Syria, Iraq, Ebola, Gaza, Mali – there has been a huge increase in the number of tragic crises in recent months... The humanitarian sector is under enormous pressure. This litany of tragedies is further cause for us to focus on the quality of assistance and protection operations for civilians. It also raises questions about the capacity and role of a sector which remains vital, but is increasingly in danger.

This situation has led to a relatively eclectic issue of Humanitarian Aid on the Move, which covers a broad range of issues. Understanding the importance of IHL, the complexity of situations, and the "turbulence to come" all depends on collective intelligence. Major health risks have emerged in the last ten years. The Ebola crisis shows how our societies have become more vulnerable, but also more reactive. Faced with the risk that it will spread to the rest of the world, our collective capacities will be put to the test.

How do we control this turbulence and violence which seem to be key factors of the future? How do we make societies more resilient, with the redefinition of the Hyogo Framework for Action (Sendai, March 2015) and the COP21 (Paris 2015), where we hope to see a global agreement on the climate? How do we rethink the humanitarian sector of the future, as the World Humanitarian Summit of 2016 invites us to do? The following articles, written by humanitarians and operational researchers, aim to contribute to these global discussions based on field practices and analysis.

Editorial
François Grünewald

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16 See Increasing respect for IHL in NIACs, ICRC, op.cit. See also, “How does law protect in war?”, Part I, Chapter 15, pp.1 to 13.
17 IASC commitment.
18 Quality and accountability initiatives like the Sphere project, Groupe URD’s Quality Comaps project and the ALNAP network are all currently going in the direction of greater protection. One can also refer to the Humanitarian Accountability Partnership (HAP International), the Listening Project, the International Network for Education in Emergencies (INEE), and the Enhanced Learning and Research for Humanitarian Assistance initiative. See also “Growing the shelter tree, protecting rights through humanitarian action”, United Nations Inter Agency Standing Committee, 2002. See also Action Against Hunger “Humanitarian principles in conflict” (http://dd0jh6c2fb2ci.cloudfront.net/sites/default/files/publications/Humanitarian_principles_in_conflict.pdf).
21 See The protection of Human Rights in Humanitarian crises, A Joint Background Paper by OHCHR and UNHCR, op.cit. To make up for these shortcomings, the IASC commissioned an independent study in order to evaluate the extent to which the humanitarian system was able to ensure protection and establish the measures that needed to be put in place in order to guarantee that protection effectively had a central place within this system.
22 International Humanitarian Law and the challenges of contemporary armed conflicts, October 2011, CICR, p.15
23 National Human Rights Commission, op.cit.
25 Though it may seem inappropriate to compare the responsibilities of an NGO with those of a company, we can learn a lot from doing so. The United Nations are increasingly looking into this issue and national tribunals are increasingly called upon to make decisions about this responsibility in connection with legal proceedings instigated by human rights associations. See Protect, Respect and Remedy: a Framework for Business and Human Rights, Human Rights Council, 2008 and the Guiding Principles on Business and Human Rights, OHCHR, 2011. See also Corporate Accountability for Human Rights Abuses: A Guide for Victims and NGOs on Recourse Mechanisms, http://www.fidh.org/IMG/article_PDF/article_a6258.pdf
26 French Penal Code, Article 113-6 and 121-2.
27 French Penal Code, Articles 222-19 to 222-21.
28 Action Against Hunger “Humanitarian principles in conflict”, op.cit., p.15
29 International Humanitarian Law and the challenges of contemporary armed conflicts, October 2011, CICR, op.cit. p.20.
30 French Penal Code, Article 222-22.
A rare opportunity

Acting as a humanitarian organisation in Myanmar is very complicated. Though the situation in 2014 has somewhat evolved, when discussions began about the possibility of MSF working in prisons (2008), there was a lack of trust between humanitarian organisations and the Burmese authorities: the regime, which was known to be one of the toughest in the world until the dissolution of the junta in 2011, was not at all happy about foreign humanitarian action, particularly in the most sensitive regions. Humanitarian needs existed (conflict, poverty, poor health services, climatic hazards, etc.), but the working conditions that were imposed made it very difficult: administrative barriers and complications; access to conflict zones in the East of the country was virtually impossible; discussions with the authorities were filtered by spokespersons from the Ministries who did not have any decision-making power; prohibitive taxes on imports; attempts to control the local staff which led to endless negotiations and uncertain results; funding which was difficult to obtain from funding agencies, etc.

