

Doctors Without Answers:  
Limits, Challenges, and Dilemmas of Humanitarian  
(Bio)medicine, and Doctors Without Borders

by

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## **Introduction**

In 1999, Médecins Sans Frontières (MSF), or Doctors Without Borders, was awarded the Nobel Peace Prize.<sup>1</sup> In his speech, the then President of MSF, Dr. James Orbinski, delivered the organization's Nobel lecture. He spoke of MSF's goals as a humanitarian organization, and how medicine helps MSF achieve humanitarian ideals. In addition to touching on many of the features of MSF that make it unique as an organization, Orbinski's speech lays out well the goals of humanitarianism as a whole:

“Our action is to help people in situations of crisis. And ours is not a contented action. Bringing medical aid to people in distress is an attempt to defend them against what is aggressive to them as human beings. Humanitarian action is more than simple generosity, simple charity. It aims to build spaces of normalcy in the midst of what is abnormal. More than offering material assistance, we aim to enable individuals to regain their rights and dignity as human beings. As an independent volunteer association, we are committed to bringing direct medical aid to people in need. But we act not in a vacuum, and we speak not into the wind, but with a clear intent to assist, to provoke change, or to reveal injustice. Our action and our voice is an act of indignation, a refusal to accept an active or passive assault on the other.”<sup>2</sup>

Orbinski makes it clear: MSF has lofty, humanitarian goals beyond just treating diseases. The organization seeks to use its medical expertise to “build spaces of normalcy,” “provoke change,” and “reveal injustice.” These goals, as ambitious they may seem, are common to most any humanitarian organization, but not every humanitarian organization receives the Nobel Peace Prize.

It is easy to see what qualities might draw the Nobel Committee to MSF. When MSF was awarded the prize in 1999, it had existed for 28 years, and in that

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<sup>1</sup> "The Nobel Peace Prize 1999". *Nobelprize.org*. Nobel Media AB 2014. Web. 9 Apr 2015.

<sup>2</sup> "Médecins Sans Frontières - Nobel Lecture". *Nobelprize.org*. Nobel Media AB 2014. Web. 8 Apr 2015.

time it had made quite a name for itself. MSF is no stranger to conflict, and it had acquired a reputation for fearlessly jumping into any situation of crisis in any location: from genocides, to civil wars, to famines, MSF had seen it all. Notable and recent activities included intervening in Chechnya, where the Russian army was bombing civilian populations, and Rwanda, where a genocide was taking place (the latter will be discussed in detail in the second chapter). MSF boasts over 26,000 employees (mostly doctors and nurses), operating in more than 60 countries. MSF also describes itself as a “movement” as opposed to an organization. Although MSF has an executive board, 24 different branches in as many countries make up the MSF movement as a whole. All of these branches are individually “independent legal entities” that hire staff, raise funds, and elect their own boards of directors. Although the different branches often connect on the ground, each branch has the freedom to plan and execute its own interventions<sup>3</sup>. This structure gives MSF mobility, independence, and variety.

MSF is a non-governmental organization (NGO) whose actions are “first and foremost medical,”<sup>4</sup> and the Nobel committee has a long tradition of awarding the Peace Prize to medically-oriented nominees. The International Committee for the Red Cross (ICRC) has won the prize three times, Mother Teresa was awarded the Nobel for her treatment of the stigmatized terminally-ill in Calcutta, the International Physicians for the Prevention of Nuclear War won in 1985, and several other physicians have received the Nobel in the prize’s century long history.<sup>5</sup> Clearly,

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<sup>3</sup> “The MSF Movement.” MSF.org. Médecins Sans Frontières, n.d. Web. 05 Apr. 2015.

<sup>4</sup> “MSF Charter and Principles.” MSF.org. Médecins Sans Frontières, n.d. Web. 05 Apr. 2015.

<sup>5</sup> “All Nobel Peace Prizes”. Nobelprize.org. Nobel Media AB 2014. Web. 9 Apr 2015.

biomedicine is both highly praised by the international community, and a reasonably common framework for humanitarian action.

It is also easy to see why biomedicine has become such an esteemed and common practice for humanitarianism. Biomedicine is a system of knowledge defining sickness as an empirical biological reality within the body. The key aspect of biomedicine is that these disease states are “biological, universal, and ultimately transcend social and cultural context.”<sup>6</sup> Therefore, from a medical perspective a given disease is the same whether in a French hospital, or in an MSF refugee camp in Syria. A biomedical framework can provide clarity in what are often the complex grey areas of humanitarian intervention. In his Nobel speech, Orbinski also said that “the humanitarian act is the most apolitical of all acts.”<sup>7</sup> Biomedicine then also offers an appealingly neutral, apolitical form of aid. Where there is physical suffering, it is hard to contest the moral act of providing health services, or to contest the right of a doctor to heal a sick patient.

In this thesis, I seek to question the certainty of this pairing. While sensible in theory, how does the structure of biomedicine inform interventions on the ground? What are the consequences of launching humanitarian missions that are conceived solely based on this particular form of knowledge? I argue that despite the appealing clarity and moral certainty that comes from the alignment of biomedicine and humanitarianism, biomedicine is often an inadequate framework when applied to the task of humanitarian action, a phenomenon that is exemplified by MSF’s

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<sup>6</sup> Good, Byron. *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge: Cambridge UP, 1994. 8-9. Print.

<sup>7</sup> "Médecins Sans Frontières - Nobel Lecture". Nobelprize.org.

interventions into HIV/AIDS in Uganda, the Rwandan Genocide of 1994, and Haiti's 2010 earthquake and subsequent cholera outbreak.

I make my argument over the course of three chapters. The first chapter will focus on MSF's intervention into HIV/AIDS, primarily in Arua, Uganda. MSF has been a presence in Uganda for almost thirty years, and it has been intervening in HIV/AIDS treatment for most of that period.<sup>8</sup> Therefore HIV/AIDS has been a staple of the work MSF has done for most of the organization's existence. HIV/AIDS is also significant and important to this thesis, because by its nature it confounds MSF's role as an emergency organization. In theory, (though in Uganda this is not necessarily the case) it is fully possible for a HIV/AIDS patient to live out a normal life expectancy with access and adherence to an antiretroviral regimen. Therefore, though HIV/AIDS meets the criteria for crisis in terms of the extreme amount of suffering and death experienced by the population, if it is treated using the best medications available, and the treatment is held to the highest possible standard, it can hardly be considered a "crisis" in terms of a finite end goal (at least from MSF's perspective of treating the HIV positive patients.) Therefore, HIV/AIDS can be used a barometer for MSF: through this intervention we can see where MSF adheres to and where it ignores the framework it has laid out for itself for medical humanitarianism.

The chapter will focus on how MSF's strict adherence to a biomedical approach towards solving the HIV/AIDS epidemic in Uganda enforces a false simplification of a complicated disease. The nature of their medical model makes it extremely difficult to point to a finite end point of their intervention, forcing them to remain in Uganda for an indeterminate amount of time. Given that the ideal end of a humanitarian

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<sup>8</sup> Iliffe, John. *The African AIDS Epidemic: A History*. Athens: Ohio UP, 2006. 67. Print.

intervention is to allow state public health officials and structures to take over, already MSF stretches the boundaries of its humanitarian model. The chapter will also discuss how the idea of “emergency” that MSF highlights so often in its charter, appeals, and speeches, is inherently contradicted by its HIV/AIDS intervention.

The chapter will continue by talking about the strategies, technologies and equipment that MSF relies on to guide its HIV/AIDS intervention. The idea of transplanting western biomedical methodologies is not ideal in a useful, long term way when these methods are placed into a country with few of the same resources, and without medical personnel of similar backgrounds to MSF’s international staff. Additionally, it will discuss how the singular focus on a biomedical approach leaves out important perspectives that are necessary to tackling a problem as daunting as the HIV/AIDS epidemic. Though MSF provides lifesaving antiretrovirals, and necessary supplementary medical care to patients suffering from HIV/AIDS, organizations that help people find employment, regain their standing in their communities, and provide counseling and support, often suffer as a result of MSF’s presence.

The chapter concludes by calling into question whether or not MSF occupies the moral high ground, because the nature of its work involves saving lives. I also begin to discuss how the narrowness of a biomedical approach often leaves important perspectives out in humanitarian interventions.

In the second chapter, I focus on MSF’s intervention into the Rwandan Genocide in the 1990s. I first discuss how MSF’s presence in Rwanda contributed to the political inaction and silence in regards to the Rwandan genocide on the part of the international community, the United Nations (UN) and France. Political actors



interpreted the humanitarian presence in Rwanda as a sign that the conflict fell under the purview of humanitarian organizations like MSF, and thus were provided a “humanitarian alibi” for their inaction. Even the Rwandan Patriotic Front (a political body and army seeking to take back control of Rwanda) took advantage of MSF and the humanitarian alibi to appear cooperative to the international community, while simultaneously violating the rights of Rwandan citizens. I use the phenomenon of the humanitarian alibi to show how MSF’s presence in an intervention has consequences for how a political situation is interpreted. In this case, the MSF presence in Rwanda indicated to the international community that the crisis was within the ability of a biomedical organization to solve, even though this was not the case.

I also discuss how MSF fiercely advocated for an international intervention in Rwanda, and how their advocacy and pressure resulted in Operation Turquoise, a mission led by France and sanctioned by the UN Security Council. However, many humanitarian organizations criticized the operation, and decried it as worse than useless. Opinions were even divided within MSF’s different branches. The result of Operation Turquoise was a highly criticized, largely ineffective armed intervention. Although not totally to blame, MSF has a role in the hastily assembled intervention. MSF leveraged its reputation, and position of authority to pressure the UN and France into action. I use this case study to demonstrate further that MSF’s model of aid is morally complex, which their straightforward biomedical model would not suggest. In fact, many of MSF’s non-medical actions have concrete ramifications for its interventions on the ground, which the organization often does not account for.

Lastly, I discuss the series of events that led up to MSF's involvement in the Rwandan Genocide, and how MSF's lack of planning or analysis of Rwanda's political atmosphere resulted in a completely ineffective intervention that may have even caused more harm than good. MSF hospitals became locations of slaughter, including patients and MSF staff. I use this example to show how intervening can have drastic consequences when the larger political and social forces are not taken into account. By solely diagnosing problems through a biomedical lens, MSF limits its understanding of the greater context in Rwanda, and this results in ineffective humanitarian aid.

Finally, in my third chapter focuses on the 2010 Haiti earthquake, and the subsequent cholera outbreak months later. The chapter begins by placing the humanitarian response in Haiti in a broader context. All parties involved agree: the recovery and rebuilding effort in Haiti has progressed far slower than is acceptable. However, the UN, NGOs like MSF, and the Haitian government disagree on the cause of the slow recovery. While the UN, MSF, and other NGOs blame the progress on the failures of Haiti's government, the Haitian government, and many prominent academics blame what has come to be known as "the Republic of NGOs" in Haiti. This concept describes how thousands of NGOs descended on post-earthquake Haiti, collectively bringing billions of dollars and innumerable strategies on how to guide the reconstruction effort. This "NGO republic" facilitated the exclusion of Haitian voices from the recovery's planning and execution, voices of both Haiti's citizens and the Haitian government. This resulted in a recovery that was not in sync with the wants and needs of Haiti's people, but instead a recovery plan that was accountable to

the visions of the boards of NGOs and various wealthy donors. I argue that MSF's singular dedication to the realities offered by biomedicine facilitates the exclusion of Haitian voices. For example, if MSF is attempting to control a cholera outbreak, they need only rely on proven methods of cholera treatment and control, and the input of other actors becomes secondary.

However, I also argue that MSF's model of medical aid is not the only framework. Partners in Health (PIH) is another organization with a distinctly medical bent, which prioritizes the input of community voices, in this case those of the Haitian people, and the Haitian government. I use the case of the Shanchol vaccine to demonstrate how a model of medical aid that privileges the input of community voices can result in much more effective humanitarianism.

## **Chapter I:** **Doctors Without Flexibility: Finding Frameworks and Breaking Tradition with HIV/AIDS in Uganda**

### *Introduction*

In 1986 MSF began its long term and intensive commitment to HIV/AIDS work in Uganda that persists to the present day. In this chapter, I first will show that this was a watershed moment for the organization, and as MSF's history in the country shows, not a planned one. The significance of this is that MSF's typical precedent for its interventions does not easily adhere to an illness like HIV/AIDS. Until then, MSF's operations had consisted of surgeries in war zones, emergency refugee care, and malnutrition projects in famines, but different external factors and competing visions led to MSF branching into work that was unlike any it had attempted before. I argue that though MSF relies on its principles as an organization in order to determine in which interventions MSF should engage, these different social and political factors play a large role in determining the interventions as well.

The consequences of this were an erosion of the typical hallmarks of an MSF intervention: namely, an intervention rooted in the notion of "crisis/emergency," and western notions of biomedicine. Although "emergency" is an apt word to describe a war zone, it is not so easily applied to a lifelong diagnosis of HIV/AIDS, at least in regards to duration of the illness. I argue that by interpreting HIV/AIDS as a biomedical crisis in this setting, MSF fails to make sustainable change in the long term. By assuming that bringing new technologies and resources to Uganda will result in lasting change, MSF inadequately addresses the needs of the Ugandan population on the ground when it comes to the multiplicity of ways in which

HIV/AIDS affects a patient. I will also show how in this way HIV/AIDS reveals the moral complexities in MSF's biomedical practices. While giving patients with HIV/AIDS access to ARVs can extend their life expectancies, it can also result in increased stigma, and create an atmosphere where patients believe the only way to gain access to hospital resources is by having HIV/AIDS.

MSF's HIV/AIDS intervention in Uganda ultimately reveals the complexities and fallibilities inherent in a biomedical humanitarian model. I argue that this case study shows how the seemingly unobjectionable framework has problems, and is subject to social, cultural, and political influences in this Ugandan setting.

### *MSF, Uganda, and HIV/AIDS*

Former exile Yoweri Museveni led a rebellion (the National Resistance Movement) against the former Ugandan government in the early 1980s. After a violent series of conflicts, Museveni successfully overthrew the government, and seized power. This was but one of many violent political struggles for power in Uganda in the 1970s, but Museveni's campaign proved to be more successful than his predecessors'. Uganda was previously too tumultuous to receive foreign aid with constantly changing governments, but once Museveni was established as president, and proved himself a more permanent leader than his predecessors, and somewhat stabilized the disorganized the country's Ministry of Health, providing foreign aid became much more feasible from the perspective of western governments, and NGOs. Museveni's acceptance of aid from western governments was an important

aspect of his foreign policy, and the result was a large influx of humanitarian aid workers into the country, including MSF.<sup>9</sup>

However, MSF's first interventions in Uganda did not address the HIV/AIDS epidemic in Uganda on which this chapter will focus. Although HIV/AIDS has been in Uganda since 1982, and MSF though staged its first interventions in Uganda in 1981 following the political turmoil, MSF did not foray into HIV/AIDS work until 1986.<sup>10</sup> MSF's first missions in Uganda were to treat civilian casualties resulting from deadly political regime changes. The organization established itself by taking over a local hospital in the town of Arua, and subsequently establishing its Ugandan headquarters there. MSF failed to gain any control over the political violence and civilian casualties, and six months later, MSF abandoned the mission. Over the next few years, however, MSF continued to treat Ugandan refugees from their bordering bases in Zaire (now the Democratic Republic of the Congo) and South Sudan. As the political violence stabilized, MSF became engaged in returning these refugees home, and from there began to engage in a host of other projects in Arua and the surrounding regions, mainly vaccination programs against various infectious diseases. It was only years later, once entrenched as a "local institution" of Ugandan healthcare in the early 1990s, that MSF began treating individuals living with HIV/AIDS. Similar to other programs in Uganda, MSF became in engaged in HIV treatment almost incidentally, years after WHO labeled the disease as a "major public health concern" in Africa, and only once it had reached disastrous levels<sup>11</sup>.

