

Defending Health Against Persecution, Violence, And Armed Conflict

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- [Home](#)
- [Archives](#)
- [Topics](#)

[Health Systems 101](#)

by [Christopher R. Albon](#) on December 23, 2011 [[edit](#)]

While health systems vary in the role of the private sector, the priority given to primary and specialized care, the level of access enjoyed by citizens, and a host of other characteristics, most health systems (particularly in less developed states) share a basic structure based on a hierarchical organization of health care provision. Most citizens' primary point of contact with health systems is usually through health posts, health clinics, and health centers. Health posts are the smallest facility in many health systems. They are staffed with one or more nurses and provide basic medical services to small communities. Health clinics are larger than health posts and provide a wider range of primary health care services including community health, basic diagnostics, ambulatory and emergency care, immunizations, and pharmaceuticals. These facilities are often staffed by a small number of nurses with regular visits from a doctor shared by multiple clinics. The largest sub-hospital facilities are health centers, offering a greater range of primary care services than clinics and are assigned one or more dedicated doctors. In urban areas, health centers can provide care to populations of around 50,000 (Westwood and Power 2007). Health posts, clinics, and centers are particularly common in rural areas, providing governments with an affordable means to expand health care access to underserved areas without the expense of a full hospital. In addition to providing health care, these facilities often play a critical part in health surveillance and data collection, from which health interventions are derived.

Minor urban areas are often served by a district hospital. These hospitals are responsible for offering a range of primary care services within their catchment area and are staffed by general practice doctors and other health workers. District hospitals are responsible for addressing the most common conditions. In addition, district hospitals often provide the laboratory services (e.g. blood and tissue tests) for nearby health posts, clinics, and centers.

Patients with conditions requiring specialized care are referred to regional hospitals. Regional hospitals are located in major urban areas and – like district hospitals – provide primary care for their local catchment area. However, regional hospitals are also responsible for providing secondary care services to large geographic regions. Therefore, in addition to general practitioners, regional hospitals are also staffed by pediatricians, surgeons, and other specialists. Regional hospitals often also provide

medical education, and public health programs. A district hospital is “the powerhouse of the region” and a vital node in the national health system (Westwood and Power 2007, 215).

The heart of most health systems is located in the capital and major urban centers. These areas often receive a disproportionate share of the health system’s budget (Macrae 1995). In addition to having their own health clinics, centers, and district hospitals, these cities have other critical components of the health system. First, major urban areas contain the state’s tertiary care referral hospitals, housing the country’s sub-specialists medical professionals (e.g. cardiologists, oncologists, and neurologists). Not only are these health professionals often the sole providers of sub-specialized care in the country, they also have a central role in improving care nationally by driving research and innovation. Central hospitals are also key nodes of international partnerships with health professionals abroad through cross-national medical exchange programs and research projects. Thus, these facilities are a major source of knowledge, education, and capacity building.

Second, capitals contain the health system’s main administrative center: the Ministry of Health (MoH). The Minister of Health and his staff conduct unglamorous – yet critical – bureaucratic functions. They manage the distribution of resources and plan the organization of the health system. Furthermore, the ministry is the primary point of connection between the political leadership of the state and the health system. Finally, the organization is a point of contact between the domestic health system and the international health community.

The entire system is organized hierarchically. At the bottom are health posts, clinics, and centers. Patients requiring more specialized care or equipment are referred to district and regional hospitals. If these facilities cannot provide treatment, the patient is referred to a tertiary hospital. The number of facilities of each type becomes less numerous as patients move up the hierarchy. Liberia’s health system exemplifies this type of hierarchical organization. Before Liberia’s civil war, the country’s public and private health system included 761 health clinics and health centers, 25 county (district) hospitals, and a single tertiary referral hospital in the capital (Joint Needs Assessment Report 2004). The capital also contained the Ministry of Health and the country’s only medical school (International Medical Education Directory 2010).

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The Broadening And Deepening of Security

by [Christopher R. Albon](#) on December 20, 2011 [[edit](#)]

What is human security? Here is a brief introduction. As the domain of security enlarged to incorporate new threats and actors, it increasingly overlapped with the field of development. The threats from poverty, environmental scarcity, famine, infectious disease and others began to be explored in both development and security communities. The growing intersection between the two was captured under the concept of human security. Broadly, human security formalized the belief that security studies should “shift from the state to the individual and should encompass military as well as nonmilitary threats” (King and Murray 2001-2002, 588-589).

United Nation Development Program (UNDP) Human Development Report (HDR). While, as Axworthy (2001) points out, the idea that populations have certain security concerns and rights is old, the HDR is the first major attempt to push the concept into the mainstream development, foreign policy, and security communities. Under the UN's definition, human security constitutes seven security dimensions: economic, food, health, environmental, personal, political, and community. This broad definition addressed many of the main concerns of vulnerable populations, but also made operationalizing the term troublesome for two reasons. First, the expansive domain covered by HDR's definition of human security could offer little information on how the seven dimensions should be prioritized (Axworthy 2001). Should governments, international organizations (IGOs), and non-governmental organizations (NGOs) focus their limited resources on public health, peace-building, or economic development? Is infectious diseases or income inequality a greater threat to human security? Paris argues the vague and expansive definition of human security was encouraged by some parties, who found it a convenient avenue to argue their area of focus (health, environment, culture etc...) constituted a threat to the security of individuals and deserved greater mainstream attention (Paris 2001). This definition of human security was "slippery by design" (Paris 2001, 88).

Second, the imprecision of HDR's definition makes research into the human security of populations difficult. Allowing human security to include a set of vague dimensions, often with overlapping areas of concern, limits the ability to measure and study concepts in order to make policy recommendations. Under this definition "virtually any kind of unexpected or irregular discomfort could conceivably constitute a threat to one's human security" (Paris 2001, 89).

King and Murray highlight the imprecision of HDR's definition through a series of off-the-record interviews with politicians and government officials. The two authors find almost universal concern "that there existed no widely accepted or coherent definition of human security" (2001-2002, 591-592). The only consensus around the definition of human security seems to be an agreement to the lack thereof. Before continuing, a selection of human security definitions is reviewed below.

While sharing the concerns of other scholars regarding the HDR's definition, King and Murray develop a similar but operationalized concept. The authors propose that human security can be thought of as "generalized poverty". In their framework, individuals experience generalized poverty anytime they fall below some established threshold in a central aspect of "human well-being" (King and Murray 2001-2002, 585). In this way, human security addresses only the more at-risk individuals who fall below some acceptable minimum standard in a vital area. For example, a family could be considered impoverished if their daily caloric intake is less than the recommended minimum. The central appeal of King and Murray's definition is measurability. With the proper data and a set of thresholds for each domain of well being, it is theoretically possible to construct a quantitative index of human security. For this purpose King and Murray propose a measure they call Years of Individual Human Security (YIHS) defined as "the expect number of years of life spent outside the state of generalized poverty" (King and Murray 2001-2002, 595). The disadvantage of this approach is that King and Murray's concept of well-being suffers from the same problems of broadness found in the HDR's definition. The authors propose including "those domains of well-being that have been important enough for human beings to fight over or to put their lives or property at great risk" (King and Murray 2001-2002, 593). However, it is clear what each of these domains are and how they can

level of generalized poverty.

Mary Kaldor's (2007) monograph offers another conceptualization of human security. Kaldor posits a new definition of security that "is about confronting extreme vulnerability not only in wars but in natural and man-made disasters..." (Kaldor 2007, 183) and a new definition of development that goes beyond improving standards of living to include "feeling safe on the streets or being able to influence political decision-making" (Kaldor 2007, 183). Based on these new definitions, she proposes five principles of human security. First, human security places human rights above all else. Second, the local population must consider a state's political institutions legitimate. Third, human security operations must 1) work with international organizations, 2) create and enforce common rules, and 3) focus on coordination. Fourth, human security approaches must be bottom-up and decisions must be made in coordination with the local population. Finally, modern conflict does not follow borders thus they must be examined at the regional, rather than the state level. While an impressive contribution, for empirical researchers Kaldor's approaches offer little advantage over the 1994 HDR's definition. It is unclear how Kaldor's human security could be operationalized, since it covers three levels of analysis: states, conflicts, and operations. Furthermore, the approach is simultaneously a set of threats to be addressed and ideals to be achieved.

Finally, Roland Paris (2001) argues that attempts to define human security suffer from an inability to separate causes and effect. Specifically, because human security has been defined so broadly, incorporating violence, famine, poverty, social marginalization, ill-health, and others it is impossible to identify a causal relationship between any socioeconomic factor and human security (Paris 2001, 93). Instead, Paris proposes a definition of human security as a category of security research "concerned with military and nonmilitary threats—or both to the security of societies, groups, and individuals" (Paris 2001, 100). This paper follows Paris' approach to human security; as a class of security studies examining threats to populations rather than states. Thus, while the theory addresses threats to individuals, it does not claim to offer any comprehensive measures of society's vulnerability.

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Civil Wars And Private Health Care Sectors

by [Christopher R. Albon](#) on November 30, 2011 [[edit](#)]

Civil wars can create a boom for private sector health care providers. The destruction of the state health system during war creates a power-vacuum of health care provision, incentivizing private actors to establish themselves in domains previously the responsibility of the government. In Uganda and Colombia, this privatization was at least partially caused by a decrease in public-sector health worker salaries during the war to below subsistence levels. This forced health workers to supplement their income with private practices. The private sector boom was more pronounced in Lebanon. Much of Lebanon's government health facilities were destroyed during the country's civil war. The destruction created an opportunity for private health care providers to fill the void left by the crumbling public health system. After the war this system became the norm, with much of the population relying on a large private health sector and the government mostly relegated to the role of

budget was spent on caring for patients in private facilities, however by the late 1990s it had risen to 80 percent.

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Wartime Health Reconstruction: An Example

by [Christopher R. Albon](#) on November 26, 2011 [[edit](#)]

Throughout their civil war, the Mozambican government continued to repair and build health facilities. During the first five years of major RENAMO activities (starting in 1982), 822 health units were destroyed by RENAMO while 567 were reconstructed by FRELIMO. FRELIMO was, in a very real sense, racing to build health facilities faster than they could be destroyed or forced to close. The struggle between the destruction and wartime reconstruction of the health system is apparent in the number of health facilities in Mozambique during almost a decade of war, shown in Figure 3.2. Before the start of major RENAMO operations in 1982, the rapid expansion of the health system that started in the pre-war era continued to increase the number of health facilities in the country. However, after 1982 the total number of each type of health facility stayed the same or decreased as RENAMO attacks and collateral damage took their toll on the health system.

Along with continuing to construct the health system, the government maintained a vigorous medical education program during the war. From 1976 to 1985, the Mozambican government trained thousands of health workers, including 569 medical aids, 818 midwives and maternal/child health nurses, 2181 nurses, 268 preventative medicine workers, 486 pharmaceutical personnel, 406 laboratory personnel, 76 health administrators, 384 specialized nurses, and 1,402 village health workers. In addition, around the same time 6,242 paramedical workers were trained. The training of these health workers represented a significant cost for the wartime government. The result of this training program during the first years of the war was that the number of health workers in semi-rural and rural areas increased from 8,163 to 10,593 between 1980 and 1984. While the number of health workers in these areas likely decreased as RENAMO stepped up its attacks after 1982, the numbers demonstrate the high priority the FRELIMO government gave the operations of the health system. In addition to training new health workers, the government invested in the improvement of its existing personnel. After the civil war made it impossible to train enough new health workers to provide child and maternal health, the Ministry Of Health started new education and training programs for the country's existing health workers, including training medical technicians to conduct emergency obstetric surgeries and educating traditional birth attendants.

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Weak Institutions And Post-Conflict Health Reconstruction

by [Christopher R. Albon](#) on November 23, 2011 [[edit](#)]

Weak government institutions can also negatively impact the coordination of international assistance in reconstruction efforts. The end of civil war often brings a surge of financial and technical assistance

granting governments access to far more resource than domestically available — and while it is almost always eagerly accepted by post-conflict regimes, the influx of support can come with unintended pitfalls. The sheer number of organizations offering assistance can overwhelm governments. After Kosovo's war, more than 400 organizations flooded into the country. In 1995, Rwanda's post-conflict Ministry of Health had to manage 89 NGOs in the health sector alone. The responsibility to oversee and coordinate the myriad of organizations most often falls on the shoulders of the government bureaucracy. Many states would have difficulty effectively managing such a sudden and large increase in responsibilities even during peacetime. After having their capacity reduced by civil war, these institutions often have little chance of successfully managing the relief effort.

Post-conflict governments often face an imbalance of power between themselves and providers of international assistance. Crippled by war, government institutions lack the de facto authority or capacity to work with NGOs and IGOs in the reconstruction process as equals, much less as leaders. This is due in no small part to the large share of reconstruction funds coming from international donors. Near the end of the Mozambique's civil war, much of the reconstruction funds were managed by the European Union and UNHCR, and not by the Mozambican government. The more the government is dependent on the support of international donors for health financing, the more leverage those donors and the NGOs they support have in shaping national health policies. While NGOs have shown to be better equipped to ramp up services quickly than state institutions, a valuable capacity when operating in crisis environments, they are self-interested actors whose interests are not necessarily parallel to those of the government. Ideally, reconstruction funds would be channeled through the Ministry of Health, which would disperse them as part of a unified national strategy for health system reconstruction; however many post-war governments lack the capacity to do so.

When this happens, international donors often select and fund health efforts independent of any central coordinating body. The end result is a proliferation of disorganized health projects funded by international donors and operated by NGOs, each with their own small area of operation and with minimal coordination with any national reconstruction strategy. This "project-based" reconstruction is particularly likely when the regime lacks legitimacy in the eyes of the international community. During the early 1990s, Cambodia's interim government was seen as lacking political legitimacy, leading many donors to sidestep state institutions and directly fund some seventy NGOs in the health sector, "some with little or no official recognition and no obligation to locally account for how resources were disbursed, this uncontrolled environment was, to take a common phase, a 'free for all'". A similar problem is seen in Somalia, where decades of ineffective government institutions created a uncoordinated project-based effort which placed more emphasis on short-term relief than long term health system reconstruction. Nowhere is this problem more apparent than in the statements of one health professional in Bosnia and Herzegovina who described international involvement in his country's health reconstruction process this way:

The magic word that opened all doors was "project." In those days, anyone with a modicum of self-respect had to have a project. Rushing to submit their project proposals, the experts would sometimes forget to change the name of the country in the project title and we would suddenly have to decide on a Breast Feeding Campaign in Moldavia or AIDS Prevention in Georgia. But, mistakes happen, no harm done. There were a lot of

Physicians against Nuclear War (although we did not have one), and Role of Nurse in the Sequence of the Rape, and of course – anti-smoking projects. If somebody wanted to help but had no idea what to do, a non-smoking campaign always came in handy. We had at least a hundred anti-smoking actions of all sorts. Millions of dollars were spent, but to no avail. The locals still smoke. It does not matter that at this moment only 30% of the inhabitants of Bosnia and Herzegovina have a safe water supply (Simunovic 2007, 5).

The inability of weak institutions to manage a unified health reconstruction effort has significant detriments to health care delivery: health providers become more fragmented and the population becomes more dependent on health care directly from NGOs. In post-war Uganda this effect was dramatic. The Ugandan health system was bifurcated; the government became responsible for secondary and tertiary care while internationally funded NGOs provided primary care. This type of health care system fragmentation can lead to inefficiencies in the health care delivery. Thus, during post-conflict reconstruction, a critical component is the government's capacity to integrate the myriad of international assistance efforts into the national health system.

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Brain Drain: A Short Literature Review

by [Christopher R. Albon](#) on November 9, 2011 [[edit](#)]

Health worker flight, “brain drain”, often occurs during civil war — triggered by threats to personal safety. Attacks on the health system often take the form of targeting health workers. RENAMO frequently attacked health professionals in the Mozambique, both mutilating (Hanlon 1992) and killing them outright (Summerfield 1988). In Nicaragua, Contra rebels used a similar strategy, attacking and kidnapping doctors, health technicians, nurses, medical students, health educators and volunteers — often in rural areas (Garfield 1985, Garfield et al. 1987). Similar attacks were seen during Nepal’s civil war where health workers were harassed, threatened, and assaulted by both the Maoist rebels and government security forces (Devkota And van Teijlingen 2009).

Fear for their personnel safety often causes health workers — especially those working close active fighting — to abandon their posts (Brentlinger 1996). During the Ivorian civil war, many regions experienced a pronounced drop in health workers of all types. In country’s north, central, and west there was a decrease of 66 percent, 88 percent, and 88 percent of health workers during the conflict respectively (Betsi et al. 2006). This brain drain was most significant in doctors. One region saw a 98 percent reduction in the number of physicians, who fled to government held areas in the south or to other countries (Betsi et al. 2006). During the 1992 war in Bosnia and Herzegovina, two-thirds of health workers left their posts (Bagaric 2000). Areas with a Croat majority were particularly hard hit, the number of doctors before the war compared to after in Jajce, Fojnica, and Travnik dropped from 79 to 4, 37 to 1, and 137 to 18, respectively (Bagaric 2000). In Uganda, 50 percent of doctors and 80 percent of pharmacists left the country between 1972 and 1985, during a period when the country had experienced both an interstate and civil war (Dodge and Wiebie 1985). The result of this health worker brain drain is an inability to staff health positions to provide adequate care. Worse still, the training of a single health worker takes years — even decades. Replacing a lost generation of health

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When Rebels Become Governments: One Post-Conflict Health Example

by [Christopher R. Albon](#) on November 2, 2011[edit]

In June 1975, after a military coup in Lisbon, Mozambique achieved independence and FRELIMO took control of the government. The health care system FRELIMO inherited was small and dysfunctional. During the colonial period most health workers were Portuguese settlers and these Europeans started leaving en masse at independence. Within a month, 85 percent of Mozambique's doctors had left the country. Despite FRELIMO's attempts to stem the flight of European health workers with offers of Mozambican citizenship, the fledgling state was left with only 30 doctors in the entire country. This exodus left many hospitals and other health facilities abandoned or crippled by understaffing. The problem was particularly damaging in rural areas that were often isolated during the chaotic first few months of independence. Health care in these areas was often provided by untrained orderlies and by the remnants of FRELIMO's liberation zone health care network.

