In the Eyes of Others

In the Eyes of Others How People in Crises Perceive Humanitarian Aid

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Edited by Caroline Abu-Sada

NYU CIC | CENTER ON INTERNATIONAL COOPERATION

Humanitarian Outcomes

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

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—Caroline Abu-Sada

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Introduction

Caroline Abu-Sada

The way humanitarian aid workers are perceived has recently attracted increased attention, mainly because of the emergence of new elements in crisis contexts that challenge the very foundations of humanitarian action, and of growing difficulties in accessing populations in conflict zones.[1] Different studies have sought to understand the mechanisms that determine the perception of humanitarian action.[2] The aim of this work is to develop the debate on the role of humanitarian action in crisis contexts through an evaluation of how MSF's work is perceived in volatile environments.

Doctors Without Borders/Médecins Sans Frontières

MSF[3] is a nonprofit, nongovernmental organization that provides medical assistance to populations caught up in crises that threaten their survival: mainly armed conflicts, but also epidemics, pandemics, natural disasters, or even exclusion from health care. Created in 1971 in France by doctors and journalists, it is now an international movement made up of 19 associations, each under the responsibility of a Board of Directors elected by its members (current and former MSF field staff) during an annual general assembly. In 1999, MSF was awarded the Nobel Peace Prize. Today, MSF provides aid

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1 Abby Stoddard, Adele Harmer, Victoria DiDomenico, *Providing Aid in Insecure Environments: 2009 Update, Trends in Violence Against Aid Workers and the Operational Response* (London: Overseas Development Institute, 2009). It is also worth noting that, at the same time, the aid system has grown exponentially in terms of staff and budget.

2 For example, the four areas examined in the Feinstein International Center study were universality, terrorism/counter-terrorism, coherence, and security.

3 In this book, Doctors Without Borders/Médecins Sans Frontières will be referred to variously as "MSF," "the association," or "the organization."

in more than 60 countries and employs nearly 27,000 people.[4] The organization considers it important, at this point in its history, to launch the Perception Project, with the goal of giving voice to the people living in the areas where MSF provides medical relief. This book presents the results and reflections resulting from the study.

MSF acts according to the humanitarian principles of independence, neutrality, and impartiality. To a degree, these principles have become MSF's hallmark and have led it to refuse to collaborate with other actors or use the infrastructures and resources used by other humanitarian or international organizations in the field, a strategy that some consider more isolationist than independent.[5] Unlike other humanitarian actors, however, MSF enjoys financial independence,[6] which sets it apart and now forms part of its identity. *Témoignage*[7] is another concept very specific to the organization and was one of the main reasons for its creation. Following the Biafran War, MSF's founders wanted to create an organization that would speak out publicly about events in the field rather than remaining silent, as they believed the International Committee of the Red Cross (ICRC) had done. Forty years later, *témoignage* is still considered an integral part of MSF's work,[8] although medical action remains the priority.

Through its communications and operations, MSF aims

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4 Anne Vallaeys, *Médecins Sans Frontières: La Biographie* (Paris: Fayard, 2004).

5 This criticism is mainly made by UN agencies and other Western aid organizations, especially since MSF officially opposed the proposed cluster coordination approach to the aid system. (MSF International "What Relation to the Aid System?" MSF April 2007).

6 In 2009, 81 percent of its international funding came from private donors. *2009 Activity Report,* (Geneva: MSF-Switzerland, 2010), p 25.

7 The act of publicly denouncing situations that the organization considers intolerable.

8 The French term is still used within MSF, but a process of reflection has started within the movement with a view to adapting it to the organization's public and institutional positioning activities.

to highlight its total independence from political and other external influence. MSF believes that its capacity for independent humanitarian action is compromised by the initiatives of certain states and international organizations to use humanitarian aid as a tool to achieve political objectives. They use humanitarian aid to further broader objectives such as establishing peace, promoting democratic reforms or stabilization, or simply imposing national political agendas. Consequently, MSF acts at two levels, in two spaces: the countries in which it operates and, more broadly, in the international arena. These two spaces influence each other; and while this influence ensures adaptability to a range of contexts, it also renders it more difficult for MSF to convey a coherent image and message (especially across 19 different associations).[9]

This challenge of conveying a unified message also raises the issue of humanitarian space, a concept which many people associate with MSF, as it was first defined by the organization's former president, Rony Brauman: a symbolic space in which nongovernmental organizations (NGOs) enjoy freedom to speak to and establish dialogue with the people with whom they work; freedom of movement; freedom to assess needs; and freedom to monitor the distribution of aid.[10] The ICRC proposed that humanitarian space could be conceptualized using "Dunant's pyramid."[11] In this view, it consists of a complex mixture of humanitarian principles (independence, impartiality, and neutrality), which form the sides of the pyramid; humanity, which forms the tip; and international humani-

9 The MSF movement is composed of 19 sections (including the five operational centers—Switzerland, Spain, Holland, France, and Belgium): Australia, Austria, Canada, Denmark, Germany, Greece, Hong Kong, Italy, Japan, Luxemburg, Norway, Sweden, the United Kingdom, and the United States.

10 Rony Brauman, *Humanitaire, le Dilemme*, (Paris: Textuel, 1996), p 53.

11 Daniel Thürer, "Dunant's pyramid: thoughts on the 'humanitarian space'" *International Review of the Red Cross,* (Geneva: ICRC, no. 865, vol. 89, 2007), pp. 47–62, http://www.icrc.org/eng/assets/files/other/irrc-865-thurer.pdf.

tarian law, which forms the base. In the United Nations (UN) system, humanitarian space is defined as the working environment of humanitarian organizations. Therefore, the notion of perception is inseparable from the concept of humanitarian space.

Perception has a considerable impact on the quality of an organization's operations, as well as on the safety of both national and international staff in the field, and the beneficiaries of those operations. Consequently, NGO teams must pay special attention to the notion of perception, both in the field and at their headquarters. The way a humanitarian organization like MSF is perceived depends on a range of diverse and varied factors that can be difficult to understand. Indeed, such perceptions are the result of both context-independent factors (the organization's activities in other parts of the world, its reputation, its visibility on the international stage, the consistency of its principles and activities); context-dependent factors (the way the organization implements its operations in the country, the relevance of its activities to the needs of the local population, its communication strategy, its position in relation to national political issues, or even its management of local human resources or its integration into the pre-existing social fabric); and characteristics linked directly to the environment in which it is operating, such as political context (history of colonization, previous military or humanitarian interventions, number and types of foreign actors present, role of religious, political, economic, and military authorities).[12]

One of MSF's main challenges is how best to translate the central humanitarian principles of independence, neutrality, and impartiality[13] into operational realities. The application

12 Caroline Abu-Sada, "La perception de MSF sur les terrains d'intervention. Le cas du Niger," *Humanitaire*, no. 24, (March 2010), pp. 46–53.

13 See below: the Médecins Sans Frontières/Doctors Without Borders Charter.

of humanitarian principles may vary in conflict as opposed to neglected contexts. *The Practical Guide to Humanitarian Law* states that the interpretation of humanitarian principles must be done "in a practical manner within the context of relief operations," as it is this adherence that protects the presence of humanitarian organizations in armed conflicts under the Geneva Conventions.[14] While this assertion is useful during armed conflicts, it is less relevant in settings where MSF is working with neglected populations and/or neglected diseases. Only 22 percent of MSF's interventions in 2009[15] were emergency/short-term interventions, which shows that MSF has also made a place for itself as a provider of longer-term medical assistance.

MSF strives for acceptance of its activities through adhering to humanitarian principles to ensure the safety of its teams in the field. This strategy only works if the populations with which MSF is working are aware of its activities and its specific approach centered on independent humanitarian action. Unlike the ICRC, MSF does not have a mandate validated by international conventions and must therefore gain its legitimacy through the relevance of its medical actions in the field. Due to changing norms and international attitudes toward humanitarian actors, including the desire by crisis-affected states to maintain greater sovereignty and control over international activities within their borders, MSF must adapt its actions in the medical, administrative, and political spheres. In the medical sphere, these changes raise questions about the choice of medical intervention (who decides?); standards and quality of care (is MSF a standard-setting institution?); impact (to what extent should MSF be accountable for its impact in

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14 Françoise Boucher-Saulnier, *The Practical Guide to Humanitarian Law* 2nd ed., Lanham: Rowman & Littlefield, 2007, p. 157.

15 *Typology of MSF Projects,* (Geneva: MSF International, 2010).

a crisis situation, given other influencing variables?); existing health systems and global health actors (is it better to prioritize integration/partnerships or emphasize autonomy/independence?); as well as ethical issues (paternalism, autonomy, resource allocation, responsibility in the event of medical errors, exceptions in emergencies). Similarly, changing norms require a reinterpretation of administrative issues such as the certification of doctors' qualifications, the management of local human resources, and so on. In the political sphere, this means that MSF must be more aware of its impact on local power structures and, therefore, more careful in its dealings with authorities.

MSF is becoming increasingly aware of its limitations as a medical humanitarian organization. It therefore decided to undertake this three-year perception study in order to gain a better understanding of the way in which it is seen in the field by a wide variety of stakeholders, with a view to optimizing the implementation of medical projects. For the Operations Department,[16] and in the organization's interactions with other actors, a thorough evaluation of perception is also the key to maintaining MSF's status as an independent and impartial actor, free of any religious, economic, or political interests.

The first part of this book describes the origins of this project, the methodology used, and the main themes that emerged from the last few years of research in different contexts. The second part presents a series of contributions from several authors, most of whom are external to MSF. We asked them to offer different perspectives on the questions raised about perception.

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16 Programs consist of all activities involved in MSF missions. The Operations Department in Geneva is made up of five "cells" (composed of a head, a deputy, a medical member, a financial member, a logistician, and a human resources manager), each of which oversees the programs in a given set of countries.

By publishing the results of this research, MSF hopes to give something back to the people who have been interviewed during this survey, provide some tools to help understand the environment in which MSF staff work, and, finally, contribute to the debate about the place of humanitarian organizations in volatile contexts.

While the French and Arabic versions were published with an independent publisher, it seemed important for MSF to co-publish the English version with the Center on International Cooperation of New York University and Humanitarian Outcomes, whose staff has been involved for years in researching the humanitarian sector and humanitarian aid operations. This ability to provide a reflective and critical look at the issues addressed by the study is demonstrated most clearly in Abby Stoddard's article.

Part I

Studying How MSF is Perceived

Origin of the Perception Project

Caroline Abu-Sada

Two events convinced MSF to undertake this project. The first was the killing of five MSF staff members in Afghanistan in June 2004. MSF had been working there for 25 years.[1] Such a long-standing presence in the country had led MSF to believe that it was known by the population and was, therefore, somehow "protected." The killings forced the organization to reconsider its analysis of the link between long-term presence in areas of intervention and its perception and acceptance by local people and actors.

The second event was more specific to the Swiss section of MSF, which, in the past, has sometimes sent out contradictory messages to the populations with which it works. The most striking case occurred in Bunia, in the Ituri Province of the Democratic Republic of Congo (DRC). MSF had taken over a number of medical activities at the Bon Marché Hospital. In 2005, the United Nations Organization Mission in the DRC (MONUC)[2] launched a military operation in Ituri to disarm the militias. As UN forces were using white all-terrain vehicles similar to those of MSF, the population conflated the two organizations. To add to the confusion, MONUC posted soldiers to "protect" the space where the MSF teams were based. It became difficult for the organization to explain its neutrality to the

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1 Five members of MSF's Dutch section were murdered on June 2, 2004, in Badghis Province in Afghanistan. This attack prompted the immediate cessation of all operations on Afghan soil.

2 MONUC was created in 1999 by the Security Council. In 2010 it was renamed the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) and is due to withdraw from the country in June 2011.

local people. MSF-Switzerland decided to repaint its vehicles fuchsia, as that color was not associated with any political or military force present in the region.

In the wake of serious security incidents and image problems like these, it was important for MSF to find out how it is perceived in the places where it works. Moreover, within the framework of a new paradigm shaping international relations, this research offers tools to understand the contexts in which humanitarian aid is deployed.

Indeed, since 2001, the new paradigm of the "war on terror" has replaced the post–Cold War paradigm of the 1990s. This shift saw the radicalization of certain political actors and the politicization of humanitarian aid, which became a means of "winning the hearts and minds" of the populations in the places where the war was being waged: Afghanistan, of course, then Iraq and the Occupied Palestinian Territories, where development assistance and humanitarian aid have always depended on the political agendas of actors external to the conflict.

The study got underway in June 2007, and by the end of the research stage, 11 projects had been visited:[3] two in Niger, two in Cameroon, one in Liberia, one in Kenya/Uganda, one in Guatemala, one in Kyrgyzstan, one in Iraq (Iraqi Kurdistan), one in Jordan, and one in the Occupied Palestinian Territories.

The first documents on the research project were produced by the UREPH,[4] in collaboration with the Operations Department.

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3 All the operations in a given country are referred to as a "mission" (so we will talk about the Kenya mission, the Sudan mission, etc.). Projects within a mission are the medical activities at the local level. For example, the Kenya mission has two projects: the Somali refugee camp in Dadaab, and the Kacheliba project, which treats the disease kala azar.

4 The UREPH is a unit of six people attached to the General Directorate of MSF-Switzerland. It organizes operational research projects, such as those on perception, violence, MSF's work in places of detention, the legitimacy of humanitarian medical action, etc.

As initially set out, the aim of the project was to understand the extent to which MSF's supposed "difference" from other humanitarian organizations is real and identified as such by the different stakeholders present in the field. This difference is understood as the fulfillment of MSF's guiding humanitarian principles, such as independence, neutrality, and impartiality.

At the beginning of the project, in 2007, one of the initial hypotheses was that people across the board were aware of MSF's financial and political independence, which underpinned the organization's unique position:[5] "A hallmark that very few can claim, financial and political independence is part of MSF's calling card, proof of its pursuit of detachment from all hierarchical dependencies other than those determined by the organization itself."[6]

However, from MSF's perspective, that independence has been severely compromised by states and international organizations exploiting humanitarian action as a means of achieving their own objectives.

The initial paper outlining the project also set out the limitations intrinsic to this position:

> But is this profession of faith, which goes so far as to translate into the refusal to use the aid resources of other relief organizations (food from the UN World Food Program in Niger, for example) understandable to all stakeholders in MSF's areas of intervention? Is it understood, recognized, and considered important by those stakeholders? Are MSF's aid and identity recognized by local stakeholders for what they represent to the organi-

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5 In 2009, 81 percent of MSF-Switzerland's budget was funded by private donations collected in Switzerland and abroad, *2009 Activity Report* (Geneva: MSF-Switzerland, 2010), p 25. These private donations are largely from individuals, as well as local and regional public entities and the broader private sector (foundations, businesses, etc.). None of the donors has a say in operational decisions.

6 *Internal document presenting the Perception Project,* MSF-Switzerland UREPH (2006).

zation: an act of solidarity and disinterested aid for the most vulnerable, provided by an impartial, independent and neutral organization?[7]

So, the question was whether, as an organization, MSF was using its resources wisely to enable local actors to distinguish between it and the other aid players and foreign actors. The challenge was also to define the main criteria for local stakeholders to assess the quality of a relief organization and the quality of the aid provided.

Methodology

Perception can be measured by adopting models used in the social sciences. This study tried to understand how MSF's image is constructed and how it is conveyed to audiences outside the organization.

Similarly, it is important to find out how this institutional identity is received and understood by the people who interact with MSF as an organization, employer, and medical structure.

In addition to the issue of organizational image, certain other questions needed to be explored:

- How is humanitarian aid—as opposed to development assistance[8]—generally perceived by the host societies? It is obvious, though not always remembered, that those to whom humanitarian aid is delivered are not simply passive recipients.
- How is the medical aspect of the organization understood? What are caregiver/care receiver relationships like within MSF's facilities? How are diseases and, by extension, patients perceived by the population? How do patients perceive medical treatment?

7 Ibid, 1.

8 Cf. Gilbert Rist, *Le développement: Histoire d'une croyance occidentale,3rd ed.* Paris: Presses de Sciences Po, 2007.

- How are the humanitarian principles of independence, impartiality, and neutrality understood by the people with whom MSF works in the field? In parallel, which principles does the population associate with MSF if not these three?

This investigation may appear biased, given that MSF is investigating itself. We decided at the outset that the aim of the project was not to carry out an exhaustive analysis, but rather to improve the way projects are implemented and perceived in the field. Therefore, we accepted the possible bias this situation might produce.

The whole process of the study has been extremely valuable. Indeed, it prompted wide debate within the teams, particularly those working on projects, in capital bases, in the "cells," and throughout MSF-Switzerland and the various departments. Trying to learn how others perceive MSF finally led the organization to try to define itself and gain a better understanding of the evolution that has taken place in its human composition, its actions, discourse, and so on.

A multifaceted methodology was adopted in order to refine notions of perception, prepare ways of comparing one context to another, and, in particular, to issue practical recommendations to enhance the organization's medical activities.

Choice of Projects Visited in the Field

At the start of the study, we envisaged the need to explore three types of contexts:

- Contexts of conflict/tension where, for security reasons, the organization must distinguish itself from other foreign (humanitarian, military, political, etc.) actors, such as in Darfur, the Democratic Republic of Congo (DRC), Chad, and Iraqi Kurdistan;

- Contexts in which the multitude of aid actors might create considerable confusion for the population, as was the case in Niger;
- Contexts in which MSF is the only foreign aid actor, such as in certain regions of Kenya or Liberia, for example.

By conducting numerous field surveys, it would be possible to validate the results and identify trends in perceptions of humanitarian action and MSF. One of the key hypotheses was the importance of issues of perception, particularly in contexts of conflict or tensions.

To avoid being overly influenced by the Operations Department, we decided in 2007 to divide the projects between stable and unstable contexts. Within these two groups, we made a random selection of six projects. This distinction (stable vs. unstable contexts) is itself extremely debatable and corresponds more to a wish to distinguish between projects where problems of perception might give rise to the need for security measures for the teams and projects where perception was more to do with achieving optimum implementation of the medical project.

Of the 12 projects selected at the start of the study (DRC, Darfur, Iraq, Somalia, Chad, and Myanmar for so-called "unstable" contexts, and Cameroon, Kyrgyzstan, Kenya, Guatemala, Liberia, and Niger for so-called "stable" contexts), not all were visited, for two main reasons. The first was security problems (the bombing of the Seleia camp in Darfur in 2008[9] took place one week before the planned visit which, for obvious

9 "From 8 to 10 February 2008, the Sudanese army, assisted by militias, launched an offensive in the north and west of Darfur. This attack, one of the most violent in recent years in this region of Darfur, resulted in major population displacements and the suspension of all medical activities in the town of Seleia, where MSF has been working since 2006." Press release, MSF, February 13, 2008, http://www.msf.fr/2008/02/13/347/darfour-des-milliers-de-soudanais-fuient-vers-le-tchad/ (consulted March 28, 2011).

reasons, was canceled). The second reason was the relative similarity of the results obtained in previous surveys, beyond the specificities of each context. It seemed pointless to spend too long carrying out field visits. Consequently, the central aim of this research quickly became the appropriation of the results by all the teams.

A pilot study was conducted in September and October 2007 in Zinder, Niger. Following that visit some questions were tweaked, but on the whole the methodology was considered satisfactory.

Methodological Tools

A number of key methodological techniques were used:

Preliminary Literature Reviews

All the literature on each MSF project was analyzed, bearing in mind the context of the country of intervention. The aim of this stage was to gain an understanding of the environment in which the project was implemented: who makes the decision to intervene (MSF or the authorities of the country in question), the context of intervention (acute crisis, conflict, nutritional crisis, stability, etc.), the history of humanitarian action in the country, and analysis of tensions with the population and/or local authorities.

Questionnaire

A questionnaire was prepared. It was quite long and grouped questions around several themes: the perception of humanitarian action (Where does it come from? Whom does it serve? Who provides it? What is its impact? What criteria are used to measure the quality of aid?); the perception of MSF (How are the principles upheld by the organization understood? How

does it set up its projects? Is it considered transparent? What is its origin? etc.). For vertical programs,[10] what is the perception of the disease treated? This last question was added following the first field visit, as we realized the importance of this factor in how the organization is perceived. Later on, we will look again at the modifications made to the questionnaire over the course of the project.

The questionnaire was translated into all the necessary vernacular languages: French, English, Hausa, Arabic, Spanish, Russian, Pokot, and Liberian English. Inevitably, some nuances were lost in translation, but every effort was made to minimize those losses.[11] Indeed, a key challenge was the process of defining certain terms, such as the principles of impartiality, neutrality, and independence.

Researchers

We chose to work in collaboration with local universities. Thanks to the heads of the departments concerned, several master's degree students (of sociology, anthropology, and political science[12]) were selected and trained in the questionnaire and in leading discussion groups. The aim of the training was to ensure that all the questions asked were understood and made sense in the contexts in which we work, and that the translation from the source language into the target language was correct. It was also an opportunity to work with the students on techniques for interviews in small groups and

10 A so-called "vertical" program is one that only treats a single specific disease without tackling other causes of morbidity and mortality in the region (HIV, malaria, etc.).

11 The questionnaire was translated from the source language into the target language, then back into the source language for verification.

12 In Kenya, MSF worked with religious studies students, as that was the only faculty present in that part of the country (the Pokot region, in the west). We felt that it was best to work with students who were able to express themselves in both English and Pokot so that they could communicate with the population. This called for more intensive training and monitoring of the students.

semi-structured interviews with several people. It is interesting to note that this research aroused a great deal of interest within the faculties themselves, as it was an opportunity for students to reflect on the ins and outs of the humanitarian aid delivered in their own countries.

Discussion Groups

The students led discussion groups based on the questionnaire. These groups consisted of 10 to 15 people and an average of 50 groups were held for each visit. So, more than 600 people were questioned at each field site. From the pilot visit, it emerged that it was preferable to organize groups according to categories. Consequently, we gathered the opinions of national staff;[13] international staff; people living near MSF facilities; people not necessarily in daily contact with the "MSF apparatus;"[14] patients and their families/companions; local authorities (e.g., the Sultan in Zinder, Niger); administrative, religious, and political authorities; those responsible for health at the local, regional, and national levels (e.g., the Ministry of Health); traditional practitioners[15] or local doctors; UN agencies; local associations; local or international NGOs; other MSF sections; other international actors (e.g., the Humanitarian Aid Office of the European Commission); and armed groups present in

13 National staff accounted for around 84 percent of MSF employees in the field in 2009, see *2009 Annual Report,* op. cit., pg. 25.

14 Offices, houses, vehicles, etc.

15 According to the World Health Organization, a traditional therapist is a person recognized by his or her locality as being competent to dispense health care, using substances of plant, animal, or mineral origin, and other methods based on socio-cultural and religious foundation and on the knowledge, behaviors, and beliefs linked to physical and mental well-being as well as to the etiology of the diseases and disabilities that prevail in that locality. *African Traditional Medicine*, (Brazzaville: WHO, 1976), p 4. In the opinion of Alain Epelboin, "We should not compare traditional medicine with scientific medicine: their semiologies and classifications of diseases cross over, but do not merge. Rather than medicines, they are systems for dealing with misfortune (biological or otherwise) that are based on theories of the body, health, disease, unhappiness, and healing, anchored in the histories of cultures and religions that have built and continue to build a country." Alain Epelboin, "Médecine traditionnelle et coopération internationale," *Bulletin Amades,* no. 50, (2002), http://amades.revues.org/index900.html (Consulted April 12, 2011).

the region. This list is not exhaustive, but gives an idea of the range of stakeholders that we contacted within the framework of this study.

Once these groups had been identified, we arranged interviews. The discussion groups were set up based on two criteria: their relationship with MSF (beneficiaries, those close to the project, those neither beneficiaries nor close to the project) and their sociological component (sex, age, and role in the population).

It is interesting to note that, at the start of the field visits, those most reluctant to take part in the study were the international staff, who perceived it as an assessment of their own work. In contrast, the national staff were more receptive, as it gave them an opportunity to voice their wishes with regard to the management of human resources and gain better access to information about the organization.

Semi-Structured Interviews

Following the discussion groups, semi-structured interviews were conducted with a number of stakeholders considered more "sensitive": some local and national political authorities, religious authorities, armed groups, etc. The same guide was used for all the semi-structured interviews. The whole structure was reproduced identically at every field site in order to enable comparison. A series of semi-structured interviews were carried out with specific stakeholders: the leader of the Zakat committee[16] and local authorities (mayors, district chiefs, etc.) whose positions made a group discussion difficult.

16 Zakat is one of the five pillars of Islam, and corresponds to the 2.5 percent of income that Muslims must give to the poor and needy, starting with those in their families. Zakat committees may be formal or informal organizations, usually local, that collect and redistribute this money in accordance with the rules of Islam.

The people interviewed were not asked to sign a consent form, as they are not identified by name in the reports.

A scientific committee was set up to monitor the project.[17] Throughout the study, this committee offered advice on refocusing the research and responding to the different reports produced. In September 2008, after a few field visits had been completed, a number of methodological and practical modifications were made following the discussion of the project by the scientific committee. The idea was to change from a semi-quantitative approach to a much more qualitative approach, using discussion groups as a way of exploring the perceptions of the people questioned in greater depth. These adaptations were possible thanks to the field visits already carried out and the identification of certain recurrent themes across the different sites, and concerned the projects in Guatemala, Kyrgyzstan, Cameroon, Iraq, Jordan, and the Occupied Palestinian Territories. The idea was to try to deconstruct the discourses of all the actors and extract the discursive reasoning behind them. This made it possible to analyze the potential role of national staff as "development brokers."[18] Linear interviews were abandoned in favor of an exploration of themes and possible logical links around those themes. Depending on the field site and the needs of the Operations Department, a series of specific questions about concerns in the field were also introduced.

17 Hugo Slim (Centre for Humanitarian Dialogue/Corporate for Crisis), Rony Brauman (MSF Foundation/Sciences Po Paris, University of Manchester), and Xavier Crombé (MSF Foundation), Antonio Donini (Feinstein Center/Tufts University), Andreas Wigger (ICRC), Béatrice Pouligny (Centre d'Études et de Recherches Internationales), François Piguet (Graduate Institute of International and Development Studies, Geneva).

18 Expression borrowed from Jean-Pierre Olivier de Sardan, *Anthropologie et Développement: Essai en socio-anthropologie du changement social,* (Paris: Karthala), 1995, p 160: "The term 'local development brokers' is used to refer to social actors based in a local arena who serve as intermediaries to channel (towards the social space corresponding to that arena) external resources coming from what is commonly called 'development aid.'"

Reports

Following each field visit, a report was drafted.[19] The target audience of these reports consisted of the field teams and the teams managing the projects at the headquarters. They contained both an analysis of the project visited and practical recommendations, some of which were implemented quite soon after the survey.

Other Research Into Perception

Another task consisted of systematically reviewing what had already been written about perception in recent years. This research project was inspired by several other projects carried out by various other institutions and greatly benefited from the involvement of external participants. Béatrice Pouligny wrote *Peace Operations Seen from Below: UN Missions and Local People*[20] to analyze how peacekeeping operations were perceived by local populations. She carried out a series of interviews, both in the field and at administrative headquarters, as well as discussion groups with local people. Ten peacekeeping operations were analyzed. Another study conducted by a team of researchers headed by Antonio Donini and Larry Minear, based at Feinstein International Center, Tufts University,

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19 Caroline Abu-Sada, *Internal Report, Zinder (Niger) Perception Report, (*MSF, October 2007);
Caroline Abu-Sada, *Internal Report, Akoloninga (Cameroon) Perception Report, (*MSF, December 2007);
Caroline Abu-Sada, *Internal Report, Magaria (Niger) Perception Report, (*MSF, February 2008);
Caroline Abu-Sada, *Internal Report, Saclepea (Liberia) Perception Report, (*MSF, June 2008);
Caroline Abu-Sada and Mikhael de Souza, *Internal Report, Kenya/Uganda Perception Report, (*MSF, August 2008);
Caroline Abu-Sada and Mikhael de Souza, *Internal Report, Yaoundé (Cameroon) Perception Report, (*MSF, October 2008);
Caroline Abu-Sada and Mikhael de Souza, *Internal Report, Guatemala Perception Report, (*MSF, December 2008);
Caroline Abu-Sada, *Internal Report, Middle East Perception Report,* (MSF, January 2009);
Caroline Abu-Sada and Mikhael de Souza, *Internal Report, Kyrgyzstan Perception Report, (*MSF, March 2009).

20 Béatrice Pouligny, *Peace Operations Seen from Below: UN Missions and Local People,* (Paris: Les Presses de Sciences Po, 2004).

surveyed similar themes over several years. They used questionnaires for NGOs (headquarters and field sites), around 30 discussion groups per country (10 to 12 people per group), and semi-structured interviews. Similarly, the ICRC added a set of questions about perception to the Voice of the People survey regularly conducted by the polling institute Gallup in some 60 countries. It has also carried out a number of research projects into the perception of the ICRC in Muslim contexts.[21] The Collaborative Learning Center has also set up a long-term research program called the "Listening Project."[22]

At the same time, MSF Belgium conducted a survey of perceptions in the DRC (questionnaires and focus groups) and Rwanda, while MSF Holland studied Haiti.[23] These surveys were mainly prompted by tensions within the MSF teams, however, to gather the opinions of national staff members. It is important to underline that the research performed by MSF-Switzerland differs from these previous studies in two ways– first, it has an operational aim and, second, it covers a much broader field of investigation than the earlier work.

The process of linking up with other research bodies or specialists working on these themes for other aid organizations made it possible not only to better define the subject and clarify areas where a more in-depth examination was necessary, but also to develop the most appropriate methodology for

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21 Andreas Wigger, "Encountering perceptions in parts of the Muslim world and their impact on the ICRC's ability to be effective," *International Review of the Red Cross,* vol. 87, 2005, pp. 139–164.

22 The whole project is available online at this address: CDA Collaborative Learning Project, http://www.cdainc.com/cdawww/project_profile.php?pid=LISTEN&pname=Listening%20Project] (consulted 16 March 2011).

23 Karl Nawej, *Report on the survey of the image of Médecins Sans Frontières/Doctors Without Borders (MSF) in the Democratic Republic of Congo (Kinshasa, January 2000), (*Kinshasa: MSF-Belgium, 2000); Sébastien Roy, "Communication Opérationnelle au Rwanda," in *Repères,* no. 27, MSF Belgium, 1998; and Alla Karpenko, *Strategy of Operational Communication,* Port au Prince, (Haiti: MSF Holland, December 2004).

implementing the survey at the chosen field sites.

It was believed that an MSF project site would be the best unit of measurement, as the effect of the MSF mission is visible through its action in the field, the scope of which is mainly local. It was likely that within a single context, local people's perceptions of MSF might differ from one project location to another.

Themes That Emerged From the Project

An initial set of working hypotheses was formulated at the start of the project. Some of them were confirmed by the study, others disproved. First of all, it should be noted that the following observations are the result of discussions with different people; they are perceptions, not facts. (For instance, just because some people think that MSF performs clinical experiments on prisoners in Bishkek, Kyrgyzstan, does not mean it is true.) Perception is a reality in itself, the validity and basis of which is debatable. We will divide our analysis into three sections: MSF as an institution (including the question of definitions concerning humanitarian action); factors influencing perception; and the perceptions of certain groups of people interviewed.

MSF as an Institution

On several occasions, MSF was nicknamed Médecins AVEC Frontières—Doctors WITH Borders. A number of explanations were given for this. To begin with, MSF's interventions are organized by country and not by region. The nutrition program in Magaria, southern Niger, is an example: 70 percent of children enrolled come from northern Nigeria and many of the people questioned did not understand the logic of having a nutrition program in Niger alone. This perception was also strengthened by the issues raised by MSF's vertical

projects. Indeed, in Cameroon, the Buruli[24] program did not treat other diseases even though, for example, child mortality due to malaria was high. Many people questioned this lack of treatment and asked for a broadening of MSF's medical activities. The name of the organization is often misleading for groups such as refugees and internally displaced persons faced with problems of mobility. "Without borders" is interpreted as expressing an ability to cross borders, giving the impression that the organization's employees do not need visas and have unlimited access to all countries. This presumed mobility prompts insistent requests by local populations to publicly denounce human rights violations in the country concerned. Additionally, the organization's offices, medical facilities, and compounds create both a physical and symbolic distance between teams and local people, which can be detrimental to the acceptance of projects and teams. The way some missions are organized, with international staff isolated and having only limited interaction with locals, further widens that gap. Most of the time, this isolation is due to security arrangements designed to reduce the risk of kidnapping. This nevertheless hinders the organization's attempts to establish relations with the population. This aspect was particularly salient in Cameroon, where inhabitants praised the "Chinese approach" (Chinese workers were living in camps near the stadium they were building and were, therefore, close to the people, while the NGO workers were living in highly protected districts).