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<sup>9</sup> Redfield, Peter. *Life in Crisis: The Ethical Journey of Doctors without Borders*. Berkeley: U of California, 2013. 212. Print.

<sup>10</sup> Iliffe, John. *The African AIDS Epidemic: A History*. Athens: Ohio UP, 2006. 67. Print.

<sup>11</sup> *Ibid*, 68.

Most of the organization's work on HIV/AIDS in Uganda comes from MSF intervening in local hospital settings and providing personnel and resources for treating HIV/AIDS patients. Funding primarily goes towards subsidizing the costs of ARVs, buying new equipment, and sending out blood samples so that HIV+/AIDS patients in the hospitals can receive care for free. It is not MSF's policy to subsidize the salaries of local health care workers, or the governments health care operations, to MSF this falls under the domain of development, and therefore not under the purview of medical humanitarianism.<sup>12</sup>

MSF's foray into HIV/AIDS was by no means instantaneous or uncontroversial, however. In fact, until the treatment of HIV/AIDS with antiretrovirals became a reality in the United States and Europe, MSF considered the disease outside of the area of expertise. Up until that point, MSF's interventions were almost exclusively emergency work, and they were well aware that HIV/AIDS would be a departure from that. Without the effective means of treatment provided by ARVs, HIV/AIDS work consisted of primarily public health concerns, like sex and health education, or prevention measures<sup>13</sup>. The only medical aspect of treatment would be hospice care for the dying, which was definitely not an endeavor for an organization focused on rapidity and mobility. Despite this, small branches of the organization, and specific individuals were certainly fierce advocates for the inclusion of HIV/AIDS in MSF's work. The Swiss section of MSF began a small scale intervention in Uganda as early as 1988.<sup>14</sup> However, the advent of ARVs changed the landscape of HIV/AIDS treatment, and the growing consensus from the international health community

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<sup>12</sup> MSF. "Opening a programme" MSF.org. Web. 9 April 2015.

<sup>13</sup> Redfield 187

<sup>14</sup> Ibid 188

became more and more focused on HIV/AIDS. MSF even released a statement in regards to ARV treatment saying that if “it is unethical to keep giving chloroquine to patients suffering from highly resistant strains of malaria . . . it is no longer considered ethical to allow the 30 million people currently infected with HIV/AIDS to die due to lack of treatment.”<sup>15</sup> Thus a dramatic shift, resulting from a combination of the reality of ARVs, shifting international attitudes, and internal pressure, changed the scope and landscape of MSF interventions for good.

### *Emergency Medicine: A Narrow Framework*

MSF’s foray into HIV/AIDS work was most significant because it was based around an illness for which there is no cure, unlike any intervention it had launched before. Thus far, each intervention had at least the possibility of an end point: a stabilized region, the end to a war, or a population no longer experiencing a famine. MSF’s strategies were therefore accustomed to this kind of emergency-centered work. However, by attempting to translate these strategies to HIV/AIDS, the typical model began to fall apart. In this section, I use Peter Redfield’s ethnography of MSF to show its emergency-based tactics, and show how the organization encountered difficulties when applying this framework to HIV/AIDS in Uganda.

Central to the identity of MSF is its international reputation for being a “global emergency room.” This identity is explored in depth in Redfield’s ethnography on MSF, *Life in Crisis*. Redfield argues that the ideas of “crisis” and “emergency” are at the core of MSF’s functioning, and that their emphasis is indicative of the overall philosophy of the organization:

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<sup>15</sup> Ibid 181



“Both terms, however, prioritize the present over the past and the future. Moreover, they suggest a state of rupture and through it an imperative need for action: something must be done and done quickly. In this sense disaster - not development - lies at the heart of the organization.”

Redfield’s analysis shows how MSF defines its expertise as a humanitarian organization in the realm of emergency, which informs how it goes about its interventions. His analysis is reflected in MSF’s policies on opening and closing interventions. When deciding to open a program, MSF says that it looks to address “the most urgent medical needs of people in crisis,” and subsequently, when MSF’s work is finished, it closes the program, “when the medical emergency ends.”<sup>16</sup> MSF’s particular brand of humanitarianism is to bring emergency medical care to populations in need all around the world, for as long as they are in crisis, but no longer.

Although “when the medical emergency ends,” is a vague criteria for finishing an intervention, MSF does not shy away from more specific regulations on the ground. For example, MSF has created a manual for its guidelines dictating the care of refugees. With the medical care of refugees being a relatively common practice for the organization, the guidelines create a standard of care that remains constant across MSF’s various interventions. In *Refugee Health: An Approach to Emergency Situations* MSF outlines criteria detailing common medical issues in refugee camps, medical necessities for care, how to prevent the spread of contagious illnesses, and other tools for MSF staff dealing with a refugee population. Additionally, the manual details the conditions one would see in a refugee camp in order for the situation to no longer be classified as an emergency, and therefore no longer requiring the services of

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<sup>16</sup> “Opening a Programme.” MSF.org.

MSF. One of these criteria is that the extrapolated mortality rate be less than 1 in 10,000.<sup>17</sup> The means of assessment in refugee camps provide similar specificity. To measure malnutrition in child refugees, for example, MSF uses an arm band that measures upper arm circumference to determine how dire the child's need is. The necessity of having these boundaries is clear for MSF. For an organization that prides itself on, among other qualities, its mobility and the rapid nature of its response, having cutoffs is necessary to be able to quickly assess when an intervention is finished, or at least beyond their expertise to help. Having statistics, and specific data points that tell MSF when to engage in a medical intervention, and when to stop therefore contributes to an alluring moral clarity, as well as a timeline of engagement. When MSF launched an intervention to combat lead poisoning in Zamfara state, it did so on the grounds that 400 children had died prior to MSF's entrance, which compelled MSF to act immediately. In a report two years into the intervention, MSF reported its success with a list of statistics, saying that mortality had been reduced by 43%.<sup>18</sup> Both the imperative for launching an intervention, and the rationale behind closing it are based on statistical data. HIV/AIDS however, in countries such as Uganda, confounds the clarity brought on by the specificity of data in several important ways.

The most obvious way in which the typical MSF model erodes is that typical markers for exiting an intervention are much more complicated when it comes to HIV/AIDS. Another one of the central tenants to MSF's brand of humanitarianism, is

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<sup>17</sup> Medecins Sans Frontieres. Refugee Health: An Approach to Emergency Situations. N.p.: Medecins Sans Frontieres, n.d. Msf.org. Web. 1 Apr. 2015.

<sup>18</sup> "Lead Poisoning Crisis in Zamfara State, Northern Nigeria." MSF.org. MSF USA, 8 May 2012. Web. 01 Apr. 2015.

that they seek to be only a temporary source of aid to communities in need. MSF describes its rationale behind program-closing on its website saying, “MSF will close a programme when a medical emergency ends: when an epidemic is over, or when people have access to health services . . . and attention must turn from relief operations to longer-term development activities.”<sup>19</sup> It strives against taking over for a local health system, saying that “it is crucial that a local or national health system does not become permanently dependent on MSF.” Such an intervention with no clear goal of leaving is not ideal for MSF. It infringes on the territory of development, which MSF makes clear that it does not do. Therefore, MSF seeks to leave the community when their need is less dire, and hand over the reins to the government and local health care systems.

However, in the case of the lifelong disease that is HIV/AIDS, finding an end to the crisis, and therefore a way to transition the treatment to the local government is not very clear. Some measures that MSF uses are mortality rate, and/or how many patients are currently receiving treatment with ARVs. Indeed, MSF uses the number of people it currently treats with ARVs in Uganda as a measure of progress in every one of its reports on the AIDS epidemic. However, Uganda’s government has become largely dependent on MSF, and foreign funding in general for the continued existence of HIV/AIDS programs. Despite their goal of working with the local government and not allowing temporary humanitarianism to take the place of the local health infrastructure, HIV/AIDS programs in Uganda have long grown far beyond the ability of the Ministry of Health to sustain. Even so, MSF’s annual reports discuss the importance of expanding these programs and the number of people treated with

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<sup>19</sup> "Closing a Programme." MSF.org. MSF, n.d. Web. 01 Apr. 2015.

ARVs. Complicating the issue further, UNAIDS reports that Africa is in the midst of a “deadly funding crisis” for HIV/AIDS. In 2010, donations fell by 10 percent, and that number is growing each year.<sup>20</sup> Although domestic spending on AIDS in Uganda is at a higher rate than ever before, if they were to completely take over their own HIV/AIDS costs currently being supplemented by NGOs like MSF, it could take up as much as 2/3 of the Ministry’s overall healthcare budget.<sup>21</sup> Therefore, in order to continue treatment for patients who are already receiving ARV, the amount of funding must remain consistent. MSF is also concerned about the shortness of funds. “After years of political willingness and financial commitment to combat HIV/AIDS, donors now seem to be disengaging from the fight, leaving behind those who are still in dire need of life-saving treatment . . . Today, this disengagement is starting to become visible in the field and the level of HIV care is beginning to deteriorate.”<sup>22</sup> If the “donor fatigue” continues, MSF risks not only not being able to expand their program, but also not being able to provide their current patients with continued treatment. Whereas sustainability of funding might not be necessary for temporary crises of only a year or two, with HIV/AIDS the funding must not only stay consistent, but also increase in order to treat more of the population. Fundraising is just one significant way that HIV/AIDS differs from a typical MSF project, but the consequence is, in MSF’s own words, the deterioration of care for HIV patients.

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<sup>20</sup> "Africa: A Deadly Funding Crisis." Allafrika.com. All Africa, 11 Dec. 2011. Web. 1 Apr. 2015. <<http://allafrica.com/stories/201112071114.html>>.

<sup>21</sup> "Africa: HIV/Aids - New Ways to Fund the Fight." Allafrika.com. All Africa, 28 Mar. 2013. Web. 1 Apr. 2015. <<http://allafrica.com/stories/201303290547.html>>.

<sup>22</sup> "No Time to Quit: HIV/AIDS Treatment Gap Widening in Africa." MSF.org. MSF USA, May 2010. Web. 1 Apr. 2015.

The concerns of MSF leaving Uganda, and being unable to sustain a comprehensive HIV/AIDS program, are reflected in local, MSF-employed, healthcare workers. Two nurses in an Aura hospital in Uganda (the main site of MSF's Uganda HIV/AIDS intervention) discussed their anxieties about MSF, saying that they felt "pressured by the spiraling workload and MSF's ever expanding projects." They are also not convinced that the Ministry of Health could hope to take it over. When discussing the possibility of MSF leaving Uganda they said, "If integration means phasing out MSF support, I wonder how we will manage. . . If MSF thinks of pulling out as in emergencies, then it will be a problem"<sup>23</sup>. However, addressing these concerns would require far more than simple adjustments to MSF's project. In order to take steps that would help the ministry of health gather the resources and infrastructure it would need to take on the long term care of hundreds of thousands of chronic disease patients, MSF would need to foray into activities that fall distinctly on the spectrum of development, and move even further away from the field of humanitarianism. MSF defines its expertise in the realm of medical humanitarianism, and directly states that it closes a program when "attention must turn from relief operations to longer-term development activities."<sup>24</sup> Such alterations to its HIV/AIDS would risk moving even closer to development, a practice in which MSF does not engage. While MSF has made changes in the past (HIV/AIDS work itself being a major one of them) they definitely show reluctance in implementing changes that move so far away from the practice of emergency medicine.

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<sup>23</sup> Redfield, 199-200

<sup>24</sup> "Closing a Programme." MSF.org. MSF, n.d. Web. 01 Apr. 2015.

### *The Challenges of Biomedical Approach*

Beyond the challenges of applying a specific set of crisis-centered, aid strategies to a lifelong illness, MSF's biomedical model itself is often an inadequate way to account for the multiplicity of social, economic problems that occur as co-morbidities with an HIV/AIDS diagnosis. While ARVs can bring up a patient's white blood cell count, and reduce their viral load, biomedical practices alone are not enough to combat the stigma that faces HIV/AIDS patients in these settings, nor can medicine help a patient get their job back, or repair a broken relationship with their family. MSF's biomedical practices only focus on some of the wide range of problems of HIV/AIDS patients. Furthermore, the narrowness of MSF's approach, and even its presence complicates these problems in tangible ways. Some examples of the ramifications of MSF's actions are the issues that arise from bringing western-centric hospital practices to a relatively resource poor-setting, the increased stigma that HIV/AIDS patients receive from having access to ARVs in Arua, and how a large, medical NGO like MSF can overshadow small community organizations doing different work in the same setting.

In Crane's book, *Scrambling For Africa*, she describes the stark gap in resources between a western hospital and Ugandan hospital, and on top of that disparity, a second gap that exists between more urban locations in Uganda, like Kampala, and more rural locations, like Arua (where MSF practices)<sup>25</sup>. Many NGOs choose to settle in the relatively resource-rich city of Kampala as the main site of their humanitarian or public health interventions in Uganda. They establish their infrastructure there,

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<sup>25</sup> Crane, Johanna Tayloe. *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science*. Ithaca: Cornell UP, 2013. 102-05. Print.

which includes things like expensive laboratories and hospital equipment. This gives the urban locations like Kampala a wealth of access to resources, and far better medical care. These urbanized centers of commerce are therefore placed in a position of power compared to more rural locations like Arua, which Crane calls a “geography of power.”<sup>26</sup> Being a relatively wealthy NGO, MSF is able to make up for much of this disparity when it is in a community like Arua. MSF is adept at setting up mobile medical units that are well equipped for its needs, and it established many of the same advantages that a city like Kampala has when it took up residence in the Arua Hospital.

However, these advantages might not translate to lasting differences in access to health services in Arua, as MSF hopes its work will do. Central to MSF’s identity is to help communities in need, while at the same time keeping in mind the need to restore the community’s autonomy after MSF leaves. The focus then, is to use MSF resources to help the community out of their time of crisis, and afterwards, leaving the community to care for itself. Therefore, a significant part of MSF’s intervention is how it “[carries] out a comprehensive handover process with national staff, local organizations and authorities to avoid the interruption of activities.”<sup>27</sup> What is not accounted for in this strategy is the relative differences in professional expertise, philosophy, and environment between Western and African healthcare professionals.

The technologies and machines that western doctors rely on, are not available at nearly the same regularity in Uganda. Thus, doctors there have had to learn to practice medicine and treat patients without the use of these devices. Availability to

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<sup>26</sup> Ibid 102.

