Assistance, protection, and governance networks in complex emergencies

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This article presents an introduction to the causes and characteristics of armed conflicts. It reviews some of the key humanitarian crises that broke new ground in terms of the technologies and practices that developed at the field level in response to each new complex emergency, with particular focus on the health sector. It introduces the concept of humanitarian governance as a framework for addressing the consequences and implications of the failure of worldwide governance for the protection of civilians in armed conflict. Here, we term humanitarian governance to include the use of international humanitarian law and human rights instruments to govern the behaviour of state and non-state organisations in conflict zones in a way that protects the lives and livelihoods of affected populations. We note, however, that terrorist concerns appear to be replacing humanitarian logic in the network of worldwide governance.

Efforts to understand famine, war, and natural disasters have prompted analyses of many prolonged and seemingly intractable crises. No longer referred to merely as civil wars, situations of chronic conflict and violent political instability have been called complex emergencies, chronic emergencies, and complex political emergencies.[1] The UN and other multilateral organisations are engaged in many, but not all (eg, Burma and Algeria), of these emergencies (panel).

Complex emergencies involve an intricate web of political, economic, military, and social forces engaged in violence. These emergencies frequently occur in conjunction with and are compounded by public health threats,[2,3] natural disasters (eg, droughts in Afghanistan, Ethiopia, and southern Africa),[4,5] environmental issues (eg, global warming and desertification),[6,7] and sociopolitical processes (eg, globalisation and marginalisation). The term emerging political complexes has been used to describe the systems underlying both the violence and durability of complex emergencies.[8] This term describes the new forms of state or non-state networks that create alternative systems of profit, power, and protection, use systems of globalised trade to obtain the necessary inputs via shadow and parallel economies, and provide defence and administrative functions with little bureaucracy. Emerging political complexes are based on systems of inequality and exploitation and can be thought of as remarkably violent but rational responses to globalisation.[8]

Emerging political complexes are highly evolved, and link local, national, regional, and international organisations.[9] These complexes form the foundations for war economies controlled by criminalised networks and fuelled by the illicit extraction of and trade in resources ranging from cattle to timber to sexual slaves.[10] Importantly, these illicit economies are closely linked to legitimate economies and thus are appropriately referred to as parallel or shadow economies. Oil from Angola's battlefields has ended up in American cars, while, for many years, Sierra Leone's diamonds found their way onto brides' fingers throughout the developed world. Involvement in these parallel economies is often central to the survival of many individuals and groups within conflict-affected societies, and provides people with access to livelihoods that they would otherwise be denied. In view of the strength and adaptability of these systems, whether these economies can be made less

Panel: UN list of complex humanitarian emergencies worldwide

Afghanistan
Angola
Balkans
Caucasus (Armenia, Azerbaijan, Georgia)
Central African Republic
Colombia
Republic of the Congo
North Korea
East Timor
Eritrea-Ethiopia border conflict
Ethiopia
Great Lakes (Burundi, Democratic Republic of Congo, Kenya, Rwanda, Tanzania, Uganda)
Haiti
Horn of Africa drought
Indonesia
Iraq
Occupied Palestinian Territory
Russian Federation—Chechnya
Sierra Leone
Somalia
Southern Africa humanitarian crisis
Sri Lanka
Sudan
Tajikistan
Uganda
West Africa

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reliant on exploitation and violence, or whether resources controlled by powerful elites can be instead used for the public good, including strengthening the provision of public health services, is questionable.

Violence, civilians, and complex emergencies

Violence in complex emergencies is targeted overwhelmingly at civilians, their livelihood systems, and social networks. Although much of the violence seems random and arbitrary, research by anthropologists, economists, social psychologists, and political scientists shows that violence can be both functional—ie, violence is useful for those controlling it, and specific—ie, violence can support economic, political, and social causes (table 1).[11–20] Attacks on civilians often lead to widespread impoverishment, but poverty is not the only source of vulnerability in complex emergencies. Powerlessness might be a more accurate concept than poverty to explain vulnerability.[10] Indeed, the wealth of some countries leads them into conflict. Countries with a high dependence upon primary commodity exports (eg, oil in Sudan, diamonds in Angola and Sierra Leone, and timber in Liberia) are more prone to civil wars than countries with more diversified economies.[21]

