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Peacekeeping - War with Other Means?

UN Medical Support in a Balkan Sideshow

Table of Contents

Foreword

The history of the United Nations' involvement in the former Yugoslavia from 1991 to 1995 continues to be a subject of intense debate. The disintegration of Yugoslavia – an event which had long been predicted by analysts and historians of the region – was always bound to present the UN with severe challenges. As an organisation, it was structurally ill-equipped to meet the kind of challenge which the scale and complexity of peacekeeping in the former Yugoslavia gradually began to assume. Not only did it lack the necessary resources but, more profoundly, the UN Charter was primarily designed to address conflicts between, not within, states. The Yugoslav wars of succession contained elements of both civil *and* international war.

The difficulties encountered by the UN in the former Yugoslavia stemmed above all, however, from the competing priorities and interests of key member states in relation to the conflict. Indeed, from the outset member states disagreed profoundly about the origins and the true nature of the conflict. Such disagreements made it nearly impossible to develop a coherent international policy towards the conflict. It also placed the UN in an increasingly difficult position as various countries resorted to the UN as a substitute for their own lack of policy or, worse still, as an instrument through which, in the words of dr Sundnes, "separate agendas" could be pursued.

Knut O. Sundnes provides a highly personal account of the pressures that were placed on the UN's medical support system at the time when he was serving as Force Medical Operations and Planning Officer with UN forces in the former Yugoslavia. As with an increasing number of studies and accounts of the conflict, Sundnes shows that much of the criticisms directed towards the UN in the former Yugoslavia have been, at the very least, misplaced. Specifically, his story throws new light on the policies of major powers in relation to certain aspects of the conflict and adds to our understanding of the constraints under which the UN was forced to operate. It also alludes to events which the American government in particular has chosen to downplay and largely ignore: "the atrocities and massive human rights violations committed by Croat forces during and in the aftermath of their Krajina offensive".[1] For all these reasons, this is a welcome and important contribution to the ongoing debate about the UN's performance in the former Yugoslavia.

Mats Berdal
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Introduction

Traditional United Nations peacekeeping is based on consent, impartiality and minimum use of force. Ideally above politics, a peacekeeping force is deployed expressly as a neutral third party to assist warring parties in reaching a peaceful solution to their conflicts. Nevertheless, elements of the national politics of troop contributing nations have influenced many missions, to the extent that the UN chain of command has been bypassed and sometimes even counteracted. Until recently, however, political interference by troop contributing countries has not had any marked effect on the overall performance, and the honest commitment of the UN and troop contributor has rarely been doubted or challenged. Inevitably there will always be an element of politics attached to such missions and, to some extent, secondary political objectives can also be accepted as long as they are conducted openly and kept in check. During the last couple of years, however, this seems to have changed. A number of "hidden agendas" have come to light, most clearly so in operations where the permanent members of the Security Council have also been troop contributing nations.

In a conflict situation, medical and other humanitarian activities can serve as a means of entry into otherwise closed areas. In spite of their ethical importance, such services have often been used for other political purposes, and the mixing of medico-humanitarian and politically-motivated concerns may soon reach critical proportions. In the conflict in the Former Yugoslavia, this limit was exceeded on several occasions by the UN and even more so by prominent troop contributing nations, with the United States dominating the picture. The pupose of this paper is to show the effect of these trends on some of the medical and humanitarian support services of the United Nations Peace Force in the Former Yugoslavia (UNPROFOR).

The UN in the Former Republic of Yugoslavia

Between 1992 and 1995, UN forces in the Former Yugoslavia were given a range of tasks and three different commands, each with different mandates, which only added confusion to the picture. As fighting continued, UNPROFOR was given additional tasks by the Security Council but did not have adequate resources to accomplish them. The establishment of the so-called "safe areas" in June 1993 was the clearest example of the failure to match mandates with resources. The perceived failure of the UN to protect these vulnerable enclaves led to strong criticism of the organisation from various quarters, even though it was the member states themselves that had failed to provide the necessary number of troops. The tendency to add tasks without a corresponding increase in resources proved to be devastating.