<sup>27</sup> MSF, “Closing a programme”

some technologies has increased in recent years with the establishment of PEPFAR, but for the most part, African doctors rely on symptoms like weight loss, infections, and mobility as markers for progression of HIV/AIDS. This differs from the strategies used by western doctors, who focus on data given in the form of white blood cell counts, and viral loads. Crane discusses how this comes as culture shock to western doctors who come to Uganda, and how “they were impressed by the ability of Ugandan clinicians to practice medicine without many of the basic medications and technologies Northern doctors had become dependent upon.”<sup>28</sup> Consequently, the Ugandan practice medicine is heavily focused on clinical examination, and not nearly as focused on lab results. Ugandan AIDS expert Dr. Joseph Muhwezi spoke to the difference in training styles as a result of environment, saying, “if you want [to learn about] clinical care of HIV-infected children, the place to go is Uganda. If I go to the Netherlands, they don’t even have patients . . . They are training doctors under video . . . Molecules and things, they are very important, but at the end of the day it’s the person that matters.”<sup>29</sup> Dr. Muhwezi poignantly identifies the difference in focus. Where Ugandan doctors rely on their clinical expertise due to a combination their vast quantity of hands-on experience and their lack of access to healthcare technologies, western doctors are taught to privilege the information from the laboratory, or “molecules and things.”

This dissonance in styles of practice leads to a difficult challenge when bringing MSF’s resources and philosophies to an area like Arua, Uganda. For the western-trained MSF doctors, it is shocking to see treatment protocols for HIV/AIDS that

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<sup>28</sup> Crane, 85.

<sup>29</sup> Ibid 85.



involve little access to CD4 cell counts, and, in most areas of Uganda, absolutely no viral load testing. These measures that are inextricable from a US patient's HIV/AIDS prognosis have little place in a Ugandan setting (Crane).

Crane's analysis of politics of geography, and the impact of international medical services in Africa can be used to call into question MSF's intervention. The sustainability of MSF's specific treatment and diagnostic practices are yet another obstacle the community hospital in Arua, Uganda must overcome after MSF's inevitable departure. Although many of these HIV/AIDS programs are still in full swing, and MSF continues to try and add additional patients, MSF still ultimately plans to leave Uganda. When MSF money and medical technologies are no longer there to support the particular brand of medicine that has been practiced for decades (a brand of medicine not native to the community health care workers, doctors, or nurses in Arua) it is hard to see how MSF's long residency will translate to a sustainable method for finding, diagnosing, and treating HIV/AIDS patients. Additionally, even if Ugandan health care professionals became accustomed to MSF's medical practices, how would they carry that strategy without the funding that supplies unlimited access to the medical technologies that they had when MSF was present? Questions of sustainability and how a rural hospital can transition into an independent healthcare establishment complicate the apparent simplicity of transplanting of foreign health care systems into Ugandan communities, and call into question its ability to affect any lasting change.

A similar implication of MSF's philosophy and unique brand of mobile emergency medicine is the kind of expertise that they bring to each situation. In terms

of the make-up of their field groups, MSF is almost exclusively made up of US and Europe trained doctors and nurses, therefore it is of little surprise that their primary method of approaching, diagnosing, and treating crises is based on a biomedical understanding of the problems involved. MSF's expertise is a powerful tool, especially for an organization with primarily human rights-based goals. In their Nobel Prize acceptance speech, James Orbinski said, "our actions is to help people in situations of crisis, and ours is not a contented action."<sup>30</sup> Orbinski makes it clear, that medicine is the tool that MSF uses to help populations out of crisis, and MSF's lofty goals go beyond simply curing disease. When compared to other organizations with similar goals like UNICEF or Amnesty International, biomedicine is an uncommon framework, and, according to Paul Farmer, an underutilized one in the field of human rights. Farmer discusses the advantages of medicine as a human rights tool in his book *Pathologies of Power* saying, "a purely legal view of human rights tends to obscure the dynamics of human rights violations." Farmer goes on to explain that a legal understanding of human rights aims to address the question "does an event/process violate an existing rule?" whereas a medical understanding of an event answers the question "does an event/process have ill effects on a patient or population?"<sup>31</sup> The distinction between the two approaches proves useful for diagnosing and treating problems that other viewpoints may not be able to identify. However, like any other framework, a biomedical one has its own limitations. The limitations can be seen clearly through MSF's work with HIV/AIDS in Uganda.

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<sup>30</sup> "Médecins Sans Frontières - Nobel Lecture". Nobelprize.org.

<sup>31</sup> Farmer, Paul. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: U of California, 2003. 219. Print.

Although the pathology of HIV/AIDS is distinctly biomedical (characterized the presence of the virus, CD4 cell counts, and viral loads), many of the consequences of it, especially in Uganda are distinctly non-biomedical. Studies have well-documented the disadvantages faced by homes in which the household head is HIV+ or has AIDS. One such study was highlighted in Monica Karnhanga Beraho's *Living With AIDS In Uganda*:

“The effect of chronic illness of an adult often results in the ill person's inability to work and this often leads to a shift of other household members labour and time to care for an ill person . . . A multiplicity of socio-economic and cultural factors determine the progression of the disease when an individual gets infected and, consequently, the extent to which HIV/AIDS-labour-related constraints is experienced across households.”<sup>32</sup>

These studies show that not only are there many other issues that come with the diagnosis, but also the socio-economic, and cultural factors inform the medical progression of the patient's HIV/AIDS.

Additionally, stigmatization and legal discrimination continues to be a significant problem in Uganda and much of Africa in general, despite the improvements highlighted by MSF patient testimonials. Even now, a law is before the Ugandan legislature that would require people who are HIV+ to reveal their status to employers, and sexual partners, would allow medical providers to reveal HIV status without a patient's consent, criminalizes transmission of HIV. With continued discrimination, and even more discriminatory laws being brought before legislature even now, human rights advocacy organizations are criticizing Uganda, with one

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<sup>32</sup> Beraho, Monica Karuhanga. *Living with AIDS in Uganda: Impacts on Banana-farming Households in Two Districts*. Wageningen, Netherlands: Wageningen Academic, 2008. 251. Print.

organization even calling Uganda the example of “how not to write laws on HIV.”<sup>33</sup> Given this context, it seems clear that the HIV/AIDS crisis (in Uganda and beyond) calls for multiple perspectives: a biomedical understanding to treat patients and the disease itself, and others to address the socio-economic, and cultural distresses that HIV/AIDS patients and their families undergo. However, not only does MSF’s biomedical work not combat the many other issues caused by an HIV/AIDS diagnosis, but also MSF’s actions in Uganda even contribute to the stigma that HIV/AIDS patients receive, both from other patients, and from the communities at large.

One example of consequences of MSF work in Uganda is the discrimination that MSF patients receive based on the nature of the free treatment. As previously stated, MSF subsidizes the treatment of HIV/AIDS patients completely, so that they don’t have to pay for the ARV medication that they receive on a regular basis. Additionally, patients that were eligible for ARVs when they first went to MSF often had serious secondary conditions as a result of their HIV status and weakened immune system, like tuberculosis, or malnutrition. These conditions were also treated for free by the doctors of MSF, in addition to their entire ARV treatment. All of the treatment takes place in the community hospital in the proximity of hundreds of other patients, who either are HIV negative or are not eligible for the ARVs based on MSF criteria (e.g. a CD4 cell count that is too high to qualify a patient for ARV treatment and MSF funds). The disparity between the treatment MSF patients receiving ARVs and other patients in the hospital does not go unnoticed by the community. In fact, a recent

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<sup>33</sup> Burnett, Maria. "Uganda: Deeply Flawed HIV Bill Approved." Uganda: Deeply Flawed HIV Bill Approved. Human Rights Watch, 14 May 2014. Web. 02 Apr. 2015.

study of rural Uganda showed that access to ARVs actually has increased stigma towards HIV/AIDS patients. The study saw that “despite widening access to treatment, perceived HIV stigma has only risen in Uganda in recent years” citing an 11% increase in perceived stigma between 2006 and 2011.<sup>34</sup> However, data is largely ignored, or unnoticed in the patient narratives MSF highlights and shares. In one such testimonial, MSF highlights the story of Rose Atibuni, a secondary school teacher, who found out she was HIV+ and was given six months to live. She says that “stigma was quite high at the time, and I felt very insecure in my job.” She began to receive treatment from MSF, saying, “the other teachers said they admired me and took courage from me.” She ends her testimonial by praising MSF, saying:

“We thank MSF very much for coming to this rural area in the North with free treatment because most services are concentrated in Kampala and the South. It has boosted us a lot. If it weren't for ARVs so that people could see the benefit of being open, we would not have come this far. Now people form their own support groups, which is really due to free treatment because otherwise what is the benefit of being open.”<sup>35</sup>

While her story is true based on Rose's experience, most testimonials follow a similar structure from Uganda, where a patient is lifted out of their problems by access to free treatment from MSF. The uniformity of these testimonials glosses over the increased stigma due to ARVs in recent years. Such a narrative also ignores patients who still struggle or feel stigma, even when given access to ARVs. One patient in MSF's Arua hospital noted the discrimination, saying, “We are given enough medicine, so there is jealousy. The others wish the MSF doctors would treat them . . . They felt we were favored by being given free food. So a feeling [arose of]

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<sup>34</sup> "Has Treatment Access Changed HIV Stigma in Uganda?" AIDSMED, 16 Oct. 2014. Web. 2 Apr. 2015.

<sup>35</sup> "Testimonies From HIV/AIDS Treatment Patients in Arua, Uganda." MSF.org. MSF USA, 14 July 2004. Web. 02 Apr. 2015.

‘I wish I had HIV so that I would get the food.’<sup>36</sup> This is not to say that withholding treatment from HIV/AIDS patients is preferable when compared to the stigma arising from even the treatment itself, but the patient’s sentiments demonstrate how MSF’s medical approach has consequences that MSF is not necessarily able to combat or prevent.

The obvious response to concerns of MSF’s limitations as an organization is that there are hundreds of other NGOs in Uganda, and many of them directly deal with HIV/AIDS. Therefore the limitations brought on by one approach, in this case MSF’s biomedical one, can be made up for with an assortment of different approaches from these other organizations. The argument is a good one, and it certainly has truth to it. However, MSF also excludes certain perspectives by nature of its presence and its interventions. TASO is one such organization. It is a local, community-organized group that — among individuals in Uganda with HIV/AIDS — combats stigma, helps in job searches, and focuses on giving individuals with HIV/AIDS a safe community. However, Joyce, a local leader of the group who also receives treatment from MSF, says that finding funding lately has been difficult “because of donor fatigue:” “Many organizations don’t want to give money for salaries . . . But how else to motivate people to work?”<sup>37</sup> Although Rose is attempting to fill in one of the many gaps that a biomedical model does not take into account, little of the finite money earmarked for HIV/AIDS in Uganda goes towards local community organizations. Few NGOs can boast as much moral clarity as “saving lives” like MSF can. From a donation perspective, it is difficult to entice people to donate to your cause when such an

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<sup>36</sup> Redfield, 196

<sup>37</sup> Ibid, 194

appetizingly simple one, a “moral no-brainer” is directly juxtaposed with yours. Thus, while MSF remains one of the best-funded NGOs in the area, organizations like Joyce’s, which address different types of needs in the HIV/AIDS community in Uganda, fall into MSF’s formidable shadow. The presence of organizations like MSF therefore not only provide a limited view with which to address a multi-faceted disease like HIV/AIDS, but also eclipse other perspectives that have more power to address equally important needs.

Despite MSF’s awareness of where their expertise may lie, awareness alone is not enough to counteract the sometimes deleterious consequences that their presence might have in Uganda, and the humanitarian aid world in general. It is hard to argue with MSF’s concrete, moral clarity of saving lives, but the increased stigma that patients on ARVs receive, and the relative lack of funding of local community organizations dealing with other issues under the umbrella of HIV/AIDS are examples of how MSF’s work has consequences in communities beyond what they intend or can change.

### *Conclusions*

MSF’s intervention in Uganda begins to illuminate the complexity of the identity of an NGO like MSF. As much as MSF relies on certain principles, expertise, and rhetoric to guide them, it is subject to changing international climates, political bodies, and the struggle to unite the individual branches within its own organization. As much as MSF tries to remain consistent, and stay true to tradition and their

historical identity by intervening in HIV/AIDS, the disease cannot be denied as a fundamental shift from that legacy, and one that was not necessarily intentional.

MSF's interventions into HIV/AIDS in Uganda can tell us several things. The first is that the clear morals brought by medical humanitarianism and the rhetoric of "saving lives" are more complicated than they appear. Redfield argues that one of the more alluring aspects of MSF's identity, and the identity of medical humanitarian missions in general is that they appear to occupy an inarguable moral high ground. How can you deny the inherent good that is brought about by 'saving lives'? The clarity is further cemented by the notion of "emergency" or "crisis" that so often appears in MSF rhetoric. Not only are they saving lives, but they are saving lives that need to be saved *right now*. However, like any other aspect of a humanitarian strategy, MSF's rhetoric and appeals to the conscience must also be subject to scrutiny. In the case of Uganda, it seems that interpreting it as a medical emergency has its own consequences, like the increased stigma of patients who are receiving ARVs within their communities. Not only is this true, but it is also a problem MSF that MSF does not acknowledge in its patient's testimonials, and the perspective is largely absent. By applying a framework MSF has used in other interventions to Uganda without altering it, the organization encounters problems that it can not only not control, but is also not even aware of.

We can also see the possible fallibility of a purely biomedical approach through MSF's HIV/AIDS work. As well as biomedicine works for solving certain types of problems, and as much as it can help even in the contexts of HIV/AIDS, a laser focus on MSF is to the detriment of the other perspectives that biomedicine excludes, like



those of local community organizations in Uganda, or of Ugandan doctors and medical practitioners. When MSF is elevated to a position where donors assume that it has the most knowledge and expertise, other organizations that offer resources and different types of prowess suffer, as do the patients, whose lives MSF is trying to save. The narrowness of MSF's biomedical model will continue to be analyzed within the next chapters on MSF's interventions into the Rwandan genocide in the mid 1990s, and after the earthquake in Haiti and the subsequent cholera outbreak.

## **Chapter II:** **Doctors Without Context: The Humanitarian Alibi and Témoignage** **in the 1994 Rwandan Genocide**

### *Introduction*

In 1994, MSF intervened in what the organization saw as political violence and civilian slaughter, but that it would come to see in the coming months as genocide. In this chapter I will show how MSF's intervention in Rwanda, though based on the straightforward biomedical premise of saving civilian lives, caused an unwitting MSF to become a player in an extremely complicated geopolitical conflict. I argue that merely by choosing to intervene before having an understanding of the greater conflict had dire ramifications in Rwanda, for MSF, the civilians it was trying to help, and even the UN and international community at large. One consequence was that MSF provided what the organization referred to as a "humanitarian alibi" for political parties implicated in the conflict. The UN and France claimed that their intervening in Rwanda was unnecessary because the conflict was a humanitarian emergency, as evidenced by the presence of MSF and other NGOs. I will show how the UN and France claimed this alibi, and how the consequences were a painfully slow international response resulting in the continued civilian slaughter in Rwanda. I will also show that MSF enabled human rights abuses perpetrated by Rwandan Patriotic Front (a warring political faction with the former Rwandan government) by the same means. Although MSF was aware of what the RPF was doing, they prioritized the treatment of the civilians over speaking out against the RPF's political games, thus enabling the abuses to continue.