Similarly, the vocabulary used by the organization can be perceived as military and sometimes casts doubt over its

24 Buruli ulcer is a skin disease that disfigures the patient and can cause the loss of use of limbs. It is transmitted by a parasite similar to that of leprosy. The disease is endemic to certain regions of Central and West Africa. Buruli ulcer is a so-called neglected disease. Most sufferers never receive any treatment whatsoever. MSF has set up a treatment center in Akonolinga, Cameroon, where it treats between 100 and 120 patients a year. MSF, 2011, http://www.msf.ch/nos-projets/ce-que-nous-faisons/en-bref/ulcere-de-buruli (consulted April 4, 2011).

very nature. For instance, the organization talks about bases, compounds, missions, sections, action plans, etc., without even realizing the impression such terminology may give.

Most of the people consulted still do not make the connection between the acronym MSF, the various translations of the organization's name, and the name in French. In Iraqi Kurdistan, for example, some people had not realized that MSF, Médecins Sans Frontières, Doctors Without Borders, and Attûba Bala Huddud (Arabic translation) were one and the same organization. Confusion is also possible between the acronyms of different organizations, for example MSF and MNF-I (Multi-National Force—Iraq, i.e., the coalition led by the United States, from which MSF is keen to distinguish itself at all costs). This confusion can give rise to security problems for the teams.

Moreover, the MSF logo and visual communication are not always known or understood. In Kenya, people tend to associate the logo with a man holding a spear (to destroy kala azar)[25] rather than with MSF. Even more crucially, a large number of those interviewed remember the "no guns" sticker more clearly than the logo. The red lines through the gun are neither noticed nor understood, and the gun is therefore interpreted as a threat.[26] Some come to the conclusion that the facilities are managed by the Kenyan government, others that it is necessary to carry a weapon in order to enter MSF's medical facilities.

Various respondents noted that the foreigners working for MSF come from far away, and therefore have different habits and cultures, which are not always appropriate. They all said

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25 Kala azar (or visceral leishmaniasis) is a parasitic disease, transmitted by a small insect (*phlebotomus*), that can manifest as either a simple skin disorder or a serious disorder affecting several organs. MSF, 2001, http://www.msf.ch/fr/nos-projets/ce-que-nous-faisons/en-bref/kala-azar/ (consulted April 8, 2011).

26 Cf. photo accompanying MSF charter on page 197

that these "discrepancies" were not very important compared to the work done by MSF, but that they did nonetheless seem "a bit odd."[27]

Challenges of Definition

The study showed that, in different contexts, the participants defined the notions of "humanitarian action" (an action intended to alleviate human suffering and provide goods and services free of charge) and "humanitarian personnel" (philanthropists and benefactors) identically.[28] In general, humanitarian aid is considered important and is favorably received in the countries. Most people associate humanitarian aid with a charitable wish to help others.[29] It is often considered useful—as all types of aid are necessary—and positive, although people do question the role of the state, particularly its management of the health system.[30] In some countries, the people interviewed compared foreign humanitarian assistance with local chari-

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27 Interview with a traditional practitioner, Kacheliba, July 18, 2008: "It's not good when women wear trousers. Those women are competing. We accept it from MSF, because they're not from our clan, they come from very far away. But it seems a bit odd." Caroline Abu-Sada and Mikhael de Souza, *Kenya/Uganda Perception Report,* op. cit., p 7.

28 "Humanitarian action can be described as activities carried out by state and non-state actors that contribute to improving people's lives around the globe, regardless of their religion, colour and ethnic background, like Doctors Without Borders, the UNHCR, Red Crescent and Red Cross. In my opinion, humanitarian aid includes all activities—whether military, political or educational—that can change people's lives towards a better future. In my opinion all activities, whether military, political or educational, that can change people's lives towards a better future, I consider to be a humanitarian activity." Caroline Abu-Sada, *Middle East Perception Report,* op. cit., p 24.

29 "The driving force of humanitarian action isn't to get rich, it's the desire to help others." Caroline Abu-Sada, *Akonolinga (Cameroon) Perception Report,* op. cit., p 7.

30 "If international organizations can help Kyrgyzstan and its people, why not accept that help, especially as the Kyrgyz government is unable to deal with the problems existing in society. But ideally, it should be the government that resolves health problems. What difference does it make where the help comes from? The most important thing is that it can be provided." Caroline Abu-Sada and Mikhael de Souza, *Kyrgyzstan Perception Report,* op. cit., p 10.

table practices such as *taimako* in Niger[31] and *apuyu*, *gbawuaka*, or *gbomon* in Liberia.[32] In the Middle East,[33] these practices have been likened to the Islamic practice of Zakat.[34] Local circumstances alter the way humanitarian action is perceived, filtering it through a cultural, religious, or political lens.

Humanitarian Principles

We sought to collect information on how the core principles of MSF's work (neutrality, impartiality, independence),[35] as well as the notions of transparency and credibility, were understood and perceived by the different stakeholders. It seems important to link the way people interpreted these principles to the way this interpretation has influenced MSF's activities and the security of its staff. The applicability of the principles was challenged in some countries, however. Respondents gave various definitions of humanitarian principles to the researchers. It is interesting to note that volunteers, employees, and members within the same organization do not always agree on a single definition of these principles. Therefore, responses were unsurprisingly varied. Moreover, it is sometimes very difficult for the teams in the field to put these principles into practice in the daily life of a project.

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31 "The local name given to humanitarian aid is 'taimako.' 'Taimako' is free for patients. As we understand it, 'tamaiko' is anything that helps mothers and children, especially things that beneficiaries are unable to do for themselves or by their own means. In other words, they are given what they don't have, free of charge (Groups of women interviewed, Mallawa).," in Caroline Abu-Sada, *Magaria (Niger) Perception Report,* op. cit., p 12.

32 "We call them 'Apuyu', which means 'the Saviour has come,'" comments from young people, Behwalley, June 3, 2008. Refugees call MSF "gbawuaka," which means "free medicine" (comments from refugees, Saclepea, 4 June) "Humanitarian aid comes from good people who want to help poor people live better" (Saclepea, June 5, 2008). "We call them 'gbomon', 'people who help'" (Saniquellie, ACDI, 7 June), in Caroline Abu-Sada, *Saclepea (Liberia) Perception Report,* op. cit., p 17.

33 Caroline Abu-Sada, *Middle East Perception Report,* op. cit., pp 27–29.

34 Cf. footnote in the methodology section.

35 Cf. Médecins Sans Frontières/Doctors Without Borders Charter, at the end of the book.

Practical application of the principles of neutrality and impartiality was called into question in Cameroon, either because "neutrality" was not seen as compatible with human subjectivity,[36] or because MSF's involvement with the national authorities forced it to take sides. Many respondents in Cameroon also doubted MSF's neutrality as it only treats one disease, even though the medical needs in the areas where MSF is present are huge. Similarly, in Kenya, although most community representatives believed that projects honored the organization's principles and that the quality of the free care was good, national staff members felt that the organization's actions were overly limited given the needs of the region and said that the project was no longer faithful to either the principles or the charter, as it only treated a single disease.[37] This type of situation suggests the problem is that the organization sometimes places greater focus on the disease than on the patient. It was pointed out that, by implementing projects that address neglected diseases—interventions that are possible thanks to its financial independence—MSF sometimes risks concentrating solely on the disease (diagnosis and treatment) to the detriment of a holistic treatment of the patient's medical needs. This demonstrates the difficulty of clearly explaining intervention criteria to the people concerned.

Meanwhile, in Kyrgyzstan, members of human rights organizations and medical personnel who were questioned said that MSF is sometimes "too" independent and should collaborate more with other social and medical actors. Some informants questioned MSF's neutrality, believing that the organi-

36 "MSF is said to be neutral, apolitical, but I'm not sure, because, after all, they're human beings. Everyone has their own ideas; not everyone can be unbiased like a church. But, nonetheless I do think they try. In any case, I've never seen MSF get mixed up in any funny business." Caroline Abu-Sada and Mikhael de Souza, *Yaoundé (Cameroon) Perception Report,* op. cit., p 12.

37 Initially, this project only treated kala azar, but that changed following the perception project visit, and medical activities have now been expanded.

zation sided with the government by not diffusing information about the situation in the country's prisons. Doubts were also expressed about the principle of neutrality in the Middle East, where the difference between humanitarian organizations and human rights organizations is not very clear to the general public. The interviews revealed a widely held belief that an organization working in emergency situations has an obligation to publicly denounce any violation of human rights.

In Kenya, a neutral organization was described as "one in the middle," "that is central, neither cold nor hot," and one that "stands without following others."[38] Neutrality was also directly linked to the presence of foreigners in the field: "a neutral organization is one that has no brokers. MSF has no middlemen, the whites bring the services to us."[39]

An impartial organization was described as one that "helps people that are most in need, without favoritism, like MSF does as [they] help those who are very sick, without discrimination" and one that "does not lie on one side."[40]

For MSF, the need for independence includes both financial independence and independence in assessing the needs of a given population[41] and the need for action. Consequently, MSF endeavors to obtain as much of its funding as possible from private sources and to diversify its institutional donors, refusing any financing that could compromise its freedom of action. Unfortunately, the majority of the people interviewed within the framework of this study were not aware of the private origin of the organization's funding. Several partici-

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38 Caroline Abu-Sada and Mikhael de Souza, *Kenya/Uganda Perception Report,* op. cit., p 9.

39 Ibid, p 9.

40 Ibid, p 10.

41 See the introduction for the notion of the "humanitarian space," as defined by Rony Brauman.

pants were surprised to learn that no government funding was used in contexts such as Iraq, the Occupied Palestinian Territories, Somalia, etc. In Guatemala, it was essential to stress the organization's independence from the political agendas of financial institutions and donors, which are often European governments.

In discussions with Kurds in Iraq, a clear link was established between transparency and credibility. They believed that some international organizations were spying for intelligence agencies, although MSF seemed more credible in their eyes: "We don't think that they [MSF] have a political agenda because they work throughout the world and come from a lot of different countries. We know they are volunteers. It's important to know that MSF got the Nobel Peace Prize, because it means that it's done something very big for humanity."[42] Some representatives of civil society considered that humanitarian assistance must be transparent to local people in order to be better accepted. Almost all the informants from local organizations said that they expected greater transparency from international NGOs and hoped for improved coordination between them.

In Guatemala, the surveys revealed that MSF's credibility is an important factor. Indeed, the organization has a reputation for being independent (in relation to authorities and having no political agenda) and neutral (unlike American NGOs, which are financed by USAID[43] and/or are faith-based). This opinion is largely based on specific actions rather than on a clear understanding of the organization and its structure.

Generally speaking, neutrality is the principle that was most questioned, since the establishment of a project in a given

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42 Interview with a medical student, Caroline Abu-Sada, *Middle East Perception Report,* op. cit., p 20.

43 USAID is the federal agency in the United States responsible for international development aid.

context is already the result of a political choice. Many noted that it is necessary to be more transparent about the difficulty of certain operational choices and stressed the need to take the time to explain these dilemmas. By contrast, the principle of impartiality was more widely recognized and appreciated by people, as it is easily understandable and visible in MSF's medical facilities.

Independence is perceived positively as it allows the organization to make its own choices. However, this independence can give rise to isolation.

Finally, the transparency and credibility of international organizations were generally identified as criteria for assessing humanitarian work. For many, these notions are linked to MSF because it is a medical organization believed to deliver quality treatment. The varied scope of the work done by other NGOs (sanitation, shelters, nutrition, etc.) makes it harder for people to understand their activities clearly. Consequently, they are perceived as less transparent and less credible.

Factors Influencing Perception

Several factors emerged during the study that influence the perception of humanitarian action in general, and the work of MSF in particular. Some were identified at the start of the project, but subsequently did not seem important, such as the duration of its presence in a country. Even MSF's very structure as a "movement"[44] was questioned. The importance of the political and social environment of the projects, and particularly the framework of analysis used by the local populations, proved to be crucial. Moreover, one aspect emerged, the importance of which had not been recognized at the start of the project: the religious context. Finally, the structure of the

44 Cf. list of MSF sections in the general introduction.

aid system and the power relationships that run through it are essential for an in-depth understanding of perception.

Duration of MSF Operations in a Country

We tried to ascertain whether the duration of MSF's presence in a country had an effect on its acceptance by local people. The killing of five MSF members in Afghanistan in 2004 called into question the causal link between duration of presence in a country and knowledge and acceptance of the organization by the population. In fact, all the research carried out in the field showed that acceptance is much more closely linked to the quality of the treatment provided, the appropriateness of the response proposed by MSF to meet the needs of the population, and the quality of the networks established by the organization with local stakeholders. In addition, many respondents referred to the need to adapt to the increasing complexity of certain contexts: "You can no longer work in these types of contexts like before; you have to go out and build networks."[45] Although MSF had been perceived well in Iraqi Kurdistan thanks to the medical activities set up in 1991, its departure from Iraq in April 2004 was taken badly by many Iraqis, who felt that MSF had left them at the time when they most needed emergency medical aid. That departure resulted in a loss of networks from 2004 to 2006 (when MSF returned to Iraq), making it difficult to start new projects in the country. Moreover, the very notion of longevity is questionable given that MSF's institutional memory is rather poor, giving rise to a loss of history and knowledge about certain contexts.

45 Interview with an ICRC representative in Jordan, Caroline Abu-Sada, *Middle East Perception Report,* op. cit., p 13.

Effect of the Presence of Five MSF Operational Sections in the Field

At the majority of the field sites visited, we noted that, apart from those in direct contact with section administrations, most people interviewed do not distinguish between the different MSF sections. In general, we observed that having several sections can be a double-edged sword. For example, in Darfur, only two of the five sections[46] were expelled, which enabled the others to continue to provide medical care. On the other hand, the problems encountered by one section can affect other sections present in the same region or country. An example is the Spanish section's difficulty registering in Syria in 2008, where the poor relationship established with the Syrian authorities had a negative effect on the other sections present in Jordan. It should also be noted that, in some contexts, especially in dealings with state authorities, the five MSF sections are known and the differences between them are sometimes exploited for national political ends.

Importance of the Local, National, and International Contexts

In the words of Rony Brauman:

> If we are to be the least bit realistic, we must acknowledge that, in reality, humanitarian action exists alongside politics, even if it is intrinsically driven to try to separate itself from political forces. Humanitarian organizations certainly operate in a highly charged political environment, but must constantly strive to steer their actions to ensure that the results of their work are not political and they do not favor a particular group or clan. Humanitarian organizations must be able to play the social game with politicians to avoid becoming a passive

46 The French and Dutch MSF sections were expelled from Darfur on March 5 and 6, 2009, by the Sudanese authorities, shortly after the International Criminal Court (ICC) issued an arrest warrant for President al-Bashir.

> instrument of politics. They must adopt an active stance and not allow themselves to be treated like objects, dragged around the political spectrum.[47]

To avoid becoming a passive instrument of politics, we must become aware of national and international contexts. Humanitarian action did not evolve in the same way during the Cold War as during the war on terror.

Political contexts at the national and international levels inevitably influence the image of humanitarian action and, therefore, that of MSF. The study shows that in the Middle East, as in all other contexts, as a result of historic, political, and social differences and the behavior of humanitarian actors, NGOs working in the field are suspected of having a hidden agenda.[48] In a way, they are associated with the Global War on Terror[49] (GWOT)[50] and the links between certain humanitarian organizations and political and military operations. According to Greg Hansen,[51] practically all humanitarian agencies kept a low profile in Iraq; this resulted in a tarnishing of their image, because nobody saw what they were doing. That, in turn, led

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47 Aurélie Loucahrt, Thomas Yadan, "L'empêcheur de tourner en rond," interview with Rony Brauman, *Evene-Actualités Culturelles,* April 2008, http://www.evene.fr/celebre/actualite/interview-rony-brauman-msf-humanitaire-israel-shoah-1302.php (consulted March 31, 2011).

48 Even free services are viewed with suspicion: "I think that foreigners living in our country bring problems and bad things to our communities. It's odd that they offer free services and don't expect anything in return. Every day we hear people complaining about the NGOs, saying that they act as though they're doing one thing, but that's just a front for something else." Caroline Abu-Sada, *Middle East Perception Report*, op. cit., p 27.

49 "I do think there's a link between humanitarian aid and international geo-strategic interests. Not for all NGOs, just USAID and the Agency for Technical Cooperation and Development (ACTED) (because they're funded by the European Union). But not MSF, the ICRC, and that, because they're independent organizations." Caroline Abu-Sada and Mikhael de Souza, *Kyrgyzstan Perception Report*, op. cit., p 12.

50 Michiel Hofman and Sophie Delaunay, *Afghanistan*, op. cit.

51 Greg Hansen was in charge of the Feinstein International Center study on Iraq: *Taking Sides or Saving Lives, Existential Choices for the Humanitarian Enterprise in Iraq, Humanitarian Agenda 2015, Iraq Country Study,* June 2007. Interview conducted in Amman on October 21, 2008, Caroline Abu-Sada, *Middle East Perception Report*, op. cit., pp 7–8.

to a great deal of misperception, mainly because the difference between NGOs and the UN and United States is not at all clear. We will discuss this confusion in more detail later on.

Another consideration is the fact that the globalization of communication and information has important consequences for an organization such as MSF. For example, what the organization is doing in Haiti has repercussions on its activities in Pakistan via all-news channels and social networks. Similarly, information about scandals surrounding humanitarian action, such as those concerning Zoe's Ark in Chad,[52] circulates very quickly and has a very negative effect on other organizations. This globalization increases the need for teams to explain more clearly the operational choices made by the organization.

The difficult economic situation in some countries has contributed to NGOs being perceived as rich organizations. Their important role in the local economy was acknowledged, but in some cases, the security of humanitarian personnel was compromised as a result (risk of theft, kidnappings, etc.). Sometimes MSF finds itself in a situation where it is the main employer of a section of the population (Kacheliba in Kenya, Magaria in Niger, Léogâne in Haiti, for example), and that creates considerable dependence. This is a critical factor for the perception of MSF that the teams must take into account, especially when it comes to closing a project.

In Iraqi Kurdistan, people consider humanitarian action as mainly needed in poor countries: "Humanitarian relief can be described as aid that poor people receive from various institutions, organizations, or even government associations, to improve their daily lives a little and rescue them from the

52 Zoe's Ark is a French organization that operated in Chad until October 2008. Under the guise of aid for orphans in Darfur, this NGO organized the kidnapping of children from the region for adoption in France. The Zoe's Ark team was arrested and tried in Chad for those acts.

danger of death, especially in the medical field. Because, as we know, the majority of people who receive humanitarian aid are in the third world. Countries in that part of the world lack appropriate medical care, especially from their own governments. So, medical humanitarian action is needed in that part of the world."[53] Sometimes, it is even a question of honor: "I don't know exactly what you mean by humanitarian action. We Kurds are not in need of humanitarian aid; what we really need is someone to help us rebuild our infrastructure to enable us to become self-sufficient again and reach the level of developed countries. We don't need your charity because we're not a poor country, but one of the richest countries in the world. So, please don't talk to us about so-called 'humanitarian action.'"[54] Some local stakeholders object to MSF's presence because "it's not Africa here."[55]

In Jordan, on the other hand, local stakeholders did not make any such criticisms. The Zakat committees, for example, are much more open to humanitarian NGOs: "The problem in Jordan is that aid at the different levels isn't coordinated and there's no discussion between NGOs, local associations, and Zakat committees."[56] This discourse also stems from a wish to be integrated into an aid system and to be recognized as one of the main participants in social redistribution in the Arab world.

People in the Middle East have difficulty understanding the motivation of secular organizations, and would feel much more comfortable dealing with organizations that assume a religious identity.

53 Caroline Abu-Sada, *Middle East Perception Report*, op. cit., p 29.

54 Ibid.

55 Ibid, p 42.

56 Ibid.

Importance of the Local Population's Analytical Framework

The association between MSF and religion would mainly seem to result from the organization's involvement with local communities, which would explain why it is not considered a secular or religious organization per se, but may be perceived as such in some very specific contexts. This explanation of proximity enables us to distinguish three scenarios: political proximity (e.g., the Occupied Palestinian Territories), religious proximity (e.g. Niger), and secular proximity (e.g., Kyrgyzstan). The question is whether this proximity is perceived positively or negatively.

The societies in which MSF works are often very religious, and that has an effect on the way people perceive the organization and its activities. Communities may give a religious connotation to organizations working in their country because that is the "analytical framework" they use. MSF has always positioned itself outside the secular/faith-based dichotomy, considering the debate irrelevant for the implementation of its medical activities in the field. Surveys have revealed, however, that religion influences the way its operations are perceived. This is partly due to the origin of its managerial staff and international volunteers,[57] the way the "missions" are set up, and the vocabulary used,[58] particularly in internal documents, which can have religious or military connotations (mission,

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57 As Rony Brauman has summed it up: "It was only in the 1970s, when politics and religion were going through that crisis and entered a long period of unpopularity, that the humanitarian sector gradually embraced the need for meaning and social utility, moving into an area that was gradually being abandoned by its traditional occupants." In Rony Brauman, "Le sacre de l'urgence," *Le Débat*, no. 84, (March-April 1995) p 7. See also: Johanna Siméant, "Entrer, rester en humanitaire: des fondateurs de MSF aux membres actuels des ONG médicales françaises," *Revue Française de Science Politique,* vol. 51, no. 1–2, (February-April 2001) pp 47–72, as well as Pascal Dauvin and Johanna Siméant, *"Le travail humanitaire: Les acteurs des ONG, du siège au terrain,"* Presses de Sciences Po, 2002.

58 Rony Brauman, "Les ONG, nouvelles missions?" Interview for *Les Cahiers de Médiologie*, no. 17, (Fayard, 2004).

field workers,[59] sections, and so on), or the religiousness of the societies in which MSF works. Pascal Dauvin and Johanna Siméant have shown that humanitarian workers in French organizations are usually involved with religious institutions, or that their religious education influenced their decision to work in the humanitarian sector. However, it would seem that the main motivation of international personnel choosing humanitarian work is its "social utility."[60] It would nonetheless be very difficult to try to pinpoint the motivations of people working within MSF, as they largely depend on personal paths rather than general trends. That said, while individuals have their own motivations, the organization as an institution must assert its own motivations, which its members are expected to adopt.

A few years ago, in a contribution to MSF's strategic review process,[61] Jonathan Benthall raised the question of whether MSF could legitimately be regarded as a faith-based organization. His point was that, although no religious connection is visible at first sight "because, historically, the creation of MSF resulted mainly from an alliance of medicine, journalism and the political left—all entirely secular institutions,"[62] three essential components of MSF's identity could give that impression. Firstly, its name and inspiration derive from medicine. Consequently, MSF could benefit from a sort of "secular sanctity." Its association with emergency medical care only accentuates the connotation of religious sensibility, which consists of making sense of death. Secondly, due to its transnational nature, it

59 MSF's field workers are people who have gone abroad to work in the field. There are currently people of more than 40 different nationalities within MSF-Switzerland.

60 Indeed, this question raises a broader debate beyond the scope of this work about the political engagement of humanitarian workers, or the political framework underlying the work of some NGOs.

61 *My Sweet La Mancha* (Geneva: MSF International, 2005).

62 Jonathan Benthall, "La certitude du caractère séculier de MSF," *My Sweet La Mancha*, op. cit., p 26.

represents all the religions of the world. Third, it shares with religious organizations a tradition of effective mass communication. According to J. Benthall, the history of the schism (first from the ICRC, then from Médecins du Monde [MdM]), and MSF's "martyrs" (people who have died during missions) are two other elements that support this theory.

Consequently, MSF could be referred to as a "secular faith-based organization." This categorization would hardly surprise those in the West who are familiar with MSF, its history, origins, and cultural framework. It would be less evident to the populations in direct contact with the organization in the field, including national staff, who do not necessarily have all the information required to place MSF in the context of its creation and evolution.

Organizational identity depends not only on the image that MSF wants to convey, but also on what the organization means to people. It is also important to note that, when the perception project questionnaire was designed, religion had not yet been identified as a fundamental consideration. This factor will certainly have skewed the results, but the research team had assumed that religion would not be part of MSF's constructed identity. The religious dimension was not, therefore, taken into account at the beginning of the project since MSF is relatively rooted in French secularism, or, at least, in the belief that it is essential to distinguish between the public and private spheres, religion being viewed as belonging to the private sphere. Other aspects were given priority, such as the assumption that MSF's financial independence would be recognized by most of the people interacting with the organization. The process of defining the terms of the project itself therefore clearly took place within a European cultural frame of reference. If that frame of reference is not explained by the teams in the field, it

cannot be understood in certain contexts by groups of people for whom religion is a reference system.

The principle of humanitarian action outside of any religious framework can be difficult to explain, although MSF never uses it as a cultural reference or as a way to identify itself. Consequently, religion is never part of the message that it sends out to the societies in which it works; nor does MSF define itself as secular in its public messages. If it had to, it would describe itself as nondenominational. The question of religion is only addressed when it affects impartiality and access to patients or vulnerable populations. The issue is not really whether MSF's discourse has religious overtones, however, but rather how that discourse is perceived, because that perception will influence its ability to carry out its operations. Indeed, perceptions can turn into political facts.

In Kenya and Uganda,[63] for example, nearly all the people questioned associated humanitarian aid with charity and, consequently, a sort of divine intervention. MSF, like other humanitarian actors, is often described as an example of "goodness" and is therefore associated with God. In particular, it is compared with "God who created Earth" *(torotot)*, "Gods who prolong life and give life to the disabled," or even "someone who helps like God" *(kingoro kut)*.[64]

Neutrality and impartiality are sometimes regarded as divine qualities: "They are neither on the side of the government nor on the side of the Church. They are people sent by God. … They have no church, their church is the hospital" and "an impartial organization is one that works in the Spirit of God."[65] In some

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63 It was a vertical project to treat kala azar (i.e., that was the only pathology treated), which was initially set up in Uganda before being transferred, due to the origin of the patients, to northwest Kenya, in a region inhabited by the Pokot people.

64 *Kenya Report,* p 8.

65 Caroline Abu-Sada and Mikhael de Souza, *Kenya/Uganda Perception Report,* op. cit., p 8.

regions of Kenya, the organization is thought to be linked to the Anglican missionaries, who are the only white people to have ever lived in the region. The medical activities themselves are perceived as having a divine origin: "God is no longer far away. He has come down to Earth to help us. … The God who gives power to MSF is good and very powerful;" "their money comes to them from God, who distributes wealth;" "they [the MSF staff] are the servants of God, whom God has sent to help people, although they are not related to them."[66] The fact that treatment is free of charge also contributes to strengthening this association with religion: "[MSF] is religious, because it is not money-orientated."

The volunteering aspect is associated with charity among both Christians and Muslims: "Al Zakat is obligatory. Not giving is a sin. But MSF is a charitable organization;"[67] "The main reason why foreigners work for humanitarian organizations is because they've been touched by the Spirit of God;" or "God has blessed them so that they may help others."[68]

In Zinder,[69] Niger, MSF was also regarded as a religious organization: "MSF is a religious organization because it's pity that brings them to look after the children." Most of the women interviewed thanked God and MSF for the free care policy and the treatment received. The majority of them made a connection between MSF's activities, charity, the Zakat committees, and the Muslim religion. Indeed, most of them thought that MSF's headquarters was in Saudi Arabia.

It is worth noting that this presumed religious origin or the connection made between MSF and a given religion usually

66 Ibid, p 9.

67 Ibid, p 8.

68 Ibid, p 8.

69 All the MSF sections have set up nutrition programs in Niger.

has a positive effect on the image of the organization and its acceptance in the social fabric. It tends to create power relationships, where international staff are seen as being "blessed" by a divine authority and, consequently, inspire more trust than local practitioners. People would therefore sometimes rather be treated by international doctors or nurses. This behavior can harm the organization's relationships with local or traditional practitioners, and this consideration must be included in strategic planning by MSF's field sites and headquarters.

In some places, medical projects have disrupted a social organization where diseases were explained by the intervention of occult forces. In Liberia, witchcraft still has a strong presence in Nimba County.[70] It is believed that witches are able to inflict diseases on people that cannot be treated by modern medicine, which is seen to explain why some patients spend several months in the health center opened by MSF[71] without being cured. The population has integrated the presence of modern medicine into its own traditions. Expatriates are considered external to the world of magic,[72] but people interviewed stressed that MSF's doctors should recognize their own limits in terms of their ability to treat all diseases and accept that herbalists ("traditional" doctors) can sometimes help modern medicine and should be incorporated into health care facilities. Even in Monrovia (Liberia), the hospital is viewed as the last resort (after self-medication, the local doctor, the traditional healer, the pharmacy, church, and clinic). The division between modern medicine and modern diseases, on the one hand, and traditional practitioners and diseases caused by

70 Nimba County is in northern Liberia, on the border with Guinea and Ivory Coast, and is where Charles Taylor's second offensive against Monrovia was launched.

71 This is a primary health care center.

72 Even though they are outside the world of magic, the MSF teams still need to bear these beliefs in mind, especially when the population says that the devil is in town, which means that people are going to die.

supernatural forces, on the other, was also referred to in other projects. The way "modern" medicine explains diseases does not tally with the spiritual explanation given to certain diseases in some societies.

In Cameroon, MSF carried out a vertical project designed to fight a neglected disease called Buruli ulcer. It is not yet known how this disease is transmitted. In Akonolinga, 73 patients receiving treatment for Buruli ulcer are now considered privileged. Indeed, the wing of the hospital where they are cared for has been renovated and these patients receive food rations in addition to their medicines. Previously, it was thought that patients suffering from Buruli ulcer had been punished for their sins (witchcraft, theft, rape, etc.). The disease played a social role in the community. In all discussions, even with MSF's national staff, two types of "atom"[74] were described: the "simple" type and the "mystical" type. The simple atom can be treated in MSF's facilities, unlike the mystical one, which, despite the willingness of the clinicians, can only be treated by the traditional healer. There were also tensions between traditional healers and MSF due to the fact that the treatment provided by MSF is free of charge, while patients must pay to be treated by traditional practitioners. The other project in Cameroon was located in Yaoundé and looked after HIV/AIDS patients. Many informants made a distinction between "biological" AIDS and a "slow poisoning" of mystical origin.

This is a dimension that MSF has great difficulty grasping. In some cases, the teams bring in anthropologists to get an idea of the social components of the communities in which

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73 Akoloninga is two hours northeast of Yaoundé. It is interesting to note that most respondents thought that MSF was a Chinese organization because of the huge investment the Chinese government is currently making in Cameroon.

74 "Atom" is the traditional name for Buruli ulcer.

they are working, but then have difficulty adapting their operational strategies in light of the information obtained.[75]

In Kyrgyzstan, secularism is historically linked to politics,[76] and consequently influences how MSF is perceived. In this context, it can be important to present the organization as nondenominational rather than secular. Indeed, secularism was imposed by the communist regime, which banned religions. In contrast, French-style secularism separates the public sphere from the private sphere, with religion belonging to the second category.

It emerges from the study that the organization is not evolving in a vacuum, totally sealed-off from religion. The fact that MSF is a nondenominational organization does not guarantee that beneficiaries, partners, and so on will not view it through the prism of their own religious economy. MSF must first understand its place in a religious environment, then it will be able to position itself more appropriately and differentiate itself from religious organizations. This differentiation is not a goal in itself, but is essential in order to present a coherent message and a homogeneous identity to the outside world. Ultimately, the objective is to improve MSF's access to vulnerable populations, which means that this debate also needs to be translated into operational objectives.

The Humanitarian Aid System

The international humanitarian aid system[77] (headed by the UN agencies) and coordination between the various NGOs and

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75 Cf "*Anthropologues et ONG: des liaisons fructueuses?" Revue Humanitaire*, Special Issue, Autumn/Winter 2007, no. 4, especially the articles by Didier Fassin, "L'anthropologue et l'humanitaire," pp 75–80, and Françoise Duroch, "Quelle plus-value une organisation médicale d'urgence doit-elle attendre de l'anthropologie?," pp 35–39.