There are legislative problems as the UN is technically not a party to conflict and as such does not fall under the terms of International Humanitarian Law. Each of the troop contributing countries, however, has signed the Geneva and Hague Conventions. Moreover, to avoid any misunderstanding it was clearly stated in the key manuals, including the *Force Commanders Policy Directive 20* (FCPD 20),[2] that all UN troop contributors must in all respects adhere to the Geneva Conventions and its Additional Protocols. Unfortunately, the warring factions were reluctantly "forced" to abide by International Humanitarian Law, but soon realised that their disrespect of legal obligations and denial of freedom of movement would have few, if any, negative consequences for them. As a result all the warring factions simply neglected these principles. They only respected International

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Humanitarian Law and basic human rights when it was of advantage to their own cause. Even high-ranking UN officers and officials appeared to lack a comprehensive understanding of these principles. In certain situations, respect for basic human rights even seemed to serve as a bargaining chip. Over time, contravention of International Humanitarian Law and the denial of freedom of movement became the norm, almost an unwritten "standard operational procedure". This was obstructive and in part devastating for the daily conduct of the mission and in the case of the medical support system, it even jeopardised the lives and health of the UN troops.

Under circumstances such as those in the Former Yugoslavia between 1992 and 1995, the medical set-up in support of a UN mission – including numbers and qualifications of personnel, equipment, medical supplies and site of deployment – must be comprehensive. Moreover, free access by dedicated medical teams – to all in need of medical attention (UN and warring factions) – must be a non-negotiable principle, regardless of the causes of war. Even in areas where UN troops are denied freedom of movement, dedicated medical units must be allowed access. If access is denied, it has to be obtained immediately at the highest political level. If International Humanitarian Law is ignored by the parties and this is not remedied, how can one expect other UN resolutions and multilateral agreements to be respected and abided by? Under the difficult circumstances in the Former Yugoslavia, International Humanitarian Law, respect for basic human rights and the principle of freedom of movement for UN personnel, could have played an important role in terms of reducing the excesses of war. The fact that this did not happen requires closer scrutiny. The manner in which the UN managed and conducted operations, at all levels, is no doubt partly to blame.

Medical Support for Peacekeeping Operations

Medical support in peacekeeping operations normally involves two elements.

1) UN Medical support for the peacekeeping troops

The UN system for medical support involves four levels of medical care:

* *Level 1* is a national responsibility: a battalion aid station with medical first aid stations at company level being the most typical example.
* *Level 2* is a higher level of medical care and is a UN responsibility if a lead nation has been assigned the task (like INDOMEDBAT in Croatia Command). Otherwise it is a national responsibility. Level 2 provides medical care for forces of regiment and brigade size. This level of support usually includes a surgical component.
* *Level* 3 is a UN responsibility and is always provided by a lead nation. A Level 3 unit is usually deployed with a force of brigade size or larger. Full surgical capacity is required as well as a treatment capacity of 30 days.
* *Level* 4 is a UN responsibility but is normally carried out by each troop contributing nation. If the troop contributor does not have the necessary capacity for medical care, a lead nation will be allocated by the UN to support it. These decisions are often made on a case by case basis.

The responsibilities and organisation of Level 3 units in the Former Yugoslavia were set out in paragraph 32 of FCPD 20. For the purposes of this paper, it may be useful to quote this section:

> Level 3 medical treatment is a UN responsibility. There are three (3) UNPF Level 3 facilities: the US hospital (USHOSP) at Camp Pleso (Zagreb), the Norwegian field hospital MEDCOY/NORLOGBAT which is located in Tuzla and the German/French hospital located near Trogir (Support Region Split (SRS)). All facilities are capable of providing up to 60 beds for patient care. They are all tasked to assist the FHO in environmental hygiene inspections and training; and, provide medical evacuation teams for AIREVAC operations, when required *[currently medevac teams are not provided by the US hospital and the French part of the*

German/French hospital is responsible for medevacs from UNPROFOR].[3] Level 3 medical evacuation is accomplished by ground or air ambulances as described in Annex F. Level 3 facilities must have a blood supply program.