In addition to this, we should also mention the very strong suspicion which was felt, at the time, by the Burmese opposition in exile and in prison, as well as by certain campaigners around the world, who accused aid organisations of playing into the hands of the dictatorship by taking action in Myanmar.

The authorities had full power over humanitarian action, without the criteria for decisions always being clear or understandable for aid organisations. As a consequence, the need to accept compromises (some would say the sacrificing of principles) often led to very heated debates within humanitarian organisations.

In 2008 the Swiss office of MSF in Yangon was unexpectedly approached, in an unofficial capacity, to work in Insein prison: Myanmar’s “silent killing field”. Someone who had formerly been in charge of prisoners’ health contacted MSF to develop an AIDS programme for prisons. Up till then, nothing had been done for infected patients. This person had already seen and appreciated AIDS programmes run by MSF in different regions of the country. According to the information we obtained, it was the deaths of political prisoners with AIDS that pushed the leaders of the junta to demand that something was done so that this did not happen again. No foreign organisation had worked in prisons since 2005.

Medical data supplied by the Burmese authorities showed that AIDS and TB were the most common causes of mortality in prisons (27% of deaths in Insein prison in 2008 were related to AIDS) even though the number of deaths had already fallen since the national programme against TB had begun to detect and provide treatment to patients with pulmonary TB (smear positive).

Insein prison, the biggest in the country, had between 6 000 and 8 000 prisoners, some of whom were only in transit, during their trial or before being transferred to a work camp. In addition, 1/5 of the prisoners were women. According to the figures provided by the authorities, 30% of female prisoners who had worked in the sex industry had AIDS (compared to 0.67% of the country’s population as a whole). And the number of cases of TB was 25 times higher in prison than in the population as a whole (according to the World Health Organisation, there were 525 cases for every 100 000 people in the general population).

A period of discussion and negotiation

At Médecins Sans Frontières, there were very heated discussions about whether or not to seize this opportunity: should we, on principle, accept to collaborate with a dictatorship to assist a population, who clearly had needs, but whose well-being was exclusively the responsibility of the authorities? Would we help patients to get back on their feet only for the system to knock them back down again? Could we refuse to assist people living in deplorable conditions, in terms of health amongst other things, when MSF was created “to go where nobody else goes”? Should we not try to provide assistance with the risk that we might quickly give up (and perhaps denounce an unacceptable situation)?

The decision was made to begin negotiations while giving ourselves all the time that was needed to achieve acceptable conditions for the project.

During the negotiation phase, MSF engaged in discussions internally about the conditions that needed to be met before we would consider going ahead with the programme. As a result, we established a kind of management chart which would help those in charge of the project to closely monitor the development of the negotiations and activities.

The preconditions for launching and pursuing activities concerned three areas:

1) In terms of security:
MSF refused to allow the presence of arms or any means of restraint in its clinic. MSF staff, to be chosen by the organisation alone, were not to be threatened or forced to take part in acts which would be harmful for the health or well-being of the patients. Access to the clinic was to be
guaranteed to MSF staff, whether foreign or Burmese. Patients were to have unrestricted and voluntary access to the MSF clinic (common law prisoners and prisoners of conscience) based on their need for treatment as determined by the MSF staff or at the request of the patient if there was a problem.

2) In terms of healthcare procedures and protocols:
The protocols were to be based on MSF’s quality criteria. Patient consultations were to be strictly confidential (consultation rooms and medical data). If necessary, patients could be referred to specialist institutions.

3) In terms of project strategy:
MSF would provide the prison authorities with support for a period of five years, if, during this period, the authorities demonstrated the will to invest in prisoners’ health beyond AIDS in the form of shared management. This period was deemed to be long enough for capacity building and skills transfer before MSF withdrew. MSF, for its part, made a commitment to find the human and material resources necessary and guaranteed that it would supply antiretroviral (ARV) and other medicine for patients receiving treatment, up to a year after the withdrawal of the organisation, regardless of the reasons.

To maximise the chances of success of this observation phase, Médecins Sans Frontières decided not to publicise the negotiations or the possible launch of this new activity. Contacts were nevertheless established with the diaspora to find out how medical work by MSF in a Burmese prison might be perceived.

