatullah Amiri, the Taliban were largely open toward the provision of health services, particularly as a response to strong demand from the local population, and religious leaders could find no grounds to restrict access to health care – in contrast to other sectors, such as education, where access and provision were more restricted.[21] For this purpose, they proactively engaged external actors and sought support to continue operating the health care system. Reportedly, the Taliban welcomed the opportunity to engage in health care provision and saw it as a priority, allegedly to show able and legitimate governance.[22] Two conditions were nevertheless imposed on access: no credit should go to the Afghan government, and clinics should have no association with progovernment forces. Jackson and Amiri find that the relatively permissible attitude of the Taliban was largely related to the political and military pressure that its leaders were facing and their wish to respond to community demands for greater access to services, especially after 2014.[23]

In some conflict contexts, territorial control is split, and health services are provided by competing actors in the same territory.[24] Political scientist Marta Furlan stresses that, to benefit from existing expertise, personnel, and infrastructures, and to be able to respond to people's needs without paying the (full) costs of direct provision, NSAAs might choose to cooperate with local or regional government structures.[25] The state may accept this arrangement in order to keep a presence in, and a link to, the territory and the population. This means that conflict actors may coordinate – directly or indirectly – in the provision of health services.

In other cases, where they do not, the consequences for civilians of receiving services from one conflict party can be dire, as actors may retaliate against them for having chosen "the other side." For example, in areas controlled by the Liberation Tigers of Tamil Eelam (LTTE) in Sri Lanka during the civil war, non-state and state actors did cooperate, with the LTTE providing primary health care to the civilian population, and the government continuing to supply the hospitals and pay salaries.[26] Still, the major government-run hospital in Kilinochchi remained under-resourced (fifteen doctors per one hundred fifty thousand people and with limited supplies), meaning that in the most serious cases patients had to travel to government territories for treatment.[27]

There is little available data on the motivations driving NSAAs' participation in or tolerance for health care provision. However, a 2016 study on NSAAs' perceptions of the broader concept of humanitarian action revealed positive NSAA attitudes, with members of these groups claiming that they strove to enable humanitarian access and wanted aid to be deployed in areas under their influence or control.[28] It was noteworthy that the NSAAs interviewed believed that they had fewer obligations to provide aid, as compared with the obligations of the state. Finally, and importantly, many of the NSAAs reportedly explained their core rationale for facilitating humanitarian action as being one of both self-interest and concern for civilians.[29] In what follows, we focus less on asking why NSAAs would respect, protect, and fulfill the right to health care in conflict settings, and instead ask why they are *not* doing so, given the range of benefits such provision could offer. In short, we seek to identify barriers to their provision of health care, by analyzing data from our surveys and consultations with the SDF and the AANES in Northeast Syria.

Northeast Syria comprises most of the Raqqa and Hassakeh governorates and the territory of the Deir ez-Zor governorate east of the Euphrates River. The population has been estimated at 2,400,000. This territory is controlled by the AANES as the de facto authorities, of which the SDF is the armed wing. There is also a Syrian military presence in some areas, most notably in the cities of Qamishli and Deir ez-Zor. The health system is under the control of the AANES Ministry of Health through regional health committees, except in Deir ez-Zor, where it is overseen by "a coalition of NGO workers and UN representatives."[30] The SDF takes part in the coordination of the regional health committees.[31]

Overall, the war has largely destroyed the health sector. In addition to deliberate attacks on health care facilities and personnel, insufficient attention has been paid to the impact of the years of conflict, human rights violations, and collapse of health systems on health and health care delivery.[32] Areas under NSAA

control host many of the IDPs and have fewer resources, yet also experience more significant public health problems: 55 percent of households in NES reportedly have at least one disabled member, and the lack of doctors and other specialized personnel is staggering.[33] Attacks on health care facilities are currently rare, but remain an underlying threat.[34] Security considerations impact access to quality health care by limiting the training of health care workers to areas under direct AANES oversight and where nongovernmental organizations (NGOs) can operate in more secure conditions (such as Al-Hasakah and Qamishli).[35] Finally, the lack of coordination among humanitarian actors, local organizations, and local actors overseeing health systems (that is, the AANES) has negatively impacted population health.[36]

Health workers on the ground have indicated that wounded SDF members have been admitted into regular hospitals for emergency cases and have then been visited by other armed members, hence putting the nonmilitary status of hospitals at risk. The treatment of wounded ISIS fighters, who were guarded by armed SDF members, has generated related problems.[37]

In addition to these difficulties, political struggles between the AANES and the Syrian government makes the environment particularly challenging for humanitarian actors.[38] Since January 2020, NES no longer has direct access to UN humanitarian aid, which exclusively comes from areas under the control of the Syrian government, making it dependent on the will of the government.[39] Only 31 percent of medical facilities in NES are benefiting from assistance, meaning that medication is scarce and limited to simple treatments, and its access unreliable.[40]

Thirty-seven local health-sector organizations are operating in NES, of which the most active is the Kurdish Red Crescent (not affiliated with the International Red Cross and Red Crescent movement), in coordination with and supported by international NGOs. In the absence of a UN coordination mechanism on the ground, the so-called NES Forum oversees all health sector responses.[41]

Structural discrimination specifically puts the health of women and girls and people with physical disabilities at risk.[42] For example, specialized medical services for women and girls are largely lacking, and are mainly limited to routine reproductive health visits and family planning. Due to the lack of skilled obstetricians and midwives, many women opt for caesarean sections. In addition, women and girls face formal and informal barriers to accessing health care, including access to female providers, who are rare. Moreover, women across Syria often need to be accompanied by their husbands or male relatives when they travel to access health services. Even female health care workers may be stopped at checkpoints and prevented from reaching patients if they are not accompanied by a male family member.[43]

All health-service provision by the SDF/AANES is shaped by a structure that includes the SDF's military instructions and rules, the existing regulatory frame-

work established by the AANES, the health care committees and institutions run by the AANES, and a set of relationships with other stakeholders engaged in health care, such as local and international NGOs.

The SDF military instructions on the protection of health care, adopted in 2021, are detailed and stretch far beyond many existing NSAA policies. In addition to calling on members of the SDF to respect and protect the wounded and sick without discrimination and regardless of affiliation, and actively support and facilitate their access to health care, they call for the respect and protection of all health care personnel, facilities, and medical transports. The instructions are presented within the frameworks of international law (IHL and human rights law) and the "relevant law" of the AANES, and pledge to coordinate and cooperate with civilian authorities and relevant humanitarian and development actors.[44] According to the SDF, the instructions have helped them frame their policies on health care, and they have been disseminated to all forces. In March 2021, while the instructions were being prepared, a specific incident in which the SDF entered, searched, and conducted arrests inside a hospital in Deir ez-Zor linked to ongoing military operations against ISIS reportedly proved to be a lesson learned for the SDF, and this "has not been repeated" since.[45] Notably, the preamble of the instructions argues that "any incident threatening or affecting health care provision not only jeopardizes the lives of those directly concerned, but also risks negatively impacting curative, promotional, and preventative health care programmes, putting at risk the universal right to health of the population."[46]

The framework that regulates the provision of health care in NES is defined and overseen by the Health Committee – established by the AANES to improve the health sector and the right to health care – and the Public Health Law. The law was drafted in coordination with "all institutions and parties working in the health sector."[47] The right to health – defined as "a physical, mental, and integral social well-being" – is integrated into the "Basic Declaration around the Rights of the NES populations to health care."[48] This echoes the SDF military instructions, of health as a universal right, belonging to the population as a whole, without prejudice or discrimination.[49] The AANES Health Committee asserts that "provision of good quality health care is one of the obligations and duties of the self-administration and the achievement of this service means development, success, and acceptance of the self-administration."[50] It argues that it has the task to work toward improving living conditions for the populations of NES, of which one of the priorities is "the provision of primary health care to all people in a fair, just, and internationally acceptable manner," free of charge.[51] This requires multidisciplinary coordination among different sectors regarding health-related issues, and, as a future goal, ownership of the populations.

Concerning the provision of health care services and its current organization and structures, the Health Committee explains that health care services are pro-

vided directly to beneficiaries through health institutions, such as the nineteen existing hospitals and one hundred and ten clinics. Health care provision is regulated through a decentralized system of (local) health committees and bodies with their own administrative structures and in line with the vision of the Health Committee in NES.

Concerning health care services for persons in IDP and refugee camps, this falls under the direct supervision of the health subcommittees and bodies, and the services are "provided with the aid of some NGOs working in the camps in the NES."[52] In terms of health care for detainees and prisoners, they are "allowed decent health care in the places where they are held, and the Office of Justice and Reforms supervises the provision of health care to this category."[53] In relation to persons with physical disabilities, a section for the provision of prostheses has been set up. [54] Concerning military victims, the SDF has its own health committee, the Military Health Committee, which is responsible for providing health care to wounded combatants, from the field to rehabilitation.[55]

In terms of relationships with other health care actors, such as local and international NGOs, and the facilitation of the provision of health care services by these actors, the AANES explains that there are many NGOs working in the medical domain and that their work is conducted in centers belonging to the Health Committee, according to defined workplans and agreements. International NGOs train the existing medical staff to fill their knowledge gaps. There is a platform for communication with all organizations working in the medical sphere and they reportedly hold periodic meetings, supervised by the joint presidency of the Health Committee, for the discussion of all medical issues.[56] The AANES sees the relationship with international NGOs (for the provision of health care services) as important as these are bridging "a gap" resulting from "the destruction of health sector infrastructure in many areas."[57] When asked how engagement with other stakeholders, such as humanitarian NGOs, could be improved, the Health Committee points to the need for improved dialogue and coordination through "channels of communication" with international organizations and agencies working in the medical domain "according to official principles meant to secure provision of health services and in accordance with official protocols."[58] More recently, the SDF has also expressed a wish for increased coordination with humanitarian NGOs on "who does what" and the existing health care needs.[59]

In terms of existing barriers to health care provision in this NSAA-controlled territory, the AANES Health Committee stresses the general debilitation of the health care system because of the ongoing war and the severe shortage in medical supplies, equipment, and facilities. The closure of all international border crossings, it argues, leads to the blockage of the delivery of medical and humanitarian supplies, making it very difficult "to rehabilitate health facilities and put them in action."[60] In addition, it sees the lack of financial resources and capacities as seri-

ous challenges, adding to the situation of displacement and migration of medical staff, especially doctors. These limitations mean that the AANES Health Committee can only provide for the more urgent needs. The challenge remains for grave cases, for which local solutions are not available or not sufficient. In the words of the Health Committee, "they [people] decide to go to areas outside our control like Damascus and the Kurdistan Region [of Iraq]. Of course, they face a lot of trouble in terms of access to those locations and they suffer financially, not to mention the security risks involved."[61]

The health care provision and/or facilitation in NES has also been significantly affected by the COVID-19 pandemic, which accentuated the existing difficulties. The AANES report taking a number of measures (for example, the closure of all border crossings, installation of medical centers to test all people entering NES, setting up a lab running tests twenty-four hours a day, establishing quarantine centers where patients also received treatment, and imposing full lockdowns), which made NES one of the least affected areas in Syria. However, challenges remained due to limited resources and the difficulty of getting vaccines into NES.

From the perspective of the SDF, a main challenge in adhering to norms concerning the protection of health structures, they argue, is the fact that "the enemies don't have such policies" for the respect and protection of health care. Hence, they argue, "we can become defenders of the hospitals, but then we also put them at risk. We try to evacuate [our forces] as much as we can."[62] Providing health services to wounded combatants is another serious concern for the SDF, with more than thirty thousand war-wounded, of which some cases are grave (three thousand have hindered mobility). The military hospitals dedicated to caring for these patients have limited capacity to do so. While these hospitals are performing some surgeries, there are some health issues they cannot respond to. As the SDF summarizes it: "We need either the technical means to respond here, which we don't have, or to take them to other countries, but we don't have this capacity," referring to the financial, administrative, political, and other obstacles to bringing their combatants for treatment abroad.[63]

The above perspectives from the armed and civilian wings of an NSAA – the SDF and the AANES – enhance our understanding of how an NSAA in this particular context seeks to respect, protect, and facilitate the delivery of health care, and some of the barriers that hinder their ability to do so. We summarize these in Table 2.

In summary, and as described above, the SDF has a comprehensive policy in place to respect and protect health care. In addition, a regulatory framework concerning peoples' right to health care without discrimination is in place in NES, through the work of the AANES. There are also local structures to organize and structure health care provision, although they are limited in the provision of many critical health care services by their capacity and resources. There are sev-

Table 2
Levels of Obligations on Health Care Applied to the SDF and the AANES

Level	Description	Application
Respect	Policies respecting health care	SDF military instructions prohibit attacks on health care facilities, vehicles, and personnel.
Protect	Policies protecting health care	SDF military instructions require active support and facilitation of health care.
	Regulatory framework on health care	AANES regulatory framework is in place to protect the universal right to health care. External factors still limit access, for example, for women (especially cultural patterns linked to gender). Training for health care staff to ensure the quality of health care is undertaken but limited by a number of factors (security, resources, capacity).
Fulfill	Provide: direct provision	Existing structures for general health care provision in NES (AANES Health Committee) and also for wounded combatants (Military Health Committee).
	Facilitate: provision by other stakeholders	A number of national and international organizations and agencies are involved in health care provision.
	Promote	This was not explicitly mentioned in interviews and consultations, but the AANES, as part of its anti-COVID efforts, undertook many public health campaigns.

Source: Authors' interviews and consultations with representatives from the AANES and the SDF.

eral national and international stakeholders that work on health care provision in NES – helping bridge an important gap in the service provision – with whom the AANES and SDF actively coordinate. Nevertheless, both the AANES and the SDF expressed a wish for improved coordination and communication with international organizations and agencies working in the medical domain.

In the course of our research, the AANES and SDF identified several challenges to the provision of health care. To contextualize and interpret their views, and identify some potential opportunities, we draw on and adapt some of the existing literature – from both scholarly and policy sources – on the difficulties experienced by humanitarian actors when attempting to engage with NSAAs. Some of the key challenges featured in this literature include the "criminalization" of certain territories, actors, and humanitarian engagement, the constraints set by concerned states (meaning those involved in an armed conflict), difficulties in communication and negotiations between humanitarians and NSAAs, difficulties of coordinating with the NSAAs on needs and priorities, limited capacities of NSAAs, security risks for those involved in the engagement, and the lack of compliance with IHL by other conflict parties.[64]

Interestingly, as Table 3 shows, some of the challenges faced by humanitarian actors in engaging with NSAAs can also be reflected in the barriers NSAAs face when attempting to deliver health services. Column A lists challenges that have previously been identified in the literature. Column B elaborates on how these challenges affect humanitarian engagement with NSAAs, while Column C specifies how the challenges play out in the health domain. Column D then turns the challenges around to show how they manifest for NSAAs seeking to provide health care in Syria, as identified in the case study. Finally, Column E proposes opportunities for engagement between humanitarian actors and NSAAs in overcoming these challenges.

As Table 3 indicates, there is a certain coherence in some of the challenges facing humanitarians seeking to engage with NSAAs and the challenges faced by the NSAA subject to our case study. This does not mean that these are all the issues facing these two actors, but that there could be certain shared interests that, if addressed, could overcome barriers to health care provision in NSAA territory, for example, those relating to improved communication, coordination, and addressing issues linked to limited capacities and resources in these territories.

We have shown that NSAAs have been enabling the right to health care in very different settings all over the world. We have explored the efforts of one NSAA in Northeast Syria to ensure the access to health care for the population under its control, by considering its actions at all three levels of human rights obligations: respect, protect, and fulfill. The efforts of the SDF and AANES to act across the three aspects of its obligations demonstrate that NSAAs,

Table 3
Challenges for NSAAs in Health Care Provision and Opportunities for Engagement

A	B	C	D	E
Engagement challenge	**Description**	**Health care specific implication**	**Challenge for the NSAAs**	**Opportunity for engagement**
1. The criminalization of territories, actors, and engagement	Terrorism legislation places sanctions on NSAAs and/or areas under their control and restricts operations and prohibits material support to NSAAs, potential arrest of local and international staff.	Some cases involving medical doctors being imprisoned and/or censured for providing medical care to wounded fighters belonging to NSAAs listed as terrorist organizations, despite clear IHL rules allowing for such work.	Difficulties in treating wounded fighters, especially due to anti-terrorism legislation.	Shared interest to overcome the challenge associated with criminalization. *Action*: Continuous engagement with third-party states, notably donors and supportive/sponsor states on the dangers of such an approach.
2. Concerned states	Reluctance of concerned states (opponents in armed conflict and/or competitors for local power) to facilitate and/or allow engagement with NSAAs.	Difficulties in introducing health care related material/equipment, potential reluctance from the concerned states due to the importance for communities of health care service provision.	Limited resources for health care due to the blockade on cross-border or, within Syria, limit on cross-line activities.	Shared interest to overcome blockage/limitations imposed by the concerned states. *Action*: Advocacy with influential third-party states to emphasize that facilitation of the access to health care is a human rights obligation.

Table 3, continued

A	B	C	D	E
3. Difficulties in communication and negotiations	One-way communication from humanitarian actors, lack of understanding of NSAA motivations and interests, overemphasis on naming and shaming without attention to creating positive incentive.	Barriers to health care delivery due to misunderstandings and different interpretations.	Communication issues for NSAA civilian and armed structures with health care organizations.	Shared interest to improve communication and understanding of the other's objectives and priorities. *Action*: Initiatives to gather information on the perspectives, interests, and challenges of the other actor to improve communication, organized dialogue to reach common understandings of the problem and to design a solution.
4. Humanitarian coordination	Expectation of NSAAs as duty-bearers under IHL, but also reluctance to treat them as important interlocutors for information exchange and priority-setting.	Limited participation of NSAAs in the prioritization of health care interventions, lengthy bureaucratic processes and slow check point procedures/delays in medical transports, and so on.	Difficulty in coordinating with humanitarian actors on health care issues.	Shared interest to improve coordination among conflict actors and humanitarian players. *Action*: Workshops focusing on coordination, health care needs identification, and prioritization of health care interventions.

Table 3, continued

A	B	C	D	E
5. Capacities of NSAAs	Lack of knowledge and expertise concerning humanitarian action, lack of access to (legal) financing for NSAAs reduces available resources for humanitarian action (compared with the state authorities), restricted access to legal markets limits availability of relevant equipment, and makes capacity-building delicate (both of which are linked to the criminalization of territories, actors, and engagement mentioned above).	Health care is a resource-intensive service, demanding significant human, technical, and financial resources, all of which tend to be limited in NSAA areas.	Limited capacity and financial and technical means for health care in general and for certain medical interventions in particular, lack of qualified medical personnel, limited medical, technical, and financial capacity to undertake dedicated surgeries for wounded combatants.	Shared interest to reduce the negative impact of limited capacities on health care services. *Action*: Provision of nonsensitive medical equipment and materials to NSAA civilian structures or clinics in areas of their control, capacity-building initiatives for civilian and humanitarian components of NSAAs.
6. Security risks	Access to NSAA leaders and territories restricted due to a lack of security guarantees.	Health care depends on relatively stable control of territory. Some health care provision is long-term and predictable (for example, the construction and operations of clinics), which makes it an easy target for conflict actors and regular criminal activity (as compared with punctual delivery of emergency aid).	Lack of access to specialized care abroad for fighters and civilians due to security risks linked to traveling, risks for high-level leaders when meeting with humanitarians and fear of targeted attacks.	Shared interest to avoid security risks for members of either actor. *Action*: Recognition of a certain amount of shared risk, agreement on joint action to limit risk exposure for both actors.

Table 3, continued

A	B	C	D	E
7) Lack of compliance with IHL and IHRL in the conflict as a whole	Negative influence from other actors, notably state armed forces, erosion of the meaning of "protected" status of individuals and objects as not respected.	Attacks on health care by various conflict actors, insufficient respect/protective measures by armed actors and difficulties in respecting principles (due to the practices of enemy forces).	Lack of compliance with the protection of wounded combatants and health care facilities by other conflict actors creates dilemmas for NSAAs.	Shared interest to improve compliance by third-party conflict actors. *Action*: Conflict-wide campaigns and engagement for the protection of health care and for the respect of human rights and IHL.

The challenges in Column D affect the SDF or the AANES, as the armed and civilian wings of the same NSAA. In Column B, third-party assistance may conflict with counterterrorism legislation in some countries, for example, *Holder v. Humanitarian Law Project*, Supreme Court of the United States, No 08-1498, June 21, 2010, quoted in Daragh Murray, *Human Rights Obligations of Non-State Armed Groups* (Oxford: Hart Publishing, 2016), 194. In Column D, security risks and fear of targeted attacks were not mentioned by interlocutors, but both challenges have been observed as a difficulty for arranging meetings in Fight for Humanity's work.

Source: Authors' interviews with representatives at the AANES and the SDF. For more information about the potential arrest of staff members, see Ashley Jackson and Rahmatullah Amiri, "Insurgent Bureaucracy: How the Taliban Makes Policy," *Peaceworks* 153 (2) (2019): 27, https://www.usip.org/publications/2019/11/insurgent-bureaucracy-how-taliban-makes-policy. For a discussion of health care providers being imprisoned or censured, see Annyssa Bellal, "Health and the Law of Armed Conflict," in *Research Handbook on Global Health Law*, ed. Gian Luca Burci and Brigit Toebes (London: Edward Elgar Publishing, 2018), 15. For more on improving engagement with NSAAs and the need to create positive incentives for them, see Ann-Kristin Sjöberg, "Where Are the Carrots? Positive Discipline for Armed Groups," Humanitarian Law & Policy, March 19, 2020, https://blogs.icrc.org/law-and-policy/2020/03/19/carrots-positive-discipline-armed-groups.

in some contexts, can be both able and willing to meet health care obligations that extend beyond the provisions set out in IHL, despite challenging circumstances and limited resources.