I will also show how MSF's "temoinage" or "witnessing" is complicated by the Rwandan genocide. When it was clear to MSF that its own interventions were inadequate to handle the conflict, certain branches began speaking out to press and media outlets in order to pressure France and the UN into intervening. The result of their campaigns was the UN and France launching Operation Turquoise, which many NGOs and MSF personnel denounced. These critiques proved largely accurate; Operation Turquoise did not save many lives. I argue that MSF created a media campaign by leveraging MSF's position as the moral authority. The campaign played a pivotal role in the creation of the hasty UN intervention, and that MSF's actions cannot be divorced from the failure of Operation Turquoise. I also argue that the campaign demonstrates how "speaking out" for MSF is not a simple or cohesive act.

I will also show how Rwanda demonstrates the tendency of MSF to enter into a conflict hastily without a knowledge of the social or cultural forces at work in the setting. The consequence in this case was an intervention that did more harm than good. A hospital where MSF was known to be treating civilians became a target for slaughter of both MSF patients and staff. I argue that this lack of knowledge of the political forces at work is the consequence of a biomedical model that excludes those perspectives. By judging MSF's ability to give aid based on suffering alone, the organization misses important information that could inform a more comprehensive strategy.

### *The Makings of a Genocide*

On April 6, 1994, a plane carrying Rwandan President Habyarimana was shot down near Kigali. The event was the spark that resulted in the slaughter of over 800,000 Rwandan Tutsi civilians over the course of three months, in an event that would come to be known as the 1994 Rwandan Genocide. There is a long history of tension between the Tutsi, who were the main targets of the slaughter, and the Hutu, who controlled the government at the time of the genocide and executed the massacre. The two ethnic groups' animosity can be traced back to when Belgians colonized Rwanda in the early 20<sup>th</sup> century. The Belgians classified the fairer-skinned Tutsi the superior ethnic group, who were more intelligent, and thus more deserving of better opportunities. This perception became pervasive, and resulted in decades of structural disadvantages for the Hutu, which eventually culminated in mid 20<sup>th</sup> century violence. This uprising of Hutu caused many Tutsi to flee Rwanda, and greatly diminished their cultural dominance within Rwanda. When Rwanda was made independent in 1962, the Hutu took control of the government, which they held until the 1990s. It was around that time that Tutsi refugees began to form a force intended to reenter their homeland, and take back governmental power from the Hutu president. The RPF made an attempt at a coup in 1990, but the Hutu governmental forces were aided by Belgian and French troops and maintained power through the uprising. That is until the RPF attempted another coup three years later. Although it was ultimately unclear who shot down the the President's plane, the Hutu used the

attack to justify a large scale slaughter of the Tutsi minority that still remained in Rwanda in events that would come to be known as the Rwandan Genocide.<sup>38</sup>

*Timeline: the MSF Intervention and the International Response*

Three branches of MSF played a prominent role in MSF's intervention into the Rwandan crisis, all of which were on the ground to witness the slaughter as it began. While the nature or extent of the conflict was not clear to MSF at this point, the immediate danger posed by remaining in the country was evident, and so within days MSF began to evacuate its international personnel to the relatively more stable surrounding countries: Burundi, Tanzania, Nairobi, and Uganda. Notably, one MSF Belgium mission continued its operations in Butare, to the south. While violence had spread quickly in other parts of the country, it had not yet come to Butare.<sup>39</sup>

It quickly became clear to MSF that Tutsi were being targeted, as were many international aid workers: specifically those identified as Belgian and French. Additionally, according to an MSF press release, "only the ICRC [International Committee of the Red Cross], known to be Swiss, are free to move inside the country."<sup>40</sup> Being stationed near the border, MSF teams from each branch continued to keep tabs on what they could glean from the no-man's land borders of each Rwanda-adjacent country. They ascertained that Rwandan Tutsi were attempting to flee the country, but the refugees were being killed in large numbers before they could reach the borders.

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<sup>38</sup> "Rwanda: How the Genocide Happened." BBC News. N.p., 17 May 2011. Web. 07 Apr. 2015.

<sup>39</sup> "Tous les membres de Médecins Sans Frontières encore présents au Rwanda seront évacués." MSF Belgium Press Release, April 10, 1994.

<sup>40</sup> "'News of evacuated MSF staff,' MSF International Secretariat Situation Report." April 12, 1994.

In response to this violence, MSF sent surgical teams back into the country masquerading under the banner of ICRC to avoid detection and escape the violence. The compromise with the ICRC was that all activities would be under the discretion of the ICRC despite the large presence of MSF personnel.<sup>41</sup> Therefore, the only teams conducting MSF operations and operating under the banner of MSF were the teams who remained at Rwandan hospitals in Butare to the south. Although the district did not see violence at first, it was not spared for long.

Violence began to encroach on the area surrounding Butare, but still MSF teams remained in the hospitals, and used their foothold to begin to expand and establish surgical outposts in the surrounding areas in order to treat the growing number of casualties.<sup>42</sup> The violence culminated dramatically for Butare, when over 150 people, mostly patients and also including some MSF staff, were targeted and killed outside of the hospital.<sup>43</sup> This incident resulted in the withdrawal of MSF personnel from the Butare hospital. The remaining MSF teams on the ground were either aiding the Rwandan refugees that made it to the borders, or engaging under the ICRC banner.

However, it was at this point that MSF teams working with the ICRC began to express their feelings of "powerlessness." Additionally, MSF decided it was no longer appropriate for it to stay silent on the violence and Uganda and began its process "witnessing" or "speaking out."<sup>44</sup> This speaking out included describing the violence its own members were experiencing as well as decrying the silence of the UN and

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<sup>41</sup> "The MSF Adventure-- Patrice Benquet-Anne Valleys -- MAHA Production 2006." YouTube, 12 May 2014. Web. 07 Apr. 2015.

<sup>42</sup> "ITW Wouter Van Empelen MSF Holland Programme Manager." YouTube, 28 Apr. 2014. Web. 07 Apr. 2015.

<sup>43</sup> "MSF (Un) Limited." YouTube. N.p., 12 Mar. 2014. Web. 07 Apr. 2015.

<sup>44</sup> "The MSF Adventure." YouTube. N.p., 12 Mar. 2014. Web. 07 Apr. 2015.

France on the issue.<sup>45</sup> MSF blamed the UN for not intervening in the face of such violence, and blamed France for not doing anything to stop the Hutu government, who were essentially French allies, from perpetrating the violence.

While MSF staff began to speak out by doing radio interviews, writing to newspapers, and critiquing the international community, MSF teams on the ground continued to treat refugees coming across borders of Rwanda. However, an incomplete understanding of the violence also led the MSF teams to treat Hutu massacrers as well<sup>46</sup>. Some of these MSF Teams were working with the tutsi RPF in what had become RPF-controlled territory in Rwanda. MSF's purpose was to aid the Tutsi civilians under the protection of RPF. However, an MSF report details how the RPF took advantage of MSF to trick the international media into believing that RPF was being compassionate towards civilians, while simultaneously committing egregious human rights abuses, like not giving the civilians under their protection food. MSF did not stop cooperating with the RPF however, and the report was not made public during the conflict<sup>47</sup>.

MSF began to describe the phenomenon they called "the humanitarian alibi" at this point during the conflict. The idea described the how the international community, and the RPF used MSF's humanitarianism as an excuse not to act in Rwanda (in the case of the UN and France) or to continue to abuse the rights of their civilians (in the case of the RPF)<sup>48</sup>. Without knowing how to counter this perception, MSF felt it had no choice but to continue speaking out. MSF France particularly

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<sup>45</sup> "Genocide of Rwandan Tutsi 1994." MSF.org. Médecins Sans Frontières, Sept. 2003. Web. 8 Apr. 2015.

<sup>46</sup> Ibid 51.

<sup>47</sup> Ibid 60.

<sup>48</sup> Ibid 40.

launched a campaign and appeal to French President Mitterand to take action on Rwanda. MSF France was subsequently invited to meet with Africa Unit of Mitterand, where he expressed his displeasure at the critiques and the "unfair attitude" of the humanitarian organization<sup>49</sup>. Despite his displeasure, MSF France continued to appeal to the UN and Mitterand, which culminated in the French branch calling an for armed intervention in Rwanda.<sup>50</sup>

The result of the appeal was that the UN and France finally acknowledged the events in Rwanda as a genocide, and launched Operation Turquoise, announced on June 22, 1994. The operation was sanctioned by the UN and to be carried out by the French army<sup>51</sup>. The goal of Operation Turquoise was to establish safe zones within Rwanda that would be controlled by MSF France. The idea was that civilians could find refuge in the "turquoise zones" where they would be safe from violence until UN peacekeepers could stabilize the region. However, the Hutu still managed to kill many Tutsi who were not able to make it to the zones, and were able to intercept some civilian groups escaping there. Additionally, France made no attempt to capture Hutu government officials who were known to be coordinating the genocide<sup>52</sup>. Despite the fact that the operation meant an answer to the appeals of MSF France, the intervention was met with extremely negative feelings from humanitarian organizations including from MSF Belgium, whose Communications Director said that "doing nothing at all" would be preferable to the intervention<sup>53</sup>. Over the course

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<sup>49</sup> Ibid 47.

<sup>50</sup> Ibid 44.

<sup>51</sup> Ibid 53.

<sup>52</sup> Dallaire, Roméo, and Brent Beardsley. "Shake Hands with the Devil: The Failure of Humanity in Rwanda." New York, NY: Carroll & Graf, 2005. Print.

<sup>53</sup> "Genocide of Rwandan Tutsis" MSF Speaks Out, MSF (55).



of Operation Turquoise, which many have historically concluded did little to save Tutsi lives, the RPF took control of the Rwandan government from the Tutsi. While the violence was not over, the coup certainly represented the denouement of the events that had become known as acts of genocide.<sup>54 55</sup>

### *Fighting the Humanitarian Alibi*

An interesting phenomenon revealed by MSF's intervention into the Rwandan genocide is what MSF referred to as the "humanitarian alibi" provided by organizations like MSF when it comes to crisis situations like in Rwanda (Genocide of Rwandan Tutsis, MSF Speaks Out). It is a term that first became relevant to its intervention in Bosnia, and soon after, in Rwanda. The MSF France program director of Rwanda, Francoise Bouchet-Saulnier, described this phenomenon saying:

"In Paris, we had endless discussions about the 'humanitarian alibi'. We couldn't accept that politicians were hiding behind humanitarian work to avoid making decisions that would enable them to save people's lives . . . The crisis point has been reached when it comes to genocide . . . National governments would have us continue our humanitarian work in the middle of a genocide . . . And we had to ask ourselves: 'What can we do to make them do something more than just provide humanitarian aid?'"<sup>56</sup>

The "humanitarian alibi," as described by MSF in different circumstances throughout the crisis in Rwanda, is when a governmental body uses the presence of NGOs and humanitarian organizations like MSF on the ground to justify its own inaction. MSF says that the behavior is harmful, because, in cases like Rwanda, governments claim a "humanitarian alibi" where the need for governmental action is

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<sup>54</sup> "Genocide of Rwandan Tutsis" MSF Speaks Out, MSF.

<sup>55</sup> Dallaire, Beardsley. "Shake Hands with the Devil: The Failure of Humanity in Rwanda."

<sup>56</sup> Francoise Bouchet-Saulnier, MSF Legal Advisor, quoted in "Genocide of Rwandan Tutsis, MSF Speaks Out" (40)

most dire, and when humanitarian action is insufficient. As described by Bouchet-Saulnier above, the challenge for MSF comes when they must dispel the alibi and force state bodies into action. In the case of Rwanda, I argue that three different political bodies took advantage of the "humanitarian alibi" provided by MSF: the UN, the French government, and the RPF. The UN and France used the alibi to justify their silence and inaction in Rwanda, and the RPF used its cooperation with MSF as a media smokescreen that disguised the human rights abuses of its army. I will first show how each political body took advantage of the alibi, and then explain how MSF's culpability in each of these consequences.

When discussing to the "humanitarian alibi" in her quote, Bouchet-Saulnier is referring to the UN Security Council's inaction, the first of these actors to do so. Early into the crisis, the UN actively distanced itself from any responsibility by withdrawing the majority of the UN Peacekeepers from Rwanda, an act that MSF protested<sup>57</sup>. Soon after, MSF Belgium began presenting eyewitness accounts of its own staff describing amounts of death and destruction they were seeing in Rwanda. The presentations included a presentation by the Executive Director of MSF Belgium to the President of the UN Security Council.<sup>58</sup> However, judging by its lack of reaction, the UN was either insufficiently convinced by him, or determined that the situation fell within the expertise and prerogative of NGOs like MSF. According to MSF, the UN was "hiding behind humanitarian work" as an excuse for inaction. Thus, the UN became the first actor in the conflict to distance itself from Rwanda, and MSF even acknowledges that the withdrawal was its own fault. Although the UN

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<sup>57</sup> "Massacres in Rwanda" MSF Holland Press Release, April 24 1994.

<sup>58</sup> "Genocide of Rwandan Tutsis, MSF Speaks Out" (29)

would later reenter the conflict, any chance at handling the situation proactively would be gone.

The second political body that made use of the humanitarian alibi was the French government. Later on in the conflict, MSF France became actively involved in both the work on the ground, and subsequently the witnessing and advocacy work. MSF France then began an aggressive PR campaign towards both the UN and its own government in order to stop the violence. The argument for implicating France in the conflict was that they were implicitly responsible for the violence due to the country's colonial past in Rwanda. Additionally (and more directly) the Rwandan government's forces, who controlled zones in which the genocide was actively occurring unhindered, were France's allies. In an op-ed in a French newspaper, MSF staff member Dr. Jean-Hervé Bradol said that the forces "have been trained, armed, and funded by France. Consequently it is hard to believe that Paris has no way of pressuring those responsible into putting an end to the massacres"<sup>59</sup>. France's response to the accusations, and calls to action leveled by MSF France was to shift the responsibility back towards MSF and humanitarian organizations. The MSF France executive board discussed the President's reaction in a meeting in late May, saying that "[the President and his advisors] were more concerned about justifying French policy in Rwanda, and informed us that France was earmarking an extra three million francs in humanitarian aid for NGOs in Rwanda"<sup>60</sup>. The response is exactly the attitude that MSF had hoped to counter. The French government made it clear through this statement that it viewed the situation in Rwanda as a humanitarian crisis,

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<sup>59</sup> "MSF: Late gesture from the UN" *Liberation*, May 18, 1994 (translated by MSF USA)

<sup>60</sup> "MSF France Board Meeting minutes, May 20 1994." MSF International. (Translated by MSF USA)

and absolved itself from any further responsibility other than fundraising. As with the UN, MSF was acutely aware that its humanitarian presence was being viewed as a substitute for political action.