The new Mozambican government also lacked a pool of skilled and semi-skilled workers they could draw upon to manage the health care system. There were six economists, two agronomists, and fewer than 1000 African high school graduates in the country. The lack of capable senior and middle level technocrats made it difficult for the government to manage the disorganized health system it took over at independence. Decision-making was often deferred to a small cadre of administrators with little room for outside opinion or flexibility.

Despite these difficulties, in July 1975 Mozambique nationalized health care and launched a major effort to transform the disparate collection of private, public, military, and missionary health facilities

into a single effective health system. The new health system was to be guided by the Marxist principles of FRELIMO and the health policies started before independence. Health reforms focused on expanding health care to rural regions of the country where a majority of the population lived through primary and preventative health care programs). FRELIMO political leaders believed that the country's political and economic future lay in improving the country's largest industry: agriculture. More specifically, FRELIMO hoped a rapid expansion of Mozambique's health system would improve the productivity of rural agricultural workers and thus the entire economy.

FRELIMO's post-independence health reforms were based around the concept of primary health care, a doctrine giving priority to the provision of basic health services and preventative care over specialized and curative care. Primary health care was seen by FRELIMO as the only way the government could improve the health of the vast majority of the population that had previously been without any health care access. To accomplish this, FRELIMO radically increased health care spending: from 4.6 percent of the government's budget to 9.7 percent only a year later. By 1981, government health spending would reach 11.9 percent.

FRELIMO's focus on expanding health care was rooted in both political strategy and ideology. Even before independence FRELIMO enjoyed widespread support amongst the population. This support was a valuable resource during the guerilla war against the colonial Portuguese Army who "faced fighting in a hostile country against a people overwhelmingly antagonistic to them" (Walt and Cliff 1986, 149). Furthermore, during the war while FRELIMO did receive some support from abroad, it relied heavily on the population for information and supplies. The close connection between FRELIMO and the population during the war had a profound impact on the development of national health policy after independence. Furthermore, FRELIMO's Marxist roots played a role in the high priority given to health. FRELIMO believed western capitalism and colonialism were the enemies of the Mozambican people, and that improvements in the new state's health and education systems were the key to escaping that poverty (Robinson 2006).

The FRELIMO government's focus on the well being of the population was responsible for a rapid expansion of the health system in the years before and at the start of the country's civil war. Between 1975 and 1982, over 2000 nurses, 110 x-ray technicians, 290 pharmacists, 272 midwives, and 1011 village health workers were trained. Similar improvements were seen in health facilities. In roughly that same period, the government built 593 health posts, 161 health centers, 130 laboratories, and 80 stomatology departments. The government also instituted a national drug formulary to reduce the amount the government and patients spent on pharmaceutical products. Mozambique's drug formulary was considered to be one of the country's most important reforms and was credited for keeping pharmaceutical spending significantly lower than other developing states. The effect on the health of Mozambican citizens was significant. By 1980, 30 percent of the population had access to health care facilities, up from 7 percent in 1974. Furthermore, by the early 1980s Mozambique had the highest vaccination rates for children under the age of five years old in any African country.

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Houses Of God And Health

With violence in Yemen quickly approaching a full-blown civil war, the New York Times has a [piece out on the use of one Sana mosque as field hospitals](#):

In its early days, the field hospital was much less organized; doctors would trip over the wounded laid out on the stone floor. But the government's continued reliance on lethal force has given the staff practice, and so the doctors and nurses move more easily around the small space now, practiced in the chaotic choreography of battlefield medicine.

"The most important thing is to be in the field of the injury — immediate care saves lives," said Tarek Noman, a Western-educated doctor who conducts triage on the patients, to determine who needs to be treated first.

Religious institutions have a long history of sheltering medical facilities during conflicts. From Bastogne to Tahrir Square, churches and mosques have provided ideal locations for setting up field clinics. First, the open interiors of most religious buildings, used in more peaceful times for believers to gather, offers an excellent area to setup medical equipment. Second, the connection between religion and sanctuary makes religious building a natural destination for those needing help and protection. Third, the prominence (and often sheer size) of religious buildings means their location is often common knowledge amongst residents. Finally, religious institutions often have a strong norm of neutrality and protection from violence. Combatants are more likely to think twice about firing on a house of God than on an office building.

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Chinese Hospital Ship Arrives In Cuba

by [Christopher R. Albon](#) on [October 25, 2011](#)[[edit](#)]

Peace Ark, China's new PLA Navy hospital ship [arrived on Saturday](#) in Havana Bay, Cuba. The ship is currently on a three month deployment in the Caribbean (Jamaica, Trinidad and Tobago, and Costa Rica), in an attempt to boost China's soft power in the region:

China's presence in Latin America has grown by leaps and bounds in recent years and it has become the creditor of last resort for cash-strapped Cuba.

Cuba owes several billion dollars to China, and earlier this year the two governments signed a series of bilateral accords that will increase Chinese participation on Cuban onshore and offshore oil exploration and in other areas of Cuban life.

The two governments are negotiating a deal for China to lead a \$6 billion refurbishment of a refinery in Cienfuegos on Cuba's southern coast, with Venezuela providing financial backing for the project.

That Peace Ark is in the Caribbean is not surprising. What is surprising is the fact that the Chinese military built the ship in the first place. A dedicated hospital ship has only two uses: to receive mass-casualties from a large amphibious landing (a la Normandy) and increase a country's soft power.

officials must be aware of, the vessel represents a significant investment in soft power. It will be interesting to see if the Chinese invest more in this health diplomacy approach, or if this is a one-off experiment.

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Guns Vs. Hospitals

by [Christopher R. Albon](#) on October 23, 2011 [[edit](#)]



Lately I have been thinking about the underreported or overlooked health consequences of war. The effects too complicated or dull to deserve a TED Talk or a spot on the evening news. One area that keeps coming up in my mind is the budgetary trade-off between security and health care provision.

Faced with an armed threat to their sovereignty or the survival of their regime, governments often prioritize defense spending over social service spending. Governments always face dueling pressures for allotting spending between “guns vs. butter”. However, during civil wars spending priorities often swing heavily in favor of the military. Military spending has been found to rise from (on average) 2.8 percent of GDP during peacetime to five percent during civil war. This has direct, negative impacts on health system budgets. During the Spanish civil war, the republican government created a Ministry of Health and Social Care to provide health services to citizens and prevent wartime epidemics, however “the military campaign drained public funds and the financial resources of the Ministry were tiny” (Baron and Perdiguer-Gil 2008, 108). A similar focus on the military has been documented in Mozambique, where government spending on health decreased from 10.7% to 4.6% during a five period in the war. Peroff and Podolak-Warren (1979) conducted a time-series analysis of appropriation requests by the US government between 1929 and 1979. They found some evidence of a trade-off in public expenditures relating to conflict, with Vietnam War producing the greatest effect during the study period. Apostolakis (1992) later conducted a more thorough analysis, using time-series data from nineteen Latin American countries between 1953 and 1987. The analysis found strong evidence of a trade-off between military spending and health. For example, every dollar increase in Argentinian military expenditures decreased health spending by 31 cents. Recently there has been renewed

interstate wars, Iqbal (2010) found that states often favor defense spending over health care spending and that the effect is influenced by the severity of the conflict. Governments involved in minor conflicts increase the percentage of total government expenditures used for military spending by six percent, while they decrease the percentage for health spending by two percent. This represents a 25 percent decrease in health care expenditures. During major conflict the change was only more pronounced, with military and health expenditures as a percentage of total government expenditures increasing 12 percent and decreasing four percent, respectively — representing a 50 percent decrease in health expenditures.

Photo Credit: [Clarissa](#)

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Sexual Violence Against Men, A Weapon?

by [Christopher R. Albon](#) on October 15, 2011 [[edit](#)]

I've [talked](#) before about rape as a weapon in war, particularly with regards to the Democratic Republic Of Congo. Usually discussions of sexual violence center around women and children as the victims. Now, a new study by Mervy Christian of Johns Hopkins School of nursing [says that sexual violence against man by armed combatants is a growing problem](#). The study uses focus groups and interviews of male rape survivors in South Kivu. Christian found that the perpetrators of the sexual assaults were armed combatants.

The question that keeps coming to my mind is this: what were the motivations behind DRC's sexual violence. One explanation often presented is that rapes in the DRC are conducted to force populations to flee areas. This is possible, but unsubstantiated through any academic research I have been able to find. Another motivation, described in [Lisa Jackson's remarkable documentary](#) is that raping someone is a key component of the "magic potions" used by some armed groups:

Congo Soldier: "The magic potion worked in such a way that you've got to rape women in order to overcome the enemies who've invaded our country, the Congo."

This superstition not just held by a few soldiers, the documentary goes on to describe how soldiers were sometimes *ordered* to rape. Since this belief is widely held, then sexual violence could be a strategy in two ways. First, whatever the reality, the soldiers *believe* they are acting strategically: raping improves combat effectiveness. That might be irrational, but it is no means irrelevant to believers. Second, political leaders could be promoting the "magic potion" superstition to motivate their fighters to conduct sexual violence which furthers the political and military goals. That is, these leaders could be strategically attacking populations by tricking their fighters into committing sexual crimes they might not otherwise do. Simply put, rape could be a weapon and the rapists do not even know it.

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by [Christopher R. Albon](#) on October 13, 2011 [[edit](#)]

CCTV has a new video from Sirte's main hospital just after it was taken by NTC forces:

Two things to take from this video. First, most of the senior medical staff had fled, leaving nurses and medical students. Why? I can't be sure, but it is likely that many of the senior staff had some connections to the Gaddafi regime (often the case in one-party autocracies) and feared reprisal. This flight has left the hospital lacking in a number of major specialties. Second, NTC fighters had and continue to violate medical neutrality by entering hospital grounds to detain patients suspected of being Gaddafi loyalist. This is not the first time I have heard these accusations. This is utterly unacceptable. More needs to be done to force the NTC to stop such practices amongst its fighters.

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1999 Timor Leste Violence: By The Numbers

by [Christopher R. Albon](#) on October 12, 2011 [[edit](#)]

In a new paper in the Journal of Forensic Sciences, Debra Komar of Liverpool John Moores University and Sarah Lathrop of the University of New Mexico have [published \[gated\] a new survey of the pattern of injuries suffered by residents of Timor Leste during the 1999 violence](#). During the

island nation, killing a reported 1000-2000. In their paper, the researchers looked at 105 autopsy and anthropology reports during that time period. Here are their results:

No trauma was found in 25% of the sample, while a further 5% had only minor, nonlethal wounds.

Where trauma was evident, sharp force injuries were most common (35%), followed by gunshot (20%) and blunt force (13.33%). (Abstract)

The pattern of wounds found in the Timor Leste sample suggest many of the wounds were caused by improvised blades and farming equipment, a fact that “strongly suggests that the perpetrators were drawn from the local citizenry, rather than representing an adequately equipped military force”. The authors also note that this distribution of wounds looks more similar to Rwanda than it does from similar studies of mass violence in Cambodia, Bosnia, Croatia, and Afghanistan.

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Bahrain Sentences Health Workers Who Treated Protestors

by [Christopher R. Albon](#) on September 29, 2011 [[edit](#)]

In what can only be described as a direct attack on the medical community, Bahrain’s civilian-military “security court” just sentenced 13 doctors and nurses to 15 years in jail for treating anti-government protestors during demonstrations earlier this year. Al Jazeera has the details:

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Tibetan Health Workers Started Secret Clinics During War

by [Christopher R. Albon](#) on September 28, 2011 [[edit](#)]

Last month, David Poort of Al Jazeera English published a [story about the secret work of Tripoli's health workers during the country's civil war](#):

Evading the terror in the hospital corridors, a group of doctors affiliated with the hospital were said to have set up a network of secret field clinics throughout Tripoli, away from the eyes of security forces.

Private homes, schools and other buildings were converted into makeshift operating theatres, supplied with medical equipment that the doctors smuggled out of the hospital's storage rooms.

It was, according to the doctors, a dangerous undertaking, as stealing equipment from the hospital was sanctioned by severe punishment if discovered.

“We were undercover doctors,” Noureddine Hassan Aribi, a vascular surgeon who was recently appointed as the hospital’s director, recalls when asked about the days when it all started.

“It was a nightmare. There were horrible injuries. My colleagues and I treated many people in houses in the neighbourhood of this hospital. If the wounds were too complicated, we’d take them to a private clinic. We removed bullets and stabilised fractures, using primitive tools such as planks of wood and pieces of metal.

“We created 24 secret field hospitals all over Tripoli. Some of the doctors were caught by Gaddafi’s forces and were taken to prison. At least one of them was killed and another one is still missing,” doctor Aribi told Al Jazeera.

This is not the first time clandestine clinics have been established during civil conflicts. In the 1990s, Slobodan Milošević revoked the autonomy of Kosovo and expanded the power of the Serbian government over Kosovo’s institutions, including the police, courts, educational institutions, and health system.

The change devastated Kosovo’s health system. Almost two thousand ethnic Albanian health workers were dismissed including 263 doctors and 140 professors of medicine. Many others quit after threats and intimidation. By 1991, while ethnic Albanians made up 82% of Kosovo’s population, they made up less than five percent of Kosovo’s public health workforce. The remaining ethnic Albanian health workers were relegated to non-management positions. New rules set down by the Belgrade demanded that Serbian be the official language used in Kosovo hospitals — a language unfamiliar to many ethnic Albanian health workers and patients. Within a few years sixty-four percent of ethnic Albanian health workers had voluntarily or involuntarily left their jobs. The Milošević government filled the vacancies with health workers brought in from other regions of Yugoslavia and from outside the country, many lacking the appropriate expertise. The political interference in the health system undermined patient confidence. After the dismissal of over forty ethnic Albanian doctors, one obstetrics and gynecology department dropped from thirty deliveries per day to fewer than two

In response ethnic Albanians organized a “parallel” health care system including private practices in their houses and a network of clinics called the Mother Theresa Society. The Mother Theresa Society ran 96 clinics around Kosovo and was supported by volunteers and a parallel tax system. The ethnic Albanian medical professors and staff fired from University of Pristina even founded a parallel medical school. Instruction was conducted in Albanian and provided students with strong medical knowledge but, due to their lack of access to health facilities, weak clinical skills. During the 1990s this underground medical school graduated 600 doctors and 1,200 nurses. However, the clinic was not safe from violence: during the Kosovo War 90% of Mother Theresa clinics were looted or destroyed.

{ Comments on this entry are closed }

Video: Treating Wounded On The Libyan Front

by [Christopher R. Albon](#) on September 27, 2011 [[edit](#)]

Continuing our [impromptu exploration](#) of ambulance-based health workers in warzones, here is a video made by the ICRC, shot by André Liohn, about the challenges and threats faced by health workers on Libya’s front lines:

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ICRC Joins The Blogosphere

by [Christopher R. Albon](#) on September 27, 2011 [[edit](#)]



This week the International Committee of the Red Cross (ICRC) took a big step into the blogosphere with the launch of [Intercross](#). The new blog is written and curated by Simon Schorno, ICRC's spokesman in DC:

Intercross is about the plight of children, women and men affected by armed conflict and armed violence. Intercross is about humanitarian action. It is about the work the ICRC and international humanitarian law and the rich history of the institution I am proud to be part of. And it is about interacting with you, our readers, and building a place for news and commentary on armed conflict that is credible and, hopefully, relevant.

The initial set of posts on the blog are great, some new articles and some old op-eds. The ICRC has long had a presence on the internet, but from the looks of it Intercross is their first *true* blog: personal, informal, and at least somewhat opinionated (which is rather rare for the ICRC). I look forward to see how their blog develops and wish them luck!

{ Comments on this entry are closed }

[**Neglect At Afghanistan's Premier Military Hospital**](#)

by [Christopher R. Albon](#) on September 6, 2011[edit]

Over the weekend, the Wall Street Journal reported on revelations of [gross negligence and criminal mistreatment of patients at Dawood National Military Hospital](#), the Afghan military's main hospital. American military officers serving as mentors in the hospital discovered last year that patients in the hospital, where the salaries are subsidized by the US, were being forced to pay bribes to receive food and even basic care:

A beefed-up group of at least two dozen U.S. military mentors had arrived at the hospital in August 2010 as part of the “surge” of American forces in Afghanistan. They began to deploy throughout the wards, replacing an earlier group that had less direct contact with patients.

By the following month, the new mentors began to document what they describe as horrific conditions. Maggots fed off patients’ open wounds. Nurses and doctors refused to help amputees to the bathroom, and they soiled their beds for days.

Several patients died of simple infections because their bandages would go unchanged for weeks, while at least four died of complications related to malnourishment, according to [mentors and internal documents](#).