In complex emergencies, specific individuals or groups might be targeted because of their wealth, power, position, ethnicity, sex, education, or age.[11,22,23] Human rights violations and the destruction of economic and public institutions combine to create almost permanent states of insecurity in which the wealth and power of some people is generated at the cost of many people.[24] The durability of these systems of exploitation have led some observers to note that complex emergencies are characterised by the absence of distinctions between war, peace, and crime.[25] The consequences of conflict, war, and systems of organised and violent predation are determined by sex and have serious repercussions for different elements of the population. The participation of men, women, boys, and girls in these violent processes is varied, ranging from roles including outright victim to perpetrator with frequent blurring of identities. The changing nature of wars nowadays challenges traditional conceptions of the (feminised) innocent civilian (eg, women and children first or women as peacemakers), and the identifiable (masculine) military force (eg, the guys with the guns).[26,27]

Men, boys, women, and girls face new roles and responsibilities in response to the risks and vulnerabilities of war.[27] Radical changes in demographics result when men and boys are killed, migrate for wage labour, or are forced to flee or go into hiding by conscription and attacks. Providers and caregivers (most of whom are women) find that their workloads increase in an atmosphere of deteriorating government-managed public services—for example, health, education, transportation and communication, water and sanitation, etc.[28] Under the Taliban in Afghanistan, households managed clandestine schools for girls, while decades of civil war in southern Sudan has resulted in reduced access to publicly managed health services.

Evolution of humanitarian response to complex emergencies

A complex network of humanitarians is working to protect and serve populations affected by disasters, including complex emergencies. As these workers face a heightened risk of militarisation (as seen in interventions in Afghanistan and Iraq), their activities must be distinguished from the military, political, and economic groups that respond to complex emergencies.[22] A selection of major complex emergencies (even if they were not called that at the time) that occurred during the Cold War reveals that a series of key lessons and pitfalls was associated with each crisis (table 2). The response of humanitarian workers to complex emergencies has been thoroughly investigated by academics[1,29] and in the popular press.[30,31] These critiques reveal that complex emergencies present significant challenges to aid workers who should now more fully understand the political, military, and economic dimensions of modern crises.[8] During the

	Function/specificity	Example
Gender violence (castrating men, mutilating women's breasts, gang raping elderly women and young girls)	Attacks on women as attacks on the nationality/the mother nation; ethnic cleansing; emasculating male pride/strength	Rwanda, Former Yugoslavia, Mozambique, Sierra Leone
Assassination, car bombing	Attacks on humanitarians as attacks on US-led politico-military coalitions	Iraq, Afghanistan, Somalia
Massacres, mutilation, mass rape, genocide	Terrorise, weaken political opposition, depopulate, ethnic cleansing	Rwanda, Bosnia
Forced displacement, impoverishment, asset stripping	Economic benefit to raiders, disempower, weaken political opposition	Sudan, Angola, Sierra Leone, Liberia, Democratic Republic of Congo
Child soldiers, forcing children to kill	Terrorise, increase fighting forces, destabilise communities	Mozambique, Uganda, Sierra Leone, Sri Lanka
Rumour, random disappearances	Destroy social fabric of trust, undermine opposition	Argentina, Guatemala, Colombia
Trafficking, sexual slavery	Economic, terrorise communities	Former Soviet Union, Burma, Thailand, Democratic Republic of Congo, Sudan