We have also demonstrated that the challenges faced by the AANES and the SDF in respecting, protecting, and fulfilling the right to health care mirror challenges previously identified for humanitarian actors engaging with NSAAs, including the criminalization of certain territories, actors, and engagement, the constraints set by concerned states, difficulties in communication and negotiations between humanitarians and NSAAs, difficulties of coordinating with the NSAAs on needs and priorities, limited capacities of NSAAs, security risks, and lack of compliance with IHL by other conflict parties.

In other words, if there are shared challenges facing NSAAs and humanitarian actors seeking to deliver health care in conflict settings, there may also be opportunities to find joint solutions. To leverage this opportunity, preconceived notions about each actor – whether an NSAA or a humanitarian organization – need to be replaced with genuine efforts to communicate with and understand the objectives, perspectives, and priorities of the other. By illuminating the perspectives of one prominent NSAA on health care, we have strived to contribute to this enhanced understanding.

ABOUT THE AUTHORS

Ann-Kristin "Anki" Sjöberg is Co-Director and Founder of Fight for Humanity. She is an experienced humanitarian/human rights professional with a demonstrated history of working on issues linked to conflict, security, and gender, notably linked to non-state armed actors. She has a PhD in International Relations focused on Political Science from the Graduate Institute of International and Development Studies, Geneva, Switzerland.

Mehmet Balci is Co-Director and Founder of Fight for Humanity. He has more than twenty years of experience in humanitarian work in the Middle East, South Caucasus, and Latin America regions, specializing in the protection of children, sexual violence issues, and the ban on anti-personnel landmines.

ENDNOTES

1 Annyssa Bellal, "Health and the Law of Armed Conflict," in *Research Handbook on Global Health Law*, ed. Gian Luca Burci and Brigit Toebes (London: Edward Elgar Publishing, 2018), 1. For the conflict-related data, she refers to Jessica Falk, "The Health Impacts of War and Armed Conflict," *Medact*, November 20, 2015, https://www.medact.org/2015/blogs/the-health-impacts-of-war-and-armed-conflict.

2 As argued by Bellal, even though NSAAs are responsible for an estimated one-third of threats affecting health care, we should not disregard "the fact that several armed groups also play positive roles when it comes to the protection of health." Bellal, "Health and the Law of Armed Conflict," 13.

3 Bellal, "Health and the Law of Armed Conflict." See also Daragh Murray, *Human Rights Obligations of Non-State Armed Groups* (Oxford: Hart Publishing, 2016); and Ezequiel Heffes, "Armed Groups and the Protection of Health Care," *International Law Studies* 95 (2019): 226–243.

4 For the understanding of NSAAs, we use a modified definition of the one proposed by Bellal for non-state armed groups as any organized armed actor "distinct from and not operating under the control [of] the state or states in which it carries out military operations, and which has primarily political, religious, and/or military objectives." See Bellal, "Health and the Law of Armed Conflict," 13.

5 This resulted in two documents: one set of military instructions or guidelines on the protection of health care, adopted by the SDF in March 2021, which we will discuss later in the essay; and one internal document on humanitarian coordination and how it is operating in NES.

6 Maciej Polkowski, head of the Health Care in Danger Initiative at the International Committee of the Red Cross (ICRC), has argued: "It may well be that the overall impact of . . . invisible low-impact incidents is actually far greater than the collective impact of those high-level incidents that are documented by human rights organizations and that make the front page of *The New York Times*." The outcome of this, Polkowski asserted, is that a lot of efforts are focused on issues that cannot be solved easily, while energy is not spent on issues that could perhaps be solved more easily. Comment by Maciej Polkowski during the book launch of *Perilous Medicine: The Struggle to Protect Health Care from the Violence of War* by Leonard Rubenstein. Maciej Polkowski, "The Struggle to Protect Health Care from the Violence of War," December 10, 2021, YouTube video, quotation at 52:01, https://www.youtube.com/watch?v=ZNKkH6jF5vw.

7 See, for example, Andrew Clapham, "Human Rights Obligations of Non-State Actors in Conflict Situations," *International Review of the Red Cross* 88 (863) (2006): 491–523, https://doi.org/10.1017/s1816383106000658; Andrew Clapham, "The Rights and Responsibilities of Armed Non-State Actors: The Legal Landscape & Issues Surrounding Engagement," *SSRN*, March 17, 2010, https://doi.org/10.2139/ssrn.1569636; Yaël Ronen, "Human Rights Obligations of Territorial Non-State Actors," *Cornell International Law Journal* 46 (1) (2013): 21–50, https://scholarship.law.cornell.edu/cilj/vol46/iss1/2; Katharine Fortin, "The Application of Human Rights Law to Everyday Civilian Life under Rebel Control," *Netherlands International Law Review* 63 (2) (2016): 161–181, https://doi.org/10.1007/s40802-016-0061-2; Murray, *Human Rights Obligations of Non-State Armed Groups*; Tilman Rodenhäuser, *Organizing Rebellion: Non-State Armed Groups under International Humanitarian Law, Human Rights Law and International Criminal Law* (Oxford: Oxford University Press, 2018); Jean-Marie Henckaerts and Cornelius

Wiesener, "Human Rights Obligations of Non-State Armed Groups: An Assessment Based on Recent Practice," in *International Humanitarian Law and Non-State Actors: Debates, Law, and Practice*, ed. Ezequiel Heffes, Marcos D. Kotlik, and Manuel J. Ventura (The Hague: T.M.C. Asser Press, 2020); and Antal Berkes, *International Human Rights Law Beyond State Territorial Control* (Cambridge: Cambridge University Press, 2021). For select examples of relevant institutional practice, see International Committee of the Red Cross, "International Humanitarian Law and the Challenges of Contemporary Armed Conflicts: Recommitting to Protection in Armed Conflict on the 70th Anniversary of the Geneva Conventions," *International Review of the Red Cross* 101 (911) (2019): 869–949, https://doi.org/10.1017/S1816383119000523; Anyssa Bellal, *Human Rights Obligations of Armed Non-State Actors: An Exploration of the Practice of the UN Human Rights Council*, Academy In-Brief No. 7 (Geneva: Geneva Academy of International Humanitarian Law and Human Rights, 2016), https://www.geneva-academy.ch/joomlatools-files/docman-files/InBrief7_web.pdf; and Nils Melzer, Agnes Callamard, S. Michael Lynk, et al., "Joint Statement by Independent United Nations Human Rights Experts on Human Rights Responsibilities of Armed *Non-State Actors*," press release, February 25, 2021, https://www.ohchr.org/en/press-releases/2021/02/joint-statement-independent-united-nations-human-rights-experts-human-rights.

[8] Millions of civilians currently live in areas under the control and influence of NSAAs. If human rights are truly universal, and as IHL does not apply to all situations and aspects of life, human rights need to apply. See, for example, Melina Fidelis-Tzourou and Ann-Kristin (Anki) Sjöberg, "Forgotten Freedoms: The Right to Free Expression in Areas Controlled by Non-State Armed Actors," Armed Groups and International Law, October 23, 2020, https://www.armedgroups-internationallaw.org/2020/10/23/forgotten-freedoms-the-right-to-free-expression-in-areas-controlled-by-non-state-armed-actors.

[9] Murray, *Human Rights Obligations of Non-State Armed Groups*, 181.

[10] Ibid., 182–183.

[11] Katharine Fortin, "Of Interactionality and Legal Universes: A Bottom-Up Approach to the Rule of Law in Armed Group Territory," *Utrecht Law Review* 17 (2) (2021): 27, http://doi.org/10.36633/ulr.669. As argued by Marta Furlan, such goods and services may include the provision of electricity, the construction of roads, the provision of health care and education, the management of a telecommunication system, the distribution of food, the provision of potable water, the collection of garbage, and/or the introduction of a transportation system. Quoted in Furlan, political scientist Jeremy M. Weinstein has argued that these collective goods are provided by the rulers in exchange for the people's consent to be governed. See Marta Furlan, "Understanding Governance by Insurgent Non-State Actors: A Multi-Dimensional Typology," *Civil Wars* 22 (4) (2020): 483, https://doi.org/10.1080/13698249.2020.1785725.

[12] Murray, *Human Rights Obligations of Non-State Armed Groups*, 205 and 256.

[13] Reyko Huang and Patricia L. Sullivan, "Arms for Education? External Support for Rebel Social Services," *Journal of Peace Research* 58 (4) (2020): 1, https://doi.org/10.1177/0022343320940749.

[14] Murray, *Human Rights Obligations of Non-State Armed Groups*, 262–263.

[15] For example, see "Unilateral Declaration on the Respect and Protection of the Wounded and Sick and on Access to Health Care," in *Protecting Health Care: Key Recommenda-*

tions (Geneva: The International Committee of the Red Cross, 2020), https://www.icrc.org/en/publication/4266-protecting-health-care-key-recommendations; and agreements with humanitarian organizations such as Geneva Call, *Deed of Commitment for the Protection of Health Care in Armed Conflict* (Geneva: Geneva Call, 2018), https://www.genevacall.org/wp-content/uploads/2019/07/Deed-of-Commitment-for-the-protection-of-health-care-in-armed-conflict-final-version-4.pdf. See also humanitarian agreements between the parties and humanitarian actors, such as two for Syria: OCHA, "Declaration of Commitment on Compliance with IHL and Humanitarian Assistance," United Nations Office for the Coordination of Humanitarian Affairs, January 7, 2014, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/declaration_of_commitment_0.pdf; and OCHA, "Engagement with Parties to the Conflict to Deliver Humanitarian Assistance in Northern Syria," United Nations Office for the Coordination of Humanitarian Affairs, December 9, 2014, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/jop_protocol_for_engagement_with_parties_conflict_eng_final.pdf. See also NSAAs' unilateral declarations and internal regulations, for example, the Syrian Democratic Forces military instructions: General Command of the SDF, "To Media and Public Opinion," SDF Press Center, March 18, 2021, https://sdf-press.com/en/2021/03/to-media-and-public-opinion-13. For more on existing tools for NSAAs, see Simon Bagshaw and Emily K. M. Scott, "Talk Is Cheap: Security Council Resolution 2286 & the Protection of Health Care in Armed Conflict," *Dædalus* 152 (2) (Spring 2023): 142–156.

[16] Murray, *Human Rights Obligations of Non-State Armed Groups*, 265.

[17] Ibid.

[18] Such as the Eritrean People's Liberation Front (EPLF) in Eritrea, the POLISARIO Front in Western Sahara, FARC-EP in Colombia, the Mahadi movement in Iraq, Hezbollah in Lebanon, the Liberation Tigers of Tamil Eelam (LTTE) in Sri Lanka, the Taliban in Afghanistan, the National Resistance Army (NRA) in Uganda, and the União Nacional para a Independência Total de Angola (UNITA) in Angola. See Murray, *Human Rights Obligations of Non-State Armed Groups*, 258, 266–267; and Furlan, "Understanding Governance by Insurgent Non-State Actors," 483.

[19] Murray, *Human Rights Obligations of Non-State Armed Groups*, 264 and 266.

[20] Geneva Call, "COVID-19 Armed Non-State Actors' Response Monitor," https://www.genevacall.org/covid-19-armed-non-state-actors-response-monitor (accessed March 13, 2023); and Irénée Herbet and Jérôme Drevon, "Engaging Armed Groups at the International Committee of the Red Cross: Challenges, Opportunities and COVID-19," *International Review of the Red Cross* 102 (915) (2022): 1021–1031, 1029, http://doi.org/10.1017/S1816383121000588.

[21] Ashley Jackson and Rahmatullah Amiri, "Insurgent Bureaucracy: How the Taliban Makes Policy," *Peaceworks* 153 (2) (2019): 25, https://www.usip.org/publications/2019/11/insurgent-bureaucracy-how-taliban-makes-policy.

[22] Xavier Crombe, as quoted in Murray, *Human Rights Obligations of Non-State Armed Groups*, 266.

[23] Jackson and Amiri, "Insurgent Bureaucracy," 26–27.

[24] Fortin, "Of Interactionality and Legal Universes," 38.

[25] Furlan, "Understanding Governance by Insurgent Non-State Actors," 488.

[26] Murray, *Human Rights Obligations of Non-State Armed Groups*, 261 and 267.

[27] Zachariah Cherian Mampilly, *Rebel Rulers: Insurgent Governance and Civilian Life during War* (Ithaca, N.Y.: Cornell University Press, 2011), quoted in Furlan, "Understanding Governance by Insurgent Non-State Actors," 499. Political scientist Joanna Richards notes, "Unlike the police and judiciary sectors of the Tamil Eelam Secretariat, responsibility for the health, education and economic development sectors was shared between the LTTE and the Government of Sri Lanka," and LTTE district chiefs and government agents actually worked side-by-side in areas under LTTE control. Because of an embargo on the transport of goods to LTTE areas, members of the LTTE health sector advocated for greater access to medication and for greater numbers of doctors. Moreover, to address the lack of resources, the LTTE actively approached international agencies and NGOs, who were mainly reluctant to enter LTTE areas until after the 2002 peace agreement. Joanna Richards, "An Institutional History of the Liberation Tigers of Tamil Eelam (LTTE)," Working Paper 10 (Geneva: The Graduate Institute Geneva, The Centre on Conflict, Development, and Peacebuilding, 2015), 46–47, https://www.bicc.de/publications/publicationpage/publication/an-institutional-history-of-the-liberation-tigers-of-tamil-eelam-ltte-ccdp-working-paper-series.

[28] Ashley Jackson, *In Their Words: Perceptions of Armed Non-State Actors on Humanitarian Action* (Geneva: Geneva Call, 2016), https://www.genevacall.org/wp-content/uploads/dlm_uploads/2016/09/WHS_Report_2016_web.pdf.

[29] Ibid., 16, 22. The governance literature elaborates by arguing that NSAAs may choose to engage in service provision as a result of a rational calculation that this will provide them with greater legitimacy. For example, expressing that "the SPLM/A coopted many international aid organisations in its educational and health care systems, which enabled the group to take credit for service provision without needing to invest its revenues therein." Mampilly, *Rebel Rulers*, as quoted in Furlan, "Understanding Governance by Insurgent Non-State Actors," 493. From our point of view, a more nuanced perspective would be needed, but this goes beyond the scope of this essay.

[30] Houssam al-Nahhas, Andrew Moran, and Anonymous, *Destruction, Obstruction, and Inaction: The Makings of a Health Crisis in Northern Syria* (New York: Physicians for Human Rights, 2021), 6, https://phr.org/wp-content/uploads/2021/12/PHR-Syrian-Health-Disparities-Report-Dec-2021-English.pdf.

[31] Authors' interview with an international health care worker in NES, May 21, 2022.

[32] Al-Nahhas, Moran, and Anonymous, *Destruction, Obstruction, and Inaction*, 1.

[33] The WHO recommends one hospital per 250,000 people. World Health Organization Health Cluster, "GHC Guidance: People in Need Calculations Version 2.0," September 21, 2021, https://healthcluster.who.int/docs/librariesprovider16/meeting-reports/ghc-pin-severityguidance-v2.0.pdf?Status=Master&sfvrsn=85ffa08e_9, 22. But in some areas in NES, there are no functioning hospitals, such as in Raqqa and Deir ez-Zor (with a combined population of around 1.5 million people). In Al-Hasakah, there is one functioning hospital for a population of 1,127,309. Al-Nahhas, Moran, and Anonymous, *Destruction, Obstruction, and Inaction*, 3.

[34] Ibid., 8.

[35] Ibid., 11.

[36] Ibid., 1–2.

[37] Authors' interview with an international health care worker in NES, May 21, 2022.

[38] Al-Nahhas, Moran, and Anonymous, *Destruction, Obstruction, and Inaction*, 10.

[39] Ibid., 5–6.

[40] Ibid., 10.

[41] Ibid., 14.

[42] Ibid., 1–2.

[43] Ibid., 13.

[44] General Command of the SDF, "To Media and Public Opinion."

[45] Authors' interview via voice messages with SDF top commander, May 21, 2022.

[46] General Command of the SDF, "To Media and Public Opinion."

[47] Written response to authors' questionnaire. Self-Administration of Northeast Syria, Executive Council, Department of Health for Northeast Syria, "Responses to Questions Posed to the Department of Health," April 13, 2022.

[48] Ibid.

[49] General Command of the SDF, "To Media and Public Opinion."

[50] Self-Administration of Northeast Syria, "Responses to Questions Posed to the Department of Health."

[51] Ibid.

[52] Ibid.

[53] Ibid.

[54] Ibid.

[55] Authors' interview via voice messages with SDF top commander, May 21, 2022.

[56] Self-Administration of Northeast Syria, "Responses to Questions Posed to the Department of Health."

[57] Ibid.

[58] Ibid.

[59] Authors' meeting with SDF top commander, Northeast Syria, June 14, 2022.

[60] Self-Administration of Northeast Syria, "Responses to Questions Posed to the Department of Health."

[61] Ibid.

[62] Authors' interview via voice messages with SDF top commander, May 21, 2022.

[63] Ibid.

[64] In December 2022, the United Nations Security Council approved Resolution 2664. Known as "a humanitarian carve-out" we still need to see which practical impact this resolution will have on humanitarian engagement with NSSAs and humanitarian work in areas under their control, including on health care. United Nations Security Council, *Resolution 2664* (S/RES/2664), December 9, 2022, http://unscr.com/en/resolutions/doc/2664.

Governing Data: Relationships, Trust & Ethics in Leveraging Data & Technology in Service of Humanitarian Health Delivery

Larissa Fast

Across the humanitarian sector, "data" permeate and inform responses to violence, disaster, and health-related crises. Delivering health care in humanitarian emergencies or conflict contexts requires many types of data: numbers and narratives about patients, staff, disease, treatment, and services. Multiple demands drive data collection at various levels, too often resulting in a mismatch between the tenets of data minimization (collect only what you need) and usage (use all you collect). Donors mandate specific data collection via both official reporting and ad hoc, informal requests, and humanitarians share data with other humanitarians and with donors. In this essay, I examine the specific issue of sharing data between and among humanitarians and donor governments. I pay particular attention to governance and the often-overlooked relational dimension of data, their implications for trust, as well as the ethical questions that arise in light of existing debates about localization and decolonizing the humanitarian sector.

Across the humanitarian sector, "data" permeate and inform responses to violence, disaster, and health-related crises. Delivering health care in humanitarian emergencies or conflict contexts requires data: patient records, staff records, epidemiological and outbreak data, data about how, when, and where patients use health services, not to mention data about the context or how conflict affects humanitarian health providers. These data take the form of everything from numbers to narratives, observations to geolocations.

As a result, the need to manage data collected during humanitarian operations is growing, with recognition of the importance of ensuring responsible use and protection of these data.[1] In its recent operational guidance, the Inter-Agency Standing Committee (IASC) – a coordination forum of the United Nations – defines data responsibility in humanitarian operations as "the safe, ethical and effective management of personal and non-personal data for operational response, in accor-

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https://doi.org/10.1162/DAED_a_01996

dance with established frameworks for personal data protection."[2] Managing data responsibly encompasses the complete cycle, from data collection, processing, analysis, use, and storage, through to sharing, retention, and destruction.

Leveraging these data in service of more effective and accountable humanitarian health delivery, however, is fraught with challenges, some of which may increase the risk to those affected by conflict and disaster and to those providing health care in these settings. What data are needed, when, and by whom? How are data used and protected throughout their life cycles, from generation through destruction? Those working at the frontlines of patient care need information about symptoms, treatment, and medical histories, while those coordinating an outbreak response require aggregated data about overall cases and locations. Moving data across these levels – usually upward, from those providing services to those coordinating, funding, or regulating these services – requires sharing data among local authorities and organizations, humanitarian actors, and host and donor governments.

These multiple and diverging demands drive data collection at the field level, resulting in a mismatch between the tenets of data minimization (collect only what you need) and usage (use all you collect), a key component of data responsibility. This is partly because the needs of these actors differ. Those funding response efforts mandate data collection via both official reporting and ad hoc, informal requests. The formal guidelines, outlined in reporting templates and signed contracts, are informed by transparency, accountability, efficiency, program design, and legal, regulatory, and policy frameworks. While official guidelines are laid out in legal contracts and data policies, the informal data requests come via multiple channels, sometimes with unclear justification. These requests can cause confusion, undermine trust and autonomy, and result in duplication or waste. In some cases, they pose risks deriving from the sensitivities of sharing data, in relation to reidentification that can increase vulnerability and discrimination.[3] As a result, they raise fundamental questions about governance, risk, and responsibility, with implications for trust among those receiving, providing, and funding health care delivery in humanitarian settings.

