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Aiding or Abetting? An Analysis of Medical Humanitarian Aid in Complex Humanitarian Emergencies

Claire Dunn
Colby College

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Aiding or Abetting?
An Analysis of Medical Humanitarian Aid in Complex Humanitarian Emergencies

Claire E. Dunn
Senior Honors Thesis
Colby College
Department of Global Studies
Aiding or Abetting?
An Analysis of Medical Humanitarian Aid in Complex Humanitarian Emergencies

Claire E. Dunn
Colby College

Abstract:

Medical humanitarianism is generally viewed very positively by society. Selfless humanitarians are going to war-torn, disaster-affected, or otherwise undesirable locations to provide medical care to those who are in need. However, when considered more carefully, it becomes clear that there are many problematic aspects of humanitarian aid. That is not to say that humanitarian aid is unnecessary, but rather that humanitarian actions are likely to have some unintended consequences or fail to live up to their potential no matter how well-meaning the intentions. Acknowledging that medical humanitarianism is but a single component of the response to complex humanitarian emergencies and lacks the ability to end wars or change political systems, medical aid is an important consideration in how populations emerge from such emergency situations. This study will examine how medical humanitarian groups operate in the context of complex humanitarian emergencies and how their varied approaches impact the effectiveness of their interventions. In order to examine this question, I will consider the unique histories and approaches of two of the most important actors on the medical humanitarian scene, the International Committee of the Red Cross (ICRC), and Médecins Sans Frontières (MSF), and how these unique histories and approaches impacted their effectiveness in the case of the Great Lakes refugee crisis following the Rwandan genocide. Analysis of the actions of both the ICRC and MSF found that both organizations had some successes during the Great Lakes crisis, but also had many shortcomings that prevented their aid from being as effective as it had the potential to be. Following the Great Lakes crisis, a number of actions were taken to address the shortcomings of the aid community, but adjustments will need to be continuously made as humanitarian emergencies continue to evolve.
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Acronyms:

ICRC - International Committee of the Red Cross

MSF - Médecins Sans Frontières (Doctors Without Borders)

CHE - Complex Humanitarian Emergency

NGO - Nongovernmental Organization

IDP - Internally Displaced Person

IFRC - International Federation of Red Cross and Red Crescent Societies

WFP - World Food Program

IRC - International Rescue Committee

UNHCR - United Nations High Commissioner for Refugees


UNAMIR - United Nations Assistance Mission for Rwanda

UN - United Nations
The Great Lakes Region and Camp Locations:

Rwanda:

Source: Marijke Verpoorten, Detecting Hidden Violence: The Spatial Distribution of Excess Mortality in Rwanda, January 2012
Zaire-Bukavu:

Zaire-Goma:

Tanzania:

Burundi:

Source: UNHCR, Global Digital Mapping, July 1999
Timeline:

1990- The ICRC begins working in Rwanda

1991- MSF begins working in Rwanda

April 6, 1994- Plane carrying Rwandan President Habyarimana and Burundian President Ntaryamira is shot down, sparking increased violence

April 29, 1994- Mass exodus of approximately 250,000 refugees to Tanzania

July 14th-18th, 1994- Goma Influx into Zaire tops the April exodus to Tanzania with approximately one million refugees entering the country

Mid-July 1994- Rwandan Patriotic Front gains control of Rwanda ending the genocide, but not the refugee crisis

November 1994- MSF-France withdraws from the refugee camps along with the IRC and CARE

April 1995- MSF-Belgium withdraws from the refugee camps, followed by all other MSF branches by the end of 1995

October 1996- First Congo War begins
Introduction

The Oxford English Dictionary defines humanitarianism as, “Concern for human welfare as a primary or preeminent moral good; action, or the disposition to act, on the basis of this concern rather than for pragmatic or strategic reasons.”¹ Many people take the idea of humanitarianism quite seriously and dedicate their lives to carrying out such work, while many others spend short periods volunteering their time to humanitarian projects. Because humanitarianism is held in such high esteem and so many are willing to put their time into this type of work, in today’s society it is very much taken for granted that humanitarian aid will be provided to people experiencing war or natural disasters. Humanitarian aid, however, has not always been a given. The origin of humanitarianism as a field can be traced back to 1863 when Jean-Henri Dunant established the International Committee of the Red Cross. Dunant turned to the field of humanitarianism after witnessing the atrocities of the Battle of Solferino between the French Empire and the Austro-Hungarian Empire in 1859. David Forsythe, a political scientist whose research focuses on the ICRC, writes, “…The major European military powers in their great wisdom provided more veterinarians to care for horses than doctors to care for soldiers wounded in battle.”² After experiencing this lack of sufficient care for the war wounded, Dunant began organizing medical assistance for soldiers wounded in armed conflicts.

The number of humanitarian aid groups has proliferated in recent decades. Groups that provide humanitarian aid can be divided into three categories. The first of these categories consists of religious aid groups. Religious groups began providing humanitarian aid before

¹ Oxford English Dictionary. s.v. “humanitarianism.”
Dunant’s time, evolving from missionary activity. While these groups have religious origins, they do not have religious conversion as a goal. In fact, they tend to walk the line between the religious and secular worlds. Groups acting within the religious sector come from a variety of faith traditions including Christianity, Judaism, and Islam, with some of the largest and most visible organizations in this category coming from the Catholic tradition. These include Catholic Relief Services and Caritas.

The next category is the Dunantist groups, which are guided by the ideas of Jean-Henri Dunant. Dunantist aid groups include, of course, the ICRC, which Dunant founded, but also groups such as Médecins Sans Frontières (MSF). The three central ideas in Dunant’s version of humanitarianism are neutrality, impartiality, and independence. Neutrality is defined as a refusal to take sides in a conflict or engage in political controversies. Impartiality, on the other hand, refers to the provision of aid based solely on need and without regard for the race, ethnicity, religion, or any other personal trait or belief of those in need. Finally, independence refers to the lack of a formal connection between an aid organization and any specific government; that is, aid organizations should not be acting on behalf of any government agency. This thesis will also be considering the idea of independence with regards to the financing of the organizations and their willingness to form partnerships. The organizations within these groups interpret these ideas in slightly different manners, but one of the main overarching principles to consider with Dunantist groups is that they operate separately from the any government and any political agenda that may be connected with the state.

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The third category includes aid organizations built around the ideas of President Woodrow Wilson and is much more politicized. The majority of aid groups that fall into this category are US-based. Groups in this category are much less focused on independence and actually “see a basic compatibility with humanitarian aims and US foreign policy objectives.”

Some of the most visible actors in this group are CARE International, Save the Children, and the International Rescue Committee.

Within these three categories, aid groups have come to hold specific niches, such as food provision, care of children, or the provision medical care, among many other tasks. This thesis is concerned with the aid organizations occupying the niche of health and medical care. Over time, the realm of humanitarian aid has changed significantly. The number of aid groups has exploded, and as a result, there have been a variety of moves to change the way in which aid organizations act and operate both individually and collectively. In spite of greater efforts at coordination, humanitarian aid groups have continued to operate within their own individual niches and under their own individual sets of norms and guidelines.

The two groups that I will examine in this study, the ICRC and MSF, are both of based on Dunantist principles. However, the ways in which the ICRC and MSF interpret the Dunantist principles of independence, impartiality, and neutrality are different and have resulted in the two taking varied approaches to the same events. As the situations in which humanitarian aid organizations become involved have gotten increasingly complicated, these ideological differences have become more evident and had an increasing impact on how effective each organization is in aid provision.

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4 Stoddard 2003, 2
Much has been written about humanitarian aid as a broad category. A portion of this scholarship is very much focused on the technical aspects of humanitarian aid, including why humanitarian aid is needed, what actions take priority, and the international guidelines that should be followed when undertaking an aid project. Increasingly, the arguments for humanitarian aid provision focus on the idea of human rights. For example, S. William A. Gunn writes, “While all intervention to reduce a person’s sickness or suffering is in essence humanitarian, Humanitarian Medicine goes beyond the usual therapeutic act and promotes, provides, teaches, supports, and delivers peoples’ health as a human right…”\(^5\) Similarly, in her article about MSF, Renee Fox writes that the organization has played a key role in connecting medical aid and human rights. MSF’s role has been so important that this movement has been called “sans frontierisme.”\(^6\) Health as a human right is also the basic idea behind many of the major international documents governing humanitarian aid, including the Universal Declaration of Human Rights. Some arguments are much more legalistic than rights-based, but regardless of why scholars argue humanitarian aid is necessary, they all do argue that aid has an important role to play.

When it comes to how to approach aid, there is also debate among scholars and practitioners. In his article “Principles, Politics, and Humanitarian Action”, Thomas Weiss divides aid groups into four groupings based on their approaches: Classicists, Minimalists, Maximalists, and Solidarists. These groupings are based on the degree to which organizations embrace the ideas of neutrality and impartiality as well as the extent of their humanitarian


agendas. Are they focused solely on providing aid, or do they have a broader agenda of trying to address the larger issue that caused the humanitarian crisis in the first place? The Classicists represent one extreme on the scale; they fully embrace the ideas of neutrality and impartiality, and they believe in insulating aid from all politics.\(^7\) The minimalists’ view moves just slightly away from the principles embraced by the Classicists, and closely follows the idea of “do no harm.” Moving toward the other end of the spectrum are the Maximalists, who aim to transform conflicts through humanitarian aid, therefore taking a much more political approach. The Solidarists go even farther than the Maximalists and represent the other extreme on the spectrum. They do not follow the ideas of impartiality or neutrality, and they reject the idea of the need for consent from national governments. Weiss places the ICRC on one extreme of the spectrum, with the Classicists, while he places MSF on the other extreme, with the Solidarists. While Weiss’s classifications are limiting in describing a sector as large and diverse as humanitarian aid, they are useful guidelines for understanding the main patterns of action among humanitarian aid organizations.

Fink and Stinson present a technical approach to aid that follows the guidelines set forth in international agreements, an approach that Weiss would call Classicist. They discuss aid provision in a very formulaic manner as far as what steps should be taken and the order in which they should occur. In spite of this presentation, these authors do recognize that providing aid is not always straightforward, as evidenced by their four case studies: Iraq, Srebrenica, Aceh, and Kosovo-Macedonia. However, they still seem to favor a very technical, traditional approach to

aid; that is, an approach that strictly follows the principles of neutrality, impartiality, and independence.

Hubert and Brassard-Boudreau take a different stance than Fink and Stinson do in their discussion of humanitarian space. Different humanitarian organizations define humanitarian space slightly differently, but the term generally refers to the access humanitarians have to their aid recipients without interference from either state or non-state actors. The two authors assert, “Adherence to traditional humanitarian principles will not guarantee space,” an argument that runs contrary to the ICRC’s opinion. Hubert and Brassard-Boudreau’s argument claims that embracing Classicist principles is no longer essential in guaranteeing access to populations in need or guaranteeing the protection of both aid providers and aid recipients.

**Complex Humanitarian Emergencies**

Humanitarian aid organizations have faced an increasing and evolving set of challenges as they have involved themselves in more complicated situations. Such situations have become known as complex humanitarian emergencies. A complex humanitarian emergency (CHE) is defined as “A disaster that comes at least in part due to human design. CHE is usually used to describe a disaster that involves multiple components such as large-scale displacement of people in the context of conflict, war, persecution, economic crisis, terrorism, political instability, or social unrest.” Lautze et al. add that, “…complex emergencies are characterized by the

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9 Ibid.
absence of distinctions between war, peace, and crime.”¹¹ A CHE is, then, generally not a clearly defined war between two state actors, each of whom abides by the international laws of war.¹²

CHEs have fundamentally changed the environment in which aid organizations operate. Since the end of the Cold War, CHEs have grown in prevalence, meaning that aid organizations are increasingly facing new challenges presented by this new form of conflict. Armed conflicts are increasingly between the state and non-state actors or multiple non-state actors rather than between two states. As such, the laws of war, of which the ICRC acts as guardian, are less applicable and less respected, though not irrelevant. It is increasingly difficult to determine who is the perpetrator and who is the victim in a conflict. Similarly, in CHEs it is very common to have a weak or nonexistent government from whom to gain permission for access or with whom an aid organization can collaborate.

Besides having to deal with different actors than in the past, humanitarian aid groups have increasingly had to deal with changes in their humanitarian space. Humanitarian space has decreased as CHEs have become more common than traditional interstate wars. Humanitarian aid organizations are no longer necessarily seen as off-limits by those involved in a conflict and have actually been the targets of numerous attacks. This has led some aid organizations to change their strategies and become increasingly involved with the military in order to protect aid workers and those receiving aid. However, deciding to work with the military adds an additional

¹² The law of war refers to the “law of Geneva” and the “law of the Hague.” These two laws were combined under the 1977 Additional protocols. Together they protect the rights of civilians and demobilized combatants in a conflict zone as well as the rights and responsibilities of the combatants.
set of issues for aid providers in that it detracts from their reputations as neutral actors. As aid organizations become increasingly willing and capable of sending workers to more complex situations, the dangers aid workers face are increasing as are the number of complex decisions aid organizations must make. This paper will consider one specific CHE, the Great Lakes refugee crisis following the Rwandan genocide.

The literature addressing the idea of humanitarian space often falls into the category of scholarship on CHEs. Hubert and Brassard-Boudreau make the point that concerns about humanitarian space arise from the increasing willingness of humanitarian groups to operate in riskier situations. The role of humanitarian aid in these complex emergency situations brings up ethical issues regarding the role of humanitarian aid and challenges the ideas of traditional humanitarian principles. For instance, Lautze et al. examine the roadblocks often faced in CHEs. These authors note that governance structures and health systems are often nonexistent or if they are existent, they are very weak in such situations. The lack of national structures to provide health services to the people leads to an increased demand for action by international aid groups. However, Lautze et al. note that the provision of aid by international aid groups can be very problematic in such situations because there is no one who is ultimately responsible for ensuring that organizations provide aid effectively in situations of great instability and minimal accountability.