The US military is reportedly now conducting a full-court push to improve conditions in the hospital.

While clinicians might get the bad press, blame for the tragedy at Dawood National Military Hospital must also be directed at the hospital's administrators. Time and again I find that the success of post-conflict health reconstruction is determined not by the number of beds in a country, but the presence of strong and responsible health administrators willing and able to manage and enforce the requisite standards of care. Although not as sexy as training health practitioners, the education and training of health administrators is often more important.

{ Comments on this entry are closed }

Pakistan's Ethnic Violence And Paramedics

by [Christopher R. Albon](#) on August 30, 2011 [[edit](#)]

In an article last week, the [Economist reported](#) that the ferocity of ethnic violence in Karachi, Pakistan, has forced the city's paramedics to adopt an unusual policy in order to safely operate in the city:

ETHNIC warfare in Pakistan's most populous city has reached such a level that Karachi's ambulance service now has to send out a driver matching the racial make-up of the destination district to pick up the victims of gang attacks. Otherwise, the district's gunmen will not let the ambulance through. Now ambulances themselves are coming under fire, as gangsters try to stop them saving the lives of their enemies.

Health workers, particularly paramedics, operating in areas of insecurity often have to adapt their standard operating procedures. However, this is the first time I have come across "ethnic matching" medics to patients in order to insure their safety during sectarian strife.

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Health Worker Safety In Juarez, Mexico

by [Christopher R. Albon](#) on August 27, 2011 [[edit](#)]

The International Red Cross and Red Crescent has a short interview on their website with a Mexican doctor working in the city of Juarez, at the heart of Mexico's ongoing drug conflict. Here is the first question of the interview, you can read the entire interview [here](#).

What sort of violence have you experienced?

The clinic where I work is in an ordinary neighborhood but it has been attacked three times. Two of the attacks were armed robberies that left people wounded. The criminals even got into the area where the patients are treated. They also came and kidnapped a gynecologist who was working at the clinic.

For more insights into the risks to health workers in the city, check out this video by [Borderland Beat](#) on the life of paramedics in Juarez:

{ Comments on this entry are closed }

[**Video: Horror Of Abu Salim Hospital**](#)

by [Christopher R. Albon](#) on August 26, 2011 [[edit](#)]

Alex Thomson of Channel4 news has [a video report on the horrific conditions inside Abu Salim hospital, Libya](#). After watching the video I only have one thing to say: [thank god for the ICRC](#).

{ Comments on this entry are closed }

What Tripoli Central Hospital Needs

by [Christopher R. Albon](#) on August 24, 2011[edit]

Today, a doctor at Tripoli's central hospital gave [Al Jazeera reporter James Bay a list of medical drugs and supplies needed by the hospital](#). The doctor hoped aid agencies could provide some of the supplies. Not only do I feel that is it important to get to word out, the list is also an important example of the types of supplies most needed by hospitals facing widespread irregular combat in large urban areas.

Drugs

- Augmentin 1g
- Augmentin 625 mg cap
- Tramadol
- Thiopental sodium
- Flagyl infusion
- Mannitol
- Sodium bicarbonate solution
- Ringer's lactate
- Pethidine
- Tramal injection

Supplies

- Tracheotomy set
- Vascular set
- Chest set
- Laparotomy set
- IV set
- Syringes
- Ciclex solution
- Rubbing alcohol
- Sterile gauze
- Gauze roller
- KY gel (gel for ultrasounds)
- Oxygen cylindrical
- Synthetic vascular patches – “Dacron”
- Gloves

{ Comments on this entry are closed }

[Save Conflict](#) [UN Principles](#) [Health Care](#) [Conflict](#) [Exclusion](#) [Terrorism](#)

Haiti

by [Christopher R. Albon](#) on August 24, 2011 [[edit](#)]

It has long been suspected that Nepalese peacekeepers serving under UN mission in Haiti (MINUSTAH) were the cause of a devastating cholera epidemic that killed more than 6000 people and made more than 300,000 fall ill. Immediately after the epidemic, the United Nations denied that peacekeepers were to blame, [arguing in November that](#) “from a medical point of view, there has been no direct connection established between cholera and this contingent of soldiers”. However, mounting scientific evidence has eroded that claim. In May, a panel appointed by the Secretary-General [concluded that](#) the Nepalese peacekeepers were the cause of the epidemic. Furthermore, last month a study in the CDC’s Infectious Diseases journal [tracked the outbreak back to the MINUSTAH camp in Meille, Haiti](#) where the Nepalese peacekeepers were based.

Now, a [new study](#) provides definitive proof of the Nepalese peacekeepers’ involvement in the cholera epidemic. The article, [Population Genetics of Vibrio cholerae from Nepal in 2010: Evidence on the Origin of the Haitian Outbreak](#), in the open-access (i.e. not gated) journal mBIO, collected bacterial samples from 24 cholera patients around Nepal and compared their genomes to those of ten previously studied cholera genomes, including three from Haitian patients. Their results: the genomes of the Haitian and Nepalese cholera strains are nearly identical. The study provides conclusive evidence that the strain of cholera found in Haiti originated in Nepal.

It is unclear what practical effects the study will have on the ground in Haiti. Given that the Nepalese cholera strain is likely to continue to impact the health of Haitians for years — even decades — to come, the damage to the reputation of the UN peacekeepers in Haiti has already been done. Hopefully this new study will prompt the UN to increase anti-cholera efforts in the beleaguered country and to give serious thought about how to prevent peacekeepers from being unwitting disease vectors in the future.

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Dangers Of 3D

by [Christopher R. Albon](#) on August 18, 2011 [[edit](#)]

On paper, the concept of 3D — [integrating US defense, diplomacy, and development efforts](#) — promises to elevate the latter two “D’s” into real policy alternatives to military force. However, it seems clear now that despite the hype, 3D is failing to strengthen the role of development and diplomacy in US foreign policy.

In recent months both the US State Department and USAID have faced [serious threats](#) to their budgets, while the [Defense Department](#) has been spared. US foreign policy is (and will likely be in the foreseeable future) highly military-centric. In this environment, the reality of 3D is that it is less about putting diplomacy and development in their proper place in foreign policy discussions and more about making both of them underfunded auxiliaries of the US military (something many in the DoD

expanded, not cut.

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Photo: Military Health Diplomacy 2011

by [Christopher R. Albon](#) on August 17, 2011 [[edit](#)]



Caption: Navy Lt. Hoan Nghiem and Cpl. Caroline Winters of the Canadian Army extract a tooth at a medical civic action project for Pacific Partnership 2011. Pacific Partnership 2011 is a five-month humanitarian assistance initiative that will make port visits to Tonga, Vanuatu, Papua New Guinea, Timor-Leste, and the Federated States of Micronesia. Photo By Kristopher Radder.

{ Comments on this entry are closed }

Are Drones A More Humane Form Of Warfare?

by [Christopher R. Albon](#) on August 17, 2011[[edit](#)]

Sadanand Dhume, a resident fellow at the American Enterprise Institute, [argued today in the Wall Street Journal that drone strikes offer a more humane method of fighting](#) Islamic militants in Pakistan than other methods:

Though even a single civilian casualty ought not to be taken lightly, the focus on alleged collateral damage distorts the essence of the drone program. In reality, technology allows highly trained operators to observe targets on the ground for as much as 72 hours in advance. Software engineers typically model the blast radius for a missile or bomb strike. Lawyers weigh in on which laws apply and entire categories of potential targets — including mosques, hospitals and schools — are almost always off bounds.

All these procedures serve one overriding purpose: to protect innocent civilian life. The New America Foundation's database of strikes shows it's working. This year civilians made up only about 8% of the 440 (at most) people killed in drone strikes in Pakistan down from about 30% two years ago. As for affecting U.S. popularity on the ground, according to the Pew Global Attitudes survey, the U.S. favorability rating — long battered by conspiracy theories and an anti-American media — hovers at about 12%, almost exactly where it stood before the program's advent seven years ago.

Whether you agree or disagree, it is an interesting argument. I am interested to see what Conflict Health's readers think. Do drones make for more humane wars?

Edit: Georgetown Professor C. Christine Fair [has a post on The Monkey Cage on drones strikes and civilian casualties](#).

{ Comments on this entry are closed }

Bahrain's Health System As An Enemy Of The State

by [Christopher R. Albon](#) on July 24, 2011[[edit](#)]

Last week, Human Rights Watch [published an excellent report](#) on the attack against health workers, health facilities, and patients by Bahrain's government during the country's recent democratic unrest. Here is the punchline:

"Since the start of the crisis in Bahrain, Human Rights Watch has documented an alarming pattern of attacks, mainly by Bahraini troops and security forces, against medical workers, medical institutions, and patients suspected of participating in protests, primarily on the basis of the injuries they had sustained. At first the attacks appeared

crackdown revived in mid-March security forces increasingly targeted medical personnel and institutions themselves, accusing some doctors, nurses, and paramedics of criminal activity as well as involvement with anti-government protests.”

The report goes on to provide detailed accounts of the allegations, and it is damning. I encourage you to read the report for yourself. One point worth noting: from the accounts it is clear is that the attacks were not the result of unclear rules of engagement or overzealous security officers, but rather a sanctioned operation by the government of Bahrain to treat its own health system as an enemy of the state. This type of official “civil war” against one organ of a government is rare in middle income, functioning states and speaks to the brutality of the crackdown. In the long term, we should expect to see the quality of Bahrain’s health workforce decline as health workers avail themselves of the [global demand for medical professionals](#) and emigrate.

{ Comments on this entry are closed }

Libyan Rebels Loot Hospitals

by [Christopher R. Albon](#) on July 21, 2011[[edit](#)]

If there was a universal law of war, I suspect it would be that young men with guns and with inadequate structure end up looting and killing, whether they are fighting for freedom or a dictator. Case in point: late last week Human Rights Watch [reported that health facilities in four towns had been looted by Libyan rebels](#):

“In Rayayinah, one resident who stayed said that rebels had looted medical equipment from the polyclinic after taking the town. Human Rights Watch visited the facility on July 2 and saw vandalized rooms, broken windows and doors, and evidence of missing medical equipment, including an x-ray machine and possibly an electrocardiogram machine.

The hospital in al-Awaniya, inspected by Human Rights Watch on July 3, was in a similar condition, with missing equipment, broken windows, and damaged furniture.

A medic sympathetic to the rebels told Human Rights Watch that he had participated in the looting of the al-Awaniya hospital after rebels took the town:

[The al-Awaniya Hospital] was very well-equipped, and we basically took everything. It was well equipped for Gaddafi troops. [Rebels] said that Zintan would be the central hospital for the region.... I heard that the equipment from [the] Rayayinah [polyclinic] went to Zintan too.

Human Rights Watch visited the Zawiyat al-Bagul medical clinic on July 3. It had also been attacked and looted by vandals.”

By my recollection (and I keep a reasonable close eye on these things), these are the first documented cases of looting and/or purposefully damaging medical equipment by rebel fighters since the civil war

kindly towards health workers. It is worrying to see that things might be changing.

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Can Naming And Shaming Protect Hospitals?

by [Christopher R. Albon](#) on July 19, 2011 [[edit](#)]



The United Nations Security Council [passed a resolution last week allowing the UN to publish a list of countries or non-state armed groups that attack hospitals or schools](#). The list will be published in the annex of an annual report on children and armed conflict.

“Persistent perpetrators need to face credible consequences,” Germany’s Foreign Minister Guido Westerwelle told the Council. “If they do not change their behavior, they should face measures through sanctions regimes.”

“We do not want to see children being used in conflicts, we do not want them to be forced to fight, we do not want them to be injured … or killed,” Westerwelle said. Germany holds the rotating presidency of the Council this month.

Will it work? No, except for a few cases. Governments and armed groups who attack hospitals, schools, and civilians tend to be unconcerned with international opinion. Why? Because they often receive support from natural resources (diamonds etc...), freeing them from the need to restrict military tactics in order to maintain public opinion. In other words, whether the world likes them or not, they will still be able to pay their fighters. Of course, there are a handful of cases to the contrary. During the Mozambican civil war, RENAMO rebels lobbied hard to win the support of key policymakers in DC. They were somewhat successful until a well published massacre made supporting the perpetrators impossible. Thus, it is likely that the only time such a UN list will be useful is when a rebel group is seeking the support of a democratic government wherein supporting a

Photo: Regional Hospital In Kandahar. Photo by Chief Petty Officer David Votroubek.

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Consequences Of Fake Vaccination Programs In AfPak

by [Christopher R. Albon](#) on July 14, 2011 [[edit](#)]

I have a new piece at ForeignPolicy.com on the consequences of the CIA's fake vaccination program on legitimate health campaigns in Afghanistan and Pakistan. The punchline:

Given the precarious relationship between health workers, militants, and civilians in many areas of both Afghanistan and Pakistan, the existence of a fake vaccination program ran by the CIA is likely all the evidence many need to accuse all vaccinators and health workers of spying. The end result will be fewer families willing to have their children vaccinated, and more attacks on health workers providing any manner of medical care to communities. Some people will no doubt say that the operation was a reasonable and necessary attempt to confirm bin Laden's location, and that nobody was directly put at risk as a result. Tell that to the next vaccination team in Abbottabad.

You can read the [entire article at FP's Afpak Channel](#).

{ Comments on this entry are closed }

Video: Health Care In Mogadishu

by [Christopher R. Albon](#) on July 13, 2011 [[edit](#)]



Al Jazeera has a short but informative video on health care in Mogadishu and the human cost of civil war in Somalia. The segment includes an interview with a surgeon in the country. Click the image above to watch the video.

{ Comments on this entry are closed }

Radio Interview: Implications Of The CIA's Fake Vaccination

by [Christopher R. Albon](#) on July 13, 2011[edit]

This morning I [discussed the implications of the CIA's fake vaccination drive](#) on [The Takeaway](#), a nationally-syndicated news radio program. You can listen to the segment here:

During the interview I mentioned Mark Goldberg, you can find some of [his thoughts at UN Dispatch](#).

{ Comments on this entry are closed }

[**CIA Conducted Fake Vaccination Drive To Hunt Bin Laden**](#)

by [Christopher R. Albon](#) on July 11, 2011[edit]

The Guardian reported today that the Central Intelligence Agency [conducted a fake vaccination program in the Pakistani town of Abbottabad](#) in a bid to get the DNA of Osama Bin Laden or his children. If the CIA could get the blood of Bin Laden's children during the vaccination process, they would be able to compare it to the DNA of his sister who died previously — thereby confirming his presence in the city. The vaccination program was administrated by local health workers unaware of their part in a covert operation:

In March health workers administered the vaccine in a poor neighborhood on the edge of Abbottabad called Nawa Sher. The hepatitis B vaccine is usually given in three doses, the second a month after the first. But in April, instead of administering the second dose in Nawa Sher, the doctor returned to Abbottabad and moved the nurses on to Bilal Town, the suburb where Bin Laden lived.

If true, the CIA's actions are irresponsible and utterly reprehensible. The quote above implies that the patients never received their second or third doses of the hepatitis B vaccine. And even if they did, there is absolutely no guarantee that the vaccines were real. The simple fact is that the health of the children of Abbottabad has been put at risk through a deceptive medical operations by the Central Intelligence Agency. Furthermore, the operation undermines future vaccination campaigns and Pakistani health workers by fueling conspiracy theories about their true purpose.

Let us be clear about one thing: health care is not a weapon and any use of it as such deserves full-throated condemnation.

Edit: I must point out that the story in the Guardian is sourced to the Pakistani Inter-Services Intelligence agency (ISI) and thus could well be false. If the ISI told me the sky is blue, I'd ask for a second opinion. Independent sources are needed before we know for certain if it happened.

Edit 2: It is looking more and more like the story is [true](#).

{ Comments on this entry are closed }

Are Libyan Rebels Diverting Humanitarian Aid?

by [Christopher R. Albon](#) on July 11, 2011 [[edit](#)]

Maybe, probably. [Last week, Marc Herman wrote an article for The Atlantic claiming that the Libyan rebels are collecting aid meant for refugees in Tunisia](#) and sending it to rebel warehouses across the border in Libya. Specifically, he claimed:

At the end of that run, Nalut, which is still under shelling most nights, has two depots, one for food and one for gasoline. Anti-Qaddafi locals at Nalut gather the supplies sent from Tataoine, sending them on to 13 other towns under control of the anti-Gaddafi militias, according to Mohammed Omar, who runs the warehouse. ... Most of the tons of rice and pasta had no identification, but large sections came from charities, noticeably Islamic Relief. Much of the cooking oil, a quantity of pallets about five meters on a side, bore stamps from USAID and the World Food Program.

The article gives few additional details, making me suspect the reporter did not realize the implications of what he had seen until much later. However, it certainly wouldn't surprise me if rebel logisticians were purchasing supplies from cash-strapped refugees. If true, it would amount to a gross but not uncommon misuse of humanitarian aid by non-state armed groups.

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Gaddafi Loyalists Occupy Hospital

by [Christopher R. Albon](#) on July 6, 2011 [[edit](#)]

Human Rights Watch is accusing pro-Gaddafi forces of [occupying a hospital in Libya's western region for six weeks](#). Units of the loyalist Civil Guard allegedly took control of the grounds of Yafran General Hospital from April 19th to June 2nd, preventing health workers and patients from leaving. The Civil Guard effectively turned the hospital into a combat clinic, forcing the detained health workers to treat wounded government forces. According to those detained, the occupation was brutal and terrifying, with Civil Guard personnel threatening both patients and medical professionals with torture and death. The Civil Guard also deployed military weapons on the hospital grounds, including anti-aircraft weapons, a clear violation of the hospital's neutrality.