Table 1: **Violence in complex humanitarian emergencies**

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	Select issues	Examples of inovations/lessons earned
Biafra 1966–70[32,33]	Internally displaced populations. Negotiating access with state and non-state organisations. Repatriation of unaccompanied children. Manipulation of starving populations for political and military aims. Visibility of the international media. Coordination of many NGOs and volunteers.	Management of massive caseloads of severe malnutrition (marasmus, kwashiorkor). Médecins Sans Frontières founded to incorporate human rights into relief work.
Cambodia 1975–79[34,35]	Genocide. Thai-Cambodia border refugee camps as political and military bases. Decimated health infrastructure. Widespread malnutrition, tuberculosis, diarrhoea, and malaria. Access denied for most of the crisis. Relief deliveries into Cambodia started in August, 1979, by UNICEF, International Committee of the Red Cross, and Oxfam with difficulties with upholding humanitarian principles and practices (eg, needing access for assessments before implementation of relief programmes, upholding standards of transparency and accountability).	NGO strategies for dealing with overtly political use of humanitarian assistance ranged from tolerating thefts and diversions to staging a march in protest. Médecins Sans Frontières expands advocacy efforts to include witnessing and the right to intervene. First refugee health guidelines developed.
Ethiopia 1984–85[1,36,37]	Large numbers of vulnerable populations in crowded displaced and refugee camps. Forcible relocation of populations. Humanitarian space as distinct from politics famously reiterated by US President Reagan who stated that a child knows no politics. Rebel organisations and NGOs clandestinely provided cross-border assistance from Sudan.	Beginnings of professional humanitarian best practices for public health (vaccinations against infectious diseases, clean water, adequate sanitation, proper management of malnutrition, including fortified rations). Foundations of analytical work on coping strategies, household food economies and livelihoods. NGOs began to consider humanitarian principles that largely had been the domain of the International Committee of the Red Cross. Rebel movements established relief wings to manage relations with humanitarian organisations.
Mozambique[1,38,39]	Widespread use of child soldiers, mutilations, rape, and other violations of human rights.	UN began to use the term complex emergency. Specialised children's programmes begun (eg, emergency psychological interventions, reunification of orphans, emergency education).
Sudan, especially, 1988–89 to present[11,40,41]	Famine of 1988 characterised by slow response by international donors and manipulation of vulnerable populations for economic and political gain. Health facilities in southern Sudan nearly non-existent. Health problems range from emergency to endemic difficulties because of duration of conflict (eg, malaria, diarrhoea, acute respiratory infections, kala azar, sleeping sickness, tuberculosis).	UN brokered Operation Lifeline Sudan with government and rebel forces for access to war-affected populations. Operation Lifeline Sudan represented the first formal instrument of negotiated humanitarian access in the midst of conflict and was grounded in fundamental humanitarian principles. Formation of ground rules further specified measures for the protection of civil populations and relief workers. Efforts to link community-based animal health programmes (eg, for the eradication of the cattle plague Rinderpest) to public health measures (eg, poliomyelitis vaccinations) and conflict resolution efforts.

Table 2: **Cold War disaster relief**

Cold War, emergency responses to conflict-related suffering were implemented by "NGOs operating within a framework imposed by overarching geo-politics, strong states and weak UN institutions".[29] The sovereignty of states affected the type of humanitarian action that could be offered.[42] Under such conditions, humanitarian organisations were mostly niche organisations providing short-term relief assistance.

With its groundings in humanitarian principles, the signing of Operation Lifeline Sudan in March, 1989, marked the beginning of a transformation of the international emergency response system's approach to work in violent settings from basic disaster relief to humanitarian assistance. This form of assistance is based on the norms and standards codified in international humanitarian law and human rights, while the disaster relief approach left political issues relating to rights, protection, and access to the international community of states and the International Committee of the Red Cross. The Operation Lifeline Sudan approach spread from Sudan to other complex emergencies where similar agreements of negotiated access, sometimes called zones of peace or days of tranquillity by UNICEF, were later attempted in Angola, Democratic Republic of Congo, and Sri Lanka to facilitate, for example, mass immunisation programmes or access to local commodity markets. These are early examples of what we call humanitarian governance—ie, the use of humanitarian and human rights instruments to govern the behaviour of state and non-state organisations in conflict zones.