CHEs also bring about unique public health concerns and warrant unique responses by medical humanitarian organizations. Beyond the health provision challenges, organizations operating in CHEs face additional challenges such as protecting aid providers, deciding whether

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13 Hubert and Brassard-Boudreau, “Shrinking Humanitarian Space?”, 6
14 Lautze et al., “Assistance, Protection”, 2139
15 Ibid, 2139
or not to distinguish between the aggressors and the victims, and, similarly, choosing between remaining completely neutral or taking a more politicized approach. It can be argued that the decisions that an organization makes regarding these issues impact its ability to provide effective medical aid that addresses the public health concerns of these CHEs because they can impact their ability to maintain access to populations in need as well as minimize potential unintended consequences.

Toole and Waldman examine the public health concerns of CHEs, specifically refugee situations. Their study discusses the many health issues that aid workers will encounter as well as provides suggestions for how to address these issues. Like Lautze et al., Toole and Waldman note the lack of functioning governments or health systems in CHEs. Similarly, these authors note that medical humanitarian aid groups have fallen short in many CHEs, stating, “Relief management decisions need to be based on sound technical information, and assistance programs need to be systematically evaluated—not merely for their quantity and content, but also for their impact and effectiveness.” In a separate piece, Waldman notes that the role of aid in CHEs is to stabilize the health of refugees or internally displaced people (IDPs) rather than to address the underlying political problem that led to such displacement. This argument supports the position that the ICRC generally takes, but opposes the position the MSF takes. Waldman clearly favors the Classicist approach to aid, a position that is counter to the views outlined by Thomas Weiss.

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17 Ibid., 309
While much has been written in a variety of disciplines on the topic of humanitarian aid and medical humanitarian aid in the case of the Great Lakes refugee crisis, the majority of the work focuses solely on ideological differences among groups and does very little to evaluate their effectiveness in providing aid. Following the genocide and refugee crisis, the Joint Evaluation of Emergency Assistance to Rwanda does address aid performance in its third volume, *Humanitarian Aid and Effects*. This volume does not focus on any particular aid group, but rather analyzes the performance of aid as a whole with specific focus on aid provision to refugees and IDPs. Like many other reports, this volume notes that the failures in Rwanda and the rest of the Great Lakes region were due to the failure of the political and diplomatic sectors rather than the humanitarian sector, however; as the volume continues, many shortcomings of the humanitarian sector are brought to the surface. For instance, many humanitarian organizations only wanted to be involved in high-profile activities such as performing surgery, which resulted in shortages of people to work in the less glamorous but more critical areas such as sanitation.19 While this report does look critically at aid, much of the literature maintains the assumption that humanitarian aid is always good, even if it has some shortcomings. This paper aims to fill a gap in the existing scholarship on medical humanitarian aid, by critically assessing the performance of two of the most important aid groups in the case of “the worst humanitarian crisis in a generation.”20 I plan to look at the tangible impacts of aid provision by both the ICRC and MSF

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as well as to examine the unintended consequences of this aid as a result of these ideological and practical differences.

**Thesis Structure and Methodology**

This paper intends to examine the effectiveness of two of the major humanitarian aid actors in the Great Lakes refugee crisis of the 1990’s, one of the biggest CHEs the world has ever seen. These two groups, the ICRC and MSF, have both provided health care and medical aid in the majority of humanitarian emergencies in recent decades. Both groups provided aid during the Great Lakes refugee crisis, but this is a case in which key differences between the two groups rose to the surface. The following chapters will examine these two groups in depth as well as analyze their specific actions in the Great Lakes refugee crisis, both in refugee camps in the countries surrounding Rwanda and in the IDP camps within Rwanda.

In order to study this topic, I have conducted reviews of secondary literature on humanitarian aid as a general category, each individual organization, the Great Lakes refugee crisis, and the actions of the ICRC and MSF in this crisis. Similarly, I have reviewed a number of primary documents from both organizations, including annual reports, press releases, and special reports. A portion of the research was conducted in Geneva in the ICRC film archives and library as well as through discussions with professionals involved with each organization. The following chapters will present this research beginning with a background and history of the ICRC and MSF in order to better contextualize the similarities and differences between the two organizations. Following the discussion of the ICRC and MSF, I will discuss the details of the Great Lakes refugee crisis and the major public health issues that arose in this situation. I will
then analyze the actions of each of the groups within this situation and attempt to determine how their levels of effectiveness varied based on their different approaches.

Effectiveness will be measured in terms of both noted successes and unintended consequences of aid provision. However, effectiveness is a difficult concept to define, especially in the case of the Great Lakes Refugee crisis. It is most reasonable to consider the tangible outcomes of medical aid provision in terms of how aid changed mortality rates and morbidity rates. Finding concrete outcomes, however, becomes complicated by the fact that so many aid organizations—a total of about 250 different groups—worked in the refugee and IDP camps during the crisis. Calculating which group contributed most to the reduction of mortality or morbidity rates is a virtually insurmountable obstacle. Additionally, data pertaining to epidemiological issues as well as the concentration of people within the camps is scarce or unreliable. For instance, before Oxfam began conducting assessments in early July 1994, the ICRC was the only agency providing information on the number of IDPs in northwest Rwanda. When Oxfam conducted its assessment it “found” an additional 200,000 IDPs as well as 300,000 more on the move that would soon inhabit the camps. Such a huge disparity between estimates and the fact that different organizations were operating with different information brings into question the reliability of the data available. Additionally, the registration process in refugee camps was unreliable in providing accurate numbers. Although the registration process in Ngara began in a relatively timely manner, the process in the Goma camp did not occur until 6 months after the major influx. Untimely registration is another reason to question the data available and frequently resulted in overestimations of the number of refugees in the camps fueled by the

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22 Ibid.
23 Ibid., 106
inflationary pressure of the media. Much of the epidemiological data found has been listed in terms of rough estimates or wide ranges, making judgments of the effectiveness of aid very difficult to make.

Due to these challenges, this paper will look at effectiveness in a broader sense. Effectiveness will be considered in terms of working in areas of greatest need, preventing duplication of efforts, and providing aid in the most cost-effective yet impactful manner. Areas in which aid was less effective or even harmful will also be considered. Such areas include the unintended consequences of aid, a lack of coordination, and all of the actions that counteracted the criteria previously outlined for making aid effective. In the end, an effective humanitarian aid organization will be an organization that is able to make the benefits of its work outweigh the unintended, or negative, consequences of its work. I believe this is the most functional definition for the case of the Great Lakes refugee crisis and that it will become clearer as the actions of MSF and the ICRC are discussed in detail.

It is not possible to unequivocally call the work of the ICRC or MSF effective or ineffective because there is no standard on which to base this classification and because the line between effective and ineffective is not clear-cut. During the Great Lakes refugee crisis, however, each organization had some areas in which they were very effective and others in which they were less effective or ineffective. An additional consideration that must be made is that the organizations discussed within this paper have carried out their own examinations of their work and noted many of their own shortcomings. An interview with Gilles Carbonnier, a former ICRC delegate and former board member for MSF-Switzerland, provided an inside view into the process of evaluation that takes place in each of these organizations. Carbonnier portrays both organizations as very self-critical, MSF more so than the ICRC. While he did not
directly address the evaluation process after the Rwanda case, he did discuss MSF’s process following the Somalian case, stating:

We got an internal audit where the debate was open to everyone and the entire audit said you had 19 missed opportunities and out of the 19 some of it was for the president, some of it was for the board, some of it was for the CEO, and some of it was for the nurses on the field and field coordinator. So all of us got our blame and this was done transparently, openly, with donors who were there and at the end everyone decided to join hands and try to do better, but you had no rumors in the corridors because everybody was there and could listen to everybody whereas in other organizations this does not happen like that.24

Keeping these facts in mind, this paper conducts an external evaluation of the work carried out by both groups, making use of some of the research carried out by the organizations themselves. This paper will argue that the work of both the ICRC and MSF during the Great Lakes crisis had problematic aspects; however, the actions of the ICRC were more problematic. As I will describe in later sections, the ICRC chose to remain in the camps providing aid while MSF chose to withdraw due to dissatisfaction with events occurring within the camps. While MSF may have left some people in need without an option for aid, the ICRC continued to provide aid in spite of the misuse of the aid by militants in the camps. The camps in Zaire were used as a base for carrying out further attacks on Rwanda as well as where the First Congo War originated, so the ICRC’s continued aid provision helped to fuel this continued violence.25 This paper will, however, argue that both organizations fell short of the ideal in the Great Lakes crisis and that the shortcomings identified in this case helped lead to changes in the humanitarian aid community. A number of the shortcomings of the ICRC in the Great Lakes case demonstrated

24 Gilles Carbonnier, (Former ICRC Delegate and Former MSF-Switzerland Board Member), interview by Claire Dunn, The Graduate Institute, Geneva, CH, January 18, 2013.

25 I use Zaire throughout this paper rather than the Democratic Republic of the Congo since the country was officially known as Zaire at the time of the refugee crisis.
that the classical approach to humanitarian aid, by which the ICRC abides, is becoming increasingly inadequate in post-Cold War conflicts where the laws of war are less respected and states are no longer exclusively the primary actors. The ICRC’s approach is certainly not irrelevant, though. MSF’s approach resulted in less collateral damage and attempted to deal with the underlying issues causing continued conflict and lack of security, but also had its shortcomings, showing that their approach is also imperfect. It is important to note that the Great Lakes refugee crisis occurred nearly 20 years ago; however, it is still valuable to consider since it served as an important driver of reform in the humanitarian aid community including for both MSF and the ICRC. These ideas will be further explored in the following chapters as I examine the details of each organization, the situation in the refugee camps and the actions of the two organizations in the camps.
Chapter 1: The ICRC and MSF — Diverging Paths

The International Committee of the Red Cross

As previously discussed, Jean-Henri Dunant founded the ICRC in 1863 following his experience at the Battle of Solferino. Dunant witnessed this battle while on a business trip to obtain an important land document from Emperor Napoleon III who was in the midst of commanding the Franco-Sardinian army involved in the battle. The Battle of Solferino was one of the major battles in the fight for Italian unification and exposed the inadequacy of medical services for injured soldiers during armed conflicts. Dunant returned home and wrote a memoir of his experience, A Memory of Solferino, leading to the creation of the International Committee for Relief to the Wounded, which would eventually become the International Committee of the Red Cross. Since then, the ICRC has become one of the largest and most important humanitarian aid organizations in the world, aiming to remedy this shortage of medical care, one which resulted in what Dunant described as a “miserable night when all false pride, all human decency even, were forgotten!” The ICRC is a unique organization with a long history of organizational secrecy and discretion. In its mission statement the ICRC defines itself as “an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance.”

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independence, the ICRC includes humanity, voluntary service, unity, and universality in its fundamental principles. In addition, the ICRC specifically refers to international humanitarian law and principles in its mission statement, showing the central role of each to the organization.

Initially the ICRC was composed of only males from the city of Geneva who were white and Protestant.\(^\text{29}\) While women were allowed into the organization by 1918, the committee still remained exclusively Genevan. In 1923 the first non-Genevans were named to the ICRC leadership, but the organization still remained exclusively Swiss.\(^\text{30}\) The entirety of the organization would remain exclusively Swiss until 1992 when the decision was made to allow for international professional staff. It has still never had a non-Swiss President. While the organization has often been characterized as nationalistic, it is not officially connected with the Swiss government, although it does receive a significant portion of its funding from it.

The structure of the ICRC is fairly complex. Within the organization there is a professional staff, an Assembly, Assembly Council, and a Directorate. Governing over all of these bodies is a President, currently Peter Maurer. Aside from the governing bodies, the ICRC is also made up of over 1,400 field staff and approximately 11,000 local staff working in each of the countries in which the ICRC has missions.\(^\text{31}\)

The organization continues to be headquartered in Geneva, but branches of the Red Cross movement exist across the world. There are 187 National Red Cross and Red Crescent Societies throughout the world and they are all united and coordinated under the International Federation

\(^{29}\) Forsythe, *The Humanitarians*, 203
\(^{30}\) Ibid., 204
of Red Cross and Red Crescent Societies.\textsuperscript{32} These organizations work with the ICRC in order to coordinate on-the-ground activities and to provide a portion of the funding to run the ICRC.

The ICRC neither quite falls into the category of nongovernmental organization nor into the category of international organization. Although the ICRC is not officially an international organization, it holds a unique role in the international system. The ICRC is known as the guardian of the laws of war because it is the conservator of the Geneva Conventions and Additional Protocols as well as other international humanitarian law documents. Similarly, the ICRC holds the status of an observer to the United Nations, a status it has held since 1990. While major international organizations are often granted this position, very few non-governmental organizations have been made observers. Clearly, the ICRC is a unique and important player on the international stage.

The literature on the ICRC focuses on its historical roots in war, not human rights. In fact, Ignatieff writes, “Dunant’s original genius lay in his acceptance of war as an essential ritual of human society, which can be tamed but will never be eradicated. This ritual, Holleufer (an ICRC communications advisor) argues, is at odds with the essentially pacifist assumptions of our age—- our culture of human rights.”\textsuperscript{33} The literature on the ICRC is divided between those who argue that the ICRC’s approach is ultimately a better approach because it nearly guarantees access to all situations by remaining apolitical, and those who believe that its approach is no longer relevant in the post-Cold War period as the nature of conflict changes and becomes increasingly complex with actors increasingly choosing to ignore the rules of war. Forsythe’s

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{32} International Federation of Red Cross and Red Crescent Societies, "Who We Are." http://www.ifrc.org/en/who-we-are/.
\item \textsuperscript{33} Ignatieff, Michael. The Warrior's Honor: Ethnic War And The Modern Conscience. (New York: Henry Holt and Company, LLC, 1997) 156.
\end{itemize}
\end{footnotesize}
work on the ICRC, for instance, is very complimentary of the organization. He writes, “My
general theme is that whereas in the past the ICRC has not been as effective as was often made
out to be the case, in contemporary times the ICRC is a very impressive agency.” While
Forsythe is critical of the organization’s failure to address its past failures or shortcomings, his
overall impression is that the ICRC is a successful and necessary organization.