The occupation ended when Rebel forces took the town of Yafran on June 2nd. According to Human Rights Watch, despite rebel fighters standing guard outside the hospital grounds, no hospital staff has experienced any threats or violence from rebel troops.

The occupation of the hospital is just one more egregious violation of international humanitarian law by Gaddafi's forces during the ongoing civil war. It is likely the Civil Guard was using the hospital as a human shield to protect themselves from NATO air attacks, knowing full well that NATO aircraft would avoid hitting a hospital.

the laws of war whenever it is tactically advantageous. These violations are only likely to increase as his forces are pushed back closer to Tripoli, making them more desperate. Therefore, we should expect more cases of the exploitation of health workers and hospitals in the future. Second, rebel forces appear to be treating the health system with a significant amount of respect. This is a positive sign since as the rebels gain more territory, the risk towards health workers and the health system decreases.

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Blue Helmets Brought Cholera To Haiti

by [Christopher R. Albon](#) on July 4, 2011 [[edit](#)]

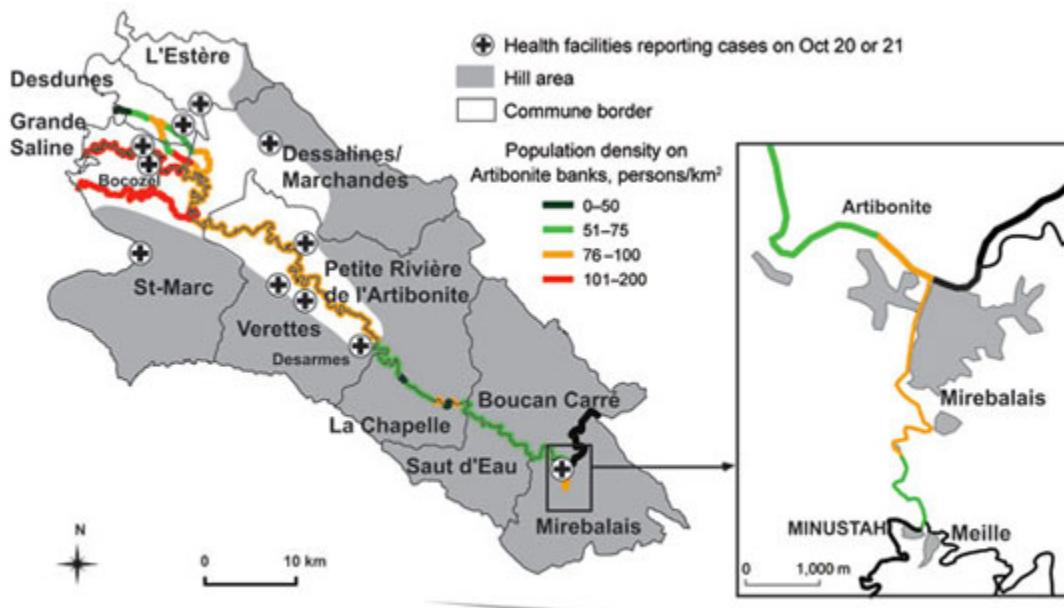


Figure 1. Location of health centers reporting cholera cases in communes along the Artibonite River on October 20, 2010, Haiti. MINUSTAH, United Nations Stabilization Mission in Haiti.

A new research article in the CDC's Emerging Infectious Diseases claims that [the 2010 cholera epidemic in Haiti was caused by United Nations Stabilization Mission in Haiti \(MINUSTAH\)](#).

Our epidemiologic study provides several additional arguments confirming an importation of cholera in Haiti. There was an exact correlation in time and places between the arrival of a Nepalese battalion from an area experiencing a cholera outbreak and the appearance of the first cases in Meille a few days after. The remoteness of Meille in central Haiti and the absence of report of other incomers make it unlikely that a cholera strain might have been brought there another way.

Interestingly, the limited contact people living around the camp had with the Nepalese Blue Helmets prevented the epidemic from flaring nearby. The team of researchers instead suspect that sewage

water stream downstream. Massive population movements after the earthquake and during the epidemic spread the disease further.

Some Haitian leaders have demanded that the United Nations be held accountable for the epidemic. The [Organization for the Solidarity of Women \(SOFA\) demanded](#) an apology, the returning of \$853 million budgeted for MINUSTAH, and “all the soldiers of MINUSTAH, break up into groups to work with organizations like PAPDA and SOFA, and other organizations of social movements, we demand this, because we are not okay, firstly with the military occupation”.

The Haitian Ministry of Public Health [reports that 344,623 cases of cholera have been recorded since the outbreak began in October](#), and it has no end in sight.

Photo Credit: [Piarroux R, Barrais R, Faucher B, Haus R, Piarroux M, Gaudart J, et al. Understanding the cholera epidemic, Haiti. Emerg Infect Dis \[serial on the Internet\]. 2011 Jul \[date cited\].](#)
<http://www.cdc.gov/EID/content/17/7/1161.htm>

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[**The Red Cross Box**](#)

by [Christopher R. Albon](#) on June 29, 2011[edit]



On April 2nd 1982, the Argentine military launched an amphibious landing on the Falkland Islands in the South Atlantic Ocean. In response, the United Kingdom flexed the last of its imperial might and deployed a task force to retake the islands by force. On May 21st, in a small bay, under heavy Argentine air attack, the British ships de-gorged themselves onto the beachheads, landing thousands of troops. For the next two weeks, Argentine and Britain would fight a brutal short campaign, availing themselves of all the benefits of modern conventional military technology.

However, even while British and Argentine infantry were engaging in some of the most ferocious close quarters battles in the 20th century at the [Battle of Goose Green](#), sixty miles to the north British and Argentine military ships stationed themselves peacefully within view of each other and regularly communicating on good terms. What was this place? [The Red Cross Box](#).

Before launching their attack on the Falklands, the British government suggested that both sides establish a neutral point on the high seas where hospital ships from both sides could operate in safety. This area, called the Red Cross Box was approximately twenty nautical miles in diameter and within its confines the peace reigned. Stationed within the box were four British and three Argentine hospital ships. Most of the vessels had only recently been converted to hospital ships, with two of the Argentine vessels [being hastily converted icebreakers](#). The ships were [periodically inspected by Red Cross officials](#) to make sure they were abiding by the rules set forth in the Geneva Convention. Both sides were in regular radio contact to coordinate their movements and the movement of patients. The proximity between the two sets of medical units allowed for the easy exchange of wounded between the ships. One British hospital ship, the S.S. Uganda made four separate patient transfers to Argentine vessels. By the end of the war, the ships of the Red Cross Box treated hundreds of British and Argentine casualties. While largely overlooked in histories of the conflict, the Red Cross Box should serve today as the epitome of the application of the Geneva Convention in modern warfare.

Photo credit: [Martin Otero](#)

{ Comments on this entry are closed }

[**CSIS Releases New Report On DoD Medical Labs**](#)

by [Christopher R. Albon](#) on June 29, 2011[edit]

Yesterday CSIS released a new report on the little known overseas research labs run by the US military. I don't have much to say since I will only be able to read the report tonight, so until then I present it here without comment. Enjoy.

In the spring of 2010, CSIS launched a year-long, independent examination of the U.S. Army and Navy overseas medical research laboratories. The impetus was an awareness that despite the laboratories' impressive scientific accomplishments and contributions to U.S. national interests and global health, they are not well understood outside of research circles and consequently find themselves undervalued in today's environment of fiscal austerity. They stand at the intersection of health and security, a topic of increased importance to U.S. approaches to global health.

The CSIS project aimed to assess the laboratories' contributions and achievements; examine the factors that constrain their performance; and propose reforms that will put them on the best course to continued success. It included considerable background research, three formal meetings of experts, travel to five overseas laboratories, and interviews with dozens of laboratory researchers and collaborators. This report lays out the project's research, conclusions, and recommendations.

[Download the full report here.](#)

{ Comments on this entry are closed }

Photo: The Newborn

by [Christopher R. Albon](#) on June 28, 2011[edit]



Caption: Afghan national security forces and coalition forces medics nursed a malnourished two-year-old female infant weighing only seven pounds back to health over two weeks by Afghan national security forces and coalition forces medics Arghandab District, Zabul Province, Afghanistan, Feb. 25 to March 12. She was brought to the attention of ANSF during a humanitarian aid mission in Zabul Province in late February.

{ Comments on this entry are closed }

Gang Humanitarianism

by [Christopher R. Albon](#) on June 27, 2011[edit]

Previously on Conflict Health we discussed the phenomena of humanitarian relief provided by non-state armed groups. While there are a number of historic examples, the most well-known (and certainly notable) example is the disaster relief operation [launched by Islamic militants](#) after the 2010 floods in Pakistan. In the aftermath of the disaster, humanitarian organizations affiliated with Islamic militants distributed food and other supplies to people affected, often responding faster than government agencies. It remains an important example of armed groups providing services to the population to increase their own political legitimacy and support. Now, there are reports of other non-state groups providing humanitarian relief after a natural disaster: the gangs of Japan.

Shortly after the earthquake and tsunami hit the island nation earlier this year, organized crime groups (called the yakuza) started their own humanitarian response. The gangs [sent dozens of trucks filled with supplies to regions of the country effected by the disaster](#). The trucks carried everything from drinking water to diapers. Interestingly, the gangs have reportedly been reluctant to talk about their contribution to the response effort, seemingly meaning to keep their organizations — currently the target of widespread investigations by the police — out of the news.

So why did they do it? Perhaps their disinterest in positive press is a ruse and their humanitarian gestures after the earthquake are an attempt to improve their image. Or, perhaps they simply felt it was their duty to help in the aftermath of the disaster. Either way, the humanitarian mission by the yakuza is an interesting example of non-state, non-NGO participation in a disaster response.

{ Comments on this entry are closed }

Video: Civilians In Sri Lanka's Civil War

by [Christopher R. Albon](#) on June 24, 2011[edit]



Channel4 has a new brilliant and emotional documentary on the unintentional and intentional killing of civilians at the end of Sri Lanka's long civil war. The show, titled "[Sri Lanka's Killing Fields](#)", is available online for the next twenty days. It is the first major depiction of the still largely untold story of civilians in the conflict. Definitely check it out.

{ Comments on this entry are closed }

[**Another Drug Rehab Center Attacked In Mexico**](#)

by [Christopher R. Albon](#) on June 24, 2011[edit]

Cartel fighters in Mexico [attacked a drug rehabilitation center in the north of the country on Tuesday](#). Masked gunmen stormed the facility in the town of Cuauhtemoc, kidnapping four people. Luckily, nobody was killed — although the fate of those taken remains unknown. Drug gunmen have shown little restraint when it comes to respecting the neutrality of health care facilities and providers in the country. The raid is the latest in a [string of attacks](#) against rehabilitation facilities in the country. Mexican officials believe the attacks are targeting people using drug rehabilitation centers to sell drugs on a rival gang's territory.

The violence has also had a devastating effect on medical tourism. Thousand of Americans travel to Mexico each year for low cost medical care, and like it or not, these patients are an importance resource of revenue for health providers. As the violence escalates, the number of patients from the United States (and I suspect elsewhere) [is dwindling](#):

“Business is practically zero now,” said Eduardo Garcia, a doctor who helps oversee

With little hope of the battle ending anytime soon, we can only hope that the health system in Mexico will be spared the brunt of the violence.

{ Comments on this entry are closed }

Photo: The Humanitarian, The Sailor, And The Patient

by [Christopher R. Albon](#) on June 21, 2011[edit]



Caption: Osvaldo Romero, left, from Latter-Day Saints Charities, talks to a patient while Lt. Cmdr. James Solomon, a Navy anesthesiologist, prepares her for surgery aboard the Military Sealift Command hospital ship USNS Comfort. Photo by Petty Officer 3rd Class Jonathen Davis.

{ Comments on this entry are closed }

Photo: Continuing Promise 2011

by [Christopher R. Albon](#) on June 17, 2011[edit]



Caption: The Military Sealift Command hospital ship USNS Comfort is anchored off the coast of Tumaco, Colombia during Continuing Promise 2011. Continuing Promise is a five-month humanitarian assistance mission to the Caribbean, Central and South America. Photo by Petty Officer 3rd Class Jonathen Davis.

{ Comments on this entry are closed }

Photo: Kasara Health Clinic

by [Christopher R. Albon](#) on June 10, 2011 [[edit](#)]

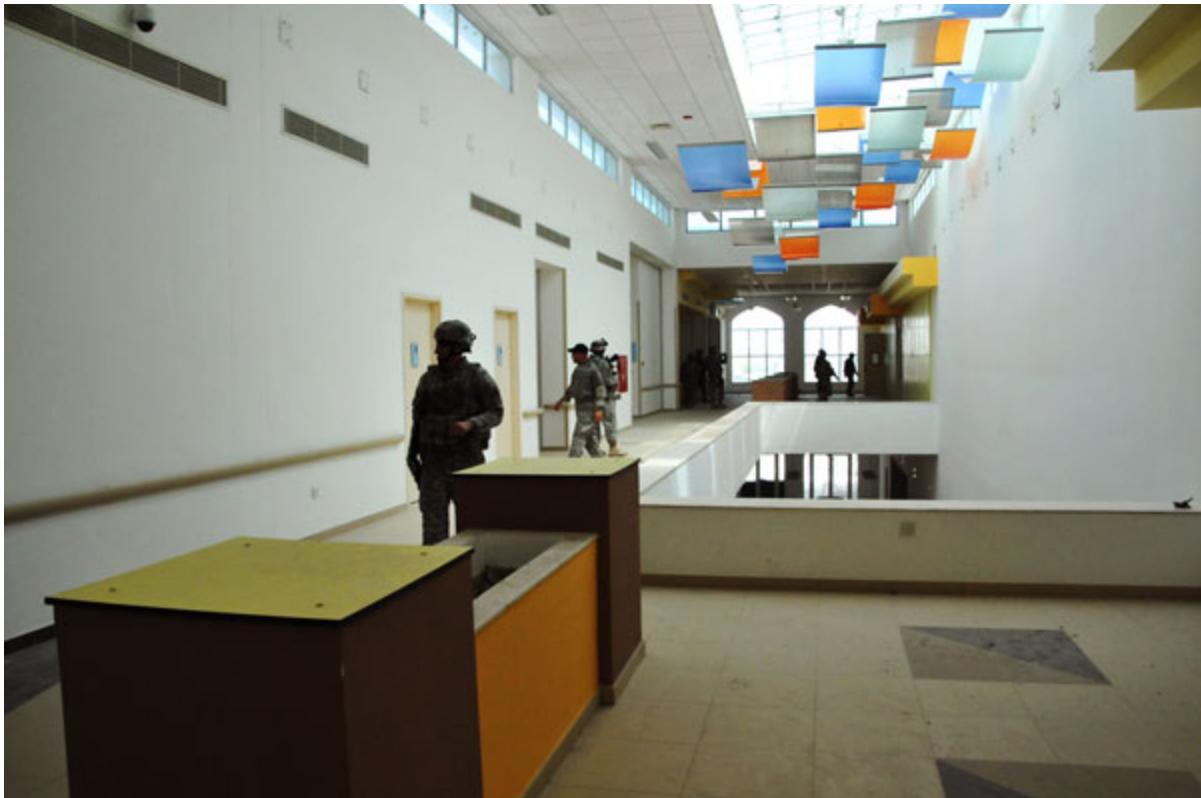


Caption: Sgt. Robert Osborne of the 401st Civil Affairs A team and children at the newly built Kasara Health Clinic in Dohuk Iraq. Photo credit: Maj. James Street.

{ Comments on this entry are closed }

[Photo: Basra's New Children's Hospital](#)

by [Christopher R. Albon](#) on June 8, 2011[edit]



Caption: Soldiers from Brigade Combat Team surgeon, 4th Infantry Division, walk through the Basra Children's Hospital and check on the progress of the construction May 28. The 94-bed, 16,000-square internationally funded hospital will be the first state-of-the-art pediatric specialty hospital in Iraq, and will also function as a training center. The hospital is slated to begin outpatient services in September with inpatient services beginning in November. Photo by Sgt. Rodney Foliente.

{ Comments on this entry are closed }

Conflict Health Roundup For June 8, 2011

by [Christopher R. Albon](#) on June 8, 2011 [[edit](#)]

I am still playing catch-up after the move, but unfortunately conflicts do not take vacations. Below are some of the most notable stories on armed conflict and public health over the last few weeks. Time to get to work.

Health Workers On The Frontline Of Conflict – In Pictures

Health workers like Head Nurse Arlette, from the DRC, work in fear every day, putting their own lives at risk for the sake of their patients. ‘Our biggest challenge is security, without doubt,’ she says. ‘We do not feel safe here.

Guatemalans sue US for deliberately spreading illness in 1940s experiment

The court brief charges that US public health doctors hired prostitutes diagnosed with syphilis or gonorrhea to have sexual relations with soldiers, prison inmates, and psychiatric patients in Guatemala with the intention of spreading the disease. Once the unknowing subjects were diagnosed with illnesses, the US medical team tested them for potential cures, including penicillin. Orphaned Guatemalan children as young as 6 years old were used as an uninfected test group, according to the suit.

