human rights law as well as on analogous refugee law, have now been developed and disseminated.[4] These principles list the important essential services that IDPs are entitled to: food, potable water, sanitation, shelter, and medical services. However, responsibility for the protection of and provision of basic services to IDPs still rests with national governments, many of which may be unwilling to prioritise the delivery of services to IDPs, or lack the technical capacity to coordinate or monitor the programmes of international humanitarian organisations during emergencies. There is an urgent need for a specific international humanitarian agency to be given the mandate for providing such services so that tangible improvements in the health and welfare of IDPs to be attained. The designation of such agency responsibility will represent an important step in preventing excess morbidity and mortality among IDPs and in providing them with the basic human rights and dignity now afforded to most refugees. Measles vaccination campaigns and adequate food rations have become a standard component of health services for refugees and such basic services should be systematically extended to IDPs. However, no matter which lead agency is ultimately chosen for this task, access by the humanitarian community to emergency-affected populations, when sovereign nations are reluctant to accept foreign interventions, will remain the key obstacle to improving health status among IDPs.

References

1 Toole MJ, Waldman RJ. Refugees and displaced persons: war, hunger, and public health. *JAMA* 1993; **270:** 600–05.

2 Spiegel P, Salama P. War and mortality in Kosovo: an epidemiological testimony. *Lancet* 2000; **355:** 2204–09.

3 Lopes Cardozo B, Vergara A, Agani F, et al. Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo. *JAMA* 2000; **284:** 569–77.

4 Deng F. Guiding principles on internal displacement. New York: United Nations Office for the Coordination of Humanitarian Affairs, 1999: 1–14.

Military involvement in refugee crises: a positive evolution?

Fiona Terry

Military involvement in refugee relief operations has undergone a remarkable evolution during the past decade, from providing logistical support to aid organisations in Kurdistan in 1991 to leading relief efforts for Kosovan refugees in 1999. Some aid organisations have welcomed this development, and increasing attention is being paid to issues of civil-military cooperation. However, although few would contest that military forces possess logistical capacities unmatched in the aid community, important questions remain as to the appropriateness of an increased military presence beside humanitarian organisations in the field.

First, the motivation of the military is different from that of humanitarian organisations, even if the intervention is couched in "humanitarian" terms. Humanitarian action is premised on the equal worth of all human beings, yet military interventions since Somalia have been selectively undertaken by governments with direct national interests: the French in Rwanda, the USA in Haiti, the Russians in Georgia, the Australians in East Timor, NATO governments in Kosovo, the Nigerians in Liberia, and the British in Sierra Leone. Conflicts that pose no threat to powerful nations, either through security concerns, lost investments, or potential refugee flows, are largely overlooked, despite the human misery they generate. The massive offensive undertaken in defence of Kosovar refugees contrasts starkly with the cynical indifference shown towards Sierra Leonean and Liberian refugees under siege from rebel forces in Guinea today. Can we accept that the lives of some human beings are worth more than the lives of others?

Second, outside military forces are rarely perceived as impartial in conflicts, compromising the image, and hence the effectiveness, of aid organisations that associate with them. Few aid organisations will accept an escort from the UN peacekeeping force in Sierra Leone since its belligerent stance against the Revolutionary United Front (RUF) hinders access to civilians in RUF-held areas. Moreover, civilian lives are put at risk through mixing humanitarian and military actions. The presence of NATO troops in Kosovan refugee camps undermined the civilian and humanitarian character of the camps, and those in northern Albania were shelled by the Yugoslav forces as a consequence.

"In Kigali, Kibeho, and Srebrenica, troops stood by helplessly and witnessed the slaughter of civilians because their mandate did not extend to such a role . . ."

Third, the military lacks the technical competence to respond to the needs of refugee populations. Military forces are trained and equipped to provide medical care and facilities to a predominately male, adult, healthy population. Many of the essential medicines used in emergency settings, such as oral rehydration salts and vaccines, are lacking in sufficient quantity in military supplies, and facilities are not adapted to the needs of refugees. The French army hospital in Goma in 1994, for example, provided excellent care to some refugees, but given the scale of the cholera epidemic that began soon after their arrival (some 50 000 deaths in a matter of weeks), it was an inappropriate use of resources. Instead, the allocation of one helicopter to transport potable water could have alleviated the supply problem caused by the congestion of roads with refugees.