In a 2004 piece for the International Review of the Red Cross, Jakob Kellenberger, the
President of the ICRC at the time, writes about the ICRC’s position on the issue of remaining
apolitical. Kellenberger, as expected, defends the ICRC’s choice to remain silent rather than
speaking out, saying, “The ICRC does not see itself as the moral conscience of mankind and
knows that it cannot prevent armed conflicts.” While this statement comes from within the
ICRC organization and is therefore not a critical evaluation of the organization’s actions, it does
help to provide insight into how the ICRC views its own actions.

Additional literature on the ICRC also notes some more problematic aspects of the
ICRC’s actions. For instance, Michael Ignatieff describes a situation in Afghanistan where other
aid organizations protested against the Taliban for decreeing that all Afghan women employed
by aid organizations be suspended from their jobs. Rather than joining the other aid groups in
protest, the ICRC obliged the Taliban’s request. After this interaction, Ignatieff writes, “I was
beginning to understand that the laws of war are one thing and human rights quite another.”
Instead of choosing to stand up for the human rights of the Afghan women, the ICRC chose to
accede to the Taliban’s request and not threaten its neutral position.

34 Forsythe, The Humanitarians, x
35 Kellenberger, Jakob. "Speaking out or Remaining Silent in Humanitarian Work."
International Review of the Red Cross 86, no. 855 (2004): 603
36 Ignatieff, The Warrior’s Honor, 146
37 Ibid.
Whether or not authors agree with the ICRC’s approach, the organization is viewed as the standard because it was the first to become involved in humanitarian aid. Even the ICRC’s critics recognize that the ICRC has set an extraordinary precedent. Thomas Weiss, who clearly states his preference for the Solidarist approach of MSF, calls the ICRC “the beacon of humanitarianism,” indicating that it is the guiding light for other humanitarian aid organizations to follow, even if only to a minimal extent.  

Although most aid organizations do not directly follow the ICRC’s lead, the example and basic ideas of the ICRC influence most humanitarian organizations at least to some degree.

**Médecins Sans Frontières**

MSF actually originated from a split within the ICRC in 1971. Bernard Kouchner, a French physician, worked for the ICRC during the Biafran War in Nigeria in 1968 and was angered by how the ICRC responded to this situation. The Biafran War, or Nigerian Civil War, was sparked by the attempted secession of the southeast provinces of the country. As in other conflict situations, the ICRC intervened to provide aid. Because the ICRC required the Nigerian government’s approval to intervene, it was careful not to be critical of the situation. Similarly, the ICRC forbade its members from speaking out on human rights issues or politicizing their intervention because of the principles on which the organization bases its actions as well as the potential for loss of access. Kouchner and a number of other members of the French branch of the ICRC criticized its response in Biafra, saying that its failure to denounce the Nigerian government made the ICRC an accomplice in a “systematic massacre of the populations.”

MSF has since “presented itself as embodying an outspoken variety of humanitarianism (in

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38 Weiss, “Principles, Politics”, 1
contradistinction to precursors such as the Red Cross) and as aggressively asserting both technical capacity and moral voice.\footnote{Redfield, Peter. "A Less Modest Witness: Collective Advocacy and Motivated Truth in a Medical Humanitarian Movement." \textit{American Ethnologist}. 33. no. 1 (2006): 5.} In this sense, the creation of MSF, which aimed to create an alternative approach to humanitarian aid, has succeeded. The organization is highly skilled and respected for its humanitarian work and generally seen as an equal to the ICRC in it abilities, and due to the level of respect MSF has garnered, its claims regarding moral issues draw attention, if not action.

MSF was founded in Paris and, although it was founded out of discontent with the ICRC, its charter sounds remarkably similar to the ICRC’s. For instance, the MSF charter states, “Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed or political convictions.”\footnote{Médecins Sans Frontières , "MSF Charter and Principles." Last modified January 03, 2011. http://www.msf.org/msf/articles/2011/03/msf-charter-and-principles.cfm.htm.} The two organizations, then, are filling the same niche. Similarly, the MSF charter states the organization’s observance of the principles of independence, impartiality, and neutrality that figure so centrally in the ICRC charter, even though Kouchner formed MSF based on his disagreement with these principles, particularly, neutrality.\footnote{Ibid.} In a further description of its principles, however, MSF begins to distinguish itself from the ICRC a bit more, stating in its charter that “MSF’s actions are guided by medical ethics and the principles of independence and impartiality.”\footnote{Ibid.} Here, neutrality is noticeably left out. When neutrality is noted a bit later in MSF’s description of organizational principles, it seems to take on a slightly different meaning in that MSF is unable to be controlled by government interests or by either party in a conflict rather, not that it will avoid speaking out against
unacceptable actions by either party to the conflict. Similarly, it is noted that témoignage, or bearing witness, is a central principle of the organization and that it is the responsibility of MSF to speak out and bring attention to humanitarian issues that are not being addressed or are being inadequately addressed.\textsuperscript{44} I previously noted that the term “humanitarianism” refers to taking actions based on a concern for human welfare, whether or not those actions are otherwise practical. The way in which MSF operates as a humanitarian organization, however, fits better with the definition of humanitarianism put forth by Peter Redfield, an anthropologist who has studied MSF extensively. Redfield defines “humanitarianism” as a refusal to accept human suffering or the sacrifice of any life for the purpose of achieving political goals. Redfield notes, “Most fundamentally, sacrifice represents a deep engagement with religious or political forces. Any claim to oppose sacrifice in general, then, suggests a significant rupture with the system of value maintained by them.”\textsuperscript{45} Redfield’s understanding of humanitarianism, then, demonstrates that any humanitarian act must also be a political act, an act in opposition to the current system that has led to human suffering. MSF’s focus on témoignage shows that MSF has adopted this conception of humanitarianism as inherently political, something the ICRC has not done.

Like the ICRC, MSF has branches throughout the world. The MSF International headquarters is in Geneva and there are MSF association branches in 23 countries throughout Europe, North America, South America, Asia, Australia, and Africa. MSF International is responsible for the coordination of all of the national branches and is led by a President, an International Board, and a General Assembly. Each of the MSF associations is committed to the principles and charter of MSF, but they are also semi-independent with their own presidents and

\textsuperscript{44} Ibid.
boards of directors.⁴⁶ There is an additional level of governance between the International and national associations in the form of operational directorates. Operational directorates work to manage humanitarian projects that are currently being undertaken by MSF. These directorates are based in Paris, Brussels, Amsterdam, Barcelona, and Geneva.

MSF, like the ICRC, has supporters and critics among academics and practitioners. In one of his articles, Peter Redfield writes, “Unsurprisingly, the group has developed considerable expertise in logistics.”⁴⁷ Redfield goes on to explain the technical expertise of MSF, particularly its development of a kit system that works to ensure that all missions have the basic materials and instructions necessary to address the issues that arise in emergency situations. These kits can be immediately shipped to any emergency situation in which MSF is working. Redfield does address the shortcomings of such an approach, especially in the expanding role of humanitarian aid, but overall seems to see MSF as a highly skilled organization. In another piece, “A Less Modest Witness: Collective Advocacy and Motivated Truth in a Medical Humanitarian Movement,” Redfield discusses MSF’s tendency to bear witness. In this piece, Redfield addresses some of the problems with MSF’s outspoken approach including loss of access, as in the case of Ethiopian famine from 1983 to 1985. Similarly, Redfield notes, “a potential overemphasis on témoignage threatens to blur MSF’s medical and field identity.”⁴⁸ Redfield

⁴⁸ Redfield, “A Less Modest Witness”, 10
again is critical of MSF, but also very complimentary of the skill with which it approaches its medical humanitarian mission, going as far as to call them “experts.”

Renee Fox takes a similar approach to Peter Redfield in that she notes the merits of MSF while also recognizing areas in which the organization has fallen short. Fox notes the large impact the Doctors Without Borders movement has had across the world, stating, “The ‘without borders’ concept is now so appreciated that a plethora of professional organizations and voluntary associations have made it a part of their mission statements and of their names.”

Among Fox’s criticisms, however, is MSF’s underestimation of the importance of cultural and historical factors in determining the best approaches to aid provision. Similarly, she addresses potential problematic features of utilizing media to mobilize action or to mobilize people to donate. Fox writes that the use of television in particular can dehumanize an event, making it seem theatrical rather than like a real human tragedy.

The differences between the ICRC and MSF fall nicely into the general debates surrounding humanitarian aid. Both organizations are recognized for their impressive technical capacity to provide medical aid; however, the ICRC focuses on providing aid in a neutral way, while MSF often feels that neutral aid provision is insufficient and bearing witness is necessary. Additional differences in terms of organizational priorities are also visible and the combination of these differences impacts the way in which each organization is able to respond to emergency situations. Since the Great Lakes case, both organizations have made numerous changes and as a result have moved closer together on many issues, however, the differences that did exist have

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49 Ibid., 19
50 Fox, “Medical Humanitarianism and Human Rights”, 1610
51 Ibid., 1613
52 Ibid., 1612
been central to the debates surrounding how humanitarian aid should be carried out and were undoubtedly important in the Great Lakes crisis.

**Organizational Comparison**

Although the ICRC and MSF come from the same Dunantist variety of humanitarianism, the two organizations did split in 1971 and have since developed some important differences. One of the major differences between the two organizations is its stance when it comes to neutrality and politicization. The ICRC chooses to remain strictly neutral in nearly every situation. Jakob Kellenberger defends this stance in the International Review of the Red Cross, stating, “The reason for this reserve is twofold: it does not want to risk losing its access to the victims of conflict by [speaking out], and it has reservations about the extent to which public declarations can mobilize opinion.”

In the case of the genocide, the ICRC did make some limited public statements, but used a similar approach to the US government in avoiding the term “genocide”, rather preferring to use terms such as “carnage”, “chaos”, or “human tragedy.” While using the term “genocide” would have implied that one side of the conflict was the aggressor while the other was the victim, avoiding the term essentially allowed the ICRC to avoid choosing sides in the conflict.

MSF, on the other hand, often chooses to speak out and take non-neutral, political stances; however, MSF does not always choose to act in this manner. In fact, I would argue that MSF straddles the line between a neutral aid organization and a more vocal human rights organization, choosing which side of the line is more appropriate for each situation rather than firmly placing itself in one camp or the other. In the case of the Rwandan genocide and its aftermath, MSF was

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53 Kellenberger, “Speaking Out or Remaining Silent”, 601
54 Ibid., 602
very vocal. Some of its comments that stood out include: “On n’arrête pas un génocide avec des médecins” (You can’t stop genocide with doctors)\textsuperscript{55} and “This humanitarian operation was a total ethical disaster.”\textsuperscript{56} The organization even went so far as to call for military action. At times, MSF’s move away from neutrality can be problematic and result in a loss of access to populations in need. MSF has been forced to leave numerous countries due to their criticism of the government; for example, in 1984 and 1985 MSF was working in Ethiopia to provide aid to those suffering from the famine. The Ethiopian government was using aid inappropriately to forcibly relocate citizens, which led MSF to speak out in criticism of the government. As a result, the Ethiopian government kicked MSF out of the country and it was no longer able to provide medical care to those struggling with malnutrition and other diseases related to the famine.

The way in which each organization interprets neutrality says a great deal about its priorities for its aid provision. The greatest priority for the ICRC is access, no matter the cost. This strategy has worked generally well for the ICRC in that it has been able to gain access to populations where other organizations have been denied. MSF also values access, but it also asks the question, “At what cost?” MSF is willing to sacrifice access if it feels that maintaining it will result in being complicit in a larger problem. Bernard Kouchner believed that the ICRC was complicit in what he felt was genocide in the Biafran War in Nigeria, meaning that although the organization was not carrying out the violence, it was also doing nothing to put an end to it. This frustration with the ICRC caused him to break away from it and to form MSF.

Another difference between the ICRC and MSF is the source of their funding. The ICRC is not an NGO. It is a part of the international system in that it has specific roles assigned to it by

\textsuperscript{55} Redfield, “A Less Modest Witness,” 8
\textsuperscript{56} Chaulia, “UNHCR’s Relief”, 3
states through international law and treaties. Due to the ICRC’s status in the international system, the majority of its funding comes from governments. The largest donors to the ICRC for the past several years have been the United States, Switzerland and additional European states, the European Union, Australia, Canada, Japan, and New Zealand. Together these states provide about 80 to 85 percent of the ICRC’s budget. Unlike the ICRC, MSF is almost completely independently funded. According to its website, MSF receives 90 percent of its funding from private, non-governmental sources. This percentage differs for some branches and, for instance, MSF-USA receives 100 percent of its funding in this manner. MSF is very proud of the fact that it receives the majority of its funding from private individuals rather than from governments and believes that independent funding is necessary to ensure its ability to act independently.

Independence is more visibly demonstrated by the way in which aid organizations interact with each other and other organizations in the field. MSF has shown willingness to collaborate with other aid organizations at times. For instance, MSF and the ICRC worked together in Kigali, Rwanda during the genocide. However, MSF more frequently chooses to avoid partnerships and to act independently. In their report In the Eyes of Others, MSF writes, “To a degree, these principles [independence, neutrality, impartiality] have become MSF’s hallmark and have led it to refuse to collaborate with other actors or use the infrastructures and resources used by other humanitarian or international organizations in the field, a strategy that some consider more isolationist than independent.” MSF self-reports that it has received criticism for

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57 Forsythe, The Humanitarians, 233
a failure to collaborate with national actors or other stakeholders to make their aid provision more sustainable due to their overly literal interpretation of the principle of independence.\textsuperscript{60}

The ICRC is in a slightly different position than MSF when it comes to forming partnerships and cooperating. While the ICRC is not officially an intergovernmental organization, it is very closely connected to the most important one, the United Nations. Similarly, it has a network of organizations with which it can cooperate in both the International Federation of Red Cross and Red Crescent Societies (IFRC) and the national Red Cross and Red Crescent Societies. While all three of these branches are part of the same movement, they are not exactly the same. In fact, the IFRC was not formed until 1991 and was intended to coordinate the national societies. This culture of collaboration carries over into the ICRC’s work in general. The ICRC is very involved in coordination efforts, especially on the level of policymaking where it has played a lead role in institutionalizing cooperation among humanitarian actors.