ICRC Forced to Cut Budget as Crises Mount

The International Committee of the Red Cross says it is forced to cut its budget this year, despite mounting crises and increased humanitarian needs. The ICRC reports donors are giving less because of economic pressures, so it will have to slash more than \$90 million from its humanitarian activities, bringing the budget down to less than \$1.1 billion.

Aid groups urge Ivory Coast to extend free healthcare

A temporary move by the Ivory Coast government to make health services free in the aftermath of the country's post-electoral unrest has expired, but aid agencies are urging the West African nation to extend the waiver and work towards permanently removing healthcare user fees.

Tackling mental health problems in Afghanistan

The hospital is supposed to receive \$300,000 from the Afghan government this year, but it has not yet been paid, said the hospital's director, Dr. Timono Shah Musamim. The hospital recently received a \$1.6-million grant from the European Union to renovate the buildings, provide medical supplies and staff training.

{ Comments on this entry are closed }

Back To Regular Posting

by [Christopher R. Albon](#) on June 3, 2011 [[edit](#)]

My apologies for the lack of posts over the last few weeks. I have been busy moving from San Francisco to the DC area. Conflict Health's regular posting schedule will begin again tomorrow.

{ Comments on this entry are closed }

Israeli Soft Power

by [Christopher R. Albon](#) on May 11, 2011 [[edit](#)]

Last week, Ronen Medzini of Ynet [published an article discussing Israel's attempts to improve its global image through humanitarian diplomacy](#).

So why should a nation that often has a prime spot on the UN agenda, largely under negative circumstances, associate itself with such an organization? It appears that the slogan that stands at the heart of Foreign Ministry efforts to move from separatism to involvement is “If you can’t beat them, join them.”

“We have reached the conclusion that the UN is not a body that makes only anti-Israeli decisions, but also does many other things,” said Eviatar Manor, who heads the Ministry’s International Organizations division. “There are issues such as epidemics, desertification and climate change, which the government cannot solve alone and there’s a need for a global effort.

“We see the UN as an instrument to promote Israeli expertise and financial activity. It’s not a crime to use the positive things that we do to enhance our ‘soft power,’ and show that we are not just a burden on the UN. We provide positive aspects as well.”

It is interesting to hear Israel — a state well known for its defiant unilateralism — talking about soft power and the power of international cooperation. Time will tell if their strategy pays dividends.

{ Comments on this entry are closed }

NGO Security: Bunkerization and Acceptance

by [Christopher R. Albon](#) on May 9, 2011 [[edit](#)]

UN Office for the Coordination for Humanitarian Affairs (OCHA) has published a new report on humanitarian security: [To Stay and Deliver: Good practice for humanitarians in complex security environments](#). The report is a collection of best practices in NGO security in complex environments compiled from interviews with 255 humanitarians and a survey of 1,100 national staff members. While I recommend reading the full report, for your convenience here are the key findings:

The “How to Stay Mindset”

The objective for humanitarian actors in complex security environments, as it is now widely recognised, is not to avoid risk, but to manage risk in a way that allows them to remain present and effective in their work. This shift from risk aversion (or, on the other extreme, recklessness) to risk management represents the culmination of the past decade’s evolution in thinking and methodology for programming in insecure conditions. Key to this shift is the concept of the enabling security approach—an approach that focuses on ‘how to stay’ as opposed to ‘when to leave’—which has been adopted in the UN system and by many organisations. This mindset in turn depends on organisations and individuals accepting a certain amount of risk—the risk that inevitably remains after appropriate analysis and all reasonable mitigation measures have been carried out.

Avoid Bunkerization

threat of direct targeting exists, which cannot be immediately mitigated through greater investment in dialogue and acceptance, or in cases where violence is perpetrated by economically-motivated criminal groups. In such scenarios good practice points to the development of ‘smart’ protection measures, which add a layer of security to the organisation but minimise negative appearances. In particular, humanitarian organisations need to do more to avoid ‘bunkerisation’ which distances them from the local community, thereby increasing vulnerability and perpetuating a negative cycle.

Increase Security Of National Staff Members

International humanitarian organisations have significant room for improvement in tackling the inequities between international and national aid workers in terms of providing adequate security resources, support, and capacities. The study found that most national aid workers believe that overall security management and the balance between nationals and internationals was improving, but most also feel that they are still more exposed and under a greater burden of risk than their international counterparts.

Neutrality Comes From Dialogue, Not Events

A headline finding of this study is that the greater an organisation’s demonstrated capacity to communicate and negotiate with all relevant actors, the better access and security is achieved for humanitarian operations. The ICRC has demonstrated the most active, effective, and sustained acceptance and humanitarian negotiation strategies. It focuses resources on strategically and continuously engaging with all parties to the conflict as well with as local communities.

Humanitarians Must Stay Neutral

While simultaneously calling for respect for humanitarian principles, in the recent past many humanitarian organisations have also willingly compromised a principled approach in their own conduct through close alignment with political and military activities and actors.

{ Comments on this entry are closed }

Gaddafi Reportedly Abusing Red Cross Emblem

by [Christopher R. Albon](#) on May 7, 2011 [[edit](#)]

Libyan rebels and aid workers in Misrata are reporting that Gaddafi’s forces are dropping sea mines into the city’s harbor [from helicopters bearing the red cross emblem of the International Committee of the Red Cross and Red Crescent](#).

Suleiman Fortiya, who represents Misrata on the Benghazi-based opposition National Transitional Council said small helicopters flew over Misrata on Thursday and Friday to

He said the choppers had been disguised as humanitarian aircraft carrying the emblems of the International Committee of the Red Cross and Red Crescent.

“They had Red Crescent and Red Cross markers so that anyone who sees them thinks it is for humanitarian aid,” Fortiya said.

An aid worker said he saw helicopters on Friday marked with the Red Crescent circling above the port and dropping mines into the sea.

The story just broke a few hours ago, not many details yet. If true — and there is reason to believe NATO might confirm the story soon — it represents another gross violation of international humanitarian law by the dictator. This latest move comes just days after pro-Gaddafi forces launched an artillery strike against a humanitarian ship offloading food and medical supplies on Wednesday.

{ Comments on this entry are closed }

Bahrain Arrests Health Workers For Collecting Data?

by [Christopher R. Albon](#) on April 29, 2011 [[edit](#)]

Could Bahrain’s security forces be arresting medical professionals for collecting health data? One opposition leader claims that they are:

Mattar Ibrahim Mattar, a former member of parliament for Wefaq, the country’s leading opposition group, told Al Jazeera that the families of medical staff who have been providing treatment to injured protesters were being arrested.

“The attack is also against the families of the activists who were against the prevention of medical services in the crackdown,” Mattar said in a phone interview on Tuesday.

Medical staff were targeted because they had been keeping accurate statistics on the number of people injured or killed in the uprising, he said, information which the government did not want to be made public.

“It is a way to hide the situation,” he said.

While not confirmed, it is a troubling accusation given the [regime’s recent behavior towards its health workers](#).

{ Comments on this entry are closed }

Libya’s Health System Before And After Revolution

by [Christopher R. Albon](#) on April 27, 2011 [[edit](#)]

Ryan Calder, a Ph.D. candidate at UC Berkeley has been publishing a [series of dispatches from rebel](#)

changing relationship between the city's health system and its citizens.

Before the revolution, some Libyans took their frustrations out on Libya's doctors. "Just a few months ago," remembers El-Fakhery, the anesthesiologist, "people hated Libyan doctors. They'd run off to Tunisia or Egypt for something as simple as a common cold." She recalls that a surgeon at her hospital was even physically attacked after a failed surgery. "We didn't have the facilities [to provide proper care]," she says.

But with the revolution, people in Benghazi began showing an outpouring of support for their doctors. She recalls how on March 19, as Qaddafi's tanks were rolling through Benghazi's streets and Revolutionary Committee members were shooting at civilians, she and other doctors were overwhelmed by the number of wounded they had to treat — and by the kindness that ordinary citizens were showing them. "In the hospital, men as old as my father would run around the ICU [intensive care unit] at Jala Hospital [in Benghazi], passing out milk and juice and boxes of dates to the doctors," she says. "They'd stuff them in the pockets of my lab coat and shake my hands, and they'd hug the male doctors. They'd bring pillows and blankets from home, giving everything they could to the hospital."

The more I research and write about health systems during conflict, the more I am convinced that they are one of the most important points of contact between citizens and their political leaders — both democratic and otherwise. The relationship between the population and the health system often parallels the relationship between citizens and the government at large. Health systems are tasked with providing care during the most vulnerable times in a citizen's life (childbirth, illness, etc...). How well health systems fulfill that role reveals the importance governments place in their citizenry. Governments requiring the support of the people build strong and effective health institutions, believing that they are a means to gain legitimacy in the eyes of population. Governments able to gather resources elsewhere — either through external support or natural resources — have little need to make such costly investments. In Libya, the rebels need the support of the people, Gaddafi did not.

{ Comments on this entry are closed }

Conflict Health Round-Up For April 20th, 2011

by [Christopher R. Albon](#) on April 20, 2011 [[edit](#)]

Ivory Coast: “Wounded Patients Are Stable, But Their Problems Are Not Over”

The first to arrive were lightly wounded—those who were able to get to the hospital on their own. Then two large trucks arrived, carrying many patients. We realized how important our disaster plan was, which MSF had developed more than two months previous. Thanks to the plan, we were able to triage the slightly wounded and the more serious cases.

There were so many patients, we had to stay in the hospital for two full days and nights.

intensive care and surgical care efforts, two people died.

Taliban Rue Ambulance Attack

The use of an ambulance by Taliban suicide attackers in a raid on a police training centre in the southern province of Kandahar on 7 April has been acknowledged as a violation of war laws and the insurgents have promised investigations.

“This will not happen again,” Zabihullah Mujahid, a Taliban spokesman, told IRIN.

The War on Soft Power

The sad irony is that the Obama administration had been moving things in the right direction. When Hillary Clinton became secretary of state, she spoke of the importance of a “smart power” strategy, combining the United States’ hard and soft-power resources. Her Quadrennial Diplomacy and Development Review, and her efforts (along with USAID chief Rajiv Shah) to revamp the United States’ aid bureaucracy and budget were important steps in that direction. Now, in the name of an illusory contribution to deficit reduction (when you’re talking about deficits in the trillions, \$38 billion in savings is a drop in the bucket), those efforts have been set back. Polls consistently show a popular misconception that aid is a significant part of the U.S. federal budget, when in fact it amounts to less than 1 percent. Thus, congressional cuts to aid in the name of deficit reduction are an easy vote, but a cheap shot.

Somalia: unexploded shells threaten hospital in Mogadishu

The 11 shells that hit Medina Hospital in Mogadishu without exploding three days ago have been collected up and stored, waiting for a bomb disposal unit to neutralize them.

Although nothing suggests that the hospital was deliberately targeted, the International Committee of the Red Cross (ICRC) and the Somali Red Crescent remind all parties to the conflict of their obligation not to harm medical staff, hospitals, clinics and similar facilities. Attacks may be directed only against persons taking a direct part in hostilities and against military objectives, and warring parties must take all necessary precautions to avoid harming the civilian population and civilian objects.

{ Comments on this entry are closed }

World Bank Report: Security First

by [Christopher R. Albon](#) on [April 18, 2011](#)[[edit](#)]

A new report by the World Bank on post-conflict reconstruction argues that [security must be a top priority in reconstruction](#):

With the world’s attention focused on the Arab Spring, the World Bank Group has released a new report that argues that security must be a top priority in reconstruction.

development. Then make a few highly visible improvements, like free health care for small children or restoring regular electricity. Also, hire female police officers.

These are among the recommendations in a new report from the World Bank that assesses the best strategies for donor nations seeking to improve conditions in countries mired in self-perpetuating cycles of violence.

Readers of Conflict Health will have heard of this argument before, just [from a very different source](#).

{ Comments on this entry are closed }

Taliban Use Ambulance As Car-bomb

by [Christopher R. Albon](#) on April 13, 2011 [[edit](#)]

Just last week I was talking about January's [ambulance car-bomb in Iraq](#). Now it appears there has been a [similar "ambulance bomb" attack in Afghanistan](#). As Taliban fighters attacked a police compound, an ambulance packed with explosives was able to fool government security forces and pass through at least one security point before detonating. The attack killed six and wounded 10. In response, the ICRC released a [statement condemning the attack](#):

"Using an ambulance for the purpose of deceiving the adversary in carrying out an attack constitutes perfidy. This is strictly prohibited by international humanitarian law and is totally unacceptable," said Jacques de Maio, the ICRC's head of operations for South Asia.

By violating the neutrality of health care services, such acts of deception endanger medical personnel engaged in caring for the injured and sick in hospitals, clinics and rural health posts. "They undermine the delivery of and access to health care, already precarious for ordinary Afghans in many parts of the country as a result of the conflict," added Mr de Maio.

Medical neutrality is critical in conflict. It is also difficult to achieve and easy to lose. It is a tragic that at least one group of Taliban is violating it to gain a tactical advantage.

{ Comments on this entry are closed }

Bahrain's Health System Is A Battleground

by [Christopher R. Albon](#) on April 10, 2011 [[edit](#)]



With civil war in [Libya](#) and [Ivory Coast](#), an [nuclear disaster](#) in Japan, and a narrowly averted [government shutdown](#) in the United States, it is understandable that the [crackdown against protesters in Bahrain](#) has been overlooked in much of the media. However, for readers of Conflict Health the events in Bahrain should be of particular interest. Why? Because much of the political unrest [is occurring](#) in the nation's health facilities.

In a [new report](#), Medecins Sans Frontieres claims that Bahrain's government has attacked and "militarized" the health system, making protesters and bystanders afraid of seeking treatment:

Following a military operation against protestors on 17 February, many sought refuge in the Salmaniya Hospital grounds. Salmaniya was seen as a safe place for the opposition protestors to go. During this time, as the protests continued, wounded demonstrators were received in Salmaniya as well. When ambulances were blocked from reaching patients, the doctors at the hospital began leading protests themselves.

Regardless of the reasons, health professionals making speeches and leading protests directly from the steps of the entrance to the hospital undermined the concept of a neutral hospital, as did the anti-government slogans painted onto the walls of the hospital.

Instead of asserting the neutrality of the medical structures, the government declared Salmaniya Hospital a legitimate military target, calling it a "stronghold of the opposition protestors." This completely and wrongfully undermined the notion that all patients have a right to treatment and all medical staff have a fundamental duty to administer treatment. This military reaction was exponentially more damaging to the trust in the health system than the activities of the opposition protestors.

Furthermore, MSF claims that the military has been arresting patients they find with the distinctive wounds from "bird-shot", the type of shotgun ammunition used by the government against protestors. Reportedly, the military is searching the wards for these types of wounds, using them to identify and detain individuals who were at the protests.

Interestingly, MSF argues that as a signatory to the Geneva Convention, Bahrain must “must allow health facilities in Bahrain to resume their core activity of treating patients in an impartial way.” However, I am not sure the Geneva Convention applies in this case. The Geneva Convention does apply to armed conflicts that occur inside a state, but does not apply to lesser forms of conflict (e.g. a murder, a protest, etc...). However, it is debatable whether Bahrain’s political unrest constitutes an “armed conflict”. If it does, then the health system of Bahrain is legally a neutral third-party with special protective rights, if not, then the actions of Bahrain’s military (while utterly reprehensible) are entirely governed by the country’s domestic laws — which I imagine are highly favorable to the military. The tragic events in Bahrain demonstrate the need for stronger de facto and de jure protections for health systems during “less-than-war” conflicts — particularly in non-democracies.

Here are some other stories from Al Jazeera on the military’s crackdown on the health system in Bahrain:

- [Bahrain medics claim army cover-up](#)
- [Bahrain’s hospital of ghosts](#)
- [Bahraini medics recount hospital horror](#)

Photo Credit: [RyanBayona](#)

{ Comments on this entry are closed }

[**Ambulance Bomb In Iraq**](#)

by [Christopher R. Albon](#) on April 6, 2011[edit]

In January an [ambulance was used as a car bomb in Iraq](#). It is one more tragic datapoint showing that health is often exploited by combatants for military advantage:

At least 12 people have been killed after a suicide bomber detonated an ambulance packed with explosives outside a security headquarters in central Iraq, officials said.

Another 55 people were said to be wounded in the attack on Wednesday.

The attack occurred at around 10am, in the middle of the ethnically-mixed city of Baquba, north of the capital Baghdad.

The blast occurred near the front gate of the Facilities Protective Services compound, which houses the local headquarters and training grounds for the Iraqi security force tasked with guarding government buildings.

{ Comments on this entry are closed }

[**Counting Libya’s Dead**](#)

by [Christopher R. Albon](#) on April 4, 2011 [[edit](#)]

James Downie at The New Republic has a great piece out on the [difficulty of counting the dead in Libya](#):

The answer is surprisingly complicated. The science of counting deaths in war is a subset of epidemiology, the science behind the cause and spread of disease. The ideal method, according to Paul Bolton, a professor at the Bloomberg School of Public Health at Johns Hopkins, is to conduct surveys by going door-to-door and tabulating the number of deaths in each household.

[...]

But, in the early phases of a war, such methods are almost impossible to carry out. “When the bullets are still flying,” says Bolton, “the only method available is to count bodies.” This, of course, poses its own challenges. Researchers must devise creative mechanisms to collect information from locals—gleaning information from cemeteries or places that sell shrouds, for example.

I encourage everyone to check it out.