2) Humanitarian assistance

All peacekeeping missions are either directly or indirectly humanitarian missions. In effect, UN medical units perform a dual function by providing direct humanitarian support to local civilians, as well as having full responsibility for medical support to UN contingents. The humanitarian obligations in the Former Yugoslavia are clearly set out in FCPD 20. Paragraph 17 states:

> HUMANITARIAN AID/LOCAL CIVILIAN MEDICAL CARE
> 17. Humanitarian assistance is one of the primary missions of UNPF. Medical units are here to provide support to UNPF. To the extent that it does not compromise their ability to care for UNPF casualties and patients, medical units should be involved in humanitarian assistance. Humanitarian assistance shall be given on the following criteria:
> a. a verified need
> b. lack of timely and adequate alternative
> c. high professional standards
> d. use of NGO medical supply to the largest possible extent
> e. given as a temporary medical assistance
> f. emergency care to civilians shall be given in accordance with normal ethical standards, International Humanitarian Law and to the extent possible in co-ordination with the local health authorities.
>
> Military medical humanitarian assistance should be co-ordinated with the efforts of other UN and non-governmental relief agencies. Where a G5 cell exists, that is the proper co-ordination point.

At its peak (August 1995) the UNPF medical support system comprised 298 physicians (including 62 surgeons and 40 anaesthetists), more than 1200 other health personnel, in addition to the support elements. UNPF had three Level 3 hospitals, 6 *Level* 2 hospitals, 18 Forward Surgical Teams, 140 soft-skin ambulances and 142 armoured ambulances. Together with 4 helicopter units, adequate deployment and well-conceived Standard Operational Procedures, all resources needed were available for the effective overall provision of medical support. The three lead nations providing Level 3 medical care were the United States for United Nation Confidence Restoration, Croatia (UNCRO),[4] Norway (for UNPROFOR) and, from August 1995, Germany (for UNPROFOR and parts of Sector South in UNCRO). The Czech Republic (UNCRO), France (Sector Sarajevo, UNPROFOR) and Indonesia (UNCRO) provided Level 2 medical care.

All troop contributing nations in a UN mission are employed to assist the UN in fulfilling its mandate. All troop contributors entrust their troops to the UN, in the conviction that the UN provides the best medical care possible under the given circumstances and that all medical units are fully committed to the safety and well-being of their fellow peacekeepers. To accept "lead nation" responsibility for the provision of medical support in a peacekeeping operation is, therefore, an ethical, as well as a professional commitment. All the nations which provided higher level medical care either deployed personnel or executed their tasks in a way which reflected a variety of hidden agendas, which had different consequences for the performance of the overall medical support system. This paper, which draws on personal experience in the field, describes how these "agendas" affected the quality of medical support and how different actors were prepared to sacrifice important principles, including their responsibilities *vis-à-vis* the troop contributors, and even violate basic medical ethical codes.

Level 2: French, Czech and Indonesian Medical Support

The French Medical Group in Sarajevo, including the French air ambulance detachment (DETALAT) in Split (Divulje) had an unofficial line of command which came to light by coincidence. This group, however, was fully committed to its allocated tasks

and sought to meet all needs within its area of responsibility, assisting UN troops as well as the warring factions. Similarly, the Czech hospital performed its duties effectively (sector south in UNCRO). It was the Indonesian Medical Battalion, however, which in all respects, proved to be UNPF's most flexible medical asset. The Level 2 medical care units, therefore, gave little or no reason for concern regarding national priorities or hidden agendas, even though these did exist.

Level 3: US and Norwegian hospitals

By contrast, two of the Level 3 units deployed in theatre – the US hospital at Pleso outside Zagreb and the Norwegian hospital (NORHOSP) outside Tuzla – had hidden agendas and followed instructions which, in the US case, placed the life of UN personnel at considerable risk and in the Norwegian case, could easily have done so. The third Level 3 unit – the German-French Hospital in Trogir outside Split – was deployed against the advice of the Force Medical Office, in favour of a cheaper, more compact, complete and well-tailored concept presented by the Belgians to UN months before the German offer. In this case the UN was pursuing political objectives rather than ensuring the optimal deployment of medical assets. This was no secret as it was a deliberate choice of policy by the UN. In the two former cases, however, the hidden agendas only became apparent after deployment. The experience and performance of these units therefore merit special attention.