Despite operating under the same main principles, MSF and the ICRC are not one in the same. Each group has its own priorities and ideas even though they each perform the same type of work in the same situations. The organizational differences impact the way in which MSF and the ICRC operate in complex emergency situations and impact how effective their aid provision can be.

\textsuperscript{60} Ibid., 60
Chapter 2: Setting the Scene — The Great Lakes Refugee Crisis

In order to best understand the actions taken by the ICRC and MSF in the Great Lakes refugee crisis, it is first necessary to understand the nature of the crisis and the context in which these two groups were operating.

Why the Great Lakes Refugee Crisis?

The case of the refugee crisis following the Rwandan genocide is particularly interesting because it both illustrates the difficult ethical choices faced by humanitarian aid organizations and emphasizes the different approaches of MSF and the ICRC to these ethical issues. Similarly, the Great Lakes refugee crisis served as an important turning point for the aid community as a whole because of the major challenges that arose out of this case. In post-Cold War conflict situations, humanitarian organizations confronted new dilemmas that challenged ideas about how humanitarian aid should be provided. Following the Great Lakes refugee crisis, the humanitarian community made a series of moves toward updating the aid system for a new international climate. In 1999, MSF was awarded the Nobel Peace Prize, which seemingly endorsed their approach to aid provision. Around the same time, the creation of the Sphere Project including the Minimum Standards for Humanitarian Assistance and the Humanitarian Charter, which supported greater institutionalization and coordination of humanitarian aid, seemed to be an endorsement of the ICRC approach. The humanitarian community will likely continue to adapt its approach to aid provision and it is likely that there will never be total agreement among all groups, but shifts toward the center can be observed among key actors. The decisions of the ICRC and MSF in the Great Lakes refugee crisis served as an important basis for these actions.
by the humanitarian aid community. The impact of this case will be further discussed in a later chapter.

**What Happened?**

In 1994, the small, east central African nation of Rwanda experienced a horrible genocide. Rwanda has two main ethnic groups, the majority Hutu who made up approximately 85 percent of the population in 1994, and the minority Tutsi who made up approximately 15 percent of the population, but held the majority of economic and political power. The two groups have a history of animosity and in 1994 this animosity boiled over into a full-fledged genocide in which approximately 800,000 Tutsis and moderate Hutus were killed. By the end of the genocide, the Rwandan Patriotic Front, a Tutsi-led group, had regained control of the country, but this did not mean that the Hutus were no longer an important force. Huge portions of the Rwandan population were forced to flee their homes either to IDP camps or to refugee camps across the border. Refugees who fled Rwanda went to neighboring countries in the Great Lakes region, which includes Tanzania, Burundi, and Zaire, leading to the Great Lakes refugee crisis. On April 29, 1994 alone, approximately 200,000 to 250,000 refugees fled Rwanda across the Tanzanian border, creating the largest mass exodus in history.  

This mass exodus of refugees was followed by an even larger movement of over one million refugees into Goma, Zaire, less than three months later, called the Goma Influx. While many of the refugees were innocent, a large number were also génocidaires, perpetrators of the genocide, who planned to use the refugee camps as a means of reorganizing and recruiting to resume the fight against the

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62 Ibid., 53
Tutsi Rwandan Patriotic Front. The largest mass movement was, in fact, organized and executed by the collapsing Hutu-led Rwandan government. This aspect of the Rwandan refugee camps raised some very difficult ethical questions for humanitarian groups. Were humanitarian aid groups becoming complicit in the killing through the way in which they distributed aid and by indiscriminately treating all individuals? The ICRC made the decision that it was not its place to take sides in the conflict, which would compromise its neutrality, so it remained in the camps providing aid despite knowing of the terrible actions occurring within the camps. MSF, on the other hand, made public statements demanding that safety in the camps be improved and that the repatriation process be changed. Similarly, it asked that those responsible for perpetrating the violence be removed from the camps.

When these problems were not addressed, multiple branches of MSF decided to terminate their programs, saying, “This humanitarian operation was a total ethical disaster.” MSF-France was the first to pull out in November 1994. Five months later, MSF-Belgium also withdrew and by the end of 1995 all five MSF branches involved in the refugee camps had withdrawn.

In addition to the problems within the refugee camps, all aid groups faced decisions about how to divide their aid between refugee camps and IDP camps. The refugee camps in Rwanda faced many of the same challenges as the refugee camps in the surrounding countries; however, many aid groups flooded the camps in Zaire while paying little attention to the IDP camps. The IDP camps within Rwanda received much less publicity than the camps in Zaire, which were

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64Medécins Sans Frontières, "Deadlock in the Rwandan Refugee Crisis: Repatriation Virtually at a Standstill." Last modified 1995. , 6
65Chaulia, “UNHCR’s Relief”, 3
photographed and reported on by all sorts of news media. The large amount of media coverage drew the attention of many aid groups and, equally as important, of the donors to these groups. The huge number of aid groups present in the refugee camps—in Zaire peaking at between 90 and 100 different groups including NGOs, 3rd party military contingents, the United Nations High Commissioner for Refugees (UNHCR), and the ICRC—led some groups to decide to operate exclusively in the Rwandan IDP camps and to avoid being redundant in the Zairian camps. These groups included Feed the Children and Save the Children-UK. Both MSF and the ICRC chose to work in both refugee and IDP situations. This decision is an important similarity between the two in this case, but is important to note because their choice of where to direct their aid efforts impacted how they were able to provide their aid and because deciding where to direct aid represents a dilemma faced by all aid organizations during the crisis.

The refugee crisis following the Rwandan genocide is a very interesting case through which to examine the effectiveness of the medical humanitarian aid of the ICRC and MSF. The two groups, while making some similar decisions, responded differently to many aspects of the crisis both inside and outside of Rwanda, resulting in different outcomes to their aid provision.

The various arguments regarding the ICRC and MSF come into play in the literature on the Great Lakes refugee crisis. Although Sreeram Chaulia does not focus on the actions of the ICRC and MSF, instead highlighting the UNHCR, he does address many of the problems that aid organizations faced in their aid provision in Rwanda, as well as the gravity of the health problems found in the refugee crisis. Chaulia’s article refers to the Rwandan refugee crisis as the

66 Borton, John, Emery Brusset, and Alistair Hallam, The International Response to Conflict and Genocide, 133
67 Borton, John, Emery Brusset, and Alistair Hallam, The International Response to Conflict and Genocide, 151
“messiest humanitarian quagmire ever.” The crisis certainly presented a number of very difficult ethical issues that aid organizations had to address. For example, Chaulia refers to the fact that war criminals received aid in the refugee camps and terrorized innocent refugees, alarming events that caused many aid organizations to withdraw from the camps.

John Eriksson’s piece evaluating the international response to Rwanda notes that, “The critical failings in the international community’s overall response, therefore, lay within the political, diplomatic, and military domains rather than the humanitarian domain.” After making this statement, however, Eriksson refers to some areas in which humanitarian aid did fall short. For instance, Eriksson writes, “This assessment identified a fundamental weakness within the humanitarian system in that it did not possess a mechanism for monitoring and analyzing information to provide warning of population movements that was either sufficiently integrated or capable of gathering information in areas that were poorly covered by relief agencies.”

In order to deal with some of the failings of humanitarian aid in the Great Lakes crisis, Eriksson calls for increased coordination between humanitarian and political policies of regional and international bodies, donor countries, and neighboring countries.

Denise Delvaux’s master’s thesis directly addresses the roles of the ICRC and MSF in the crisis. Delvaux addresses their differing approaches, using Weiss’s classifications to distinguish between the varied approaches of the ICRC and MSF. She places the ICRC in between Classicists and Minimalists and MSF between Maximalists and Solidarists. In terms of the Great

68 qtd. in Chaulia, “UNHCR’s Relief”, 5
70 Ibid., 26
71 Ibid., 29
Lakes refugee crisis, Delvaux sees the two groups as occupying separate, but interconnected spheres. Rather than viewing their differences as problematic for humanitarian aid provision, Delvaux writes, “It reflects a division of labor based upon different priorities with the same initiative - to alleviate the suffering of populations caught in a complex emergency.” In other words, Delvaux argues that it is necessary for aid organizations to approach aid in different manners so that each organization addresses the issues about which they have the specialized knowledge. As a result, the organizations will support and complement each other’s actions rather than duplicate them.

**Public Health Challenges of Refugee Camp Situations**

The abundance of public health challenges in refugee camps not only provides significant challenges for medical humanitarian organizations, but also emphasizes the important role that these organizations can play. The refugee camps and IDP camps in the Great Lakes region were no exception and certainly had their fair share of health challenges. Health consequences of genocide and refugee camps can be divided into various areas including infectious disease, nutrition, and direct consequences of violence. M.J. Toole and R.J. Waldman state that “mortality rates among Rwandan refugees in 1994 were among the highest ever documented.” The close proximity of large numbers of people as well as a lack of potable water and adequate sanitation make refugee camps breeding grounds for infectious disease. The two largest causes of mortality in the North Kivu refugee camp and the Mugunga Camp, both in Zaire, were watery diarrhea and bloody diarrhea. The reason for the prevalence of deaths attributable to diarrhea

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72 Delvaux, “The Politics of Humanitarian Organizations”, 90
73 Toole and Waldman, “The Public Health Aspects of Complex Emergencies”, 288
was an outbreak of cholera followed by an outbreak of dysentery in the camps.\textsuperscript{74} In the Goma camp, for example, a cholera outbreak immediately following the July 1994 influx resulted in 100 percent of refugees being infected to some degree within just 2 to 3 weeks and about 10 percent of the refugee population developing moderate or severe cholera. The initial fatality rate reached over 50 percent, but about 2 weeks into the epidemic dropped to around 10 percent.\textsuperscript{75} Cholera and dysentery were major problems in the camps due to a lack of capacity among aid agencies to purify water; other camps, like the Kibumba camp, were also quite far from the nearest source of water. Similarly, poor sanitation schemes and a lack of interest by aid organizations in working on this issue contributed to the prevalence of these diseases. Although it is unlikely that a cholera outbreak could have been prevented in the Lake Kivu region because of its already high prevalence in the area, the actions of aid organizations certainly impacted the amount that the disease was able to spread.

In addition, nutritional concerns are of great importance in refugee and IDP camp situations and an area in which many aid organizations struggled during the Great Lakes crisis. In the Rwandan refugee camps in Zaire, for instance, the prevalence of acute malnutrition was between 18 and 23 percent.\textsuperscript{76} The outbreak of various infectious diseases can further harm the nutritional status of refugees. While a great deal of food was provided, much of the food was foreign to the refugees and therefore culturally inappropriate. The grain provided, for example, was maize grain rather than the sorghum grain to which the refugees were accustomed. Additionally, the beans provided for food required soaking, a very uncommon practice in the Great Lakes region. Providing such culturally inappropriate food made the food aid less

\textsuperscript{74} Toole and Waldman, “The Public Health Aspects of Complex Emergencies”, 293
\textsuperscript{75} Borton, John, Emery Brusset, and Alistair Hallam, The International Response to Conflict and Genocide, 69
\textsuperscript{76} Toole and Waldman, “The Public Health Aspects of Complex Emergencies”, 297
impactful. In addition to being unusual for the refugees, the beans required more cooking fuel than other foods, meaning that choosing to provide this type of bean also required aid agencies to bring in extra cooking fuel, adding additional—and unnecessary—costs. In addition to adding costs, such food aid was unable to have the desired impact. Rather than eating unidentifiable foods, refugees would sell it in exchange for goods with which they were familiar, but which also often had lower energy contents. When providing aid, small considerations such as the type of grain provided for refugees may seem minimal. Why should it matter what type of food is being provided as long as people in need are receiving food? The previous example demonstrates how matters that initially seem minimally important can quickly become of the utmost importance without proper forethought.

Finally, the direct results of violence are of major concern in CHE situations. War trauma-related injuries and post-traumatic stress are major concerns in these settings. In the case of the Great Lakes crisis, and frequently refugee camps in general, protecting people from further attack in the refugee camps is also a major concern and can certainly cause ethical dilemmas among aid groups. During the Great Lakes crisis there was a large number of attacks on aid workers, even the staunchly neutral ICRC workers. Choosing to use military protection can compromise an organization’s neutral status, but due to the dangerous situation in which they were operating, aid organizations were forced to seriously consider whether they were doing more good by avoiding military protection and remaining neutral or by using military protection to guard their workers and those refugees and IDPs they would still be able to access.

**Additional Challenges**

Aside from the numerous health issues that aid organizations had to address, the Great Lakes refugee crisis presented many additional challenges for effective aid provision. One such challenge was the location of the crisis itself. Although there are a number of major lakes in the region, Rwanda and the other countries in the Great Lakes region are landlocked. The landlocked situation of the countries made bringing relief supplies a much greater challenge leading the head of the Relief Division of the ICRC at the time of the crisis to say, “It was easier to bring 20,000 tonnes of food per month to Somalia than 8,000 tonnes to landlocked Rwanda.”

The region’s location led organizations to rely on air transport to bring in supplies, a much more expensive undertaking than similar action in more accessible countries. Transportation of supplies and relief workers was further complicated by difficult terrain and poor road conditions throughout the region. In the Joint Evaluation of Emergency Assistance to Rwanda’s report, the terrain on the way to the Goma camps is described as made up of recent lava flows, leaving cars little option for driving off road. The inability to drive off the road was very problematic as the roads were incredibly congested with refugees walking to and from the camp as well as relief vehicles and FAR military vehicles. Additionally, the rough terrain made it very difficult to set up medical clinics and distribution centers for food and supplies. For some camps, location also limited accessibility to fresh water. As previously noted, the Kibumba camp near Goma was a significant distance, 25 kilometers, from the nearest water source.