Finally, the last political body to invoke the humanitarian alibi was the Rwandan Patriotic Front (RPF). The RPF is the political party founded and controlled by Tutsi that sought to overthrow the Hutu-controlled government responsible for the genocide of the Tutsi in 1994. Their armed branch, the Rwandan Patriotic Army (RPA) was the army used to accomplish the coup. The RPF fled to neighboring Rwanda before the genocide occurred, and reinvaded in order to overthrow the Hutu in 1994.<sup>61</sup> Judging by the fact that the RPF is made up of Tutsi leadership, it might appear that they are protecting the Tutsi civilians being massacred, but according to MSF staff on the ground, it was not the case. MSF Belgium worked closely with civilian populations that came into contact with the RPA, and saw numerous human rights abuses. According to reports from MSF Belgium, "orphans that [MSF Belgium] was supposed to move were dumped at the bridge by the RPF and kept there for three days on purpose. Nobody was allowed to touch them . . . [an RPF official] accused MSF of . . . being personally responsible for the mistreatment"<sup>62</sup>. The Belgium coordinator went on to conclude that the RPF "is not representing the majority of Rwandan Tutsi" and that they do not have the population's best interests at heart, but instead seek to seize control of the government by any means necessary. Not only do they commit egregious human rights abuses, however, but they are also able to mask their actions using MSF and other humanitarian NGOs: "The cover, that they care for

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<sup>61</sup> "Rwandan Patriotic Front." Wikipedia.  
<[http://en.wikipedia.org/wiki/Rwandan\\_Patriotic\\_Front](http://en.wikipedia.org/wiki/Rwandan_Patriotic_Front).> Retrieved February 26, 2015.

<sup>62</sup> "Summary of Incidents with the RPF" MSF Belgium coordinator in Rwanda, July 9, 1994.

their population, is a perfect smoke screen for gaining support from the Western world." He goes on to say that the RPF "play the media game splendidly." This allows the RPF to gain a political edge by tricking both local and Western media into supporting them, or at least not hindering them, and by giving an outward appearance of cooperation with humanitarian NGOs, while simultaneously sacrificing civilian populations for resources, and military advantage. The staff member of MSF Belgium concluded his report on an incredibly pessimistic note, detailing on his opinion of the effect that MSF was having in Rwanda given their relationship with the RPF and the Tutsi civilians they were attempting to treat, saying, "curing created disease [by the RPA], regardless of present and future for those people we cure, is making us accomplices of the crime."<sup>63</sup> In this case, MSF is not only aware of the effect its presence is having for the Tutsi civilians, but it also did not stop working with the RPF, and continued to enable the behavior. MSF's issue thus became not just the unintended consequence of its actions, but also how it prioritizing the organization's continued intervening over the human rights abuses its presence enabled.

The various ways in which the three different political bodies (the UN, the French government, and the RPF) took advantage of humanitarian NGOs, and MSF particularly, illustrates an important consequence of MSF's humanitarian action. Even without considering the quality of work MSF did in Rwanda, it is clear that MSF's mere presence had consequences for how the crisis was interpreted, and therefore how it was handled by the international community. The UN removed its troops and abandoned Rwanda, the French government claimed no responsibility, and the RPF manipulated MSF into bolstering its public image. There are two interpretations of

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<sup>63</sup> Ibid

the response from France and the UN that Rwanda is a humanitarian crisis that shouldn't have international involvement. The first interpretation is to take the UN and France at their word. They genuinely misinterpreted the crisis for the majority of the time in which the genocide occurred. Then, hastily realizing their mistake, attempted to intervene. The second interpretation is that due to complicated political implications, both the UN and France decided that it was not in their best interests to intervene, and eventually only bowed because of public pressure exerted on them as the genocide grew to international infamy. In the first scenario, the presence of MSF, and MSF's treatment of the situation as a displaced refugee intervention complicated by a civil war convinced them that political involvement would be both unnecessary and harmful. In the second scenario, MSF provided a convenient justification for political ends that allowed them to be idle for the vast majority of the genocide. In either case, their inaction was aided by the humanitarian alibi provided to them by MSF and other NGOs. The same is true in the case of MSF's interactions with the RPF. Even though their purpose of treating the civilians being victimized by the RPA were noble in theory, MSF's presence allowed the RPF to wield the health and well-being of the Tutsi civilians as a political tool to manipulate both MSF, by using their own ideologies against them, and the international community as a whole by appearing to cooperate with MSF and to care for its civilians in front of the media. The takeaway is that MSF has the ability to influence situations, in the case of Rwanda, negatively, merely by choosing to intervene in the first place. Though MSF might not be in control of how its actions will be perceived, MSF is often aware of it, as was the case with the RPF. The report detailing the human rights abuses of the

RPF called the MSF staff "accomplices of the crime" by continuing to work with the RPF. So, even when MSF was aware, the organization chose not to alter its intervention as a result.

*Témoignage: The Complexities of Advocacy*

The phenomenon of the “humanitarian alibi,” and the ensuing work MSF undertakes to counter it, directly tie in to MSF’s work as an advocacy organization. In their charter, MSF says it is its job to bear witness, which means “to bring attention to extreme need and unacceptable suffering” to different situations, including “when crises are neglected”<sup>64</sup>. In the case of Rwanda, MSF interpreted the action of bearing witness as fiercely advocating for international intervention into the genocide, to varying levels of success. MSF Belgium and MSF Holland were responsible for the petitions to the UN Security Council, and further into the timeline of the genocide, MSF France aggressively petitioned its own country to become involved. However, I argue that the Rwandan genocide also brings to light the lack of cohesion in MSF's witnessing. MSF France called for an armed intervention, but when this call to action was realized, other sections of MSF spoke out against the decision. Rwanda also shows the amount of influence MSF wields internationally. The UN answered MSF France's media campaign, and the result was the armed intervention Operation Turquoise. Given that this operation was largely considered a failure, I argue that MSF is not always prepared for the consequences of its acts of witnessing.

When the situation in Rwanda began to escalate, MSF Belgium was the first to call for an international response. Their staff was on the ground first, and without any

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<sup>64</sup> “MSF Charter and Principles.” MSF International.

greater context for what was happening, they quickly became overwhelmed by the destruction and death around them. In early April some staff spoke to the press: "The idea at this time was to ask for safe havens and an international intervention - to call for an area where Tutsi could evacuate. That was what we said to the press."<sup>65</sup> However, mere days later, the UN Security Council chose to withdraw their Peacekeeper troops from Rwanda in light of the massacres, despite protests from MSF Belgium and MSF Holland.<sup>66</sup> MSF Belgium's call for international attention marked the beginning of MSF's advocacy campaign in Rwanda. A press release from MSF UK also implicated the UN, calling for a "more robust United Nations engagement in Rwanda"<sup>67</sup> days after the UN withdrew their troops.

It was when MSF France became embroiled in the intervention and the conflict, and when it began to put public and media pressure on the French government that international authorities finally became involved. The MSF France appeal took advantage of their vast donor base, sending out a petition, which at this point in the conflict was calling for an armed intervention. The letter accompanying the petition said:

"This Appeal is made by all MSF doctors. If it is to be heard by those who have the power to stop the genocide, we need to gather as many supporters as possible, people who are concerned about the suffering of others. We need your support. Do not delay: when children are pursued by murderers, every day counts. Send us proof of your support today by return of post, by signing the appeal accompanying this paper... you are the force that can save thousands of people from genocide. Your moral support is as essential to us as your financial assistance."<sup>68</sup>

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<sup>65</sup> "Genocide of Rwandan Tutsis, MSF Speaks Out" (25)

<sup>66</sup> "Massacres in Rwanda" MSF Holland Press Release

<sup>67</sup> "MSF calls for stronger United Nations presence in violence-stricken Rwanda" Press Release MSF UK. April 28, 1994.

<sup>68</sup> "APPEL DE MEDECINS SANS FRONTIERES A: Monsieur le Président de la République, Monsieur le Premier Ministre, Mesdames et Messieurs les Députés." MSF France, June 1994. (Translated by MSF USA).



The petition was addressed to the President of France and his cabinet, and decried for their inaction along with the United Nations. The petition invokes MSF's moral authority, arguing that each day that France fails to engage in Rwanda results in the deaths of children. The appeal worked, and there was aggressive and negative media attention on the UN and the French government for their inaction in the face of what was now officially being classified as a genocide, and no longer merely violence and death resulting from civil war. The language in the petition captures the sentiment that MSF continued to press in various radio interviews, op-eds, and general media appearances and press releases. The press campaign even included an open letter to the French President, saying, "the international community, and France in particular, must accept political responsibility and put a stop to the massacres."<sup>69</sup> Importantly, the letter did not specify what the intervention should entail, but its call to action was clear.

The campaign ultimately resulted in both the UN and France caving, and planning a reluctant intervention. The intervention, called Operation Turquoise, was to be spearheaded by the French government and backed and funded by the UN. As if to confirm that the intervention was in large part due to pressure leveraged by MSF, President Mitterand met with the directors of MSF France and described the operation before it was publicly announced. The French president described MSF's campaign against him as "propaganda". Additionally, Mitterand described the dramatic about-face the French towards the Rwandan crisis. According to Bradol, the operation, and his meeting with the president indicated a shift in the French government from

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<sup>69</sup> "Open Letter from Médecins Sans Frontières to the President of the French Republic" *Le Monde*. Paris, France. May 18, 1994. (Translated by MSF USA).

"perceived neutrality" towards Rwanda, to "a humanitarian-hostile position."<sup>70</sup> MSF's campaign had thus resulted in a shift in French foreign policy. The government now officially viewed the Rwandan conflict as a violation of humanitarian principles.

The operation, sanctioned by the UN security council and to be carried out by France, would send armed French troops into Rwanda to take control of specific zones where large civilian portions of Tutsi were known to be under attack. Operation Turquoise was by no means embraced by the NGOs on the ground in Rwanda however, and it caused quite a divide among the different sections and staff members of MSF. In an interview for *La Nouvelle Gazette*, Dr. Pierre Harzé, Director of Communication at MSF Belgium said, "I am convinced that doing nothing at all is better than the French intervention. . . [It] is likely to be catastrophic." He also stated, "we are all agreed" referring to the opinion of MSF France on the issue.<sup>71</sup> However, there was certainly no unanimity between MSF France and MSF Belgium on the issue. In an interview with the French Newspaper *Libération* an MSF France staff member said, "the problem of who should intervene is only secondary. France is clearly not the ideal choice. UN intervention would have undoubtedly been preferable, but all that matters is that genocide is taking place and it must be stopped by any possible means."<sup>72</sup> Clearly, though some MSF staff and media outlets assumed MSF as whole was on the same page, it was not the case. On one hand, MSF had been campaigning for a UN sanctioned intervention for many weeks, but on the other, MSF risked not only its reputation, but also the lives and safety of thousands of Tutsi

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<sup>70</sup> "Interview with Dr. Jean-Herve Bradol." *YouTube*. YouTube, 25 Mar. 2014. Web. 27 Feb. 2015.

<sup>71</sup> Toubeau, Corrine. "MSF: 'Mieux Vaut Rien Que Les Francais'" *La Nouvelle Gazette* [Belgium] 21 June 1994. Print.

<sup>72</sup> "Genocide of Rwandan Tutsis, MSF Speaks Out" (55)

if Operation Turquoise turned out to be the failure that many NGOs anticipated it would be. Given that France had intervened in Rwanda only years earlier to stabilize and support the government that was now committing a genocide, many worried that a French presence would only destabilize the region more, and throw Rwanda into even more chaos and violence.

MSF's advocacy work on behalf of the Rwandan Tutsis brings to light interesting problems and challenges that are brought on by the seemingly straightforward act of "witnessing." MSF treats the action as if it were extremely straightforward, saying, "when MSF witnesses extreme acts of violence against individuals or groups, the organization may speak out publicly."<sup>73</sup> However, as the Rwanda genocide demonstrates, "speaking out" is not necessarily a cohesive action, or one that all sections do the same way, or at the same time. Equally clear from Rwanda is MSF's skill at reaching out to the media, and its sway over public opinion in matters of international humanitarianism. Despite prolonged inaction from the UN and from France, MSF successfully launched a campaign that exerted enough public pressure on both political bodies to change their positions and launch a large scale intervention.

However, as became clear from the many different, contrasting statements from various MSF officials, Operation Turquoise was by no means universally accepted among MSF branches and staff. Given MSF Belgium's position that "anything would have been better than a French intervention," it seems that they never supported a campaign to pressure France into intervening at all. The lack of unanimity reflects the scattered nature of MSF as an organization. Different sections have different

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<sup>73</sup> "MSF Charter and Principles." MSF International.

leadership, who all have their own interventions and their own agendas. Although a timeline can be pieced together post-hoc, it is clear from Rwanda that it is not unusual for little communication between sections as events occur in real time. Therefore it is unsurprising that one section with several loud, influential voices can push for a course of action with which other sections might vehemently disagree. However, by the time they voiced their dissent, it was too late to stop Operation Turquoise.

Even MSF France seemed not to anticipate that its actions would lead to an intervention like Operation Turquoise. From interviews, MSF France made it clear that the intervention was not "ideal," but they were forced to accept it since time for the Tutsis was running out. The aggressive nature of its campaign called the international silence and inaction on Rwanda unconscionable, and "insulting"<sup>74</sup> to the Rwandan people. MSF used its position to create an atmosphere of moral certainty that pressured the UN and France into acting quickly. The result was a less than ideal operation according to MSF's standards. However, MSF twisted the French President's arm, and thus cannot be removed from its part in the problematic parts of the hasty operation. As President Mitterrand's meeting with MSF officials showed, MSF's influence was in large part responsible for the urgent pressure France felt to come up with an intervention quickly. Despite the fact that it had called for the operation, MSF France came to regret it.

Therefore, "witnessing" cannot be seen as an action removed from MSF's interventions on the ground, or even an action that contains moral clarity. In his Nobel lecture, former MSF President Dr. James Orbinski said that when it comes to

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<sup>74</sup> "Genocide of Rwandan Tutsis, MSF Speaks Out" (37).

speaking out "silence is deadly."<sup>75</sup> In the case of Rwanda, witnessing proved to be dangerous, too. It is a complicated action that can have direct affects in actions taken on the ground, if not by MSF, then by the international community. It is just as morally unclear, and requires just as much thought and consideration as any medical intervention. Without careful consideration, and if misused, witnessing becomes a tool just as dangerous as a poorly planned medical procedure. Finally, the dissidence between different sections, and complications around witnessing show that social forces play a large role in determining the course interventions for MSF. Even though their planned interventions are thought of in terms of a biomedical understanding of events, social and political factors play determinant roles in how events play out on the ground.

### *Curing Genocide with Doctors*

One aspect of the Rwandan intervention with which even MSF itself expressed frustration, was the inadequacy of a humanitarian framework to end a genocide. One must wonder then, if MSF doubted its own abilities to handle the conflict, let alone solve what caused them to get involved in the first place? To answer this crucial question, it is important to understand that MSF's involvement in the Rwandan genocide was not necessarily a deliberate act, but, similar to MSF's involvement in HIV/AIDS in Uganda, the result of a series of previous steps that culminated in an inextricable engagement in the events of Rwanda in 1993 and 1994.