In this essay, I examine the opportunities and challenges posed in managing data in humanitarian settings, and the specific practical – also ethical – dilemmas these developments pose for humanitarian health responders. In particular, I focus on *sharing* data between and among humanitarians and donor governments, as well as issues that arise related to trust, governance, and ethics.[4]

In doing so, I first define data and the range of data collected in support of humanitarian response and summarize some of the inherent risks of managing data for the humanitarian sector. Using political scientist Michael Barnett's notion of humanitarian governance, I then discuss data sharing in relation to who governs this sharing and how it is organized and accomplished, with particular attention

to the unintended consequences and implications for trust and the relational dimensions of data.[5] I conclude with some reflections on the ethical questions that arise in relation to Barnett's first and central query – what kind of world is imagined and produced? – and discuss these issues in light of existing debates about localization and decolonizing the humanitarian sector.

Using technology requires and produces data. In a humanitarian context, these data may be deliberately collected to inform decisions, monitor progress, or report to funding agencies. They may be by-products of using the technology, as in the case of the metadata (data that provide information about other data) that identify locations or IP addresses of those putting information into the system.[6] Yet their potential uses do not provide any specificity about the parameters of these data, raising the question: what are they?

In the context of the humanitarian sector, data have multiple meanings and characteristics. Data are quantitative and qualitative, personal and nonpersonal, sensitive and nonsensitive, group and individual, aggregated and disaggregated. For example, humanitarians collect pieces of demographic and contact information from those receiving assistance and aggregate these for donor reporting. Sensitive personal data include identifying information (name, date of birth) and patient medical and treatment histories, as well as location and group categories (age, gender, ethnicity). Equally, they can refer to data collected for purposes related to financial, audit, and compliance requirements, organizational human resources and recipient/beneficiary information, and situational and contextual reporting, as well as to inform and monitor programs.[7]

These data are often shared via open platforms, such as the UN Office for the Coordination of Humanitarian Affairs (OCHA) Humanitarian Data Exchange (HDX) or the World Bank's DataBank.[8] In other cases, data are collected and aggregated to provide information and analysis to support and inform humanitarian responses, such as the needs assessment work of ACAPS or the assessment data analysis and dissemination activities of REACH.[9] In some cases, these data concern the status and needs of specific groups, such as internally displaced persons (IDPs) or refugees. These include the Internal Displacement Monitoring Centre (IDMC), the International Organization for Migration's Displacement Tracking Matrix, the Joint IDP Profiling Service (JIPS), and UNHCR's Operational Data Portal.[10] Individual agencies also gather and store data on customized platforms, such as the World Food Programme's SCOPE, designed to manage beneficiary information.[11] The World Health Organization (WHO) maintains and makes available a range of health data sets to support humanitarian response, such as the Health Responses and Services Availability Monitoring System (HeRAMS), while the second edition of the District Health Information Service (DHIS2) serves as a platform for national governments and others to manage district-level health information.[12]

Clearly the quantity and range of data collected in support of humanitarian responses, including health programs, are vast and varied. These data, in turn, are shared among humanitarian actors and donor governments. Donors require formal financial and programmatic reporting to provide assurances that the money is going to fulfill its intended purposes, and to advocate for or justify policies and decisions.[13] More specifically, these data may be used to account for how funding is directed to particular populations, as in the case of the gender, age, or disability markers designating assistance to women, elderly, or differently abled people. They are used to advocate for additional funding and to provide evidence of the ways in which a donor government has supported a particular humanitarian emergency. Data are also required to evidence that money is not misused (such as reporting related to corruption, fraud, or counterterrorism provisions) or to illustrate how agencies are responding to safeguarding concerns. In some cases, donors informally request data from humanitarians about particular programs, beneficiaries, or the security situation in a given conflict setting. These data may be sensitive (personal data) or not (general situational data). In requesting these data, donors are implicitly and explicitly mandating data collection, highlighting an indirect relationship between data requests and data collection. In short, humanitarians collect data partly because donors ask them to share these data. This, in turn, can result in more data being collected than are needed, and can also increase risk. These risks include increased opportunity for reidentification or exposure to hacking and unintended uses of data, simply because more data are available.

Some donor governments also require data sharing to support the overall humanitarian response, such as those requiring that program-related data sets be uploaded to open platforms or shared in support of coordination efforts. In requiring data sharing, donors aim to encourage more effective and efficient programs. For example, sharing data can enable joint analysis of needs and ostensibly minimize the amount of data collected from those affected by conflict or disaster. In theory, a joint, comprehensive needs analysis could identify multiple types of needs (water, shelter, nutritional status) across populations in a category (by gender, age, disability), and could be accessed via shared platforms. All too often, however, communities complain that they provide information, often repeatedly, but do not receive a commensurate response.

The constraints to sharing data, however, are many. At a rudimentary level, this includes underinvestment on the part of donors and humanitarians in the capacities and practices of conducting or supporting joint assessments.[14] Moreover, the systems and platforms that agencies use to manage data may differ (for instance, customized databases versus Microsoft Excel or Google Sheets). Likewise, the conventions of format (raw data or PDF data) and defini-

tions (such as varied cut-off ages for "youth") can limit the possibilities for easy sharing. Each of these variables places technical or other obstacles in the way of transferring data from one actor or platform to another.[15]

Fundamentally, controlling data, including what and how data are shared, determines and reinforces power in the humanitarian system. The agency that collects the data controls the narrative – about the extent of need and the populations who need assistance – and acts as a gatekeeper by determining who has access to this information. As such, data serve to designate parameters for action and mark the territorial boundaries of agencies. For example, the UNHCR collects data about refugees, the International Organization for Migration (IOM) monitors migrants, while the internally displaced who do not cross borders may fall between mandates and data collection. The data these agencies collect thereby define their populations of interest and set out areas of influence and authority. Any individual or agency wanting more information about these populations must then request data from the agencies. The data from these organizations, in turn, influence donor decisions and public perceptions, including trust in data. For instance, the official death toll from Hurricane Maria, which devastated Puerto Rico in 2017, was sixty-four people. Questioning this number, researchers sampled the population and estimated excess deaths at more than 4,600 people.[16] The publicity that resulted led authorities to revise their count upward.

As the Puerto Rico example illustrates, organizations have incentives to promote their narratives and, by extension, the qualitative or quantitative data underlying these narratives. In their synthesis of evidence and analysis of famine data, food security scholars Daniel Maxwell and Peter Hailey emphasize how political influences shape the data that are collected (or missing) as well as the analysis, often more accurately reflecting political considerations of governments or agencies instead of on-the-ground realities. As they write, these considerations originate with

> governments who do not want the depth of a crisis to be exposed, donors who do not wish to investigate deeply the impact of counter-terrorism restrictions or who expect to see "results" from the money devoted to humanitarian response over the previous period, or agencies who also want the analysis to reflect the positive impact of programmes.[17]

In another well-known example, a series of International Rescue Committee reports claimed more than five million excess deaths from conflict in the Democratic Republic of the Congo (DRC) between 1997 and 2008, which a subsequent Human Security Report rebutted.[18] Whereas the first estimate served to generate attention and increase funding to humanitarian agencies operating in the DRC, the questions from the second arguably served to erode trust in casualty data from humanitarian agencies. Staggering numbers generate public attention, but they

can also serve to undermine trust in these numbers.[19] Equally, governments and armed belligerents have incentives to downplay the human costs of armed conflict or disease. For evidence, one has only to look at controversies surrounding civilian casualties in the wars in Iraq, Afghanistan, or more recently Ukraine. When numbers diverge, they cause confusion for outside observers who may not be as familiar with the intricacies of definitions and the parameters of collection. In these cases, who arbitrates between competing data? In short, whose data are "right"? The competing COVID-19 death estimates are a case in point, with many podcasts and entire books devoted to unpacking and understanding these numbers.[20]

Beyond these constraints, sharing data about individuals and groups of people can pose and create risks.[21] These risks are myriad and include everything from reputational risks, surveillance, and privacy violations to the dangers of reidentification by combining data sets or the potential use of data beyond their original purposes or intended scope, particularly for nonhumanitarian purposes. For instance, UNHCR shared the biometric data of Rohingya refugees with Myanmar authorities, the same authorities accused of committing genocide against the Rohingya.[22] The outcry that accompanied this story caused reputational harm to UNHCR.[23] While perhaps an extreme example, it illustrates one of the ways in which these data circulate widely, sometimes without the knowledge or permission of the data subjects. In the early days of the West African Ebola crisis, the personal data of patients were shared via Google documents and email because this served as the easiest way to share information in a dynamic and deadly epidemic, in which those with or exposed to the disease were often targets of discrimination and harm.[24] Contact tracing requires names and locations, and because these data circulated without adequate privacy protections, they could have been used to seek out and harm those exposed to Ebola. Although there is less concrete evidence of these risks consistently materializing, the examples of data hacking and misuse point to the possibilities.[25]

While the risks of sharing personal data are well-documented, those related to group data (such as data about an ethnic group) are sometimes overlooked. For instance, mobile phone data, even aggregated, can provide detailed surveillance about population movements that may put certain populations at risk. This surveillance also increases possibilities for misinterpretation if those interpreting the data lack contextual awareness.[26]

Particularly in conflict settings, the control of information becomes a currency of power and influence.[27] In such settings, the sensitivity of location-specific data may increase, as such information can be used to target specific actors or entities. In Syria, where health facilities were repeatedly targeted for attack and moved underground as a result, some humanitarian health actors refused to share the locations of facilities for fear that this information would be used to identify them.[28] At the same time, widely sharing this information serves the purpose of ensuring

that those targeting health facilities cannot claim ignorance about the locations of health facilities, which are protected in armed conflict under international humanitarian law.

Implicit in managing data, and particularly sharing data between and among humanitarians and donors, are questions related to governance. To discuss these, I draw on aspects of Barnett's definition of humanitarian governance, notably the questions of who governs data sharing and how this is organized and accomplished.[29] Taking this one step further, to discuss his first and central question about the implications of governance for the kind of world that is imagined and produced, I explore how governance confers and reinforces power and control.

Data are usually collected by frontline humanitarians or health workers, such as those with direct and primary contact with aid recipients or patients. These data are usually shared in raw, aggregated, abbreviated, or desensitized/anonymous formats, depending on the circumstances. Sharing happens internally within the organization in support of program implementation and monitoring, or externally with other organizations as part of coordination activities. Thus, a local nongovernmental organization (NGO) or health facility shares data with other NGOs within the humanitarian cluster system or with local authorities. This represents a mostly horizontal movement of information.

Although data are often shared horizontally between humanitarian actors, the primary direction of travel is upward. In this case, data move vertically, shared with national authorities or donor governments, in the form of reporting indicators or statistics, and information used in service of national or international coordination efforts. Whereas data sharing tends to move upward from the field, donor data-sharing requests usually travel in reverse: from donors to implementing partners, whether UN agencies or international NGOs, and then down to those doing the actual collection. In some cases, feedback loops are closed, returning this information to the original sources, such as when anonymized patient data are logged in health facility information systems and aggregated upward to inform national health priorities and donor funding, and then returned to facilities and administrators in terms of support for staffing and requests for medical equipment and supplies.

All too often, however, data are not returned to those with the least power in the system: those collecting the data and the data subjects themselves. This has consequences for the quality of data collected and for their usage. Incentives to collect or provide quality data increase if individuals see an immediate benefit to doing so, such as in the case of the closed feedback loops discussed above. Instead, however, much of the data are gathered to account for funds or report against externally defined indicators. Donors themselves have indicated that the formal reporting requirements, as specified in contracts and templates, are

not necessarily "fit-for-purpose." Data requests may be burdensome and not focused on the "right" data, meaning that the data requested may be more for donor decision-making than "a tool for partners to make evidence-based adjustments in programming."[30] For instance, adjustments to make programming more effective are more likely to require contextual, qualitative data rather than numbers of beneficiaries, regardless of category.

The mechanisms for sharing data are formal (contracts and reporting templates) and informal (queries at site visits, over email and telephone). They are also intentional and unintentional. The formal and informal mechanisms imply an intentionality to sharing. But data are also abandoned. Humanitarian programs close, and data may or may not be properly destroyed. Violence and insecurity may force humanitarians to depart, potentially leaving behind sensitive data – not to mention colleagues.[31] The 2021 withdrawal of the U.S. military and its allies in Afghanistan is just one example.[32] This raises ethical and practical questions about the risks these abandoned data pose to the people left behind.

Finally, as the complexity of the technology used to collect and share data increases, such as blockchain or distributed ledger technologies, drones, and artificial intelligence, so too does the need for technical expertise to understand these technologies and their implications, and for "translators" who are attuned to the humanitarian context and have the technical expertise to deploy these technologies safely and effectively in humanitarian settings. In the case of blockchain, understanding the technology itself is a challenge for many humanitarians, not to mention the legal and regulatory frameworks regulating its deployment, the intellectual property related to its initial development, and the ethics of doing so. This all requires significant and diverse expertise.[33] Without proper safeguards, we run the risk of "humanitarian experimentation," or the use of new and often untested technologies on already vulnerable populations.[34]

Taking this discussion further, there are multiple potential, if unintended, consequences of gathering and sharing data. First, data reporting requirements mean that humanitarians are collecting and sharing more data than they might otherwise, thereby increasing the potential data risk and undermining key principles of data responsibility. In the interviews I conducted with humanitarian workers, they told me they often justified additional data collection by saying "our donor requires it." The additive effect only increases as the data chain lengthens and complexifies with additional implementing partners: government donors that contract with humanitarian actors (UN agencies or international NGOs) that, in turn, subcontract other entities, often national or local NGOs. As one interviewee explained, if the amount of data collection required to satisfy reporting requirements increases with every additional implementing partner, then it will be impossible to limit data collection and sharing.

Second, the notion of "data quality" can be used both as a justification for humanitarians not to share data and as an excuse for donors not to fund programs or organizations. As my interviewees highlighted, the data that are collected as part of humanitarian programs and reporting may originate from different sources (such as two implementing partners), perhaps using different approaches and resulting in discrepancies in data quality. As one interviewee stated, "In these reports we have a combination of data that we collect. Some we collect, but others come through [other actors]. So we have an estimate but maybe this is not that accurate. We may be combining apples and oranges and pears." These differences can become an excuse not to share data with other humanitarian actors or donors, because the data are not "good enough." This may also turn into a pretext to hoard and control data. If data are not widely shared, or if one organization controls the data about the type and extent of needs in a humanitarian context, then this organization controls the overall narrative of need, with consequent implications for funding and coordination. It could also result in the duplication of efforts as multiple agencies collect similar data from the same population, thereby wasting resources. In this way, data confer power to the organization that controls them.

At the same time, concerns about data quality or the misuse of data mean that donors require more detailed data because they question the quality and accuracy of what has been reported or shared. As one humanitarian told me, "I think the more the donor is interested in the quality of the results, the more detailed data would be requested. Also, the quality sometimes gets linked to the political interests [of donors]." These concerns can affect the willingness to fund programs or organizations. In the words of one interviewee, "Data has become an excuse for donors to not fund. We've heard this in the past few years, in the sense that 'your data is not accurate enough' . . . or not disaggregated enough. Or that we don't trust your data, or that it is inflated data." In these ways, the issue of data "quality" can feed mistrust. This mistrust operates at multiple levels: between donors and humanitarian responders, and also between humanitarians and the general public, when these entities lose confidence in the data generated in support of a humanitarian response. Because the data are not perceived to reflect reality, this could result in less public support for a proactive response or simply serve as a justification for offering less funding to an appeal.

A related question, one that is well-trodden and especially thorny, is that of consent in humanitarian contexts. Informed consent is one of the bases of existing legal personal data protections. Critics charge that it is not possible to gain voluntary consent in a humanitarian response, since receiving assistance is predicated on the provision of personal (often biometric) data. On the other hand, humanitarians are legally required to share data, such as aggregated indicators, to account for funding (such as the number of patients treated) as part of donor grants and contracts. In most cases, if consent was not initially given for this purpose,

humanitarians have used the legal concept of "legitimate interest" to permit the legal sharing of data with a donor, since the donor has an interest in ensuring that money is efficiently and properly used.[35] In terms of governance, however, this raises further questions. As one interviewee stated, "If you haven't told people you are going to need it for that purpose, you can't change the purpose just because they are poor and disempowered, and have no way to sue you to get back at you."

Another set of implications relates to trust, and the inverse relationship that exists between trust and data sharing. On one hand, high-profile scandals and breaches of trust result in more scrutiny and, consequently, more detailed or onerous data-sharing requests. In my research, donors and humanitarian interviewees saw more stringent monitoring and accountability in the humanitarian sector as legitimate, requiring more data. Interviewees named multiple factors that have increased attention to and oversight of humanitarian programs: the high-profile political debates about aid provision or effectiveness, the provision of assistance in conflict-affected areas where agencies operate remotely or where they lack consistent access to populations in need, and the often high-profile corruption, mismanagement, or other conduct violations by humanitarian actors. For instance, after high-profile media reports that aid workers from multiple organizations, including Oxfam, Médecins Sans Frontières, and the World Health Organization, among others, were sexually exploiting those seeking assistance, donors began requiring regular and mandatory reporting of safeguarding cases. The UK government even paused its funding for Oxfam on two separate occasions due to these accusations.[36] Donor interviewees highlighted cases of fraud and corruption as precipitating increased scrutiny of their processes and procedures, including on budgets and programs, and of the humanitarian sector more broadly. This scrutiny has resulted in more data requirements and additional data-sharing requests, particularly where financial or audit-related or compliance requests (such as those related to counterterrorism efforts) appeared to be linked to ensuring humanitarian funds are not supporting terrorism and are being used to provide assistance and protection to those most in need.

On the other hand, established trust and long-term relationships between humanitarians and donors appear to enable more nuanced and productive discussions about data sharing and expectations. Exceptions and compromise appear to be more possible when donor-partner relationships are established based on mutual trust and evolve and deepen over time. In one example from my research, a donor and humanitarian agency have negotiated a long-term funding relationship that involves a limited degree of data sharing, such as a set of predefined and mutually agreed indicators to account for the funds provided. This last point underscores the crucial yet often overlooked relational element of data: that data collection and sharing rest on relationships. Research has pointed to the "social

life" of data, and the importance of the personal relationships that influence the ways that data may be trusted, or not, and disseminated.[37]

To conclude, it is worth reflecting on the question of the world imagined and produced through the management of data, and to point to some ethical questions that arise, particularly related to debates about the primacy of local humanitarian action and the need to decolonize the sector.[38] I offer four observations. First, as with many other fields, the humanitarian sector tends to pay attention to what is counted. And as indicated above, the voices that are too often missing in conversations about data and their management are the same ones that are muted or absent in the sector as a whole: the data subjects, also referred to as recipients or "beneficiaries" of assistance, as well as frontline humanitarians and health workers. Instead, we privilege donor commentaries and requirements, which prescribe particular questions, indicators, and categories. In short, those controlling the collection and use of data already wield power in the system. Even if humanitarians ask the beneficiaries of assistance what they need, this is often not counted or aggregated. Moreover, the richness of their stories and expertise is lost in the aggregation. What is missing as a result? What questions and what answers? How might these missing pieces shift our collective frames of reference? At present, the practices of collecting, using, sharing, and managing data all too often replicate and reinforce the structural inequalities that already exist in the humanitarian sector.

Second, the increasing use of data in support of the sector is creating a corresponding, and ever-increasing, body of professional expertise required to deploy technologies or gather data in conflict, disaster, or health emergency settings: in data science to analyze large data sets, in computer science or engineering to develop the technologies, as well as knowledge of increasingly sophisticated research methods, and in other specialties to understand the national and international law and regulation of these technologies (including that which does not yet exist). All of these are required to deploy effectively and ethically these technologies and to use the data. Yet, while this expertise is crucial, we must ask who this body of expertise privileges and who it leaves behind. Unfortunately, the answers read familiar: those left behind are likely the recipients of assistance, the local organizations, and the first responders who react and are then too-often displaced when the international humanitarian system takes over.

Third, paying attention to the social life of data and the role of trust forces an examination of the links between trust and data sharing, and how this replicates the existing modes of action. Meaning, the organizations that have the long-term relationships with donors that allow trust to grow are the existing, established, and usually Northern humanitarian organizations. This further reinforces the privileged standing of these organizations in the humanitarian sector. Moreover,

it is these same agencies that have the capacity and resources to invest in data management and protection. As donor governments require more stringent data management as part of their partnership agreements or contractual relationships, they are likely to preclude partnerships with local humanitarian actors that do not have the same awareness, policies, or resources, thereby undermining the push to support local action. Together these pose additional, mostly invisible barriers for newer, less established, usually national or local actors seeking a more prominent role in humanitarian response, barriers that further undermine efforts to "localize" humanitarian action.

My final observation builds on the preceding ones, focusing on the relational dimension of data. Much of the discussion about data and data sharing centers on technical elements and guidance, overlooking the relationships that facilitate data collection and govern data management, sharing, use, and destruction. These relationships include and exclude individuals and actors and perpetuate the power imbalance in the system. Shining light on the digital relationships inherent in humanitarian data collection, use, sharing, and destruction could provide additional pathways to challenge power in the system and address these asymmetries.

While better data might have the ability to improve the effectiveness of humanitarian (health) response, examining the current governance of data sharing suggests that the world that is being imagined and reproduced is similar to the one that currently exists, with all its flaws. In short, the imperfections and power asymmetries of the current system are mirrored in its digital manifestations. Changing this will not be easy. Ensuring closed feedback loops (where those providing and collecting the data actually see results from their efforts), promoting data literacy across the sector that accounts for both the technical and relational dimensions of data, and allowing data and indicators to emerge not only from humanitarians and donors but from those receiving assistance all represent a new beginning, a shift toward a different, imagined humanitarian world.