Humanitarian intervention after the Cold War resulted in a series of new challenges and innovations (table 3). As the Cold War came to a close, there was heightened political support for the concept of humanitarian governance—ie, a broad political and military commitment to using international laws, norms, and organisations to facilitate protection and assistance for affected populations in complex emergencies. The international diplomatic community seemed mobilised to address widespread humanitarian crises such as the one facing Somalia in the early 1990s. The creation of safe havens for the Kurdish population in Iraq in 1991 seemed to signal a new willingness to

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	Select issues	Examples of innovations/lessons learned
Iraq, 1991[43]	Urbanised refugees ill equipped to cope with winter conditions. Saddruddin Aga Khan appointed by UN Secretary General to coordinate humanitarian operations in Iraq, Kuwait, and border areas. US military created Civil-Military Coordination Centers. Safe haven in northern Iraq created for Kurds.	Difficulties in coordination led to the establishment of the UN's Department of Humanitarian Affairs.
Somalia, 1991–present[44,45]	Growth in the use of NGOs/decline in capacity of government institutions. Increased numbers of humanitarian organisations. Declining security & protection of humanitarians. UN peacekeeping and humanitarian responses, militarised humanitarianism. Security of humanitarian personnel. Power of media to influence policymakers.	Use of wet-feeding to combat massive malnutrition and theft of relief commodities. Use of private security personnel to protect humanitarian operations. Joint military/NGO simulations to manage technical difficulties of civil-military operations. NGOs faced with new ethical dilemmas of working with militaries in complex emergencies. Focus on linking relief and development gains popularity.
The former Yugoslavia, Rwanda (1994), and Bosnia	Relief as the primary form of political engagement by the west with many countries. Managing multi-mandate operations. Rape as war crime. Ethnic vulnerability.	Standards, Sphere and Codes of Conduct. Professionalisation. The failure of safe havens (eg, Srebrenica) without adequately robust peacekeeping.
Angola and Liberia	Diamonds, oil and war economies, failed peacekeeping, failure of relief-development linkages. Political and humanitarian coordination functions separated.	Analysis of the political economy of war as instrument for assessing vulnerability.

Table 3: **Post-Cold War humanitarian assistance**

intervene to protect basic human rights.[46] In 1992, UN Secretary-General Boutrous-Boutrous Ghali outlined An Agenda for Peace based on a vision of targeting conflict, poverty, and other worldwide troubles.[47] The UN formed the Department of Humanitarian Affairs in 1992 to promote greater coordination in UN agencies responding to these emergencies. Non-governmental organisations also made initial steps towards the establishment of a universal code of conduct and of professional minimum standards for relief interventions known as the Sphere standards.[48]

Providing "relief after the demise of the state",[29] however, brought specific challenges to emergency medical practitioners and the broader humanitarian community. Aid workers were expected to have a wider range of skills including not only technical skills (for example, public health) but also skills in the social sciences—eg, human rights, anthropology, and political science.[49] The relations between aid workers and foreign militaries (in Somalia, Haiti, Kosovo, and Afghanistan, for example) have been characterised by both conflict and cooperation.[50]

In many high profile crises in the early 1990s, aid workers could expect support from the diplomatic and military communities. By the time of the Rwandan genocide in 1994, humanitarian assistance had become the primary—and sometimes only—involvement from developed countries in complex emergencies, particularly in parts of Africa.[51] This moment marked the beginning of the end of the short-lived worldwide commitment to humanitarian governance. Meanwhile, the number of crises led analysts such as Mark Bradbury to coin the phrase an "accommodation of suffering"[52] to describe the growing tolerance of ever-increasing rates of malnutrition, morbidity, and mortality before humanitarian organisations, donors, and developed countries would provide aid. Some analysts focused on the unintended negative externalities or results generated by disaster relief operations, including the potential for aid to prolong wars through providing sustenance to warring factors and by facilitating the elimination of state responsibilities for social welfare functions.[29,53] Based on this analysis, the humanitarian community was encouraged by Mary Anderson to adopt the medical practitioners' Hippocratic Oath of do no harm as a principle of engagement.[8,54] When armed groups and those who participated in the Rwandan genocide used the refugee camps in Goma as a place to launch further attacks, the aid community was confronted with the complexities arising from the fact that both the perpetrators and the victims of these new wars were civilians, and the perpetrators' ability to move between the roles of civilians and combatants.