MSF Holland and MSF Belgium were the first branches of MSF on the ground in Rwanda. Preceding the genocide, parts of Rwanda were embroiled in a bloody civil

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<sup>75</sup> "Médecins Sans Frontières - Nobel Lecture". Nobelprize.org.

war leading to a shift in government power. MSF Belgium intervened in order to aid the displaced refugees from the conflict, resulting in two missions that were several months long in the early 1990s, and finally a third mission that placed them in Rwanda at the time the genocide was beginning in February of 1993. MSF Holland was present in a different area of the country, north of the capital, on a longterm mission that began in 1992. MSF Holland also was in Rwanda at the beginning of the genocide, and in place to witness the beginnings of the conflict. MSF Belgium admitted later on to the lack of knowledge of the events taking place, saying, <sup>76</sup>"MSF cannot claim, any more than the United Nations, to have said at any time: 'there's a genocide in the making' . . . We were entirely focused on the advancing front, the problems with the refugees, and the huge number of displaced people."<sup>77</sup>

MSF France had a different means of entry, and only entered once the events that would become known as "genocide" were already taking place. When President Ndadaye was assassinated, hundreds of thousands of refugees fled the massacres that were occurring in the fallout. Although they were unaware of the context beyond the obvious political nature of the assassination, MSF France rushed in to help the sections of MSF Belgium and Holland who were overwhelmed by the sudden influx of the malnourished and injured population.<sup>78</sup> MSF France also characterized the events as a political conflict early on, and there was some critique early on of the lack of reflection on the political nature of the events happening in Rwanda leading to the displacement of so many refugees. In the minutes of an MSF France board meeting, it was said that "[MSF] gives no thought to the political aspects: the right to asylum,

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<sup>76</sup> "Genocide of Rwandan Tutsis, MSF Speaks Out" (11)

<sup>77</sup> Dr. Eric Goemaere, quoted in "Genocide of Rwandan Tutsis MSF Speaks Out" (13)

<sup>78</sup> "Genocide of Rwandan Tutsis, MSF Speaks Out" (11)

why people are fleeing, the nature of the enormous conflict between the Hutu and Tutsi."<sup>79</sup> Thus, all three sections of MSF that became involved in the Rwandan genocide all went in without a clear political understanding of the events taking place.

However, despite MSF determining that it did not have a thorough understanding of the crisis situation it was now entering, the various interventions from the three MSF sections continued, and proceeded for the following months. For Rwanda was, if nothing else, a crisis situation, and it is unsurprising that tMSF became involved. MSF already had extensive experience treating displaced populations fleeing violence in many countries across the world. It is hard to ignore the necessity for the treatment of hundreds of thousands of refugees.

The intervention proceeded in the fashion that MSF missions had for years. MSF took over local hospitals, recruited and trained local volunteers, and supplemented the hospital with their own international staff. According to minutes of another MSF France board meeting, "[NGOs] tended to over-employ Tutsi because of their skills, their diplomas,"<sup>80</sup> and the result was most of the MSF local volunteers were of Tutsi origin in Rwanda. According to the minutes, MSF France was aware that an ethnic conflict was at the heart of the violence, between the Hutu and Tutsi, and that The Hutu had recently come into governmental power, but that was the limit of their understanding of the conflict at the time.

The result was a hastily put together intervention that took into account neither Rwanda's political atmosphere and recent shift in governmental power, nor the effect

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<sup>79</sup> "Compte Rendu de la Reunion du Conseil d'Administration du 25 mars 1994" March 25, 1994. MSF France Board. (3)

<sup>80</sup> "Compte rendu du Conseil d'administration de MSF France du 20 mai 1994" MSF France Board.

that MSF's presence would have on the conflict on the ground. The Tutsi massacre continued in the following weeks. Thousands were dying in the streets and the violence showed no sign of tempering. In MSF's hospitals, patients were targeted. The medical coordinator of MSF Belgium, Dr. Rony Zachariah, reported, "150 of our hospital patients, women children, and adults were killed."<sup>81</sup> MSF hospitals were no longer safe spaces for patients, and victims of the genocide. Patients were not the only population in danger, however, MSF staff also became targets of Hutu violence. MSF's fears of being seen as "pro-Tutsi" in the conflict were realized when the Hutu began killing hospital staff known working in MSF-controlled hospitals. MSF reported that "dozens of locally recruited aid workers had been slaughtered."<sup>82</sup> Without the protection of the UN peacekeepers that had since evacuated, MSF's work was rendered useless and ineffective by the unceasing onslaught of violence in even designated humanitarian spaces like MSF hospitals.

### *Conclusions*

MSF's intervention, which lacked any political consideration or larger planning, had drastic consequences on the ground in Rwanda. MSF became involved in Rwanda the same way it becomes involved in every intervention, by witnessing widespread suffering through a medical lens, and intervening. MSF quantified the suffering with its various measures: number of displaced refugees, amount of casualties on the ground, and the lack of native infrastructure or ability to handle the crisis. A political context, or an understanding of the greater framing did not factor

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<sup>81</sup> "MSF (Un) Limited." *YouTube*. YouTube, 12 Mar. 2014. Web. 02 Mar. 2015.

<sup>82</sup> "Thousand feared massacred in Kigali." *Irish Times*, Ireland. April 9, 1994.



into MSF's planning, and in Rwanda, the lack of knowledge resulted in a failed intervention, and dozens of its staff murdered. However, a biomedical framework is certainly not useless when looking at Rwanda. It provides sharp clarity, and the amount of violent casualties correctly presents a distressing image of emergency and suffering. The problem then, is not in MSF's ability to realize that there is a problem, but in the belief that it has the unequivocal ability to solve those problems by the same biomedical means. In Rwanda, not only could they not resolve the conflict, but MSF even made it worse in some circumstances by providing Hutu with the guaranteed locations of hundreds of injured Tutsi in MSF hospitals. MSF also used its biomedical framework and moral authority to leverage appeals to the UN and French government when the organization said that each day of inaction represented more lives of children lost. MSF is aware that humanitarianism has limits. In the Nobel acceptance speech, Orbinski said, "humanitarian action comes with limitations. It cannot be a substitute for political action."<sup>83</sup> This is an important lesson to take away from Rwanda, but it is not the only lesson. What Orbinski failed to take into account was that MSF's biomedical framework itself also comes with limitations. Only by acknowledging the limits of biomedicine as a humanitarian vantage point, and by including a holistic political context in its understanding of the conflict can MSF make its interventions safer and more effective.

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<sup>83</sup> "Médecins Sans Frontières - Nobel Lecture". Nobelprize.org.

**CHAPTER III:**  
**Doctors Without Progress: The NGO Republic and Alternate Models of Aid after Haiti's Earthquake and Cholera Outbreak.**

*Introduction*

On January 12, 2010 a 7.0 magnitude earthquake struck Haiti. The turmoil and political violence that followed led to a massive humanitarian response. In this chapter I argue, in post-earthquake Haiti, NGOs have launched a series of interventions in Haiti that have been out of sync with the needs of the Haitian people. This is primarily because the input of the Haitian government and the Haitian people has been systemically left out, both by the structure of the recovery, and behavior of the actors like MSF leading the recovery. The result is an achingly-slow recovery, and millions of displaced, suffering Haitian citizens. In the case of MSF, its biomedical model of aid facilitates this systemic exclusion, since biomedicine privileges the concrete over the lived experiences of Haitians.

However, the overall failure of Haiti's reconstruction effort is not the only model of humanitarian aid given by NGOs. Partners In Health (PIH) is another healthcare-centered NGO that partners with local community organizations in Haiti, putting Haitian ideas at the forefront of their recovery efforts. PIH's model significantly differs from the top-down expertise offered by NGOs like MSF, and the result is more more effective aid, led by the people who stand to lose and gain the most.

*Haiti: Before and After the Earthquake.*

Haiti has long been the site of massive NGO activity, including MSF. In the early 1990s, a military coup against the former president of Haiti, Jean-Bertrand Aristide,

was the first in a series of events that destabilized the country economically and politically. One of the most significant events was when Haiti lowered its import tariffs on foreign goods. Many countries, including the US took advantage of the turmoil by overproducing rice and selling it cheaply to Haiti. Haitian farmers, an integral part of the Haitian economy, could not compete with the low price of the various foreign agricultural imports and largely went out of business. The collapse of this large part of the Haitian economy led to further political and economic crisis in a country that had previously been on the rise.<sup>84</sup>

The turmoil led to violence, and MSF stepped in to Haiti to assess the situation, and treat the casualties resulting from the violence that led up to another coup. MSF has remained in the country ever since, first to strengthen the collapsing health systems, then reacting to various natural disasters, like hurricanes and floods.<sup>85</sup> So when a 7.0 magnitude earthquake shook Haiti on January 12, 2010, MSF was already positioned to help. They were not alone: thousands more NGOs converged on the country, spending billions of dollars, and implementing many different strategies to “build back better” in Haiti.<sup>86</sup> However, despite the immense international funding and NGO presence, Haiti is by no means happy with the progress. Three years after the earthquake, President of Haiti Michael Martelly made a statement on the massive western presence in the country, saying, “We don't just want the money to come to

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<sup>84</sup> Brandenburg, Matthea. "Beyond Aid: The Flood of Rice in Haiti." PovertyCure.org. Poverty Cure, 14 Mar. 2013. Web. 24 Mar. 2015.

<sup>85</sup> "HAITI: Doctors Without Borders/Medecins Sans Frontieres (MSF) Six Month Report." HVC Analysis. MSF, 16 July 2010. Web. 24 Mar. 2015.

<sup>86</sup> Sontag, Deborah. "Rebuilding in Haiti Lags After Billions in Post-Quake Aid." NYTimes.com. The New York Times, 23 Dec. 2012. Web. 24 Mar. 2015.

Haiti. Stop sending money. Let's fix it. Let's fix it.”<sup>87</sup> Martello’s remarks reflect his own frustrations with the NGO-led recovery, but also the dissatisfaction of Haiti’s citizens in general. On the other hand, MSF (and many NGOs) blame the slow progress on “the failures of Haitian authorities.”<sup>88</sup> Despite the money and effort funneled into Haiti, supposedly to Haiti’s benefit, foreign NGOs like MSF and Haiti are at odds when it comes to handling Haiti’s reconstruction, and who is to blame for its painfully slow pace.

One might assume that MSF was prepared to deal with the medical consequences of the earthquake, and the cholera outbreak months later, (a disease that is easily treatable, but quickly becomes fatal when left alone.) However, despite MSF’s long history with cholera (MSF has launched cholera interventions in Nigeria, Mozambique and other countries)<sup>89</sup>, its experience with Haiti, and the plethora of other NGOs in the country, Haiti’s recovery has lagged, especially when it comes to healthcare. MSF’s intervention has proved to be not very effective, access to health services in Haiti remains abysmal, and the cholera outbreak shows no signs of slowing. Every day the recovery lags, Haiti pays the price.

MSF responded to the earthquake by reinforcing its presence in Haiti, and taking over local hospitals to provide emergency care. When the cholera epidemic began, MSF set up Cholera Treatment Centers (CTCs), large, impermanent tents where cholera patients could be treated with fluids and antibiotics. MSF continues to treat

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<sup>87</sup> Beaubien, Jason. "What Happened To The Aid Meant To Rebuild Haiti?" NPR.org. NPR, 28 Feb. 2013. Web. 24 Mar. 2015.

<sup>88</sup> Brauman, Rony, and Fabrice Weissman. "Haiti: On Aid and Reconstruction." CRASH Fondation Médecins Sans Frontières. MSF, 14 Jan. 2011. Web. 15 Mar. 2015.

<sup>89</sup> "Cholera in Mozambique: A Worrying Situation." Médecins Sans Frontières (MSF) International. N.p., 27 Feb. 2015. Web. 08 Apr. 2015.

patients, but according to head of mission Joan Arnan, “it’s unlikely that MSF will be able to hand over the management of these [hospitals and CTCs] to Haitian authorities anytime soon.”<sup>90</sup> It is clear that MSF will be in Haiti for the longterm, and will continue to do damage control. Cholera remains a major public health problem with hundreds of new cases each day, and Haitian citizens travel great distances to receive treatment of any kind, since health services have yet to be replaced in most areas since the quake.<sup>91</sup>

Although Martelly, the Haitian government, and the Haitian people can see that progress is lacking, none of these actors possesses any real power to change the course of the recovery. While the interventions, policies, and strategies for recovery are meant to be for the benefit of Haiti, Haitians are largely left out of all aspects of the NGO led recovery. While Haitians suffer from the lack of any infrastructure, housing, or healthcare, the United Nations has used some of the recovery funding to build a logistics base where NGO leaders and UN committee chairs can meet to discuss strategy, award grants to NGOs, and allocate the billions of dollars in funds that have been donated to the Haitian recovery. Of those funds, only one percent has gone to the Haitian government, and anywhere from seven to ten percent of the grants awarded to foreign NGOs goes towards administrative costs of the organization. So despite the claim that the Haitian government’s failures are to blame for the slow recovery, in reality, Haitians have almost no say when it comes to the direction of their country.

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<sup>90</sup> "Health Care Lags In Haiti's Post-Earthquake Rebuilding Efforts." Doctorswithoutborders.org. MSF USA, 7 Jan. 2013. Web. 24 Mar. 2015.

<sup>91</sup> Ibid

First, I will further discuss the conflict between Haiti and the NGOs in residence, explaining how each actor blames the other for the slow recovery. MSF places the blame on Haiti's failures as an effective governing body, while the Haitian government blames the multitude of NGOs that have taken residence in the country, circumventing their authority, turning Haiti into what has been called a "Republic of NGOs." Then, I will establish the ways in which NGOs at large, and MSF in particular, have created a culture in which the ideas of the Haitian government, and Haitian communities are not integrated into the recovery strategies, resulting in inadequate aid, and a slow rebuilding effort. Finally, I will compare and contrast the models of MSF and PIH as two health-focused NGOs. I will use the case of the Shanchol vaccine, an oral cholera vaccine, to argue that PIH's model of medical humanitarianism results in the inclusion of Haitian voices in the recovery, which manifests in much more effective aid.