AUTHOR'S NOTE

This research was funded by the Research Council of Norway, as part of the PRIO grant, "Do No Harm: Ethical Humanitarian Innovation and Digital Bodies" (Project #286836). For more on the project, visit https://www.prio.org/projects/1816.

ABOUT THE AUTHOR

Larissa Fast is Professor of Humanitarian and Conflict Studies in the Humanitarian and Conflict Response Institute at the University of Manchester. She is also a Global Fellow with the Peace Research Institute in Oslo and a Research Fellow with the Humanitarian Policy Group at the Overseas Development Institute. She is the author of *Aid in Danger: The Perils and Promise of Humanitarianism* (2014) and has recently published in *International Studies Review*, *Conflict & Health*, *Disasters*, and *International Peacekeeping*.

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Swept Away

Tariro Ndoro

Fiela *verb* to sweep
Fiela *verb* to sweep [Sotho]
Fiela *verb* to sweep rubbish
Fiela [see also *restore order*]
Fiela human rubbish clogs the system
Fiela am I different because of my visa?
Fiela what is the degree of separation between
Fiela legal rubbish and non-legal rubbish? Go back
Fiela to your country, *foreigner*, my friend said it
Fiela jokingly but I felt the sting // are we ever safe?
Fiela Jodi Bieber captured monochrome stills of prisoners
Fiela shackled in twos en route to ~~deportation~~ repatriation fields
Fiela I wanted the images but you can't take pictures in the gallery
Fiela Mother escaped with a canvas bag of her past five years, sleeps
Fiela in refugee camp at Beitbridge // says she has nowhere to go to but
Fiela government minister says disloyal citizens got what they deserved //
Fiela Black Easter sparked by lynching foreign criminal woman // exodus begins

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"Swept Away" was first published in Oxford Poetry*, Winter 2017. It also appeared in Tariro Ndoro's poetry collection* Agringada: Like a Gringa, Like a Foreigner*, published by Modjaji Books, 2019.*

ABOUT THE AUTHOR

Tariro Ndoro is a Zimbabwean writer, poet, and storyteller. Her debut poetry collection *Agringada: Like a Gringa, Like a Foreigner* (Modjaji Books, 2019) received the inaugural NAMA Award for Outstanding Poetry Book. Her poetry, short fiction, and creative nonfiction have appeared in *Afreada*, *The Kalahari Review*, *Kotaz*, *New Contrast*, *Oxford Poetry*, and *Puerto del Sol*.

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https://doi.org/10.1162/DAED_a_02006

Talk Is Cheap: Security Council Resolution 2286 & the Protection of Health Care in Armed Conflict

Simon Bagshaw & Emily K. M. Scott

In May 2016, as attacks on health care in armed conflicts were increasing globally, the United Nations Security Council adopted Resolution 2286, demanding warring parties comply with their international obligations to prevent and address such attacks. The resolution was adopted unanimously by the Council and cosponsored by eighty-five UN member states. New data collection and public attention on attacks against health care at the time signaled that, contrary to scholarly expectation, the Council might use tools already at its disposal to ensure compliance with the resolution. Yet in the years that followed, the Security Council and states took few concrete steps to implement Resolution 2286. In this essay, we identify and analyze barriers that prevented the use of existing structures and mechanisms to influence the conduct of war. We contend that the experience of Resolution 2286 can tell us a great deal about the value of such resolutions as a response to pressing issues of humanitarian concern.

In May 2016, as attacks on health care personnel, facilities, and transport in armed conflicts were increasing around the world, the United Nations (UN) Security Council adopted Resolution 2286 on the protection of medical care in armed conflict.[1] The resolution condemned attacks on medical care and demanded that warring parties comply with their obligations under international humanitarian and human rights law to prevent and address attacks against medical care in situations of armed conflict. The resolution was adopted unanimously by the Council's fifteen members and cosponsored by eighty-five UN member states. Some state representatives said Resolution 2286 sent "a strong message" and "a clear signal" from the Council of the need to protect health care.[2] The then-president of the International Committee of the Red Cross (ICRC), Peter Maurer, described it as a "momentous step in the international community's effort to draw attention to a problem that we otherwise risk getting used to through the sheer frequency of its occurrence."[3]

While active scholarly discussion tells us the UN rarely uses enforcement mechanisms or its full powers to bring about compliance with its resolutions –

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https://doi.org/10.1162/DAED_a_01997

for example, by referring individuals to the International Criminal Court for war crimes – there seemed to be reason to hope for change in the years preceding the adoption of Resolution 2286.[4] New data collection and high-profile attacks on health care were putting significant public pressure on both the Security Council and individual member states to act to prevent and enforce international humanitarian law (IHL).[5] In 2015, an attack by United States forces on the Médecins Sans Frontières (MSF) trauma center at Kunduz in Afghanistan became the latest high-profile episode in a litany of attacks on health care personnel, facilities, and transport. These stretched beyond Afghanistan to the Central African Republic (CAR), the Democratic Republic of the Congo (DRC), Iraq, Libya, South Sudan, Syria, Ukraine, Yemen, and elsewhere.[6] During debates on Resolution 2286, Joanne Liu, international president of MSF at the time, reported that four of the five permanent members of the Security Council were "implicated" in attacks against health care in Yemen and Syria.[7] In light of this global attention, the Security Council seemed to be poised to address illegal conduct in war.

But in the years that followed, the UN Security Council and member states took few concrete steps to implement Resolution 2286, according to the secretary-general's reports and UN Secretariat. In his 2021 report to the Security Council on the protection of civilians in armed conflict, UN Secretary-General António Guterres noted that persistent violence, threats, and attacks against medical care, combined with the effects of conflict and the COVID-19 pandemic, had intensified human suffering, and placed enormous strain on weakened health care services.[8] He further noted that while some states had developed and implemented good practices to protect medical care, much more needed to be done. Others have noted the "unhappy consensus" that Resolution 2286 "has made little difference on the ground."[9]

The experience of Resolution 2286 can tell us a great deal about the value of UN Security Council resolutions as a response to pressing issues of humanitarian concern. In this essay, we outline and critically analyze tools the UN Security Council and member states have available to shape the conduct of war and consider why these often go unused. Rather than finding that the Security Council and member states lacked the prevention and enforcement mechanisms to alter the behavior of warring parties, we contend that mechanisms at their disposal gathered dust. We identify and analyze a set of barriers that prevent the use of existing structures and mechanisms to influence the conduct of war.

Our analysis of efforts to protect health care since the passage of Resolution 2286 in 2016, while attacks have continued to rise, has useful potential implications for how we understand the Security Council's willingness and ability to influence the conduct of parties to a conflict and to protect civilians.[10] We also highlight the ways in which Resolution 2286 was particularly politicized because Security Council members were implicated in attacks. We suggest this is a potential

explanation for both the Security Council member states' failures to turn talk into action and the diffuse and limited implementation of Resolution 2286 by a handful of other member states/non-Security Council member states, nonstate actors, and nongovernmental organizations (NGOs) that followed.

Resolution 2286 was drafted by representatives from Egypt, Japan, New Zealand, Spain, and Uruguay (the "penholders"). They were supported in their efforts by the ICRC, MSF, and the UN, all organizations with first-hand, field-based experience and understanding of the problem of attacks against health care. These organizations were also instrumental in drawing attention to attacks. For example, since 2011, the ICRC-established Health Care in Danger project has aimed to influence the doctrine and practice of weapon bearers, document interruptions of health service and the frequency of violent incidents, and monitor the impacts of attacks on the effectiveness and sustainability of health care. This initiative also sought to mobilize a "community of concern" to address the issue and increase accountability for attacks through effective state investigations and prosecution of crimes committed against health care personnel, facilities, and transport.[11]

As a result, the resolution's analysis of the problem and the possible responses to it were solidly grounded in the experience of key actors engaged in settings of armed conflict. Peter Mauer remarked on this publicly at a Security Council meeting:

> Every comma [in the resolution] has been carefully considered and negotiated and the result is strong.... In clear language, the Council has underlined the importance of international humanitarian law and called on all States and all parties to armed conflict to comply with their obligations and develop effective measures to protect people's lives by preventing and addressing violence against medical personnel, facilities, transport and humanitarian personnel engaged exclusively in medical duties.[12]

The resolution's language was also reviewed and revised through rounds of negotiation.

What the resolution says – and does not say – falls into three parts, with calls to action outlined in its final paragraphs. First, the resolution recalls legal obligations and reminds parties of the relevant IHL. The resolution's preambular paragraphs recall the specific IHL obligations of parties to a conflict to respect and protect medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, and hospitals and other medical facilities, and to ensure that the wounded and sick receive medical care and attention. They recall the obligation to distinguish between civilian populations and combatants, the prohibition against indiscriminate attacks, and obligations to do everything feasible to verify that targets are neither civilians nor civilian objects and are not subject to spe-

cial protection, including medical personnel, their means of transport and equipment, and hospitals and other medical facilities. These opening paragraphs also recall the obligation parties to a conflict have to take all feasible precautions to avoid and minimize harm to civilians and civilian objects.

Second, reminders turn to condemnation as the resolution points to rules that are not being followed, and identifies some of the most significant areas where human lives are being lost as a result of attacks on health care. Having laid out the legal framework, the resolution expresses the Security Council's deep concern that "despite these obligations, acts of violence, attacks and threats against medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities, are being perpetrated in situations of armed conflicts and that the number of such acts is increasing."[13] It further and rightly observes that "locally recruited medical personnel and humanitarian personnel exclusively engaged in medical duties account for the majority of casualties among such personnel in situations of armed conflict" and that "the delivery of humanitarian assistance, including medical assistance, to populations in need is being obstructed by parties to armed conflicts in many conflict situations."[14]

Finally, the resolution turns to questions of what is to be done. Here, the resolution shifts to softer language when calling for action on practical measures for protecting health care and accountability for the perpetrators of attacks. The operative paragraphs of the resolution provide a series of actions to be taken by parties to a conflict, and member states, to keep health care safe from attack. The resolution "demands" that parties to a conflict comply with relevant IHL and human rights law (HRL) obligations, and that parties to a conflict and member states develop effective measures to prevent and address acts of violence, attacks, and threats, including at the domestic level and in the conduct of military operations. The resolution also calls upon member states to ensure that their armed forces integrate practical measures for the protection of the wounded and sick and medical services into the planning and conduct of their operations. What these practical measures might entail is left up to individual states. The text of the resolution further urges member states to conduct independent and impartial investigations into incidents affecting the protection of medical care in conflict that may fall within their jurisdiction, with a view to reinforcing preventive measures and addressing the grievances of victims. It aims to end impunity for violations.

One interpretation of the resolution's call to action, without any specification of *what action* should be taken, is that it acknowledges the diverse and context-specific measures needed to protect health care in different types of conflict. A less charitable characterization of the resolution is that, by failing to ask state and other actors to undertake specific actions, it gives conflict parties a way out of tangible behavioral change.

The challenges of turning talk into action were noted at the time of the resolution's adoption by Joanne Liu, who insisted that the Council "must translate this resolution into action. It must recommit unambiguously to the norms that govern the conduct of war. [The] resolution must lead to all State and non-State actors stopping the carnage."[15] And since the adoption of Resolution 2286, a range of actions has been undertaken by different state and non-state actors in support of the protection of health care in armed conflict. From 2017 to 2021, the secretary-general's reports on the protection of civilians have documented various efforts to strengthen the protection of health care, including state-led reviews of national legal frameworks, efforts to improve the collection of data on attacks against health care, and the development and sharing of good practices. However, our analysis of the secretary-general's reports during this period also shows that the actions taken by states have focused predominantly on debate and advocacy, with only limited reporting of any new state-developed "effective measures to prevent and address acts of violence, attacks and threats against medical personnel and humanitarian personnel" that Resolution 2286 calls for.[16] Since 2016, NGOs have been the primary actors that have taken, or been handed, responsibility in moving the issue forward. However, these organizations do not conduct war, nor can they change its conduct themselves.

The period of 2017 to 2021 saw a range of intergovernmental initiatives purportedly in support of Resolution 2286. In 2016, Canada and Switzerland established an "informal group of friends" of Resolution 2286, which includes Australia, Austria, Belgium, Brazil, France, Germany, Italy, Japan, Liechtenstein, Luxembourg, the Netherlands, Norway, Portugal, the United Kingdom, and Uruguay. Members of the group made statements at the annual open debates on the protection of civilians in armed conflict, advocating respect for IHL and HRL and protection of health care by parties to a conflict and full implementation of Resolution 2286. Here, states were engaged in advocacy that repeated much of what was already called for in Resolution 2286. These states, with a few exceptions, were not engaged in active conflict.

In a similar vein, France proposed a "Declaration on the Protection of Medical and Humanitarian Personnel" in 2017, which was subsequently endorsed by eleven other UN member states. The endorsing states pledged to take "practical measures to enhance the protection of, and prevent acts of violence against, the medical and humanitarian personnel, and to better ensure accountability for violations."[17] The initiative was welcomed at the time as a "concrete step" toward implementation of Resolution 2286.[18] In terms of substance, however, the declaration covers similar ground to the resolution and raises the question of why these states felt the need to adopt a declaration committing themselves to actions already called for under Resolution 2286.

Much of the state action taken during this period layered new promises on top of those that were articulated in Resolution 2286. These statements and declarations did not introduce new implementation mechanisms and, perhaps as an unintended consequence, distracted the global community from ongoing inaction. As reported by the secretary-general, some national armed forces have adopted measures to better protect medical care. For example, these national militaries factored in the location of medical facilities when establishing defense and attack zones and movements of troops and material, refrained from using medical objects to support the military effort, took precautions in the conduct of war (for example, by issuing warnings), separated evacuation routes and areas from those intended for armed forces, verified that rules of engagement were in line with international humanitarian law, and ensured the presence of a legal adviser to counsel the chain of command.[19]

Some nonstate armed groups have demonstrated greater openness and transparency regarding attacks on health care than UN member states involved in armed conflict. In 2018, the NGO Geneva Call launched a "Deed of Commitment on Protecting Health Care in Armed Conflict," which seeks to ensure that armed groups provide and maintain access for affected populations to essential health care facilities, goods, and services, without adverse distinction – that is, ensuring civilian facilities are identified and not attacked – and that armed groups facilitate the provision of health care by impartial humanitarian organizations.[20] At the time of writing, four armed groups have signed the deed of commitment and, in doing so, agreed to allow and cooperate in the monitoring and verification of their commitments by Geneva Call.[21] This could include visits and inspections in all areas where they operate, and the provision of the necessary information and reports. Thus far, states have accepted much less scrutiny and oversight in relation to implementation of their IHL obligations in general, let alone in relation to the protection of health care.

The various actions and initiatives discussed above notwithstanding, it should be noted that the extent to which state and nonstate actors have been motivated by and acted in response to Resolution 2286 is not clear. Actions may have stemmed from the concerted efforts of organizations, such as the ICRC, to engage the concerned actors, and promote and support such measures in the context of its Health Care in Danger project. It might also be the case that these actions were part and parcel of broader efforts to implement IHL or were taken for altogether different reasons.

Nonetheless, the secretary-general's reports between 2017 and 2021 have continued to emphasize the need for parties to a conflict to comply with IHL and ensure the protection of health care personnel, facilities, and transport; and for member states in particular to step up their efforts to implement the provisions of Resolution 2286. Other analysts and commentators have been even more direct in

their assessment of the degree to which the resolution has been implemented. Referring to the "global onslaught of violence against health workers, facilities, and transport from 2016 through 2020," the Safeguarding Health Care in Conflict Coalition chastised the Security Council and member states for their "abject failure... to take any meaningful measures to prevent attacks or hold those responsible to account" as required by Resolution 2286.[22]

The sources of this failure are twofold and connected. First, the Security Council did not use the mechanisms already at its disposal to prevent attacks against and enforce protections of health care. Resolution 2286 did not include a formal process for ensuring monitoring, reporting, or accountability, although there are precedent-setting resolutions that do so and thus could have served as models. Second, diffuse implementation by a few cannot make up for a general avoidance of responsibility, particularly by Security Council members but also by other member states. As existing mechanisms go unused, a culture of state impunity is encouraged, and so too is a willingness to shift state responsibility to others, such as NGOs.

Beginning with the most general mechanisms available, the Security Council has at its disposal tools for promoting and ensuring implementation of its resolutions and compliance with IHL and for sanctioning noncompliance. It has increasingly used targeted sanctions in response to some violations of IHL and HRL. The designation criteria for sanctions regimes – which determine who is subject to sanctions – in the Central African Republic, the Democratic Republic of the Congo, Mali, Somalia, and South Sudan expressly include individuals or entities responsible for attacks on hospitals (which might initially appear rather limiting but could be interpreted broadly by the sanctions committees to apply to health care personnel, facilities, and transport).[23] The designation criteria for Libya, Sudan, and Yemen are less specific but include planning, directing, or committing acts that violate IHL and HRL, which could potentially include attacks on health care.[24]

The Security Council also has the authority to establish commissions of inquiry to further examine situations involving serious violations of IHL and HRL, as it did in relation to Darfur in 2004 and the Central African Republic in 2013.[25] It can refer such situations to the International Criminal Court for further investigation and prosecution of alleged perpetrators, as it has done in relation to Darfur in 2005, on the basis of the report of the commission of inquiry, and Libya in 2011.[26] Again, there is scope within these measures for the Security Council to address attacks against health care, should it choose to do so.

What is more, along with attacks against schools, attacks against hospitals are one of the six grave violations of children's rights that are subject to the Security Council's monitoring and reporting mechanism (MRM) on children and armed conflict (CAAC).[27] For more than fifteen years, the MRM has "worked to document

and verify failures to protect children in armed conflict – namely, instances where there have been grave violations against them – and has encouraged dozens of parties to conflict to engage with the UN toward making concrete changes that have positively affected the lives of children living through conflict."[28]

Established pursuant to Security Council Resolution 1612, the MRM systematically gathers information on the six grave violations.[29] In addition to attacks against hospitals and schools, these include killing and maiming children; recruitment or use of children by armed forces or armed groups; sexual violence against children; abduction of children; and denial of humanitarian access for children. The mechanism is automatically activated by the listing of a party to an armed conflict in the annexes to the UN secretary-general's annual reports on children and armed conflict. These and country-specific reports are then reviewed by the Security Council Working Group on Children and Armed Conflict and used to inform its conclusions and recommendations.[30] These can range from referrals to sanction committees, recommendations to governments and armed actors, or even suggested referral by the Security Council of a given situation to the International Criminal Court. No such formal process was embedded in Resolution 2286, but processes under the MRM do seek to protect humanitarian access and hospitals. For example, in the secretary-general's 2022 CAAC reports, parties are listed for attacks on schools and hospitals, alongside other violations.[31] While criticisms in recent years have suggested that the listing mechanism has been politicized, allowing some states to remain off the list and avoid scrutiny, these are measures "with teeth" that work, however imperfectly, to encourage compliance with international law.[32]

Last but not least, the option also exists for the Security Council to request that the secretary-general appoint a special representative on the protection of health care who would be mandated to monitor, support, and report on the implementation of Resolution 2286 by member states and parties to a conflict. Special representatives of the secretary-general have been appointed with respect to children and armed conflict and conflict-related sexual violence at the request of the Security Council. The Council has, so far, not chosen to do so for the protection of health care.

Resolution 2286's failure to alter the conduct of war can also be attributed to the politicization of attacks on health care and the diffuse implementation of the resolution. Ultimately, implementation rests on the willingness of individual parties to a conflict, states, and the UN secretary-general – to whom the resolution's operative paragraphs are addressed because existing prevention and enforcement mechanisms go unused, and new mechanisms are not formally embedded in Resolution 2286.

This reliance on political will appears to have emerged in part because the conditions we see at play during the drafting of Resolution 2286 differ from those that

allowed for the formalization of enforcement mechanisms in Resolution 1612 and subsequent resolutions on CAAC. The CAAC resolutions focused on strengthening protection for children in armed conflict, which is a topic that can easily gather broad agreement and be discussed without quickly implicating Security Council members, member states, and other parties to a conflict. By contrast, documentation of attacks on health care, calls for prevention, and demands for accountability strike at the heart of state conduct in war. Recall that in 2016, during debates on Resolution 2286, the UN Security Council was reminded that four out of five of its members had perpetrated attacks on health care. At the time, the United States and Russian Federation were also engaged in war by proxy on multiple fronts, in which attacks on health care were consistently reported. Restraint was therefore likely perceived as a potential source of disadvantage in ongoing conflicts, making it unlikely that Resolution 2286 would include formalized enforcement mechanisms.

As discussed above, implementation of the resolution was taken on by a few states engaged primarily in debate and advocacy, as well as by nonstate armed groups and NGOs. Additionally, rather than formalizing state and warring party responsibilities and accountability, the resolution asked the secretary-general to provide country-specific situation reports, to report on the issue of the wounded and sick, medical personnel, and humanitarian personnel (that is, their transport, equipment, and medical facilities), and to recommend prevention and accountability measures. This meant that the secretary-general was a key player in the implementation of Resolution 2286, but the demands quickly overwhelmed his office.

The UN secretary-general was mandated to follow-up in a range of ways, but directives proved difficult to fulfill due to a series of structural barriers, including missing information, impediments to information sharing, and limited political will from the Security Council. The secretary-general was encouraged by Resolution 2286 to alert the Security Council of any situation in which the delivery of medical assistance to populations in need is being obstructed by parties to the armed conflict – an action he has yet to take. He was further requested to use both his regular country-specific reports and his annual report on the protection of civilians to document specific acts of violence against health care, remedial actions taken by parties to conflict and other relevant actors to prevent similar incidents, and actions taken to identify and hold accountable those who commit such acts.[33] The Security Council also requested that the secretary-general provide briefs every twelve months on the implementation of the resolution.