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79 Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, ch. 2
Aside from geography, politics presented a significant challenge in the refugee crisis. The only exception to this rule was Tanzania. The Tanzanian government limited the number of aid organizations operating in the camps on their territory near Ngara to groups that had already been in the country prior to the crisis, allowing only CARE to begin a new operation in the country. As a result, only 12 groups operated in the Benaco camp in Ngara, creating a less competitive environment than the camps in other countries in the region, especially Zaire. Limiting the number of organizations operating in the camps led to a more organized situation in which efforts were not being duplicated, and unqualified groups were not present. Although Tanzania was generally a better environment in which to operate, aid groups still faced some challenges. In one instance that shook the entire aid community, the Gatete incident, aid groups were forced to withdraw from the camps for a minimum of two or three days when a mob trying to protect a génocidaire began attacking NGO personnel. While this is only one major incident, camps in other countries experienced many such incidences. The more difficult conditions in the other countries can be attributed to the fact that other governments in the region were not as organized or restrictive as the Tanzanian government. Rwanda, of course, was in the midst of a major conflict over its government, making government assistance and regulation for IDP camps minimal, but the impact of political factors on the cases of Burundi and Zaire were particularly interesting.

Burundi neighbors Rwanda to the south and the two countries share many similarities. Because of its bordering location, Burundi was a natural site for refugees to flee; however, Burundi had its own internal struggles that made it a problematic site for refugee camps. Burundi’s population, like Rwanda’s, is largely made up of Hutus and Tutsis, and following the

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81 Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, ch. 6
assassination of President Melchior Ndadaye on October 21, 1993, widespread violence between the two groups broke out. This violence began the Burundian Civil War, which still plagues the country today. As a result of the ethnic violence many Burundians actually fled to Rwanda in the year preceding Rwanda’s own internal struggles. The flow of refugees in the opposite direction, from Rwanda to Burundi, exacerbated the internal struggles in Burundi. While 12.91 percent of international aid during the Great Lakes crisis went to Burundi, Rwanda’s southern neighbor was not the major story; it did not experience influxes of refugees on the same scale as Tanzania or Zaire and did not receive nearly as much attention for the violence in camps on its territory as Zaire. 82 Despite the lack of attention paid to Burundi, Burundian camps were very important for refugees and faced many of the same conditions as the camps in other countries, particularly Zaire. Because of the lack of stability in both Burundi and Rwanda, working with refugees flowing into and out of both of the countries was an added challenge for aid organizations. MSF, for instance, decided to make contingency plans in case considerable violence broke out in Burundi. Such a contingency plan was necessary since violence was prevalent in the area surrounding the camps. For example, a March 1995 attack on the Majiri camp killed 12 refugees and injured 20. 83 The political violence and instability in Burundi was a significant added challenge for aid organizations working in refugee camps, reinforcing the connection between political conditions and humanitarian aid.

The impact of politics on humanitarian aid is especially evident in looking at the refugee camps in Zaire, particularly in the Goma area. The camps in Zaire experienced the largest influxes of refugees, already making the camps in the country challenging for humanitarians.

82 Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, 26
83 Medécins Sans Frontières, "Deadlock in the Rwandan Refugee Crisis", 5
The Goma camps were known for being particularly violent and security was a problem for both refugees and aid workers. For instance, a survey of the Mugunga camp found that within the first month after the Goma Influx, 8 percent of deaths —4,200 total deaths— could be attributed to traumatic injury.\(^{84}\) Due to these security problems, aid workers were often not able to stay in camps after dark.

The situation in Zaire was further complicated by a history of tensions between the Rwandese and the Zairians. In the 1950’s and 60’s numerous Rwandese Hutus and Tutsis settled across the border in the Zairian North Kivu region either as migrants or refugees. Many Rwandese Tutsis began to find economic prosperity, which led to clashes with the local population. As Goyens et al. note, “The Native Zairians have the political power, the Rwandan immigrants have the land.”\(^{85}\) The situation between Rwandese and Zairians then, was not very dissimilar from the situation between Hutus and Tutsis in Rwanda where a minority group had disproportionate control of some major resource; in Rwanda this resource was political power and in Zaire, it was land. Further clashes occurred in the 1980s and the major inflow of refugees following the genocide in Rwanda left many Zairians feeling threatened. On top of the Zairians not being the most welcoming of hosts, the Zairian military posed a major challenge to refugees and aid workers. Even before the influx of refugees from Rwanda, the Zairian military and police structures were less than ideal. The police barely functioned and the military was poorly trained and in many cases had not been paid for months. The status of the security forces in Zaire, then, often contributed to the problems in the camps rather than working to

\(^{84}\) Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, 52

\(^{85}\) Goyens, Phillipe and others, "Humanitarian Aid and Health Services in Eastern Kivu, Zaire: Collaboration or Competition?." *Journal of Refugee Studies*. 9. no. 3 (1996), 270
remedy them. Police and military personnel were often involved in diverting aid, for instance.\textsuperscript{86} The local government had little control over the security forces, but in general, the Zairian government supported and had been allied with the Habyarimana, or Hutu-led government of Rwanda, often leading them to provide less than adequate protection to the refugees and instead to favor the militants within the camps.\textsuperscript{87} With such a complex and hostile political situation in Zaire, it is no surprise that it is the country in which aid organizations faced some of the greatest challenges.

Managing each of these challenges presented obstacles for aid organizations, but the way in which such challenges were addressed says a great deal about how effectively an organization was able to act. Now that the larger context within which the ICRC and MSF were working is set, the next section will provide a detailed examination of the actions of each of these groups as well as an analysis of their respective levels of effectiveness.

\textsuperscript{87} Ibid., 311
Chapter 3: The ICRC — An Old Organization, A New Crisis

The ICRC began its work in Rwanda in 1990 and was one of the few groups in Kigali when the genocide began. The organization’s operation in the country prior to the height of the crisis gave them the ability to prepare and act rapidly in the IDP camps as well as the refugee camps. Additionally, the ICRC’s proximity to the crisis and preparation before the genocide allowed it to play a role in alerting the international community to the extent of the crisis. It’s positioning also allowed the ICRC to take a lead role in the aid effort, particularly early on in the crisis. The ICRC was one of the most important humanitarian actors throughout the crisis and in 1994, the Red Cross Movement accounted for 17 percent of all aid flows. Since the ICRC is such a large organization, it was involved in a large variety of activities ranging from data collection to health care provision to food distribution to registering unaccompanied children and working to reconnect them with their families. I will focus on the organization’s activities that are most relevant to the health of the refugees and IDPs including direct health care provision, food aid, water and sanitation work, and data collection, noting that the ICRC did have a broader role that could also be examined, but that does not fit into the scope of this paper.

When considering medical humanitarian aid, the easiest place to begin is with the direct provision of medical care, be it through surgery, medicine provision, or otherwise. The ICRC played an important role in the direct provision of medical care because it had early, and only minimally restricted, access to populations in need. According to its 1993 Annual Report, the ICRC gave medical care to approximately 80,000 Rwandese patients in 1993 alone. In the next two years the need for medical humanitarian aid would increase, and with it, challenges to aid

88 International Committee of the Red Cross, “ICRC Special Brochure: Rwanda”, 3
89 Borton, John, Emery Brusset, and Alistair Hallam, The International Response to Conflict and Genocide, 5
provision. Within just 10 days of the shooting down of the presidential plane, which sparked a major increase in violence, only the ICRC and the United Nations Assistance Mission for Rwanda (UNAMIR) had effective presences in Kigali. After April 6, 1994, only the UN Advance Humanitarian Team and the ICRC were able to remain working in Kigali at the King Faisal Hospital. MSF-France physicians were able to come into King Faisal Hospital and perform surgeries, but only by working under the ICRC flag. Later, when a very limited number of groups were allowed into the area, the ICRC had the most freedom of movement. The fact that the ICRC was able to stay and move around relatively freely when others were not supports the thinking that neutrality leads to access and shows that there have been times when the ICRC has been able to be more effective simply because it maintained this access when other groups did not.

In addition to providing for the physical health of the Rwandan population, the ICRC also provided for the mental health of the population. Mental health is a critical aspect of health provision in CHEs and was a significantly under-covered area during the Great Lakes crisis. In August 1994, the ICRC assisted in reopening the Ndera psychiatric hospital in Rwanda. This hospital was the only one of its kind in the country and helped victims suffering from the trauma and depression associated with war. National Red Cross Societies soon took over the renovation and management of the hospital, but still acted under the authority of the ICRC. Addressing the need for mental health provision was a significant achievement of the ICRC during the crisis and filled an area that other organizations were not covering.

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91 Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, ch. 2
The ICRC continued to provide direct medical care within refugee camps. In Goma, for instance, the ICRC immediately began supporting the Goma hospital and also set up an additional emergency facility in the local stadium. The team of surgeons working to treat the wounded in this new facility performed 80 operations in the first week alone. The ICRC’s work is certainly noteworthy, but what is more so is its decision to end its work in the Goma hospital and to allow other groups to take over in August, just one month after the influx. The ICRC’s presence in the area allowed it to act quickly when the Goma influx occurred, but it was efficacious that the ICRC passed the work in the Goma hospital on to other qualified organizations after these organizations were able to arrive and get organized in Goma. Many organizations only had the expertise and willingness to work in hospitals. The ICRC, on the other hand, had much broader expertise that allowed it to work in additional areas such as water and sanitation. By choosing to carry out other activities for which it had the expertise, the ICRC prevented the duplication of efforts in the hospital.

The ICRC also provided ambulance service in order to facilitate the direct provision of medical care, but doing so turned out to be a dangerous undertaking. Although the ambulances were marked with the Red Cross emblem, there were multiple attacks, including one in which armed militia shot and killed six of the wounded in transport despite the presence of the armed forces. This example shows how the ICRC’s neutrality can fall short and fail to protect the ICRC and its patients, especially in cases where government officials play no part, but instead armed militia groups, who may not know or care about the ICRC’s neutral stance, are involved.

While the ICRC’s work in direct medical care was largely effective, it did reveal shortcomings in the organization’s basic principles. The ICRC provided direct medical care in a

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very timely manner, addressing the need while other organizations scrambled to arrange for aid workers, to gather supplies, and to make the trip to central Africa. Once these other aid groups arrived, the ICRC made the decision to delegate some of its work in direct medical care to other qualified groups, a decision which enhanced its effectiveness because it prevented duplication of efforts and allowed the ICRC to begin working in other areas of need that were not being adequately covered. While I classify the ICRC’s work in providing direct medical care as an overall successful effort, its neutrality model was certainly challenged. Neutrality allowed the ICRC to continue working in Kigali while others could not, but it did not protect ICRC aid workers from the violence in and around refugee camps. Neutrality should, in theory, be known to and respected by all actors in a conflict; however, in the conflict addressed in this study, many of the actors were not government-sanctioned actors. As a result it is possible, and quite likely, that the ICRC’s position was not well known among these nongovernmental actors. The ICRC relies heavily on others knowing and respecting its neutrality and being informed about international humanitarian law, an expectation that I argue is naïve in situations such as the Great Lakes crisis and shows the limitations of both neutrality and humanitarianism in CHEs.

In addition to direct medical care provision, the ICRC was instrumental in providing food aid, a critical service for maintaining the health of refugees. In its Special Brochure on Rwanda, the ICRC stated:

When [the refugees] arrived in the new camps for displaced people in Rwanda or in the refugee camps across the border in Tanzania, Zaire, and Burundi they had no food stocks with them. Weak and hungry, they are now entirely dependent on humanitarian organizations for their survival.94

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94 International Committee of the Red Cross, “ICRC Special Brochure: Rwanda”, 1994, 8
After the World Food Program (WFP), the ICRC was the group most involved in food aid, with 22 percent of aid channeled through it. The majority of the food aid channeled through the ICRC was directed to Rwanda and the IDP camps. The ICRC had some noted successes when it came to food aid. Similar to the case of direct health care provision, the ICRC’s prior positioning in the region gave it the ability to prepare and act before other groups arrived. When it came to food provision, the ICRC was able to plan for the large influxes of refugees and began building up supplies near Benaco, Tanzania where the first of these influxes was directed. As a result of this preparation it was possible to begin food distribution rapidly after the influx took place.

While it was critical to have food available to distribute, it was also important to organize food distribution in an equitable and economical manner. The way in which food was distributed varied from one camp to the next and some distribution schemes were more efficient than others. Some camps distributed food using a commune system where leaders prepared lists of people within their commune and then aided in the distribution of food. This system allowed for a quick start to food distribution, but it was also open to abuse by commune leaders. The other common manner of distribution was the head-of-household system, where the head of each family unit received and distributed food for their family, but this system required more personnel and could delay the start of food distribution. A survey conducted by MSF found that there was a high level of wastage—17 percent—in one of the ICRC-run IDP camps, likely due to the way in which food was distributed. The ICRC should have taken more time to consider the

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95 Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, ch. 5
96 Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, ch. 5
consequences of its choice of food distribution system in order to allocate food more equitably and prevent waste of valuable resources.

In addition to stockpiling and distributing food aid, the ICRC played a central role in transporting that aid. As previously noted, transportation was a significant challenge throughout the Great Lakes region; however, the ICRC did not adequately exploit all transportation options. Rail transportation, though imperfect in the region, was a viable and relatively economical option. The WFP made much better use of this option than did the ICRC, which relied more heavily on air transport, a much more expensive option. While economic efficiency may seem like an insensitive consideration in times of crisis, by choosing the most economically efficient mode of transportation the ICRC could have been able to provide additional food aid or use the funds it had saved to enhance any of its other aid initiatives.

The ICRC’s efforts did help to make food aid available to a significant number of people during the crisis, likely sustaining the lives of many refugees and IDPs, but its food aid provision was less efficient than it should have been. The ICRC chose neither the most economical means of transportation nor the most equitable and efficient means of distribution. Such decisions led the ICRC’s food aid to fall short of its potential positive impact. Different decisions with regards to food transportation and distribution could have potentially allowed the ICRC to provide more food aid, while also minimizing the amount of aid that was diverted.

The water and sanitation sector was an additional and crucial sector in which the ICRC worked throughout the crisis. Many aid groups neglected the sanitation sector, as it was lower profile than areas like surgery; however, it was arguably a more critical area to maintaining the health status of refugees and IDPs. The Joint Evaluation of Emergency Assistance to Rwanda found “an overemphasis upon high-profile, curative services within the international relief
system, and a distinct lack of capacity (or unwillingness of agencies to work in) lower-profile, but nevertheless crucial preventive activities."  