But the most serious shortcoming of military involvements in relief operations of the past decade does not concern what they do, but what they do not do. Protection from violence is the most vital need of refugee and displaced populations today, and is a task that humanitarian organisations are unable to assume. Yet most military forces have been deployed with a humanitarian mandate aimed at providing or protecting relief supplies. This mandate gives governments an image of doing

Lancet 2001; **357:** 1431–32

Médecins Sans Frontières, Paris 75011, France (F Terry PhD)

(e-mail: FTERRY@paris.msf.org)

something, to appease public outcry, while avoiding engagement in potentially dangerous or protracted conflicts. In Goma, the military fought *Vibrio cholerae* while the Rwandan leaders and army responsible for the 1994 genocide installed themselves in the refugee camps in full view of the military contingents present. As a consequence, the refugee camps were attacked by Rwandan government and rebel forces 2 years later, and 200 000 refugees remain missing to this day.

In Somalia and Bosnia, the military were tasked with protecting aid convoys. But the provision of humanitarian aid is a means to an end, the end being the preservation of life and dignity. Although insecurity can prevent aid reaching vulnerable populations, the deployment of military forces to protect the means in isolation of the ends is a dangerous travesty. A full belly does not provide civilians with protection. What is the point of protecting the aid supplies when the civilians it is intended to assist are in greater danger of losing their lives to violence? The most appalling consequence of the limited mandate is the false sense of security it provides to civilian populations. In Kigali, Kibeho, and Srebrenica, troops stood by helplessly and witnessed the slaughter of civilians because their mandate did not extend to such a role.

Aid organisations have called for military intervention in the past and no doubt will do so again in the future. But such calls are for political, not humanitarian action. This is the area in which the military can complement humanitarian activites, if the political will can be mustered to assume such a role.

Ethics of research in refugee populations

Jennifer Leaning

A debate is now underway within the relief community about the proper ethical guidelines to apply when doing research in refugee populations and among internally displaced peoples (IDPs). The debate pivots on the tension between the need to develop evidence-based emergency health measures and the need to protect vulnerable populations from possible exploitation or harm. At a time when there is widespread support for the development of minimum international practice standards,[1] there remains an acknowledged absence of good science behind much of what is done in the field. Emergency relief workers are painfully aware that questions abound about virtually every health and social intervention now undertaken in crisis settings—whether it be the amount of water required or the assessment and treatment of sexually transmitted diseases. As remedy, a range of research studies in emergency settings has been proposed,[2] all of which fall into one of three categories of inquiry: aetiology or prevalence investigations (what is causing this outbreak of diarrhoea? what percentage of the population is vaccinated for measles?); assessment of operations or systems (did this mode of soap distribution reduce skin infections?); and clinical intervention research (is the cure rate the same with 3 days of antibiotics as with 5 days?). Yet although the knowledge gained might be very useful, it is apparent to the humanitarian community that doing research on people who are desperately poor and frightened raises many issues about the ethics that support and constrain such studies.

Refugees are vulnerable as subjects for research for several reasons. First, in terms of political status, refugees inherently possess fewer defined political rights than people who can claim citizenship within stable national frontiers. The protective framework of the 1951 UN Convention on Refugees and its additional Protocols establishes only basic standards for the treatment of refugees, allowing host countries to apply additional domestic law at their discretion. Many countries have done little in this respect, with the result that refugees stand outside the regulatory protection of domestic legislation and are vulnerable to arbitrary action on the part of the host country. The status of the internally displaced in settings of collapsed or collapsing states is even more ill-defined.

Another related reason is that refugee flows now usually occur in the midst of complex emergencies, where human rights abuses are rampant and where refugees are considered hostile targets by those who force them to flee. In settings like the war and famine in Somalia, the genocide in Rwanda, or the conflicts in Chechnya and Kosovo, the prevailing powers in the region are unwilling or unable to provide adequate oversight to research involving refugees.

A third factor is that little technical guidance is available from the usual international instruments on biomedical ethics, such as the Declaration of Helsinki or guidelines from the Council for International Organizations of

Proposed guidelines for research in refugee and internally displaced populations

- Undertake only those studies that are urgent and vital to the health and welfare of the study population
- Restrict studies to those questions that cannot be addressed in any other context
- Restrict studies to those that would provide important direct benefit to the individuals recruited to the study or to the population from which the individuals come
- Ensure the study design imposes the absolute minimum of additional risk
- Select study participants on the basis of scientific principles without bias introduced by issues of accessibility, cost, or malleability
- Establish highest standards for obtaining informed consent from all individual study participants and where necessary and culturally appropriate from heads of household and community leaders (but this consent cannot substitute for individual consent)
- Institute procedures to assess for, minimise, and monitor the risks to safety and confidentiality for individual subjects, their community, and for their future security
- Promote the well-being, dignity, and autonomy of all study participants in all phases of the research study