One key challenge is related to the availability of the kind of detailed data requested by the Council and the abilities of the secretary-general's office to report on it. Data collection initiatives are ongoing, such as the World Health Organization's Surveillance System for Attacks Against Health Care, which was launched in December 2017, and Insecurity Insight data on attacks against health care,

published by the Safeguarding Health in Conflict Coalition (SHCC). UN field-based data also inform the secretary-general's annual reports. However, country-specific situation reports and protection of civilians reports, which are limited in length, cannot accommodate additional detailed information while also meeting other mandated reporting requirements on, for example, the protection of journalists, missing persons, persons with disabilities, and conflict-related food insecurity or emerging protection of civilians issues.[34] With the exception of his 2021 report, which focused on implementation of Resolution 2286 to mark its fifth anniversary, the secretary-general's annual protection of civilians reports have been limited to providing general information pertaining to attacks against health care without identifying alleged perpetrators.

Furthermore, detailed and specific discussion of the measures taken by states and other actors to enhance the protection of health care and implement the provisions of Resolution 2286 are often absent for a variety of reasons. This may indicate that information is not (yet) available or may reflect the limited political will of parties to a conflict and states to report on their lack of progress in implementing the resolution. For example, in 2018, the UN Secretariat canvassed the members of the informal "Group of Friends" of Resolution 2286 on steps they had taken to implement the resolution. Only one state responded.[35] A similar survey of all 193 UN member states in advance of the 2021 report focusing on implementing Resolution 2286 received only fourteen responses.[36]

We see limited political will at the Security Council as well. In August 2016, the secretary-general submitted a comprehensive and detailed set of recommendations in response to the request contained in Resolution 2286 that the secretary-general outline "measures to enhance the protection of, and prevent acts of violence against, the wounded and sick, medical personnel and humanitarian personnel."[37] The recommendations sought to establish a framework to prevent attacks and promote the practical implementation of precautionary measures throughout military operations, and ensure documentation of acts of violence, attacks, and threats, as well as accountability for violations and redress for those affected. There was "wide agreement" among humanitarian, human rights and health organizations, and many governments that the secretary-general's recommendations "could, if implemented, dramatically increase protection of health care on the ground."[38] To date, however, the Security Council has not raised the recommendations for consideration despite having itself requested them. The Council is not willing to act. And yet its responsibility for the protection of health care cannot be delegated to institutions or NGOs that do not take part in war.

There are things that the Security Council *could* be doing. Regarding the protection of civilians, attacks against health care are essentially problems of state and nonstate parties to a conflict not complying with their existing le-

gal obligations, and specifically international humanitarian law. There is no doubt that the next penholders on resolutions that address the conduct of war will have their work cut out for them should they wish to successfully strengthen and ensure respect for IHL. They will need to overcome a fundamental problem of power: how to get someone to do something they otherwise would not do. The reasons for complying with IHL or not, for attacking or not attacking health care, are myriad. They can change from one context, one day, one party to the conflict, one military unit, or one combatant to the next.[39] What is clear is that merely reaffirming existing commitments to international law, as Resolution 2286 does, will do little to address this state of affairs without the Security Council taking more concrete and direct steps to promote and ensure implementation of the resolution. For example, the Security Council could impose targeted sanctions or refer situations involving attacks against health care to the International Criminal Court. However, in the contemporary era, with a divided Council and a veto-wielding member continuing to carry out attacks against health care in Ukraine, the opportunities for progress in this regard are slim.

We agree with the Safeguarding Health in Conflict Coalition when they highlight the need for states (and, one would add, parties to a conflict) to be held to account for failing to carry out their commitments under Resolution 2286. However, we question SHCC calls for additional UN secretary-general reporting or for the secretary-general to appoint a special representative to monitor and report on state performance, as well as make recommendations to ensure greater compliance with Resolution 2286.[40] It is admirable to increase the secretary-general's ability to report in this way, but we are not convinced that this will be achievable given the current political climate and structural barriers at the Security Council. First, this appointment would require a Security Council request, which returns us to the issue of political will, which is currently lacking. Second, without a formal agreement from the Security Council, it is not clear what status the new reports of the special representatives of the secretary-general would have and whether and how they would be considered by the Council and member states.

Our assessment suggests that we turn to the future and ensure that penholders and advocates for new resolutions on issues of humanitarian concern focus, at the time of drafting, on formally tying new issues to existing mechanisms that hold states and nonstate actors to account. This would reduce strain on the secretary-general's office, prevent too much reliance on implementation by a willing few, and place responsibility back in the hands of the states – who have the greatest power to alter conduct in war. In the meantime, to protect health care, the secretary-general's resources would be better spent using – and showing a willingness to use – existing mechanisms, such as those that protect against the six grave violations against children. Demonstrating a willingness to turn talk into action would hold states avoiding responsibility to public and formal account, and begin to undermine a culture of impunity.

ABOUT THE AUTHORS

Simon Bagshaw is an Adjunct Professor and Research Affiliate at the Centre for International Peace and Security Studies at the Max Bell School of Public Policy at McGill University. He has published widely on the protection of civilians in armed conflict. Prior to joining McGill, he was a Senior Policy Advisor at the UN Office for the Coordination of Humanitarian Affairs.

Emily K. M. Scott is a Lecturer in the International Development Department at the University of Birmingham and Research Affiliate in the Centre for International Peace and Security Studies at McGill University. Her most recent research on attacks against aid workers and health care was published in the *Journal of Global Security Studies*.

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An Evacuation

Elliot Ackerman

PROLOGUE

In the U.S. military, we have a code: leave no one behind. As Kabul fell in August 2021, an improvised personal network of veterans, journalists, and activists rallied together to evacuate as many of our Afghans allies as possible and to honor that code. We made lists, we called in favors with old comrades, we even negotiated with the Taliban. Like so many involved in this effort, this dredged up conflicted memories from my past, sucking me back into a war I thought I'd left long ago.

No American war has ever ended the way that Afghanistan did, in which those who were being abandoned could communicate directly with the outside world on WhatsApp, Signal, and other platforms. The result was not only what's been called a "Digital Dunkirk," but also a strange collapse of distance, in which I could be on summer holiday with my family while simultaneously helping an Afghan family navigate the Marine checkpoints at Kabul airport on my phone. I soon found myself back in touch with old comrades, like Chris Richardella, the lieutenant colonel who commanded the Marines at Kabul airport's North Gate as well as a contingent at the Abbey Gate, where a suicide bomber would kill 13 U.S. servicemembers and 170 Afghans on August 26, 2021. And Ian, a former CIA officer, as well as strangers who needed help to include an interpreter named Shah and his pregnant wife Forozan.

Did we fulfill our obligations to the Afghans? Perhaps the answer to the question lies in the specifics of what happened a year ago.

SHAH'S STORY

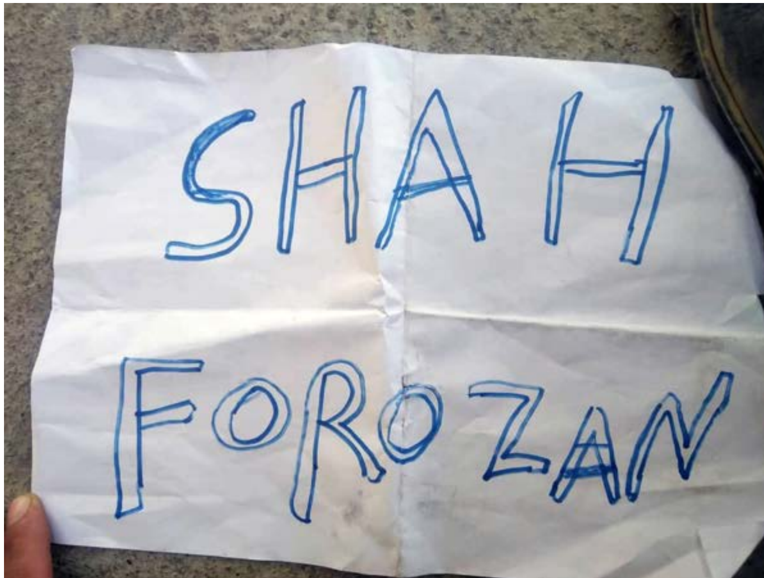
My wife counts our bags. Then she counts our children. We have everyone and everything. Shoulder-to-shoulder we load into the taxi. She also counts the time, which she's made sure we'll have plenty of, so we won't miss our flight. We're heading from the airport in Venice to the next stop on our vacation, in the south of Italy. I've often teased her about how early she makes us arrive at any airport. But because of her we've never missed a flight, and likely never will.

Shah is also on his way to the airport, as are the eight Afghans from Ian's group. Richardella, who is inside Kabul International Airport, posts in our chat: *Let's shoot for 1300. Consolidate who you can and tell them to move toward the front of that side gate.*

Our chat has a new addition, Danny. He fought alongside Shah in Afghanistan and is a friend of a friend. He is in direct contact with Shah. After Richardella sends his message, I post: *Rgr. Ian, copy? Danny, copy?*

Both reply: *copy.*

The Marines will need to be able to recognize Shah in the crowd. To signal them, Shah writes his name in blue block letters on a piece of white printer paper along with that of his wife, Forozan. It's the best he can do. Danny posts a photograph of Shah's paper sign to the chat, so Richardella can pass it along to the Marines who will be looking for him.



Ian is struggling to get in touch with his eight at the mosque. He posts, *I've lost comms with Adeeba and group. Her WhatsApp was last seen an hour ago, don't want to hold you guys up.*

Richardella posts, *Let's get as many in at once as possible. This site is burned. I want to get this group in before we shut it down for a while.*

Ian asks Danny if he knows what Adeeba said to Shah when they last spoke the night before.

When I arrive at the airport with my family, Danny still hasn't responded to Ian's question. The taxi driver is helping us unload our bags and I am doing my best to pay attention to the chat and to help my wife count the bags and the chil-

dren as we move into the terminal. We are at the ticket counter when a response from Danny finally arrives: *I think she just made contact . . . Standby . . . She's close to the north gate . . . She called Shah . . . He is looking for her.*

Ian answers, *I needed that. Thanks.*

Danny posts a photograph taken by Shah to the group chat. It is of his perspective with relation to the North Gate. A pair of wheelbarrows sit in the foreground filled with bottled water that vendors are selling to the desperate, exhausted crowds. Beyond the vendors, those trying to leave have pressed themselves against a concrete wall. The top of the wall is threaded with coils of concertina wire.

At a distance, a single helmeted head wearing wraparound sunglasses pokes above the wall. The muzzle of a rifle is trained on the crowd. It's one of the Marines from my old unit – the 1st Battalion of the 8th Marine Regiment, said "one-eight" in Marine speak. I fought in 1/8 as a 24-year-old platoon commander in Fallujah. They're known as "The Beirut Battalion" because nearly 40 years before, on October 23, 1983, Marines from 1/8 were guarding the airport in Beirut when Hezbollah detonated a pair of truck bombs, killing 241 Americans. Given 1/8's legacy, its deployment to Hamid Karzai International Airport only adds to the myriad minor subplots in the drama unfolding at the airport.

Shah now draws a big red arrow on the photograph pointed down at this Marine with the rifle. When he shares it, Danny writes, *Working to get a better picture but this is what I got. Shah didn't want to get too close.*

Ian sends the photo to Adeeba. Their two groups are struggling to find one another at the North Gate. He writes, *Trying to talk her through sharing location with me on WhatsApp.*

My wife needs my passport. She has checked our bags at the ticket counter, and they are now printing out our boarding passes. "Didn't I already give my passport to you?" I ask, shifting my attention away from the phone. She shakes her head, no. In her hand are everyone else's passports except mine, and she reminds me how when she had offered to hold onto all of the passports at the beginning of the trip, I had insisted on keeping track of my own. I rifle through my pockets, until I recall that I'd put the passport in my carry on. I hand it to her and return to my phone, where I see that Richardella has posted another message, *The team needs to move to the fence gate. Get to the front and sit tight. How many are we extracting?*

I write, *Danny, I'm tracking you're: 2 pax* [passengers], *Ian, I am tracking you're: 8 pax. That's 10 pax total. Confirm.*

Both confirm the numbers traveling in their groups and that they are now headed to the side gate. Richardella posts, *Let us know when the group has linked up and are in position. We'll be ready.*

The crowd around the North Gate is a thick swaying mass, jammed chest-to-chest and shoulder-to-shoulder. In recent days, the Biden administration has publicly remarked that those with visas to the U.S., as well as green card holders and American citizens, are free to enter the airport for processing. Except entering the

airport is no small feat. The crowds are so dense, the environment so chaotic, that what we're asking Shah and Adeeba to do is the equivalent of finding each other in the crowd at a packed rock concert – say, The Rolling Stones at Altamont – and then working their way to the front of that crowd and then getting the attention of the band so they can be lifted up on stage.

Ten minutes have passed when Ian writes, *Update: Adeeba says she can see the gate and is trying to get there. I've tried to talk her through sharing location in WhatsApp, but for now seems better that she just keep moving. I will ping her in a few and reassess.*

Danny responds, *Shah is at location where tear gas was just dropped as a reference point for location.*

Another 10 minutes go by. I am waiting in the security line with my family at the airport when Ian posts, *She seems far still.*

Danny writes, *Shah close to gate, but not pushed up so as to link up with Adeeba.*

Ian confirms that Adeeba is still struggling to get up to the gate. Danny tells him that Shah will keep waiting. Shah has never met Adeeba. She is a stranger to him, but he'll wait. Then Ian posts, *Appears to me she will get there right at 1300.*

Richardella pops up in the text, *How many are ready to go?*

Danny: *Link up with two groups happening at north gate now, standby for confirmation.*

Richardella: *Roger, let us know. They can link arms, move to the front, and we'll bring them in.*

A few more minutes pass. Danny comes up in the chat. It seems the link up between Shah and Adeeba has occurred, though it's not entirely clear and I post: *Roger, so I copy all 10 pax linked up and moving to North Gate now.*

Danny confirms this as I'm emptying my pockets into a dish, to include my phone. I pass through the metal detectors at security. In the few minutes it takes me to gather my things and walk with my family to the gate for our flight, the text chain proceeds like this:

Richardella: *We're here and ready. What's signal of lead trace?*

I repost the sheet of paper with Shah and Forozan's names printed in blue block letters.

Danny: *Linking arms. Pushing to front now.*

Richardella: *Copy on all. We're ready.*

For good measure, I repost a photograph of Shah while Danny reposts a photograph of Forozan, so both will be more easily recognizable to the Marines.

Richardella: *This is what it looks like from our end. Canal to the south, t-walls north which is the vehicle entrance. Vendors are right behind the group in front of us.*

The photograph he posts is taken from down a narrow open-air corridor, a ravine of barricades, dominated by a cement wall on one side and a chain-link fence on the other, which drops a dozen feet into a putrescent canal. Empty bottles of water seemingly hurled over the wall by the crowd, as well as shreds of cardboard and rocks, litter the ground. Tangles of wire lurch toward one another as though frozen

in the act of collapse. Their contorted attitudes reinforce every conceivable point of vulnerability, from the tops of the walls to the opening of the single steel door at its far end. The plan is for the Marines to charge down this corridor, out into the crowd, and then to haul our group inside.

Danny: *Relayed your picture. Their view.*

The photograph is taken by Shah. He is wedged into the crowd, so the frame is mostly consumed by the backs of other people's heads. In the distance you can see a pair of Marines barricaded behind a concrete wall with a roll of concertina wire unspooled across its top and a security camera with its black orbed lens dangling overhead on a small crane.

Richardella: *They are in front of the vehicle entrance the fence gate is to their left on the south side of the t-wall. They need to move back, go around and swing left.*

Danny: *Rgr. Communicating it to him.*

Richardella: *The canal is to their left. That's the catching feature. Hit the canal and turn right. Come to the fenced gate.*

(A minute of silence passes.)

Richardella: *Got visual. Keep coming forward.*

Danny: *Lost comms he's moving.*

Richardella: *We're moving now. We see him.*

Danny: *On phone w Shah that's him*

Richardella: *We have him.*

Danny: *I love you. Thank you sir.*

I have since arrived at my gate. My son is sitting beside me, playing a World War II fighter pilot game on his iPad. He blasts Nazi Messerschmitts and Japanese Zeros out of the sky. The other children are doing much the same, playing games on their phones or their iPads, watching videos, gently bickering with each other and generally killing the 30 or so minutes until we board our flight. My wife slips into the seat next to mine. "You OK?" she asks. I show her my phone. She scrolls through the past 15 minutes or so of messages. My wife cries easily – I've even seen her cry watching football. It's one of the many things I love about her. When she hands me back my phone, she is wiping tears from her eyes and she says only, "Thank God."

At this, my son glances up at the two of us and asks, "Are you guys OK?"

"We're fine," says my wife. "Some people who your dad has been trying to help look like they're going to get out of Afghanistan."

"But that's good news," he says. "Why are you both crying?"

My wife places her hand on the back of my neck. Very quietly, she says, "I think I'm just happy for those people." Then she looks at me and adds, "And I'm happy for your dad."

My son sits up straight, flaring back his shoulders ever so slightly. He puts his hand on my shoulder. He considers me for a moment like a general reviewing one of his troopers in the ranks, and with all the seriousness, composure and gravitas a 9-year-old boy might muster he says, "Good work, Dad. I'm happy for you too." Then he goes back to his game.

In the chat, we're trying to confirm that everyone got through the gate, that in the chaos no one was inadvertently left behind. Ian reposts the manifest for Richardella to confirm. In addition to confirming the manifest and that consular services have now processed everyone into the airport, Richardella posts a selfie. Shah stands center frame with his left arm embracing Forozan. To their right is Richardella whose arm is outstretched as he snaps the picture. He still wears his helmet and body armor, with a small and familiar 1st Battalion, 8th Marines unit crest velcroed to his chest alongside his rank insignia. The eight others in

the group are huddled around these three, cramming themselves into the frame. Their smiles are unrestrained.

Ian writes, *Heroes.*

I write the same.

Danny writes, *I'm crying. Heroes. There's the fucking mannnnn*

Our flight is going to board soon. My wife asks me if I wouldn't mind grabbing us a few sandwiches as we're going to miss lunch and who knows what they'll serve on the plane. I wander off into the terminal, to a small kiosk, where I wait in line. On a separate thread, just to Richardella, I write: *Rich, on a side note, I was wondering which of your companies got them A, B, C, Wpns? Just as an alum. Really damn fine work. I'm so grateful to you and those 1/8 Marines.*

He doesn't answer right away. He's busy, of course. I pick out a few sandwiches, some waters, a treat for each of the kids. In my pocket, I feel my phone ping with Richardella's response, but need to finish paying. I take my change from the cashier and with my arms full manage to find a place to sit down. I fish out my phone. Rich has written, *Your old company of course. Anything for a Beirut Marine.*

My two wars, which spanned two decades, seem to collide with one another in this message. The force pins me to this seat in the airport. I sit there with the bag of sandwiches at my feet, in a daze, while whole packs of travelers seem to float by. I am staring vacantly across the terminal when my son eventually finds me. "Dad," he says, "It's time to go. We're boarding."

He and I rush to the gate. When I arrive at my seat on the plane, there's a last message posted by Danny: *Any idea where they are flying to?*"

POSTSCRIPT

Today, Shah and Forozan live outside Baltimore. Lieutenant Colonel Richardella and his Marines have since returned to Camp Lejeune. For Ian and Danny, life has resumed its familiar rhythms. And yet each of us carry our memories of those weeks as a bookend to our war.

During the Kabul Airlift – as it has come to be known – the U.S. government evacuated roughly 120,000 people over a seventeen-day period, only a fraction of those who came to the airport.[1] After the last flight departed, President Biden described the effort as an "extraordinary success" while his critics continue to label the withdrawal as "an absolute debacle and an embarrassment."[2] I remain conflicted. We fulfilled an obligation to people like Shah and Forozan, but we failed too many others to whom we made promises and with whom we had partnered over two decades. They remain trapped in the Taliban's Afghanistan. Ultimately, how we judge last summer one year later and our nation's obligation to Afghanistan is less relevant than how it's judged in future years by other generations of Americans. I'm thinking of one person when I imagine that judgement: Daniel Ahmad, born an American, in America, and named for the man who saved his Afghan parents.

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ABOUT THE AUTHOR

Elliot Ackerman is a *New York Times*-bestselling author whose books have been nominated for the National Book Award, the Andrew Carnegie Medal in both fiction and nonfiction, and the Dayton Literary Peace Prize, among other honors. He is a former White House Fellow and Marine and served five tours of duty in Iraq and Afghanistan, for which he received the Silver Star, the Bronze Star for Valor, and the Purple Heart.