{ Comments on this entry are closed }

[**Libyan Rebels Pledge To Not Use Landmines**](#)

by [Christopher R. Albon](#) on April 2, 2011 [[edit](#)]

Buried near the end of [this article by Human Rights Watch](#) is one of the most interesting piece of news I have seen about Libya in the past week. It comes in a single paragraph:

Rebel forces in Benghazi, now in control of the stockpile of antivehicle mines in the city’s arms depot, told Human Rights Watch that they will not use any type of mines. The pledge was made by Gen. Khalifa Hifter, commander of the rebel forces in Eastern Libya, during a meeting in Benghazi on March 25.

As an opponent of land mines, I take this news as a hopeful sign. However, as a political scientist I cannot help but ask myself why the rebels would make such a pledge. During the first few days of the Libyan civil war, it seemed that the rebels could reach Tripoli within the week. However, now the military situation has largely equalized with both rebel and government victories. Given that there is the real possibility that Gaddafi’s forces could march on Benghazi in the future, it seems strange for the rebels to avoid using an effective (and inhuman) weapon. Of course, we cannot overlook the real possibility that the general’s comments were cheap talk and he would deploy landmines if the situation became dire. Regardless, I hope for his sake and the sake of the civilians in Libya that he finds no reason to make such a decision.

{ Comments on this entry are closed }

Libyan Rebel's Frontline Hospital

by [Christopher R. Albon](#) on March 31, 2011 [[edit](#)]

Earlier in the month AP [published a short piece on the health system](#) used by the Libyan rebels. Two things come across in the article. First, the health system is largely ad-hoc, relying on a loose collection of medical students, doctors, and paramedics. Second, the health professionals have little experience with war trauma. Let's hope the international community can help with the latter.

A tiny clinic built mainly for foreign workers at this oil facility has turned into a front-line field hospital for the rebel army. Volunteer doctors from across Libya's east have replaced the long evacuated foreign staff and toil to patch together fighters blown up by the rockets and tank shells of Moammar Gadhafi's army.

"We've followed the revolution," said medical student Ahmed Abdel-Jalil, gesturing at his colleagues sitting in an ambulance outside the hospital earlier Tuesday.

As the eastern-based uprising against Gadhafi has gathered pace and moved west, doctors and nurses have moved with it, taking over small local hospitals and dealing with a flood of gunshot and shrapnel wounds unfamiliar to most medical workers.

"This is the first time for most doctors to face war injuries and stuff like that," said Dr. Mohammed Maftoudh, who returned from advanced medical studies in Atlanta, Georgia to help out at a Benghazi trauma hospital.

{ Comments on this entry are closed }

Libya's Health System Round-Up

by [Christopher R. Albon](#) on March 29, 2011 [[edit](#)]

Over the last week I have been scouring the news for stories on the impact of the civil war on Libya's health system. Below are a few of stories I have collected.

Anesthesia in Libya

Access to safe emergency and essential surgery is fundamental for delivering comprehensive health services in Libya. It is essential not only for treating the injured, but for ensuring safe access to comprehensive emergency obstetric care and treatment of emergency surgical needs extraneous to the conflict (among others).

Surrounded by tanks, snipers, Libyan hospital is fortress of fear

The battle in Libya has reached the doors of Dr. Aiman's clinic in Misrata: A man was killed in its entrance late Wednesday, he said, probably by fire from the tanks that have

Gadhafi.

Oxford-based doctor returns from Libyan mission

The orthopaedic surgeon, who works at the John Radcliffe Hospital, is originally from the Libyan town of Benghazi where the rebels are based.

He went back with a small medical mission from Canada, US and Britain.

At a Libyan Hospital, Pride and a War's True Cost Are Seen

A short walk from the morgue, men gathered at noon Wednesday before a billboard that read “Free Libya” and listed the dead and wounded in the fighting that had raged for days a couple of hours away along the Mediterranean. No. 15 was Mahmoud Abdel-Hamid, from Benghazi. No. 43 was Ibrahim el-Sharif, from Ajdabiya.

UAE gives equipment to hospital on Libya-Tunisia border

The United Arab Emirates (UAE) has delivered medical equipment to a hospital in a Tunisian town on the border with Libya.

The equipment – which are a grant from UAE’s Zayed Bin Sultan Al Nahayan Charitable and Humanitarian Foundation – will enable the hospital in Ben Gardan town to use an intensive care unit for the first time to accommodate six critical patients.

Moroccan Military Field Hospital At Libya Tunisia Border

The Moroccan field hospital, located at refugee camp near Shusha to RassJdir Tunisian-Libyan border (560 km southeast of the capital), began Sunday to offer medical services to hundreds of refugees of various nationalities.

The hospital began receiving hundreds of sick and injured. By mid-day, more than 70 patients of various nationalities (Bangladeshis, Egyptians, Tunisians) have received medical care for various conditions. This numbers went up to hundreds of people as the day unfolded. Moroccan nationals from Libya also benefited from the care provided by the medical facility. Between 15 and 20 Moroccans a day flock to the hospital, some accompanied by their families and children.

{ Comments on this entry are closed }

Send The Enterprise?

by [Christopher R. Albon](#) on March 19, 2011[edit]

A few days ago I received an email from James Knochel at SendTheEnterprise.org. I had never heard

a dedicated disaster response ship:

The Navy is planning to send the Enterprise on two 6-month cruises before throwing it away. They'll have to cut it up to extract the nuclear reactors, so there's no prospect for turning it into a museum. The Enterprise's replacement, the USS Gerald R. Ford, is specifically designed to reduce operating costs. The Enterprise is just too expensive for the Navy to keep as an active warship.

Instead of throwing away a perfectly functional ship, we propose that the Enterprise be dedicated to disaster response.

This is a horrible idea. Enterprise is too big, too deep, too costly, and too old to be a viable dedicated humanitarian and disaster relief ship. The fundamental problem with Knochel's idea is that it seems primarily interesting in finding a mission for the ship, rather than finding the right ship for the mission. In other words, it is about saving Enterprise, not saving people. If you are really interested in providing effective humanitarian relief, loading disaster response modules onto many ships would be a better choice.

However, given that it is clearly an original idea, I thought I would throw it out there to readers and see what your thoughts are.

{ Comments on this entry are closed }

Allies And Disasters

by [Christopher R. Albon](#) on March 14, 2011 [[edit](#)]

American military units, [including a small fleet of ships](#), continue to arrive on station in Japan and conduct disaster relief missions as requested by the Japanese government. The disaster relief operation is being called [Operation Tomodachi](#), or Operation Friendship. But one Japanese speaker points out that the name is more nuanced than simply "friendship". [According to one aid worker](#): Tomodachi is usually only used to refer to very close friends with mutual obligations. It is a perfect name for U.S. response in Japan.

Japan is a highly developed state, second only to the United States in gross domestic product. Unlike Haiti, it has significant emergency services which have been [responding brilliantly to the disaster](#). So, when the USS Ronald Reagan set sail for Japan, it was unknown whether they would even be needed.

Time has shown that the US support has been helpful in Japan, [supplying coolant for nuclear reactions](#) and delivery humanitarian supplies. But even if they were not needed, there is a greater point to the disaster relief mission: a show of our support.

Japan might have never needed our help. They might have been able to handle the disaster response entirely on their own. But the deployment of US military personnel sends a single, critical missive to the island nation: 日本の皆様、世界が応援している, roughly translated: People of Japan, we have [your backs](#).

Special thanks to [Mark Williams](#) — an American expat in Japan and a friend — for the translation.

{ Comments on this entry are closed }

Photo: U.S. Navy Disaster Relief In Japan

by [Christopher R. Albon](#) on March 14, 2011 [[edit](#)]



Caption: Lt. Cmdr. Albin Quinko from San Diego, assigned to the Black Knights of Helicopter Anti-Submarine Squadron 4, embarked aboard the aircraft carrier USS Ronald Reagan, hands over supplies to a Japanese aid worker during earthquake and tsunami relief efforts near Sendai, Japan. Ronald Reagan is off the coast of Japan rendering humanitarian assistance and disaster relief following an 8.9 magnitude earthquake and tsunami. Photo by Seaman Dylan McCord.

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[Feeding Benghazi](#)

by [Christopher R. Albon](#) on March 10, 2011 [[edit](#)]

On Monday on [TheAtlantic.com](#) I argued that the United States should assist rebel groups in Libya by [sending food aid](#). This option would allow the U.S. to provide much needed supplies to the rebels while avoiding direct military involvement in the conflict. Interestingly, yesterday The Washington Post reported that Europe and the United States were [considering some very similar to my proposal](#). Now my ego would like to believe I played some role that (rumored) plan, but we all know governments do not move that fast.

If true — and at this point that is a big *if* — the next question is how can the US and other states deliver the aid. Luckily, the provisional capitol of the rebel of Benghazi has [decent port facilities](#). Last week [HMS Cumberland](#) and a [World Food Program ship](#) both used the port, although the latter aborted a previous attempt due to reports of airstrikes in the area.

The question I pose to readers is this: If the US Navy was called upon to delivery food and other aid to rebel controlled areas of Libya, what would be the best way to go about it?

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[Medecins San Frontieres Used To Ambush Civilians?](#)

by [Christopher R. Albon](#) on March 10, 2011 [[edit](#)]

For more than a decade Medecins San Frontieres (MSF) — an organization for which I have a particular soft spot — has been conducting immunization campaigns in the Democratic Republic of Congo's North Kivu region. As with other MSF missions in conflict zones, the organization negotiated security guarantees from the belligerents. This guarantee is critical for the humanitarian organization to operate in unstable regions and provides some level of protection for staff and patients. However, on October 17th, 2009 the MSF vaccination program in North Kivu was exploited: it was the bait in an ambush.

According to [an MSF press release from two years ago](#), the health services provided by its teams were used by Congolese army units to target rebels and civilians gathered at the vaccination sites:

“We feel we were used as bait,” said Luis Encinas, head of MSF programs in Central

civilians in extreme risk. Thousands of people, and the MSF teams, were trapped in the gunfire. The attack was an unacceptable abuse of humanitarian action to fulfil military objectives. How will MSF be perceived by the population now? Will our patients still feel safe enough to access medical care? We are compelled to strongly denounce this situation as such actions seriously compromise our neutrality.”

I have not talked to MSF about this incident and the press release contains few details, but if true it is a disheartening case of humanitarians being used as unwitting pawns in combat operations.

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Video: Rebel Hospital During The Battle For Zawiyah

by [Christopher R. Albon](#) on March 8, 2011 [[edit](#)]

SkyNews has a video on the [ongoing battle for the Libyan city of Zawiyah](#). Fast forward to 6:00 for video footage from a rebel hospital in the city. Includes footage of Libyan army firing on an ambulance — from the ambulance’s perspective.

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Send Food To Libya

by [Christopher R. Albon](#) on March 8, 2011 [[edit](#)]



This week I have a new article on The Atlantic [proposing a different type of U.S. intervention in Libya: food aid](#):

It still appears unlikely that Qaddafi will step down on his own accord. If the rebels are to free Libya, it will probably mean taking Tripoli by force and toppling Qaddafi outright. Currently, rebels in eastern Libya are mustering an army — mostly raw recruits and seized weapons — which they may use to do just that. But Benghazi is just over 1,000 km, about 630 miles, from Tripoli. Defeating Gadaffi would require this irregular force to travel hundreds of miles across the Mediterranean coast, all the while supplying itself through what would likely be a series of battles along the Gulf of Sidra, Sirte, and then in Tripoli itself.

Warfare has changed much since Napoleon's Grande Armée marched across Europe, but one of the Little Corporal's maxims is just as true in Libya today as it was near Waterloo two centuries ago: armies march on their stomachs. The anti-Qaddafi rebels are no different. The push to Tripoli would require consistent access to — amongst other things — food supplies. While having adequate food alone would not be sufficient to take the capitol (they also need war materials, training, and transportation), it is an absolute necessity. And, right now, the rebels don't have enough. But we do.

When I was originally conceiving the piece, the debate on what — if any — US intervention should take place was squarely fixed on three options: arming the rebels, enforcing a no-fly zone, and conducting air strikes. While definitions of the term vary, I think it would be fair to consider all of these options as "hard power" approaches to the crisis. The purpose of my article was to inject a soft power option into the discussion: with a win-win outcome, lower financial cost, less risk to American

shortages have had on military operations in the past (notable for General Lee's army in the US civil war and Napoleon's Grand Army in Europe) there is a solid precedent for the benefits food aid can have on an rebel's fighting capacity, both directly through feeding the fledgling army and indirectly though assisting the civilian population they govern.

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Impact Of The Eritrean-Ethiopian War On Child Health

by [Christopher R. Albon](#) on February 27, 2011 [[edit](#)]

From 1998 to 2000, Ethiopia and its former territory Eritrea fought a devastating border conflict. This was not some minor dispute, but rather a total war between two modern states. Both countries invested hundreds of millions of dollars — an incredible portion of their national budgets — towards the conflict. The battles were brutal, hard, and mechanized — often fought [between entrenched armies with armor and artillery support](#). Much of the war would have not felt out of place in the 1916 Somme.

Late last year, three researchers published a [working paper at the Household in Conflict Network \(HiCN\) \[PDF\]](#) on the effect of the war on the short and long-term health of children in both countries. Using household surveys, the researchers examined the height differences of children in each countries before and after the war. Previous research has established that the lack of health (e.g. disease and malnutrition) is reflected in childhood growth rates, measurable by their height divergences from the average.

The study found two results of interest. First, the researchers argue that displacement and deportation were likely the greatest causes of health insecurity during the conflict. Fighting caused widespread displacement amongst both Eritrean and Ethiopian civilian populations. Furthermore, thousands of families were forcefully deported back to their countries. This would be particularly damaging to rural farmers unable to harvest their crops or prepare for the next season.

Second, the impact of the war was different for children in Eritrea than in Ethiopia. Children born before or during the war in Ethiopia had a smaller difference in height than children born before or during the war in Eritrea. Given that the war was eventually won by Ethiopia, this result lends credence to the theory that there are meaningful differences in health depending on the military outcome of the conflict.

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Explosive Remnants Of Nepal's Civil War

by [Christopher R. Albon](#) on February 22, 2011 [[edit](#)]



Last week on UN Dispatch I discussed a new journal article in this month's [Injury Prevention on explosive remnants of war \(ERWs\) in Nepal](#). The study surveyed 307 civilian victims of ERWs five years after the civil war ended. It offers an interesting snapshot of the long-term consequences of explosive devices on the battlefield. Here are takeaway points:

75.8% of injuries were caused by homemade explosive devices. A majority of the injuries came from improvised explosive devices, most notably homemade grenades. This is rather unusual. In other conflict zones, landmines or unexploded ordinances were the primary causes of ERW casualties. The likely explanation is that these poorly made explosive devices failed to detonate during battles, becoming de facto landmines. The two deadliest types of homemade bombs were sutali bombs and socket bombs (also called pipe bombs). These weapons accounted for 30.9% and 28% of all ERW injuries reported in the study.

55% of victims were under the age of 18. Following patterns found in other former warzones, children are disproportionately at risk from injury by ERWs. The reason is likely that children are unaware of dangers from handling ERWs. Indeed 50% of injuries reported in the study were sustained "when victims were handling or otherwise tampering with (throwing, hitting, or burning) explosive devices" (Bilukha et al. 2011, 3).

38% of injuries occurred in the victim's home. The researchers suggest one reason for the high number of injuries at home is because some people were "unafraid to handle explosives" and "willing to bring them to or store them in their homes" (Bilukha et al. 2011, 5). This is a clear sign that more ERW education is necessary.

It seems clear from the statistics that the best intervention against these types of injuries is education. This is especially true for children, who are often injured or killed while tampering with ERWs they find near their homes.

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Egyptian Military Field Hospitals On Libyan Border

by [Christopher R. Albon](#) on February 21, 2011[[edit](#)]

As democratic protests in Libya continue to face widespread violence, including [air attack](#), Egypt's transitional military government is attempting to provide some humanitarian aid to those fleeing the fighting. [Reuters is reporting that](#):

Egypt's army has set up two field hospitals and also camps to receive Egyptians on the border with Libya, the army said on a website on Monday, after increasingly bloody battles between Libyan security forces and protests. Libyan leader Muammar Gaddafi was under increasing pressure to hang on to power on Monday when anti-government protests against his 41-year rule struck the capital Tripoli after days of violence in the east.

There are few details available on these field hospitals, but they are likely the [same ones that were setup in Bagram in 2003](#).

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Video: Blood And Dust

by [Christopher R. Albon](#) on February 17, 2011[[edit](#)]

Last week, Al Jazeera English showed a [24 minutes documentary](#) by filmmaker [Vaughn Smith](#) on American MEDEVAC crews in Afghanistan. The film is both an independent exploration of their mission and an emotional testament to their professionalism. It is a powerful film. It is more than just interesting to watch, it is important to watch.

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Biological Warfare During Colonial Times

by [Christopher R. Albon](#) on February 10, 2011 [[edit](#)]

The [Colonial Williamsburg Journal has a great overview article on germ warfare during colonial times](#). While Europeans in the colonies had little understanding of the disease, they knew enough about its practical effects and methods of infection to use it as a crude, if effective, weapon:

During Pontiac's uprising in 1763, the Indians besieged Fort Pitt. They burned nearby houses, forcing the inhabitants to take refuge in the well-protected fort. The British officer in charge, Captain Simeon Ecuyer, reported to Colonel Henry Bouquet in Philadelphia that he feared the crowded conditions would result in disease. Smallpox had already broken out. On June 24, 1763, William Trent, a local trader, recorded in his journal that two Indian chiefs had visited the fort, urging the British to abandon the fight, but the British refused. Instead, when the Indians were ready to leave, Trent wrote: "Out of our regard for them, we gave them two Blankets and an Handkerchief out of the Small Pox Hospital. I hope it will have the desired effect."