Aid organizations were uninterested in working in lower profile activities like sanitation because they were not glamorous areas that would receive large amounts of media coverage and encourage donors to give more money, like would performing emergency surgery. The water and sanitation sector surely falls under the category of lower-profile preventive activities. Cholera and dysentery were more prevalent due to a failure of aid groups to provide effective sanitation schemes. The ICRC did involve itself in sanitation work, helping to fill a void left by other organizations. The organization’s work in this sector was largely focused in Rwanda, rather than in surrounding countries; it worked in the IDP camps and prepared the country for the eventual return of refugees. The ICRC’s 1994 annual report states that the organization dedicated equipment worth two million Swiss francs to water and sanitation work in Rwanda. This funding helped to set up emergency water distribution systems in IDP camps and to restore main water treatment stations throughout the country by providing technical assistance and materials like aluminum sulfate, chlorine, and lime. The organization also used water tankers to temporarily distribute water until the distribution systems were once again functional. In addition to working on the technical aspects of water provision and sanitation, the ICRC carried out education campaigns encouraging IDPs to practice good hygiene and teaching the basic methods for doing so. The actions of the ICRC in the water and sanitation sector within Rwanda were very much needed, but were not able to prevent massive outbreaks of diseases such as cholera and dysentery, as the most severe outbreaks of the diseases were found in the IDP camps in southwest Rwanda where the ICRC was focusing its efforts.

97 Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, 73

98 International Committee of the Red Cross, “Annual Report 1994”, 7-12
The Kibeho camp, for instance, had mortality rates 20 times the average for the camps during the month of September, a fact that can be largely attributed to the lack of experienced ICRC personnel working in the camp and delays in the provision of clean water. Although the severity of the cholera and dysentery outbreaks in this region cannot be classified as a failure of the ICRC exclusively, the ICRC’s prominent role and investment in sanitation in Rwanda likely could have been directed more effectively to prevent or minimize such major outbreaks.

In addition to working to improve the water and sanitation for IDPs, the ICRC advocated for providing better water and sanitation schemes for the overcrowded prisons throughout Rwanda. Part of the ICRC’s mandate that is unique among medical humanitarian organizations is to visit prisoners. Because of this role, the ICRC was able to see problems, like significant overcrowding, that would have been invisible to other organizations. The severe overcrowding of the prisons made sanitation a growing concern. In a 1995 news release the ICRC notes, “The prison population was growing by 1,500 every week, and in a number of institutions there were now up to four inmates per square metre of floor space throughout the compound and up to six persons per square metre in the dormitories.” Such close proximity led to numerous health concerns and made sanitation work particularly necessary. While the ICRC’s attempts to improve sanitation schemes in overcrowded prisons were laudable, conditions were unlikely to significantly improve until the issue of overcrowding was addressed. This is a case in which speaking out might have been a useful tactic for the ICRC. The organization sent memoranda to the Rwandan authorities as well as the international community to draw attention to the prison conditions, but did not make public statements that might have created public outrage.

99 Borton, John, Emery Brusset, and Alistair Hallam, The International Response to Conflict and Genocide, 45
surrounding the issue, pushing these official actors to actually address the problem. Again, speaking out may be considered problematic by some in that it may have resulted in the ICRC losing access to the prisons or having its access restricted, but by neglecting to speak out the ICRC failed to address the problem in a timely manner. The ICRC did take some actions on its own including equipping new facilities to lessen overcrowding, but it also continues to note prison overcrowding as a problem in reports from 1996 and 1997.\footnote{Deprived of Freedom. Geneva: International Committee of the Red Cross, 2002. http://www.icrc.org/eng/assets/files/other/icrc_002_0685.pdf; and "ICRC Operational Updates No. 97/03." International Committee of the Red Cross, April 1997.}

The ICRC did not play a large role in sanitation outside of Rwanda, leaving that task to other agencies. Water and sanitation actions by the ICRC in Rwanda were largely successful in addressing areas, such as prisons, that were not covered by other organizations. The ICRC’s actions, however, were imperfect and could have been more successful in minimizing negative health outcomes, such as the spread of cholera, if carried out in a more effective manner.

A final crucial area in which the ICRC helped to support the health of refugees was data collection.\footnote{Data collection in this section refers to data on the movement of people throughout the Great Lakes region as well as the number of people inhabiting the IDP and refugee camps, rather than to specific epidemiological data. The section on MSF will address epidemiological data.} Although data collection may seem irrelevant to health, it does play a critical role in informing aid organizations of the movement of people so they can begin to prepare for large influxes of refugees. These data also inform organizations about how many people they will need to assist and the quantity of supplies they will need to do so. In the case of the Great Lakes refugee crisis, data collection was lacking. Few organizations were carrying out this task and the small amount of data that was collected was frequently inaccurate. The ICRC was the only organization gathering data on the number of IDPs in northwestern Rwanda in early 1994. Taking on this role was significant because no other organization was doing so; however the
ICRC data were questionable. When Oxfam began collecting data as well, it found an appreciable difference between its numbers and those of the ICRC, with the ICRC’s numbers being significant underestimates. While it was important that the ICRC provided data when no other organization was, its importance is negated by the fact that the data was inaccurate.103

Another facet of the ICRC’s work that warrants evaluation is closely related to the main principles of the organization: independence, impartiality, and neutrality. Each of these issues has already come up in the discussion of the ICRC’s actions regarding health, but each should also be explicitly discussed. When discussing the ICRC as an organization, this paper argues that the ICRC’s interpretation of independence tends to be focused on independence from governmental forces and parties to a conflict—be they governmental or nongovernmental—rather than from other aid organizations and as a result, it is more willing to collaborate with other aid organizations. In the Great Lakes refugee crisis, the ICRC did not consistently demonstrate a willingness to collaborate. The ICRC was not alone in its unwillingness to collaborate; lack of collaboration was a major problem among all organizations involved in the relief effort. Failing to collaborate was a necessary choice in some instances as it meant the ICRC was working in an area of need that other organizations had failed to cover. At other times such failure to collaborate was not beneficial or possible. In the case of the Ginkongoro IDP camps in northern Rwanda, five organizations, including the ICRC, worked in the water and sanitation sector. However, coordination was poor among all of the groups and eventually Oxfam took on the majority of the work.104 Additionally, the ICRC is noted to have had poor coordination with the UNHCR, the organization meant to serve as a coordinating body for all aid

103 Borton, John, Emery Brusset, and Alistair Hallam, The International Response to Conflict and Genocide, ch. 1
104 Borton, John, Emery Brusset, and Alistair Hallam, The International Response to Conflict and Genocide, ch. 4
organizations. The Joint Evaluation of Emergency Assistance to Rwanda states, “Poor relations between the ICRC sub-delegation and the UNHCR team in Goma appear to have prevented the ICRC estimate of 250,000 IDPs around Ruhengeri from reaching the UNHCR team.”

Ruhengeri was a critical IDP camp for predicting inflows to Goma and the ICRC’s poor relationship with the UNHCR meant that it was unprepared for the size of the Goma influx. The ICRC was not unique in its struggle to coordinate during the Great Lakes crisis, but it could have been much more effective in its work if it had maintained independence from government agencies while working with other aid organizations and coordinating bodies such as the UNHCR. Instead the ICRC did not collaborate enough resulting in a lack of preparation, as was the case in Goma, or the creation of less effective programs, as was the case in Ginkongoro.

In terms of impartiality, the ICRC stood by its principle, but this decision has been seen as very controversial and cause for ethical dilemmas. Impartiality implies that the ICRC provided aid to all people based on need and without consideration for any other factor. This means that aid was provided to the victims as well as the perpetrators. While this would be less cause for concern if the conflict had come to an end and perpetrators had disarmed and demobilized, this was not the case. Rather, the camps, particularly those in Zaire, were being used by the génocidaires to regroup to carry out additional attacks. As a result, the ICRC’s interpretation of impartiality may have resulted in the organization becoming unintentionally implicated in further violence. While this paper does not intend to argue that impartiality is never an acceptable principle by which to abide, it does argue that there are cases, such as the Great Lakes crisis, in which impartiality can do more harm than good. Moving forward, rather

\[105\] Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, 5

\[106\] Ignatieff, *The Warrior’s Honor*, 124
than always abiding by the principle of impartiality, the ICRC should instead consider the conditions under which it is operating to ensure that its aid is not indirectly causing harm rather than good.

The final principle that requires examination is neutrality. The ICRC maintained neutrality throughout the majority of the crisis, working through established institutional channels to inform state and international actors of the problems it saw during its aid provision. The ICRC has a large amount of experience working within institutions so it can be assumed that the organization made the best possible use of these institutional channels, but sometimes institutional channels result in dead ends; this was the case in the Great Lakes crisis.

Governments in the region were either biased toward one side in the conflict or were in turmoil themselves, and as a result, they were not in the position to take action. The international community was not responsive to calls to action, a fact that can partially be attributed to the nature of the international community and its reliance on individual governments to act. When regional governments and the international community fail to act, humanitarianism can accomplish little. Neutrality does have its benefits, and these benefits came through in the Great Lakes crisis by giving the ICRC access where other groups were restricted or denied. The ICRC made a limited number of statements showing its concern with the situation in the region. For instance, in an August 1995 press release, the ICRC stated its concern with the situation in Zairian refugee camps. While the press release notes some of the issues in the camps, such as forced repatriation, it ignored many others and lacked a call to action to address any of the problems and failed to cause outrage among the public to push official actors to make changes.¹⁰⁷

In order to maintain neutrality, the ICRC failed to make public statements during the genocide.

that would have placed the blame on either side, refraining even from the use of the term “genocide” which would have signified that one party was to blame from the beginning.

The idea of how humanitarian aid organizations should approach neutrality is a contentious issue, but the problems with neutrality very much came to the surface with the ICRC’s actions in the Great Lakes crisis. In light of the major shortcomings of a strictly neutral approach, it is necessary that the ICRC rethink this principle and adapt it for future conflict situations. Governments are still central actors in all conflicts, but with the growing prevalence of CHEs there are more and more nongovernmental actors playing central roles. As a result, I argue that the ICRC needs to adjust its neutrality to fit the CHE context, which likely means a loosening of its interpretation of the principle. Since the Great Lakes crisis, the ICRC has in fact made this adjustment and, while continuing to embrace neutrality, has eased its interpretation.108

While this chapter has pointed out many of the shortcomings of the ICRC’s work, it does not delegitimize the role the ICRC played in the crisis. The ICRC did very important work during the crisis, including rapidly beginning aid provision when others were unprepared and accessing a large population. The ICRC’s own reports and the Joint Evaluation of Emergency Assistance to Rwanda, however, show that the organization could have been much more effective. While the ICRC provided food to a large number of refugees and IDPs, for instance, the organization failed to distribute the food in the most equitable, economical manner resulting in high levels of wastage and the diversion of food aid from the refugees to the militants. By failing to put adequate weight on the political conditions in the camps, the ICRC fed and treated génocidaires who had not yet demobilized. Additionally, although the ICRC has not frequently been criticized for its unwillingness to collaborate, it did not collaborate frequently enough

108 Carbonnier, Gilles. Interview.
during the Great Lakes crisis, leading to less effective aid provision. The actions of the organization show that even organizations that have been working in the humanitarian field for as long as the ICRC can still improve, especially since all of the situations in which it works are different and require unique approaches. An examination of the ICRC’s work in the Great Lakes crisis leads me to believe that the ICRC’s basic principles are reasonable to keep in mind throughout all conflicts, but will need to be adjusted and loosened in order to make the its work more appropriate for new contexts.
Chapter 4: MSF – The Experts at Work

Five branches of MSF operated in the Great Lakes refugee crisis: France, Belgium, Holland, Spain, and Switzerland. MSF first began its work in Rwanda in 1991 and has since left the country, handing over its remaining programs to other organizations in 2007. Because of its presence in the country prior to the genocide, MSF, like the ICRC, was positioned to act quickly and take on a leading role in the humanitarian effort. Unlike the ICRC, MSF has a narrow mandate focused only on medical care and while the ICRC’s work was largely concentrated in Rwanda, MSF’s work was spread throughout the Great Lakes region. This section will examine the effectiveness of MSF in carrying out medical aid, both through direct care and supporting means, as well as how its principles came into play in their actions.

MSF’s role in direct medical care was a central facet of its approach to the Great Lakes crisis. During the genocide MSF provided a large amount of medical care, but also faced numerous challenges, particularly when it came to protecting aid workers and patients. Attacks in the Butare and Muganza IDP camps shortly after the start of the genocide in 1994 forced MSF to withdraw temporarily from Rwanda. MSF was able to return just a few days later by moving in through Uganda, Rwanda’s northern neighbor. Once MSF returned to Rwanda it provided care in existing hospitals and opened its own hospital in a former orphanage in Nyamata, as well as a health center in the Amahoro Stadium in Kigali, both staffed with the additional personnel sent after the conflict escalated.