### *"The Haitian Republic of NGOs"*

At any given moment, no one knows exactly how many NGOs are in residence in Haiti. Many have tried to quantify the substantial international presence whose ideas, projects, and money have become the driving force in Haiti's reconstruction after the earthquake in 2010, but estimates range all the way from 343 to 20,000 total NGOs<sup>92</sup>. The leaders of each NGO's respective interventions even have a central base where they can discuss strategies and details of the recovery effort. The log base, as the center is known, has therefore become intellectual center of the Haitian recovery. The

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<sup>92</sup> Ramachandran, Vijaya. "Is Haiti Doomed to Be the Republic of NGOs?" *Center For Global Development*. N.p., 9 Jan. 2012. Web. 15 Mar. 2015.

building is within a fenced-off premises complete with a manicured lawn and gardens, and an interior that would be considered ornate even without the destruction surrounding destruction where it is located in Port-au-Prince.<sup>93</sup> The meetings there are held in English (as opposed to Creole, the native language of Haiti), and even to enter the grounds, guests must show various documentation, which few Haitians possess, or an invitation, which are rarely given. The governing body of the base is a committee of representatives from various NGOs, a committee on which no local, Haitian NGOs serve.<sup>94</sup>

The occupation of Haiti by hundreds (or thousands) of NGOs is referred to as a “republic of NGOs” by critics of the humanitarian aid industry, and by Haitian academics. The “republic of NGOs” criticizes humanitarian organizations, who “followed their own agendas and set their own priorities, largely excluding the Haitian government and civil society” from Haiti’s recovery efforts. The result of which being a set of strategies and projects that are unattuned to the needs of Haiti’s government and people.<sup>95</sup>

Given that MSF is a major presence in Haitian hospitals and in cholera treatment centers across the country, the “republic of NGOs” certainly includes MSF’s humanitarian medical interventions. On the one hand, MSF is clearly aware of the substantial criticism leveled at it, however, it ultimately makes its position clear that “the republic of NGOs” is not the cause of trouble in Haiti. In one article, MSF addresses why the reconstruction efforts in Haiti have lagged considerably given the

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<sup>93</sup> Polman, Linda, and Klarreich, Kathie. "The NGO Republic of Haiti." *The NGO Republic of Haiti*. The Nation, 31 Oct. 2012. Web. 15 Mar. 2015.

<sup>94</sup> Ibid

<sup>95</sup> Ibid

significant amount of money being funneled into Haiti. According to MSF, who tried to address the lagging recovery in order to get back on track, different actors have different interpretations for what is going wrong in Haiti, namely, the UN and the Haitian government: “For UN diplomats this handicap is the result of the incapacity and dubious morality of the Preval government.” If MSF’s interpretation of the UN position is accurate, then by placing the blame on Haiti’s Prime minister, the UN fully denies the existence of this “republic of NGOs,” as well as any role they play in facilitating it. MSF says that the Haitian government has a different interpretation of the slow reconstruction progress, saying, “For Larsen [Haitian Minister of Health] it is the will of the UN and international donors to impose a neoliberal development model.” Larsen’s explanation agrees with the criticism others have put forth on humanitarian aid to Haiti. MSF then sets out a strategy to overcome the animosity between the two parties, while acknowledging Larsen’s concerns, saying, “aid actors should . . . Ask themselves how to improve the day-to-day life of Haitians taking into account the uncertainties in the reconstruction, and not dream about transforming Haitian society for them.”<sup>96</sup>

However, MSF goes on to clarify that the critique is ultimately not the root of the slow development process, saying, “the ‘republic of NGOs’ . . . Is the symptom, not the cause of the failures of the Haitian authorities.”<sup>97</sup> The quote in this article reveals MSF’s position on the causes of slow, ineffective development in Haiti. MSF’s position can be broken down into several significant statements. The first part of their position makes it clear that while the ‘republic of NGOs’ does exist in some form, it

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<sup>96</sup> Brauman and Weissman, “Haiti: On Aid and Reconstruction”

<sup>97</sup> Ibid



is a “symptom” of the problem, while the “failures” of the Haitian government are the real issue. Secondly, implicit in MSF’s statement is a denial of its own role in the problem. After articulating the health minister’s position, they then proceed to give advice as to what “aid actors” should do to address his concerns. MSF says that aid actors should adapt their policies so that they “ask themselves how to improve the day-to-day life Haitians.”<sup>98</sup> By mandating a solution to other aid actors in Haiti, MSF distanced itself from the critique by implying that it had already taken this advice, or that it was at the very least in the process of doing so. Additionally, the advice MSF gives still does not require NGOs to include the Haitian government or Haitian communities into their operations. NGOs merely have to “ask themselves” what is best for Haiti, rather than include them in the strategy-making. MSF is therefore distancing itself from any wrongdoing in Haiti’s reconstruction by claiming three things: the Haitian government is truly responsible for the slow reconstruction, MSF has no role in any NGO occupation of Haiti, and the solution to the NGO republic is that other aid actors must slightly alter their strategy making. MSF’s actions in Haiti, and its work in controlling the cholera epidemic problematize all aspects of this claim, and the evidence can be seen through both MSF’s actions and its rhetoric.

First, MSF’s entrance into the cholera epidemic, and its subsequent interactions with the Haitian authorities and the communities in which it was working show that even if the NGO republic is simply a symptom of a larger failure, MSF is still very much a part of this occupation. MSF began its Haiti cholera intervention by establishing its credentials, and its many other interventions on the disease and its control. Doing so allows MSF to cement its status as the expert in Haiti. At the

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<sup>98</sup> Ibid

bottom of each of its press releases on the progress of the cholera intervention read, “MSF has extensive experience intervening in cholera outbreaks in varied locations throughout the world.”<sup>99</sup> MSF also made sure to establish its medical authority, with a field coordinator saying in an interview, “They [Haitian Health Ministry] were overloaded because they were lacking staff and supplies, and did not really know the protocol, since cholera is relatively new in Haiti. It has not been here for at least 60 years. So of course they needed help.”<sup>100</sup> MSF makes its position clear: it is MSF’s practical experience, and emergency medical expertise that is most important. The attitude manifested itself in many ways throughout the following months, including MSF issuing top-down recommendations and protocols to the Haitian government about what the nature and scale of its efforts should be. In another press release, an MSF emergency medical coordinator said, “[cholera] may be new to Haiti, but the ways to treat it are long established. Without an immediate scale up of necessary measures by international agencies and the government of Haiti, we alone cannot contain this outbreak.”<sup>101</sup> The press release went on to include a list of ways other agencies and the Haitian government could “scale up” their efforts. MSF’s actions systemically removed the need for the input of the Haitian government in its intervention, which resulted in unilaterally decisions determining the direction MSF’s medical intervention should take.

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<sup>99</sup> "Haiti: Cholera Treatment Continues, Assessments Underway in North." MSF USA. N.p., 2 Nov. 2010. Web. 15 Mar. 2015.

<sup>100</sup> "Haiti: Responding to the Cholera Outbreak in Petite Riviere." MSF USA. N.p., 28 Oct. 2010. Web. 15 Mar. 2015.

<sup>101</sup> "Cholera In Haiti: MSF Calling On All Actors To Step Up Response." MSF USA. N.p., 19 Nov. 2010. Web. 15 Mar. 2015.

MSF also excluded the input of the Haitian communities in which it worked. MSF would build and staff cholera treatment centers (CTCs) in many communities, where patients far from hospitals could still be treated for cholera. However, the construction of CTCs often resulted in distrust and suspicion within a community. In a blog post, the head of mission in Haiti, Stefano Zannini said that cholera had caused “panic in the population.” He goes on to say, “Some people are staying away from the cholera treatment centers or are afraid to have them in their neighborhoods because they think they help spread the disease.”<sup>102</sup> MSF’s interactions with Haitian communities show that MSF lacked good communication, and the result was distrust, and stigmatization of MSF resources and patients. So not only did MSF exclude the government from intervention planning, but communities as well.

Even without examining MSF’s claim that the republic of NGOs is only a symptom of a greater issue, it is clear that MSF cannot distance itself from the “NGO republic.” By excluding the Haitian government and the Haitian communities they work in from having an active role in their recovery, MSF is in fact a prime example of the issues raised by the Haitian health minister and critics of humanitarian aid.

MSF is not wrong to say that the Haitian government has a history of corruption and failure. The current government has only been in power for a few years, and Haiti has seen many different leaders, governments, and coups over the last few decades. In 2006, Haiti topped the list of the most corrupt countries, ranked by Transparency International.<sup>103</sup> However, it is not valid to claim that the legion of NGOs in residence is merely a “symptom” of the government’s failure to mount a proper

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<sup>102</sup> Zannini, Stefano. "Cholera in Haiti: "All of the Hospitals in Port-au-Prince Are Overflowing with Patients"" MSF USA. N.p., 11 Nov. 2010. Web. 15 Mar. 2015.

<sup>103</sup> "Haiti Tops World Corruption Table." BBC News. BBC, 06 Nov. 2006. Web. 15 Mar. 2015.

reconstruction/development effort after the devastating 2010 earthquake. In fact, NGOs have been a major presence in Haiti since the 1990s, notably, MSF itself. With significant pressure from the US government, Haiti lowered its tariffs on US rice to three percent, causing the Haitian market to flood and collapse. The resulting economic and political turmoil caused a humanitarian crisis that led to hundreds of NGOs taking residence in Haiti.<sup>104</sup> MSF entered the country in 1990s to deal with the civilian injury and death as a result of the political violence. MSF has stayed in Haiti ever since. So to say that its presence, or that of other NGOs, is solely due to the inadequacy of the Haitian governments fails to take into account the role international actors, namely the US and European governments, have played in damaging the Haitian economy.

The other half of MSF's claim that the Haitian government is to blame for the NGO presence and slow recovery is that had the government done things differently, or had fewer "failures" then the recovery would have gone differently. However, the Haitian government has little say over how recovery funds are spent, or how interventions should be carried out, due to the fact that international bodies circumvent their input. As of March 2011, out of the \$2.43 billion in international aid given to Haiti by that point, only about \$24 million, or one percent, was given to the Haitian government.<sup>105</sup> In comparison, the MSF operating budget in Haiti over the course of the same year was \$105 million.<sup>106</sup> So while the Haitian government is

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<sup>104</sup> Polman and Klarreich, "The NGO Republic of Haiti."

<sup>105</sup> Ramachandran, "Is Haiti Doomed to be the Republic of NGOs?"

<sup>106</sup> "Haiti One Year After: A Review of Médecins Sans Frontières' Operations." MSF USA. 10 Jan 2011. (31).

given little money under their own discretion, MSF expects them to carry all of the blame for the progress of the recovery, and for the presence of NGOs in the country.

So if the massive presence of NGOs and Haiti's slow recovery are not just symptoms of systematic governmental failure, as MSF posits, then the alternate claim, that the NGO-occupation of Haiti is to blame, must have merit. Internationally-run NGOs, including MSF, have created a "republic of NGOs" where they consistently exclude both the Haitian government and the Haitian populous from participating in their own reconstruction. For its own part, MSF facilitates the exclusion by asserting its impressive credentials as a humanitarian organization, and by touting its medical expertise and authority in all matters of emergency medicine and cholera control. By claiming a specialized knowledge to which the Haitian government and people do not have access, MSF can present a convincing argument to exclude their voices from funding and mounting interventions. Additionally, MSF has experienced significant medical consequences resulting from the exclusion of Haitians. These ramifications are important, for they determine if the exclusion of Haiti from its reconstruction has tangible consequences for MSF's intervention on the ground. Predictably, the lack of communication and cooperation with the Haitian government and local communities had a visibly negative impact on the organization's operations that MSF itself noticed.

Some of the consequences that MSF noticed were structural ones, which ended up affecting medical operations. At the beginning of the relief effort, a few months after the earthquake caused the collapse of the already scarce medical infrastructure in Haiti, the two MSF hospitals near Port-au-Prince were overrun with thousands of

patients. The massive earthquake led to a diverse array of different emergency traumas, including difficult to treat brain injuries and limbs that needed to be amputated. Although the MSF hospitals were reasonably well-equipped for some of the more common injuries, some traumas required sending a patient out to a specialist not in the hospital. MSF discussed the massive increase in surgical case load in a reflective publication released a year after the earthquake:

“Referrals, however, were difficult to provide due to a lack of awareness and communication about what other capacities were available in Haiti, including at other MSF facilities. There was no central hub that had an overview of available services. Different strategies were gradually developed to deal with referrals. Some patients were referred to Santo Domingo for advanced treatment. Some severe burn injuries were referred to the USS Comfort ship docked off the main port. But this required extensive logistics.”<sup>107</sup>

By failing to cooperate or work within Haiti’s existing health infrastructure, MSF sacrificed communication in its haste to respond to the emergency as quickly as possible, and the result was not having knowledge of the resources available to MSF, and patients receiving less than ideal care. Additionally, the lack of a “central hub” is indicative of the multitude of NGOs in Haiti that each work according to their own agenda. A central database of local structures and healthcare providers, medical or otherwise, would imply a cohesiveness and efficiency of MSF’s activity in post-earthquake Haiti that does not exist.

Another negative consequence a lack of communication with Haiti’s government had was when MSF attempted to build a hospital after the earthquake. Deciding to engage in a project so long-term was not done lightly by MSF, but its the organization’s dissatisfaction with government progress ultimately led MSF to decide that its presence in Haiti should shift towards the development end of the aid

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<sup>107</sup> Ibid 15.

spectrum: “With no real national progress . . . it was clear that MSF would not only have to replace the medical services it provided before the earthquake, but also maintain a scaled-up level of assistance for years to come.”<sup>108</sup> In a watershed moment, MSF made the conscious decision to remain in Haiti in the long-term, and decided to build infrastructure that would help it achieve its goal. However, its lack of experience in the realm of development, and its continued lack of cooperation with Haitian authorities made creating their own infrastructure a challenge: “MSF did face some difficulties during this longer-term planning phase . . . planning for the hospital in Delmas 33 was hampered by insufficient communication between MSF and the Haitian Ministry of Health.”<sup>109</sup> Without proper communication with the health ministry, regulatory hurdles became significant obstacles that caused substantial delays in the construction project. MSF was set back months, and the treatment of the community where the hospital was being constructed was delayed as well.

As these examples illustrate, calling Haiti a “republic of NGOs” is not an overreaction or a misinterpretation of the work western NGOs are doing in Haiti. The international response to the Haitian earthquake has earned the criticism it has received. NGOs have taken residence in Haiti, and the substantial money they receive from international donors and governments has made it easy for them to circumvent the Haitian government and people and prevent them from taking ownership of their country’s recovery. MSF does not quite deny the issue, but the organization certainly downplays its significance by calling it a “symptom” of the inadequacies of the Haitian government. Although the government may have issues, by dismissing their

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<sup>108</sup> Ibid 24.

<sup>109</sup> Ibid 25.

valid concerns, MSF overlooks its own culpability in the slow progress of the Haitian recovery. MSF's uses its unique expertise, and its viewpoint as an emergency medical organization as a means of shutting out Haitian input. The consequence is sub-par medical care, poorly planned construction efforts, while all the blame circles back to Haiti's government and people.

*Two NGOs: Partners in Health, MSF, and the Shanchol Cholera Vaccine*

Partners in Health (PIH) is similar to MSF in many ways. Both are NGOs founded by western medical professionals, and both have a medical/health focus to their humanitarianism. Both organizations also have a social justice bent to their medical work: MSF highlights its commitment to advocacy for those who are in situations of extreme suffering in its charter<sup>110</sup>, and PIH's mission states that its goal is "to serve as an antidote to despair."<sup>111</sup> PIH's revenue is just a fraction of MSF, however, with an annual budget of about \$100 million<sup>112</sup> compared to MSF's total operating budget of over \$1 billion. However these organizations are not as alike as it may seem, and PIH has several distinct differences in its philosophy and interventions that make it an interesting corollary to a discussion of MSF. Especially given the similar goals of both of their medical interventions in Haiti.