Despite the complexity of the working environment, the expectations for emergency assistance grew after the Cold War partly because of the combined trends of reduced non-humanitarian engagement in complex emergencies and a growing concern over the potentially negative ramifications of humanitarian assistance. The humanitarian objective of saving lives and reducing suffering was challenged as inadequate; increasingly, short-term aid provided during conflicts was seen as an opportunity to promote human rights standards including sex equity, to lay the foundations for development, to further the cause of conflict resolution, and to contain crises.[55] This expanded agenda was broadly subsumed under the idea of the "relief to development continuum"[56,57] (and the related concept of linking relief and development) that was based on models of emergency relief in natural disasters. This

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new scope of activities (eg, conflict resolution, development, capacity building, etc) was accompanied by marked increases in the willingness of formerly independent non-governmental organisations to apply for and implement grant programmes funded by donors from developed countries.

The idea of a smooth, linear transition from conflict to rehabilitation to development has been discussed by academics and practitioners who found it insufficiently robust for situations characterised by violent, protracted conflict.[58,59] At the same time, concern was expressed that this so-called regime integration had led to a loss of specialisation in relief organisations and to fewer resources available to meet the fundamental humanitarian imperative of saving lives and reducing suffering.[22,60] Health care systems and humanitarian health care practitioners are increasingly having to deal with this situation. The challenges for humanitarian health specialists are diverse, and include delivery of emergency health care, assessment of health conditions in vulnerable populations, and assistance in reestablishing national health care systems.

Health, protection, and complex emergencies

The 1949 Fourth Geneva Convention describes the actions that warring parties have to take to protect civilian populations from the effects of war. Warring parties must grant medical personnel, and everyone involved in providing medical care, full and complete protection from interference or harm. This neutral status for medical relief (and, by extension, all humanitarian aid) is based on the assumption that people who deliver this relief will behave in accord with the highest standards of their professional ethics and will take some specified steps to maintain a non-partisan and neutral view towards the warring parties.

This set of principles is based on the fundamental assumption that the world's military forces will find it in their collective interests to maintain a distinction between the military and civilians during war. This rational view of military interests and behaviour has been challenged in the years since World War II. The bombardments of London, Rotterdam, Dresden, Hamburg, Hiroshima, and Nagasaki were precursors of military tactics aimed at attacking civilians to obtain significant military advantage from the destruction, terror, flight, and chaos that these attacks produced. In the years since the end of World War II, most war casualties have been civilian.[61] Deliberate war against civilians, waged by untrained forces using light arms, has evolved.[62] Civilian populations and the civilian infrastructure have acquired a strategic importance in the conduct of hostilities for various reasons. The international community has been compelled to reconsider its approach towards the protection of civilians.[63] Under international law, civilians in situations of armed conflict have a right to international protection and assistance when these have not been made available by their national authorities. When states are unable or unwilling to meet their obligations towards civilians in conflict situations, the international community should ensure that they receive the assistance and protection they need to safeguard their lives.[64]

New strategies are being developed to expand the concept of humanitarian protection. Many human rights and humanitarian organisations have developed their advocacy and protection-related activities using five distinct strategies: early warning,[17,65–68] specification of behavioural standards,[68–71] mobilising international action,[51,71,73] expanding capacity in conflict monitoring,[74–76] and developing rights-based strategies for mitigation and prevention of human rights abuses.[77–79] At the same time, violations of international standards regarding provision of humanitarian assistance and treatment of captive fighters by US-led and UK-led forces in countries such as Afghanistan and Iraq is deeply troubling.

Complex emergencies have a series of direct and indirect effects on health and health systems (table 4). The principal resources provided by the external world are within the domain of public health (food, water, shelter, vaccination, basic primary health care). The continuing needs are for security, environmental restoration (including de-mining), building or re-building physical infrastructure (roads, bridges, schools, clinics), and development of institutions and human capacities. These needs can also be understood and approached within the broad context of public health, since the manifestations of this pervasive social collapse are very high rates of death and morbidity from many causes, including the related endemic and epidemic diseases of malaria, tuberculosis, and HIV/AIDS, but also from widespread nutritional deficiencies, diarrhoeal and respiratory illnesses, measles, war-related violence, and maternal deaths.