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by [Christopher R. Albon](#) on February 9, 2011 [[edit](#)]

Last week Jenna Krajeski published a [short piece in The New Yorker on the health clinic setup by protesters in Tahrir Square](#):

On Monday, around midnight, I went to Abdel Rahman with three of my Al-Masry Al-Youm colleagues. Badges made from tape identified a group of men at the door as security; like so many roles in the city abandoned by the police force, volunteers were keeping the clinic safe. The scene inside was active but calm. The front area had been converted into a treatment room, with patients on the floor or sitting on chairs, having their blood pressure taken or being handed medicine from the impressive stock that lined a back corner. Barriers made from hanging prayer mats partitioned the women's section from the men's; inside, a few women slept in their clothes. The back area was full of sleeping men—protesters too sick or exhausted to persevere in the square, where it had begun to drizzle lightly—immobile lumps under thick, synthetic blankets.

A few days after her article was published, there were reports (although I cannot find a link to them anymore) of three similar makeshift hospitals in the area. It is a brilliant example of the self-organization of health services in crises.

Update: Here is an earlier related article about [hospitals during the protests](#).

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[Protests And Egypt's Health System](#)

by [Christopher R. Albon](#) on February 8, 2011 [[edit](#)]

So far I have been quiet on events in Egypt, mainly because the health effects have been (thankfully) relatively minor. However, with pro-democracy protests in Egypt continuing for their third week, the strain on the nation's health system are beginning to mount. Last week at UN Dispatch, I [attempted to summarize some of the health effects of the protests](#), particularly regarding real and potential strains on the nation's health system. The takeaway point:

Away from the protests the situation is similarly dire. With little to no police presence in many areas, the health system is vulnerable to ransacking and looting. Residents of one Cairo neighborhood organized a posse to protect a local pediatric cancer hospital from a group of armed men. Violence and checkpoints on the street also appears to be deter some health workers from working out of fear of their personal security. While much of the press coverage is focused on the health of the protesters, it is the stories from other areas that should give us pause. They show an Egyptian health system which is at best stretched to its limits, and at worst teetering on the brink. There is a real risk that all Egyptian citizens will face long term reductions in health access, even those individuals uninvolved in the protests.

[Check it out](#)

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Health Effects Of AU Intervention In Côte d'Ivoire

by [Christopher R. Albon](#) on February 3, 2011 [[edit](#)]



My first post on UN Dispatch is now live. It is [a short discussion of the possible health consequences](#) of an AU intervention in Côte d'Ivoire:

Currently, incumbent President Laurent Gbagbo controls the vast majority of the country while the internationally recognized winner, Alassane Ouattara, remains holed up in an Abidjan hotel protected by United Nations troops. While calls for western involvement have cooled in recent days, there is still the real possibility of an African intervention as the African Union summit sets to start this weekend. With the debate about an African Union intervention in Côte d'Ivoire coming to a head, it is worth considering the health implications of such a use of force, specifically the risk of infectious disease.

To be clear, I am not saying an AU intervention in Côte d'Ivoire is necessarily a bad idea. However, I do believe that debates over the application of military force, even by international bodies, must take into the account the potential health impacts for the local population. When doing the cost-benefit analysis for international intervention, we would do well to look beyond the strictly political ramifications.

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Stavridis On Health Diplomacy

by [Christopher R. Albon](#) on February 3, 2011 [[edit](#)]



Somehow during his tenure as SOUTHCOM commander, current EUCOM commander and Supreme Allied Commander Europe Admiral James G. Stavridis, found time to pen a 292 page book on the United States' relationship with Central America (except Mexico), South America, and the Caribbean. The book was just published by NDU press and is [available for free on their website](#).

Stavridis' book, Partnership For The Americas, is not your typical command memoir; rather it reads more like a manifesto on the potential of soft power in US-South relations. His main takeaway point: "We are all in this together".

The book covers a range of topics, from counter-narcotics operations to innovation in the Department of Defense, but of particular interest to me is the Admiral's chapter on health engagement. Specifically, the role he argues medical diplomacy can play in a combatant command:

"It may seem at first incongruous for a combatant command, even one which strives to be as interagency-oriented and forward-leaning as U.S. Southern Command, to be engaged in efforts to improve public health. And perhaps it is, particularly if that is how our engagement efforts are expressed or viewed. If, however, we restructure our strategic approach and message to convey that we subscribe to the understanding that "public health" plays a vitally important role in maintaining long-term stability, then we can restate our strategic objectives more along the lines of removing and/or reducing health issues as a potential factor to increased likelihood of conflict. Thus, our continuing commitment to engaging in what some have termed "medical diplomacy" becomes inherently synchronized with our previously stated strategic goals to promote security, enhance stability, and allow for economic prosperity." (Stavridis 2010, 140)

This is not something you would expect to read from a man occupying the same office as Eisenhower and Ridgway. However, Stavridis is absolutely correct. While the core competency of the American military will always be combat operations, there are a growing number areas where United States interests and goodwill can best be secured through soft power, including health diplomacy. In an ideal world these tasks would be the responsibility of USAID and the Department of State, but, to adapt a phrase from former Defense Secretary Donald Rumsfeld: you advance US interests with the agencies you have, not the agencies you want. And if you can do so with hospital ships instead of gunboats, all

the better.

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[Writing For UN Dispatch](#)

by [Christopher R. Albon](#) on January 30, 2011[edit]



I am pleased to announce that I am now an official contributor for [UN Dispatch](#). Funded by the [United Nations Foundation](#), UN Dispatch offers commentary on global issues including the United Nations itself. While I have been given carte blanche to write on the topics of my choosing, the vast majority of my pieces will be on the connection between health and conflict. I am a firm believer in writing what you know.

What does this mean for Conflict Health readers? Simply put: more posts. In addition to my regular posts on Conflict Health, I will also be linking to my relevant articles on UN Dispatch. So grab a coffee or a beer, and enjoy the show.

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[Video: MEDEVAC In The Vietnam War](#)

by [Christopher R. Albon](#) on January 24, 2011[edit]

The Internet Archive has posted a short film from the Vietnam War on medical evacuations. The Vietnam War was an important step forward for American military medicine, and it is good to step back and see how far the field has come:

Hat Tip: [A Repository For Bottled Monsters.](#)

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David Brown On Military Medicine

by [Christopher R. Albon](#) on [January 20, 2011](#)[[edit](#)]

Two months ago, Washington Post Staff Writer David Brown wrote a [series of articles on modern military medicine](#), mostly in Afghanistan. I know I am playing a little bit of catch up by highlighting the articles now, but they are good pieces and I think Conflict Readers will find them useful. The articles are listed below:

A military hospital's all-encompassing mission

American soldiers critically injured on the battlefield spend only a day or two here, many unconscious and on ventilators, before being sent to Bagram air base, then to a hospital in

ad_icon

At the other end of the continuum are the Afghans who make up about half the patients.

Medical research is part of the military's combat mission, too

There are 96 military “research activities” underway or being planned in Iraq and Afghanistan.

Before any begin, an eight-person Joint Combat Casualty Research Team addresses two key questions: Does this study have to be done here? Is it feasible? If the answers are yes, the team helps researchers fine-tune their study design and sometimes helps collect data. A “human protections administrator” audits the activities, which are first approved by ethics panels in the United States.

War zone trauma cases yield medical insights

Military medicine has made consistency and self-scrutiny part of the mission. It takes to heart the quality-assurance mantra “If you can’t measure it, you can’t change it.” It values publication in peer-reviewed journals as much as does the faculty of Harvard Medical School.

Teleconferencing from the war zone improves treatment for wounded soldiers

The conference helps ensure no injuries are overlooked in patients who often have a dozen wounds or more. It’s a way of double-checking innumerable pieces of information that have been entered into a database and will be studied to help improve practice. It’s also a way of gently monitoring everyone’s performance.

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Free eBook: Handbook On War And Public Health

by [Christopher R. Albon](#) on January 18, 2011 [[edit](#)]

The first book I ever read on the health effects of war was a neglected library copy of Dr. Pierre Perrin’s Handbook on War and Public Health. The book, originally written in french, is a guide for planning and conducting health operations in conflict environments. While it contains very little theory, it is packed with practical information and insight. For a week I poured over the book again and again, trying to take in everything I could. Many of the topics I am still researching today were originally inspired by concepts in Perrin’s book.

I always wanted a copy of the book for myself, however the only copies I could find cost over \$500 (the current price on Amazon is \$965). So you can understand my excitement when last week I discovered that the Health Library For Disasters has [published the full text of Perrin’s book online](#), for

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Why You Should Read Gail Fisher

by [Christopher R. Albon](#) on [January 5, 2011](#)[[edit](#)]

When it comes to armed conflict and public health, Gail Fisher is my kindred spirit. She is an expert on the US military's health diplomacy capacity and an occasional blogger. She also just returned from a deployment in the US Army Reserve. Eventually, I am going to persuade Gail to pen a few guest posts for Conflict Health, but until then I invite you to [read her blog](#) and welcome her back to the good ol' US of A. To get you started, here are two of her latest posts:

Biological Warfare: “1491” by Charles C. Mann

As Charles' army fled a counter attack, mercenaries split off from the main retreating body, spreading syphilis as they went via their habit of rape and pillage. Within a year, European cities were banishing people who suffered from syphilis. It's not clear whether the disease came from American with Columbus' returning voyage, as suggested, with an equal number of arguments for and against. Hence any positive assertion of biological symmetry is sketchy at best. Mann makes the point that while smallpox toppled empires, syphilis did not, even if it did come from the Americas.

The history of foreign aid: “Samaritan Diplomacy”?

Also relevant, the theory of counter insurgency calls for massive development expenditures in dangerous areas in order to create sympathies for the legitimate government, in order to assist people attain their basic life needs—water food shelter—so they feel better about their government and ‘buy in’ to its legitimacy, lay down arms and stop harboring terrorists. But, as pointed out in the Washington Post front page yesterday, it's not that easy. USAID and the US State Department in Afghanistan, for example, only want the military to provide “security” so they can provide development assistance. Yet their vision of security and the military version are disparate. And sometimes discussions about where to deliver development assistance veer toward the absurd when geographical areas are deemed “too safe” for development assistance and other areas not safe enough. USAID doesn't want to deliver aid where it's unsafe, and they don't want to waste their aid on places where it's too safe. And they damn sure don't want the military to meddle in their humanitarian space (as they call the battlefield) by delivering aid or creating development projects.

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Health Diplomacy During Korean Unification

by [Christopher R. Albon](#) on [January 3, 2011](#)[[edit](#)]



Late last year, CSIS released a [short paper by Stephen J. Morrison](#) on the impact of Korean unification on North Korea's health systems. It is a brief but solid analysis and I encourage everyone to read it.

In the article, Morrison makes a number of points, but one in particular resonated with me:

“Health reform is a powerful ‘soft power’ tool to win ‘hearts and minds,’ bring quick tangible gains, and consciously help legitimize a new order. Attention in the first instance should be paid to the most vulnerable victims of the current failed system. In the North Korean context, that means targeted attention to children; pregnant and lactating mothers; the elderly; orphans; and populations newly pauperized, in urban settings as well as marginalized regions such as the northeast.”

Morrison argues, and I agree with him, that the quick reconstruction of North Korea's dilapidated health care system could play a critical role in stabilizing the political process of reunification. When Korean reunification occurs, whether through the unlikely event of peaceful political transition or the violence collapse of the North Korean regime, it will be imperative for the South and her allies to help reestablish a governing institution seen as legitimate in the eyes of North Korean citizens. This is no easy task, political legitimacy is hard to develop in the best of circumstances and even more difficult in situations of extreme political stressors such as regime transition or collapse. We only need to look to Afghanistan to see the difficulties of building legitimate national governing institutions.

The benefit of focusing on health as a means of building political legitimacy in post-unification North Korea is twofold. First, improving health care is one of the few short-term actions available to South Korea that is relatively immune to misinterpretation. Second, due to the massive disparities between North Korea's and South Korea's health systems, a health access benefit can be provided to North Korean citizens relatively cheaply. Extending the South's health system a few hundred miles to the North would be difficult, but certainly less so than rebuilding a national health institution from scratch. Furthermore, the South Korean health system would face fewer of the cultural and linguistic barriers usually seen during international health reconstruction efforts. Compared to other methods of gaining political legitimacy, rebuilding the health care system of the North is, for lack of a better phrase, low hanging fruit.

Source:

Morrison, J. Stephen. 2010. Health Reconstruction in North Korea. Washington, D.C.: Center for Strategic and International Studies.

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The Devil In The Definitions

by [Christopher R. Albon](#) on December 30, 2010 [[edit](#)]

Read enough about health care in Afghanistan and one statistic keeps popping up: 85% of Afghans have access to health care, up from 9 percent in 2002. It is a figure regularly cited [government reports](#) and [mainstream newspapers](#). And, it is [false](#).

~~As is often the case with quantitative claims, the devil is in the definitions. In this case, a person is defined as having access to health care if they live in a province district with one or more basic health facilities. Thus, the entire population in any province district with a single hospital, or perhaps even a clinic, is considered to have health access. The problem is that many provinces are vast, spanning thousands of square miles of rugged, mountainous terrain. One of Afghanistan's largest provinces, Kandahar province, covers 20,858 square miles. This makes Kandahar province slightly larger than Costa Rica. It would be laughable to claim a single hospital in San José would provide adequate health access to all of Costa Rica, but that is the claim we are making in Afghanistan.~~

Update: Smart Conflict Health reader Francis Regan has pointed out that the definition uses “districts” not “provinces”. So, I have to eat my words a bit, since there are 34 provinces and around 398 districts. So, the the claim is still disingenuous, but not nearly as much as I originally thought.

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Conflict Health Roundup For December 27th

by [Christopher R. Albon](#) on December 27, 2010 [[edit](#)]

Cuban Medics A Big Force On Haiti Cholera Frontline

With a tradition of service in the world’s poorest and most forgotten states, the Cubans are a major frontline force in the multinational response to the raging epidemic, which has killed at least 2,000 people and probably more, since mid-October in the impoverished country.

While many Western aid workers crowd Haiti’s capital, where more than 1.3 million vulnerable homeless survivors of the January 12 earthquake are crammed into tent camps, Cuba’s medics are seeking out cholera victims in hard-to-reach rural hamlets.

Haiti Cholera Likely From UN Troops, Expert Says

has killed at least 2,000 people, a French scientist said in a report obtained Tuesday by The Associated Press.

Epidemiologist Renaud Piarroux concluded that the cholera originated in a tributary of Haiti's Artibonite river, next to a U.N. base outside the town of Mirebalais. He was sent by the French government to assist Haitian health officials in determining the source of the outbreak, a French Foreign Ministry official said Tuesday.

War And Sickness In Afghanistan

Conflict and war have almost certainly contributed to the resurgence of leishmaniasis in Afghanistan. Dr. Chris Beyrer at Johns Hopkins Bloomberg School of Public Health has described a similar rise in the disease as a result of guerrilla activities and drug trafficking in Colombia.

Sadly, this link between contagion and conflict is a common theme for many neglected tropical diseases. They are the most important diseases you have probably never heard of: Chronic parasitic infections such as hookworm, schistosomiasis, Chagas disease, African sleeping sickness, elephantiasis and river blindness, as well as bacterial and viral infections such as trachoma, cholera and dengue fever.

Hospitals In Helmand Hot Zone Treat More ‘Collateral’ Patients

“We do not ask anyone which side they belong to, or who injured them. Our work is limited to offering free medical care to anyone who comes to the hospital,” says Stefano Argenziano. He is the project coordinator for Doctors Without Borders – known by its French acronym MSF – in Helmand province. Accordingly, nobody at Boost speaks of “Taliban terrorists;” they use the term “government opposition” instead.

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Photo: Balad Joint Medical Clinic

by [Christopher R. Albon](#) on December 23, 2010 [[edit](#)]



Caption: The Joint Medical Clinic, the first medical clinic to be staffed by both Army and Air Force providers at Joint Base Balad, Iraq, opened April 26 at JBB. The JMC replaced the Phipps Troop Medical Clinic and the Air Force Primary Care Clinic. Photo by Sgt. Keith Vanklompenberg.

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Conflict Health Roundup For December 23rd

by [Christopher R. Albon](#) on December 23, 2010 [[edit](#)]

A month ago I was in South Africa, now I am sitting in a hotel lobby in Philadelphia, shortly after spending a week in Baltimore and shortly before staying weeks in Boston and New York respectively. All of this is to say I am strapped for time, and will be through the near future. This roundup is an attempt to clear the clutter off my virtual desk. Happy holidays all.

Norway Launches Research Collaboration On Foreign Policy And Global Health

The research project will analyse and document how foreign political priorities affect health, and how states' global health efforts influence foreign policy. The project is linked to the Foreign Policy and Global Health Initiative , in which Brazil, South Africa, Indonesia, France, Thailand, Senegal and Norway participate with a view to putting the health-foreign policy nexus on the international agenda.

Case Study: Health Effects of Political Unrest in the Ivory Coast

When we discuss health issues in African countries the usual conversation revolves around HIV/AIDS, Tuberculosis, Malaria, and the issues around treatment and cure. Rarely do we discuss the repercussions of war and political unrest on African health issues. However, recent political developments in the Ivory Coast illustrate the deadly intersection of political unrest and access to health care.