One initially intriguing difference is the willingness of some to absolve PIH from the critiques leveled at other NGOs in Haiti. On PIH's most recent completed project, the building of a teaching hospital in Haiti, one author writes, "for all of the disappointments of the recovery process, there have been some successes, instances

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<sup>110</sup> "MSF Charter and Principles." Médecins Sans Frontières (MSF) International.

<sup>111</sup> "Our Mission." Partners in Health. PIH, n.d. Web. 12 Mar. 2015.

<sup>112</sup> "Annual Report 2014." PIH, n.d. Web. 2014. (33).



of NGOs working closely with Haitians to meet their needs as well as possible. One example of this kind of effort is the hospital being built by PIH.”<sup>113</sup> PIH’s differences manifest themselves in the interventions it launches, and they are articulated well in PIH’s mission statement:

“By establishing long-term relationships with sister organizations based in settings of poverty, Partners In Health strives to achieve two overarching goals: to bring the benefits of modern medical science to those most in need of them and to serve as an antidote to despair. We draw on the resources of the world’s leading medical and academic institutions and on the lived experience of the world’s poorest and sickest communities. At its root, our mission is both medical and moral. It is based on solidarity, rather than charity alone.”<sup>114</sup>

The first aspect of the mission statement that differs significantly from MSF is PIH’s upfront commitment to remaining in locations in the long-term. This commitment is in direct contrast to MSF, who strives to only stay for as long as a community is in emergency. However, crisis is not the driving force behind PIH’s interventions. This is as clear in its projects, like the teaching hospital construction project it led after the earthquake, as it is in its advocacy work and rhetoric. In a United States congressional meeting on the cholera epidemic in Haiti, a PIH representative, Dr. Ralph Ternier, was invited to speak. In his remarks, he spoke to resisting the tendency only to intervene in dire circumstances, saying that the international community should “avoid acting as firemen responding to crises after they have emerged.” In an op-ed for the Tampa Bay Times, another PIH representative wrote on the necessity of creating lasting solutions, as opposed to merely keeping an emergency at bay, saying that PIH’s approach works because it “confronts difficult interconnected problems with significant solutions, not small

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<sup>113</sup> Ramachandran, “Is Haiti Doomed to be the Republic of NGOs?”

<sup>114</sup> PIH, “Our Mission.”

cheap interventions . . . that, by themselves, offer little hope of lasting change.”<sup>115</sup>

This is therefore the first significant difference between MSF and PIH: PIH aims to transform health care and access health services with longterm strategies, as opposed to emergency medical interventions that end when a crisis has subsided.

Another difference revealed in its mission statement is PIH’s collaboration and partnerships with local, community organizations. Every PIH project is co-run by one of its local “sister organizations.” Having such partnerships affirms PIH’s priority of hearing the voices of those in the affected communities. Drawing on their “lived experience” allows the community to guide their own recovery. In Haiti, PIH collaborates with Zanmi Lasante (ZL), the NGO with which PIH partnered in the construction of the Mirebalais teaching hospital. The idea for the hospital was conceived when the Haitian ministry of health identified that it needed a technologically up to date teaching hospital after the earthquake. The subsequent PIH/ZL collaboration with the ministry of health resulted in the successful realization of this idea.<sup>116</sup>

Finally, PIH’s mission talks about the idea of “solidarity rather than charity.” Though not necessarily a simple quality, this subtle difference in language can be seen in the way PIH advocates for communities, and how it sees its projects and partnerships. Solidarity can almost be viewed as a parallel to MSF’s witnessing, since both actions go beyond the medical, and venture into the human rights advocacy territory of each organization. However, the subtle linguistic distinction is that solidarity involves standing united with PIH’s partners, whereas witnessing implies a

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<sup>115</sup> Garry, Stephanie. "New Hospital in Haiti Proves That Aid Done Right Can Change Lives." Tampa Bay Times [Tampa] 24 July 2013. Web. 16 Mar. 2015.

<sup>116</sup> Garry, “New Hospital in Haiti Proves That Aid Done Right Can Change Lives.”

separation from those for whom MSF advocates. For example, when discussing the UN's blame of Haiti for its slow recovery, a PIH member said in an op-ed that "Haitians weren't in charge of the [recovery] projects" so neither should they "shoulder the blame for failures."<sup>117</sup> The op-ed stands in solidarity with Haiti, as opposed to directing criticism from above, as MSF did when they blamed the slow recovery on the Haitian government's inefficiency.

While the ideological differences between the two organizations reveal much about the organization and focus of PIH, it is even more useful to see how these distinctions shape an actual PIH-led project on the ground. One such intervention, is the case the cholera intervention in Haiti. Specifically, I discuss PIH's advocacy for the Shanchol vaccine when the first cases of cholera began to appear after the earthquake in 2010.

In late 2010, months after the earthquake, many patients in Haiti began to present with the hallmark symptoms of cholera, namely watery diarrhea. Cholera is a disease with a fast onset, and while it is relatively easy and inexpensive to treat, it can quickly be fatal if the patient is not rehydrated fast enough. A cholera outbreak in Haiti is particularly deadly, because cholera is spread through water sources contaminated with fecal matter, and the earthquake had destroyed most of the existing public health infrastructure, including any water sanitation structures. Several strategies exist for controlling and treating a cholera outbreak. On a patient-to-patient basis, IV fluids and antibiotics are indispensable for saving a patient from a cholera diagnosis. On a macro-level, cholera can only be stopped if people are no longer drinking from, or washing in a cholera-contaminated water source. Public health

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<sup>117</sup> Garry, "New Hospital in Haiti Proves That Aid Done Right Can Change Lives."

strategies include dispensing chlorine tablets, teaching good hygiene (like hand washing), building water sanitation facilities, and, in some cases, vaccinating. Two oral vaccines exist for cholera, Dukoral and Shanchol.<sup>118</sup> Both vaccines boast significant protection against cholera, both vaccines require two doses taken at different times, and both must be kept in temperature-controlled storage. However, Shanchol does not require a buffer solution to be given with each dose, making it a logistically easier option for a mass-vaccination campaign. So it was on Shanchol that PIH/ZL set its sights, and the two organizations began advocating for its use in Haiti after the cholera outbreak turned into an epidemic. Notably, vaccination had never been used to control a cholera epidemic before, only smaller outbreaks. However, PIH/ZL were convinced that a vaccination campaign would relieve suffering, and help stop the spread of the epidemic in rural and mountainous regions where cholera had not yet spread. Studies of Shanchol show that even if not everyone is vaccinated in a given area, it's possible to reach “herd immunity.” So Shanchol’s distribution would result in cholera protection for vaccinated and unvaccinated alike<sup>119</sup>. However, PIH/ZL’s campaign for the vaccine was met with much resistance from powerful organizations, namely from the CDC, the Haitian government (at first), and MSF. MSF and the CDC opposed the vaccine, citing logistical challenges, and according to some accounts, influenced the Haitian government to do the same.

The CDC was the first to evaluate the use of oral vaccination to control the cholera epidemic in Haiti. They evaluated its use in 2010 when the first cholera cases

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<sup>118</sup> Date KA, Vicari A, Hyde TB, Mintz E, Danovaro-Holliday MC, Henry A, et al. “Considerations for oral cholera vaccine use during outbreak after earthquake in Haiti, 2010–2011.” *Emerg Infect Dis* [serial on the Internet]. 2011 Nov [date cited].

<sup>119</sup> Ibid

presented in Haiti, and before PIH/ZL began their joint campaign for Shanchol. The CDC report detailing their evaluation determined that oral vaccination was not recommended in Haiti for several reasons. The first was that the vaccine had yet to be prequalified by WHO, which means that the UN would be unable to put in an order to procure it for vaccination campaign. Although WHO went on to prequalify the vaccine in 2011, the CDC did not change its position, due to its remaining three reasons. First, it would be logistically difficult to store and distribute the vaccine effectively, second, resources and money would likely be more cost-effective if they were spent on sanitation and hygiene projects, and third, even if the population was vaccinated, it might not have a positive enough effect to justify its use.<sup>120</sup>

The Haitian government also originally opposed PIH/ZL's plan to use the Shanchol vaccine. Much of the Haitian government rhetoric for opposing the campaign echoed the critiques of the CDC, but some say that the motivation is more complex: "the previous Haitian government opposed cholera vaccination. Insiders say that's largely because influential agencies such as PAHO and CDC signaled their opposition."<sup>121</sup> It is not hard to imagine a scenario where powerful international bodies leveraged influence over a the fragile Haitian government, especially since their recommendations carried so much weight in the Haitian recovery. However, after a set of elections, a new crop of government officials took office, and Minister of Health Dr. Florence Duperval Guillame endorsed the PIH/ZL campaign.

Finally, MSF expressed its own doubts on the idea of using vaccines to control the cholera outbreak, for many of the same reasons as the CDC: "One issue is the

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<sup>120</sup> Ibid

<sup>121</sup> Knox, Richard. "Vaccination Against Cholera Finally Begins In Haiti." NPR.org. NPR, 12 Apr. 2012. Web. 16 Mar. 2015.

capacity of the manufacturer . . . Money is another big issue . . . Money spent on vaccines should not come at the expense of money spent on permanent water and sanitation measures.” Echoing the CDC, MSF viewed mass vaccination as cost-ineffective, logistically difficult, as well as taking funding and energy away from the more important emergency interventions that MSF itself was mounting. Additionally, MSF said, “it won’t be easy to vaccinate in rural areas with poor access,” which were the primary areas PIH/ZL planned to intervene.<sup>122</sup> MSF concluded its position on vaccination by saying “its not MSF’s responsibility to make that choice [whether or not to vaccinate],” ultimately placing the responsibility on another party.

Although the international community had its doubts, the Haitian communities that would receive the vaccine were not split: “PIH/ZL’s community meetings made it clear that anyone at risk of dying from cholera preferred using the vaccine.”<sup>123</sup> PIH/ZL proceeded to fiercely advocate for the vaccine’s use, and their work successfully resulted in the implementation of a pilot program, to be led by PIH/ZL, where they would vaccinate a few thousand people in rural, mountainous regions in Haiti that had yet to be affected by cholera. The pilot program was by all measures a success, proving much of the criticism wrong. Despite the perceived logistical difficulty, “90% of the patients . . . Completed the full two doses.” The vaccine also offered significant protection, and “fully 63% of patients were protected against cholera infection.”<sup>124</sup> When the critiques of PAHO, MSF, and the CDC proved wrong, a much larger scale vaccination campaign was launched by PIH and the

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<sup>122</sup> Olson, David, Dr. "Haiti: Cholera Vaccines One Possible Option For Preventing More Outbreaks." MSF. MSF USA, 19 Oct. 2011. Web. 16 Mar. 2015.

<sup>123</sup> "Cholera Vaccine Succeeds in Haiti." PIH.org. Partners in Health, 20 Feb. 2015. Web. 17 Mar. 2015.

<sup>124</sup> Ibid

Haitian organization GHESKIO. The successful pilot study in Haiti even caused the WHO to add the Shanchol vaccine to its protocols on controlling a cholera epidemic, and according to PIH, “WHO has begun stockpiling the drug for use in future outbreaks.”<sup>125</sup> Even MSF embraced the vaccine’s success, and used a similar strategy in a concurrent intervention in South Sudan several months after the pilot study: “It is rare for a cholera vaccination of this size to be conducted as a preventative measure, and a first for MSF. Because the refugees in the camps in Maban County are so particularly vulnerable, this innovative approach was justified.” The intervention represents a complete turn around from their earlier position. By embracing the Shanchol vaccine, MSF acknowledges it as both logistically feasible intervention for a rural area, and as an effective solution that does not detract from other sanitation projects.<sup>126</sup>

PIH’s push for the Shanchol vaccine with its sister organization ZL, despite international resistance from almost every side can ultimately be traced back to its unique approach. The campaign was born from the Haitian NGO ZL’s own assessments, and community meetings with the people who would benefit from the vaccination. PIH’s solidarity with the Haitian people and its sister organization affirmed its commitment to the project, and saw it from advocacy, to a pilot study, to a mass vaccination campaign. Organization founder Dr. Paul Farmer made his position clear when PIH first began its advocacy for the vaccine, saying “it’s the

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<sup>125</sup> Ibid

<sup>126</sup> "South Sudan: Oral Cholera Vaccination Campaign in Maban." MSF.ie. MSF, Mar. 2013. Web. 17 Mar. 2015.

ethical and equitable thing to do . . . If cholera had exploded in the United States like it did in Haiti, everybody would have gotten the vaccine by now.”<sup>127</sup>

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<sup>127</sup> Sontag, Deborah. "Vaccinations Begin in a Cholera-Ravaged Haiti." NYTimes.com. The New York Times, 12 Apr. 2012. Web. 17 Mar. 2015.



## **Conclusions**

As Dr. Orbinski said in his Nobel lecture, “No doctor can stop a genocide.” In his speech, Dr. Orbinski used this quote to describe the need for an international political response to the Rwandan genocide rather than a humanitarian one, but I argue that Dr. Orbinski’s sentiment must be taken several steps further. A doctor also cannot solve the complexity of problems faced by an HIV/AIDS patient in Uganda, for HIV/AIDS cannot be reduced to a set of biomedical symptoms to be cured by ARVs. Nor can a doctor repair the broken healthcare system in Haiti, since biomedicine cannot function in a vacuum. Indeed, a biomedical approach is an meager tool for the reconstruction of a country without the input and lived experience of Haiti’s citizens. A biomedical framework alone is inadequate to attempt to solve fully any of these diverse problems. However, it is also by no means a useless framework. Biomedicine has demonstrated its significant power in curing diseases, and treating infirmity in humanitarian settings. Also, as PIH showed in Haiti, a biomedical framework can be integrated with development strategies in the long term. When merged with ideas, feedback, and criticism from the population, biomedical interventions have the power to accomplish significant humanitarian work. However, given that PIH is overshadowed in financial scope by many other humanitarian medical NGOs, MSF included, this example remains far from the norm.

MSF continues a steady financial growth each year of about 1%, which allows MSF to expand its programs and influence.<sup>128</sup> The same applies to the many other

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<sup>128</sup> MSF. “Médecins Sans Frontières Financial Report 2013.” MSF International, 1 Jul 2013.

humanitarian medical organizations as well, so the lessons learned from these interventions continue to be relevant going forward. It is tempting to believe that scientific advancements in the field of medicine will result in more effective medical interventions, and a more comprehensive ability to deliver humanitarian aid. This mentality was part of the logic that involved MSF in HIV/AIDS care. The development of cheap ARVs convinced many that HIV/AIDS had become a solvable medical issue. But the fact that HIV/AIDS rates in Uganda continue to rise years later shows that these biomedical solutions alone are not a panacea for humanitarian issues.<sup>129</sup> Therefore, humanitarian organizations, governments, and donors alike must resist this tempting idea. Medical humanitarianism is a framework like any other: it comes with its own inherent problems, blind spots, inadequacies, and dilemmas along with its advantages. Only by examining this framework under intensive scrutiny can it succeed in accomplishing the lofty humanitarian goals with which we task it.

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<sup>129</sup> Kron, Josh. "In Uganda, an AIDS Success Story Comes Undone." NYTimes.com. The New York Times, 02 Aug. 2012. Web. 10 Apr. 2015.

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