



Ensuring Public Health Neutrality

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In June 1968, a clearly marked Swedish Red Cross plane flying relief supplies into the breakaway state of Biafra was shot down by Nigerian fighters.¹ Before the war was over, many relief planes would

be shot down and far more would crash because the Nigerian government's shoot-to-kill order forced them to fly at night. The brazen targeting of Red Cross relief flights on civilian humanitarian missions was hard to imagine. In the minds of some people, however, these attacks were justified by another clear violation of humanitarian neutrality: on at least one occasion, a plane painted with the Red Cross insignia was actually carrying weapons.^{2,3} That rare instance of military action masquerading as humanitarian relief completely undermined the neutrality of everyone who operated by the accepted rules of humanitarian assistance, cost the lives of both aid workers and aid

recipients, and provided a blanket of impunity for the future criminal actions of the Nigerian government.

To underscore the necessity of humanitarian neutrality, 12 deans from prominent U.S. schools of public health sent a letter to President Barack Obama on January 6, 2013, protesting the conduct of a sham vaccination campaign as part of the hunt for Osama bin Laden.⁴ In the lead-up to the May 1, 2011, targeting of Osama bin Laden in Abbottabad, Pakistan, the Central Intelligence Agency (CIA) reportedly hired a Pakistani surgeon named Shakil Afridi to go house to house vaccinating children but also drawing back a little blood in the syringe in or-

der to analyze the DNA of the household members. The ploy appears not to have worked in the bin Laden compound, since Afridi's team was kicked out. Nonetheless, in a *60 Minutes* interview last June, Defense Secretary Leon Panetta said that Afridi was helpful in finding bin Laden.⁵ In May 2012, Afridi was convicted of treason and sentenced to 33 years in prison.

Because of these events, Pakistan expelled the foreign staff of the international aid agency Save the Children from the country in September 2012 — a move that threatened the network of health and development services that the organization had established over the past 30 years. In December, eight polio vaccination workers were killed in an apparently coordinated set of attacks (see photo), and the United Nations has suspended its polio-eradication efforts in Pakistan, where 150,000



Protests after the Killing of Vaccination Workers in Pakistan.

children die of vaccine-preventable illnesses each year. After decades of a global campaign funded largely by the U.S. government and recently by the Bill and Melinda Gates Foundation, polio has been eradicated from all but three countries: Afghanistan, Nigeria, and Pakistan. It has taken many years and hundreds of millions of dollars to bring us to the brink of global eradication of polio, an achievement that appears to have been made much more difficult by the CIA's actions.

The deans of the schools of public health asked the President to commit the United States to refraining from disguising military or intelligence actions as public health activities. Defending the interests of global public health workers, they wrote, "International public health work builds peace and is one of the most constructive means by which our past, present, and future public health students can pursue a life of fulfillment and service. Please do not allow that outlet of common good to be

closed to them because of political and/or security interests that ignore the type of unintended negative public health impacts we are witnessing in Pakistan."

For physicians who have taken the Hippocratic Oath, the wisdom of the 2000-year-old pledge is evident: "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice." For those of us who work in politically unstable settings where armed conflicts are under way, the pledge of humanitarian neutrality is equally essential. This pledge is codified in the Geneva Conventions, which are also U.S. law, and the Red Cross Code of Conduct under which the United Nations and major aid agencies operate. This code of conduct provides operating parameters within which United Nations and nongovernmental organizations engage communities in crisis. The codified principles of humanity, impartiality, and independence require that all people be treated humanely in all circumstances and that the international community provide

humanitarian assistance for those in need; that the provision of services be based not on nationality, race, religion, or political point of view, but on need alone; and that aid organizations implement their interventions independently, without the influence of national political agendas. Whereas the articles of the Geneva Conventions compel governments to abide by international humanitarian law, the code of conduct compels the civilian aid community to protect recipients from exploitation and to serve without bias.

This code, which virtually all major U.S. nongovernmental organizations have pledged to adhere to, serves as a barometer for appropriate interventions; it also, at least ideally, assures the access and safety of aid workers in conflict situations. Today, in virtually all crises, lifesaving aid in the form of water, food, and medicine is provided by unarmed people protected by the image that they are humanitarians first and foremost, working for the health of people in need. The fact that their protection is the trust and common purpose of the communities in which they work enables public health campaigns to transcend nationalism, race, and ethnicity. It also permits public health endeavors to save millions of lives every year.

Although some U.S. policy-makers consider immediate national security concerns a higher priority than long-term global health efforts, the CIA's false vaccination campaign in Pakistan may cause collateral damage with profound long-term implications for national security. If every aid worker with a syringe is suspected of being a spy, the children, families, and communities of the

world will no longer have protection against our greatest killers. Ultimately, if the neutrality of public health efforts is undermined, the world will become a more violent and unhealthy place.

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Security of Health Care and Global Health

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My introduction to “global health” was rude. In the late 1980s and early 1990s, I worked as a surgeon in field hospitals of the International Committee of the Red Cross (ICRC). I treated hundreds of wounded people in eight different countries in Africa and Asia, where I visited many local health care facilities, the majority of which were hopelessly understaffed or undersupplied because of armed conflicts. Our surgical actions were just one part of a wide array of health care activities, and the ICRC is only one of many organizations attempting to support or deliver health care in contexts of violence. The security of facilities, patients, and staff was an everyday working consideration, and the problems we faced were common to all health care providers. Certain roads could not be traveled, ambulances were attacked, supplies were looted, staff and patients were subject to a variety of threats, and worst of all, patients and my colleagues were sometimes targeted directly and kidnapped or killed. Often such violence or wide-

spread insecurity resulted in the termination of health care programs, which left entire already-vulnerable populations without health care.

Among all the constraints facing health care delivery in such settings, the most difficult one to address is a lack of security.¹ One of our head nurses put it quite simply: “We can't do anything without security.” In the bigger picture, the success or failure of our efforts to provide health care rested less on impeccable program planning and execution than in the hands of the people who were responsible for our security (or lack thereof), and it became clear to me that the relationships among security, insecurity, health, and health care are extremely complex. Moreover, armed conflict generates immediate and additional health care requirements for wounded and sick people that exceed peacetime needs. Hospitals may fill rapidly with wounded people, both military and civilian, and the additional health care requirements arise at precisely the time when the ac-

companying insecurity makes it most difficult to address them. Even providing prehospital care for the wounded, including first aid and transport by ambulance, becomes dangerous, since health care personnel, ambulances, and health care facilities may be open to attack.

The uprisings in North Africa and the Middle East in the past 2 years have taken place largely in urban environments, where the preexisting facilities on which wounded people — whether civilian, police, or military — would normally depend for health care suffer a range of security problems, in part because these facilities and the people who staff them become integrated into the events. Ambulances may be attacked, and their staff harassed, because of the patients they are carrying. Health care providers may be prevented from treating members of one side of the dispute or the other. Hospitals may be seen as a place where enemies or “terrorists” can be arrested, interrogated, or even killed. Again, insecurity may be the factor de-