76 The decision to withdraw the reference to the secularism of the Kyrgyz state from the Constitution in 2007 triggered a great deal of political unrest. See, for example, Mathijs Pelkmans, "The 'Transparency' of Christian Proselytizing in Kyrgyzstan," *Anthropological Quarterly*, vol. 82, no. 2, (Spring 2009), pp. 423–445.

77 MSF International, *"What relation to the 'aid system'?"* op. cit.

local associations shape how foreign agencies are perceived. In some contexts, the image varies according to the country or region of origin of the humanitarian action. Local charitable traditions and local definitions of humanitarian action were another feature to be taken into account.

In its current form, humanitarian assistance is largely considered a "Western" product provided by "whites." In Cameroon, the link between the "whites" and humanitarian aid is permanent. Aid is seen both as a guarantee of quality and as an obligation that "whites" have towards "blacks."[78] The landscape of humanitarian action is nevertheless evolving, as China, for example, is now cited as a development actor in the medical field.[79]

In the case of emergency relief, as in Iraq, the results of the analyses confirm that there is no clear-cut distinction between the perception of humanitarian action and other types of intervention motivated by political, military, economic, or religious factors. Moreover, humanitarian organizations do not seem to be perceived as detached from the interests of their countries of origin[80] and their actions are regarded as Western.[81] An interest in finding natural resources in Iraq was often mentioned as an underlying reason for intervention.

78 "For many people, free goods and services are not seen as a gift but as a right: the whites have a duty to give back what they plundered from Africa." in Caroline Abu-Sada and Mikhael de Souza, *Yaoundé (Cameroon) Perception Report* , op. cit., p 42.

79 "The Chinese can help us develop our own traditional pharmacopeia. It's a new way of viewing medicine, which places greater value on local knowledge. Considering the rate at which China is growing, it can take us with it; it can help us grow too. I hope that the Chinese will enable us to develop our traditional pharmacopeia, which is something the others have never sought to do . . . " See below, the article by Li Anshan: "China-Africa Medical Cooperation: Another Form of Humanitarian Aid."

80 "Humanitarian activities are a means and a pretext for powerful states to muscle their way in to regions they want to get their hands on," Caroline Abu-Sada, *Middle East Perception Report*, op. cit., p 24.

81 "Let's ask ourselves a question: Do Western nations allow organizations, agencies or government associations into their countries without knowing exactly who they are, where they're from and what their precise intentions are? No. What I want to say is that one shouldn't be too optimistic about so-called humanitarian action," Ibid, pg. 25.

In Kyrgyzstan, although humanitarian aid generally has a positive image and is considered useful, the motivations of individuals and of humanitarian action are often difficult to understand. It is interesting to note that for younger respondents, who have no memory of the USSR and its influence in the world, "humanitarian action" was mainly developed by Europeans. Older respondents suggested that humanitarian aid was like a "Trojan horse" for political activities. One employee recalled that, in the Soviet era, international cooperation did exist, particularly with African countries, but that its main objective was to fight capitalism in the world.

In Guatemala and Niger, a minority of respondents expressed concerns about the possible establishment of dependencies on humanitarian aid, which is perceived as taking responsibility away from the state and reducing the endogenous resources of the local populations. However, most civil society organizations stated that they value collaboration and proximity with international humanitarian NGOs. The fact that these organizations bring certain problems to light was also seen as a valuable form of support for national organizations, which can benefit from the fruits of their labor. Involvement with international NGOs could also force local organizations to adopt a position on issues they would otherwise have avoided addressing, such as violence against women. In a few rare cases, however, the representatives of civil society organizations fear that excessive focus on international organizations could undermine the position of national organizations and give the impression that they are acting as representatives of foreign interests.

For many people in Cameroon, as well as in Iraq, the concept of a "totally free" gift is difficult to grasp. The idea of

free health care can arouse suspicion.[82] For example, people are afraid that NGOs might be spying for foreign governments[83] or military forces, or are conducting medical trials. Some respondents see links between humanitarian aid in general and a system of North-South domination.[84]

The Kurdish population in Iraq is unfamiliar with MSF's activities in its own country, but seems to have more information about its work in other parts of the world.[85] The Iraqi impression that their country had lost its place on the international scene often emerged in interviews and many people were eager to complete medical training in order to regain that place: "One day I'll be a doctor and I'd like to work for MSF because of my studies. Iraq was really well known for medical studies all over the world, and now we have to go to Jordan or Iran to get even the smallest operation."[86]

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82 "We're not in favour of intervention from foreign humanitarian medical organizations, because no aid is free. You give corn to the hen to catch it, lure it in. . . . These foreigners treat us like guinea pigs. They try out their products on us, by offering them free of charge," Caroline Abu-Sada and Mikhael de Souza, *Yaoundé (Cameroon) Perception Report*, op. cit., p 8.

83 In early October 2008, Bernard Kouchner, then French Foreign Affairs Minister, announced, following a visit to Gaza, that the French government obtained information from French NGOs working in the Gaza Strip. MSF and MdM produced press releases denouncing the accusations as unfounded and dangerous as they cast suspicion over the two organizations' activities in the territory. Despite the press releases, the comments of the Minister had the effect of increasing Hamas' suspicion of foreign organizations like MSF. MSF-France, "Territoires palestiniens: MSF s'insurge contre les propos tenus par M. Kouchner," Press Release, October 7, 2008, http://www.msf.fr/2008/10/07/997/territoires-palestiniens-msf-sinsurge-contre-les-propos-tenus-par-m-kouchner (consulted April 11, 2011).

84 "I actually think they're looking for ways to profit from the situation. I don't believe they're only here to do good, without expecting anything in return. All we see is aid and donations, but you always have to look at what's underneath that. The Africans here believe that their work is genuinely altruistic, but the Westerners have their own agendas, for example, they might want to get, through the NGO, some raw materials, some children who can go and work for them, etc. They have ulterior motives." Caroline Abu-Sada and Mikhael de Souza, *Yaoundé (Cameroon) Perception Report*, op. cit., p 9.

85 "I looked for MSF on the internet when I heard about them in Baghdad. I was interested not only in MSF, but in every organization that helps humans, including the Red Crescent societies. They're doing their best, but their budgets aren't enough, because they're nongovernmental organizations." Caroline Abu-Sada, *Middle East Perception Report*, op. cit., p 19.

86 Ibid, p 20.

Perception Among Different Groups

Perceptions Among Patients

In general, the presence and medical treatment offered by MSF are appreciated by the beneficiary populations. The organization's clinical management and approach to patients were described as very consistent and complete. In Cameroon, patients stressed the personal approach and psychological support[87] that they received in addition to the medical treatment. In Niger, the relationship between patients and medical staff, the trust in the staff, and their ability to listen, were cited as being equally important as the quality of the treatment.

In some contexts, patients underlined the dual role of MSF's presence in the region in terms of economics and political effect on medical programs. For example, in Kenya, patients felt the effects of MSF's economic role when the head of the household received a treatment: "We need their services to raise our living standards . . . MSF has reduced our expenses because hospital bills are free of charge, so we don't have to sell our animals."[88] Similarly, in Liberia, many people appreciated the free care while never questioning the quality of care provided. The project met their needs because it "helps us to survive."[89] In Kyrgyzstan, most patients said that their medical situation and living conditions had greatly improved since the start of the project. Furthermore, the presence of the organization and the care provided by it were perceived as very

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87 "MSF focused on our skills, our values. For years, we've been treated as patients, or rather as volunteers, but MSF has also spoken to us as experts;" "MSF really put the patients at ease. That welcome was our first medicine, our first dose of ARVs," Caroline Abu-Sada and Mikhael de Souza, *Yaoundé (Cameroon) Perception Report,* op. cit., p 9.

88 Caroline Abu-Sada and Mikhael de Souza, *Kenya/Uganda Perception Report,* op. cit., p 15.

89 "The project meets our needs because it 'helps us to survive,'" Caroline Abu-Sada, *Saclepea (Liberia) Perception Report,* op. cit., p 16.

important in terms of respect for human dignity, a value they did not feel from the doctors working in the prison system.[90] In Niger, MSF programs were said to have made people aware of the problem of malnutrition and the fact that they did not receive full information from the government.

Among the criteria for assessing MSF's work, many of the people consulted mentioned the following: time spent on, and quality of, the services provided; relevance and appropriateness of the programs and services offered to patients in relation to their needs; transparency and clear communication about the financing, objectives, goals, and beneficiaries of the aid;[91] improvement of patients' health; distribution of aid; improvement of general quality of life for local populations; and basic health education provided by MSF. These factors improved trust in medical care. Local populations no longer view traditional healers as the only option for getting well. In Kenya, patients said that they were satisfied with the health education provided to the local populations. In Niger, health awareness campaigns, especially on the preparation of porridge to prevent malnutrition, made mothers feel that they were no longer passive recipients of aid.

For many patients in Niger and Liberia, geographical coverage was mentioned as a real problem, as they had to travel long distances to reach health centers. It would also seem that MSF did not communicate enough with patients regarding

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90 "MSF treat us as human beings, not just prisoners. This attitude helps us feel better. Psychologically it's very important to feel supported and respected. We feel better and get well quicker;" "But the prison doctors have such a bad attitude towards us, are so disrespectful and aggressive, that patients don't want to listen to them and don't want to take their drugs. That generates feelings of rejection towards the doctors," Caroline Abu-Sada and Mikhael de Souza, *Kyrgyzstan Perception Report*, op. cit., p 9.

91 Interviews with groups of women: "The information we need is to know its origin, where it's from, we want to know its activities, its objectives. Do they want to teach us something? How is that going to be done? Do we have to pay for it? It is charity? Or is it private? We also want to know its name and the language they speak, to facilitate communication. Its name, origin, the reasons for its arrival, its destination and its objectives." Caroline Abu-Sada, *Magaria (Niger) Perception Report*, op. cit., p 11.

admission criteria or its reasons for setting up a given medical project. It is interesting to note that, in Kyrgyzstan, most prisoners, as well as the other respondents, thought that the main reason MSF was providing tuberculosis treatment in prisons was public health rather than individual rights to medical care.[92] In addition, some prisoners thought that MSF's treatments were clinical experiments.[93]

An overview of feedback from patients in different contexts shows that people appreciate MSF's presence, services, and impact on health programs, even though they were not always able to identify MSF, its principles, or its logo. Patients' perceptions also demonstrate the need to improve the organization's communication about its projects, the reasons for its intervention, the geographical areas where it is present, and the groups targeted by medical projects.

Reportedly, MSF's activities not only improve patients' access to treatment in remote areas, but also change people's perception of diseases. As well as the indirect economic and political effects, MSF's projects would seem to have a positive influence on empowering patients and enabling them to look after themselves in order to progressively improve their health.

Perceptions Among Authorities

It is interesting to note that perspectives differ between well-educated urban respondents and people who use MSF medical facilities in isolated locations, which are often in rural areas a long way from an urban center. By way of example, the differences found in Niger are rather striking. While those (mainly

92 "MSF works here to treat tuberculosis because it's a source of infection for normal people," Caroline Abu-Sada and Mikhael de Souza, *Kyrgyzstan Perception Report*, op. cit., p 21.

93 Ibid, p 30.

women) frequenting the nutrition rehabilitation centers were extremely positive about the program set up by MSF in the regions of Zinder and Magaria in the east of the country, certain intellectual and political circles in the capital, Niamey, were very critical of MSF's intervention. Moreover, the approach adopted by humanitarian organizations during the 2005 food crisis in Niger[94] was heavily criticized. The authorities said that, on the one hand, humanitarian organizations arrived in a region en masse, without any coordination, and, on the other, failed to take into account either local conditions or the strategies already in place, particularly with regard to agricultural development.

In Liberia, however, local authorities had a positive perception of MSF's work because it was seen as bridging the gap in medical care. Nevertheless, all respondents underlined their concern about the lack of information regarding the transfer of MSF's medical activities upon its imminent departure from the country. In Kenya, the government administration encourages people to attend MSF's clinics.[95]

It would seem that a shortage of local facilities and the inaccessibility of medical care are additional arguments in favor of the organization. Populations in remote areas of Cameroon, for example, and the prison authorities in Kyrgyzstan welcomed MSF's medical assistance, as such treatment was previously non-existent. By contrast, medical aid was viewed almost as a humiliation in Iraq. This brings us to the question of the humanitarian aid system.

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94 Xavier Crombé and Jean-Hervé Jézéquel, *Niger 2005: Une Catastrophe Si Naturelle* (Paris: Karthala, 2007).

95 "MSF is an organization which is recognized and legitimate because if it wasn't recognized or legitimate, it couldn't be in Kacheliba," "The Chief has advised the people to cooperate with MSF," and "the Members of Parliament recognize MSF and he [the DO] came during the opening ceremony of the center," Caroline Abu-Sada and Mikhael de Souza, *Kenya/Uganda Perception Report*, op. cit., p 16.

In all the contexts visited, the medical actors interviewed and the main partners of MSF projects regard the organization as a reliable and competent partner, an essential provider of medicines and equipment, and an expert in the medical field. For example, in Guatemala, the staff of the Ministry of Health described MSF as a partner that contributes to improving the quality of treatment delivered and lightens their workload.

Medical personnel and health authorities expressed a number of concerns linked to communication about projects and working methods, the duration of MSF's presence in a given region, training and the transfer of knowledge to local medical personnel, the coordination of activities, and so on. For instance, medical actors in Cameroon complained that the expatriate doctors work in a "closed circle" and prefer to treat their patients without involving or integrating national specialists or training national health personnel. In addition, the medical authorities described MSF's attitude toward them as sometimes inconsistent (broken promises, unclear schedules) and often critical.

In Kenya, MSF contacts in the Ministry of Health voiced grave concerns about MSF's use of generic drugs instead of officially registered drugs. Likewise, they complained that MSF financial aid did not go directly to the Ministry as part of a capacity-building strategy. It is important to note that MSF accepts these two criticisms, as they reflect strategic choices. While the Kenyan medical authorities commend MSF's ability to work in remote areas of the country and involve the community in disease screening initiatives, they question the recruitment of international doctors to manage medical projects. It seems that they would prefer the empowerment of local resources, which they consider to be equally skilled, knowledgeable, and professional as foreign personnel.

Summarizing the opinions expressed by institutional partners, it is important to stress that the medical expertise and competence of MSF's teams appeared to be highly appreciated in all the contexts analyzed. Nevertheless, the presence of foreign doctors was questioned by some medical authorities concerned with the "balance of power." Similarly, concerns were expressed about the integration of the program into national structures, strategies for transferring medical activities, the training of local personnel and the transfer of knowledge to reduce dependence on MSF's services.

It is worth highlighting the striking differences of perception depending on the proximity to and use of the health centers run by MSF. Indeed, it would seem that the further away and less informed the authorities are about the organization's activities, the more critical or negative their perception. This observation should encourage us to remain attentive to the quality and frequency of contacts established and maintained by the leaders of field projects with the authorities of a country.

Perceptions Among MSF Staff

In practically all contexts, the people questioned stated that the main reason they work for MSF is the need to have a job and the fact that MSF is considered a good employer. Working conditions are not limited to salary or social assistance. Employees mentioned the good atmosphere on projects, the fact that their opinions were taken into consideration, the offer of good training, attractive internal and external career opportunities, and the opportunity to speak foreign languages. Most staff felt well-informed about the projects, but said they did not have the opportunity to participate directly in the development and implementation of strategies.

In Kyrgyzstan, almost all employees mentioned that they

joined MSF by chance. In other contexts, such as Iraq or Guatemala, medical personnel stated that they had already heard about MSF and its projects elsewhere in the world before applying. Working conditions were one of the main indicators cited for assessing their satisfaction at work.

In other contexts, although some national employees had already heard of MSF, it was through working on its projects that they came to admire MSF for its humanitarian identity. In Cameroon, some employees had gone even further and joined the MSF-Switzerland association, saying that they were proud to contribute to its development. It is interesting to note that most international workers did not specifically choose MSF from among the variety of humanitarian agencies, either. However, most of the international workers interviewed said that working in the humanitarian sector was something they had been considering for a long time, and that had influenced their professional and academic choices.

National staff in Niger were not very well informed about the organization's principles and interventions, despite the fact that many of them had been working for MSF since the beginning of the project.

Overall, teams thought that the organization did not communicate enough. They felt that better communication would help both to define the organization's position in itself and to raise public awareness about health problems. Furthermore, national employees in Kenya saw major limitations in MSF's willingness and ability to tackle the medical needs of the population.

Turnover of international workers, their presence, and the balance of power were discussed in all the countries visited. In Cameroon, in spite of an excellent overall impression of coop-

eration and exchange between national and international staff, difficulties linked to the high turnover of MSF field workers were mentioned by the majority of national employees. Moreover, the presence of international workers was often perceived as a lack of trust in national staff and as a "culture of control."

In Iraq, the general perception was that MSF is an international organization that hires locals, but that senior staff and decision-makers are strictly European. The high turnover of the teams was cited as being unsettling not only from an operational point of view, but also for analysis of the context. Indeed, international teams need time to adapt to the context and national staff find it hard work having to continually repeat explanations about the country to new arrivals in the field.

The role of national staff has almost always been seen as one of "implementation," where they are responsible for carrying out the decisions taken by the international coordinators, but without having a direct influence on the actual decision-making process. The national staff have always considered their position frustrating and lacking acknowledgment. Various employees—both national and international—stated that responsibilities should be shared to improve the follow-up of project activities and improve HR policies.

In all contexts, the lack of exit strategies and mechanisms for transferring skills and empowering national structures generated debate and concern. In Iraq, it was stated that successive closing and reopening of projects was harmful to MSF's image. The organization should be flexible and suspend operations rather than closing them altogether.

Doubts were raised about cultural sensitivity and understanding of context in some countries. For example, Iraqi

national staff recommended sending experienced MSF field workers who speak one of the local languages to improve acceptance of the organization in the region. In the Occupied Palestinian Territories, national staff pointed out that the authorities' understanding of the terms "emergency," "security," and "without borders" differs from that of MSF, sometimes giving rise to unnecessary tensions between the organization and the authorities.

Internal and external communication practices were severely criticized by both national and international staff. Frustrations with project design, management and exit strategies, and the balance of powers within MSF missions were expressed on numerous occasions. The teams seem to have very limited knowledge of the organization's history and principles, or awareness of communication strategies.

Perceptions Among Other Institutional Actors

It was important for the ICRC to set itself apart from other organizations and US actors in Iraq. In this respect, only institutional communication and visibility policies secured the ICRC access to vulnerable groups and ensured the security of its personnel. To achieve this, a thorough dialogue with all the stakeholders present proved necessary.[96] Consequently, in the opinion of ICRC respondents, the high turnover of MSF staff makes it difficult to establish long-lasting contacts and diversify its network of partners, which, in turn, makes the organization vulnerable.

Human resources management was mentioned in relation to different aspects of MSF's image. In Iraq, having a network of medical and non-medical partners was considered the orga-

96 See below, the article by Ronald Ofteringer, "The Dialectics of Perception, Acceptance, and Meaningful Action"

nization's main strength in operational terms. The issue of staff turnover and a lack of mature, experienced teams in a complex and demanding environment[97] was perceived as one of the biggest challenges for human resources management.

The fact that local NGOs are regarded as being politicized in the Middle East is an important factor to take into account when choosing which ones to collaborate with. In this respect, disseminating information about MSF's financial independence could be perceived as a major advantage in a complex and politicized humanitarian space in which the UN has questioned the existence of humanitarian principles.[98] The specific attention given to funding sources, especially in the context of the Middle East, was regularly referred to by respondents.

MSF's adherence to its principles was mentioned as differentiating it from other organizations within the context of operations in Iraq and Afghanistan, where the mixing of military and humanitarian interventions creates security problems. In the theaters of the war on terror, the representatives of the United States have declared in their official discourse that NGOs are the "multiplication factor" of humanitarian strength[99] and the "soft power," implying that they represented the other face of military intervention. That has generated confusion between

97 "Everything linked to security is an issue of perception. And perception is linked to the geopolitical landscape. . . .The dominant perception of us is that we are a rich, Western and possibly Christian organization. If we can simply be tolerated then that's good; to be accepted is even better. Everything is about perception. Individual behavior of organization members definitely impacts perception. Recruitment, behavior and respecting the rules at the individual level can all impact perception." Caroline Abu-Sada, *Middle East Perception Report*, op. cit., p 41.

98 "95 percent of NGOs working here are funded through the UN or the USA, so neutrality of humanitarian actors does not make sense anymore. MSF, ICRC and IFRC are NCCI observers but they don't participate at all. MSF should have been and should be much more vocal on the situation in Iraq. That's something you do well, so do it," Ibid, p. 39.

99 See the address given by Secretary of State Colin Powell, "Remarks to the National Foreign Policy Conference for Leaders of Nongovernmental Organizations," Loy Henderson Conference Room, US Department of State, Washington, DC, October 26, 2001, the Avalon Project, Yale Law School, http://avalon.law.yale.edu/sept11/powell_brief31.asp (consulted April 11, 2011).

military forces and humanitarian actors in the minds of the population and insurgents. In fact, it has also given rise to a dilemma for some UN agencies that are part of both the political system and the humanitarian apparatus.[100]

This need to make the actions of MSF public was often mentioned by such stakeholders as the staff of the Office for the Coordination of Humanitarian Affairs (OCHA): "MSF is on the extreme side of the purity of humanitarian action, while at the other extreme are NGOs working with the MNF-I. A continuum of all NGOs is important, because not everybody stands for MSF's purity. . . . No one is actually purely following Dunant's principles."[101]

Various respondents mentioned the need to participate in humanitarian forums. The ICRC explained that it shared the same analysis as MSF with regard to working in "clusters,"[102] but that it preferred to participate in those meetings in order to remain informed.[103]

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100 "In Iraq, we are trying to demarcate ourselves. The problem is that the Deputy Special Representative of the Secretary General is also the Humanitarian Coordinator and the Resident Coordinator. We, the UN, are not neutral anymore and some NGOs such as MSF could criticise that. . . . MSF is able to speak out on things the UN can't, but you're not positioning yourself. You're not coordinating with other actors, you don't get data and then you can't communicate. If you became part of a broader humanitarian forum, you could do your job better. MSF could adopt a leadership role for other NGOs, rationalizing their action and building upon commonalities." Caroline Abu-Sada, *Middle East Perception Report*, op. cit., p 13.

101 "MSF core activities are advocacy and medical aid. MSF is on the extreme side of the purity of humanitarian action, while at the other extreme are NGOs working with the MNF-I." Ibid, p 40.

102 "Clusters" are defined by the OCHA (Office for the Coordination of Humanitarian Affairs) as thematic coordination groups that are a key instrument of humanitarian action. Thematic groups bring together all stakeholders working within a defined area of expertise including local authorities, NGOs, and UN agencies, and are the forum for coordination of every aspect of humanitarian response formulation including: assessments, data management, strategic planning, setting technical standards; monitoring and reporting on the effectiveness of the response; as well as contingency planning. This view of clusters is criticized in the MSF document *"What Relation to the Aid System'?,"* op. cit.

103 Interviews with ICRC representatives: "With regard to the cluster approach, the ICRC and MSF are in agreement. The ICRC prefers to participate as an observer, just to see where this approach is heading. The ICRC and MSF have converging points of view about how we should be perceived: what we share are independence and neutrality. The UN, on the other hand, is bureaucratic and not very efficient." Caroline Abu-Sada, *Middle East Perception Report,* op. cit., p 38.

Medical aid also seems to have become politicized.[104] According to the French Consul in Erbil (Iraq), MSF should treat patients while also trying to make long-term changes to the health system:

> I really regret that the knowledge, the competencies, and the proximity that characterise MSF can't be used to improve the health system in place or, at least, improve the health system of the hospital close to MSF's projects or train the medical staff of that hospital. A medical act leaves a political trace. When the NGOs leave, they will have left nothing; they will have only shown that Westerners know how to do things properly while the local government does not, and the health system will not have improved as a result of their presence. MSF is the only NGO that is financially independent, but people aren't aware of that—neither the Ministry of Health nor the other stakeholders. You should say it loudly because it's important to let people know that you are not funded by any government. You should also take the time to explain your strategy to your partners, explain that your strategy isn't linked to fundraising.[105]

MSF's lack of communication and coordination with other international organizations, NGOs, and local associations was a major topic of discussion with all respondents. It is a serious problem that hinders MSF's work and has an effect on its image, the security of its personnel, access to aid beneficiaries, and the effectiveness of its projects.

All participants, in several different contexts, stressed the same recurring themes: the importance of perception and

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104 See below, article by Paul Bouvier, "*Perception of Humanitarian Medicine by Military and Political Stake-holders.*"

105 Caroline Abu-Sada, *Middle East Perception Report,* op. cit., pp 16–17.

public image for security, the local approach to security, the importance of local contacts and networks and the vital need to maintain those networks, the perception of differences, discussions about the applicability of principles, the dissemination of project achievements as a basis for public communication, and the need to adapt HR management.

Conclusion

We have now looked at all the themes that were addressed during the field surveys.

Lack of communication concerning MSF's objectives and identity was raised frequently by our respondents. In most cases, people know about the organization because of a previous intervention in the region (Iraq, in 1991, for example) or because of interventions that have received high-profile media coverage in other regions of the world (natural disasters such as the Haiti earthquake attract a lot of media attention). However, people who are not employed by MSF seem to have little understanding of ongoing projects and what differentiates MSF and its objectives from other organizations working in the region.

A lack of coordination and collaboration with local and international actors was mentioned as a consequence of an excessively literal interpretation of the notion of independence. Many would like to see greater collaboration with other stakeholders, including national health systems, to make MSF's missions more sustainable. People often express their concern about the dependency that the organization creates and the medical and economic consequences of its departure. More training is requested, not only for national staff but also for civil servants and certain government employees, in order to guarantee the sustainability of medical action.

Although one of the main working hypotheses was knowledge of MSF's financial independence as a key aspect of its hallmark, the study showed that the general public are generally unaware of its funding sources. Similarly, at the start of the study, we postulated that the perceived quality of aid projects would be one of the main criteria determining acceptance of the actor. Recognition of the medical quality of the projects implemented by MSF at all the field sites visited was noted by the vast majority of respondents, but some believe that the organization's medical intervention choices are not always appropriate.

Another initial hypothesis was that being an external (rather than necessarily Western) actor was more important than all the other considerations for acceptance. All the responses disprove this, however. As we have seen, the analysis and interpretation frameworks of local populations do not necessarily include this dimension. The premise that the proximity of the teams to the population contributed to a positive perception was generally disproved. Indeed, to the contrary, security management measures usually created a distance between MSF's teams and the local populations.

Perceptions among MSF staff were one of the key elements of this research project. As long as there continues to be a lack of communication with national colleagues about MSF's identity and actions, it is wrong to think that the host society will be familiar with the organization. There is a widespread idea among international employees that national staff members working on MSF projects are intermediaries between the international teams and local populations and are, therefore, the best vector for conveying messages to the population as a whole. This idea does not hold water for several reasons. The first is that, generally, apart from at very specific times of crisis, little

information about the organization per se is disseminated to national staff. The second is that the organization's associative nature is rarely explained or, in any case, rarely understood by the national teams in the way headquarters would like. In the Occupied Palestinian Territories, for example, local associations and organizations created at the start of the 1980s were usually set up as an alternative to the political parties banned by the occupying power. The idea of a nonpolitical association is therefore imported, and sometimes difficult to understand. The third reason is that, within the teams, MSF is, and will remain, first and foremost, an employer in countries where the situation is generally difficult for the population. The high turnover of international staff makes it difficult to establish long-lasting contacts and is believed to hamper MSF's understanding of contexts and ability to act.

At field sites, we received requests for investment in the training of local health workers and in infrastructures, for a variety of reasons. In Cameroon, for example, at the Akoloninga project, which treats Buruli ulcer, local health personnel employed by the Ministry of Health lack knowledge of this disease and the latest advances in dressings. According to several respondents, the training of health workers by MSF would make it possible to continue treating this disease after the organization has left Cameroon. In Iraq, although there are health facilities in place, the war has seriously disrupted medical training. Moreover, many organizations, including the ICRC, have donated large amounts of equipment and drugs, which means that Ministry of Health staff and private health facilities have a greater need for medical training, particularly in specialist fields, than for medical equipment.

International staff do not always have a good understanding of the political, economic, and cultural contexts in which they

work. In any event, the image the organization transmits is that of a western NGO. MSF is sending field workers with increasingly technical profiles into the field, overlooking generalists who might be better able to understand the complex contexts. Respondents suggest that MSF move away from this technical model, instead placing more emphasis on general profiles in each mission, making it possible to develop links with authorities and the community. Moreover, it would be interesting to study the relationship with power and its exercise by coordinators—the type of leadership they choose, for example—and the consequences on image-building among those who are exposed to MSF.

MSF's quality standards were also questioned. Some informants considered the standards too high to enable them to be taken over by national authorities. Others, particularly within the organization, think that MSF should always strive for excellence in its standards.[106]

It is important to note that a population's analytical framework significantly influences its perception of an organization such as MSF. As analyzed above, religion was eventually incorporated into this study, although it was not initially included within the scope of the research.

Finally, MSF should definitely get back into the habit of negotiating with the parties involved: politicians, ministries of health, and local people. In the practice of humanitarian action, perhaps because of excessive confidence in the power of humanitarian organizations, there has been a tendency to neglect these negotiation processes. They are, however, indispensable.

Concerning the caregiver/care receiver relationship, a great

106 See article by Jérôme Amir Singh, "Humanitarian Medicine and Ethics."

deal of internal work still needs to be done. This was discussed at length, as we will see below.

In most projects, step-by-step explanations to help patients understand medical treatments are lacking. This issue requires sustained attention in the majority of projects. Nevertheless, the direct impact on patients is what sets MSF apart from other organizations. These studies of perception have enabled teams to become aware of their environment, to be less focused on their own projects, and to understand that MSF is part of a broader system, the workings of which need to be understood. Perceptions that do not correspond to what we would like to hear are not the result of misunderstandings, but reflect reality. The process of changing perceptions, should that prove necessary, is not just a matter of communication, but rather a problem of institutional identity and exercising that identity.

THE DYNAMIC GENERATED BY THE PROJECT

Internally

Over the project's three years, it has had real repercussions within the organization. First of all, an important aspect has been to involve the MSF departments in the research in order to ensure subsequent appropriation of its results. Unsurprisingly, the Operations Department has been the most concerned, as it was in direct contact with the research team before and after field visits. The individual country reports, written following each visit, made it possible to quickly modify certain facts, behaviors, or strategies which could have a negative effect on the perception of the organization.

Perception is now a dimension that is integrated from the start of each project. For the Medical Department, although the themes of "caregiver/care receiver relationships," "vertical

programs," and "ethical questions" were present before, they are now the focus of specific research programs. Meanwhile, the HR department has developed a number of procedures, such as the briefing of expatriates (what type of information should be given to people going into the field regarding the context, project, and socioeconomic characteristics of the populations targeted by the project), volunteer profiles (a technical or more general profile, as advocated by some), and training (the recommendations and trends that emerged from the study have now been incorporated into all training in order raise the awareness of people going into the field). MSF's Communications Department has also reviewed its policies in light of the results of the study. There is now increased motivation to decentralize the apparatus (communications officers are now more systematically recruited at field sites) and the target of communications activities (from communications directed toward the societies where the operational centers are based, i.e., Europe and North America, to communications geared toward the societies where MSF has its operations).

Technical assessments of the projects have also included the dimension of perception. For example, the assessment of the activities of the first three months following the earthquake in Haiti, in January 2010, took into account for the first time patients' perceptions of the medical response provided by MSF.

Numerous presentations of the study and its results have been given in all MSF sections as well as to other NGOs, which have then been able to address the issues for themselves. Furthermore, the study has prompted considerable debate within the organization, with several General Assemblies focusing on the subject of perception.

Externally

Two working days were consequently organized in Geneva on September 30 and October 1, 2010. The purpose was to share the results of the research with other MSF sections. We also asked external speakers to offer an alternative view of our topics, which can tend to be very MSF-specific. The two days were organized along the following lines: a few external guests gave reasonably short presentations, then the participants were split into working groups to discuss the issues raised in the presentations and by the Perception Project itself.

The first day was dedicated to political issues. We tried to understand how the gap between perception and reality influences medical humanitarian action. Several research projects, including this one, have shown how crucial it is for humanitarian aid actors to understand how they are perceived by local, regional, and international stakeholders, and how that perception can affect their capacity to implement effective operations. There are clearly discrepancies between the way organizations are actually perceived and the way they think they are perceived.

