<u>EDITORIALS</u>

# Healthcare workers in conflict zones– fright or flight?

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The noble intention of helping fellow human beings can have consequences that are both risky and life-threatening. Increasingly, humanitarian health workers and the healthcare system in conflict zones are themselves becoming targets of assault. On January 5, 2012, Dr Khalil Rashid Dale, an International Committee of the Red Cross (ICRC) delegate working as  health programme manager, was abducted by unknown armed men while returning to his residence in Quetta, the capital of Baluchistan province in Pakistan. While the perpetrators of the abduction maintained intermittent contact with various authorities, the beheaded body of the kidnapped official was found in an apple orchard on April 29, 2012. It is now being revealed that the motivation for the abduction and killing could be the ICRC's refusal to pay a ransom. Declining to pay a ransom for abducted staff is consistent with the ICRC's security policy. Of special significance is the fact that the perpetrators of the crime were aware of the credentials of the doctor, as he was travelling in a clearly marked ICRC vehicle (1).

Attacks on humanitarian healthcare providers are a less understood aspect of conflict, primarily because they constitute a smaller proportion of the overall number of violent events. The consequences of these attacks are extremely drastic and disproportionate in their impact.  For instance, in January 2012, Medicins Sans Frontieres (MSF) closed down two major medical centres in the Hodan district of Mogadishu, the capital of Somalia, following the killing of two staff members. The two 120-bed medical facilities were the largest of MSF's 13 projects in Somalia. Their closure reduces the organisation's presence in Mogadishu by half. Moreover, according to MSF the facilities served an area with a population of 200,000 and had, since August 2011,  treated close to 12,000 malnourished children, and provided measles vaccination or treatment to another 68,000 patients(2).

In the Sudan, MSF ran a primary healthcare centre in the town of Pibor in Jonglei state, and from there established two smaller outreach clinics in the more remote areas of Lekwongole and Gumuruk, which are only accessible by plane or boat during the rainy season. In July 2010, an armed group entered the Gumuruk clinic and stole boxes of the ready-to-use therapeutic food with which MSF treats severely malnourished children. Three days later, more ready-to-use therapeutic food was stolen along with medical equipment. Then, later in the month, four MSF staff members travelling by boat from Pibor to Gumuruk were robbed by armed men. Following these three separate security incidents the organisation suspended all activities in Gumuruk and Jonglei state. Apart from a small ministry of health facility in Pibor town, MSF was the only primary healthcare provider in this part of Jonglei state, which is home to around 150,000 people (3). Already, a  major consequence of the killing of Dr Khalil Rashid Dale has been  the suspension of the ICRC's health projects in Balochistan and the closure of a rehabilitation centre for the physically challenged, functioning out of the Christian Hospital in Quetta (1).

However, non-state actors are not the only perpetrators of violence against healthcare providers. States themselves have engaged in numerous acts that obstruct the provision of healthcare. In May 2009, the Sri Lankan army attacked the Mullaivaikal hospital three times in the space of a week, killing more than 91 persons, including an ICRC worker (4). In June 2011, a police official in Chhattisgarh accused the MSF and ICRC of "facilitating" the medical treatment of Maoist insurgents (5).

## The limits of protection for healthcare provision

The current state of knowledge in the field of "conflict studies" is not able to discern the motivations of armed actors in conflict zones. Increasingly, it is being found that the intentional targeting of civilians and civilian institutions is becoming more pervasive. The shifting burden of conflict onto civilians and civilian institutions is an area of concern, especially when we seek to understand the constraints on healthcare service delivery in conflict zones and "fragile states."

Given the diversity of security challenges facing healthcare provision, there is an absence of any cohesive body of international law that exclusively provides legal protection for healthcare provision in situations of conflict. The formal protections for healthcare provision arise from the four Geneva Conventions of 1949, the two Additional Protocols of 1977 and the third Additional Protocol of 2005. This body of international humanitarian law (IHL) essentially provides a template of conduct but does

not outlaw the act of war. Rather, it provides a set of norms or a "protection framework" to be adhered to by the parties involved in the conflict. Firstly, medical assistance is viewed as a neutral activity, which should be universally accessible to the wounded, sick and prisoners of war. Second, these standards "impose the duty on warring parties to not interfere with medical care for wounded or sick combatants and civilians, and not attack, threaten, or impede medical functions" (6). Moreover, "warring parties must also permit medical functions to have access to the sick and wounded, refrain from using medical facilities for military purposes, and spare patients from violence, intimidation, or harassment (6). Lastly, "the parties [must] respect principles of medical ethics; they (the norms) forbid the punishment of medical personnel for adherence to ethical standards of the profession, and outlaw use of compulsion against health providers to engage in acts that are inconsistent with medical ethics"(6).