While continuing to provide direct medical care within Rwanda, MSF placed a major focus on the refugee camps following the spread of the crisis from Rwanda to the surrounding countries. In a July 1995 report, MSF states that at that point it was running three field hospitals.

in Goma with the help of 2,100 national staff and 25 expatriates, eight health clinics and five
field hospitals in the Ngara, Karagawe and Biharamulo districts of Tanzania staffed by 41
expatriates, 130 local staff and 725 refugee volunteers, and four field hospitals and several small
health clinics throughout Burundi.110 While MSF worked in Burundi, Tanzania, and Zaire, it
had a particular focus on Zaire. Once the cholera outbreak began to run rampant in the Goma
camps, MSF played a central role in treating the disease and dispensing the necessary
medications. Once the cholera epidemic began to dwindle, dysentery broke out. A major
problem arose when it came to treating dysentery; a large portion of the refugee population was
resistant to the main treatment course of ampicillin, cotrimoxazole, and nalidixic acid. Many
organizations continued to rely on these antibiotics despite the problem of resistance because
they were the cheapest and most accessible treatment option. The MSF treatment center
provided ciprofloxacin to its patients as an alternative to the antibiotics and reported an 85.6%
rate of effectiveness in its patients.111 Another crucial step in treating dysentery is early
rehydration. In the Katale camp outside of Goma, MSF-Holland was the only organization to
successfully organize community rehydration teams before the end of July 1994.112 These two
actions by MSF were very important in dealing with the dysentery outbreak and although they
were limited in scope—ciprofloxacin was only given to 326 patients and the community
rehydration teams were limited to a single camp—they show that MSF was willing to take the
necessary steps to truly help the refugees rather than just going through the usual motions,

110Medécins Sans Frontières, "Deadlock in the Rwandan Refugee Crisis", 5
Caused by Type 1 Shigella Dysenteriae During an Epidemic in Rwandan Refugees in Goma in
Of the 326 patients treated 285 were effectively treated, 14 experienced positive results but did
not follow through with the entire treatment course, and 6 did not have successful results.
112Borton, John, Emery Brusset, and Alistair Hallam, The International Response to Conflict and
Genocide, Ch. 4
which, in this case, were not effective approaches. In addition to cholera and dysentery, measles was a major problem in the region. MSF participated in multiple vaccination campaigns against measles, one in Goma under the coordination of the UNCHR and another in the Rwanda IDP camps with assistance from Merlin.113

As refugees began to return from refugee camps to Rwanda, either by choice or by force, MSF provided care en route. On its timeline of events, MSF writes, “MSF assists Rwandan refugees forced out of camps in Zaire as they return home but is blocked by the Rwandan army and allied Congolese rebels from assisting many of those fleeing further into Zaire—people who fall victim to widespread massacres.”114 Many refugees were forced to repatriate involuntarily and the trip back to Rwanda could be long and hard and was taken on foot. The need for medical care on the route back from the camps was high and while the ICRC prepared for the return of large numbers of refugees returning in Rwanda, MSF helped them complete the journey. The role MSF played in this situation was critical, left uncovered by other aid groups, and coordinated very well with the ICRC’s actions.

MSF’s direct medical care efforts should be viewed as a success. Despite setbacks due to violence, which were experienced by all groups, MSF was able to provide care to a large number of refugees and IDPs and was willing to take different approaches when the most common practices were not showing signs of success. MSF is considered an expert when it comes to providing medical care in emergency situations and it showed why it has earned this distinction through its work in the Great Lakes refugee crisis.

113 Merlin is a UK-based international health organization that operates in emergency situations
Like the ICRC, MSF also provided for the mental health of refugees. Mental health care centers are noted as components of MSF’s work in all of the countries involved in the crisis. MSF did not get involved in mental health care until 1989, so it was still relatively new to the field during the Great Lakes crisis. The organization, however, realized the need for such work for people who had experienced the trauma of genocide. MSF does not usually directly carry out mental health counseling, but rather provides training and support to local counselors. With severe cases, MSF specialized clinicians would provide treatment.115 MSF continued its work in mental health care for a number of years after the crisis, expanding the program in 2003 when the Rwandan government released 40,000 people implicated in the genocide from prison.116

MSF played a much more minimal role in the area of food distribution, but nonetheless was involved. The importance of food aid to the health status of refugees and IDPs makes it very reasonable for MSF, a medical focused group, to be involved to some degree. The ICRC and WFP dominated food aid so MSF’s role was limited, but it did have strong opinions about this sector of aid provision. In a 1995 MSF Special Report, the organization presented its own analysis of food aid in the crisis. The report criticizes aid organizations and the donor countries that favored withholding food aid because of a shortage of food and as a means of encouraging repatriation. While MSF did not generally support withholding food aid, it did have qualms about the aid community providing food aid to génocidaires. The Special Report states, “MSF also believes it is very serious that the international community still feeds soldiers and militia

who are alleged to have been implicated in the genocide.” 117 Such claims show MSF’s concern with this sector as well as its willingness to comment when it disagreed with the actions of other groups.

MSF’s biggest contribution to food aid was its implementation of supplementary feeding programs. These programs aimed to address moderate malnutrition in children and protect them in case a shortage of food aid should occur. Programs were implemented rapidly even though the nutritional status of refugees coming into the camps was considered relatively good. MSF’s reason for implementing such programs early on was due to lessons from its experience with Burundian refugees in Tanzania in 1993. In this instance there was a delay in the food supply that led to increased rates of malnutrition. 118 MSF succeeded in implementing a supplementary feeding program in Ngara, but failed to get the program established in Goma where there was a lack of agreement on the program among the NGOs that would be involved in the program’s implementation. Many NGOs did not support the idea of a supplementary feeding program for all children under five, believing it was unnecessary. It is possible, then, that MSF’s work in this area was an unnecessary use of resources; however, its reason for implementing such a program is proactive rather than reactive and based on recent experience in the same region. Preventive measures are often neglected in favor of reactive measures due to the nature of emergency work. But by taking preventive measures, MSF helped avoid the need to address a major malnutrition problem later in the emergency.

117 Medécins Sans Frontières, "Deadlock in the Rwandan Refugee Crisis: Repatriation Virtually at a Standstill", 7
MSF focused more of its attention on the water and sanitation sector. MSF was one of the main organizations to fill the gap left in this sector when other groups chose to focus on higher profile activities. MSF branches carried out water and sanitation work in each of the countries in the region where it had a presence. In Goma, for instance, MSF-Belgium was critical in the transportation of water to the Kibumba camp, a camp completely dependent on tankered water. MSF-Belgium initiated tankering operations, later receiving assistance from UNICEF and the French military, but lacked additional support until a month after the influx. Additionally, when MSF-Belgium took over the management of tankering, the efficiency of the project increased, showing MSF’s expertise and skill.\footnote{Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, 71-72}

This paper previously noted the terrain of the Great Lakes region as a challenge for aid organizations. The terrain was a particular challenge for organizations working in the sanitation sector. For example, digging latrines was not a viable option initially because it required digging through volcanic rock and there was no heavy machinery available to assist in this work. MSF was not the only organization working in water and sanitation to struggle with the terrain, but MSF was one of only seven organizations in Goma working in sanitation and one of four in Ngara. Despite these obstacles, MSF-France succeeded in introducing an effective defecation scheme in the Kibumba camp within a month of the influx.\footnote{Ibid., ch. 4} MSF-France’s scheme served as a model for others and was necessary to compensate for the lack of latrines.

MSF’s work in water and sanitation was generally a success. It was critical that the organization, with its skill and experience, get involved in this sector because of the shortage of groups willing to undertake the work and the lack of aid workers qualified to undertake such
work. There is very little evidence of shortcomings in MSF’s approach in this sector either in MSF’s own reports or in the Joint Evaluation of Emergency Assistance to Rwanda’s report, although, water and sanitation was a challenge throughout the crisis simply due to shortages of resources in terms of physical and human capital.

Another area in which MSF was one of a very limited number of organizations working was data collection. MSF has an epidemiological data collection satellite called Epicentre that was founded in 1988. Data collection was largely lacking during the crisis, but Epicentre was central in the minimal amount that occurred. Epicentre attempted to collect data on refugees in Goma, but noted many obstacles, such as violence in the camps and a very large population, that inhibited its work.\textsuperscript{121} Due to these obstacles, much of the information gathered by Epicentre has shortcomings. Some of these shortcomings should not be attributed only to Epicentre and MSF, but rather to the failure of aid organizations as a whole to guarantee proper registration procedures within the camps that would have allowed for better estimates of population sizes. MSF and Epicentre should be held accountable, however, for some of the shortcomings in their data collection. These groups were filling a gap in humanitarian aid, but this does not mean that their work should be of any less quality than if they were competing with other groups. For example, the Joint Evaluation of Emergency Assistance Rwanda notes that between the months of July and September the only epidemiological data collected in the IDP camps in Rwanda was in camps where Epicentre and MSF had a presence, but calls the data “very patchy and of variable quality,” which should not have happened considering the large amount of resources

allocated to the crisis.\textsuperscript{122} One area in which MSF’s data collection was accurate and helpful was its data collection on drug resistance for shigella dysenteriae type 1, the strain of dysentery that spread throughout the camps. It has already been noted that MSF was one of the few groups to use a treatment regimen other than the typical antibiotic treatment to address the dysentery outbreak in the camps. The main reason for this is that MSF, in conjunction with the Mgwanza hospital, conducted resistance surveys in July showing complete, high, and moderate resistance to the three main antibiotics being used.\textsuperscript{123} MSF was then able to use this information to try a new treatment. Despite the fact that MSF was able to try a new approach, its data unfortunately did not have a widespread impact as most other aid groups continued to use the old treatment in spite of its decreased effectiveness.

The overall quality of data coming from the Great Lakes refugee crisis was low and the same is true of MSF’s data. Having accurate data is necessary to ensure adequate resources are provided and that these resources are directed to the areas with the greatest need. MSF’s work in the data collection sector attempted to take on this role, but did not achieve the results necessary to have the desired impact.

Now that the actions, both direct and supporting, that MSF took in protecting refugee and IDP health have been examined, the way in which its actions fit into the three main principles, independence, impartiality, and neutrality, will be examined. The first principle that will be analyzed is independence. While previously noted that MSF is sometimes too independent, leading to less effective results, the organization showed its willingness to cooperate with other organizations during the Great Lakes crisis. Like the ICRC, MSF worked in some areas in which

\textsuperscript{122} Borton, John, Emery Brusset, and Alistair Hallam, \textit{The International Response to Conflict and Genocide}, 68

\textsuperscript{123} Borton, John, Emery Brusset, and Alistair Hallam, \textit{The International Response to Conflict and Genocide}, Ch. 4
other organizations were not working. Such work is an example of how independence can be beneficial. MSF, however, also worked in the Goma camps that were overwhelmed with aid organizations. Such situations required MSF to take a more collaborative approach. MSF worked with Merlin to carry out successful vaccination campaigns, collaborated with the ICRC to provide care within Rwanda when MSF was unable to work under its own emblem, and collaborated with CARE and the International Rescue Committee to organize sanitation schemes in the Ngara camps. All of these actions helped MSF to provide more for the refugees as well as to create better results. Collaboration was a problem with the humanitarian response to the crisis, and MSF did not always collaborate to improve the results of its aid efforts, but it did show a greater willingness to collaborate in the Great Lakes crisis than it has in other instances.

The next principle, impartiality, caused major moral dilemmas for MSF just as it had done for the ICRC. Strictly following impartiality would mean that MSF would have treated all of those in need regardless of their role in the conflict. MSF, however, made statements that showed its struggle with whether or not to provide care for the génocidaires in the refugee camps, particularly because they had not demobilized and were reorganizing to continue the fight from within the camps. As noted in the analysis of food aid, MSF made statements about its disagreement with the approach of other aid groups that continued to provide food to the génocidaires. While impartiality is an important principle for humanitarian aid generally, it was problematic in the case of the Great Lakes crisis. I argue that impartiality should only be a guarantee when the perpetrators of violence have demobilized and are therefore no longer involved in harming others. In the Great Lakes crisis this was not the case, and providing aid to the génocidaires was, in effect, enabling them to continue fighting and killing. Discrimination was an appropriate policy in this case—even though it likely would have meant more
génocidaires did not survive—because it also would have helped to limit further violence and even more deaths.

Of the three main principles, neutrality was the most controversial for MSF during the Great Lakes crisis. MSF did not maintain a strictly neutral position during the crisis, choosing instead to apply an outspoken approach to the situation. In fact, in response to the Rwandan genocide, for the first time in MSF’s history, the organization called for military action to be taken.124 Additionally, on November 3, 1994, along with 15 other NGOs, MSF composed a statement to the UNHCR calling on the international community to improve safety within the camps, including having UN troops to patrol the camps.125 Each organization involved wanted to protect its own workers, but also feared becoming accomplices in further acts of violence.126 While this statement did not have the desired impact, it did show MSF’s willingness to move away from neutrality in this controversial and complicated situation. MSF continued to speak out about what it saw in the camps and eventually all of the branches pulled out of the camps. Four days after the publication of the joint statement, MSF-France withdrew from the camps in Zaire and Tanzania, the first of the MSF branches to do so, noting specifically the “continued diversion of humanitarian aid by the same leaders who orchestrated the genocide, the lack of effective international action regarding impunity, [and] the fact that the refugee population was being held hostage.”127 While withdrawing as a political statement may seem contrary to humanitarian principles, it is important to note certain facts. First, MSF-France did not withdraw

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124 Médecins Sans Frontières, "History and Principles."
125 The NGOs that signed this letter include: MSF-Belgium, MSF-France, MSF-Holland, CARE (Canada, International Coordinator for Zaire, Britain, USA, Norway, and Austria), International Rescue Committee, American Refugee Committee, Farmacenticos sin Fronteras, Centre Canadien d’Etude et de Coopération Internationale, Oxfam, and Médecins du Monde
127 Medécins Sans Frontières, "Deadlock in the Rwandan Refugee Crisis"
until after the health situation within the camps had stabilized and the mortality and morbidity rates had dropped significantly. The organization was not withdrawing at the height of the cholera and dysentery epidemics when their care was desperately needed, but after the situations had stabilized. Secondly, MSF-France was not the only organization to take such actions. Eventually all of the MSF branches withdrew as did another well-respected organization, CARE. This decision by CARE shows that MSF was not alone in its feelings about the situation within the camps. Acting in a non-neutral way did not significantly harm MSF’s ability to provide aid in the Great Lakes crisis, contradicting the main argument in favor of neutrality, but its actions also failed to have exactly the result for which the organization was hoping. Eventually camp security improved slightly, but humanitarian aid was still diverted. In fact, the perpetrators of the genocide were able to regroup and carry out attacks on the new Rwandan government as well as spark the First Congo War that began a period of instability and violence in Zaire, the present day Democratic Republic of the Congo, that continues even today. In the case of the Great Lakes crisis, MSF made the right decision by taking a non-neutral stance.