ENDNOTES

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https://doi.org/10.1162/DAED_a_02007

Localizing Responses to Gender-Based Violence: The Case of Women-Led Community-Based Organizations in Jordan

Dima M. Toukan

While the rationale for localizing humanitarian health response is well established at the level of policy rhetoric, the operationalization of the concept and its mainstreaming into concrete practice still require clearer intentionality. With COVID-19 pushing more people further into vulnerability, placing local communities at the heart of humanitarian and development health efforts has never been more urgent. Focusing on Jordan, this essay brings attention to the significant toll of violence against women and girls in conflict-affected communities and the importance of empowering local actors with community knowledge and resources to prevent and respond to gender-based violence. The essay follows on from the research conducted for CARE Jordan's She Is a Humanitarian *report (2022) and draws on interviews I conducted with the heads of women's organizations in the summer of 2022. The essay explores the role of local women humanitarian actors as frontline responders, the challenges that hinder their role, and the advantages such actors enjoy, which, if harnessed, can achieve gains in accountability, health service quality, and gender equality.*

In recent years, Jordan has been weathering a deteriorating situation, caused by a confluence of factors including the conflicts in Iraq and Syria, the regional turmoil resulting from the 2011 Arab uprisings, and, more recently, the COVID-19 pandemic. Jordan hosts 760,000 refugees, which constitutes the second largest proportion of refugees per capita in the world.[1] Only 17 percent of refugees live in refugee camps, with the majority living in urban and rural areas across the country. The prolonged displacement of refugees has placed significant pressure on the country's already overstretched resources and services. The situation is severely impacting women and girls in Jordan, increasing gender-based violence (GBV) risks and incidents for refugees and host communities alike, and hiking demand for related health services.

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https://doi.org/10.1162/DAED_a_01998

Jordan's refugee community is diverse. Approximately 88.5 percent of registered refugees are Syrian, 8.8 percent are Iraqi, and the remaining are other nationalities, including Somalis and Yemenis.[2] Social protection is provided to refugees and Jordanians through governmental services and civil society, with refugees relying more heavily on UN agencies and nongovernment actors and community-based mechanisms, including for a range of health services.[3] Women-led organizations are an integral part of these mechanisms providing services, as well as protection and empowerment programming that uplift women and meet survivors' needs. The essay unfolds in several parts to highlight their role in addressing rising GBV incidents, the challenges they face, and the role they could potentially assume with more effective support. In a country reeling from the impacts of regional conflict and the COVID-19 pandemic, there is a clear imperative to localize GBV services through support and empowerment of women-led community-based organizations as part of a broader localization agenda.

Gender-based violence is a multidimensional problem that finds root in gender inequality, harmful cultural norms, and the abuse of power.[4] More than 25 percent of married Jordanian women between the ages of fifteen and forty-nine have experienced a form of violence by a partner, and about one-half of women and more than two-thirds of men consider domestic violence to be justified in certain circumstances.[5] Refugee women and girls suffer additional risks because of displacement, conflict, separation of families, and disruptions to vulnerable livelihoods, support systems, and protection structures.

As a global health issue, GBV creates both immediate and long-lasting health impacts on physical and mental health, including injury, unintended pregnancy, sexually transmitted infections, depression, post-traumatic stress disorder (PTSD), and even death.[6] Other than PTSD and depression, intimate partner violence, which remains the most common form of GBV around the world, is consistently associated with protracted disabling sleep disorders, phobias and panic disorder, suicidal behavior, and self-harm and psychosomatic disorders.[7]

As elsewhere in the world, Jordan has experienced an increase in GBV incidents during the COVID-19 pandemic. A 2020 rapid assessment commissioned by the United Nations Population Fund – conducted in three governorates and the two refugee camps of Za'atari and Azraq – revealed that 69 percent of survey respondents and informants reported increasing prevalence of GBV. Emotional abuse and physical abuse, often by an intimate partner or member of the family, were the most commonly occurring forms of abuse. GBV remains underreported, and mobility restrictions, due to COVID-19 lockdowns, left survivors with fewer options for reporting and a decreased access to related services. Women shelters had to close their doors to reduce their staffing.[8] Survivors, especially of domestic violence and intimate partner violence, were hesitant to seek help when they were

stranded at home with their abusers. The lack of access to mobile phones also affected their ability to call for help.[9]

Refugee women in Jordan have also had varying degrees of access to critical health services. Indeed, twelve years into the Syrian crisis, the integration of Syrian refugees into existing service systems in Jordan is still limited. Parallel service structures continue to exist with different services being provided in camps and in urban areas to both out-of-camp refugees and host communities. As a result, services vary in quality, accessibility, and affordability.[10] In the Za'atari and Azraq camps, services are free at the point of access and adhere to international standards and norms. In urban areas, by contrast, not all services are free at the point of access and quality tends to be lower.[11]

Nevertheless, service gaps exist both in and outside of camps. Refugees are not always consulted on the design of programs. Outreach to communicate about available services is also deficient in many locations. This is particularly the case for GBV, for which there is a need for additional GBV hotlines that render less stigmatized access to services, as well as psychosocial specialists who can provide gender-sensitive quality of care. Some health care providers harbor victim-blaming, or other negative attitudes toward those seeking help. Such individual-level provider attitudes, in turn, inhibit reporting and access to services, and affect the delivery of quality services.[12]

Women, however, are not only victims or passive recipients of assistance.[13] Today women across the world are becoming a leading force in disaster risk reduction and emergency response, including health services. Though underrepresented in leadership positions, women make up more than 40 percent of the humanitarian workforce.[14] Their ability to take humanitarian action therefore enables participation by and accountability to crisis-affected populations.[15]

In a study of seventy countries over four decades that examined the most effective way to reduce women's experiences of violence, the most critical factor was the strength of women's organizations or the women's movement in that country.[16] It also found that women's participation at all levels is key to the operational effectiveness, success, and sustainability of peace processes and peacebuilding efforts.[17] When women are able to participate equally, humanitarian responses – including those related to health services – are also more effective and inclusive.[18]

Whether as individuals or as part of women-led organizations, women humanitarians play an active role in responding to immediate crises and carrying out longer-term development work. Operating at the grassroots level, women's organizations are quick to act as first responders providing material assistance and life-saving services and supporting awareness raising and risk communication. Furthermore, these organizations have a clearer understanding of the com-

munities they serve and will often provide a more contextualized response that leverages social capital and networks and helps deliver gender transformative and sustainable solutions.[19]

In Jordan, in light of the country's legacy as a host state to waves of refugees, including Palestinians, Iraqis, and most recently Syrians, the civil society to which these organizations belong has long been involved in humanitarian work. Women-led organizations are well represented within the sector, especially those that work within the humanitarian space. Women-led community-based organizations (CBOs) can access affected populations more easily and navigate complex local dynamics more readily, thereby providing culturally situated responses.[20]

Because of prevailing social norms, women's mobility in Jordanian communities is generally restricted. CBOs serve as one of the few public spaces in which women can gather and engage. Furthermore, the tribal nature of Jordanian society frowns upon referrals to more formal institutions. According to the heads of several women-led organizations, many GBV incidents in the country are addressed through informal mediation – whether by family members, tribal leaders, or CBOs – to "contain the situation and maintain family unity."[21] As a result, health-related GBV consequences, especially mental impacts, do not always receive proper attention. And yet, as female-only spaces, women-led organizations default as safe spaces for both Syrian and Jordanian women. When effectively supported, such organizations serve as entry points for quality services and information.

In recognition of their vital role, the localization of aid agenda calls for a greater inclusion of local actors to make humanitarian and development action more effective and efficient. As stated in the "Grand Bargain" at the World Humanitarian Summit in May 2016, the reliance on national actors – including nongovernmental organizations (NGOs) – should be more predominant in the future design and delivery of humanitarian assistance.[22] In fact, the Grand Bargain includes a section focused on promoting a "participation revolution" to "include people receiving aid in making decisions which affect their lives."[23] Gender equality and women's and girls' empowerment also emerged as an overarching theme of the Summit.[24] The first related commitment called for empowering women and girls as change agents and leaders, including by increasing support for local women's groups to participate meaningfully in humanitarian action. Of the thirty-two core commitments made at the Summit, the commitment to gender-responsive humanitarian programming received one of highest number of endorsements.[25] Financial support to grassroots women's groups was also pledged by various stakeholders, while others made commitments to capitalize on the expertise of local women and women's groups and to support them as agents of change.[26]

Despite strong international commitments toward localization and support of national actors, progress toward the concrete operationalization of localization

has been slow. The onset of the COVID-19 pandemic brought to the fore legitimate questions regarding local capacity and agency as well as the sustainability of local development and humanitarian efforts. Testing systems and local capacity, the pandemic served to expose many of the gaps between policy commitments to localization and realities on the ground, and thus catalyzed the need to accelerate progress.

Many governments, including Jordan's, prioritized the COVID-19 response over GBV-related health service provision and failed to pay adequate attention to the need to integrate GBV risk mitigation measures into their response plans.[27] Humanitarian funding for GBV fell sharply and humanitarian activities were significantly downsized. The UN-launched Global Humanitarian Response Plan included only USD 50 million (out of a total budget of USD 2.01 billion) for GBV programs in sixteen of the sixty-three countries slated to receive COVID-19 humanitarian assistance.[28]

Several health services in Jordan and elsewhere were also disrupted during the pandemic. Many organizations restructured their programs to focus on "critical only" interventions, such as case management, to the detriment of other important services. Activities related to early marriage, sexual and gender-based violence prevention, child protection and education, livelihood activities, and capacity-building were all downscaled or impeded as a result.

Humanitarian health interventions, including GBV services, were further challenged by precautionary measures taken by humanitarian organizations, and by mobility restrictions. International staff were often unable to stay in the countries in which they served because of their organizations' weakened medical defenses. This led to significant staffing gaps that national and local organizations had to step in and fill. [29]

With lockdowns and movement restrictions, GBV service providers, including women's organizations, started to adapt their service delivery. In particular, they switched to remote service provision through the phone, social media, or other online platforms. Providers established WhatsApp chat groups to support the delivery of food and medicines in the same community, while trainings and awareness-raising sessions continued on Zoom and case management/psychosocial support and timely referrals were provided via new hotlines. The interviewed leaders of Jordanian women's organizations reported that they frequently led online sessions and held informal gatherings at home to disseminate information about COVID-19 and provide guidance about how to mitigate health risks. They also continued to raise awareness on GBV through online sessions, and to receive survivors, sometimes at their own residences.

Formal support channels gave way to informal community-based support and a de facto localized approach, as many international organizations working in Jordan opted to rely more heavily on their local staff or national and local organiza-

tions.[30] Women-led CBOs continued to receive and manage cases with limited resources and to the best of their ability. Most of the smaller women's organizations shifted to addressing immediate needs, leveraging their grassroots network to access women and girls. Given their strong roots in their communities, they were able to do so more easily than other actors.

This localized approach nonetheless revealed many of the challenges local organizations regularly grapple with in humanitarian work. Despite stepping up to address community needs, women-led organizations reported decreased local and international funding and engagement. [31] In fact, funding levels fell short of the Grand Bargain commitment to fund local organizations at 25 percent, which ran contrary to the increased responsibilities these organizations shouldered during the pandemic.[32] Even though women's organizations served as the safest entry points for GBV services amidst rising violence levels, they were stripped of their resources, calling into question the extent to which the localization agenda, which calls for a more equitable model of cooperation among international organizations and local civil society, is being achieved.[33]

Even before the pandemic, women's organizations continued to face a host of structural challenges that circumscribed their role in humanitarian health delivery. Community-based organizations struggle with staff capacity and core funding shortages. They also confront knowledge deficiencies in technical standards, especially as they relate to these organizations' ability to recognize violence and differentiate between its types, and to conduct safe referrals and provide mental health and psychosocial support. The sustainability of services also remains an outstanding issue, as CBOs continue to be donor dependent, with services linked to project funding cycles.

Partnership modalities also affect the role of women-led CBOs and the localization of humanitarian health services. To begin, humanitarian funding from the biggest donors is channeled to local implementing organizations through international nongovernmental organizations (INGOs), meaning that local organizations cannot access funding mechanisms directly.[34] Second, formal collaboration with international organizations is usually project-based.[35] When working with grassroot organizations, INGOs also tend to prefer subgranting models that dole out small amounts to a large number of local partners at the expense of long-term partnerships that build organizational capacity, leadership, and agency. The reluctance of the donor community to make sustained, long-term investments in developing the capacities of a vetted group of local actors dampens the ability of local organizations to participate meaningfully in priority setting, as well as project design and implementation. Third, given their risk aversion, INGOs prefer to engage with relatively larger organizations that need less programmatic and operational support and that already participate in coordination mechanisms. This

tends to result in partnerships with a small number of national organizations that have staff and compliance capacity, rather than a larger number of smaller CBOs, some of which would likely include community-based women-led organizations.[36] Finally, the short-turnaround timelines associated with requests for proposals do not allow INGOs or local actors the time to take stock of service needs, or to assess what is already available and can be used to optimize results. While project funding is sometimes unearmarked, it is more often restricted to specific project activities, with limited opportunities to divert resources to institutional systems or provide services based on an independent assessment of needs rather than donor criteria.[37]

According to several women-led CBOs across Jordan, INGOs usually contract them to implement a set of predefined activities, including awareness raising, case management, psychosocial support, and referral. The proportion of funds they receive, the length and nature of engagement, and the capacity-strengthening modalities do not lend themselves to the development of meaningful partnerships, nor to impactful outcomes.[38] Moreover, strict limits on overhead costs are often insufficient to cover local actors' "real" operational costs and affect their capacity to retain staff long term. As a result of short-term project models, women-led organizations are particularly likely to report high staff turnover.

Overall, the lack of long-term engagement leaves local organizations in constant survival mode. Upward accountability to donors, mostly in the form of quantitative targets of beneficiaries reached, weakens downward accountability to beneficiaries for quality of services. Compliance with different donors' requirements detracts from the ability of local actors to focus on services, as they scramble to report on outcomes they did not necessarily define and focus on generating data on service "pockets" rather than on national needs and critical gaps. Furthermore, the lack of reporting on the value brought by *local* partners hinders both the construction of an equitable international-local relationship and the promotion of a vibrant and local civil society.[39]

During interviews with the heads of several women's organizations engaged in GBV prevention and response, respondents claimed that even before COVID-19, the internationally supported projects they ended up working on were short-term and disjointed.[40] They further reported that international organizations rarely engaged them in project design, and that local input was rarely sought beyond the facilitation of access to communities and information to improve understanding of local contexts. "They ask us to bring community members for their focus groups and don't share the findings with us," said one interviewee. By chasing after short-term funding for various development and humanitarian interventions, local CBOs are also losing the opportunity to develop deep sectoral and technical expertise, as the need to appeal to different donors leads them to prefer broad mandates. The lack of sustainable funding also drives competition between small local actors.

In spite of the challenges outlined above, there remains a strong imperative to localize GBV services. To begin, localization both allocates responsibility to local actors to ensure accountability to survivors of this kind of violence and builds the type of community ownership needed to change power structures that reinforce gender and other inequalities. But localization also has the potential to improve the effectiveness of both immediate and longer-term prevention and response, including health services, by capturing and sharing what works and what does not within a local context. And last, local organizations are best positioned to undertake the kind of long-term work needed both to change the belief systems and social norms that enable GBV, and to empower women.

Local organizations' GBV services are not always easy to classify as either humanitarian response or development.[41] In fact, CBOs provide spaces for connecting longer-term health needs and immediate humanitarian solutions, working toward sustainable outcomes that can then allow both humanitarian and development organizations to plan their exit. Given the protracted length of refugees' stays in Jordan, this connection between the development and humanitarian agendas is particularly important, and can help build sustainable solutions that in the long run will reduce the need for aid. With the right capacity, women-led CBOs can serve as drivers of social change at the community level, and lead policy change at the national level, leveraging both humanitarian and development efforts to reduce risk and vulnerability and empower women.

Indeed, intersectional analysis of GBV risks and needs confirms that women's empowerment and livelihood programming can complement GBV services.[42] Without this, women remain silent to abuse or resort to harmful coping measures. As first responders, strong women-led CBOs can encourage survivors to report GBV through survivor-centered reporting mechanisms, engaging survivors in their design. GBV, especially in a domestic context, remains chronically underreported in both Jordanian and Syrian families based in Jordan. The relatively high level of acceptance of GBV contributes to its perception as a minor problem and a "family matter" that does not merit external intervention. In addition, survivors who wish to avoid filing complaints are discouraged from seeking assistance, especially advanced medical services (as opposed to primary health care) because of a legal requirement for mandatory reporting to the police.[43]

Many victims of GBV in Jordan either are unaware of relevant services, succumb to social pressure, or fear social stigma and/or secondary victimization by gender-insensitive law enforcement officers and unsupportive family members. This is exacerbated by the limited capacities of existing service providers and large geographical distances to service centers. Available data also indicate that most survivors of GBV access services more than one month after the incident, highlighting the need for better outreach to inform both refugee and local communities of available services.[44]

As microcosms of their communities, women's organizations in Jordan can sometimes embody the conservative, patriarchal, and traditional values of their communities and may not recognize various forms of violence against women. At the same time, many of these same organizations have the potential to serve as vehicles for broader social change. Women's organizations can go beyond service delivery and engage in community mobilization, advocacy, and policy dialogue on necessary changes to the social norms that facilitate harmful behavior. In the same vein, community-based organizations provide much needed platforms for women to gather and connect, serving as a key enabling factor for women's humanitarian and political leadership and activism.[45] Heads of women's organizations often go on to run in local elections.

Related, a strengthened national system to prevent and respond to GBV, in which women-led organizations provide local solutions and track their impact, can help raise the profile of the civil society in Jordan. Beyond those organizations engaged in the provision of social services, this sector still suffers from low public trust. A raised profile could nudge the Jordanian government to ease legal restrictions over the sector and ensure more gendered policies.

And finally, grounding GBV prevention and response in grassroots organizations can help address service gaps in remote areas outside the capital Amman. In Amman, a wider range of services is available to women, including women's and girls' safe spaces, hotlines and helplines, GBV case management, security, legal services and documentation, psychosocial and mental health support, emergency cash assistance, education and shelters, awareness raising and advocacy, programs targeting men and boys, and parenting programs.[46] Empowering women-led organizations across the country can help meet the needs of underserved communities and reduce disparities between governorates.

Grassroots women's organizations are well-positioned to address GBV as a public health issue that requires a multisectoral approach and long-term engagement. They have the contextual knowledge of their communities and, with the right capacity, can bridge humanitarian services with development interventions to ensure transformative social change. At the same time, however, these organizations continue to face structural challenges that limit their role.

Localizing solutions to GBV will cultivate much-needed agency and ownership of these solutions and anchor responsibility for them in the communities from which they emerged. It will also ensure the kind of consistent funding that will give women-led organizations the flexibility to follow needs and tailor solutions that feed into broader societal change. While progress on implementing the commitment to localization has been slow, positive steps have been taken to embed the concept as a norm in humanitarian action.[47] More attention is still needed to bring localization commitments under the Grand Bargain into action on the

ground, and to domesticate and reshape them to align with local conditions, defining in the process the respective roles of international and local organizations in delivering and sustaining services and community-based intersectional responses to gender-based violence.

ABOUT THE AUTHOR

Dima M. Toukan is the Founder and Chair of Integrated International, a development consulting firm based in Jordan. Previously, she served as Political/Women's Issues Specialist at the MEPI Regional Office in Abu Dhabi covering Jordan, Yemen, and the Gulf Cooperation Council. She also served as Head of Communication and Foreign Affairs at the Jordan Institute of Diplomacy and was a researcher at the Jordan Center for Strategic Studies at the University of Jordan.

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A survival guide for exiles

ko ko thett

- For the sake of your health get out of bed first thing in the morning before tuning into news and gossips from your homeland.
- Don't collect anything you cannot carry with you—be prepared for a life on the move.
- Don't expect your hosts to have ever heard of your country's name. Don't expect them to be responsible for your wellbeing. Expect them to give you a family name!
- Just as a second for gods is a life for humans, your one year in exile may translate into a lifetime in your homeland.
- Don't burden yourself with the weight of the world. For some people exile means business. War and pandemic mean business.
- Do not associate with exiles who will add more woes to yours, be them compatriots or foreigners.
- Your nation-state you have clung to may go up in smoke overnight. The nation within you no one can destroy.
- Don't be a trauma clown; analysed and anonymised by anthropologists, turned into a feature by film makers or your suffering co-written and edited by privileged White writers whose lives have nothing in common with yours—tell your story in your own chosen form.*
- Revolution will not be less perfect without you.
- Don't look too far. Even the earth has her own fever, her own dukkah.
- Don't look back—when you left it was spring. Today it might as well be a cold dark bitter winter.

* For trauma clown by Vivek Shraya and how to beat it, see https://nowtoronto.com/culture/how-did-the-suffering-of-marginalized-artists-become-so-marketable

"A survival guide for exiles" was first published in periodicities: a journal of poetry and poetics, *April 4*, 2022.

ABOUT THE AUTHOR

ko ko thett is a Burma-born poet, editor, and translator. His poems have been widely translated, and his translation work has been recognized with an English PEN Translates Award. He was poetry editor for *Mekong Review* from 2017 to 2022. ko ko thett's most recent poetry collection is *Bamboophobia* (2022).

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https://doi.org/10.1162/DAED_a_02008

Localizing the NGO Delivery of Health from the Outside In

Amanda Murdie & Morgan Barney

International health nongovernmental organizations (NGOs) can provide the necessary assistance and expertise to save lives in times of crisis. Health NGOs often bring innovation, expertise, and resources to those in need. However, many commentators have questioned whether the involvement of health NGOs impedes a country's ability to rebuild its own health sector in ways that do not depend on foreign actors. Building on the results of our survey of almost one thousand public health NGOs in the summer of 2021, we findthat health NGOs may be a unique set of organizations that allow for more local decision-making and employ local staff more often than other populations of NGOs. Health NGOs also have a comparatively greater focus on peace than NGOs from other sectors. The essay examines the pathways by which some health NGOs can both alleviate short-term suffering and help foster long-term localized health delivery.