The second part of the session was more focused on developments in the political context of medical humanitarian action. The participants explored the possible benefits of those developments for actors such as MSF, as well as their repercussions on the aid system more generally.

External participants presented some recommendations. According to them, the briefing of MSF field workers going into the field should be improved and deepened, so that they understand all the implications of their work in a specific context. In addition, the teams should take the time to explain the project that is going to be set up to local people, how it will

function, admission criteria, and so on, in order to avoid any misunderstandings with communities or patients.

According to Li Anshan, the central goal in humanitarian aid is to prioritize the transfer of knowledge to the local population. Antonio Donini highlighted four points that can illustrate the different perspectives of people in the field: the universality of humanitarian values, the effect of policies resulting from the "global war on terror" on the perception of international NGOs, the manipulation of humanitarian work by the political world, and problems related to the security measures taken by international NGOs. NGOs should prepare to deal with new non-Western international actors in the field: this development also reflects a stronger challenge to the dominant Western discourse. It is envisaged that in 10 or 20 years' time, the Western point of view will carry less weight than Brazilian, Chinese, and Indian perspectives, for example. The institutionalization of humanitarian action has contributed to the shift from a "powerful discourse" to a "discourse of power." Perceptions are important because they give meaning, but they can also have very negative consequences for humanitarian actors. In order to change this and move forward, it is necessary to work in close collaboration and establish new relationships with all stakeholders.

The points discussed following the presentations can be divided into four different categories: points on which the participants reached a consensus, points on which opinions diverged, unresolved questions, and, lastly, recommendations emerging from the discussions.

Consensus

MSF's added value is its medical identity. That enables it to maintain privileged links with medical circles and project

an image that is clearly understandable for the majority of actors. The recognized quality of the care it provides and its appropriateness for the needs of the populations is, without doubt, the best way of becoming accepted. Several participants highlighted the fact that the organization prompts changes in local health care systems and challenges certain local medical protocols which sometimes have not evolved for decades. It therefore has a considerable role to play in the field of medical innovation thanks to its ability to undertake costly long-term programs (treatment of tuberculosis, putting patients with HIV/AIDS on antiretrovirals [ARVs], etc.).

As MSF does not have a delegation of authority or mandate from the states signatory to the Geneva Conventions (as the ICRC does), the interactions between MSF and states that are reasserting their sovereignty require much more negotiation than in the past. Although nowadays NGOs inevitably have a discourse of power, they are nonetheless confronted with state actors who challenge that power. MSF will always be viewed as an organization external to the context and will always have to explain its intervention criteria and programs to authorities, and especially to target populations. A real investment should be made in dialogue with the main partners and beneficiaries.

MSF cannot and must not totally remove the gap between reality and perception. Sometimes, keeping a certain distance can be a real strength. Thanks to its independence, the organization is able to tackle medical problems without any political or economic interests coming into play. MSF should nevertheless be aware of the way it is perceived and change that perception through concrete actions, by adapting its organizational identity.

According to participants, MSF should work on reducing its isolation (by establishing contacts with the populations for

and with whom it works, gaining a better grasp of the circumstances in the field, etc.). This can be achieved at two levels: at the international level, by becoming a more influential actor, and at the local level, by trying to have an influence on the regions around its projects. There is a consensus that, as an organization, MSF is in fact a very influential political actor and must, therefore, be more involved. A good image among the local population is not an aim in itself, but strongly influences a project's success.

Debated Points

Several participants were keen to provide additional details about some of the points raised in the presentations. First, they stressed the fact that criticism of MSF (arrogance, vehicles, isolation, etc.) does not reflect the work of volunteers in the field, who are sometimes very close to the local populations. MSF is not systematically isolated. The question of medical standards also elicited divergent points of view. Several people underlined the fact that standards within the projects were too high to enable a smooth handover to the local authorities. Others, meanwhile, highlighted the need to provide the best possible quality of care, even if that makes an exit strategy more difficult.

MSF should expand its networks and make contact with all the stakeholders present in the contexts in which it acts, while avoiding any manipulation for political ends. According to A. Donini, a process of "oligopolarization" is underway, which promotes a Western vision of universality. That causes frustration among other aid actors and can cause tensions with the organization. Resolving those tensions requires dialogue.

The reassertion of sovereignty by some state actors and the reshaping of international relations (the growing power

of actors such as Brazil, Russia, India, and China) prompted heated discussion. Indeed, some participants thought that MSF should welcome the rise in power of certain states that are now better able to take care of the medical needs of their populations, while others pointed out that a recovery of control could be detrimental to some populations and that the organization should ensure that the provision of health care was adequate. In this context, the notion of independence can be a source of confusion and misunderstanding. Indeed, the boundaries between political independence, financial independence, and technical independence (i.e., operational independence from other groups in the field) are sometimes unclear.

The question of the impartiality of MSF's work was addressed. Some called for clarification of the definition of the criteria for intervention and asked why some populations seem to deserve more help than others: Why intervene in Iraq rather than Laos, for example? Impartiality is a clearer concept than neutrality and should be MSF's guiding principle. Neutrality was described as being less and less pertinent. The political choices behind the decision to intervene in a given country were also debated, on the basis of two considerations: MSF's political will to be present in complex situations, and the medical needs of the populations, which are not always sufficiently pressing. Finally, for some participants, constraints in terms of the management of human resources are considered detrimental to MSF's investment in certain more complex contexts.

Unresolved Questions

Several questions remained unanswered at the end of the discussions, but deserve to be addressed. The perception gap—that is, the difference between the way MSF thinks it is perceived and the way it really is perceived—has still not been clearly

defined. What gap are we talking about in terms of perception? What is the definition of perception or a perception gap? Can we talk about its security implications, knowing that nowadays perception is directly linked to a specific time—the evaluation, exploration, and setting-up of a project? Will the gap between reality and perception decrease if MSF is perceived as less Western or, on the contrary, adopts a clear Western position?

What ethical considerations come into play in the constitution of this perception gap? MSF should be careful not to establish an overly paternalist relationship with patients and populations, considering that the organization already decides, when setting up a project, what it considers best for those populations. Participants all felt that MSF should take more time to explain its position, highlighting the medical aspect of its involvement, which is the only objective element in the construction of its image.

Recommendations

A set of recommendations was developed based on these discussions.

First, MSF must establish cooperation with actors in the political sphere, while taking care to avoid being exploited.

Next, it should be more consistent in its public positioning, communication, actions, and advocacy work. It must adopt a more "readable" position. Concerning communication, several issues were underlined. First, participants said that the organization should be much more precise in its communication. It still presents itself as an emergency relief organization, while a large part of its programs are not perceived as such, either internally or externally. Second, because of the increased bureaucracy within MSF, messages tend to lose their substance

and become less political. Third, the target audience for MSF's communication is mostly Western, when it should be focusing on the countries where it has operations.

The second day was dedicated to the medical aspect of MSF. The effect of medical humanitarian aid on fragile health systems is often questioned (recovery of costs, handover, co-infections, neglected diseases, etc.). Does medical humanitarian action add value to public health systems? To what extent are medical structures taken into account in conflicts?

The general consensus is that the medical field has become politicized as well. The day was structured around three main themes.

The first was the perception of humanitarian medical action by its "beneficiaries." Samia Hurst, from the University of Geneva, demonstrated the shift from a model of all-powerful medicine, which has at its core an attitude of charity toward the poor, to a model of medicine more attentive to patients' expectations and the emergence of the right to receive medical care. In this context, the main challenge for MSF as a medical organization is to define its priorities. In practical terms, who benefits from what?

The second was the perception of humanitarian medicine by other actors. Paul Bouvier, from the ICRC, highlighted that the issue of perception is skillfully exploited by power holders to win the trust and secure the cooperation of local populations. In his opinion, it is precisely because humanitarian action is viewed in a very positive light throughout the world that military forces, bankers, and big businesses want to establish close collaborations with NGOs, or even set up their own charitable organizations.

The last topic addressed, in a presentation by Jean-Hervé

Bradol, former president of MSF-France (2000–2008), was the impediments and synergies between humanitarian medicine and public health systems:

Jean-Hervé Bradol, *former president of MSF-France, research director, **CRASH***

I would like to talk about the relationship between MSF and public health policies. Since MSF's creation, we've been involved with public health systems in various capacities, even, in the most extreme cases, by delegation (from local or national authorities, or by choice). For instance, in refugee camp settings, UNHCR is often overstretched or lacks qualified staff to coordinate the medical operations, and we are then asked to step in and perform the role of "Ministry of Health" of the refugee camps. In more open contexts, outside the camps, some of us have assumed the role of provincial health director, for example, for the public administrations in countries like Guinea, Chad, the Democratic Republic of Congo, and Burundi. MSF can play a wide variety of roles: it can substitute the teams of the Ministry of Health, or simply act as a private-sector agent, in competition with the public health system. So, in 40 years, we've performed all sorts of roles.

We've supported most of the major drives that have made it possible to establish what is known today as "global health." The first operation of this sort was the 1974 expanded program on immunization (EPI), which MSF supported and helped implement in a modest capacity at the start of the 1980s and throughout that decade. It has also supported primary health care: at the international conference in Alma-Ata in 1978, MSF defended the policy of developing primary health care, while pointing out that the ultimate

objective was utopian and the means of achieving it were inadequate. That's why, in 1987, the Bamako Conference constituted a turning point, establishing new guidelines for managing the human and financial resources of structures in charge of primary health care.

I know that for some of you it won't quite fit with the MSF "legend," but I remember that one of the first positions that was offered to me by the French section, in 1989, was as a doctor for the public administration in Kankan (Guinea). This type of work may seem to contradict the perception of a French section that steers clear of development actions, but historically, that's not true. MSF has also done a great deal, not only to promote the subsidization of user costs, but also to harmonize the care provided. In the 1980s, it became important to establish national protocols, and one of the points at the center of the debate at the time was the WHO list of essential medicines. That was a major advance in terms of public health, and MSF firmly supported the initiative. Those years also witnessed an improvement in the international medical response to crises; MSF was obviously one of the contributors to that international response. More generally, during that period, at its field sites, MSF did a lot to spread the word about "biomedicine" and evidence-based medicine, through Epicentre and MSF's publications. Looking through these medical publications, it is impressive to note that, in some medical fields, MSF provides a large part of the scientific data.

The question of how well MSF understands the different socio-cultural contexts in which it works is often asked. Today, the "typical profile" of a caregiver in an MSF project is an African woman of around 30 years old; she is more likely to be a nurse than a doctor; she speaks the local language, and is familiar with the prevailing cultural context in her region. Consequently, the following question is asked:

Are local staff given an appropriate position within the organization? From the point of view of the patients, if they need a consultation, they will be seen by people who speak their language, even if it's not the language most commonly used in their country. I'm not implying that there are no intercultural difficulties, but having an organization of 25,000 employees in 70 countries, 90 percent of which are nationals of the country in question, clearly illustrates the reality of cultural interactions within MSF. Unfortunately, there is still inequality in access to positions of responsibility between people who join the organization in their own country and those posted abroad.

Obviously, we are more in favor of public health institutions than private health institutions. I would like to add, briefly, that this ideological position is actually largely unfounded, because throughout the history of public health systems, there has been major contribution from the private sector, even in the case of one of the key countries when it comes to public health education, namely the United States. For example, the Rockefeller family and the Rockefeller Foundation contributed considerably to the development of the public health system in the United States. The Gates Foundation also plays a clear role today. In the debate about development, there were two main trends: one advocated a style of development based on public services and taxation to cover the expenses of those public services, while the other trend was more based on individual rights and a market economy. Throughout most of MSF, the culture that is still dominant in the minds of the majority of volunteers is that of public services and public institutions paid for by taxes.

One of the other comments made to us concerns the sustainability of our actions to support the development of public health care institutions. So we made a choice—which needs to be re-examined,

because it is rather a political choice, that was made in a very specific historical context—but overall, we were in favour of the creation of public health institutions. We've tried to contribute to them, but it hasn't always been successful. Field operations like those launched after the Bamako Conference, at the end of the 1980s, were generally classed as failures. That's not to say that we didn't learn anything from those experiences, but most of us have stopped making it our operational focus. The same applies to management, because although we were in favor of developing public health institutions, it was often pointed out to us that we were not sufficiently legitimate or qualified to contribute to their development, since what we introduced in those public health institutions wasn't sustainable. An entire discussion could be devoted to this point alone, as when MSF contributes to the modification of national protocols for malaria, tuberculosis, or the AIDS virus, isn't that a sustainable action? When MSF participates in the importation of a new generation of treatments into a country, that's an extremely sustainable public health action.

The example of Haiti is interesting. It's understandable to be pessimistic about the building of public health institutions in Haiti today. In the current social, political and economic situation, it's difficult to identify the necessary conditions to establish quality public health infrastructures. In Haiti, the situation is a bit paralyzed because the legitimate actors, such as the state, perhaps lack the necessary will, and those who have the means are not legitimate (I'm talking about the UN, the United States, etc.). They lack legitimacy, at least in the eyes of the population of Port au Prince, for one obvious reason: they're foreigners. That comes across very clearly when you talk to people. In this type of context, medical

centers dependent on religious structures or groups are very common: they are private and religious, but are recognized by the Ministry of Health as contributing to public health. And if you want to participate in the meetings that coordinate that kind of activity, for me, it's a tactical question: Are those meetings effective? What is their dynamic? That's why I started by mentioning that MSF has historically adopted a wide variety of stances on these matters, ranging from deep involvement to adopting an arms-length approach to public institutions.

There's also a great deal of discussion about the process of selecting MSF's target populations. The choice is obvious when responding to an acute disaster, but less obvious for chronic disasters, and in situations where access to care is very limited, what MSF's role should be remains to be determined.

Another controversial point is that MSF has been one of the few medical organizations participating in the public debate on transnational health issues in various circumstances. Today, and over the past five years, one cannot help but notice that MSF is participating less and less in the debate about the international response to wars, or to conflict situations more generally, but is increasingly active in the political debate about global health issues. MSF even has what could be described as an "advocacy unit" with the Campaign for Access to Essential Medicines, which is entirely dedicated to this activity. It's not that common to see a medical organization getting so involved in the public political debate about health issues.

MSF has also participated in training activities, contrary to what has often been said. That training has been technically successful and we've learned a lot from it. Technically speaking, it's been a

very interesting and fruitful experience, but from a social perspective it's been very difficult, because when you're not in control or you're not fully integrated into the system, staff training is a waste of time, because they never end up working where they would be most useful from a public health point of view. In the debate on sustainability, public institutions are always portrayed as being sustainable. In our environment, if we base our assessment on a set of objective criteria, the structures of the Ministry of Health have been extremely unstable. You know, we arrived shortly after decolonization. In the 1980s, in Africa, most of those structures collapsed, for a number of reasons, notably the structural adjustment policies implemented by the World Bank and the IMF. Consequently, the setting was completely unstable, yet ideologically, when we talk about the Ministry of Health, we think "stable," and when we talk about private structures, including MSF, we think "unstable." However, in many situations, we are actually more stable in that environment, in terms of service delivery, than the public institutions. In my view, it is a political bias.

Two main issues were addressed in the discussions on the second day.

The first concerns the very notion of "beneficiary." Is it the group that benefits from the medical act itself, or the broader group that benefits from the intervention? Some people explained that the use of this word is not neutral, as it creates a certain order of things. By delivering a benefit, the organization is contributing something positive. The terms "victim," "patient," and "beneficiary" underline the fact that the person is in a state of suffering. The term "user" places the emphasis on the fact that the person in question is using a service. That draws on the principle of mutuality and reciprocity of giving. Humanitarian aid implies an imbalance and an asymmetrical

relationship. Although "beneficiary" may not be the most appropriate word, the term "client" also sounds odd. "Patient" is an outdated way of viewing medicine and the latest definition of this term does not really reflect a sense of autonomy. It doesn't come naturally, from a medical point of view, to refer to a patient as a "beneficiary," since the term has economic connotations. Use of the term "beneficiary" establishes a paternalistic attitude toward the patient. That being the case, is it MSF's role to define who its beneficiaries are? Shouldn't it be left to the people themselves to answer that question? MSF should merely define a target group. To conclude, the term "beneficiaries" has been highly criticized, first because it implies a certain passivity, second because MSF is not actually expected to provide a "benefit" but rather to improve access to health care, and, finally, because patients do not seem to regard themselves as "beneficiaries."

The second issue concerns the caregiver/care receiver relationship. MSF must ensure that its teams connect with patients. We should "take time to have a cup of tea."[107] Similarly, it is important to give consideration to friends and relatives, in order to make more of a connection with the communities and to care for patients better. Care staff must clearly explain the stages of the treatment and the consequences of the disease. The idea of having a users' charter was mentioned several times. MSF should take time really to understand how medical services are organized around the person being cared for. We must engage more with patients, as caregiver/care receiver dialogue and the feedback process are essential parts of the medical procedure that warrant greater attention. We must take our responsibility toward patients more seriously (there's a link between dialogue and the quality of medical care), as it is essential for gener-

107 Johanna Grombach-Wagner, "'L'art de boire du thé' ou l'art de la conversation à l'amiable," *My Sweet La Mancha*, op. cit., pp 51–54.

ating a positive perception of the organization. Human dignity was identified by everyone as the element that should be at the heart of MSF's medical apparatus.

To conclude, it was pointed out that MSF's weight today gives it certain responsibilities. The process of placing more emphasis on some diseases over others is not insignificant. These responsibilities are towards patients, donors, and the target populations, as well as towards the governments of the countries in which MSF works. Although medical structures are increasingly implicated in political conflicts, the fact remains that the relationship between caregivers and care receivers must be depoliticized.

The two days of discussions ended with a speech from the President of MSF International, who reflected on the organization's position in the new landscape of global health actors:

Unni Karunakara, *president of MSF International since 2010*

Setting up health systems requires the kind of commitment that we're probably not in a position to provide at the moment. Health systems need planning and long-term commitment, an ambition that must come from the national government, with the participation of civil society and other nongovernmental actors.

We've already talked about some of the constraints that need to be addressed, such as human resources. We should also discuss managerial and large-scale control capabilities, as well as the setting up of national supply and distribution systems. Health systems require solid management of epidemiological capabilities and information, in order to be able to predict and deal with epidemics.

It's also necessary to have stable, long-term funding, bearing in

mind that in most of the countries in which we work, only a small percentage of the funding comes from the country itself. Most of the time, the budgets allocated to health are determined by the Ministry of Finance, which has little understanding of the health needs of the population. Consequently, it is mainly international actors such as the WHO or the Gates Foundation that steer or influence health sector spending in those countries.

A major transformation has taken place in the world of health over the past 10 years. In 1999, when we received the Nobel Peace Prize and later decided to create the Campaign for Access to Essential Medicines, many influential agencies and organizations, such as the Global Fund, the Gates Foundation, the Clinton Foundation, PEPFAR (the US President's Emergency Plan for AIDS Relief) and the President's Malaria Initiative, to name but a few, didn't exist. Since then, billions of dollars have been spent to provide populations with treatment against certain diseases and, lately, to address problems linked to health systems. Numerous international political entities have also expressed an interest in getting involved in questions of global health, although many of those promises do not translate into a significant injection of funding. Although there's still a shortage of funding to tackle the glaring health problems, more attention is being focused on global health today than ever before.

As a humanitarian medical organization, we must clearly state that our mission is to save people in distress and not health systems in peril. Of course, it goes without saying that we must collaborate with the health system of the country in which we're working, so that we can help its population and provide appropriate care. However, our objective isn't to take on responsibility for the development of those health systems.

Current notions of sustainability depend greatly on capacity- and system-building activities, and securing a constant, reliable flow of funding. In many of our programs, we often make important contributions to the national health systems. We manage to make an impact in the short term by offering training or undertaking collaborative activities. Although we set up these activities and sometimes even work in a country for a prolonged period, that doesn't necessarily mean that our projects will be sustainable.

As our organization grows, we must reflect on what our size and capabilities bring to the contexts in which we operate. Even though our programs have a positive medical impact, our actions could have negative consequences on the health system and the local human resources available for other programs. It's not our job to define a country's road map or development program. Of course we can offer our help, but at the end of the day, it's up to the government to decide which route to take and up to the country's citizens to make sure the government honors its commitments.

I'd like to suggest that we look at the notion of sustainability from another angle. Over the years, we've used our operations, our research capacity, and our political influence to introduce health care models that have become the norm in various contexts and several countries. That's the case in the fields of HIV, malaria, nutrition and neglected diseases such as kala azar, sleeping sickness, and Chagas disease. Whether these initiatives involve introducing a new tool, setting up a new operational or medical approach, designing adapted models of care that can be extended not only by us, but also by governments, they all constitute sustainable actions.

Above, I mentioned a list of organizations created within the past

10 years. Those agencies are very powerful, and they have a lot of influence and resources that can serve to establish a global consensus and start global action. However, we remain an organization with a strong presence on the ground, which treats patients and shares its expertise. No other organization's programs match the scope, caliber and depth of ours. But how can we get those agencies to provide better conditions and better treatments for our patients? We still have a very important role to play in this new world of health, but we need to think about the best way of using our operational experience and our political influence.

At the end of the day, perception depends on the relevance of our operations and our interactions with the host communities. Good communication is vital. We have a gift for communicating with our donors about our activities, but we're less gifted at informing the communities with which we work about our principles and operations. As the implementation of our humanitarian mission becomes more complex, we must endeavor to explain our challenges, operational dilemmas, and choices about programs to the public more clearly. This very notion of accountability can only materialize if we treat our donors and host communities as adults and as our equals.

Bibliography

Abu-Sada, Caroline. *Rapport interne, rapport perception Zinder, Niger*. MSF-Switzerland, 2007.

Abu-Sada, Caroline. *Rapport interne, rapport perception Akoloninga, Cameroun*. MSF-Switzerland, 2007.

Abu-Sada, Caroline. *Rapport interne, rapport perception Magaria, Niger*. MSF-Switzerland, 2008.

Abu-Sada, Caroline. *Rapport interne, rapport perception Yaoundé, Cameroun*. MSF-Switzerland, 2008.

Abu-Sada, Caroline. *Rapport interne, rapport perception Saclepea, Libéria*. MSF-Switzerland, 2008.

Abu-Sada, Caroline. *Rapport interne, rapport perception Moyen-Orient*. MSF-Switzerland, 2009.

Abu-Sada Caroline. "La perception de MSF sur les terrains d'intervention: le cas du Niger," in *Humanitaire*, no. 24, March 2010, http://humanitaire.revues.org/index704.html.

Abu-Sada, Caroline and De Souza, Mikhael. *Rapport interne, rapport perception Kenya/Ouganda*. MSF-Switzerland, 2008.

Abu-Sada, Caroline and De Souza, Mikhael. *Rapport interne, rapport perception Guatemala*. MSF-Switzerland, 2008.

Abu-Sada, Caroline and De Souza, Mikhael. *Rapport interne, rapport perception Khirgizstan*. MSF-Switzerland, 2009.

Annaud, Mathilde. *Plutôt mourir que pleurer, Mission anthropologique Damagaram*. Niger: MSF-Switzerland, 2005 (Internal Document).

Bayart, Jean-François. "Le politique par le bas en Afrique Noire, Questions de méthodes," in *Politique Africaine*, no. 1, March 1981, pp 53–83.

Bellion-Jourdan, Jérôme. "Islamic Relief Organizations: Between "Islamism" and "Humanitarianism," in *ISIM*, no. 5, May 2000, p 15.

Bellion-Jourdan, Jérôme. "Les ONG islamiques sont-elles purement humanitaires? Réflexions sur une vraie fausse question," in *Humanitaire*, no. 17, September 2007, pp 40–51.

Benquet, Patrick and Vallaeys, Anne, *L'Aventure MSF* (film documentary). Maha Productions/INA, 2006.

Benthall, Jonathan. "L'humanitarisme islamique," in *Cultures & Conflits*, no 60, December 2005, pp 103–122.

BERCI International. *Peacekeeping Operations in the Democratic Republic of the Congo: The Perception of the Population (Conducted in June and July 2005)*. Peacekeeping Best Practices Section, Department of Peacekeeping Operations, 2005. http://www.peacekeepingbestpractices.unlb.org/PBPS/Library/MONUC%20perception%20of%20population.pdf.

Biquet, Jean-Marc. *Le diable de la rivière*. Geneva: MSF, 2002 (Internal Document).

Boinet, Alain. "Témoignage sur l'aide humanitaire et l'Islam, en Afghanistan et ailleurs," in *Humanitaire*, no 17, September 2007, pp 52–65.

Bouchet-Saulnier, Françoise. *The Practical Guide to Humanitarian Law*. Lanham: Rowan & Littlefield Publishers, 2007.

Bouillon, Florence, Fresia, Marion, and Tallio, Virginie. *Terrains sensibles: Expériences actuelles de l'anthropologie*. Paris: Centre d'études Africaines/EHESS, 2006.

Brauman, Rony. "Le sacre de l'urgence," in *Le Débat*, vol 84, no 2, 1995, pp. 5–9.

Brauman, Rony. *Humanitaire: Le dilemme*. Textuel, 1996.

Brauman, Rony. "Les dilemmes de l'action humanitaire dans les camps de réfugiés et les transferts de populations," in Moore Jonathan (ed.), *Des choix difficiles. les dilemes moraux de l'humanitaire*. Paris: Gallimard, 1999, pp 233–256.

Brauman, Rony. "Vous avez dit . . . humanitaire?" in *Le Nouvel Observateur*, no 2004, April 2003.

Brauman, Rony. "L'image avant l'action (entretien)." *MCSinfo*, Strasbourg: Université Robert Schuman, 2003. http://mcsinfo.u strasbg.fr/article.php?cPath=10&article_id=3171.

Brauman, Rony. "La communication des ONG: une affaire d'États?" in *Revue internationale et stratégique*, vol 56, no 4, 2004, p 109.

Brauman, Rony. "Les ONG, nouvelles missions?," in *Cahiers de médiologie*, Fayard, 2004, pp 165–171.

Brauman, Rony. "Biafra-Cambodge, un génocide et une famine fabriqués" in *Colloque international "Face aux crises*

extrêmes." Lille: Faculté des sciences juridiques, politiques et sociales de Lille, October 2004. http://www.msf.fr/drive/2004-10-21-Brauman.pdf.

Burtscher, Doris. *You Cannot Break the Culture of Silence*. Barcelona: MSF-Spain, 2005. (Internal Document).

ICRC. "'Our World. Views From the Field.' Summary Report: Afghanistan, Colombia, Democratic Republic of the Congo, Georgia, Haiti, Lebanon, Liberia, and the Philippines, June 2009. http://www.icrc.org/eng/resources/documents/report/views-from-field-report-240609.htm.

Crombé, Xavier and Jézéquel, Jean-Hervé. *Niger 2005: Une catastrophe si naturelle*. Paris: Karthala, 2007.

Dauvin, Pascal. "D'une logique d'entreprise à celle de l'engagement," in *Messages*, no 141, Juillet 2006.

Dauvin, Pascal and Siméant, Johanna. "Travailler sur l'humanitaire par entretiens—Retour sur une 'méthode'" in *Mots, Les languages du politique*, vol 65, no 1, 2001, pp 117–133.

Dauvin, Pascal and Siméant, Johanna. *Le Travail humanitaire: Les acteurs des ONG, du siège au terrain*. Presses de Sciences PO, 2002.

Donini, Antonio. "Western Aid Agencies Don't Have a Humanitarian Monopoly," in Humanitarian *Affairs Review*, October 2004, pp 12–15.

Donini, Antonio. *Looking Ahead: Making our Principles Work in the Real World*, July 2007. http://www.reliefweb.int/rw/lib.nsf/db900sid/AMMF-75MGB9/$file/Tufts-July2007.pdf?openelement.

Donini, Antonio. *The State of the Humanitarian Enterprise*. Medford: Feinstein International Center, 2008. http://www.humansecuritygateway.com/documents/TUFTS_humanitarianagenda2015_stateofhumanitarianenterprise.pdf.

Donini, Antonio and Minear, Larry. "International Troops, Aid Workers, and Local Communities: Mapping the Perceptions Gap," in *Humanitarian Exchange Magazine*, no 32, December 2005. http://www.odihpn.org/report.asp?id=2766.

Donini, Antonio and Minear, Larry, et al. *Humanitarian Agenda 2015: Principles, Power, and Perceptions: Preliminary Report*. Medford: Tufts University/Friedman School of Nutrition Science and Policy/Feinstein International Center, 2006. http://hdl.handle.net/10427/37850.

Duroch, Françoise. "Quelle plus-value une organisation médicale d'urgence doit-elle attendre de l'anthropologie?" in *Humanitaire*, no 4, December 2007, pp 35–39.

Epelboin, Alain. "Médecine traditionnelle et coopération internationale," in *Bulletin Amades*, no 50, May 2002. http://amades.revues.org/index900.html.

Fassin, Didier. "L'anthropologue et l'humanitaire," in *Humanitaire*, no 4, 2007, pp 75–80.

Frison, Xavier. "Terrain mouvant," in *Politis*, May 2007. http://www.politis.fr/Terrain-mouvant,1181.html.

Fritz Institute. *Surviving the Pakistan Earthquake: Perceptions of the Affected One Year Later*, 2006. http://www.fritzinstitute.org/PDFs/findings/PakistanEarthquake_Perceptions.pdf.

Fritz Institute. *Recovering from the Java Earthquake: Perceptions of the Affected*, 2007. http://www.fritzinstitute.org/PDFs/findings/JavaEarthquake_Perceptions.pdf.

Fritz Institute. *The Immediate Response to the Java Tsunami: Perceptions of the Affected*, 2007. http://www.fritzinstitute.org/PDFs/findings/Javatsunami_Perceptions.pdf.

Gbétoho Sokpoh, Bonaventure, Levy-Simancas, Karla, and de Geoffroy, Véronique. "Est de la RDC, Participation des populations affectées et des organisations locales dans la sécurité humanitaire," in *Humanitaires en guerre : Sécurité des travailleurs humanitaires en mission en RDC et au Burundi*, Brussels: Complete Editions, 2004, pp 149–168.

Glaser, Max P. "Engaging with Non-State Armed Groups in the Context of the 'Global War on Terror': Observations from Lebanon and Gaza," *Humanitarian Exchange Magazine*, no 37, March 2007. http://www.odihpn.org/report.asp?id=2875.

Goemaere, Eric and Ost, François. "L'action humanitaire: questions et enjeux," *La Revue Nouvelle*, November 1996, pp 76–96.

Grünewald, François, et al. *Bénéficiaires ou partenaires: Quels rôles pour les populations dans l'action humanitaire?*, Paris: Karthala, 2005.

Hansen, Greg. "Taking Sides of Saving Life, Existential Choices for the Humanitarian Entreprise in Iraq,

Humanitarian Agenda 2015, Iraq Country Study," in *Humanitarian Agenda 2015*, Medford: Feinstein International Center, 2007. https://wikis.uit.tufts.edu/confluence/display/FIC/Humanitarian+Agenda+2015+--+Iraq+Country+Study.

Hazan, Pierre. "Les ONG au coeur de la polémique sur l'humanitaire, Entretien avec Rony Brauman et Hugo Slim," in *Libération*, December 2004.

Hoffman, Michiel and Delaunay, Sophie. *Afghanistan: A Return to Humanitarian Action. Special Report*. MSF-USA, 2010. http://www.doctorswithoutborders.org/publications/article.cfm?id=4311&cat=special-report.

Karl, Nawej. *Rapport interne de l'enquête sur l'image de l'organisation Médecins Sans Frontières (MSF) en République Démocratique du Congo (Kinshasa, Janvier 2000)*. Brussels: MSF–Belgium, 2000. (Internal Document).

Karpenko, Alla. *Strategy of Operational Communication (Haiti)*, Port au Prince: MSF-Holland, 2004. (Internal Document).

Koné, Mariatou and Moha, Mahama. *La crise alimentaire de 2005 au Niger dans la région de Madarounfa et ses effets sur la malnutrition infantile: approche socio-anthropologique*. Niamey: LASDEL (laboratoire d'études et recherches sur les dynamiques sociales et le développement local), 2006. http://www.lasdel.net/resulta1.php?id_article=78.

Lahou, Rachid. "L'humanitaire en Islam ou les principes du droit des pauvres," in *Humanitaire*, no 17, September 2007, pp 35–39.