However, despite the existence of a normative framework enshrined in the Geneva Conventions, healthcare is under threat, because of the limits to which the norm is internalised by the perpetrators of violent acts. There are certain fundamental normative assumptions of IHL that are being challenged by the actual conduct of contemporary warfare. As a body of law, international humanitarian law essentially evolved at a time when "states" were seen as the primary stakeholders in the conduct of war. Even though the Addition Protocol II (1977) is applicable to "Non-International Armed Conflict" (NIAC), it still envisages this type of conflict as military action which takes "place in the territory of a High Contracting Party between its armed forces and dissident armed forces or other organised armed groups which, under responsible command, exercise such control over a part of its territory as to enable them to carry out sustained and concerted military operations" (7). The last part of the clause assumes, for instance, that once these conditions are met, the organised armed group will also be in a position to "implement" the Protocol. However, in situations of state failure, the conditions of NIAC rarely fit such categorisation. It is extremely difficult to determine, especially in the case of "organised armed groups" the degree of "responsible command," the extent to which they exercise "control over territory" and their ability to "carry out sustained and concerted military operations." In many cases armed actors, whether state or non-state, do not necessarily have fixed hierarchical organisational structures; nor do they actually control discernible swathes of territory.

This leads us to the issue of implementation of IHL in conflict zones. In most instances, conflicts lead to breakdowns in existing legal structures and ethical principles. Adherence to international law by armed actors is extremely difficult to enforce in the absence of any centralised governing authority, this being a hallmark of contemporary conflict processes. For instance in 2010, the "internationally recognised" transitional government of Somalia officially controlled a territory of eight square miles in the country, which was limited to a part of the city of Mogadishu (8). The rest of the city and the country were considered disputed territory, governed by warlords, militias and rebel groups. Another aspect of protection is that IHL only provides standards of conduct for warring parties. There is no formal enforcement mechanism by which members of armed groups or state armed forces can be held criminally accountable for their actions. While IHL can provide the basis of classifying certain acts as "war crimes" for future criminal trials, the process of actually trying individuals for "war crimes" is a distinct political process which requires the creation of international tribunals, the formulation of stringent rules of evidence and, above all, international commitment to the sustenance of specific war trials.

## Existing gaps in knowledge

It would not be correct to place the onus of protection exclusively on the warring parties. While the focus of this editorial has been on international humanitarian healthcare provision, there is virtually an absence of any knowledge on the intimidation faced by local healthcare providers (including local staff of international organisations) who actually account for a larger share of casualties compared to expatriates (9). The fact that local health workers are at the forefront of collapsing health systems requires serious consideration. Moreover, little is known about the resilience of local health providers in sustaining the integrity of medical care provision in the face of intimidation, polarised political contexts and acute psychological stresses. In most cases, local health workers do not have the option of exiting their posts, despite the deaths of or injury to their colleagues. This lack of awareness arises primarily from a distorted focus on the large international humanitarian health service providers.

The dearth of knowledge of national health systems in conflict zones is also complemented by an absence of understanding of the conduct of humanitarian health providers themselves. In situations where there are no overarching governance structures, there is a need to understand the forms of regulation that ensure that expatriate medical practitioners maintain ethical standards of practice. Emanating from this is also the question of the ethical aspect of international humanitarian health agencies closing down entire programmes due to security threats. Again, very little is known about the manner in which populations can become dependent on external medical assistance and the impact on local societal structures of withdrawal of medical aid. Further, it is not known whether local health systems become resilient or whether they tend to regress after such withdrawals. Discussions on medical humanitarian assistance thus require a debate on the nature of accountability in the field of humanitarian healthcare. Who will provide these life-saving services to the civilian populations once the agencies leave, is an open question.

## Conclusion

The increasing use of force against healthcare facilities and medical personnel is an issue that requires systematic research. The inescapable aspect of armed conflict is that there is a clear spillover of the "political" dimension into such a fundamentally critical and non-aligned arena as health provision. The fact that modern day armed groups and state actors do not conform to the standards and ethics enshrined in IHL with regard to protection of healthcare provision is echoed in the findings of an ICRC report titled *Healthcare in danger*. The report concludes that the "means to address this problem do not lie within the health-care community; they lie first and foremost in the domain of law and politics, in humanitarian dialogue, and in the adoption of proper procedures by State armed forces" (10). However, attributing the solution to the political domain is not enough, as it dissociates the issue of humanitarian healthcare from its own ethical responsibilities in conflict zones. Seen from the lens of civilian protection, the onus of the protection of healthcare facilities must not be limited to state and non-state actors. Rather, serious ethical reflection on the provision of humanitarian healthcare is required, which also takes into account the responsibility of aid agencies towards vulnerable populations.

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# "Medical humanities" for India

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## Is there a problem?

A 21-year-old senior medical student is standing at the bedside of a patient in a general ward.  The intern has been told that it is important to pick up the patient's hand, and look into his face, before asking any questions. He has seen his teacher do this. He moves his hand stiffly, watches it go towards the patient's hand, and pause, and in those few seconds, realises this is not going to work. He gives up, and asks: "Tell me what the problem is."

The young men and women who enter medical colleges in India are of above average intelligence, many are exceptionally bright, and all yearn to do good. This is largely true, even though our entrance exams do not really test intelligence or aptitude, and these young people stopped looking beyond physics-chemistry-biology at the age of 13, becoming little more than marks-scoring machines. Miraculously, many of them survive these battles with their intelligence intact and clinging still to their desire to be of service. The battle scars are there --  fear lies beneath the "cool", "don't care" surface. There are countless doubts. Am I in the right place? Am I good enough? But isn't this wrong?  What should I do?

Not addressing these questions can be dangerous: to the individual medical student whose doubts gradually vanish, leaving him numb, or worse, indifferent; to the patient who has to confront an emotionally stunted doctor; to the national healthcare scene dominated by people who learned to leave their humanity behind years ago.