International health nongovernmental organizations (NGOs) *could* be the ideal provider of health services in conflict and postconflict areas. When adequately funded, international health NGOs can deploy quickly to an affected area, bringing much needed expertise and supplies. If international health NGOs can partner effectively with local actors, existing case study and anecdotal evidence suggests that they could help provide long-term solutions to health care and build capacity in postconflict countries.

Despite their tremendous potential, we still have relatively little specific data on health NGOs. To our knowledge, there is no systematic, cross-national study on whether health NGOs improve localized health outcomes in postconflict societies, and no current data set provides the information that would be necessary to carry out such a study. While scholarship on NGOs has increased in the last twenty years, most of the focus within international relations still remains on organizations that specialize in human rights or environmental advocacy.[1] Even recent efforts to collect data on humanitarian actors leave out the work of health-specific organizations.[2]

Before we can further substantiate the increasingly vocal arguments about localization in postconflict health delivery, we need to better understand the char-

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https://doi.org/10.1162/DAED_a_01999

acteristics and behavior of the international NGOs often acting as a conduit for health services in fragile areas. We need more information on the unique qualities of health NGOs, especially at the intersection of health and conflict. Further, drawing on recent discussions on the importance of localization, sustainable health delivery requires us to better grasp the efforts these health NGOs have taken to localize health services and build critical domestic capacity.

This essay is one small step in that direction. We surveyed 2,495 international NGOs, one-third of which could be categorized as health NGOs. We examined their broad interests and their efforts at localization, comparing the sector as a whole with non-health NGOs. Our findings show that health NGOs may be a unique set of organizations that allow for more local decision-making and employ local staff more often than other populations of NGOs. Health NGOs also have a comparatively greater focus on peace than NGOs from other sectors. Our survey and results are thus important steps in better understanding the whole health NGO sector and its unique capabilities for localization and sustainable service delivery.

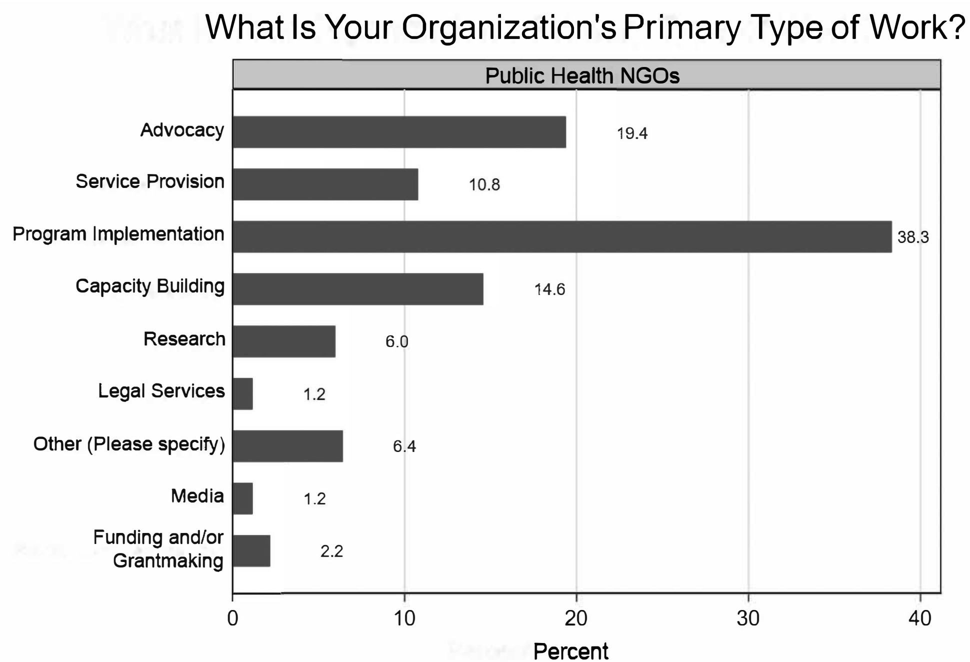
What We Know about the Work of Health NGOs

Health NGOs technically include everything from not-for-profit hospitals to organizations that focus only on advocating for a specific health policy or affected population. In this essay, we focus mainly on international NGOs – defined as those organizations that are operating in countries other than their base or headquarters country – that self-identify as having a focus on public health. Médecins Sans Frontières (Doctors without Borders), Imamia Medics International (IMI), and International Medical Crisis Response Alliance would all be categorized as international public health NGOs. Additional examples of health NGOs include faith-based organizations such as Hospitals of Hope, American Jewish World Service, Samaritan's Purse, Medair, and Cure. Other efforts include more regional-specific health NGOs that are privy to tight networks of volunteers who are able to deploy for service with little to no prior notice.

Numbering in the thousands, health NGOs can act as a stopgap when government and for-profit health services are destroyed, often working to establish lasting public health programs as countries rebuild.[3] NGOs are nimble and bring specialized knowledge built on extensive experience. When compared with other potential suppliers of health services in the aftermath of conflict, like peacekeepers or foreign military interveners, health NGOs often bring less political baggage, and as a result, these organizations may be able to reach rebel-held populations that could prove dangerous for armed interveners.[4]

There is no one dominant approach for international health NGOs; organizations work in a variety of different ways. This variation is illustrated in Figure 1, drawn from our survey (which we elaborate on further below). As shown, while

Figure 1
Public Health NGOs: Primary Work Type



Source: Data compiled from authors' survey, summer 2021.

many health NGOs focus on service provision and program implementation, some organizations are also involved in advocacy, capacity-building, and research.

Even among the set of health NGOs focusing on program implementation and service provision, organizational tactics and approaches vary. Many organizations carry out services themselves using a combination of both local staff and international volunteers and employees. International health NGOs are also often involved in the training and equipping of local health providers. Some of these NGOs directly interface with governments on reforms and improvements to public health systems.[5] Some organizations also work to educate populations on vaccine efficacy, nutrition, or other public health concerns.

Issues of Localization for Health NGOs

While the activities of some individual health NGO efforts may be short-term or narrowly defined, like helping to coordinate cleft palate repair in a specific location

over a two-week period, for example, other health NGO efforts involve a longer-term commitment and provision of a broad portion of a location's health services. For example, as political scientists Abdallah I. A. Yagub and Khondlo Mtshali's interviews of health NGOs in North Darfur in the early 2010s showed, at that time, international health NGOs were "providing 70 percent of curative health services to the State's population by contributing 52.9 percent of the health budget and 1,390 health personnel."[6]

However, such NGO dominance in health care provision within a country is not ideal. For decades, there has been widespread concern that international NGOs that provide health care services will erode government initiative and harm a local population's expectations and respect for the domestic political system. As one commentator put it, NGOs could eat away "all the flesh of the state."[7] By providing services themselves, NGOs might help their own longevity, but they might also create cycles of dependence that could ultimately harm sustainability and local capacity. However, despite concerns to the contrary, no health NGO has the goal of taking over state roles.[8] In fact, transitioning from a health system that is NGO-dependent to a more sustainable, locally led public health system is the more typical objective of international health NGOs.[9]

Discussions of the importance of local capacity and buy-in have increased in recent years, spurred on by the World Humanitarian Summit in 2016. Localization is defined broadly as efforts intended to move international aid away from international donors and large NGOs and direct the aid more toward local and national civil society.[10] Among the many commitments to localization is a goal of at least 25 percent of humanitarian aid going directly to local or national actors.[11] Localization efforts have previously been justified on both moral and effectiveness grounds.[12] Morally, localization works to address power dynamics and legacies of colonial repression. From an effectiveness perspective, localization helps to build community trust, support, and buy-in, which limits "brokerage" costs or the role of so-called middlemen. Localization as discussed and agreed to at the 2016 World Humanitarian Summit was not entirely new, and many have remarked on how local capacity building and service delivery have been aid goals for decades.[13] Many international NGOs have already adopted a hybrid local-international approach to program design and delivery.

There have also been some arguments against localization, especially in times of conflict.[14] International organizations may have both the capacity and the neutrality that national or local organizations could lack during a conflict. There are also concerns about the potential for localization to create increased risk for local staff, while international actors remain on the sidelines.[15] Nonetheless, the ongoing discussions about localization have led to an increased focus on the need for locally informed decision-making and staffing. Local ownership, training, and decision-making may be especially important in the postconflict stage, as the aid

returns from bypassing state actors and governments increase their capacity to carry out health services in peacetime.[16]

Obstacles for Health NGO Effectiveness

There are many obstacles to the work and effectiveness of health NGOs, even in peacetime. For example, organizations often do not coordinate with each other and with other government and international efforts that are also aimed at reducing suffering.[17] Health NGOs are often operating within an aid framework that fosters competition with one another in order to ensure their own organizational survival.[18] This lack of coordination can harm collaborative efforts, leading to an overabundance of resources in some locations and a lack of resources in others.

The possibility of rapid changes in funding streams also harms the work and effectiveness of international health NGOs. Donations can be redirected to the "next big disaster," often leaving organizations scrambling to change their portfolios.[19] The nature of their funding stream can also influence their work. If funded by foreign governments, for example, NGOs may lose access to certain populations and could be seen as political agents.[20]

Government and intergovernmental organizational funding may nonetheless be required for the broad scope of the health concerns needing to be addressed; local, individual contributions simply may not be enough to address the needs of a crisis-affected population. In this context, some local governments may view NGOs as competitors for aid funds, especially if foreign donors are channeling aid to NGOs that had previously been directed at national governments.[21] The aid environment, together with the quickly evolving conditions in conflict- and natural-disaster locations, may lessen the ability of NGOs to carry out their own research on what works and may increase concerns about the need for organizational monitoring and accountability.[22]

A further challenge is the potential for "voluntourism," which often involves NGO staff engaging in short-term volunteer efforts for personal gain or self-fulfillment.[23] Voluntourism may result in a myriad of negative effects for local populations, including re-traumatization, abuse of life experience for NGO fundraising efforts, or the misuse of the volunteer's name/likeness for the sake of NGO marketing campaigns. Scholars have raised concerns about international health service trips involving students, during which local individuals often feel that their preferences are ignored and that populations served by volunteers receive lower quality of care due to lesser-skilled volunteers.[24] Using international aid as a platform for training or other related student activities commodifies local populations and suppresses the ongoing work of local NGOs and more locally engaged international NGOs. While many health volunteers operating through NGOs may initially have altruistic motives, their presence has in some cases resulted in tragic

consequences and even death. One pertinent example of this occurred in Jinja, Uganda, where Renee Bach faced charges for allegedly faking her identity as a medical professional when opening a health NGO, an action which resulted in the deaths of multiple children.[25]

Health NGOs are also concerned about their own safety and longevity, both for their staff members and volunteers and for the organization as a whole. NGOs must attend to the potential risks to their ongoing work, including the personal safety of their volunteers, and their ability to both secure funding and avoid repression efforts by local governments. In carrying out public services, workers from international health NGOs can be targeted by crime and political violence, both in times of conflict and during peacetime.[26] Even neutral health NGO workers may be mistaken for peacekeepers or foreign military interveners, thereby placing them at greater risk.[27] As risks increase, organizations face difficult choices and often must make compromises in the quality of care and in the safety of staff members.[28]

Taken together, trends such as these have contributed to a more general backlash against foreign-funded NGOs over the last twenty years, with organizations being kicked out of countries where they previously had long-term cooperative service-delivery arrangements.[29] When allowed within a country, international health NGOs have seen an increase in restrictions and host government oversight. While some of these restrictions may be justified by the regime to help curb corruption, protect against terrorism, or otherwise deal with some of the shortcomings in the sector discussed above, many of the limitations on NGO operations are part of a larger trend of democratic backsliding and human rights abuses.[30] International NGOs are increasingly being associated with Western interference and attacks on state sovereignty, which could lead to a populist backlash against even local civil society actors.[31]

All of these challenges, which are endemic to the health NGO system, are compounded in times of conflict. Attacks on aid workers increase with the severity of the conflict.[32] Concerns about safety may lead to international health NGOs fully halting operations or moving their operations across a border, which can also complicate health care delivery, coordination, monitoring, and trust.[33] Local health workers may also flee the conflict zone, making it more difficult for international health NGOs to find local partners and staff. Nonetheless, we do know that organizations still provide necessary health services in times of conflict and often aid in rebuilding health services in the aftermath of conflict. Some international health NGOs work directly with populations harmed by the conflict, setting up field hospitals and triage centers as in Syria, for example. Other NGOs may continue to work on communicable diseases or their non-conflict health-related missions. And some organizations manage to negotiate access to provide these health services in rebel-held areas and advocate for health-related ceasefires. For example, UNICEF and the Catholic

Church helped to create a widely praised ceasefire that allowed for childhood immunization in El Salvador in 1985.[34] The Carter Center negotiated a ceasefire with the Sudan People's Liberation Army for aid workers to help treat populations affected by Guinea worm disease and river blindness in 1995.[35] Although not always successful, organizations are currently negotiating with rebel groups for COVID-19 vaccine distribution, despite deep mistrust of foreign interveners of any type.[36]

As fighting ends, health NGOs may be the only option for starting to rebuild health services. On the positive side, there is large-scale evidence that health NGOs are successful in reducing infant mortality in developing democracies.[37] Evidence shows that the activities of international health NGOs also lead to an increase in government spending on health care provisions, an outcome that helps to illustrate that international NGOs do not harm a government's incentive to provide their own health services and may increase demand for public health measures.[38] In fact, international health NGOs often try to partner with governments, hoping to help transition a country from dependence on external health services to a fully functioning government public health system.[39] The quality of these partnerships varies, with some governments seeing NGOs as an untrustworthy competitor for aid funds.[40] Regime leaders in democratic governments may have more incentives to partner with international NGOs and transition to providing bureaucratic services themselves, since widespread electoral support is critical for their own political longevity.[41] Recent experimental research also finds that international NGO projects may increase the public's approval of the government, calling into question concerns about potential deleterious effects of NGO-provided services on government initiative and state-society relations.[42]

Urgent Need for More Information on Health NGOs

As the studies discussed above illustrate, international health NGOs could be a key solution for health and human security, even in conflict and postconflict situations. However, there are many ongoing issues with the sector, including concerns about a lack of local capacity-building and local buy-in. To our knowledge, there is no data source that would allow us to examine both the problems and conditional effectiveness of health NGOs on a broad, cross-national scale.

In the summer of 2021, we used a survey approach to collect new NGO data, through an original email survey of more than thirty thousand NGOs that constitutes one of the first cross-national, global surveys of NGOs. We tried to be as inclusive as possible in our list of possible recipients, using organizational email addresses listed in the UN's integrative Civil Society Organizations (iCSO) System and other publicly available websites and organizational contacts.[43] We received 2,495 responses to our survey. Of those organizations, 845 reported that they had a focus on "public health."

Our survey asked eighteen questions, focusing on organizational-level activities and functions, which allows us to refer to respondents as "organizations" throughout. The survey questions included a variety of demographic-related topics, such as founding year, headquarters location, staff sizes, and funders. In addition to the demographic information, we also included questions focused on each organization's type of work, collaborators, organizational decision-makers, framing decisions, meeting attendance, and issue focus.

Our survey data will be helpful for researchers interested in addressing many of the unanswered questions about the nature and behavior of contemporary health NGOs. Here, we focus specifically on the results of the survey that will improve our knowledge about the current work of health NGOs in regard to localization and peace.

First, there is evidence that international health NGOs are acting somewhat more consistently with the goals of localization than organizations without a health focus. As Figure 2 shows, 90.8 percent of health NGOs report that they employ local staff. A χ^2 test (or chi-squared test) allows us to conclude that this is statistically distinct from the lower 85.7 percent of local staff employed by other types of NGOs.

Even when employing a high percentage of local staff, however, it appears that international health NGOs, like the broader population of NGOs, still do not routinely involve local populations in their decision-making. As seen in Figure 3, roughly 70 percent of public health NGOs reported that local populations are not making decisions for the organization. This is statistically distinct from the 87 percent of non–public health NGOs that also report not having local populations make decisions for the organization. Taking these figures together, it does appear that there are some localization efforts currently being undertaken by NGOs, especially by public health NGOs, although the general levels of localization may be far from the ideals set out by the 2016 World Humanitarian Summit.[44]

The less-than-ideal localization efforts may be a function of the funding structure. As shown in Figure 4, when organizations are asked about their funders, the largest group of NGOs report that they are primarily funded by international organizations. There is no statistical difference in funding sources between public health and non–public health NGOs. This information could suggest that any additional attempts at increasing local decision-making may need to be led by international organizations and further incorporated into their funding requirements.

Unfortunately, as our survey was general, we did not ask participating organizations any questions about their involvement in armed conflict situations. However, organizations were able to indicate multiple areas of focus in their responses, including a focus on "peace." No definition of peace was given in the survey itself, but organizations were able to indicate whether this was one of their focal areas. As Figure 5 shows, we did find that public health organizations were much more

Figure 2
Staff Localization

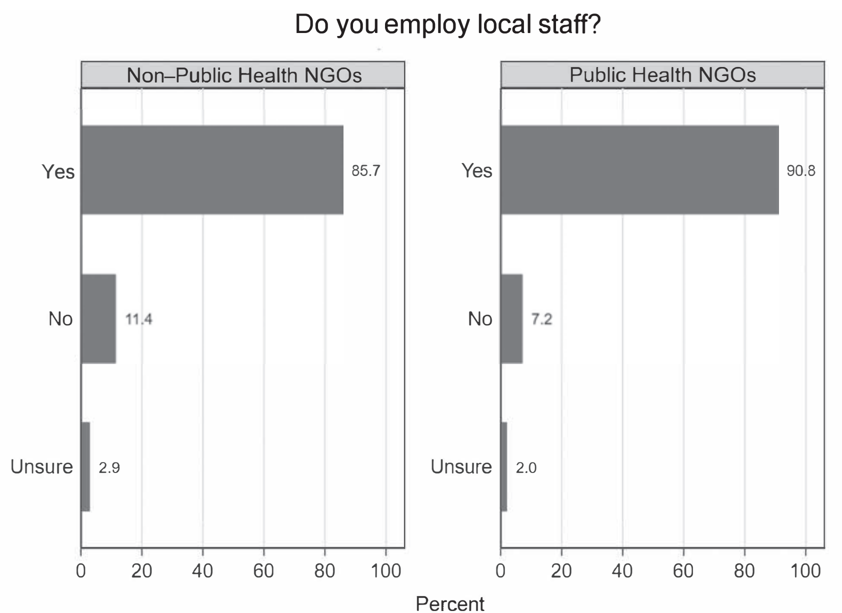
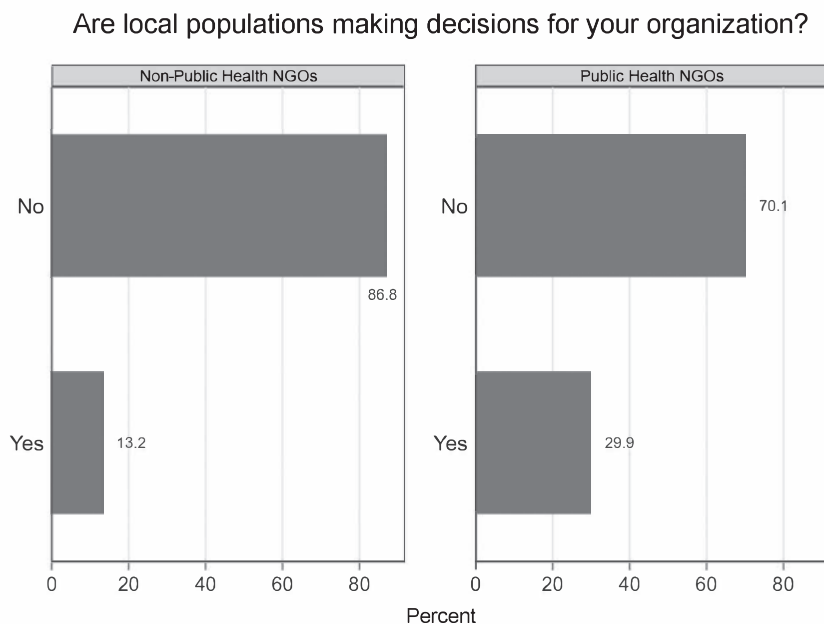


Figure 3
Local Population Decision-Making



Source (Figures 2 and 3): Data compiled from authors' survey, summer 2021.