Louchart, Aurélie and Yadan, Thomas. "L'empêcheur de tourner en rond, Interview de Rony Brauman." *Evene-Actualités Culturelles*, April 2008. http://www.evene.fr/celebre/actualite/interview-rony-brauman-msf-humanitaire-israel-shoah-1302.php.

MSF. *Darfour: des milliers de Soudanais fuient vers le Tchad (Communiqué de presse)*. February 2008. http://www.msf.fr/2008/02/13/347/darfour-des-milliers-de-soudanais-fuient-vers-le-tchad/.

MSF-France. *Territoires palestiniens: MSF s'insurge contre les propos tenus par M. Kouchner (Communiqué de presse)*. October 2008. http://www.msf.fr/2008/10/07/997/territoires-palestiniens-msf-sinsurge-contre-les-propos-tenus-par-m-kouchner.

MSF International. *My Sweet La Mancha*. Geneva: MSF International, 2005. (Internal Document).

MSF International. *What Relation to the "Aid System*?" Geneva: MSF International, 2007.

Médecins Sans Frontières International, *Typology of MSF Projects*. Geneva: MSF International, 2010. (Internal Document).

MSF-Switzerland. *MSF-CH, Annual Plan 2007*. Geneva: MSF-Switzerland, 2007. (Internal Document).

MSF-Switzerland. *Field Associative Debates*. Geneva: MSF-Switzerland, 2007. (Internal Document).

MSF-Switzerland. *Rapport d'activités 2009*. Geneva: MSF-Switzerland, 2010.

MSF-UK. *Islam and Humanitarian Action, Briefing Paper*. 2007. (Internal Document).

Murphy, Theo. "Civil Society and Islamic Aid in Iraq: Unseen Developments and Threats," *Humanitarian Exchange Magazine*, no 27, July 2004, pp 33–35.

Médecine traditionnelle africaine. Brazzaville: Organisation Mondiale de la Santé, Afro no 1, 1976.

Pelkmans, Mathijs. "The 'Transparency' of Christian Proselytizing in Kyrgyzstan," *Anthropological Quarterly*, vol 82, no 2, 2009, pp 423–445.

Pérouse de Montclos, Marc-Antoine., "De l'impartialité des humanitaires et de leur perception par les bénéficiaires: les enjeux politiques de l'aide internationale au Burundi," *Autrepart*, vol 38, no 3, 2006, p 39.

Pouligny, Béatrice. "Perception des missions civiles de paix par les populations locales," in *L'intervention civile: une chance pour la paix.* Paris: Assemblée Nationale, October 2001. http://www.irenees.net/es/fiches/analyse/fiche-analyse-746.html.

Pouligny, Béatrice. *Ils nous avaient promis la paix : Opérations de l'ONU et populations locales*. Paris: Les Presses de Sciences Po, 2004.

Powell, Colin. *Remarks to the National Foreign Policy Conference for Leaders of Nongovernmental Organizations*. The Avalon Project, Yale Law School, Loy Henderson Conference Room, Washington DC: US Department of State, October 2001. http://avalon.law.yale.edu/sept11/powell_brief31.asp.

Rambaud, Elsa, and Dobry, Michel. *La construction identitaire des médecins sans frontières*. Paris: Université Paris 1, Panthéon La Sorbonne, Département de Science Politique, 2005.

Rist, Gilbert. *Le développement: Histoire d'une croyance occidentale,* 3rd ed. Paris: Les Presses de Sciences Po, 2007.

Roy, Sébastien. "Communication opérationnelle au Rwanda." *Repères,* no 27, 1998.

Salignon, Pierre. "Guerre en Irak: les représentations humanitaires en question." *Humanitaire*, no 8, September 2003. http://www.medecinsdumonde.org/fr/content/download/3576/28962/file/Revue_Humanitaire_n8.pdf.

Sardan, Jean-Pierre Olivier de. *Anthropologie et Développement: Essai en socio-anthropologie du changement social*. Paris: Karthala, 1995.

Schloms, Michael. "Le dilemme inévitable de l'action humanitaire." *Cultures & Conflits*, no 60, December 2005, pp 85–102.

Sicoit, Pierre. *MSF dans les Grands Lacs: Une ONG est passée*. Paris: Fondation Médecins Sans Frontières, 1999.

Siméant, Johanna. "Entrer, rester en humanitaire. Des fondateurs de Médecins Sans Frontières aux membres actuels des ONG médicales françaises." *Revue française de science politique*, vol 51, no 1–2, 2001, pp 47–72.

Slim, Hugo. "Not Philanthropy But Rights: The Proper Politicization of Humanitarian Philosophy in War." *The International Journal of Human Rights*, vol 6, no 2, 2002.

Slim, Hugo. "Humanitarianism with Borders? NGOs, Belligerent Military Forces, and Humanitarian Action," in *International Council of Voluntary Agencies (ICVA) Conference on NGOs in a Changing World Order: Dilemmas and Challenges.* Geneva: International Council of Voluntary Agencies, February 2003. http://www.jha.ac/articles/a118.htm.

Slim, Hugo. *Marketing Humanitarian Space: Argument and Method in Humanitarian Persuasion*. Geneva: Centre de dialogue humanitaire, May 2003.

Slim, Hugo. "How We Look: Hostile Perceptions of Humanitarian Action," in *Conference on Humanitarian Coordination.* Geneva: Center for Humanitarian Dialogue, April 2004. http://www.hdcentre.org/files/How%20We%20Look.pdf.

Slim, Hugo. "With or Against? Humanitarian Agencies and Coalition Counter-Insurgency." *Refugee Survey Quarterly*, vol 23, no 4, December 2004, pp 34–47.

Slim, Hugo. "Post-Colonial Dilemmas, International NGOs, Government and Civil Society in War and Disaster," in *Dead Sea Spring Conference for Third Sector Research 10th Anniversary Conference of the Israel Center for Third Sector Research.* The Dead Sea: Ben Gurion University, March 2007.

Stoddard, Abby, Harmer, Adele, and DiDomenico, Victoria. *Providing Aid in Insecure Enviroments, 2009 Update: Trends in Violence Against Aid Workers and the Operational Response*. London: Overseas Development Institute, 2009. http://www.odi.org.uk/resources/download/3250.pdf.

Thürer, Daniel. “La pyramide de Dunant: réflexions sur ‘l’espace humanitaire,” in *Revue Internationale de la Croix Rouge*, vol 89, no 865, 2007, pp 47–62.

Vallaeys, Anne. *Médecins Sans Frontières: La biographie*. Paris: Fayard, 2004.

Wigger, Andreas. “Encountering Perceptions in Parts of the Muslim World and Their Impact on the ICRC’s Ability to be Effective,” in *International Review of the Red Cross (IRRC)*, vol 87, no 858, June 2005, pp 343–365.

Part II

Essays on the Perception of Humanitarian Action

Introduction

Caroline Abu-Sada

We asked several people to offer an external perspective on these questions of perception. These articles are personal contributions from practitioners and academics who are all connected to the humanitarian sector and have observed MSF up close or from afar. It should be noted that the opinions expressed in these articles only reflect the views of their authors.

The first contribution is from Bruno Jochum, general director at MSF-Switzerland, whose department carried out the research project. He looks back to the origins of the project and highlights some lessons that the field teams can learn from the research findings.

The remaining articles have been grouped into three sets.

The first, entitled "Humanitarian Action and MSF Viewed from Outside," includes contributions from external actors that shed light on the organization.

Abdul-Wahab Soumana and Jean de Dieu Fosso, both now doctoral students, participated as members of teams of students in two studies, one conducted in Niger and the other in Cameroon. Therefore, the opinions expressed in their contributions reflect both the more precise results of the surveys carried out in those two countries and the personal views of the authors about the research process and the organization.

Linda Ethangatta, director of the Social Sciences and Medicine Africa Network based in Nairobi, Kenya, has worked

with humanitarian organizations (though not MSF) for several years. She comments on the organization's activities from the viewpoint of a nutritionist and academic.

Li Anshan, a professor at Peking University who specializes in relations between Africa and China, offers a completely external perspective, which is partly personal and partly reflects an institutional consensus on Chinese international policy. This contribution demonstrates the importance of the words we use to define the terms of the debate and how crucial our analytical framework is when we are dealing with concepts.

The second set of articles addresses issues linked to the blurring of the distinction between humanitarian action and stabilization missions (peacekeeping missions, and political and military missions carried out in the name of humanitarian principles). This confusion, cleverly manipulated by some actors, threatens humanitarian action as advocated by MSF and the ICRC, for example.

In her contribution, Abby Stoddard, an academic and former program manager for Doctors of the World specializing in the area of security, analyses the impact of actions to fight "global insurgency"—represented at the local level by groups like Al Shabaab in Somalia or the Taliban in Afghanistan, and at the international level by organizations such as Al Qaeda—on humanitarian action.

Samir Elhawary, a researcher in the Overseas Development Institute's Humanitarian Policy Group, explains why the objectives and strategies of stabilization missions and humanitarian organizations will always be different. This difference explains why the perception gap between these two groups cannot and must not be reduced.

In his contribution, Paul Bouvier, a medical advisor to the

ICRC, describes why it is in the interest of political and military actors to allow the confusion between their interventions and medical humanitarian action to persist.

The third set of contributions looks at questions that remained unresolved in the research process and solutions that other organizations have already implemented.

In his article, Jérôme Amir Singh, a bioethicist and member of MSF's Ethics Committee, points out that medical intervention that takes place in a variety of contexts, like that of MSF, has an impact on the quality standards of medical care as well as on national public health systems. An organization like MSF must be aware of this type of impact and bear it in mind in its analysis of each situation.

Ronald Ofteringer, a political advisor to the ICRC, shows that the Geneva institution quickly became aware of these issues of perception and proactively tried to reduce the gap, where necessary, by implementing high-quality operations.

This set of external contributions ends with a paper by Antonio Donini, who led the first ever large-scale research project into the perceptions held by the beneficiaries of humanitarian action for Tufts University in Boston. He explains the extent to which the discourse of Western NGOs is a discourse of power and stresses that it must give way to other forms of universality if we want this humanitarian action to really help the populations it is intended to assist.

Perception Project

A Remedy Against Complacency

Bruno Jochum

Like any other actor, humanitarian organizations and aid workers are entangled in a web of multiple perceptions in the societies in which they work, and as participants they influence those societies through their activities, behavior, and discourse. The dynamics of how perceptions fuel social interaction are as old as human societies. What seems more recent is the way everyone today finds a social utility in requalifying their actions as "humanitarian," from the local charity active at every street corner to army special operations units, not to mention the myriad multi-mandate NGOs promoting social transformation through civil society, elections, and gender equality. Such rhetoric has an effect that is eagerly sought after: it tends to create a "narrative" by which various national, religious, philosophical, or economic interests are presented as helping "humanity" at immediate risk. On the other hand, it's important to remember that the re-labeling of intentions as "humanitarian" has a long history, and similar practices actually predate the signing of the first Geneva Convention in the nineteenth century.

So if perceptions are always a given and seemingly out of control, why did MSF choose to launch a specific project on them in 2007, selecting field programs to carry out a series of perception studies? And how did the results influence our decision-making?

In 2004, MSF decided to leave Iraq after the bombings of the UN and ICRC in Baghdad. In 2005, five MSF staff members were murdered in Afghanistan and the organization departed. Strategists from both the US administration and Al Qaeda were theorizing that no neutral space was left in the conflict, and that the only choice for all other actors was to be with them or against them. The possibility for medical facilities to be a respected "sanctuary" in conflicts seemed to be behind us. A majority of NGOs either left or deliberately aligned themselves with a side in this sweeping politicization of aid. "Adapt or become irrelevant" was the motto.

Almost at the same time, the International Criminal Court began its first investigations of politicians and military personnel in power. In Darfur, this development created such a backlash against aid workers that several organizations, including two MSF sections, were expelled in 2009.

Internally, MSF was also tackling questions about its modus operandi, forcing the organization towards greater introspection. Though this trend is widespread in the "aid community," MSF realized that some deeply entrenched habits were limiting its ability to build programs in tense settings: coordinators unconnected with the societies in which they were active; a sense of overconfidence in what MSF represented and what it meant to others; the frequent overlooking of key stakeholders in negotiations; and a tendency to require others to adapt themselves to us rather than the opposite.

To be blunt, aid workers saw themselves in positions of power and MSF was contributing to this trend.

It is not academic interest that triggered MSF-OCG's[1] initiative on perception. It is both a sense of vulnerability and the realization that a fundamental characteristic of humanitarian work, the attention to others, had progressively disappeared from the general modus operandi of the international aid community. A certain form of unilateral power was being exercized in host communities. On the one hand, big donors had succeeded, slowly but surely, in building an aid system based on a cascade of contracts and subcontracts, with funds being directed toward the achievement of general political and military goals. Of equal concern was the fact that a majority of NGOs were choosing to assist powers through the provision of essential packages to populations, rather than prioritize the effective delivery of humanitarian assistance to vulnerable people. At a time when Western powers are actively engaged in most conflicts around the world, either through the "war on terror" (Afghanistan, Pakistan, Iraq, Yemen, Somalia, Philippines) or by backing UN interventions (DRC, Sudan, Ivory Coast), this specific modus can only foster a critical wave of rejection of aid workers, sometimes through violence, more often through harsh intellectual criticism of "humanitarianism" or "aid" as a tool of dominance.

For an organization such as MSF, investigating perceptions in the field implies looking at ourselves in the mirror and questioning what we see. It implies moving away from the comfort zone to expose discrepancies between our own narrative and the realities expressed by external actors in the field. I can only recommend that others do the same.

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1 Operational Center Geneva

This series of studies was performed randomly, in totally different contexts, ranging from Guatemala to Iraq, and in completely different types of medical projects.

The first thing we learned is that most ordinary people have little or no idea of who we are and what we do. The range of misconceptions is amazingly broad: from MSF being a Chinese organization to a Muslim confessional charity to a subsidiary of Western states. Our operational choices are frequently misunderstood, especially when we offer medical care for a single pathology (malaria or surgery, for example) and not the wide scope of services expected. The list of miscommunications at a local level is long—too long. The internal language within humanitarian circles—often derived from military tradition or civil security—affects perceptions of our action. MSF jargon is full of such terms: "operations," "interventions," "missions . . . " maybe too bellicose a tone to speak about what is primarily a medical action in man-made or natural disaster zones.

National staff are perhaps even more important than international staff in shaping relations with the immediate environment. For example, the behavior of crowd controllers or of educated, upper-class management brought from the capital to a traditional social setting often has more effect than anticipated, and deserves close attention.

Almost everywhere, the quality of care provided to individual patients determines perception by populations, and is extremely well appreciated. The immediate effect we have on their acute health problems plays an immense role in the respect expressed towards MSF, in a context of aid where many promises are made but are often not kept.

Much more than the modus operandi itself (direct action or partnership, international or national staff, coordination),

the effectiveness of the assistance makes the difference. Using standard level drugs when most are sub-standard, taking care of severe medical cases when most offer only primary health, being present in case of emergencies, avoiding stock ruptures and interruptions of service due to absences, and following up with patients regularly until they are cured are all components that elicit immense respect for the organization that provides them.

The indicators used in the aid system and its multiple "logframes"[2] miss most of these qualitative aspects by focusing exclusively on the volume of the input or activity. But for HIV, it is not the number of patients initiated on ARVs that counts; it is how many are still alive and stabilized a few years later. And for health care in Afghanistan, it is not how many health posts or centers are open in the country (the theoretical coverage of health services) that counts, but whether they are effectively accessible and used by the population when they need care. People feel deceived if announcements are not followed by action, or if what is delivered does not reflect the budgets alotted.

Also, while MSF is often well-perceived by those benefitting from its projects, there is a worrying divide between those beneficiaries and the local administrative or intellectual elites. Of all findings, it is this one I find most serious in terms of consequences. In a growing number of societies, critics see humanitarian action as a costly, archaic form of unilateral charity, weakening national states or civil society actors. They are urging us to be more associated, to be part of a relationship of equals. They want to work with us, not necessarily under us. On one hand, the eagerness to build bridges and cooperate is encouraging, and should serve as a reminder that the "clash of civilizations" is far from being a social reality. But we are

2 Logical Framework

criticized because we are perceived as insufficiently inclusive, and failing to strengthen long-term capacities at a local level through greater transfer of knowledge and resources.

Some of these tensions are normal, as assisting neglected vulnerable populations for an immediate result can be seen as going against political priorities or diverting resources from longer-term national institutional objectives. Because international humanitarian assistance often reveals the limitations of local elites' capacity or willingness to act, it should never be taken for granted that such assistance will be welcomed. The damaged credibility of aid workers among local elites nevertheless has to be strategically and practically addressed by all organizations wishing to remain relevant in the coming years.

Whether by MSF or other organizations, the emphasis on perception at the beginning of the twenty-first century is no coincidence. It is definitely a reflection of something gone wrong in what is usually called the "aid system," and the need to confront it directly. It also reflects the legitimate aspiration of emerging states and civil societies to organize and mobilize to assist their populations in the best possible way. As a matter of fact, most states and societies are, increasingly, developing autonomous national/regional capacities to reduce reliance on international aid.

Unfortunately, while lamenting environmental constraints, too many aid organizations have forgotten the basics, and neglected the perceptions created by their own choices.

In the end, the lessons learned from these studies and other observations are shamefully obvious, but this in itself says a lot. They should inspire both a greater degree of humbleness in our relation with the environment and a greater sense of responsibility when it comes to delivering what we claim.

- Don't take for granted familiarity with the organization—it is actually the exception more than the rule, so explain your purpose constantly.
- Communicate with everyone who has leverage in the situation and keep the channels open—whoever it may be.
- Negotiate your program in a relationship of equals, and explain all decisions beforehand so they are understood and can be adapted if required.
- Act according to what you announce, whether in terms of goal, activities, or principles of action. *[Does it mean anything to be neutral if an NGO does not communicate with the belligerents of a conflict? To be humanitarian if this intention is secondary to overall political, military, or social transformation purposes? To be impartial if needs are only evaluated when they are on the right side and made compatible with an overall political frame?]*
- Regularly report achievements or difficulties with full transparency.
- In all circumstances, the relevance, quality, and impact of the assistance for individuals determines in a large part the respect for the teams and their security.

In practice, the perception project has reinforced for MSF the importance of prioritizing high-impact quality projects while encouraging improved networking, emphasizing negotiation with all actors, implementing proactive communication strategies toward societies in which we operate, better integrating national staff in key management and advisory positions, and creating training curricula for our coordinators. It has also reinforced our determination to avoid some of the most disturbing developments in the aid system over the past years: overconfidence in the value of what NGOs represent, becoming part of an organized coordination mechanism under

the authority of donors and poorly connected to local realities, subcontracting the security of teams to external companies which then control all contact with the environment, and subcontracting to local organizations without being able to manage the quality of assistance.

Last but not least, the perception project is little by little producing the change to internal culture we were looking for. Our field teams know that the ability to work in any situation is the result of negotiation, but also that respect for our action has to be earned. It cannot be gained from a display of the power that resources provide, nor from the repetition of principles as slogans.

Humanitarian Action and MSF Viewed From Outside

MSF-Switzerland in Southeast Niger

Abdul-Wahab Soumana

Southern countries seem to be the preferred base of a number of international institutions, NGOs, and projects and programs for both development and humanitarian action. Niger is no exception to this rule. There are a number of humanitarian organizations involved in Niger, including the Red Cross, the Red Crescent, and MSF divisions, to name just a few. This analysis will focus on MSF-Switzerland.

This analysis is based on our participation in two field studies that MSF-Switzerland organized in the region of Zinder. They were conducted in order to form an idea about how the actions of the organization are generally perceived. During these studies, we visited different intensive therapeutic feeding centers (ITFCs) and ambulatory therapeutic feeding centers (ATFCs) to talk with parents of malnourished infants. We also visited villages to interview residents and community leaders, as well as health centers to talk with public health workers.

It was in this context that we used the collected data to briefly analyze these two field surveys so as to bring to light some unexpected realities in the field, general findings, and the technical and scientific conduct of the studies.

But first, it is helpful to formulate a few questions to better perform our analysis:

- Is MSF well-known in Niger?
- If yes, in what way?

- Is MSF confused with other organizations operating in the same domain?
- How do people in southeast Niger view the actions of MSF-Switzerland?

MSF-Switzerland's Arrival in Niger

Any discussion of southeast Niger basically means the region of Zinder, populated mostly by the Haussa and Kanuri. MSF-Switzerland set up its operations in the middle of this region to treat malnutrition following the 2005 food crisis.

Name and Acronym of MSF

There is a high rate of illiteracy in the Zinder region and other regions of Niger, especially in rural areas. This directly impacts name recognition as well as MSF's objectives and material and financial resources. Thus, MSF-Switzerland is known by a variety of names that stem from its activities or "Haussian" phrases for malnutrition, such as "ain san horontiyère" or "ain tamôa."

The strong presence of many projects and programs means that illiterate people tend to rely on symbols (emblems, logos, colors, or vehicle brands) to recognize and distinguish between different institutions and organizations. But it's often difficult to differentiate similar symbols, leading to widespread confusion regarding the differences of national origins of NGOs. As a result, it is not easy to tell MSF-France from MSF-Switzerland, or the French Red Cross from the Spanish Red Cross. Despite this, "ain tamôa" (or MSF) distinguishes itself from other organizations through its interventions focusing, in particular, on malnutrition, with the establishment of AFTCs and ITFCs in many towns and villages in the MSF intervention zone.

MSF's Activities

In terms of perception, it should be mentioned that MSF-Switzerland's activities were beneficial on more than one level.

Reduction of Malnutrition

At first glance, it is necessary to clarify that these actions largely contributed to the reduction of malnutrition in the intervention zone. Besides malnutrition, the actions helped to care for many children who would have suffered or even died at home, as the parents did not know about or did not seek out health centers.

Interaction With Health Professionals

On another level, these actions were extremely beneficial, providing a true forum for interaction between the public and health specialists. The actions provided the chance to talk with mothers, grandmothers, and older sisters of children who had borne the pain of losing a young family member and who had paid a high price to a government that was almost insensitive and resigned toward its citizens at the time. In this same line of thought, MSF provided a relaxed framework, an escape valve for emotions, and a sense of hope for these disoriented, distraught parents who watched their children die just because they weren't able to find them enough food to survive.

An Awareness of the Seriousness of the Situation

During the crisis, the government denied the existence of any famine by playing a word game with itself, creating a dichotomy between words that are almost synonymous, such as "famine" and "food crisis." It was the actions of MSF that triggered a general awareness about the dangers of the food crisis in 2005–06 and the socioeconomic consequences of the newcomers to the Niger population.

MSF in Health and Socioeconomic Roles

Considering each perception, we see clearly that the actions of MSF have been a source of information and training regarding health issues but also an important source of employment, with significant impacts on the economy and society.

Perception: A Variable Concept

We know that the question of perception touches on issues of freedom and relativity, meaning that the actions of humanitarian organizations are not always appreciated for their real value, especially by the ruling class. Even though it doesn't openly admit it, the government sees these interventions as a type of bad publicity, a way of exposing its failures to a broader public.

A Questioned and Questionable Humanitarian Action

Since perceptions are by their very nature subjective, one can question the view of the beneficiaries. Three elements generally hold true at this level.

The first involves the circumstances of the intervention, namely the crisis periods, the difficulties involved, and the uncertainty. Or, to put it differently, why doesn't MSF get involved until the situation is on the brink? These men and women are unaware of the principles of humanitarianism. Still, they can only react the way they do when they benefit from actions that help their children. Here it would be interesting to reflect on how to help them understand the logic behind intervention practices by humanitarian organizations in general and MSF specifically.

The second element of assessment concerns the choice of beneficiaries. This element involves two levels: on the one hand, the fact that aid only essentially involves children and, on the other hand, the strict nature of the selection criteria and selection of children. This situation creates results that are both strange and upsetting. For example, some needy women suffering from hunger or extreme poverty are refused grain or sugar and milk because their children do not meet the requirements to be accepted in the MSF program. These women sometimes commit illegal and dangerous acts just to gain access. They might give the child too much tamarind juice or other products that induce diarrhea just to be admitted into an ITFC or ATFC. What needs to be done to face such an objectionable situation?

It is necessary to sensitize people who live in these areas, especially the most trusted and respected opinion leaders or those who are most feared in African society. Their acceptance is synonymous with the acceptance of the masses.

The third element is the importance of reflection on efficient mechanisms of follow-up evaluations of the organization's activities—for example, an impact study on a generation of children who have suffered from malnutrition and who have benefitted from the actions of MSF after a specific time period.

The Survey on Perception: Questions on Methodology

Moreover, it is important to discuss some evaluation elements related to the survey methods used to collect information in 2008. First of all, to have a true and well-informed perception of an action or a series of implemented actions, it would be more suitable to make a qualitative study based on discussions and guidelines for conversations that are less directives and more flexible options for the persons being interviewed. We

conducted a study based on a questionnaire that is too dense and long, which had a harmful effect on the efficiency of the collecting data. Regarding surveys, a questionnaire that takes more than one hour becomes annoying, especially for sick persons and their caretakers. For those conducting the survey, the length of the interview can affect their ability to record information, especially with a questionnaire that is not well suited to group interviews.

Conclusion

In any event, each organization is judged by its actions or how it organizes work and deals with realities in the field, depending on how one questions the beneficiaries, the agents, or the observers. That is why MSF must question all these actors, but also not neglect organizations with similar roles, such as the ICRC, so as to also understand their perception of MSF.

A Look at the Activities of Humanitarian Organizations and MSF

Akonolinga and Yaoundé, Cameroon

Jean de Dieu Fosso

Introduction

In its inception, humanitarian action was viewed as a specific necessity that would compromise a return to normalcy if not performed. It was considered to be absolutely essential for victims of natural disasters or epidemics and less important for those who had been spared by the catastrophe. All humanitarian organizations aimed to remain free, independent, and impartial. How these organizations are viewed today has changed, due to their complex connections to biopower, biopolitics, and biosociality, which extends their reach beyond troubled zones and their direct contacts. Within this research perspective, we conducted a survey with MSF in 2007 on the perception of humanitarian organizations in general and MSF in particular in Akonolinga, a town outside of Yaoundé, the capital of Cameroon. In 2008 we resumed this same study in Yaoundé, Cameroon, but added a few variables to the subject being explored. The reason MSF was present in these two locations was to provide care and assistance to people in Akonolinga suffering from a disease known as Buruli ulcer. Public hospitals in the area treating the disease were powerless under the scale of the outbreak and the damage it inflicts on the human body. The situation was so dire that some doctors

quickly diagnosed the disease as having metaphysical causes. The symptoms are generally not described in doctors' usual reading material—the disease is said to be neglected or forgotten by public health system authorities. In Yaoundé, the activities of MSF focus on HIV/AIDS. The survey was meant to gather data on the perception of humanitarian organizations deployed in Yaoundé, on MSF, and on the perception of AIDS.

Methodology

This research is part of a group of recent studies on perceptions in the humanitarian aid sector, and particularly on international development in general. With the two teams in Akonolinga and Yaoundé, MSF set up a shared system to collect data, which was then used by researchers in the field to compile information on events concerning each of the studies. The project required numerous training sessions to ensure that all researchers had a shared understanding of the elements involved. The use of a common framework helped to collect comparable information for each case setting. To conduct this study, we relied on a qualitative method based on group conversations or focus group discussions and in-depth, individual interviews. We analyzed the results according to themes.

The starting point of this study is centered on the concept of perception, which is widespread in social and cultural anthropology and is also used in the management of local policies of organizations. Admittedly, it was difficult for us to assume the attitude of an impartial observer in this study. We were sometimes faced with patients in agony, and all that we could do was to ask them if they regularly received their antiretroviral medicine from MSF personnel or an affiliated organization combating HIV/AIDS.

We became involved in this work, even though our contribution started after the initial planning phase and the development of the survey tools. We were present at meetings and field training and have performed an analysis of the compiled data. We were struck by the presence and influence of lobbying by management personnel from MSF in Cameroon.

Some Results

Humanitarian Aid Perceived as Western Domination

From a thematic analysis of the data, we see that survey respondents had much to say on the subject of image. Six respondents emphasized rather clearly that, in general, humanitarian aid is the "showcase" for Western domination of Africa, the symbol of poverty. However, what is also surprising is that respondents rated the West's superiority as being the most important goal for humanitarian organizations. This perceived goal was rated higher than impartiality, transparency, neutrality, and independence—all values cherished and espoused by humanitarian organizations. In the two contexts that were studied, the notion of dominance is hardly a pejorative connotation. In fact, it was shown that poor countries take full advantage of this international aid.

To adapt an expression of Arthur Rimbaud, everything takes place as if the poor were an "other," practically reduced to the state of animals, their destitution being viewed as something radical and unthinkable. This distancing through "exotic accentuation" of the other's suffering seems to be a mechanism that strongly resembles those used in other distress situations (Boltanski, 1993).

Survey participants have difficulty grasping the concepts of humanitarian aid and humanitarian organizations, both in the

capital of Yaoundé and in the countryside near Akonolinga. They associate it with a few things seen on television, or it is synonymous with the big cars that drive through the cities and countryside. In light of this, the effectiveness of MSF is only perceived by persons who by chance have had the opportunity to stay informed on the organization's activities. Yaoundé is a large city. Here MSF is almost lost among the multitude of other organizations, whereas Akonolinga has a smaller population, and other organizations such as Plan-Cameroun or Emicam are dwarfed by MSF. This situation means that the results from Akonolinga offer a better assessment of the organization.

One idea that plays an important role in this study comes from Norbert Elias and John Scotson. It involves the opposition between the "established" and the "outsiders" within an organization such as MSF. Within such an organization, actors or employees are not blocked by an objective factor such as qualification or salary. Rather, obstacles come from the fact that the "established" belong to this culture and to a well-defined ethnic group, whereas the "outsiders" only manage to penetrate this culture with difficulty and are portrayed negatively. The study's data shows that this practice exists within the organization in Yaoundé and must be eliminated. It creates a situation where one group, recruited through connections and privilege, dominates the other, and leads to many operational problems.

Influence of Context on Perception

In Akonolinga, sociocultural beliefs and practices strongly impact the actions of MSF in its effort to provide care to patients suffering from Buruli ulcer as well as HIV/AIDS. Traditional treatment is often the first step for persons suffering from these diseases. For Buruli ulcer, even though MSF pays

for the expensive surgical treatment, the fear of operations and concerns about scars and possible amputation influences patients' behavior. Patients often delay a medical examination as they are concerned about their appearance and are afraid of being ostracized. As a result, patients often go first to a county hospital located in the same premises as MSF, where treatment is expensive and a lack of infrastructure and trained professionals jeopardizes recovery.

Influence of MSF on the Public Health System

In this region, MSF is seen as a benefactor not only because of the care its doctors and nurses provide to victims of Buruli ulcer. Their service extends beyond this domain. Many activities contribute to the public perception of MSF: schooling for some sick children, distribution of food parcels, clothing for the neediest, small presents for patients. It turns out that MSF's role is much greater than we think. MSF's image in the public eye is all the more important because the organization came to solve a medical problem whose etiology the local residents ascribe to witchcraft. Thus, since MSF has been in Akonolinga, the organization's work has succeeded in demystifying how the disease is viewed. The government and the only school of medicine in Cameroon have already started to show interest in training young doctors to provide clinical care to patients suffering from Buruli ulcer.

The conclusions of the surveys conducted in Akonolinga and Yaoundé are rather important in this regard. Subsequently, in 2007 and 2008, MSF had the good sense to intervene in situations for illnesses that were not part of a public health problem, even if politically the contrary could be shown. Both the full support given to persons suffering from Buruli ulcer and the distribution of antiretrovirals to HIV/AIDS patients at a time when triple therapy was not yet available to most people

had a major impact. In fact, MSF was very well viewed by the people who were aware of the organization's actions, despite a few internal logistical problems.

A Transparent Organization?

In light of the analysis, it appears that the organization operates with transparency and that its annual reports are accessible to the public. MSF is credible to the people of Akonolinga and, to a lesser degree, to residents of Yaoundé due to its rigorous management of funds. For example, our survey revealed that everyone is familiar with the employee pay scale.

Bibliography

Berthier, Nicole. *Les Techniques d'Enquête en Sciences Sociales: Méthodes et Exercices Corrigés.* Paris: Armand Colin, 4th edition, 2010.