Two years of negotiations were needed before the two parties felt sufficiently comfortable and MSF’s activities started in the prison.

Implementation under strict surveillance

A letter of agreement was signed in August 2010 between the prison authorities and Médecins Sans Frontières which allowed collaboration to begin, treating prisoners with AIDS. The letter specified that if the collaboration was fruitful, other medical treatment could then be provided by MSF.

Both parties observed and tested each other during the launch phase of the activities which began concretely at the end of 2010. MSF staff provided the 140 prisoners who had been referred by the prison’s medical services with treatment in the MSF clinic which was set up just outside the prison (140 was the number of prisoners mentioned in the letter of agreement).

Conscious of the dangers of its activities being manipulated, MSF adopted a special monitoring regime to monitor activities and negotiations in order to react immediately to any problems that were encountered: management chart of indicators related to working conditions; discussion group including experienced people who were not linked to the running of the project, to regularly review how the negotiations were progressing; annual visit of the project, etc.

MSF saw the first year as a pilot phase which would ideally lead to AIDS treatment being integrated into the prison’s general healthcare services and genuine co-management of healthcare.

Results

During the three years of collaboration, MSF staff achieved some very positive results:

- 1 401 patients (15 188 consultations in total) received treatment from MSF, 448 of whom received ARV treatment in satisfactory working conditions. What is more, the authorities accepted and respected MSF’s preconditions during the whole period in terms of treatment protocols, access and security.

- In terms of mortality, whereas 49 deaths were recorded as being caused by AIDS in 2010, there were 23 in 2011, 12 in 2012 and 19 in 2013. The deaths often took place when patients were referred to MSF when the disease was in a very advanced stage. In addition to the medical and psychological consultations related to AIDS, MSF was in charge of opportunistic diseases, other sexually transmitted diseases, vaccinations (including hepatitis) and referrals to specialist services and hospitalisations.

Viewed positively by the patients who received treatment, the MSF staff never heard any stories of violence carried out by the prison staff against one or more prisoners.

The relations between MSF staff and the prison authorities were cordial, and the coordination meetings to monitor and manage the problems which arose regularly, proved to be effective. To illustrate this, we will now look at examples of problems that were dealt with: discrimination against AIDS patients; and providing treatment to patients who had been released from prison and patients who were from other prisons in Myanmar.

Very quickly, the patients who were seen by MSF were subjected to certain forms of discrimination by other prisoners and prison staff because they were identified as carriers of the AIDS virus: everyday tasks were imposed or refused, and they were subjected to baiting and insults. Having been informed of this, the prison authorities helped change this behaviour. Cells were opened for prisoners with AIDS. This measure was imposed by the prison authorities and was appreciated by the patients. Once they were stabilised, the patients were able to go back to their shared cells. Awareness-raising sessions for the prison’s medical and security staff helped to stop the discrimination.

Contrary to received wisdom, prisons are open spaces, in the sense that most prisoners end up leaving: either
because they have served their sentence or because they have been granted amnesty. Through negotiation, the MSF staff were able to get advance notification of the prisoners-patients who were going to be released. Through links with medical structures who were able to provide these patients with care in their home region (national and international NGOs and the Ministry of Health), 86% of the prisoners who were released were successfully referred.

At one point, the MSF staff realised that the prisoners who were sent to their clinic were from other prisons in the country, without MSF knowing on what basis these transfers were made (in exchange for money?), and without being able to follow up these patients. Faced with the risk of becoming the auxiliary of the whole Burmese prison system, and with negotiations still underway to establish the limits of each party’s responsibilities, MSF decided to oppose this trend through negotiation (from the moment MSF announced its withdrawal, the organisation no longer had any control over this). In total, 25% of the people who died among the large number of people treated by MSF staff came from other prisons than Insein, where no treatment or care for AIDS was available.

However, MSF successfully campaigned for women imprisoned for prostitution and who were HIV positive to be able to stay in a rehabilitation centre for a return to civilian life, where living conditions were much better, rather than going to Insein. In the end, the Ministry of Health accepted to put in place healthcare for the disease in this rehabilitation centre.