Figure 4
Organization Funders

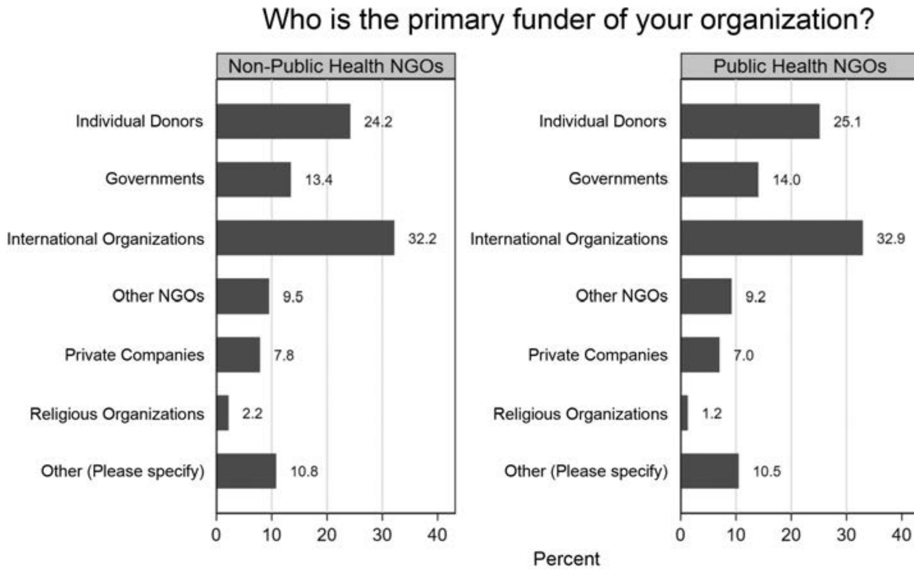
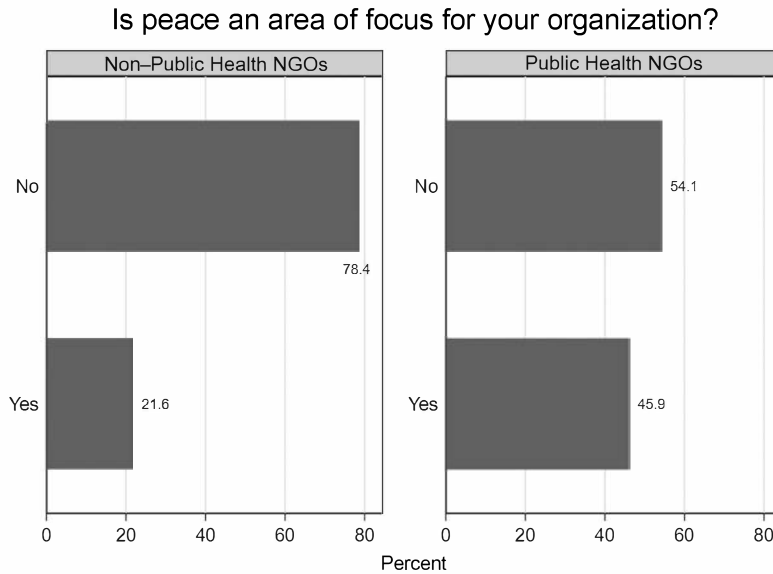


Figure 5
Peace and Health NGOs



Source (Figures 4 and 5): Data compiled from authors' survey, summer 2021.

likely to report that they also had a focus on peace than non–public health organizations. This relationship is statistically significant, as determined by a χ^2 test.

Our collected data demonstrate the need for more surveys of health NGOs, specifically on ideas around conduct during and after conflicts. How might health NGOs uniquely serve in the peacebuilding process? What is the relationship between health NGOs and other important stakeholders on the ground who are also actively involved in the peacemaking and peacekeeping process? How do health NGOs relate to UN peacekeepers and other NGOs focused on other conflict-related issues? How do health NGOs view local populations and localization efforts? Do opinions of localization shift in times of conflict? These questions may be best answered through survey research focused on NGOs, their activities, and priorities.

A Way Forward

International health NGOs are a critical link in public health, and we are just beginning to fully grasp the processes by which they could affect both short- and long-term solutions in conflict and postconflict areas. Already difficult NGO work is made even more challenging by fears of violence. While problems with the sector undoubtedly exist, earlier concerns with NGOs leading to a lack of government initiative or investment or changes in state-society relationships appear to be overblown. Newer research indicates that national governments can benefit from international NGO service provision and that NGO partnerships may help governments invest in public services and improve their own capacity and legitimacy.[45] These results are general, however, and more emphasis on how armed conflict dynamics could complicate these trends is necessary. Efforts at localization, both during conflict and in peacetime, should also be examined in more detail.

We have argued here that data collection efforts are a crucial part of improving health NGO service delivery. Rigorous program evaluation and analysis are necessary to understand the impact of health NGOs' efforts and the consequences of their decision-making processes. Otherwise, there remains the risk of harming local populations by the efforts designed to initially improve quality of life. Our research thus points to the need for heightened investment by academics and policymakers alike into understanding the particular mechanisms and predictors of localization of health NGOs in various contexts. Outcomes vary depending on the country of focus, so further case study work on this topic would help us understand which strategies work best depending on where they are located.

While survey research of NGOs is an important step in this process, we would also recommend investment in public opinion research on health NGO services and efforts. We need to better understand how recipient populations think about health NGOs and whether *they* see a way forward that empowers local actors and community needs. One of the frequently overlooked aspects of research is pri-

oritizing the participant experience, whether due to lack of access to these respondents or ethical concerns – all of which create roadblocks to accurate information. These challenges demand creativity from the academic community and NGOs alike to assess the needs of local populations without placing undue burden on respondents. By increasing efforts to improve the impact of localization on health NGOs during times of peace and conflict, NGOs can better prepare for the future and best allocate resources to proficiently serve some of the world's most vulnerable populations.

ABOUT THE AUTHORS

Amanda Murdie is the Georgia Athletic Association Professor of International Affairs and Head of the Department of International Affairs in the School of Public & International Affairs at the University of Georgia. She is also Editor-in-Chief of *International Studies Review* and Co-Editor of the University of Georgia Press Studies in Security and International Affairs Book Series. She is the author of *Help or Harm: The Human Security Effects of International NGOs* (2014).

Morgan Barney is a Project Analyst at ECS Federal. She has published in journals such as *Human Rights Review*, *Journal of Human Rights*, and *International Migration*.

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Disbound

Hajar Hussaini

I’m awakened to an atrocious dream : my sister cuts
her hand   an extreme amount of mist

          I can’t make out
          the image

                                the scene has taken place
in the kitchen and as she walks into the living
the innocence of her one question hangs

                  What do *you* think ?

per the word of mouth
the solicitudes and the dis
-figured candidate proceeds

                  At any rate, secure that delicate passage

Uneased, she asks if she could dhl this to my house
                          where I sit on my bed
examining my past and future

Two weeks following the dream

a last province falls

a coward
president

renounces the country

midair

the dream

follows the fall of a last
province

mid-week flees
a coward

two fellows renounce their bodies

mid dream

for a delicate passage

precedes the scene

of fall

extreme mist

an imagine

I examine

amounts

to

nothing

This June in the Bronx with my partner and his oldest friend
we watched one episode of *exterminate all the brutes*

soon

The documents affixed themselves to the members of my family
haunting me in ways unbeknownst to my lover or the old friend

Why do my people submit to this treatment?

terror jackets

spit motherfucker

air-striked

curse

blood

sewage

I am

that lucky bird

Frying Pan Park

The foundation two years before the takeover registers
that four in ten would leave given the opportunity

    by opportunity

many, possibly, mean a dignified manner of conveyance
dignity, an intriguing practice

    to be off tarmac a given dignity a
    singular opportunity

for those whose command of a foreign language is found to be useful

        to write requisition after requisition
        claims such as “my so and so” “deserve” a) and b) also c)
        hereby I promise not causing you an injury

and for those whose eyes must behold heart-wrenching capture

        plane after plane taking off
        the burial ground of locals
        leaving behind most

    concurrent misfortune

To inhale parallel particles in the air

my firstborn brother
—whose healing depression surges
across the heart's bottom—
abandons Bamiyan
adieu indigeneity!

our second sibling
—whose eyes have taken on
the task of his tongue—
renders fear and welfare
welcome like a shrine!

our third a sportsman
—whose information includes
not being on an evacuation list—
cornered in a crescent kick, he drives
from a few neighborhoods east

to arrive in an apartment where the sisters live
where in a daydream I have painted myself
with an elongated arm stretching across
the continents to reach Venus's hand
I create this tenderness to call them
with spiritual prerequisites

I barely hear
any fully formed thought
a babble, vanquished
sometimes a child's cry
I try not to ask
what now and then

That intangible item, in and out of focus, hope like a sign of change
that everyone talks about, lives underground. It's not uncommon
for it to persist or have little resistance to a flow of despair.

I try to grasp—is it a possibility to bring them :

My patient question ciphers irregularly.

Like neutrality amassing only to blow up in anger.

Despite the predictable tendencies, I'm sorry.

For up until the last flight, I was worried about my persons.

The plural scattered and in silence chanted *god the greatest* in support of an army
whose bodies were left in four hundred beds the nemesis press releases
cannot differentiate the dead's roots from its belongings

It's almost November

Two and half months of two-point-o

My husband whom I married in that invasive
August mentions in passing:

I didn't expect us to suffer this much
this early into our marriage

The world's wildest ideological practices

on that infamous
site
of

experimentation

I rehearse the sum of all interferences
and my own insignificance :

my forms oppose irresponsible innovations

as a colleague describes they self-emerge and self-suffice

Bare
and humbled by the bombardments
with no expectation of idiosyncratic
declarations

this poem:

fourteen hundred words plant the pledge
re-do, re-do

And even though I have stranded
many architectures of you

always there lingers an outline
of something I must get back to

When my father died

the constables were *not* poets

a cruel variant was traveling through the houses

—we had no procession of mourners
the killer banned all trends of grieving—

Outside, maps of the opponents were advancing

his gravestone on the long list of

soon-to-be-carved

if I ever go back

I will find him

lying next to my mother

nameless, at last

I want to go back

my father has died

their poets have traveled

to the outer maps

their killers have banned

all trends of advancing

constables' cruel variant

fled from the country

a coward

carved a gravestone

for each house

to grieve a long list

of mourners

who had no procession

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ABOUT THE AUTHOR

Hajar Hussaini is an Afghan poet and literary translator. Her poems in *Disbound* (2022) scrutinize the social, political, and historical traces inherited from one's language that retrieve a personal history between countries (Afghanistan and the United States) and languages (Persian and English) that has been constantly disrupted and distorted by war, governments, and media.

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https://doi.org/10.1162/DAED_a_02009

Conclusion

Paul H. Wise, Jennifer M. Welsh & Jaime Sepúlveda

This collection of essays raises the fundamental question of whether the current infrastructure and practices of humanitarian health provision are increasingly out of step with the nature and scale of human needs generated by new forms of violence and a political context increasingly hostile to humanitarian values. The introductory essay by David Miliband and Ken Sofer articulates this challenge with clarity and power.[1] It outlines in sharp relief a failed global commitment to the humanitarian mission and provides important, pragmatic opportunities for urgent ameliorative action. Each of the essays in this volume focuses on a different dimension of the challenge, some more attentive to conceptual issues, others to operational realities. Together, they provide a coherent mosaic of critical scrutiny, and lay an essential foundation for understanding both the obstacles and opportunities for strengthening current practices and implementing needed reforms.

In her essay, Anastasia Shesterinina examines the evolving character of contemporary civil conflicts and its implications for an effective humanitarian response.[2] She underscores the dynamic character of current humanitarian challenges and details the growing diversity of combatants and constantly changing, adaptive relationships between them. While Shesterinina provides a cogent, conceptual analysis, she also emphasizes the contingent nature of service provision in these areas and how the shifting identities and often veiled interests of violent actors can obscure the boundaries between threat and safety for humanitarian operators on the ground. Shesterinina also reminds us that humanitarian services themselves can become just one more coercive tool in these complex settings, by which those who control access to needy populations vie for resources, legitimacy, and power. These emerging challenges can become especially complex when a variety of nonstate armed groups (NSAGs) control access to humanitarian supply routes and populations in need. In their essay, Ann-Kristin Sjöberg and Mehmet Balci explore the role of these groups in detail and outline strategies humanitarian health providers can employ to navigate this often labyrinthine terrain.[3] Of particular concern has been the institution of global restrictions on engaging with NSAGs considered "terrorist" or included on sanctions lists at the international,

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https://doi.org/10.1162/DAED_a_02000

regional, or domestic level. These restrictions can take the form of financial or even criminal penalties and have hindered necessary humanitarian services in a variety of conflict settings.

Perhaps the most potentially catastrophic humanitarian challenge is the prospect of armed conflict between great powers. Over the past decade, the U.S. and allied militaries have pivoted from a preoccupation with waging counterinsurgency to intense preparation for conducting large-scale military operations against peer or near-peer militaries. It is not clear that the humanitarian health community has responded accordingly and expanded its planning and capabilities to meet the potential humanitarian demands of such a conflict. Sir Lawrence Freedman's contribution to this volume provides an acute and disturbing analysis of the Russian invasion of Ukraine, a war that has provided a preview of what large-scale combat operations might look like.[4] This interstate war departs from the far more prevalent civil conflicts of the past three decades and offers a graphic illustration of the humanitarian impacts of massive artillery, missile, and drone attacks on urban populations. Russia has focused these attacks not only on military targets but also against civilians and civic infrastructure. In so doing, it has not only violated the laws of war but done so *strategically* to undermine the Ukrainian capacity and will to fight. As Freedman observes, this strategy to target civilians and civilian infrastructure has yet to result in any major military advantages, but it has tragically and likely criminally generated a humanitarian catastrophe and large-scale refugee flows. Freedman's essay also recognizes the potential for a protracted stalemate, as well as a rapid escalation involving a cascade of reciprocal actions that could lead to a widening of the war, and possibly the use of nuclear weapons.

Several of the contributors also address emerging trends and challenges to modern humanitarian action. Keith Stanski examines the unique requirements of providing humanitarian services in urban areas. Urban warfare is not new. However, the recent use of explosive and chemical weapons in densely populated areas has raised significant legal and operational challenges for humanitarian efforts.[5] Of special concern is the interdependence of urban infrastructure and social norms that make civilian life and humanitarian operations particularly vulnerable to attack. Damage to any one of these systems can have powerful reverberating effects. Recent Russian air assaults on the Ukrainian energy grid have affected the delivery of essential services, including food and water supply, sanitation, transportation, and health care at public facilities. Stanski draws on his varied field experience to outline constructive steps to mitigate the destruction of urban communities and protect particularly important civilian structures, such as hospitals, and focused humanitarian initiatives, such as relief convoys.

Technical innovation is also transforming the capabilities and vulnerabilities of the humanitarian mission. Larissa Fast assesses the rapidly expanding requirements of the digital environment in conflict and the humanitarian response.[6]

Modern humanitarian activities demand coordination, and modern coordination requires the sharing of data. However, as Fast points out, the ethics and governance of data collection, sharing, and use require urgent attention. This is because the collection, sharing, and use of data, regardless of intention, inevitably involves the negotiation of power. The issue of consent in humanitarian settings will often require a dialogue between those in desperate need and those who control the resources essential to meeting this need, a dialogue that must be rooted in trust, but a trust that must navigate profound differentials in power. Moreover, in humanitarian settings, data can function not only as an empowering tool but also as a potential vulnerability and ruinous weapon. Data can be used to advance a variety of harmful objectives, including the identification of individuals or communities for targeting, and to mount harmful attacks on social media. Fast outlines the requisite technical and governance protections for data involved with humanitarian efforts, all of which must marry technical sophistication with an unwavering respect for the interests and voices of the communities at risk.

While the evolving nature of conflict and combatants has generated new humanitarian challenges, so too have new political and moral understandings of what effective and just humanitarian services require. The essays by Amanda Murdie and Morgan Barney and by Dima M. Toukan articulate the requirements of localization, a general commitment to respect the role of local communities in shaping the objectives and machinery of humanitarian provision.[7] The diverse representation of affected populations is fundamental to this commitment, especially those long excluded from humanitarian leadership, including women, ethnic and religious minorities, and socially marginalized groups. The authors also note the difficulties that humanitarian actors have encountered in fully meeting the requirements of localization, requirements that raise serious questions about the viability of long-standing humanitarian practices.

The essay by Sergio Aguayo also confronts traditional humanitarian health perceptions by arguing that some of the most protracted humanitarian challenges are being generated by political and criminal violence in areas not formally considered to be at war.[8] Aguayo uses the case of Mexico to argue that humanitarian crises associated with modern mass migrations are best understood as part of an illicit ecosystem of human trafficking governed by organized criminal enterprises and corrupt government officials. This is an important challenge to conventional legal and operational humanitarian frameworks that have been constructed for interstate and civil wars. More broadly, his essay serves as an important reminder that in settings of extreme violence, the boundaries between political grievance and criminal greed can be blurred, a reality of veiled menace that can threaten even the most benevolent of humanitarian actors.

The ultimate challenge to the humanitarian health community is the direct threat of violence. In 2022, there were almost eleven hundred attacks on health

workers or their facilities, resulting in more than two hundred deaths and four hundred forty injuries. In many ways, these figures represent a synoptic expression of the destabilizing array of challenges the essays in this collection articulate so well. There was hope that a strong global recommitment to the protection of humanitarian health would bolster the safety of health workers and facilities in areas of extreme violence. However, as Simon Bagshaw and Emily K. M. Scott describe in their essay, just such a recommitment, Resolution 2286, passed by the United Nations Security Council in 2016, has largely failed to provide any strengthened protection.[9] Indeed, the failure of Resolution 2286 has only underscored the perceived erosion of humanitarian norms and the sense of vulnerability among humanitarian health workers around the world.

Together, these essays suggest that the rich, complex development of humanitarian health has reached an inflection point, a historical moment that demands a fundamental rethinking. The humanitarian mandate remains unchanged. However, the evolution of organized violence and an increasingly unstable geopolitical order have generated challenges so profound and varied that a reconsideration of humanitarian health's most basic tenets and pragmatic practices seems imperative.

In this context, the ethical foundation of humanitarian health becomes an essential component of this rethinking. In her essay, Ana Elisa Barbar argues that the ethical principles that have guided humanitarian health for decades require purposeful reexamination and, ultimately, validation or revision.[10] Perhaps the most consequential reassessment will involve the emerging tensions between the core principles themselves, tensions generated seemingly paradoxically by expanded efforts to make humanitarian health more effective, ethically responsible, and just. Localization initiatives are not only likely to enhance the effectiveness of humanitarian health services but also address justice issues that have long been ignored. However, in areas in which communities are affiliated with distinct political or combatant groups, intimate engagement with these communities can challenge the humanitarian principles of neutrality and independence. Similarly, while the purposeful inclusion of long-marginalized groups is welcome, it should be pursued with careful attention to the requirements of impartiality, which demands that medical care be provided based on medical need and not on other characteristics or claims.

Finally, innovative strategies to improve the effectiveness of humanitarian health delivery are also creating tensions among accepted humanitarian principles. For example, recent evidence-based analysis of humanitarian health delivery has emphasized the need to stabilize injured patients as quickly as possible. This led the World Health Organization during the Battle of Mosul in Iraq to embed humanitarian medical personnel with Iraqi security forces close to the front

lines.[11] This strategy did, in fact, save lives, thereby honoring the essence of the humanitarian principle of humanity. However, it simultaneously violated the core humanitarian principles of neutrality and independence.

These challenges reflect the reality that legitimate calls for reform, even those based on greater effectiveness or strong justice claims, may not always align or even be compatible. The rethinking of humanitarian ethics, therefore, will ultimately require careful negotiation between sometimes competing imperatives, a negotiation that may have to tolerate, if not embrace, a respect for nuance, local conditions, and humanitarian needs.

The essays in this collection recognize that humanitarian health provision depends upon compliance with ethics, international law, adequate global financing, and ultimately, the exercise of power. However, humanitarian care also depends upon humanitarian norms, broad patterns of behavior shaped by a shared appeal to succor and material relief based not on nationality or kinship, but merely on being human. Yet years of study and experience in the field have revealed that norms cannot be solely mandated; they must also be felt. Humanitarian health depends upon things that transcend rules and principles but engender a common sense of compassion, a shared commitment to protect, and the sentiments that stir people to act in the interests of others. In many ways, this is the realm of the arts – of music, paintings, photography, literature, and poetry. It is fitting, therefore, that the artistic contributions in this issue of *Dædalus* recognize, in some small way, the role of the arts in shaping humanitarian norms and the power of imagination when it is mobilized in service to empathy, outrage, and justice.

ABOUT THE AUTHORS

Paul H. Wise, a Fellow of the American Academy since 2018 and cochair of the Academy's project on Rethinking the Humanitarian Health Response to Violent Conflict, is the Richard E. Behrman, MD, Professor of Child Health and Society, Professor of Pediatrics, Co-Director of the March of Dimes Center for Prematurity Research, and a Senior Fellow at the Freeman Spogli Institute for International Studies at Stanford University. He participated in two other projects at the American Academy: Civil Wars, Violence, and International Responses; and New Dilemmas in Ethics, Technology, and War.

Jennifer M. Welsh, a Fellow of the American Academy since 2021 and cochair of the Academy's project on Rethinking the Humanitarian Health Response to Violent Conflict, is the Canada 150 Research Chair in Global Governance and Security at McGill University. Her most recent books include *The Return of History: Conflict, Migration and Geopolitics in the 21st Century* (2016) and *The Responsibility to Prevent: Overcoming the Challenges of Atrocity Prevention* (2015).

Jaime Sepúlveda, a Fellow of the American Academy since 2014 and cochair of the Academy's project on Rethinking the Humanitarian Health Response to Violent Conflict, is the Haile T. Debas Distinguished Professor of Global Health and the Executive Director of the Institute for Global Health Sciences at the University of California, San Francisco. He is also a member of the U.S. National Academy of Medicine. He has published in journals such as *The Lancet*, *NEJM*, *Vaccine*, *Health Affairs*, *BMJ*, *Science*, and *Nature*.

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