Boltanski, Luc, La "Souffrance à Distance," *Morale Humanitaire, Médias et Politique.* Paris: Métailié, 1993.

Boucher, Manuel, *Penser les Questions Sociales et Culturelles Contemporaines: Quels Enjeux pour l'Intervention Sociales?* Paris: L'Harmattan, 2010.

Carden, Fred, *Des Connaissances aux Politiques: Tirer le Meilleur Parti Possible de la Recherche en Développement.* Paris: L'Harmattan, 2009.

Elias, Norbert and Scotson, John, *The Established and the Outsiders: A Sociological Enquiry into Community Problems.* London: Frank Cass & Co., 1965.

Lerner, Melvin, *The Belief in a Just World: A Fundamental Delusion*. New York: Plenum, 1980.

Seca, Jean-Mari, *Les Représentations Sociales*. Paris: Armand Colin, 2nd edition, 2010.

Perceptions of MSF

Based on Experiences of an Emergency Relief Worker in the Field

Linda Ethangatta

Who Knows What and Who MSF Is at the Field Level?

Generally speaking, the majority of my professional colleagues in humanitarian work regard MSF's professional humanitarian service very positively. The reasons for MSF's renown among peers are many and sometimes depend on the section of MSF as well as the nature of actual program or project in a set area of service delivery (emergency response, nutrition, water, and sanitation, etc.). Overall, based on my more than 15 years of experience working in emergency, as well as experience in more sustainable country programs, I believe MSF should be congratulated. At the same time, it is important to raise several questions and concerns about the organization and about humanitarian work in general.

Is MSF Visible in the Project Area Where It Performs Its Interventions?

In terms of humanitarian interventions it is useful to know who does what and in which geographic area. This helps avoid overlap in service delivery and informs beneficiaries where they should go to receive services. MSF brings a high level of resources in health and related interventions. However, MSF has an unwillingness to present a national (or regional) visibility in areas where it provides service. By standards of national governments, MSF does not feature anywhere in the national arena when identifying partners in a majority of interventions.

However, to local partners and other players at the regional and subnational level, MSF is well known in the immediate geographical area of coverage. MSF is well known by partners as an agency of "endless potential to support the needy in a crisis." For example, MSF usually provides essential drugs kits at health units at the grassroots level, making it possible to meet the needs of the most vulnerable members of a community. Again, in the majority of developing countries, essential medical kits and surgical and lab equipment are hard to come by, and that is why MSF support is well appreciated. MSF is also respected for sharing protocols and technical guidelines, utilizing its technical know-how to develop and share up-to-date information. Partners on the ground appreciate this generosity and make use of these materials for training and technical updates.

It has never been clear to us professionals working at the grassroots level why MSF likes to keep such a low profile, especially among national leaders, when providing these noble services.

MSF as a Poor Communicator: More Communication and Social Marketing Are Required to Educate the Community on the Health Interventions Covered in Project Areas

Communication about projects at different levels can lead to better use of MSF services. MSF often seems none too keen to let partners or communities know why they choose to undertake a particular intervention. Perhaps MSF uses appropriate data analysis to select a particular country, region, or district for interventions. However, most partners on the ground in areas of operation just find MSF setting up an operation. This lack of communication has led to cases of overlap in services and some resentment. For example, there was a section of MSF setting up a feeding center in a remote geographic region which another NGO claimed to be their area of coverage. There had been no

communication at all from MSF even though the other NGO had a feeding center not far from where MSF chose to establish its center.

Does MSF Consider the Importance of Building Local Groups' Capacity in Anticipation of Handing Over a Project at the End of a Funding Period?

Partners on the ground observe that MSF sections do not always consider this aspect of all projects. As a professional colleague from another humanitarian agency, I have seen some projects abandoned with no continuation after the exit of MSF. The closing of centers that provide needed relief—leaving no continuity—is not positively received by professional teams or communities. It seems that at times there is no exit strategy for MSF. MSF could train local staff to continue after exit. This can be achieved through partnership with local actors. It could also be possible if temporary facilities are built within established centers instead of stand-alone buildings, especially for the non-emergency health conditions like kala azar and tuberculosis (TB). In some of these health interventions (TB, HIV/AIDS, kala azar) the host communities suffer for many years without assistance from the local administration. When MSF comes to support the community everyone is most grateful. It's tragic if MSF leaves without planning a proper exit strategy for a sustained approach that addresses the health condition in the future.

MSF often works in complex situations in which there is more than one partner on the ground. In these complex emergency situations MSF is seen as a champion because of its ability to provide most essentials (drugs, logistics, personnel, even airlifts for the critically injured). In these situations local staff are essential to help reduce the burden of work and fatigue. I have personally seen MSF international workers become "burnt out" because they work very long hours and

under tremendous stress. The question then is: “Is there no policy within MSF to train, coach, and mentor locals, who are in many ways already trained health personnel, to support the international staff?” This is one component of MSF work that I found unacceptable, especially in emergency situations.

Why Send Professionals Who Are Highly Skilled in One Area of Medical Work Into Remote Conditions Where a Broad Range of Health Needs Are Observed Among Many Patients?

Many MSF professionals present great skill in their area of specialization. Doctors are strictly doctors, so are the nurses. In some cases nurses come out into the rural areas straight from ICU experiences in Europe. These professionals are ill-prepared to work in remote villages with no electricity, and are also prone to infections like malaria. When presented with real medical crises, such as a patient suffering from acute malaria, the doctor is not even able to diagnose the condition. It is important to screen the appropriateness of skills a volunteer has and deploy them to the field only after a sound analysis of the role they can play in service delivery.

In similar—though indirect—situations I have observed a failure to meet minimum operational standards like those found in the “Sphere Guidelines.” In such cases MSF staff members who have no knowledge of a particular intervention are given the authority to take charge. Without a basic understanding of the phenomena, the correct application of protocols and guidelines is impossible. In one field situation, I witnessed an MSF section not following the criteria for admission into a therapeutic feeding program for the severely malnourished children. This led to a situation where mothers with very sick and severely malnourished children were made to stay at home and access the service as outpatients. This is why I am saying

that MSF did not ensure that properly skilled staff members were matched to this intervention.

The perception from others is that sometimes the guidelines are not observed because the MSF section wants to be seen in the context of numbers of people reached or geographic area covered. This means spreading interventions too thinly to have a sustainable impact. This has been interpreted by partners on the ground as a "political" attempt by MSF to be perceived as an agency that is able to reach a large number of people and to be seen as a leader among humanitarian agencies.

Why Does MSF Perpetually Rely on Short-Term Field Staff?

It is common knowledge in the field that MSF has an extremely high staff turnover. This is unfortunate both for professionals and the organization. A staff working for only three months has very little time to learn and apply knowledge. This is critical, especially in the context of doctors or experts who may leave a project just at the point that they have begun to understand the medical problem they are handling. It may be useful for MSF to review this policy and identify a better approach to personnel management.

A Sign of Courage

For many years I regarded MSF sections as very courageous. MSF was quick to get very close to combat zones to treat the injured. I saw this firsthand in southern Sudan. MSF sections were able to operate in the most remote areas and in so doing were really appreciated by all, especially the agencies who had limited logistical support. As years went by and MSF became targets in conflict zones, it became evident that MSF was just as vulnerable as other agencies and therefore needs to exercise caution to protect staff.

China-Africa Medical Cooperation

Another Form of Humanitarian Aid

Li Anshan

China has its own way of thinking and acting regarding aid and cooperation in Africa. Like MSF, China has provided humanitarian assistance to Africa for a long time. However, China's medical cooperation with Africa covers a broad range of services, rather than focusing only on the provision of emergency medical aid.

The medical cooperation between China and Africa started in 1963 when the first Chinese medical team (CMT) was sent to Algeria. In the CMT system, a Chinese province is responsible for one or more African countries and provides CMTs there. At the beginning of 2009, 45 CMTs had worked in 44 African countries, and about 900 members are now working in about 100 hospitals or health centers. In addition to CMTs, the China-African cooperation also includes provisions for medication, facilities or hospitals, training of African medical specialists in China or Africa, humanitarian medical aid, peace keeping with medical care, and more. China also set up anti-malaria centers in African countries after the 2006 Summit.[1]

The China-Africa relationship is one between equals, which is quite unique considering that equality in international relations is often neglected, although the concept has been an aim in almost all the social movements in the history of any

1 China-African Summit, November 2006

country. China has never used the term "donor-recipient" (a philanthropic idea) to describe China-African relations, using "partner" instead. China believes that assistance is not unilateral, but mutual. Both China and Africa appreciate each other and cooperate with each other. The principles guiding China-African relations include equality and mutual respect, bilateralism and co-development, no-political-strings-attached and non-interference with domestic affairs, and stress on the capability of self-reliance.

China views Africa as a promising, rather than "hopeless," continent. Modern nation-building is a very difficult process for every country. With many assets such as human resources, natural resources, and cultural heritage, why should Africa be poor and hopeless? No-political-strings–attached and non-interference with domestic affairs is a particularly important principle for China. China and Africa have had similar colonial experiences, and China and many African countries both place great emphasis on national sovereignty. Regarding African issues, China always defers to United Nations (UN) and African Union positions. What's more, international affairs show clearly that external interference rarely settles problems and often worsens the situation.[2] China's assistance policy also put a stress on self-reliance, an experience from China's own development. With help from China, Sudan has gone from being a net oil importer to an oil exporter.

As far as medical cooperation is concerned, CMTs have contributed a great deal of service to Africans, improved health systems, and raised the standard of local medical service.

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2 "Where the West regularly changes its development advice, programs, and approach in Africa . . . China does not claim it knows what Africa must do to develop. China has argued that it was wrong to impose political and economic conditionality in exchange for aid, and that countries should be free to find their own pathway out of poverty. Mainstream economists in the West today are also questioning the value of many of the conditions imposed on aid over the past few decades." Deborah Brautigam, *Dragon's Gift, The real story of China in Africa, (*Oxford U.P., 2009), p 308.

To Serve Africans in the Chinese Way

To serve the people is the fundamental aim of public heath systems, which Chinese doctors try their best to contribute to. In Algeria, for example, in 45 years, CMT expanded its 16 treatment stations to 21 provinces and cities, covering more than 10 medical specialties, and this program became the biggest and most influential of all CMTs in Africa. The greatest advantage of CMTs is Chinese traditional medical treatment, especially acupuncture. The reputation of CMT has spread to neighboring countries as well. In Mali, where the climate and living conditions cause many cases of rheumatism, arthritis, and sciatic strain, acupuncture is the most effective cure for the cases. CMTs in Niger treated 57,330 patients—5,120 with acupuncture—and several ministers were treated by Chinese medicine and acupuncture as well. The same thing occurred in Tunisia, Cameroon, Benin, Serra Leone, Tanzania, Mozambique, etc.

To Improve the Local Medical System

In order to help improve local public health systems, China has cooperated with African countries in various ways, such as building hospitals and medical facilities, providing free medications, and transferring Chinese medical techniques. In the Republic of Congo, the hospital for gynecology and obstetrics was a small one in the 1960s. Now, it is the third biggest comprehensive hospital in Brazzaville, with 23 Chinese doctors who play a significant role in the hospital's work. The department or specialty of acupuncture has appeared in Tunisia, Cameroon, Lesotho, Namibia, and Madagascar. This cooperation has also promoted institutional innovation in African medical systems. The establishment of the Center of Acupuncture and department of acupuncture in Biserta Hospital in Tunisia is an example. Courses on acupuncture have started at universities

in various countries, such as Conakry University in Guinea, Universidade Eduardo Mondlane in Mozambique, and Madagascar State Public Health School, among others.

Helping to Raise Local Medical Standards

Chinese doctors have also tried to transfer medical techniques to local doctors. When Prime Minister Zhou Enlai visited Zanzibar in 1965, he told the CMT there, "the CMT would sooner or later return back home. We should train Zanzibar doctors and help them to work independently. Therefore to leave a medical team which would never go away. . . . Our assistance is to make the country able to stand up. Just like to build a bridge, so you can cross the river, and without a staff. That would be good."[3]

CMTs usually help local doctors by offering free lectures, training courses, and operation teaching. In Tanzania, in order to train local medical staff to learn acupuncture, CMT members used their own bodies for the local doctors to practice, directly teaching them to grasp the technique. In this way they trained a large number of medical specialists. CMTs also made the best use of local media to publicize medical knowledge. In Algeria, the CMT held more than 20 training courses, more than 30 lectures, and trained more than 300 personnel who have become the backbone of local medical institutions. Liberia suffered from war for a long time, resulting in many patients. CMT's service was noticed by David Shinn, the former US Ambassador to Ethiopia and Burkina Faso. He said, "China received praise in Liberia for its medical teams because they prioritize the transfer of knowledge and technology. They sent specialists and general practitioners, who upgraded and built

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3 Jiangsu Provincial Health Burea ed. *Glorious Footprint, In Memory of Fortieth Anniversary of Jiangsu Province to Dispatch Medical Team Abroad (*Nanjing: Jiangsu Science and Technology Press, 2004) p 3.

the professional skills of local heath workers. In the case of war-torn Liberia, this is a critical medical need."[4]

African governments awarded about 600 CMT members with various medals for their service to the humanitarian cause.

Fighting Malaria in Africa

China adopted several measures such as CMT training programs, anti-malaria projects, free facilities and drugs, and anti-malaria centers. Fighting malaria is a major task for CMTs, who usually distribute free medications to patients. Cotecxin, the most effective anti-malaria drug produced in China, and acupuncture have won a great reputation in Africa. In certain areas, life habits and the abuse of medication cause serious disease. In Mali, malaria is very common and people have to take Quinine for treatment and many people suffer from limb hemiplegia caused by overuse of Quinine. Chinese acupuncture experts cured cases by using silver needles. CMTs also compiled booklets for training of local medical workers.

China holds training programs at home and in Africa to provide anti-malaria training for African specialists and officials. In 2002, the Jiangsu Center for Verminosis Control and Prevention (JCVCP) was designated as a base for international assistance. Since then, the center has run six programs for African medical staff and officials, offering training to 169 officials and special technicians from 43 countries. In 2003, two anti-malaria programs ran in Madagascar, Kenya, and Cameroon to train medical staff from 35 African countries. In Moheli Island, Comoros, villages are seriously affected by malaria. In 2007, a joint project started between Moheli Island and Guangzhou University of Traditional Chinese Medicine (GUTCM) in China.

4 David H. Shinn, "Africa, China and Health Care," *Inside AISA*, no. 3 and 4 (October/December, 2006): p 15.

To combat malaria, drugs are of vital importance. When a delegation of senior African government officials visited a Shanghai-based pharmaceutical company in 2005, they called on Chinese companies to set up branches in Africa for medicine production. DihydroArtemisinin, or "Cotecxin," was first developed by Beijing Holley-Cotec in 1993. It was approved by the World Health Organization (WHO) as an effective anti-malaria drug. In 1996, China's Ministry of Health designated Cotecxin as the required medicine for CMTs. It is also chosen many times as aid materials to Africa, either by governments or pharmaceutical companies. Another important measure is the set-up of anti-malaria centers in Africa, a direct result of 2006 Summit.

There are obstacles in the bilateral cooperation, such as the lack of a comprehensive system of aid and the difficulty of selection of a CMT. What's more, with the effective use of Cotexin, the abuse of Chinese traditional medicine in Africa has appeared as a problem. On the African side, CMTs should be used more effectively. At present, CMTs mostly serve as practitioners doing simple service in remote regions where local doctors are unwilling to go. In some countries, CMTs are not recognized as doctors, so that they cannot serve at hospitals. Future medical cooperation needs a joint effort of China and Africa to find more effective methods, establish law enforcement and quality control systems to supervise the medical sector, and guarantee a healthy working condition for future cooperation.

Some Remarks on MSF

MSF as an organization, is doing a great job, and saving people's lives is a great cause. But it should not interfere with other countries' internal affairs since standards are different and the understanding of local things is usually different from outsiders. MSF has made great progress and

expanded all over the world. If MSF believes its own deeds are correct, then it should keep doing its work. But if MSF's purpose is to save people's lives in emergency situations, it should keep in mind that it should not meddle with others' business in a country it knows very little about.

The Chinese perspective on humanitarian action is not much different from MSF's. China regards humanitarian action as a great cause since it includes either releasing other people from their suffering, or curing their disease or saving their lives. It is a selfless deed and should be praised in whatever situation.

Humanitarian aid and development aid are both for the benefit of people. The difference is that humanitarian aid is delivered in emergency, for a temporary purpose, while development aid should be linked to strategic planning and a long-term goal.

Although MSF claims to be a humanitarian organization, and most of its deeds are related to that, it cannot change the fact that it is an organization initiated in a colonial master country and that its headquarters and most administrators are based in the West. Since the development stages are different and the values and cultures are different, MSF can't judge situations from its own point of view, which usually is that of the West or developed countries. MSF's working area is in most cases in developing countries that are very sensitive to their colonial heritage, especially the negative parts. If MSF meddles with others' internal business, no doubt it will make more trouble than it solves.

Many INGOs have a bad name in the South simply because they are so interested in meddling with others' affairs based on the presumption that they are the saviors. It's important to differentiate between help and interference.

Humanitarian Action and Stabilization Missions

Mirror, Mirror on the Wall

Stabilizers, Humanitarians, and Clashes of Perception

Samir Elhawary

Globalization and the greater interconnectedness between the North and South have created unprecedented opportunities for global governance and the expansion of capitalist development. Yet at the same time, globalization's darker side has meant that threats such as organized crime, terrorism, weapons proliferation, and pandemics do not respect geographical boundaries, and their spread is seen as a major risk to national and international stability. This has driven "stabilizers" to the fore of international politics: donor states are increasingly interested and engaged in the "borderlands" of the world system, those areas beyond the reach of liberal governance and capitalist development and characterized by weak governing structures, violent conflict, poverty, and crime (Duffield 2001). They are also known as "fragile states."

Through a range of military, humanitarian, diplomatic, and economic instruments, this engagement ultimately seeks to eliminate or contain these sources of instability. The stabilizers, however, go beyond narrow security objectives and claim to enable the political and social conditions necessary for recovery, reconstruction, development, and lasting peace. This is partly because achieving short-term security objectives is deemed to require longer-term transformation. As emphasized by the former United Kingdom defense minister Liam Fox, "the primary reason for sending our armed forces to Afghanistan was one of national security. . . . But clearly, if we are to make the long-term gains that will provide the stability to maintain

the momentum when our armed forces eventually hand over to the forces of the Afghans, we will require a long period of development in concert with the international authorities, the NGOs, and our and other countries' aid programs.[5]"

These stabilization efforts are by no means homogenous; they take different forms at different times, and can be governed by diverse sets of rules and executed through varied networks of alliances. Yet despite these differences, they are underpinned by the common objective of forging, securing, or supporting a particular political order that is deemed to protect or enhance national and international stability (Collinson, Elhawary, and Muggah 2010). These efforts, despite their emphasis on improving human security, have clashed with classical notions of the humanitarian endeavor and its commitment to unconditionally alleviate suffering and protect the lives of civilians without ulterior motives. This clash is partly one of perception: of the roles, means, principles, and objectives that guide each actor, and, where these conflict, perceptions of who represents the greater good, or, in the language of Snow White, "the fairest of them all." This brief article explores these clashes of perceptions.

Means and Ends

Humanitarian assistance is deemed to be an important part of the stabilizers' "toolbox." Delivering emergency health, education, water, and sanitation services is considered crucial to bolstering security (Pavanello and Darcy 2008), creating immediate benefits that serve to enhance the legitimacy of stabilizers and their allies and undermine support for rivals. This improved stability is then meant to create the space for

5 Cited in "Liam Fox Calls for Afghan Mission To Be Scaled Back," The *Guardian* May 23, 2010, http://www.guardian.co.uk/politics/2010/may/23/liam-fox-afghanistan-troops-withdrawal.

recovery and longer-term development. These theoretical assumptions underpin most stability efforts. NATO forces in Afghanistan have sought to weaken support for the Taliban through the delivery of humanitarian and development aid. The Pakistani military has used a similar strategy against Islamic militants. The Colombian government has used the same tactics to recover territory from guerrillas. The UN stabilization mission in DRC, MONUSCO, is employing humanitarian and development aid to help the government increase stability in the east of the country. The US government in Yemen has placed humanitarian assistance and livelihood support at the heart of its strategy to support the government and undermine Al Qaeda. The list goes on.

These trends have humanitarians worried. Stabilizers are accused of politicizing and securitizing humanitarian assistance, hitching it to wider goals that ultimately violate the boundaries and core principles that guide humanitarian action. Humanitarian engagement in conflict contexts, critics argue, is based on an implicit covenant with belligerents: in exchange for non-interference, that is, following the principles of neutrality, impartiality, and independence, belligerents allow humanitarians to operate and respond to needs (Leader 2000). This implies focusing on alleviating the immediate symptoms of crises or instability, rather than dealing with the causes. The use of humanitarian assistance as part of a stabilization strategy violates this covenant and places the work of humanitarians at risk. They are likely to be denied access to populations in need, and in the worst cases may even be subject to attack if belligerents associate them with a political project they oppose.

In sum, humanitarians reject the attempt by stabilizers to include them in their wars as it is perceived to politicize

them, while stabilizers perceive humanitarian assistance as an effective means to help stabilize societies.

The Greater Good

Tensions come to the fore when humanitarians insist on providing independent and impartial relief that is perceived to undermine the stabilizers' objectives. For example, in Somalia the delivery of assistance in militia-controlled areas was resented by donor state diplomats and the UN Political Office, which argued that the distribution of relief in these areas was enhancing the legitimacy of militia groups and providing them with sources of revenue. In the name of the "greater good" of strengthening the state, they called for assistance to be channeled through the Transitional Federal Government (TFG) (Menkhaus 2010). In fact, the UN special representative of the secretary general, Ahmedou Ould-Abdallah, saw the humanitarian response as being little more than a distraction from the wider tasks at hand, even going so far as to equate humanitarian neutrality with complicity (Menkhaus 2010).

Similar tensions are apparent in other stabilization contexts. In Colombia, when humanitarians raised protection concerns, the government labelled them "defenders of terrorism" and accused them of taking sides with the guerrillas (Elhawary 2010). Likewise, in Sri Lanka, efforts by humanitarians to work on both sides of the conflict have led to depictions of them as allied to "terrorist" groups (Goodhand 2010). Yet humanitarians reject the idea that these stabilization agendas represent a greater good; they argue that, despite being couched in the language of peace and stability, the stabilizers' objectives are part of highly political and contested projects. In Somalia, humanitarians claim that the TFG lacks the capacity and willingness to organize an effective humanitarian response, and that its predatory behavior is itself a major source of

civilian insecurity (Menkhaus 2010). Channeling assistance through the TFG would jeopardize humanitarian neutrality, fail to help those most in need, and ultimately make humanitarians more vulnerable to attack. Similarly, in Colombia and Sri Lanka, humanitarians argue that these stabilization efforts, despite often being labelled as "humanitarian operations," are primarily about protecting state interests, often to the detriment of the civilian population. In fact, the alliance between humanitarians and stabilizers is perceived by some as undermining the humanitarian imperative and its values, often sacrificing lives today in favor of promised (but not guaranteed) political gains tomorrow. As Jean-Hervé Bradol explains, the problem resides "in the allegiance of humanitarian actors to institutional political authorities who have the power to condone human sacrifice, to divide the governed between those who should live and those who are expendable . . . when humanitarian aid operations lose sight of their objective [saving as many lives as possible], they are not only ineffective for people in need, but they become embroiled in the production of political violence and exacerbate the human consequences they are supposed to relieve" (Bradol 2004, 21).

Who Is Fairest of All?

The root of the problem lies in the clash of interests between humanitarians and stabilizers. Stabilizers, while possibly admiring the solidarity and humanity of humanitarians, will still seek to oppose principled humanitarian action if it is deemed a hindrance to the pursuit of their objectives, and if they feel that they can benefit from a more politicized humanitarian response. Similarly, humanitarians, who may well share the stabilizers' desire to end violence and establish the conditions for a more stable society, will reject stabilization if they see it as securitizing and politicizing humanitarian action in a

way that hinders their ability to impartially alleviate suffering and save lives.

These tensions have been reinforced by developments within the humanitarian sector. The 1990s saw, along with the expansion of the humanitarian system, an extension of the boundaries of humanitarian action itself. In practice, if not in principle, many agencies have come to accept the need for a transformative agenda, and see humanitarian action as part of broader human rights, development, peace-building, and state-building (Barnett 2005). No longer content with dealing with the symptoms of crises, many humanitarians are now seeking to influence the causes and risks that shape vulnerability and suffering among populations. Consequently, they accept the political corollary that these actions imply. What has yet to emerge, however, is a coherent humanitarian paradigm that incorporates these different spheres of action. Humanitarian action is still largely defined in terms that exclude or even reject broader responses to humanitarian crises (Collinson, Elhawary and Muggah 2010).

This disconnect between discourse and practice reinforces the clashes of perception between humanitarians and stabilizers. Those humanitarians agencies, often dubbed "Wilsonians" after Woodrow Wilson's belief that societies can and should be structurally transformed so as to encourage progress (Stoddard 2003), still seem to cling to the notion that they are neutral, impartial, and independent, despite aligning themselves with stabilization projects. Therefore, either a coherent paradigm needs to emerge that brings together these different spheres of action, or greater attention needs to be paid to constructing a "humanitarian consensus" in which the boundaries of humanitarianism are more clearly defined (including the actors that constitute it) in opposition to stabilization (and

other) agendas (Donini 2010a). A continuation of the status quo is likely to increase confusion and misperceptions, not only among humanitarians and stabilizers, but perhaps among the communities and individuals they aim to help.

It is important to note, however, that a "humanitarian consensus" among Dunantist organisations (those that seek to position themselves outside of state interests by adhering to the principles of humanitarian action) is unlikely to be the answer on its own. Humanitarian action has always had to navigate treacherous political waters, and while the principles of humanitarian action are a guide to protect it from being manipulated by politics—"the rules for supping with the devil without getting eaten" (Leader 1998, 290)—they are not always foolproof. Even a strict adherence to principles does not alter the fact that humanitarians are a vector of values and modes of behavior that many of those in the borderlands find hostile and reject (Donini 2010b). There is also a lack of regulation within the humanitarian sector, with agencies collaborating or adhering to agreed practices only when there are clear incentives to do so. So while a "humanitarian consensus" may be agreed upon in theory, collective action problems persist in practice. Furthermore, attacks against humanitarians might not result from their politicization but rather from the benefits of demonstrating "the might of the attacker, the weakness of the victim, and the inability of the opposing force to prevent such attacks" (Hammond 2008, 290). In other words, whether stabilizers and their rivals respect principled humanitarian action is likely to be contingent on the perceived utility of humanitarian assistance in any given context. Principles cannot guarantee this.

This may partly explain the will of some agencies to align themselves with stabilization as a shortcut to enhancing their utility (at least to one actor in a conflict), attracting resources

and offering a means to transform the structural causes of vulnerability. Yet a note of caution is called for here: scratch the surface of the stabilization discourse and one finds not the happily-ever-after fairy-tale ending, but rather, as witnessed in countries such as Afghanistan, Somalia, and Iraq, projects that are failing to deliver what they promised. The lack of evident success, coupled with the sheer cost, waning domestic political support, and an environment of financial austerity, are likely to lead stabilizers to abandon the more ambitious and difficult task of "emancipating" the borderlands, and concentrate their efforts on narrower security objectives related to containing identified threats, with those "humanitarians" who are willing acting as one of many technologies of control.

Bibliography

Barnett, M. "Humanitarianism Transformed," *Perspectives on Politics,* vol. 3 (4), 2005.

Bradol, J. "The Sacrificial International Order and Humanitarian Action" in Weissman, F. (ed), *In the Shadow of 'Just Wars': Violence, Politics and Humanitarian Action.* Hurst and Company & MSF, London, 2004.

Collinson, S., S. Elhawary, and R. Muggah. "States of Fragility: stabilisation and its implications for humanitarian action," *Disasters*. vol. 34, supplement 3, 2010.

Donini, A. *Afghanistan: Humanitarianism Unravelled?* Briefing Paper. May. Feinstein International Center, Medford, MA, 2010a.

Donini, A. "The Far Side: The Meta Functions of Humanitarianism in a Globalized World," *Disasters* vol. 34, Supplement 2, 2010b.

Duffield, M. "Governing the Borderlands: Decoding the Power of Aid," *Disasters*. vol. 25 (4), 2001.

Elhawary, S. “Security for Whom? Stabilization and Civilian Protection in Colombia,” *Disasters*. vol. 34, supplement 3, 2010.

Goodhand, J. “Stabilizing a Victor’s Peace? Humanitarian Action and Reconstruction in Sri Lanka,” *Disasters*. vol. 34, supplement 3, 2010.

Hammond, L. “The Power of Holding Humanitarianism Hostage and the Myth of Protective Principles” Barnett, M and Weiss, T. G. (eds), *Humanitarianism in Question: Politics, Power, Ethics.* Cornell University Press, London, 2008.

Leader, N. “Proliferating Principles or How to Sup with the Devil without Getting Eaten,” *Disasters*. vol. 22, No. 4, 1998.

Leader, N. *The Politics of Principle: The Principles of Humanitarian Action in Practice.* HPG Report 2, ODI. London, 2000.

Menkhaus, K. “Stabilization and Humanitarian Access in a Collapsed State: the Somali case,” *Disasters*. vol. 34, supplement 3, 2010.

Pavanello, S. and J. Darcy *Improving the Provision of Basic Services for the Poor in Fragile Environments: International Literature Review Synthesis Paper.* Overseas Development Institute, London, 2008.

Stoddard, A. “Humanitarian NGOs: Challenges and Trends,” in Macrae, J and Harmer, A. (eds), *Humanitarian Action and the “Global War on Terror”: A Review of Trends and Issues.* HPG Report 14, Overseas Development Institute, London, 2003.

Collateral Damage

Internationalized Counterinsurgency and Its Toll on Humanitarian Action

Abby Stoddard

Introduction: Casualties of the New Proxy Wars

International humanitarian actors have reached the limits of their ability to secure themselves in the world's most violent places. Over the past decade, aid agencies have increased their security awareness and improved their risk management, aid workers are better trained, and more resources are available for operational security than ever before; yet the number of major attacks on aid operations has tripled. Unlike soldiers, none of the 242 aid workers who were killed, kidnapped, or seriously wounded in 2010 had the benefit of military training or force protection.[1] Most did not go to work with the explicit understanding that their mission was potentially fatal or that they were considered an enemy target. Nonetheless the statistics reveal that humanitarian aid has higher casualty rates most years than UN peacekeeping missions, and is among the deadliest of all civilian professions.[2]

Violence against aid workers is, of course, nothing new. In conflict, aid resources make for attractive and relatively easy spoils, and, for those seeking a global platform, killing or kidnapping foreigners has always been an effective means to shock their way into the world's attention. What does appear

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1 Statistics on violence against aid workers are drawn from the Aid Worker Security Database (www.aidworkersecurity.org), a project of Humanitarian Outcomes.

2 When compared to mortality rates for civilian professions as compiled by the US Bureau for Labor Statistics.

to be new, since researchers began tracking the incident data, is the dramatic rise and the simultaneous concentration of the attacks in a small number of conflict settings. Three quarters of all attacks on aid workers since 2006 took place in just five countries: Afghanistan, Sudan, Somalia, Pakistan, and Chad,[3] with the steepest increases seen in Afghanistan and Pakistan. In addition, the attacks have been increasingly sophisticated and lethal, making use of heavy explosives, improved explosive devises (IEDs), and suicide bombing tactics previously unseen in attacks on aid workers. (Stoddard, Harmer, and DiDomenico 2009).

In some of these conflicts humanitarian action has become a proxy target for national insurgent movements—and for their international jihadist supporters engaged in asymmetric warfare against the US and the West. These "internationalized insurgencies" face correspondingly internationalized counterinsurgency campaigns in which the US and its allies support the national governments through military and/or political means. Gaining and maintaining secure access in these environments presents the most difficult challenge humanitarian actors have ever faced, and their task is made considerably harder by counterinsurgency tactics that employ the provision of aid—and at times the blocking of it—to achieve military ends.

This article looks at counterinsurgency doctrine as the tactical expression of the global stabilization strategy pursued by the United States and its allies, and the fundamental challenge it poses to neutral humanitarian action in these conflict settings. The undeniably Western origins and orientation of the international humanitarian endeavor exacerbate this challenge, and addressing this inherent weakness may hold one key to increasing secure access for neutral humanitarian action.