PBS FRONTLINE – Brain Wars

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Risky Road To Hospital

At 4am, Abdul Malek and his pregnant wife were in a rented car heading to Boost Hospital in Lashkargah, capital of southern Helmand Province.

The couple decided to leave their home in the Sangeen District as early as possible to avoid roadblocks by pro-government forces or being seen by anti-government forces.

Southern Afghanistan: A Day In The Children's Ward At Mirwais Hospital

Mirwais Hospital in Kandahar is a government-run 350-bed medical facility with over 500 staff. Christian Shuh, a paediatric nurse, is one of 21 ICRC medical specialists – nurses, surgeons, gynaecologists, nutritionists and doctors – who provide extensive support to this war zone hospital.

{ Comments on this entry are closed }

Photo: Military Pediatrics

by [Christopher R. Albon](#) on December 21, 2010 [[edit](#)]



Caption: Navy Lt. Jisun Hahn, a medical officer with Combat Logistics Battalion 5, cleans an Afghan girl's foot, during a female health care engagement, just outside Combat Outpost Riley, Marjah, Helmand province, Afghanistan, July 10. Photo by Cpl. Megan Sindelar.

{ Comments on this entry are closed }

A Korean Dunkirk

by [Christopher R. Albon](#) on December 21, 2010 [[edit](#)]

[Craig Hooper](#) and I have a [new article on The Atlantic](#) discussing the evacuation of US citizens off the Korean peninsula in the event of renewed hostilities. We argue that the difficulty of evacuating 140,000 US citizens and select foreign nationals might well require the US to ask China and its military for assistance:

Even under the best conditions, a mass evacuation is no easy task. In July 2006, as a battle brewed between Israel and Lebanon-based Hezbollah militants, the U.S. took

nearly a month to evacuate 15,000 Americans. According to the Government Accountability Office, “nearly every aspect of State’s preparations for evacuation was overwhelmed”, by the challenge of running an evacuation under low-threat conditions in a balmy Mediterranean summer.

Evacuating a Korean war-zone would be far harder. And the U.S. would likely have no choice but to ask China for help.

Read the full article [at The Atlantic](#).

{ Comments on this entry are closed }

Should US Military Aid Be Contingent On Human Rights?

by [Christopher R. Albon](#) on December 21, 2010 [[edit](#)]

Last month, Obama administration, in a little discussed announcement, [connected the provision of military aid to the human rights record of the recipient](#):

The US government plans to cut military aid to several Pakistani military units as punishment for human rights abuses, including torture and extrajudicial executions, according to senior officials.

...

The sanctions centre on the deaths of hundreds of people at the hands of Pakistan’s regular and paramilitary forces in the Swat valley since an operation to drive out the Taliban started in May 2009.

...

The units to be sanctioned have not been identified, but they are understood to include elements within 12 Punjab infantry regiment, which is based in north-western Mardan, and units from the Frontier Corps, the paramilitary force recruited from the Pashtun tribes.

Personally, I am not sure how the US is able to cut aid to specific units of the Pakistani Defense establishment or, if they are, how the US can guarantee that the sanctions are not subverted by some enterprising Pakistani officers. But, the broader question is this: What takes priority in US foreign policy: short-term national security interests or long-term human rights interests?

One needs not look far in history to see that traditionally the former has held sway while the latter is given mostly lip service. It is for this reason that I am interested in the implications of this new policy. This action by the Obama administration could well be part of a larger realization that the health and human rights of foreign populations do matter in modern international affairs. In a world of super-empowered individuals, you can’t just win hearts and minds, you have to make sure your allies are

Update: The anonymous Gulliver, who writes at [Ink Spots](#), and who knows more about military assistance than myself makes this smart comment:

“Military assistance,” in this case, is NOT fungible. We’re talking about specific pieces of equipment and training, not just cash grant aid. So the USG monitors the end-user of the assistance and ensures that defense articles and services aren’t being provided to human rights violators. This is not a “new policy” — it’s actually a requirement of the law (via Leahy), and as such is not something that’s left to the discretion of the administration. Leahy is an ever-present in deliberations about military assistance to Central and South American forces, and has also complicated the growing U.S. security relationship with Indonesia.

{ Comments on this entry are closed }

[Photo: Delivering Medical Supplies](#)

by [Christopher R. Albon](#) on December 14, 2010 [[edit](#)]



Caption: U.S. Soldiers with 3rd Platoon, Bravo Company, 214th Infantry, 10th Mountain Division, 2nd Brigade Combat Team deliver medical supplies to a clinic in Baghdad, Iraq, June 29. U.S. Soldiers with Bravo Company were tasked to take supplies to clinics in the city of Baghdad. Photo by Spc. Joshua E. Powell.

Photo: Working With The UN

by [Christopher R. Albon](#) on December 14, 2010[edit]



Caption: Petty Officer 3rd Class Jerdone McGhee, a logistics specialist and an interpreter for the amphibious dock landing ship USS Gunston Hall African Partnership Station staff, sits in the back of a U.N. truck with U.N. Soldiers as they prepare to drop off supplies at the Operation Hope for Children of Haiti clinic in Killick.

{ Comments on this entry are closed }

Photo: Say Ahhhh II

by [Christopher R. Albon](#) on December 7, 2010[edit]



Caption: Lt. Cmdr. Philip Albedt, a dental corpsmen with Operational Health Support Unit (Camp Pendleton), and Petty Officer 3rd Class Andrew L. Mattingly, a hospital corpsmen with Operational Health Support Unit (Great Lakes), perform an extraction on a patient during the U.S. Army South New Horizons – Haiti 2010 exercise at the Poteau medical assistance site June 24. Photo by Spc. Jessica Lopez.

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2009-10 Human Security Report Released

by [Christopher R. Albon](#) on December 2, 2010[edit]



The venerable [Human Security Report Project \(HSRP\)](#) at Simon Fraser University is one of the leading centers of research on, amongst other things, the health effects of armed conflict. This

[full report \(by section\) on their site](#), or read the Cliff Notes summary points below:

- “- Four of the world’s five deadliest conflicts—in Iraq, Afghanistan, Pakistan, and Somalia—involve Islamist insurgents.
- Over a quarter of the conflicts that started between 2004 and 2008 have been associated with Islamist political violence.
- In the post-Cold War period a greater percentage of the world’s countries have been involved in wars than at any time since the end of World War II.
- Armed conflict numbers increased by 25 percent from 2003 to 2008 after declining for more than ten years.
- Intercommunal and other conflicts that do not involve a government increased by more than 100 percent from 2007 to 2008.
- The impact of the global economic crisis on developing countries risks generating political instability and increasing the risk of war.
- Wars have become “intractable”—i.e., more difficult to bring an end.”

Of particular interest to Conflict Health readers is the report’s detailed discussion of the reliability of Battle-Death data in [Part 3 \[PDF\]](#) of the report. The punchline:

“Given the range of different ways of collecting data, why do conflict researchers seeking to understand the causes, duration, and deadliness of conflicts rely increasingly on the battle-death data produced by organizations like PRIO and UCDP? The short answer is that notwithstanding their utility for the purposes for which they were intended, none of the other estimation methods can be used to provide annual global and regional battle-death trend data in a timely manner.”

This should be a clarion call to public health and conflict researchers both inside and outside academia on the need for better data on the health impacts of armed conflict, a point driven home in the [huge variation the estimated civilian casualties during the Iraq War](#). Battle-death data is one of the most commonly used variables in large-N studies of armed conflict. Without reliable measurements of the health cost of armed conflict, amongst other things, we lack the means to accurately target health interventions both during and after war.

{ Comments on this entry are closed }

[Photo: Say Ahhh](#)

by [Christopher R. Albon](#) on December 1, 2010 [[edit](#)]



Caption: U.S. Army Spc. Derek Awantoh, a medic with 2nd Battalion, 14th Infantry Regiment, 2nd Brigade Combat Team, 10th Mountain Division, checks the throat of a young Iraqi boy in Mullah Fayyed, Iraq, June 6. Photo by 1st Lt. Becky Bort.

{ Comments on this entry are closed }

How Manning Stole The Cables

by [Nick Dubaz](#) on November 30, 2010 [[edit](#)]

Today Conflict Health presents something different. This week [Wikileaks released a quarter million US diplomatic cables onto the internet](#). Many outside the military and diplomatic communities have wondered just how such a large amount of sensitive missives could have been taken. As a public service, Conflict Health is very pleased to publish a guest article from Captain Nick Dubaz, an Active Duty Army Civil Affairs Officer, explaining in full technical detail how it happened.

A number of commenters on the latest Wikileaks release have questioned how one junior enlisted Army intelligence analyst could possibly have collected and stolen such a massive number of documents unaided and undiscovered. Indeed, the very mention of “intelligence” evokes notions of secure, guarded, windowless facilities under constant surveillance employing the latest biometric technology to secure America’s secrets. This image may have once been partially true in the case of Top Secret and Compartmented information, but the distributed nature of our modern intelligence community and the proliferation of secret network access necessitated by our wars in Iraq and

technical methods Private First Class Bradley Manning, the accused leaker, may have used to obtain and steal the material and transmit it to WikiLeaks are simple and demonstrate the intelligence community's vulnerability to an insider threat.

All mission traffic in Iraq and Afghanistan occurs on computer systems classified at the Secret-Releasable to NATO/ISAF level or above. Historically, mission traffic occurred at the Secret-NOFORN (Not Releasable to Foreign Nationals) level on the SIPR network (Secret Internet Protocol Router) and non-US elements operated on separate networks known as CENTRIX segregated by organizational membership (NATO, ISAF, etc). This caused significant information sharing problems and now lower level U.S. forces are transitioning many functions to CENTRIX to create a common mission network. Regardless, these information systems are now present at every Company-level headquarters and above, providing wide access to Secret-level intelligence and diplomatic information processed and disseminated on the network. Access to Top Secret (TS) and Sensitive Compartmented Information (SCI) information systems remains much more limited, but is still partially vulnerable to Bradley Manning-like insider threats.

The WikiLeaks reports on Iraq and Afghanistan are from a system known as CIDNE (Combined Information/Data Network Exchange) which is the latest iteration of the database of record for all tactical reporting across the OIF and OEF theaters. The release is only a tiny percentage of the actual data contained in the database. Each record in the WikiLeaks release is only the initial text report often transcribed from the radio or secret chat rooms. After the incident/action is completed, each record is typically updated with new information, pictures, videos, PowerPoints and other relevant documentation. To allow for transfer into incompatible systems and other software packages, CIDNE includes an "Export to Excel" feature that allows for the rapid filtering and transfer of records to other systems. Bradley Manning likely utilized this feature to export the comprehensive CIDNE database that he would later transmit to WikiLeaks. Such an action could be completed in less than an hour depending on the bandwidth available and leaves no signature that would be readily noticed as unusual or alarming.

State Department "Cables" reside on a different system on State's SIPRnet website, but are no more protected or less vulnerable to aggregation and theft by an insider threat. In addition to the website, Cables are also disseminated through the Defense Messaging System's (DMS) SIPRnet website known as M3 (Multimedia Messaging System) which rapidly transmits intelligence reports, cables and other messages to designated recipients and is searchable by other users. Both systems provide the capability to export massive numbers of records rapidly and it is likely that the leaker utilized these systems to collect the records now plastered on newspapers and websites worldwide.

Once downloaded on a computer system, removing the files is no more difficult than their export. As an Analyst in the Headquarters of the 4th Brigade, 3rd Infantry Division out of Fort Stewart, but deployed to Iraq, Bradley Manning likely worked in a Secure Compartmented Information Facility (SCIF) accredited to process Top Secret, Sensitive Compartmented Information. In the United States and its permanent facilities worldwide, SCIFs are built to exacting standards of secure construction outlined in the Unclassified DCID 6/4 accreditation and TEMPEST electronic emissions security standards. SCIFs often have several layers of security and are regularly inspected to ensure compliance with strict security regulations. In the austere conditions of Iraq and Afghanistan, such

with only SIPR have significantly fewer restrictions and indeed it is not rare to see a mud hut on remote mountaintop outposts in Afghanistan with SIPR network access.

Whether in a modern SCIF in Fort Stewart or a remote mud hut with SIPR access, the responsibility for security for information and physical security resides with the owning unit. The vast majority of units and individuals in these units take security very seriously and self-inspect and police to ensure compliance with regulations for fear of severe consequences should an inspection discover lapses or violations. Nevertheless, it is not unusual to see rules bent or broken and iPods or music CDs brought into a SCIF particularly in austere, deployed locations where oversight is lax. Indeed, in a post-thumb drive access Army, Bradley Manning burning a CD in his workplace in Iraq would have garnered little attention from co-workers and his alleged marking of the disk as “Lady Gaga Music” did little to facilitate the theft of the data. Furthermore, I have seen no distinguishing origination information in the records and had Bradley Manning not exposed himself as the leaker to Adrian Lamo, we may have never discovered the original source of the leaks.

In perhaps less than one hour from start to Lady Gaga-labeled CD filled with Secret records, our post-9/11 information sharing programs and basic information systems technology enabled the greatest theft and public release of current intelligence and diplomatic cables in United States history. Both our information systems security and counter-intelligence programs are largely focused on outsider threats to classified information, largely ignoring insiders outside of periodic security clearance reviews and rare polygraphs. The insider threat to classified information cannot be solved through re-compartmenting access to intelligence information and adding further challenge to the already difficult work of intelligence analysis. These leaks should give us pause to evaluate our failed security clearance system and internal electronic audit and security procedures, but must not precipitate a return to pre-9/11 stovepipes that served our nation so poorly.

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[**African Laboratories And Bioterrorism**](#)

by [Christopher R. Albon](#) on November 29, 2010 [[edit](#)]

Earlier this month, the New York Times [reported on Washington's fears about weak security at Africa's infectious disease laboratories](#):

Senator Richard G. Lugar, Republican of Indiana, and a delegation of Pentagon officials visited the laboratories on Wednesday for the first stop on a three-country tour of East Africa to assess the next generation of American security concerns.

The team also visited the Uganda Virus Research Institute, where the Ebola and Marburg viruses are taken to study and kept in a spare room in a regular refrigerator near the bottom of the compound. Warning signs say “restricted access,” but the doctors there say that hardly means the area is secure.

Fears about Ugandan labs have become particularly penitent since Al-Shabab's [recent activity in the](#)

non-state groups. Of course, this threat is contingent on these groups having the technical capacity to transport and weaponize the specimens, something easier said than done. Probably our best defense against this type of bioterrorism has nothing to do with ourselves and everything to do with the terrorist organizations. There are cheaper and more dependable methods of attacking US interests. Most Islamist groups have decades of experience with conventional explosives and might see little valuable in investing in a complicated and untried method of attack. From the perspective of an Islamist bomb-maker with finite resources, it is better to build 100 inkjet bombs than steal and weaponize an Ebola specimen from a Ugandan lab.

This does mean we can ignore the threat? No. We should take serious pause from the fact that the Japanese cult Aum Shinrikyo sent a [medical team to Zaire in an attempt to research and weaponize Ebola](#). However, the technical difficulty of weaponizing infectious diseases combined with easy access to more conventional weapons does moderate the threat from insecure African laboratories.

{ Comments on this entry are closed }

Photo: Hospital Security

by [Christopher R. Albon](#) on November 28, 2010 [[edit](#)]



Photo: U.S. Soldiers assigned to Charlie Company, 1st Battalion, 38th Infantry Regiment, 4th Stryker Brigade, 2nd Infantry Division pulled security with Iraqi police during an ambush at a local hospital in Abu Ghraib, Baghdad, Iraq, May 15. The Soldiers were part of a Operation Medical Alliance to provide knowledge between Iraqi and American providers for the growth of Iraqi provider health care networking. Photo by Spc. Advin Illa-Medina.

{ Comments on this entry are closed }

Thailand Uses Aircraft Carrier For Disaster Relief

by [Christopher R. Albon](#) on November 23, 2010[edit]



In late October and early November, Thailand's southern provinces were [hit by major flooding](#). The flooding, triggered by a tropical depression, [affected around 100,000 people by one account, with waters up to three meter high](#).

In response, the Thai government sent the Royal Thai Navy vessel that is an oddball of world navies. While most coastal nations maintain naval forces, only handful operate aircraft carriers (Brazil, France, India, Italy, Russia, Spain, Thailand, UK, US). The vessel, HTMS Chakri Naruebet, is the flagship of the Royal Thai Navy and is the smallest aircraft carrier in operation. Since being built by Spain in the mid-90s, the carrier has been most famous for rarely leaving port (one source claims the ship only has funding to leave port one day a month). However, it does deploy sometimes. Since coming into service the ship has taken part in four disaster relief missions. This makes disaster relief a (if not the most) common mission for the ship.

However, you'd be wrong to compare the HTMS Chakri Naruebet's disaster relief mission with those of the United States Navy. Based on an article in the Pattaya Daily News, the aircraft carrier contribution to the [relief effort was limited to single truck load of supplies \(mostly bottled water, according to the photos in the article\)](#) and [a few helicopter flights over the disaster area](#). Far from being the nations knight in grey armor, the carrier's mission seems to be mostly disaster relief theater on the part of the Thai leadership. This is not the first time Thai military has been used to provide token disaster relief, in mid-october Thai Royal Highness Princess Soamsavali ordered [two Amphibious Assault Vehicles to assist flood victims in Thai's northeast region](#). Two! You'd probably be better off hiring some local fishing boats.

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