This chapter has noted areas in which MSF performed particularly well and areas in which MSF’s actions produced a less-than-adequate result. MSF was very successful in producing positive results in areas in which other organizations neglected to work such as water and sanitation. The medical care provided by MSF was also largely a success. Data collection, on the other hand, was not as effective. The overall quality of MSF’s data was poor, and when MSF had accurate data, it did not successfully disperse this data to other organizations. When it comes to principles, MSF took a different approach to independence, impartiality, and neutrality than did the ICRC, a decision that was very appropriate for the situation in which it was

128 Borton, John, Emery Brusset, and Alistair Hallam, *The International Response to Conflict and Genocide*, Ch. 2
operating. The decisions made by MSF regarding these principles are not necessarily applicable to all CHEs, but in the Great Lakes Crisis, they enhanced the organization’s effectiveness largely by preventing the organization from becoming an accomplice in further violence. This analysis of MSF supports my argument that, despite a more appropriate interpretation of the basic principles for the situation, MSF still had some shortcomings to address; however, MSF was able to provide a large amount of effective aid with many fewer unintended consequences than was the ICRC.
**Conclusion: Lessons Learned and the Future of Medical Humanitarianism**

This paper intended to analyze the effectiveness of the medical humanitarian aid carried out by the ICRC and MSF during the Great Lakes refugee crisis. Each organization undertook projects in a variety of categories that supported the health of refugees and IDPs either directly or indirectly. The categories examined in the analysis include the direct provision of medical care, food aid distribution, water and sanitation, and data collection. Additionally, this paper examined the ways in which the aid actions of each group operationalized the basic principles of independence, impartiality, and neutrality. While this paper is unable to unequivocally claim that one organization was effective while the other was not, it was able to uncover the successes and shortcomings of each organization in their respective aid efforts. Such successes and shortcomings were determined by an examination of secondary sources and primary documents from each of the organizations. This analysis of the ICRC’s and MSF’s work during the Great Lakes refugee crisis is not only important in better understanding the crisis, but has broader implications for understanding and improving the humanitarian aid community as a whole.

When asked how humanitarian aid organizations measure their own effectiveness, Gilles Carbonnier noted that about fifteen years ago, the aid community switched from focusing on outputs to outcomes. Measuring effectiveness by outputs was ineffective because it weighed quantity over the quality and impact of the aid. I asked what led to this change fifteen years ago and was given two specific reasons. The first reason was that aid organizations have increasingly become involved in chronic emergencies, leading them to remain in countries for longer periods of time and frequently overlapping with development organizations. About fifteen years ago, the development industry moved from an outputs to outcomes system of
evaluation and this influenced humanitarian organizations to go the same way. The second reason is more applicable to this paper: aid organizations collectively viewed Rwanda and the Great Lakes refugee crisis as a trauma for humanitarianism, leading to a push for greater accountability and a shift towards impact evaluation rather than simply the quantity of goods and services put into the aid effort. The change from evaluation systems based on outputs to outcomes is a significant result of the Great Lakes crisis and shows that the aid community has learned from this event.

Along with individual aid organizations changing their approaches, the Great Lakes refugee crisis spurred major adjustments by the aid community as a whole. In 1999, MSF received the Nobel Peace Prize “in recognition of its pioneering humanitarian work on several continents.” Dr. James Orbinski delivered the Nobel lecture in which he stated, “But we act not in a vacuum, and we speak not into the wind, but with a clear intent to assist, to provoke change, or to reveal injustice. Our action and our voice is an act of indignation, a refusal to accept an active or passive assault on the other.” This lecture included a number of references to the Great Lakes crisis. The awarding of such a prestigious prize to MSF so close to the end of the crisis showed that the international community respected MSF’s work and their approach to aid provision. In discussing the reasoning behind its decision, the Nobel Committee noted not only the importance of MSF’s willingness to work in all types of situations, but also its attempts to draw attention to major issues driving the crises where it is working. The Nobel Committee noted that MSF’s work “helps to form bodies of public opinion opposed to violations and abuses

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129 Carbonnier, Gilles. Interview.
of power."\textsuperscript{132} This major international recognition shows that MSF’s actions have gained respect on the international stage and that the decision to withdraw during the Great Lakes crisis did not cause the organization to lose support or legitimacy. In fact, aid organizations have adapted their views on speaking out. According to Carbonnier, the ICRC has begun to speak out and communicate significantly more than in the past.\textsuperscript{133} This move toward greater communication has been further facilitated by the creation of a set of very clear guidelines for when the organization will and will not speak out.\textsuperscript{134} The awarding of the Nobel Peace prize to MSF and the change in the ICRC to allow for speaking out shows a recognition that, as Redfield notes, humanitarianism is a political process and that cannot be adequately undertaken through a strictly neutral approach.

In addition to MSF receiving the Nobel Peace Prize following the Great Lakes crisis, the international community began moving in a direction that would institutionalize guidelines for humanitarian aid organizations as well as increase accountability for their actions. Moving toward greater institutionalization and accountability was a necessary move following the Great Lakes crisis, in which many organizations did not act responsibly and were not held accountable for any harm they may have caused as a result. The major project toward greater accountability in the aftermath of the Great Lakes crisis was the Sphere Project. The Sphere handbook was first published in January 2000 and contains the Humanitarian Charter and Minimum Standards in Humanitarian Response. The Humanitarian Charter provides the background for the Minimum Standards by noting the legal precepts that serve as the backbone for the beliefs and principles

\textsuperscript{133} Carbonnier, Gilles. Interview.
\textsuperscript{134} Ibid.
discussed in the Standards. In addition to a legal framework, the Charter also presents a moral and ethical framework based on the idea of a common humanity between all of mankind. The moral and ethical aspects of the Charter are based on the idea of humanitarian imperative, “that action should be taken to prevent or alleviate human suffering arising out of disaster or conflict, and that nothing should override this principle.” Prior to the Humanitarian Charter, however, aid organizations understood the principle of humanitarian imperative, and what they really lacked was a structure to hold them accountable for the actions they took in order to achieve the goal of alleviating human suffering. The Charter begins to address this issue in the section entitled “Common Principles, Rights, and Duties.” This section presents three rights that all people in need of humanitarian assistance maintain at all times: the right to life with dignity, the right to receive humanitarian assistance, and the right to protection and security. Each of these core rights was not fully respected during the Great Lakes crisis not only due to the shortcomings of humanitarian organizations, but also due to the failure of political actors. While the Humanitarian Charter may help to guarantee that humanitarian actors continue to respect these three principles, it can do little to influence political actors and will likely not have any more impact than does international humanitarian law on political actors who do not wish to follow the rules.

After the Humanitarian Charter, the Sphere Handbook presents the Minimum Standards. The Minimum Standards are broken up into six core standards: people-centered humanitarian response, coordination and collaboration, assessment, design and response, performance transparency and learning, and aid worker performance. Each of these core standards is then

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136 Ibid., 21
divided up into key actions, key indicators, and guidance notes that indicate how to implement the standard and subsequently measure the effectiveness of the organization in meeting the standard. The Sphere Standards are an interesting attempt by the aid community to address many of the problems that plagued its efforts during the Great Lakes crisis. The Sphere Project attempts to increase institutionalization among aid organizations and has garnered a large amount of support, most notably from MSF and the ICRC. In fact, the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGOs) in Disaster Relief, which was created in 1994 during the Great Lakes crisis, served as a basis for the Sphere Minimum Standards.  

Additionally, MSF was one of the initial sponsors of the Sphere project. MSF fully participated in the first phase of the project—there were three total phases—but ended its participation and support before the second and third phases. MSF, along with a number of other French NGOs, expressed their concerns with the Sphere Protocols in what became known as the French letter. One of MSF’s major concerns with Sphere was that it would lead to a loss of independence from funders. In a report published by MSF-UK it is noted that, “By insisting on adherence to the technical standards as a prerequisite for funding, it would provide a mechanism through which donors could exert control over aid agencies.”  

Independence is a critical principle for MSF’s identity, so it is not surprising that the potential to lose a degree of independence would lead MSF to turn away from Sphere. MSF also noted additional concerns such as the standards being used as an excuse for inaction if the context meant they could not be met, or for aid organizations to be coopted by governments—which tend to be the largest donors

137 Ibid., 366
to aid organizations— for their own intentions. While MSF saw the need for minimum standards following the Great Lakes crisis, the organization was unwilling to compromise its principles or add additional problems when the standards were meant to eliminate problems.

Sphere has continued despite the withdrawal of some organizations like MSF and some of the criticisms from the French letter have been taken into consideration to make the Sphere Project stronger. While it may not be a perfect plan, the Sphere Project is one of the ways in which the humanitarian aid community has made changes for the better as a result of understanding its shortcomings in the Great Lakes refugee crisis. The combination of a move toward speaking out against human rights abuses, though doing so with caution, and creating greater accountability for aid organizations is an important move in the right direction for the aid community.

While the efforts by the aid community to fix its internal problems are necessary and critical to increasing the effectiveness of aid provision, not only by the ICRC and MSF, but also by all other humanitarian organizations, they cannot address every problem. The major issue that has not been addressed through increased témoignage and institutionalized accountability is the fact that humanitarian aid is just a single part of the international community. Humanitarian aid has the ability to save lives by providing food, medical care, shelter, and other necessities to people in need due to natural or political disasters, but it is limited. The aid community does not have the ability to end civil wars, for example. In order to carry out its work, humanitarian organizations are reliant on more powerful actors. Individual states have the ability to expel humanitarian organizations or restrict their abilities to carry out their work and many governments have done so in the past. Additionally, when governments are noncompliant or lack control over all of their territory, as was the case in Rwanda, Burundi, and Zaire, then
humanitarian aid organizations become reliant on the international community. Additionally, more powerful states, like the United States, have the ability to put pressure on less powerful states to change their policies and put an end to the root cause that has necessitated aid provision. No matter what actions the humanitarian aid community makes to improve its effectiveness, aid provision will only ever be as effective as political actors permit it to be. This is not to say that there is no hope for humanitarian aid; it is just to say that humanitarian aid must do everything it can to be as effective possible within its sphere of responsibility. Humanitarian actors have minimal control over major political actors and as a result need to take actions like establishing the Sphere Protocols and speaking out in a responsible way to guarantee that they are having the most significant positive impact possible in spite of the challenges presented by other actors.

Both the ICRC and MSF provided critical services during the Great Lakes refugee crisis, but the crisis revealed a number of shortcomings. The aid community has made notable attempts to address these shortcomings in the aftermath of the Great Lakes crisis, showing recognition of the inadequacies and a need for adjustments. Because CHEs are not all the same and crises change over time, the aid community cannot rest yet. In order to provide effective humanitarian aid that has the largest possible positive impact with the smallest possible number of unintended consequences, the aid community will need to continuously evaluate its work. Evaluations will reveal failures and successes and likely lead to the need for adjustments in guidelines such as the Minimum Standards, but this is not problematic as long as aid organizations continue to show a willingness to evolve and address problems as they arise, just as they did in the aftermath of the Great Lakes refugee crisis.
Appendix
Appendix A

MSF Charter and Principles:

Charter
Médecins Sans Frontières is a private, international association. The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims. All of its members agree to honour the following principles:

Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed or political convictions.

Médecins Sans Frontières observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and claims full and unhindered freedom in the exercise of its functions.

Members undertake to respect their professional code of ethics and maintain complete independence from all political, economic or religious powers. As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them.

Our Principles:
MSF’s actions are guided by medical ethics and the principles of independence and impartiality.

Medical ethics
MSF’s actions are first and foremost medical. We carry out our work with respect for the rules of medical ethics, in particular the duty to provide care without causing harm to individuals or groups. We respect patients’ autonomy, patient confidentiality and their right to informed consent. We treat our patients with dignity, and with respect for their cultural and religious beliefs. In accordance with these principles, MSF endeavours to provide high-quality medical care to all patients.

Independence
Our decision to offer assistance in any country or crisis is based on an independent assessment of people’s needs. We strive to ensure that we have the power to freely evaluate medical needs, to access populations without restriction and to directly control the aid we provide. Our independence is facilitated by our policy to allow only a marginal portion of our funds to come from governments and intergovernmental organisations.

Impartiality and neutrality
MSF offers assistance to people based on need and irrespective of race, religion, gender or political affiliation. We give priority to those in the most serious and immediate danger. Our
decisions are not based on political, economic or religious interests. MSF does not take sides or intervene according to the demands of governments or warring parties.

**Bearing witness**
The principles of impartiality and neutrality are not synonymous with silence. When MSF witnesses extreme acts of violence against individuals or groups, the organisation may speak out publicly. We may seek to bring attention to extreme need and unacceptable suffering when access to lifesaving medical care is hindered, when medical facilities come under threat, when crises are neglected, or when the provision of aid is inadequate or abused.

**Accountability**
MSF is committed to regularly evaluating the effects of its activities. We assume the responsibility of accounting for our actions to our patients and donors.
Appendix B

ICRC Mission and Fundamental Principles:
The ICRC's Mission Statement

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance.

The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles.

Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.

Fundamental Principles:

The Fundamental Principles were proclaimed by the 20th International Conference of the Red Cross, Vienna, 1965. This is the revised text contained in the Statutes of the International Red Cross and Red Crescent Movement, adopted by the 25th International Conference of the Red Cross, Geneva, 1986.

**Humanity**
The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

**Impartiality**
It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

**Neutrality**
In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

**Independence**
The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.
**Voluntary service**
It is a voluntary relief movement not prompted in any manner by desire for gain.

**Unity**
There can be only one Red Cross or one Red Crescent Society in anyone country. It must be open to all. It must carry on its humanitarian work throughout its territory.

**Universality**
The International Red Cross and Red Crescent Movement, in which all Societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.
Appendix C

Aid Allocation by Country and Agency:

Figure 2
Allocation of aid by country during 1994 (in percentage)

- Unspecified - 11.20%
- Burundi - 12.91%
- Zaire - 24.11%
- Rwanda - 35.33%
- Uganda - 1.08%
- Tanzania - 15.37%

Source: Data base compiled by Study III using the DHA Financial Tracking System as its base.

Figure 3
Breakdown of allocation by agency/type of agency during 1994

- Other civil defence (5.77%)
  US$74.2m
- Military humanitarian (10.32%)
  US$132.7m
- UNCHR (23.86%)
  US$306.7m
- WFP (17.59%)
  US$226.1m
- NGOs (19.18%)
  US$246.5m
- UNICEF (4.59%)
  US$59.1m
- Other UN agencies (2.49%)
  US$32.0m
- Red Cross movement (16.20%)
  US$208.2m

Source: Data base compiled by Study III using the DHA Financial Tracking System as its base.
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