3 Iraq had earlier seen a similar escalation in aid worker attacks, but the widespread reduction of the international aid presence after the bombing of the UN and ICRC in 2003 naturally brought down the casualty figures.

Major Attacks on Aid Workers: Summary Statistics, 2000–2010											
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of incidents	42	29	46	63	63	75	106	119	165	138	129
Total aid worker victims	91	90	85	143	125	172	239	208	278	278	242
Total killed	57	27	38	87	56	54	86	78	127	101	69
Total injured	23	20	23	49	46	95	87	84	91	85	86
Total kidnapped*	11	43	24	7	23	23	66	46	60	92	87
International victims	21	28	17	27	24	16	26	35	51	73	38
National victims	70	62	68	116	101	156	213	173	227	205	204
UN staff	31	28	18	31	11	28	61	39	65	101	44
International NGO staff	45	48	54	69	69	111	109	121	157	113	143
LNGO and RCS staff**	5	2	5	35	43	28	55	34	46	54	45
ICRC staff	9	11	7	8	1	3	10	4	5	9	10

**Live release or escape (kidnappings where victims were killed are counted in the 'Killed' totals)*

***Local (host country) nongovernmental organizations and National Red Cross/Red Crescent Societies*

Post-Statist Warfare and Counterinsurgency Doctrine

As the sole remaining superpower, the United States maintains "overwhelming superiority" in conventional military power over other nation-states. However it is confronted in various parts of the non-Western world by what has been described as a "globalized insurgency," comprised of two distinct but interlinked levels (Kilcullen 2009, p xiv). At the local/national level there are religious fundamentalist and traditionalist movements such as the Taliban in Afghanistan and Al-Shabaab in Somalia, which reject the authority of weak and corrupt central governments, and seek to fend off what they see as the encroachment of modernization, threatening their cultural norms. At the international level are the international jihadists, notably Al Qaeda, that have aspirations for a global upheaval culminating in a new world Islamic order. With varying degrees of infiltration and control, the international movement finances, supports, and colludes with the

local insurgencies to seize power in their countries and in so doing to challenge the hegemony of the United States and the West.

To meet this and other non-state threats (such as transnational organized crime), the United States government and its allies have engaged in a global campaign described in broad political terms as "stabilization" (Collinson, Elhawary, and Muggah 2010). More of a general approach than a specific strategy, the concept of stabilization is the attempt by the hegemonic power to shore up fragile states in order to maintain the world order and status quo of power relations. In the current theaters of the "global war on terror" (Afghanistan, Pakistan, and Iraq) and the secondary areas of concern (Somalia), the stabilization effort is reflected in the practical application of counterinsurgency strategy.

Counterinsurgency doctrine (COIN, in US military parlance) is a highly complex operational model borrowing lessons from the past centuries' imperial and colonial powers, and using unconventional means to pursue strategic ends. The primary focus of COIN is not on enemy forces (who can easily disperse, go underground and regroup later) but on local populations. Using a "hearts and minds" approach, COIN endeavors to protect and provide assistance and good governance to communities that will then, it is reasoned, have a stronger incentive to reject the insurgents, and even help to root them out and fight them off.

> At its core, COIN is a struggle for the population's support. The protection, welfare, and support of the people are vital to success. . . . Political, social, and economic programs are usually more valuable than conventional military operations in addressing the root causes of conflict and undermining an insurgency.

> COIN participants come from many backgrounds. They may include military personnel, diplomats, police, politicians, *humanitarian aid workers*, contractors, and local leaders (United States 2006) (Emphasis added).

In other words, in counterinsurgency doctrine the provision of aid is not merely supportive of the military strategy, but central to it. This would seem to negate the concept of separate "humanitarian space" and leave very little room for classical neutral humanitarian action. This would be the case even if the military and the independent aid agencies worked in strictly separate spheres of aid. For instance, even if the Provincial Reconstruction Teams in Afghanistan and their for-profit contractors focused only on longer-term rehabilitation and reconstruction assistance while the "traditional" humanitarians stuck to critical relief aid, the insurgent forces have little incentive to make the distinction. Within these scenarios, the insurgents' goal, naturally, is to effect the opposite of stabilization, in a protracted and indirect campaign: "The insurgent wins by avoiding defeat, creating disorder, maintaining a force-in-being challenged the government's monopoly of authority, and preventing the population from cooperating with the government" (Kilcullen, 2009). By attacking the agents of stabilization they are striking a blow against the government and the international forces. If aid becomes a military activity then aid providers become a legitimate military target. And in truth, the lines between humanitarian, reconstruction, development assistance are rarely brightly drawn. Most of the major humanitarian agencies undertake a broad range of programming, from humanitarian to development, and often concurrently in the same setting.

A corollary to the problem of co-option of aid for political and military objectives is where humanitarian assistance is

blocked from going into areas of insurgent control. Although the United States and coalition forces have no official boots on the ground in Somalia, these governments have achieved a de facto blocking of humanitarian assistance by defunding relief programs in Al-Shabaab-controlled areas of the south-central region. Ostensibly done for reasons of accountability and security (preventing diversions of aid by Al-Shabaab) the defunding has occurred not in conjunction with diversions, but rather in conjunction with increasing territorial gains by the insurgents.

It is arguable that this particular type of conflict context—i.e. the battlegrounds of "the global war on terror"—is fundamentally unfavorable for humanitarian action. Henry Dunant's vision of *inter-arma caritas* was conceived to apply in interstate conflicts, as an agreement between similar state parties and their comparably matched armies.[4] Never a simple endeavor to begin with, it surely becomes far more problematic in the borderless and asymmetrical conflicts of the post–Cold War, post-9/11 environments. However, similar doubts were expressed regarding the civil conflicts and violent state fragmentation that characterized the conflicts of the 1990s, and international humanitarian action did not cease. On the contrary, it strengthened significantly in numbers, capacity, and performance. Civilians still suffer and require assistance in these conflicts; the humanitarian imperative persists. The critical question for international humanitarianism is how to execute its mission effectively and securely in these environments.

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4 The greater part of the law of war codified in the Geneva Conventions applies only in international conflicts. Common Article 3 refers to internal conflicts, though not specifically insurgencies, and does stipulate humanitarian protections, including a role for "an impartial humanitarian body, such as the International Committee of the Red Cross" (Common Article 3, Geneva Conventions, 1949).

International humanitarian actors perceive themselves as engaged in a global endeavor, applying universal precepts. While it is true that helping people in need is a universal human value, it is also true that the international humanitarian system as it exists today is manifestly Western in its origins and composition. The "Western-ness" of international humanitarian action is more than just a question of perception: The six largest NGOs—accounting for roughly 60 percent of the NGO staffing presence and 40 percent of the operational expenditure[5]—are all based in Britain, France, or the United States. The next two largest tiers of NGOs, consisting of 23 organizations with overseas program budgets between $50 million and $250 million, are also (with just two exceptions) from North America and Western Europe. The same holds true for the 16 largest government donors, contributing over 90 percent of the official humanitarian contributions for emergencies: with the exception of Japan, it remains an all-Western club (Stoddard 2008). The contributions of the "non-traditional" or "non-OECD Development Assistance Committee" donor governments, while often among the first to arrive in the crisis contexts, are channeled predominantly in the form of bilateral, government-to-government assistance, and amount only to an estimated 12 percent of the total official aid (Harmer and Cotterrell, 2005). While some Gulf States and other non-Western countries are beginning to increase their contributions to the system, they still play a marginal donorship role in the organized system of donors and operational agencies. As far as the UN humanitarian agencies are concerned, they are inseparable, in the minds of many populations and belligerents, from the UN's political role—as shaped by its predominantly Western permanent Security Council members. Finally, the

5 Figures from 2008 (Harvey, Stoddard, Harmer, and Taylor, 2010).

quintessential humanitarian organization, the International Movement of the Red Cross and Red Crescent (notwithstanding the addition of the Crescent emblem) is fundamentally a Swiss invention within the context of a Western nation-state system.

If the international humanitarian community is loath to admit that it is Western on its face, then it is in even deeper denial about the Western roots of its core tenants. There exists, of course, a universal value of compassion and helping others in need. The basic notion of empathy and the will to relieve suffering of others is common to all religions and societies, but the concept of a neutral entity having a protected presence amid conflicts to provide aid to civilians is not. Such a concept is in fact inseparable from a Western, secular conception of the nation-state system. It makes less sense in a worldview that does not hold religion, the state, and civil society to be separate spheres.

For all these reasons it should come as no surprise that the international humanitarian community is seen in these contexts as fully of a piece with the Western political and military agenda the insurgents are battling against. The humanitarian principles as expressed as a set of universal values or ideology not only fail to persuade the non-state belligerents, they also don't always resonate with local actors and governments. Importantly, however, when practically applied as operational and negotiating tools, they seem to have continued usefulness for securing access for aid. A strong majority of respondents in a survey of national humanitarian aid workers in high-risk operational environments expressed the opinion that their security in the field was enhanced by their organizations' adherence to the humanitarian principles of impartiality, independence, and neutrality in programming (Egeland, Harmer, and Stoddard, Forthcoming).

This article does not attempt to assess whether or not COIN is effective in meeting its strategic objectives, nor does it express an opinion as to whether beneficiaries are better served by traditional humanitarian providers rather than in the framework of a military hearts and minds campaign. It has instead sought to illustrate (broadly and in brief) how and why traditional humanitarian action has become increasingly endangered in modern-day contexts of internationalized insurgency/counterinsurgency.

So what are the options for humanitarian actors seeking to remain operational in these environments? Antonio Donini and MSF's Michiel Hoffman among others have urged a back-to-basics Dunantist humanitarian approach. This entails unequivocal separation and independence from military and political actors, and a pared down focus on only core humanitarian activities as opposed to development and stabilization-oriented programs (Donini 2010; Hoffman 2010). A recent study on high-risk humanitarian operations found certain evidence in field practice that supports this proposition. Most notably, that the ICRC, and increasingly MSF, have been able to operate more openly in more places than any other international humanitarian actor. This has been accomplished by making major institutional investments in its capacity to reach out to and negotiate with belligerents on all sides, and focusing on their core missions. Currently, other international NGOs lack comparable capacity for humanitarian negotiation, but to a lesser extent, some have also been able to gain and maintain secure access high risk in limited local settings. At least for these actors, more important than the type of programming undertaken seems to be the following four factors: 1) a demonstrated track record of programming benefitting the population; 2) localizing their programming by recruiting all staff directly from the community where programs are run; 3) deem-

phasizing their international brand (i.e., Western) identity both to avoid attracting unwanted attention and to enhance local acceptance; and 4) communicating actively and consistently with all relevant interlocutors among the community and parties to the conflict—stressing transparency with all, allegiance with none (Egeland, Harmer, and Stoddard, Forthcoming). Moreover, the more local the insurgents and the greater the hold they have over the territory in question, often the easier it is for humanitarian actors to negotiate safe access. Local insurgents tend to be less ideological and more practically oriented than their global jihadist supporters, realizing that once they gain ground they must adopt their own version of a hearts-and-minds strategy to build their legitimacy and retain the sympathy of the local population. They are thus more amenable to negotiating with traditional humanitarian providers, if they are convinced of their independence from the foreign forces, in order to be seen as allowing the provision of aid to the community.

Reemphasizing humanitarians' impartiality and independence from political actors is right and necessary in these environments. However, "back to basics" must not be construed as remaining within the Western box that negatively defines international humanitarian action to much of the non-Western world. International organisations should strive instead to think beyond the boundaries of their traditional institutional culture and to reinterpret the humanitarian imperative more effectively for local audiences. This could include active efforts to diversify the international base of donors and implementing agencies, and to strategically devolve more operational capacity and responsibility for humanitarian action to local actors—as opposed to simply transferring the risk.

Bibliography

Collinson, S. E. *States of fragility: Stabilisation and its implications for humanitarian action.* London: ODI, 2010.

Common Article 3, Geneva Conventions. *Diplomatic Conference for the Establishment of International Conventions for the Protection of Victims of War.* Geneva, 1949.

Donini, A. *Afghanistan: Humanitarianism Unraveled?* Boston: Feinstein International Center, Tufts University, 2010.

Egeland, J., Harmer, A., and Stoddard, A. Report of the study on Operating in Complex Security Environments, forthcoming.

Harmer, A., & Cotterrell, L. *Diversity in donorship: The changing landscape of official humanitarian aid.* London: ODI, 2005.

Harvey, P., Stoddard, A., Harmer, A., & Taylor, G. *The State of the Humanitarian System: Assessing Performance and Progress - A pilot study.* London: ALNAP/Overseas Development Institute, 2010.

Hoffman, M. and Delaunay, S., *Afghanistan: A return to humanitarian action*. *MSF Special Report,* 2010.

Human Rights Watch. *Lessons in Terror: Attacks on Education in Afghanistan.* New York: HRW, 2006.

Kilcullen, D. *The Accidental Guerilla: Fighting Small Wars in the Midst of a Big One.* Oxford: Oxford University Press, 2009.

Stoddard, A. *International Humanitarian Financing: A review and comparative assessment of instruments.* New York: Humanitarian Outcomes, 2008.

Stoddard, A., Harmer, A., and DiDomenico, V. *Providing Aid in Insecure Enviroments, 2009 Update: Trends in Violence Against Aid Workers and the Operational Response.* London: Overseas Development Institute, 2009.

United States. *Counter Insurgency (COIN Manual).* Washington DC: Headquarters, Department of the Army, 2006.

Perception of Humanitarian Medicine by Military and Political Stakeholders

Paul Bouvier[1]

Humanitarian Medicine and the Mirrors of Perception

Compared with other human activities, humanitarian assistance enjoys a globally positive perception in our contemporary world. By contrast, military, political, or commercial activities may arouse rather negative perceptions. This may induce some stakeholders to associate with humanitarian assistance in order to globally improve their image and be perceived in a more positive light by local people. In armed conflicts, however, blending humanitarian aims with military, political, or commercial goals often leads to a blurring of objectives and a confusion of roles. This could in turn change the perception and acceptance of humanitarian action by potential beneficiaries and other stakeholders.

On the other hand, armed conflicts have catastrophic effects on the health of populations, and the provision of medical care to populations affected by armed conflicts responds to major health needs (Levy and Sidel, 2008). Furthermore, political authorities and military forces have a duty to provide medical care to the wounded and sick and to the affected populations.

1 The author is the senior medical adviser of the International Committee of the Red Cross (ICRC). The opinions expressed in this article are the author's alone and not necessarily those of the ICRC.

Based on some examples, this article will explore the risks associated with medical programs designed to influence perceptions, and the conditions which should be respected by stakeholders in the provision of medical assistance in armed conflicts.

Military Medical Operations for Populations Affected by Armed Conflicts

During the Vietnam War, the US military introduced a new kind of medical program inside the combat operation, the Medical Civic Action Programs (MEDCAP), defined as "the use of military medical personnel and resources to treat the native population." This program would become a significant operational activity, with about 40 million encounters between American military physicians and Vietnamese civilians, at a cost of $500–750 million, from 1963 to 1971 (Wilensky 2004).

The program was conceived as a way to improve perception by the population of South Vietnam, with the objectives "to enhance the prestige of the Government of Vietnam in the eyes of the people" and "to win the confidence, and gain the cooperation of the local population in areas where relatively large US military forces are employed" (Eisner 1966). In addition to the political goal to "win the hearts and minds of the people," (Wilensky 2004), there were tactical objectives as medical care could yield useful intelligence. However, it seems that the program didn't have significant public health impact, and questions are raised over whether it was lacking relevant and efficient approaches. Opportunistic, poorly planned, and isolated medical visits to remote villages could only provide, at best, transient relief of diseases and ailments, but couldn't have any significant lasting impact on the health of the population. However, the primary concern seems to have been perception by the population rather than community health impact. A doctor involved in the program wrote in 1966 that "MEDCAP,

to be effective, must be on a regularly scheduled basis. A single visit to a hamlet produces no lasting impression, but regularly scheduled sick call is a potent factor in demonstrating to the people that their government and their allies have a continuing interest in their welfare" (Eisner 1966). Obviously, for this practitioner, MEDCAP activities in Vietnam were about people's perception. Indeed, the medical care provided by "sick-call patrols" in remote villages was extremely limited and rudimentary. There is no evidence that capacities developed by US doctors transferred to South Vietnamese medical personnel; on the contrary, these programs may have emphasized the inability of the Republic of Vietnam to provide basic health care to its own people. The ethics of this practice were also questionable (Malsby 2008).

MEDCAP operations recently returned to activity in Iraq and Afghanistan. They started in a rather improvised way before integrating into a strategy aimed to "win hearts and minds." Whereas their impact on the health of the population remains unknown, military health authorities have been rather enthusiastic about their impact on the perception of the US military by the local population (Cascells 2009). In 2009 the approach developed into a new concept, the Medical Stability Operations (MSOs), which would build on the experience of MEDCAP in a more professional and effective way (Pueschel, 2009). Recognizing the limits of MEDCAP, the new strategy seeks to learn from this experience and to collaborate with humanitarian organizations (SOMA conference, 2009). In order to facilitate collaboration with humanitarian actors, the US military forces have created a guide covering its interaction with NGOs: "The guide shows how the military can work with NGOs that may not want to be perceived as being aligned with people in uniform on the ground" (US DoD, Jan. 2010).

A supplementary role is recognized for NGOs: "In many cases NGOs can operate in space Department of Defense (DoD) can't. They can move faster through customs, etc., and many NGOs have been in countries longer than DoD and have experience. NGOs prefer to maintain neutrality from the government, so there is an inherent friction between them and DoD. There are some NGOs that have former military members in them that are more amenable to working with DoD, and then a wide range of other international and local NGOs." (Pueschel 2010). Interestingly, while they recognize that NGOs can access vulnerable populations that military medical services couldn't reach, the authors fail to see that this access is only possible because these humanitarian NGOs remain absolutely neutral to the conflict and independent from governments and military forces. Even more worrying is the perception of humanitarian neutrality as a cause of tension between humanitarian actors and armed forces.

In May 2010, the US DoD announced a new policy which "elevates the importance of military health support in stability operations, called Medical Stability Operations (MSOs), to a DoD priority that is comparable with combat operations" (US DoD, May 2010).

Medical Assistance to War Wounded in Afghanistan

At about the same time, the ICRC published an operational update article about the medical assistance to war wounded persons in Kandahar. In this article, the ICRC reiterated that it provided basic first-aid training and dressing kits to arms carriers and to civilians living in conflict areas, and stated that in April it reached "over 70 members of the armed opposition" (ICRC May 2010). In fact, since 1987 the ICRC has provided medical assistance across Afghanistan, to care for conflict victims and to provide neutral, independent support to health

structures and staff across Afghanistan (ICRC 2009). Training first aid workers living in remote areas of conflict is part of this humanitarian assistance. These training sessions are also a unique opportunity to disseminate humanitarian principles.

The ICRC's operational update triggered critical reactions in international media, and the organization had subsequently to justify its action, explaining that "It's the core of its mandate to make sure that people are cured whether they are from one side or the other side" (the *Guardian*, the *Huffington Post*, *USA Today*, 2010). This episode revealed how fundamental humanitarian principles such as impartial care to wounded persons and medical neutrality could become a matter of controversy in international media—even when they were accepted by armed forces in the field. It also provided the ICRC with an opportunity to reaffirm the vital importance of respecting those humanitarian principles.

Perception of Humanitarian Principles in the Media and in the Field

In striking contrast with controversies in international media regarding the neutrality of medical action in conflicts, persons directly affected by armed conflicts and wars affirm the vital importance of these humanitarian principles.

This was recently demonstrated by a survey, published by the ICRC in June 2009, about the perception of humanitarian principles by people in countries in war (ICRC 2009). About 4,200 persons from eight countries affected by armed conflicts were interviewed, notably about their views regarding provision of health care to victims of conflict. Ninety-six percent of all participants agreed that "everyone wounded or sick during an armed conflict should have the right to health care." For 89 percent, "Health workers should treat wounded

and sick civilians from all sides of a conflict"; and 89 percent agreed that "Health workers must be protected when they are treating wounded or sick enemy combatants, especially when treating enemy civilians." For 89 percent, under no circumstances is it acceptable for combatants to target health workers in a situation of armed conflict, and 87 percent agreed that combatants should never target ambulances.

This important study demonstrates that, for the populations living in contexts of armed conflict, despite all the suffering and losses endured during war, the principles of humanity and impartiality and the respect of medical neutrality are essential.

Medical Assistance Must Have Strong Ethics

The devastating effects of armed conflicts on the health of populations and on their access to medical care represent major challenges to the political and military authorities. Medical care and public health programs should be provided in response to the health needs of the populations affected by the conflict and not driven by strategic goals.

In many contexts, political and military stakeholders face enormous difficulties in organizing services and providing medical care to vulnerable populations. Much can be learned from the experiences of the US military forces in Vietnam or in Afghanistan (Malsby 2008). The recent evolution from MEDCAP programs to an MSO policy could improve the efficacy and pertinence of these interventions.

In a different context, the activity of first-aid workers in Afghanistan working in very insecure and deprived conditions poses very difficult challenges. In these situations, as in any other context, the sole and unique purpose of health care assistance should be to respond to the needs of sick and wounded

persons. Health care must be impartial and medical neutrality must be respected by all parties at all times. Health personnel shall never engage in acts of war, and the provision of health care must always respect the principles of medical ethics (Sidel and Levy 2008). The insertion of political or military goals into medical or public health programs is not compatible with the fundamental principles of international humanitarian law.

Stakeholders should be extremely cautious when faced with the temptation to use any form of humanitarian assistance for the sake of their image or perception. Most importantly for them, populations affected by armed conflicts actually understand their own needs and recognize the importance of neutrality and impartiality in the provision of health care. It is comforting that, even when some media raise controversy on neutral and impartial humanitarian action, the affected populations demonstrate their commitment to ethical and humanitarian principles. They know by experience, with their blood and tears as much as with their hearts and their minds, that even in armed conflicts, respecting principles of humanity and ethics is a vital matter.

Bibliography

Casscells, W. "The Role of the US Military in Global Health," Center for Strategic and International Studies. http://www.health.mil/Content//docs/CSIS%20Transcript%20Jan%207%202009.pdf, Jan 7, 2009.

Eisner, DG. Medical Civic Action Programs (MEDCAP). USARV Medical Bulletin 1 (7), 27–28, 1966.

ICRC. "Afghanistan: ICRC Steps Up Efforts to Help the Sick and Wounded." http://www.icrc.org/web/eng/siteeng0.nsf/htmlall/afghanistan-update-250510, May 25, 2010.

ICRC. "Afghanistan: Assistance to the War-Wounded." http://www.icrc.org/web/eng/siteeng0.nsf/htmlall/afghanistan-feature-080409, April 8, 2009

ICRC. "Our World—Views from the Field: Summary Report: Afghanistan, Colombia, Democratic Republic of the Congo, Georgia, Haiti, Lebanon, Liberia, and the Philippines." IPSOS & ICRC, 2009. http://www.icrc.org/web/eng/siteeng0.nsf/htmlall/views-from-field-report-240609, June 24, 2009.

Levy and Sidel. *War and Public Health*. New York, Oxford University Press, 2nd ed., 2008.

Malsby, RF III. "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" Thesis, Faculty of the U.S. Army Command and General Staff College, Fort Leavenworth, Kansas, 2008.

Pueschel, M. "Developing Training for Health Stability Deployments." US Department of Defense. http://fhp.osd.mil/intlhealth/news.jsp?newsID=122, Nov. 2009.

Pueschel, M. "A Hit at SOMA: 'New Guide Aimed at Improving DoD-NGO Work in the Field'." http://fhp.osd.mil/intlhealth/news.jsp?newsID=130, Dec. 2009.

Sidel, VW. "The Roles and Ethical Dilemmas for Military Medical Care Workers." In Levy BS, Sidel VE. *War and Public Health*. New York, Oxford University Press, p 393, 2008.

SOMA Conference. "International Health Growing Theme at Special Ops Medical Conference." Tampa (FL) http://fhp.osd.mil/intlhealth/news.jsp?newsID=129, Dec. 2009

The *Guardian*. "Red Cross Gives Aid Lessons to Taliban." http://www.guardian.co.uk/world/2010/may/25/red-cross-first-aid-taliban?INTCMP=SRCH, May 25, 2010

The *Huffington Post*. "Red Cross Under Fire for Teaching First

Aid to Taliban." http://www.huffingtonpost.com/2010/05/26/red-cross-under-fire-for-_n_590577.html, May 25, 2010

US DoD. "New Guide Aimed at Improving DoD-NGO Work in the Field." http://fhp.osd.mil/intlhealth/news.jsp?newsID=130, Jan. 2010.

US DoD. "New DoD Policy Outlines Military Health Support in Global Stability Missions." http://www.health.mil/News_And_Multimedia/Releases/detail/10-05-24/New_DoD_Policy_Outlines_Military_Health_Support_in_Global_Stability_Missions.aspx, May 24, 2010

USA Today. "International Red Cross Defends Taliban First Aid Courses." http://www.usatoday.com/news/world/afghanistan/2010-05-26-red-cross-taliban-training_N.htm, May 26, 2010

Wilensky, RJ. *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*. Texas Tech University Press, 2004.

Other Questions Raised by the Issue of Perception

Humanitarian Medicine and Ethics

Jerome Amir Singh

Introduction

It has been argued that humanitarian medicine "goes beyond the usual therapeutic act and promotes, provides, teaches, supports, and delivers peoples' health as a human right, in conformity with the ethics of Hippocratic teaching, the principles of the World Health Organization, the Charter of the United Nations, the Universal Declaration of Human Rights, the Red Cross Conventions, and other covenants and practices that ensure the most humane and best possible level of care, without any discrimination or consideration of material gain."[1] Given the complex nature of this field, humanitarian medicine practitioners should be cognizant of some of the ethical issues they could encounter in this line of work. This paper explores some of these issues and attempts to provide guidance in relation thereto. In particular, it will focus on the ethical issues implicit in introducing a new standard of care in a humanitarian setting, as well as the dual loyalty obligations implicit in practicing and conducting research in humanitarian settings.

Introducing a New Standard of Care in Humanitarian Settings

Humanitarian medicine is often practiced in settings where the prevailing public health system is nonexistent, rudimentary, dysfunctional because of poor state policies and/or

1 Gunn SWA. The right to health of the burnt patient and fire victim. *Annals of Burns and Fire Disasters* Sept 2004; vol. XVII (3), http://www.medbc.com/annals/review/vol_17/num_3/text/vol17n3p117.htm

inadequate resource allocation, facing collapse, or has already collapsed (for example, as a result of a major natural disaster or sustained armed conflict). In such instances, the very presence of humanitarian organizations such as the International Committee of the Red Cross (ICRC) or MSF may render them the primary providers of health care services by default. Humanitarian medicine practitioners entering such settings may find that the best existing standard of care for a particular health condition is absent in that setting. This state of affairs could give rise to an ethical dilemma: Should humanitarian medicine practitioners introduce a new standard of care into a humanitarian setting if the existing local standard of care for the health condition at hand is "no treatment," if efficacious treatment exists elsewhere, and if it would not otherwise become available?

Not introducing the best existing standard of care in a setting that lacks it will mean that the health issue at hand will remain unaddressed, resulting in dire public health consequences for that setting, and, in some instances, the surrounding region. However, while introducing the relevant standard of care may, on the face of it, seem to be ethically obligatory, it may, in certain instances, yield more negative consequences overall. Humanitarian initiatives are often "parachute missions," entailing only a temporary provision of humanitarian services until the humanitarian emergency in question has been stemmed and the setting stabilized. When such stabilization occurs, the humanitarian service provider typically withdraws from the region, and their relevant provision of humanitarian aid, including medical services, ceases. In such instances, the introduction of the best existing standard of care, while laudable, may be unsustainable post-withdrawal, and, accordingly, not be in the interest of public health. For example, if treatment for HIV or TB is nonexistent in a particular human-

itarian setting, the introduction and subsequent cessation of treatment for such diseases because the humanitarian mission has ended could yield drug-resistant forms of those diseases, unless the country's authorities can continue to provide such treatment. If they are unable to, the costs of second-line treatment options for emerging drug-resistant strains of those diseases could prove prohibitively expensive for the country in question. Humanitarian medicine practitioners should thus carefully consider the implications of introducing new standards of care in settings where they envisage only a temporary presence. They should prospectively liaise with government authorities on the introduction of such care, and, where possible, negotiate the sustained provision of that care (with authorities and other humanitarian bodies, if applicable), after they withdraw from that setting.

The ethical principle of beneficence requires practitioners to assume an advocacy role by making reasonable attempts to change the prevailing poor state of health conditions in settings where they practice, if possible or necessary. However, humanitarian medicine practitioners should bear in mind the logistical challenges of doing so. For example, they may have to obtain regulatory approval for the introduction of a new standard of care/prevention (if relevant regulatory mechanisms even exist or are functional in the setting at hand), source preferential pricing for that care/prevention and secure associated sponsorship, train local health personnel to provide continuity of care by administer the newly introduced standard of care/prevention after the humanitarian mission ends, develop local laboratory capacity for surveillance of the condition at hand (if applicable), and establish effective infection control measures in relation to the health threat in question. These measures are time-consuming and could factor against the initiation of a new standard of care in some settings. Accord-

ingly, it is arguable whether humanitarian organizations should introduce an efficacious standard of care in a humanitarian setting for just the duration of their mission, unless they can secure an undertaking from local authorities that the latter will assume the responsibility of continuing that standard of care, once the humanitarian service provider withdraws from the country. Humanitarian medicine practitioners need to be cognizant that they do not have the power to compel authorities to approve or to implement an efficacious standard of care. However, this should not stop such practitioners from trying to do so. If they are unable to secure such undertakings from authorities (or other humanitarian service providers, if applicable), they may have to reconcile themselves to not initiating that new standard of care in the setting for the limited period they will operate there if doing so could have serious public health implications after they leave.

The Notion of a "Dual Loyalty" Obligation and Humanitarian Medicine

Health professionals, including clinicians and researchers, often have obligations to other parties besides their patients or research subjects—such as employers/sponsors and governments—that may conflict with undivided devotion to the patient or research participant. This competing interest can be characterized as a "dual loyalty." In 2003 the Dual Loyalty Working Group (DLWG), a multinational, multidisciplinary team of experts versed in law, bioethics, and human rights proposed a comprehensive set of guidelines on dual loyalty conflicts, entitled *Dual Loyalty and Human Rights in Professional Practice*.[2] Convened by Physicians for Human

2 Dual Loyal Working Group (2002). "Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Standards." (Boston: Physicians for Human Rights), http://physiciansforhumanrights.org/library/documents/reports/report-2002-duelloyalty.pdf.

Rights and the Health Sciences Faculty of the University of Cape Town, the DLWG defines a dual loyalty as a *clinical* role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party. Humanitarian medicine practitioners could conceivably encounter a dual loyalty dilemma in the context of practice, or even in the context of research. Each context merits brief exploration.

Dual Loyalty Dilemmas in the Context of Research in Humanitarian Settings

Humanitarian organizations sometimes find the need to conduct health systems research, operational research, or implementation research[3] in settings where they operate.[4] They may do this to better understand how they can improve their services, or to lobby apathetic or obstinate governments to change their existing treatment policies. In such instances, the conduct of research in humanitarian settings could give rise to challenging dual-loyalty dilemmas and conflicts of interest when the role of clinician and researcher combine. The toggling of clinician-researcher roles can create confusion for the research participant/patient as well as difficult conflict of interest dilemmas for the health professional concerned. For example, the physician's primary duty to care for the patient and put his or her interest first could be undermined by secondary factors such as the duty to further the ends of science or protect the study sponsor/their employer (for example, if

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3 Remme JHF, Adam T, Becerra-Posada F, D'Arcangues C, Devlin M, et al. (2010) "Defining Research to Improve Health Systems." PLoS Med 7(11): e1001000. doi:10.1371/journal.pmed.1001000. Accessible: http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1001000.

4 Schopper D, Upshur R, Matthys F, Singh JA, Bandewar SS, et al. (2009) Research Ethics Review in Humanitarian Contexts: "The Experience of the Independent Ethics Review Board of Médecins Sans Frontières." PLoS Med 6(7): e1000115. doi:10.1371/journal.pmed.1000115. Accessible: http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000115.

the research findings highlight improper or negligent practices on their part). There are differences in the ethical duties owed by a researcher and clinician. Research is usually conditional upon prospective third party review and approval while therapy typically isn't. Similarly, the roles of research scientist and clinical practitioner are also very different.[5] Morin, et al. describe the difference as follows: Investigators act to generate scientific knowledge that *may potentially* result in *future* therapeutic benefits. Practitioners are focused on *present* health and welfare of patients.

