Humanitarian medicine is more than a technical exercise

What a sad indictment of our times that the Turkey Hub of the Health Cluster, a UN-activated humanitarian health coordination body, has begun to calculate the confirmed number of attacks against hospitals in Syria. Mohamed Elamine and colleagues,1 as part of the Lancet Series on health in humanitarian crises,2–5 present evidence on the use of the Monitoring Violence against Health Care tool to detect and verify attacks on health-care services and describe their effect in Syria. The tragic story these statistics tell highlights the need for action to stop attacks against health-care settings and workers in Syria and elsewhere in the world.

At Médecins Sans Frontières (MSF), our identity as humanitarian medical responders has been scarred by attacks against our personnel and patients in recent history. Tragic incidents in Afghanistan, South Sudan, Syria, Yemen, and elsewhere have shaken us to our core. These attacks have caused untold damage to health-care systems and workers, as well to the patients and communities deprived of health care. The extent of attacks in Syria has forced humanitarian medicine to reconsider its capability, pushed innovation and adaptation, yet still caused MSF to face our limits.

Without offering a transparent account of the methodology used to verify attacks, as suggested by Elamine and colleagues,1 individual attacks can be too easily denied or dismissed as not deliberate,6 collateral damage,7 errors,8 or an inevitable consequence of the fog of war.9

Humanitarian organisations such as the International Committee of the Red Cross and MSF have highlighted the impact of violence on the provision of medical care through projects such as Healthcare in Danger and Medical Care Under Fire. The challenge is to ensure that awareness of humanitarian law, understanding of the long-term consequences of such attacks for the civilian populations and health-care systems of the countries concerned. But since the resolution was passed, there has been no serious commitment to its implementation and attacks have continued. On Aug 15, 2016, MSF sustained its fifth and deadliest attack on an MSF-supported medical service in Yemen, amid many other attacks on health facilities and services elsewhere in the world.10 On Aug 18, 2016, the UN Secretary General provided the UNSC with recommendations on measures to enhance the protection of, and prevent acts of violence against, patients, health personnel, and medical facilities. But as the 1-year anniversary of the resolution has passed by, its implementation has yet to be discussed by the UNSC.

While attacks on medical facilities in conflict have generated public attention, the practice of humanitarian medicine is not defined by this phenomenon alone. Humanitarian medicine is inscribed in a rapidly evolving aid sector. Sandra Colombo and Enrico Pavignani outline the “recurrent failings” of humanitarian medicine.4 These failings cannot be separated from those of the wider humanitarian sector that Paul Spiegel describes as “no longer fit for purpose”.5 Irrespective of the validity of such an indictment and recommendations offered within their Series papers, these authors are not alone in their critique. MSF too has been vocal about its own failings and those of the wider health and aid system in the response to the outbreak of Ebola virus disease in west Africa. The well documented delays and obstruction to recognising the severity of the outbreak6 are mirrored in the response to more common outbreaks of measles, malaria, cholera, and meningitis that take place every year, with profound consequences and substantial loss of life.7

In 2016, the humanitarian sector witnessed major calls for reform at the World Humanitarian Summit, the UN Summit on Refugees and Migration, and in debates on reform of WHO.8–10 Localisation of aid responses, inclusion of beneficiaries, better coordination and leadership, more efficiency and effectiveness, breaking down distinctions between development and humanitarian aid, integrating lessons learned, better data, use of cash and reform of humanitarian financing, and more accountability are all themes the humanitarian sector is occupied with.

While these critiques and processes may or may not drive reform, the sector’s overall evolution will remain linked to the politics that both condition its funding and...
direct its focus. It has been asserted that it was media-fuelled fear of Ebola in high-income countries, after the first laboratory-confirmed case in the USA with a man who had travelled to Dallas from Liberia, that triggered the mobilisation of resources rather than the massive medical needs of the affected people in west Africa. High-income nations responded with strategies of containment on the basis of national security interests or domestic politics rather than altruistic concern. Despite many reviews of the response to the Ebola outbreak, it is unclear how the epidemics of tomorrow will be better addressed, since global health actors are increasingly framing discussions of health security as a peace and security issue to secure funds rather than a humanitarian issue.

The international politics that influence humanitarian response are shifting. From the 2018 budget proposal of President Donald Trump’s administration that seeks to cut USAID and US State Department funding by 28.7%, to governments in Europe diverting humanitarian funds to stem migration flows, the future shape of the humanitarian sector is in question. Criticism of the humanitarian sector must be translated into meaningful reform and not simply act as an excuse to diminish resources and contribute to its demise.

While the recommendations of this Lancet Series may be of value to drive improvement in the provision of humanitarian medicine and the development of a stronger evidence base, it is vital to understand that humanitarian aid goes beyond technical improvements. The success or failure of humanitarian medicine and aid, as well as the safety of those who receive and provide it, is largely dependent on access to populations in crisis. Humanitarian action also inevitably involves fighting the established order responsible for such crises, since it “rejects the logic that divides humanity into those who may live and those who must die”. MSF cannot embrace this fight without a humanitarian spirit and the relentless pursuit to access and care for vulnerable populations. There will never be an indicator or an evidence base for this pursuit and resolve, but humanitarian organisations must not forget our success depends upon it.

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VH is Executive Director and AHP is Head of Programmes at Médecins Sans Frontières-UK. We declare no other competing interests. We thank Alastair McCready and Sarah Venis for their help in preparing this Comment.