**Dilemmas and decisions**

All this progress did not allow three conditions to be met that had become essential in MSF’s view for the collaboration to continue: indiscriminate access by MSF to all prisoners who needed medical care, the early detection of patients with HIV and a real investment by the prison authorities in order to be able, eventually, to totally fulfil their responsibilities with regard to the health of the prison population.

Ethically speaking, it was becoming increasingly unbearable to know that though the prisoners who were referred to MSF by the authorities had the right to a quality service, all the other prisoners had to go through the prison healthcare system, which was known to be very limited. The negotiations which began at the end of the first year in favour of a global approach to the prisoners’ health came up against a wall of refusal. MSF was never able to integrate the services it provided to patients with AIDS into the existing hospital in the heart of the prison, even though MSF staff were able to visit it, observe the relative absence of patients and propose improvements to the healthcare provided. The impact in terms of the general improvement of health conditions for all the prisoners was therefore limited.

In June 2012, a cholera epidemic broke out in the prison. Officially, around 450 patients and members of the prison staff were infected. Fortunately there was only one death. Despite unofficial requests by prison staff and managers to receive assistance from MSF, all offers of services from the organisation were officially rejected. This was further confirmation that the collaboration, from the point of view of the authorities, was just a sub-contracting of services to an external actor kept on the outside...

One of the biggest problems that came up in terms of effectively treating patients with AIDS was the late detection of cases, who were usually referred when the disease was in an advanced state. Tests were carried out by the prison health staff, in ethically and qualitatively questionable conditions. Médecins Sans Frontières’ proposal to share in providing full medical care for new prisoners, moving towards joint management of the healthcare, was refused irremediably. The administration only agreed to delegate responsibility for carrying out HIV tests to MSF, in the MSF clinic, for all new prisoners that they referred.

Though, from the end of the first year of the project (end of 2011), discussions between MSF and the prison administration focused on opening a new phase of partnership for the benefit of the prisoners, any proposals that were made with precise content and duration were rejected. So too was real investment by the authorities to allow them to eventually take on MSF’s responsibilities.

Clearly, and in an increasingly official way, the objectives and limits of the partners became clearer... and contradictory. The Burmese prison system was not planning to begin providing healthcare for AIDS in prisons and was only looking to outsource this activity to an external partner.

In June 2013, after more than a year of negotiations, MSF officially decided to withdraw from the programme, giving the authorities six months to develop their action plan for the future. Rapidly, an international NGO (The Union) stated that it was interested in taking over MSF’s activities on the terms imposed by the authorities. The handover therefore went as well as could be hoped.

**What lessons have been learned?**

Independently of the success of having treated all the patients provided with healthcare by Médecins Sans Frontières and now by another organisation, as well as all the experience acquired by the organisation and its staff in...
Should a programme have been started without all the conditions having been fixed and codified in advance in a full agreement to which both parties were tied?
For MSF, the question of the long-term sustainability of an operation or the guarantee of success are not prerequisites before launching an operation. In this case, it was decided that the conditions for beginning a medical programme had been met (pilot phase limited to providing healthcare for AIDS patients, while being open about the objective of running a global project in due form).

Without doubt, in Myanmar perhaps more than anywhere else, negotiating the conditions of a programme in a prison is crucial to maximise the chances of success. The risks involved in the programme should be reduced to a minimum by investing the necessary means to respond to its specific characteristics.

Is it possible to anticipate and manage the problems and risks of being manipulated when a programme takes place at the heart of a repressive dictatorial regime?

Unless we consider that prisoners do not deserve to receive aid like any other human being, it is natural to envisage a project that responds to recognised needs. For Médecins Sans Frontières, the unacceptable level of mortality related to AIDS fully justified the operation: the cost-benefit ratio clearly leaned towards launching the project.
At the same time, the characteristics of the prison environment, regardless of the country, mean that a specific kind of monitoring (of procedures and resources) is necessary for this type of project: there are genuine risks of manipulation and participation in the repression of prisoners – even if this is involuntary.

The specific tools that were used by MSF for the Insein project were not particularly complicated, and could easily be replicated in other similar contexts.

Can a humanitarian organisation, which conducts programmes which have a limited timescale, try to reform the healthcare provided to AIDS patients in a prison environment (what is more, in Myanmar)?