Complex emergencies are associated with crises in governments and in systems of governance, and with violence against civilian populations. Of particular relevance to health practitioners is the crumbling infrastructure of health service networks from Sudan to Afghanistan. The diffusion of state functions that were once the sole responsibility of governments is only one result of the struggle for power, wealth, and authority in an increasingly competitive world underpinned by

Direct effects	Indirect effects
Death	Economic pressures and disruption
Disability	Reduced food production and distribution
	Family destruction (eg, more orphans and abandoned children)
Destruction of health services	Refugees
	Psychological stress
Disruption of health programmes	Effects on housing, water supply, and sewage disposal
Psychological stress	Economic pressures on those caring for war-disabled
Illness	Environmental (landmines, deforestation)

Table 4: **Effects of political violence on health and health systems[80]**

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processes such as globalisation and marginalisation that, like complex emergencies, actively produce so-called winners and losers.[11,81]

Like natural disasters, complex emergencies damage health and other social services, market networks, and agriculture enterprises, while simultaneously increasing demands for the essential services these systems provide. Unlike natural disasters, however, complex emergencies involve both the random and, more significantly, the deliberate creation of crises that result in further destruction of fragile health, education, welfare, political, economic, and environmental systems.[82] These dynamics make complex emergencies fundamentally more devastating in human terms than natural disasters, particularly in select regions of the world, such as parts of Africa. Additionally, people engaged in waging wars against civilians have sometimes denied these people access to essential humanitarian relief, including access to health services. This denial of access characterised many wars, including those in Sudan, Mozambique, Afghanistan, Palestine, Chechnya, and Angola. These people defend their actions by appealing to the principle of national sovereignty in matters they believe are within their domestic jurisdiction. Within their national boundaries, these warring parties block relief convoys, obstruct ambulance passage, invade hospitals, destroy clinics, and harass and terrorise national and international medical and other humanitarian relief workers, creating conditions that threaten or inflict grave harm on those who are obliged by professional and international legal norms to provide aid to civilians in need.

In many of the poorest countries, conventional assumptions regarding the institutional basis on which public health relies have been challenged by the breakdown of ministries of health and their counterparts at district level. With this breakdown, there has been a tendency for international and often private providers to become increasingly important service providers. These internal and external organisations (eg, civil society organisations, UN agencies, donors, non-governmental organisations, or international organisations) have been criticised for recurrent difficulties with weak coordination and for the use of uneven skills, resources, mandates, and accountability to govern the provision of essential public health and other life-saving functions in times of conflict and violent political instability.[42,83–85] Although the involvement of such organisations for service delivery might be desirable, the question of which agency is then ultimately responsible remains.

This shift in responsibility and competence from state governments to local, national, regional, and worldwide governance networks that characterises the post-Cold War era is a great challenge to the effective delivery of health services in complex emergencies. The drawbacks of ineffective governance that characterise complex emergencies emphasise the inability and unwillingness or both of states to uphold their obligation to protect civilians in armed conflict, and of non-state organisations to fulfill these obligations instead. It is necessary to develop new mechanisms for ensuring a worldwide commitment to the protection of the rights of civilians in conflict, or what we have termed humanitarian governance, a vigorous expansion of state's obligations for international law-based protection and assistance to the entire network of organisations engaged in worldwide governance.

Although such a commitment is needed to focus renewed attention on the principle of protection, it does not address the ethical and practical dilemma of the most effective forms of intervention to prevent violence. The issue of humanitarian views on the use of force to prevent violence force seemed to disappear after the killing of 18 US marines in Somalia in 1993; nowadays, the logic of violent intervention by foreign states seems driven by national security concerns, especially by the US reaction to the attacks on New York and Washington in Sept 11, 2001. It can be argued that terrorist concerns are replacing humanitarian concerns in the networks of worldwide governance. Although legitimate, these concerns around terrorism and the protection of US homeland security should not be allowed to undermine the vast array of instruments and regimes that have been developed to protect both civilians and soldiers in times of conflict.

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