The distinction between research and treatment is particularly not clear to the patient-participant. Since subjects might misconceive the nature of a research project, particular attention must be paid when researchers offer some medical benefit that can be integrated easily into a course of treatment.[6] Although trial patient-participants may be offered a treatment of unproven efficacy, some may believe they are receiving "cutting edge" treatment guaranteed to improve their condition. Moreover, they might believe that the purpose of a study or clinical trial is to benefit them rather than just gather data for the purposes of contributing to scientific knowledge. This phenomenon has been termed "therapeutic misconception."[7] Morin, et al. note that this perception may be reinforced when subjects receive the same experimental treatment from the same clinician who has administered medical care to them in the past, in contrast to being referred to a clinical investigator located in an academic setting with

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5 Beauchamp TL and Childress JF. *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press; 1994): 441.

6 Morin K, et al. *Managing Conflicts of Interest in the Conduct of Clinical Trials. (JAMA* 2002); 287: 385–391.

7 Appelbaum PS, et al. False hope and best data. *Hastings Centre Report (*1987); 17: 20–24.

a reputation for conducting research.[8] In such instances the US National Bioethics Advisory Commission has advised that researchers make clear to research participants, in the initial consent process and throughout the study, which activities are elements of research and which are elements of clinical care.[9] They should also indicate in their research protocols how they would minimize the likelihood that potential participants may believe mistakenly that the purpose of the research is solely to administer treatment rather than to contribute to scientific knowledge.

Dual Loyalty Dilemmas in the Context of Practice in Humanitarian Settings

Humanitarian medicine practitioners may encounter irrational or unreasonable state policies (or even irrational or unreasonable internal policies of their own organization) in the course of their work. This could place them in a difficult ethical dilemma as, in the case of the state, exposing or attempting to stop such state practices could enrage local authorities and threaten the very presence of the humanitarian body in that setting. Conversely, failing to act or speak out against certain practices in the humanitarian setting could, in certain instances, have an impact on how the organization is perceived by local (or even international) stakeholders.

In its proposed *General Guidelines for Health Professional Practice,* the DLWG provides helpful guidance on how health professionals should handle dual loyalty obligations of the nature outlined above. The *Guidelines* are designed to address

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8 Katz J. "Human Experimentation and Human Rights." *St Louis Univ Law Journal* (1993); 329:573–576.

9 National Bioethics Advisory Commission. Ethical and Policy Issues in International Research: Clinical Trials in Developing Countries. Report and Recommendations of the National Bioethics Advisory Commission. vol. 1. (Bethesda, Maryland, April 2001). Accessible: http://bioethics.georgetown.edu/nbac/clinical/Vol1.pdf.

how the health professional can identify situations where subordination of patient interests to those of the state or other third party implicates human rights; clarify the responsibilities of the health professional in these situations; and enable the health professional to respond appropriately, especially where the health professional faces personal or professional risks by adhering to obligations to the patient.

According to the *Guidelines*, where the state has failed to take necessary steps to establish a health system that affords equitable access to health services, the health professional participating in that system has an obligation to press for alternative policies designed to change this state of affairs. Rather than adjust one's behavior to the constraints imposed by discrimination or the state's failure to develop a fair and equitable allocation of health resources, the health professional should act to change it.

Admittedly, such actions may not be possible or feasible in some humanitarian settings. In such instances, humanitarian organizations should prospectively plan how to manage such occurrences should they arise in the course of their humanitarian missions. Doing so could include prospectively establishing relevant stakeholder engagement mechanisms and communication strategies, if applicable.

Conclusion

The practice of humanitarian medicine can be a rewarding but daunting experience. Those involved in this field should carefully consider the ethical dimensions of their acts and omissions. They should also make a concerted effort to learn about the relevant instruments of international (and domestic, if applicable) human rights law, international humanitarian law, and refugee law, as these may be applicable to the settings

that they operate in. Doing so will help humanitarian medicine practitioners resolve some of the complex ethical challenges they may encounter in the course of their work, which will ultimately benefit their patients.

The Dialectics of Perception, Acceptance, and Meaningful Action

Ronald Ofteringer

The global humanitarian community—the "humanitarian enterprise," as the researchers of the Feinstein Center at NN University have put it—is facing an increasing perception crisis, that has at some points reached the level of outright rejection of humanitarians. Because of this, dialogue and interaction with civil society, authorities, armed groups and transnational networks are a cornerstone of the ICRC's principled action in the second decade of the 2000s.[1]

With these lines, I would like to present in broad lines the concept that the ICRC has put in place to meet the operational challenges and the general and specific perception issues the institution and its work for victims of armed conflict and organized violence is facing. I will situate in this framework the place and relevance of the ICRC's *dialogue* with all those engaged in, or in a position to influence, armed conflicts and other situations of violence, as a part of the operational practice of ICRC delegations, and as a means to safeguard, implement, and develop meaningful humanitarian action. This work is centered on understanding how relevant stakeholders in each context perceive the ICRC's action, approach, and identity, how these perceptions are evolving, how acceptance can be achieved by responding to the needs of the victims,

1 The views expressed in this article reflect the author's opinions and not necessarily those of the ICRC.

and ongoing dialogue, with the necessary level of security assurances. This continuous work is being complemented by perception studies and a constant monitoring of debates and issues, be it in the highly volatile contexts of today's armed conflicts, be it on the regional and global level.

The challenges for the ICRC, with its specific mandate to work for the protection and assistance to victims of armed conflict, are changes in the nature of armed conflict and other situations of armed violence, on the other consequences of transformations in international relations, technology, and mass communication—and in the humanitarian sector itself. These dynamics and challenges, and the way the ICRC, other humanitarian actors and local communities, states, non-state armed groups, and other stakeholders are dealing, have dealt with, or adapted to these changes, have shaped the perception of humanitarian action.

The situations of—predominantly non-international—armed conflict and other organized violence below the threshold of armed conflict are increasingly protracted, and the fragmentation and proliferation of armed groups and militias, at times trans-nationally connected, is an increasing challenge. This is the case in the Democratic Republic of Congo, where the ICRC interacts today with 40 different armed groups, but also in Somalia and Iraq.

The duration of conflicts over decades, such as the Israeli-Palestinian conflict, has increased and multiplied the suffering of affected populations, and created a complex setting of direct and indirect consequences, which require a profound analysis, and sophisticated and multidisciplinary responses.

The integration of humanitarian or reconstruction components into military strategies, doctrines, and practice, particu-

larly in counterinsurgency warfare, with the goal of "winning the hearts and minds" of the people, bear the risk that parties to conflicts and local communities associate all humanitarians with specific military and political objectives, be it in Afghanistan or in other contexts.

The emergence of a multi-polar world in which non-traditional regional and global powers exert a growing influence in international relations has considerable impact on the dynamics and constellations in a variety of conflicts, i.e., in South Asia, on constellations and alliances of the parties to these conflicts, on efforts to mediate and find solutions to these conflicts, and finally also on approaches to assist and protect the victims of these conflicts.

Issues of international politics and international relations that are beyond the realm of humanitarian work (or to which humanitarian work is just one among many other contributing factors), such as the crisis sparked by the publication of caricatures of the prophet Mohammed by a Danish newspaper in 2005, have a huge impact on the environment in which humanitarian action is taking place, and at times a direct impact on humanitarian action itself.

In addition to the aforementioned factors, the evolution of mass media and electronic means of communication, the emergence of new centers of power, have changed substantially the relations between beneficiaries, humanitarians (local, national, international) and donors.

Dialogue and Networking—A Centerpiece of Neutral and Independent Humanitarian Action in Contemporary Conflict

In response to the challenges the ICRC and other humanitarians have been facing the first decade of the 2000s with the

September 11 attacks, the subsequent global "war on terror" and the polarization, security challenges, and outright attacks on humanitarians that came along with it, the ICRC focused on its core mandate and the essential humanitarian principles of impartiality, neutrality, and independence, to maintain and gain access to victims of these conflict situations. [2]

Dialogue with all parties to a given conflict is the centerpiece of this concept and practice. Under the impact of polarization, and in face of the considerable security risks that have emerged for humanitarian workers, this has been a demanding endeavor. This confrontation on global scale that characterized the first decade of the 2000s was mainly taking place in the lands of Islam, and was essentially related to a complex setting of issues and grievances in the wider field of relations between the Muslim world and the West, and the rise of different forms of Islamism in parts of the Muslim world. Based on its specific mandate, and its long presence and experience in this part of the world, the ICRC took action to create the conditions for an intensified and systematic outreach to the almost inaccessible parties to the ongoing confrontation, and to a variety of other stakeholders. This has involved increasing the awareness of its delegates; actively involve delegation employees and those working for national Red Cross and Red Crescent societies; recruiting and developing career opportunities for people with the necessary background, language skills, and cultural sensitivity; and a proper analysis of the wider context and underlying causes of specific conflicts and wider schemes of confrontation.[3]

2 For an explanation of this concept see: Pierre Krähenbühl, The ICRC's approach to contemporary security challenges: A future for independent and neutral humanitarian action, International Review of the Red Cross (IRRC), vol. 86, no. 855, (Sept. 2004) 505–514.

3 Andreas Wigger, Encountering perceptions in parts of the Muslim world and their impact on the ICRC's ability to be effective, IRRC, vol. 87, no. 858, 343–365.

Perception studies and opinion surveys carried out by the ICRC on different occasions in several countries plagued by armed conflict have provided an important contribution to deepen the ICRC's understanding of the way people affected by armed conflict see and evaluate the action of the ICRC and other humanitarian actors, as well as on the effects and consequences of war and armed conflict on people. The most recent example has been an opinion survey and in-depth studies in several countries which the ICRC commissioned in the framework of the "Our World. Your Move" campaign for the 150th anniversary of the Solferino battle. This global research study captured the experience and opinions of civilians who are living with the everyday reality of armed conflicts—in Afghanistan, Colombia, Georgia, Haiti, Liberia, the Democratic Republic of Congo, Lebanon, and the Philippines.[4]

Other perception studies and field research by polling institutes and researchers, such as the field studies of the Feinstein Center at Tufts University have made essential contributions to a better insight on how populations affected by armed conflict, as well as man-made and natural disasters, perceive the motives, practice, and interaction of different humanitarian actors.

Perception and reputation studies are giving a relatively detailed and reliable picture on general attitudes and specific issues, and are thus the basis for operational decision making and the formulation of strategies, but they are specific to certain time periods. The operational dialogue and informed interaction with all relevant stakeholders in a given context is on the other hand a more continuous and immediate way to understand how we are seen and perceived by communities, local and national authorities, rebels and outlaws, but also

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4 The summary report of this study is available under: http://www.icrc.org/eng/resources/documents/report/research-report-240609.htm.

transnational actors that are influencing constellations and the wider environment of conflict in a number of contexts. This goes hand in hand with a continuous monitoring of the debates and issues that are informing and shaping the attitudes and perceptions of different actors.

This dialogue and interaction between ICRC delegates and field workers on a daily basis exemplifies the complex interrelation and conditionality between the multiple needs of the victims, the intent and ambition to carry out meaningful humanitarian action, the security challenges and risks in the field, the growing degree of interrelation between conflicts, armed groups and networks, and other stakeholders having an impact on conflict situations. Dialogue and networking with all relevant stakeholders in a given context like Yemen, Afghanistan, or Iraq are intertwined with the security of its personnel and operations, access and proximity to victims, the meaningfulness and effectiveness of the protection and assistance activities, and the way the ICRC is designing its visibility and communication—in these highly volatile environments, dialogue and networking are indispensable to get assurances for safety and security from the different parties to the conflict and other relevant actors, while the most important means to acquire acceptance by these stakeholders is the difference the ICRC makes with its protection and assistance activities.

The dialogue is also a means to detect issues that might involve risks in highly volatile environments, at times related to the aforementioned crises and "mega-issues" beyond our impact and control, at others our own action or the action of other humanitarians that is misunderstood or goes de facto wrong, and to adapt mode of action, patterns of individual and collective conduct and self-representation.

This work requires respect and sensitivity for different

cultures and values, but also critical distance and capacity for analysis. For the delegates, delegation employees, and staff members of the national Red Cross or Red Crescent societies working in these contexts, it consists of a constant learning process to develop the ability to see the world, ourselves, and our work through the eyes of those with who we are interacting, and to make serious efforts to integrate the perspective and cultural specifities of people and countries—on the principles of humanitarian action, on the rules of international law—in our discourse and presentation, while maintaining the essentials of these principles and rules.

Another crucial element in the relation and interaction with communities, authorities, armed groups, and other relevant stakeholders is to be consistent in the way we are presenting ourselves and are communicating with others, and the way we are doing our work.

In Iraq, the second largest operation of the ICRC in 2011, the ICRC has maintained and developed its visits to detainees, family visit programs for the families of detained persons, and carefully designed assistance programs for female-led households and rural communities, in an environment of ongoing violence, with scores of civilian victims. Based on the visits of ICRC delegates to tens of thousands of detainees held by the US–led international forces over the years since the 2003 war, fall of the previous regime and occupation of Iraq, the ICRC delegates and field workers have built a network of regular contacts with a wide range of interlocutors which reaches from the current authorities, political parties and movements, religious leaders and institutions, tribal figures, to the armed groups and jihadi networks that are part of the insurgency today. Quite some of those who are leading the insurgency groups of today are former detainees. Continuous contacts

and relations of trust and confidence with detainees and their families, the effectiveness of its protection and assistance activities, and the confidence and trust built in this dialogue, have made the ICRC known and accepted in diverging degrees by the movements, armed groups and jihadi networks that are part to the confrontation in Iraq today. In the highly volatile situation in Iraq—as well as in other comparable contexts—this relative acceptance can't be taken for granted, it has to be checked and maintained in daily contact and interaction, and beyond that depends on not always predictable changes and dynamics in the context and conflict.

Beyond this context-specific operational dialogue and networking, the ICRC has, based on its specific mandate ad role as guardian of international humanitarian law, engaged in dialogue with intellectuals, academics, and scholars in various parts of the Muslim world, with the aim of laying the foundations for greater mutual understanding, dispelling existing misconceptions and find common ground for protecting human dignity in armed conflict. This endeavour started in the late 1990s in Pakistan, and has been taken up since the early 2000s in other parts of the Muslim world. In cooperation with well-established Islamic institutions, such as the International Islamic University in Islamabad, the central Hawza and other religious institutions in Qom/Iran, the Qarawiyyin University in Fès/Morocco, and the Higher Islamic Council in the Republic of Mali, a series of workshops, seminars, and international conferences were organised. Ulema, scholars, and Islamic activists have participated to this dialogue alongside with ICRC lawyers and delegates as well as representatives of national Red Crescent and Red Cross societies, to explore and discuss the commonalities between IHL and corresponding rules of Islamic law, misperceptions, and obstacles in the way of impartial humanitarian action, but also means and measures

to improve the protection and assistance for victims of armed conflict, and the respect for the universal rules protecting those who are not or no longer actively taking part in hostilities, from an Islamic perspective.

As part of its operational dialogue and coordination in the field, but also in the framework of discussions and coordination between humanitarian organizations on the global level, the ICRC has engaged in a dialogue with Islamic charitable and humanitarian organizations, knowing that in numerous countries in the West and the Muslim world, Islamic charities were affected by the measures that were taken by main Western countries, the respective UN mechanisms as well as member countries of the Arab League and the OIC against personalities and entities accused of being involved in the support of terrorism. These measures have not only deprived beneficiaries and needy people in different parts of the world from receiving assistance, they have also contributed to the suspicions and mistrust against Western and international humanitarian actors in parts of the Muslim world.[5]

This experience has lead to an increased diversity in the teams of the ICRC, which in itself has prove to be an important factor for the ability of these teams to connect differently with local communities and stakeholders, and has also affected the way the ICRC is perceived by these communities and other stakeholders.

In the face of the ongoing and new challenges for humanitarian action in a rapidly changing world, these efforts to maintain and develop relations and networks with actors of influence will have to be increased and systematized. The

5 See on this e.g., the work of the Geneva-based Islamic Charities project (http://graduateinstitute.ch/ccdp/religion-politics-islamic-charities.html), as well as the website of the Humanitarian Forum (www.humanitarianforum.org).

experience gained in this field will nurture and enrich efforts such as the ones to further diversify and broaden the ICRC's relations with the authorities and civil society of states with regional or global reach and influence.

Humanitarianism, Perceptions, Power

Antonio Donini

The Good News . . .

Universality was one of the key themes of a major research project conducted at the Feinstein International Center under the rubric "Humanitarian Agenda 2015: Principles, Power, and Perceptions." The research involved 13 country case studies of local perceptions of the work of humanitarian agencies in conflict and non-conflict environments.[1] Qualitative information was collected from several thousand respondents—beneficiaries and non-beneficiaries—via interviews and focus groups at the community level. The research yielded a wealth of information on how local people viewed the work, attitudes, and behaviors of aid workers and their agencies with a focus on what was meaningful to those interviewed, i.e., "judgments" rather than "facts." It also said a lot about how humanitarians see themselves, but more on that later.

The importance of universality in the conduct of the humanitarian enterprise emerges clearly from all the case studies, as it does from other similar research.[2] Humanitarianism—and the values of compassion and alleviation of suffering that underpin it—is a global good broadly recognized the world over. A common core of humanitarian values emerges from

1 Case studies included Afghanistan, Iraq, Colombia, Sudan, Palestine, Sri Lanka, Burundi, Liberia, Georgia, Nepal, Northern Uganda, Pakistan earthquake, and DRC. All case studies and the final report, *The State of the Humanitarian Enterprise* (2008), are available at fic.tufts.edu.

2 Such as the "Listening Project," the MSF perceptions studies, and the growing anthropological literature on the aid world.

the country studies, although these values may be interpreted differently from place to place, reflecting the experiences of particular conflicts and crises.

It seems that only Al Qaeda and some extremist militant groups it inspires,[3] maintains an outright rejectionist stance. Many belligerent groups, of course, want to manipulate humanitarian action to their advantage or, as with the Liberation Tigers of Tamil Eelam (LTTE) in Sri Lanka, to accept the provision of relief only on their own terms. Even the Taliban, which has often targeted aid workers, has developed a more nuanced position. They are able to distinguish between the International Committee of the Red Cross (ICRC), and other "Dunantist" actors, with whose principles they have no quarrel, and the "corrupt agencies" that have taken the side of the government and the US-led coalition forces. Similarly, in Iraq, despite the toxic political and security environment, we found a strong resonance between the core elements of the humanitarian ethos and Islamic and Iraqi understandings of what "good charity" entails. Neutrality and impartiality, the studies show, are not theoretical concepts or pie-in-the-sky constructs; they are essential ingredients of effective humanitarian action. "Neutrality is not an abstract notion in Iraq," our country study concluded, "but is regarded by communities and most remaining humanitarian organizations as an essential protection against targeted attack."

There are of course a number of variations on the basic theme of universality. There is no situation where humanitarian action is totally principled and allowed to operate as such. Nor do all humanitarians strive to insulate their activities from partisan politics, advocacy, or expressions of solidarity.

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3 Such as Al Qaeda in the Islamic Maghreb who is allegedly responsible for the killing of (at least) three French aid workers in Niger and Mauritania in 2009–2010.

From the perspective of the affected communities, such nuances and the affiliations of agencies to the political agendas of donor governments do not appear to be a cause of major concern, except to the extent that political baggage directly affects the quality of the assistance and protection provided. In life-and-death situations, assistance will generally be accepted whether it comes in a Wilsonian, Dunantist, or even military truck. But over time, the nature of the giver begins to matter. This was most evident in Iraq and Afghanistan—where the animosity vis-à-vis agencies seen as linked to "the occupier" was palpable—as well as in Palestine and Darfur, where the UN aid agencies and NGOs are widely seen as "guilty by association" with donor-promoted political frameworks and where the anti-terrorist legislation of donor countries directly affects the conduct of humanitarian action. In Afghanistan, except for the ICRC and MSF, the contract of acceptability between aid agencies and communities has broken down in large swaths of the country. Not only is it too dangerous for NGOs (let alone the UN) to access communities where they have sometimes worked for decades, communities themselves often refuse assistance, not because they don't need it, but because of the associations it carries.

In sum, humanitarianism emerges from the research as a universal value that resonates in all cultures and societies. The specificities may differ from place to place, as does the actual respect for norms and values, but the universal substratum is solid—perhaps surprisingly so. In all cultures people recognize themselves in largely similar precepts of what is admissible and not admissible when conflict or disaster strikes. We all seem to share this fundamental aspect of our common humanity. But this is where the good news ends.

. . . And the Bad News . . .

Universal ethos, Western apparatus: Humanitarian ideals have the potential to unite, but humanitarian practice very often divides. Our findings show that the universality issue underscores a real and often damaging clash between the value systems of "locals" and "outsiders." The humanitarian enterprise affirms that the core values of humanitarianism have universal resonance, but this is not the same as saying that such values have universal articulation and application. Our case studies document many instances of friction at an operational level, reflecting general cultural insensitivity, poor accountability, and bad technique among humanitarian agencies. Cultural insensitivity affects the humanitarian relationship on both sides, though the onus for dealing with complex and delicate cultural issues in an appropriate manner falls primarily on aid workers and their organizations. The other two negatives—poor accountability to beneficiaries and bad programming or technique—are the sole preserve of aid workers. The consequence is that the "otherness" of the humanitarian enterprise undermines the effectiveness of assistance and protection activities. The prevalence of questions about the motivation, agenda, *modus operandi*, and cultural baggage of Western aid agencies is clearly troubling and presents major challenges. "Why do these young people come to our country?" people ask. "Is it because they can't find work at home?" or "They want to help, but they tell us what to do without asking us."

Our case studies, as well as more recent work we have done in Nepal, Somalia, and Pakistan[4], reconfirm the seriousness of this tension between insiders and outsiders arising from the cultural and political "baggage" that aid agencies bring to the

4 See the report on perceptions of social transformation in Nepal and the country briefing notes issued by FIC in 2010–2011 at fic.tufts.edu.

communities they serve. The nuances are different, but the message is the same: humanitarian action is a top-down, externally driven, and relatively rigid process that allows little space for local participation beyond formalistic consultation. Much of what happens escapes local scrutiny and control. The system is viewed as inflexible, arrogant, and culturally insensitive. This is sometimes exacerbated by inappropriate personal behavior, conspicuous consumption, and other manifestations of the "white car syndrome." Never far from the surface are perceptions that the aid system does not deliver on expectations and is "corrupted" by the long chain of intermediaries between distant capitals and would-be beneficiaries.

In other words, seen from below, the enterprise is self-referential and reflects the expectation that humanitarian theaters should adapt to it, rather than the reverse.[5] It thrives on isomorphism (you can join us, but only on our terms) and deploys its network power through the imposition of management practices and standards that act as barriers to entry for local initiatives or non-like-minded national players or community groups.[6]

What This Tells Us About Ourselves

As with other aspects of globalization, the nature of the processes of humanitarian action and the standards that guide them are decided by outsiders and imposed through network power.[7] Moreover, the top-down nature of the enter-

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5 This does not necessarily mean that aid agencies create their own (parallel?) reality. But it does mean that, because they have money and power, they are able to define who is vulnerable and who isn't and where to intervene, thus contributing to the shaping of the contexts where they work.

6 On network power as a form of "imperialism" see D. Grewal, *Network Power: The Social Dynamics of Globalization.* (New Haven, CT: Yale University Press, 2008).

7 Extrapolating from Development Initiatives estimates, it can be said that between two-thirds and three-quarters of all recorded humanitarian assistance is provided through the UN system, ICRC, and a cartel of five consortia of transnational NGOs (World Vision, CARE, Oxfam, Save the Children, and MSF).

prise affects not only the response but also, and perhaps more importantly, the conceptualization of crises: as humanitarians, that we address those vulnerabilities that we recognize and fit our schemas, we speak to those who speak our language and who have copied our institutions, we impose our mental models, we tend to shape reality in our image rather than trying to see it from the ground up.

While agencies and academics have sharpened their tools to analyze local perceptions—and this in itself may well be a positive thing—has this actually made any difference in our relationships with communities on the ground? Paradoxically, not much.

We cannot see ourselves. We may hear the feedback, but it is very difficult for us to listen to it and to see how we really look. And the growing cottage industry of perception studies may well just be a fig leaf to justify what we do and how we do it. The perception gap is wide because we hear what we want to hear and people often tell us what they think we want to hear. The perception issue is a minor aspect of a much more serious problem: the essentially lop-sided nature of the relationship between outsiders and insiders that breeds disempowerment, and sometimes victimization. Like it or not, the discourse is a dominant one where "we" control the terms of the relationship—and the volume button.

The point here is that "humanitarian action" can mean very different things to the aid worker in her big white vehicle and to the "helpless recipient" or to the extremist who negates the value of humanitarian action. What "we" experience is not what "they" experience. "The experience of receiving humani-

tarian action is not the experience of being a humanitarian."[8] For the well-meaning, compassion-driven international aid worker, the baggage and trappings that come with the job and the dust they kick up are not problematic. They may be critical or feel ambivalent about their work, but the big white vehicles, antennas, satphones, food aid, water pipes, expertise, competence, swashbuckling, Sphere Handbook–waving are integral parts of what they do. They may or may not see that the arrogance and the technology combine to create distance. For the people on the ground, the perceptions and the meanings of these same objects and activities may be quite different. "The same warm metal of Toyotas and water pipes may feel physically the same but might be mentally shaped by ideas of imposition, conquest, colonialism, arrogance, and outrage."[9] Some extremist fringes will reject assistance altogether as an intolerable humiliation and will try to capitalize politically on the imposition. Most will accept the food aid and the new school even if it is not what they asked for. Many will wonder about the patronizing attitude of the outsiders who are here one day and gone the next.

The Bigger Picture

Humanitarian action works as a powerful vector for Western ideas and modes of behavior. It is a powerful mechanism for shaping the relationships between the "modernized" outsiders and the multitude of the insiders. Technical knowledge and expertise—the nutritionist, the camp manager, the protection officer—are never neutral. Try as they may, aid workers carry baggage, practice, and ideology that shape the relationship. And power.

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8 Hugo Slim, "How We Look: Hostile Perceptions of Humanitarian Action," presentation to the Conference on Humanitarian Coordination, (Wilton Park Montreux, April 21, 2004), p 5.

9 Ibid.

This is somewhat paradoxical because, like its human rights cousin, humanitarianism emerged largely in confrontation with power. We were on the side of the vulnerable and powerless, but in the process we have become strong. Humanitarianism started off as a powerful discourse; now it is a discourse of power, both at the international and at the community level. The humanitarian establishment mobilizes and moves huge resources,[10] it interacts with politics (and business) at the highest level. It has become part of governance. Some would even say that it is part of government. The Northern/Western humanitarian enterprise has positioned itself as the central vehicle for relief and protection in crisis. It has lost the aura of voluntariness and the sense of mission it had when it was at the margins. It is now central to the conceptualization and management of the relations between the citadels of the north and the borderlands of the vast third-world periphery. It has crossed the threshold of power, even if most humanitarians—with a lack of self-awareness that borders on the schizophrenic—are loathe to admit it.

At the local level, it is deceitfully participatory. Despite much rhetoric about consultation and accountability to beneficiaries, it imposes pre-designed terms of engagement. Humanitarianism imposes Western forms of organization, concepts of management, technical standards, and the like. It brings the values, food, clothing, and music of the North to the last corners of the earth. The encounter between MTV-generation humanitarian outsiders and vulnerable groups in the periphery is not always easy or effective. Even when the outcome is positive, however, the encounter takes place on the terms and power relationships of the outsiders. The network power of the system acts as a barrier for different or alternative approaches.

10 Between $10 and 18 billion per year over the last decade according to Development Initiatives.

Why This Matters

"There is nothing so ethnocentric, so particularistic, as the claim of universalism."[11] The challenge for those who recognize themselves in the values inherent in humanitarianism is to determine whether or not it is feasible, intellectually and practically, to devise a more culturally grounded approach to providing assistance and protection to people in extremis, that is, an approach that is based on truly universal values—a sort of "universal universalism"—rather than on the currently dominant Western universalism. So far, there is no consensus, no clear picture of what such a framework might look like. Is it a big picture ethical framework applicable across all cultures? Or perhaps a coalition of compatible universalisms? Should an open debate where "we" do not determine "their" agenda conclude that some new and more acceptable synthesis is indeed possible, it would go a long way in re-establishing the bona fides of a humanitarian apparatus that is currently seen as blind-sided and compromised. This would imply addressing the question of whether the relationship between the "giver" and the "receiver" is inherently a disempowering one or whether it could tend towards equality.[12] It would also imply turning on its head the top-down nature of the current enterprise—a tall order given the drive to isomorphism and the power dynamics that are pushing in the opposite direction.

A glimmer of hope is to be found, perhaps, in the fact that humanitarianism in its different manifestations—as an ideology, a movement, a profession, and a political economy—remains a fundamentally ethical endeavour. The question, then, is to explore whether the humanitarian ethos can become a rallying point around which a more balanced, culturally

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11 Immanuel Wallerstein, *European Universalism. The Rhetoric of Power*, 40.

12 Mary Anderson, "The Giving-Receiving Relationship: Inherently Unequal?" in *The Humanitarian Response Index 2008* (DARA, Madrid, September 2008).

sensitive, and grounded enterprise could be rebuilt.

Humanitarians often find themselves in the uncomfortable situation of being "condemned to repeat."[13] It is neither practical nor useful for Northern humanitarians to claim a monopoly in holding up a Sisyphean boulder that may well end up crushing them. It is essential that they reach out to others. To be successful, however, any such attempt would have to be grounded in an approach that allows perspectives other than the dominant Western universalist discourse to emerge and be heard.

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13 Fiona Terry, *Condemned to Repeat: The Paradox of Humanitarian Action* (Ithaca, NY: Cornell University Press, 2002).

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MSF’s Charter

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Doctors Without Borders/Médecins Sans Frontières (MSF) is a private international association. The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims.

All of its members agree to honor the following principles:

Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed or political convictions.

Médecins Sans Frontières observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and claims full and unhindered freedom in the exercise of its functions.

Members undertake to respect their professional code of ethics and to maintain complete independence from all political, economic, or religious powers.

As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them.

Abbreviations / Acronyms

ATFC	ambulatory therapeutic feeding center
CBO	community-based organization
CMT	Chinese medical team
COIN	counterinsurgency doctrine
DAC	OECD's Development Assistance Committee
DRC	Democratic Republic of Congo
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
ICRC	International Committee of the Red Cross
ICU	intensive-care unit
IED	improvised explosive device
ITFC	intensive therapeutic feeding center
LTTE	Liberation Tigers of Tamil Eelam
MEDCAP	Medical Civic Action Programs
MONUSCO	United Nations Organization Stabilization Mission in the Democratic Republic of the Congo
MSF	Doctors Without Borders/Médecins Sans Frontières
MSOs	medical stability operations
NATO	North Atlantic Treaty Organization
NGO	non-governmental organization
OIC	Organization of the Islamic Conference
SOMA	Specials Operations Medical Association
TB	tuberculosis
TFG	Transitional Federal Government (Somalia)
UN	United Nations
US	United States
US DoD	United States Department of Defense

Over the past 40 years, Doctors Without Borders/Médecins Sans Frontières (MSF) has developed a reputation as an emergency medical humanitarian organization willing to go almost anywhere to deliver care to people in need.

Yet when questioned about MSF, people in countries where it works had different perceptions. One thought MSF was from Saudi Arabia and financed by Muslim charities. Another thought it was a China-based corporation. And yet another believed MSF requires everyone who enters their medical facilities to be armed (quite the opposite, in fact).

These are just some of the surprising revelations found in *In the Eyes of Others: How People in Crises Perceive Humanitarian Aid*. Co-published with Humanitarian Outcomes and NYU's Center on International Cooperation, the book is a result of MSF's attempt to better understand how its work and principles of neutrality, impartiality, and independence are perceived by those who receive its emergency medical care.

A variety of scholars, researchers, students, and other humanitarians also contribute essays expanding on issues of perception and exploring the many facets of humanitarian action today.

In the Eyes of Others How People in Crises Perceive Humanitarian Aid

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