In the end, the issue which caused the most controversy within the organisation itself was the objective of structural change in the quality of healthcare provision to the prisoners via a short-term project in a prison. Time is a major factor of success: beyond the slogan, “we cannot know until we have tried”, which is debatable but is used, it was very important for such a difficult project that the objectives of the project should have been compatible with the time given to achieve them.

In this case, there were clear difficulties in establishing working relations between foreign actors and the Burmese authorities and in understanding the reasons why a request was refused or accepted. Other characteristics, however, provided a counterweight to these unfavourable factors: the request for action came from the Burmese authorities themselves. What is more, they have begun to include the treatment of AIDS in their healthcare provision for people outside the prison system and Insein has the infrastructure and medical staff that are needed.

The fact that Médecins sans Frontières’ initial action took the form of a pilot phase which only addressed AIDS cases may have had an ambivalent impact: it allowed MSF to immediately be effective for the patients while respecting the conditions of the collaboration with a view to greater investment, but it deprived MSF of a major asset in the negotiations for a global health project: the authorities’ initial request – the provision of healthcare to patients with AIDS, was immediately satisfied. Why would they then accept broader collaboration? MSF felt that it was worth the risk...

No doubt Médecins Sans Frontières will run projects in prisons again in the future, given the enormous needs and the limited number of organisations who are willing or able to do this kind of work. The direct impact in terms of mortality will certainly be a major criterion behind the decision to act. Nevertheless, experience shows that the conditions in which the project are to be implemented need to be analysed in detail and sufficient time needs to be taken to make an informed decision.

Beyond MSF’s involvement in the future, given the specific characteristics and challenges of prison environments, humanitarian and medical operations in prisons could become a domain (or niche) in which existing experience and expertise could be brought together in a specific type of service. This could be developed within an organisation which is already active (MSF or other), or via the creation of a new organisation.

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1 “…I got a fairly comprehensive impression of the conditions of detention around the world. In many countries I was simply shocked by the way human beings are treated in detention. As soon as they are behind bars, detainees lose most of their human rights and often are simply forgotten by the outside world” Extract from the Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment” of 5/2/2010,
Point of view

Problems of quality in humanitarian action: what exactly are we talking about?

On 15, 16 and 17 September 2014, at Groupe URD headquarters, the Autumn School on Humanitarian Aid brought together specialists on issues of Quality and Accountability. Much is happening in this area, with two important projects being presented in Copenhagen on 12 December 2014: the Core Humanitarian Standard, which has been developed due to the need for greater coherence between the various standards that exist, and the results of the Certification Project led by the Steering Committee for Humanitarian Response.

The key points of the Autumn School will be published on Groupe URD’s website in October. The aim of this article is not to give a detailed account of the very rich discussions which took place, but rather to talk about a specific issue which was a common theme throughout the discussions: what is the fundamental nature of the problems of quality in the humanitarian system? And to give Groupe URD’s point of view on these questions.

Different definitions of quality depending on points of view

Agreeing on a definition of quality is not easy in any sector of activity. It is essentially made up of very subjective characteristics and has very different meanings depending on the point of view of the people involved. Attempting to define quality for humanitarian aid, a very complex and multi-party sector, is extremely difficult. At one end of the chain, the people affected by disasters mainly need to have access to assistance which is adapted to their situation and their priorities and which is delivered in a timely manner. At the other end of the chain, donors of course want to satisfy these basic needs, but they also have a lot of other pre-occupations such as obeying the policy directives of their governments, ensuring that their operational partners respect administrative and financial regulations, and checking their activities in the field. These additional imperatives come from the donor’s role in managing public funds and the strong legal constraint in relation to public opinion which comes from having to justify how funds have been spent and what effect this has had.

Each stakeholder in the aid system – affected communities and people, local and national authorities, individual donors, operators, etc. – therefore has their own idea of what a good quality humanitarian operation should be. These different perspectives are also present within humanitarian organizations who have an obligation both to satisfy the demands of those who fund them and to respond to the needs of disaster-affected people. Tension is common within organizations between, on the one hand, the management who want to consolidate the structure by satisfying and reassuring the funding agencies, individual donors and the media, and on the other hand, the operational staff who are in contact with the affected people, who are more concerned about the quality and relevance of the operations in the field.

One specific characteristic of the sector comes from the fact that the international aid system is not structured in a way that gives the “beneficiaries” control over the organizations who provide them with assistance. This is a fun-