The Role and Influence of the United States

The role of the American hospital has to be seen within a larger framework. The strong US influence both within NATO and the UN Security Council was highlighted on several occasions. The US had also clearly taken sides in the conflict by branding the Serbs exclusively as the "bad guys". To those of us working alongside US personnel in the field, this was demonstrated on several occasions; that the US violated the weapons embargo, directly or indirectly, was a well known secret. When, during a Force Commanders Briefing, US Air Force officers from Operation Deny Fly were confronted with their highly selective monitoring of the "No Fly" zone, no convincing answer was given. During the Croatian Krajina offensive in August 1995, US air support eliminated the two most important Serb launching pads for surface-to-surface missiles[5] and there is also reason to belive that the US provided military advisers who were both civilians and military.[6] In Bosnia, US military advisers openly supported the Muslim forces, and on one occasion during springtime 1995 the UN Brigadier General in command of Sector North-East was ordered, in spite of his own protests, to receive a US General who arrived at Tuzla air base with Muslim colleagues in a UN helicopter.

The incursion of the regular Croatian Army (HV) into Bosnia and its active participation in the war in Bosnia alongside Bosnian-Croat forces (HVO) was silently accepted by the world community. Increasingly, UNPF was forced to take drastic action by the US using its powerful position in the Security Council and in NATO. Such actions (notably air strikes) often endangered the lives and conditions of UN troops. The shell which landed in the market-place in Sarajevo on 30 August 1995 was the most delicate of these incidents. It was used to justify the heavy bombing campaign by NATO aircraft which eventually turned the tide of the war. The UN observers normally charged with crater analysis, were denied access to the site and were later silenced by the military command system.[7] Instead, a specially designated group was tasked to investigate this specific shelling. Similarly, a demand by the Humanitarian Crisis Cell to investigate fresh mass graves and the atrocities which occurred in West-Slavonia following its recapture by Croat forces (HV) in May 1995, was side-stepped and no action was taken. Similar incidents occurred in Bosnia where only Muslim mass graves were investigated. The partiality of the US government was further demonstrated to the Field Medical Office when, on one occasion, the hospital commander denied us access to the paediatric drugs needed for refugees on the grounds that the refugees were Serb children. This

was justified as being against US national orders that US troops should not assist in any humanitarian actions benefitting the Serbs. Fortunately, this decision was overturned by the Commander of the Joint Task Forward Provide Promise (non-medical). However, the fact that US medical officers were prepared to violate the Geneva Convention on national orders, is a source of very serious concern. From the point of view of the UNPF HQ, there was never any doubt that American personnel were pressurising the UN to pursue policies that were in accordance with US priorities. Several UN HQ staff (civilians and officers) were under the impression that US thinking overall failed to take account of the complexity of the situation on the ground. The US seemed neither capable nor willing to recognise the substantial differences between the various Serb factions and the fact that a great number of Serbs were also victims in the conflict. At the same time, the US largely ignored the more sinister aspects of Croat (HV and HVO) and Bosnian government policies. Considerable evidence, for example, has now emerged regarding the atrocities and significant human rights violations committed by Croat forces during and in the aftermath of the Krajina offensive in August.[8]

Finally, one of the original perpetrators of the conflict, the Serb politician Slobodan Milosevic, was invited to the negotiation table. Milosevic, together with President Tudjman, more than any of the Serb leaders already indicted by the War Crimes Tribunal in the Hague, deserves to be charged with war crimes. In short, the policies pursued by US certainly made the work of UNPF extremely difficult.

The US Hospital

The role of the US hospital and the national restrictions placed on it have to be understood in this wider perspective. Initially, following the implementation of US restrictions in late spring/early summer 1994, various episodes were considered mere mishaps and/or understandable short-term measures for safety reasons. Gradually, however, it became clear that the US medical contribution reflected priorities which differed from those which should govern the provision of medical support in a war zone.

During the summer of 1994, US authorities issued instructions that no US soldier from the US hospital was allowed to leave Zagreb. With the exception of a short period during the Croatian attack on West-Slavonia in early May 1995, this order also included medical evacuations by air and ground forces. As a result (and without prior warning), 15,000 UN troops (in Croatia Command) were deprived of this crucial element in their medical support system as no feasible back-up system was available. Already in late summer 1994, a Canadian soldier, who had suffered war wounds in Sector South, was refused medical assistance on the grounds that US national restrictions did not permit his evacuation. Permission was requested from the Commander of Joint Task Forward Provide Promise (JFTPP) in Zagreb who, himself unwilling to make an exception, forwarded the request to Joint Task Forward HQ in Naples in Italy. After 90 minutes the request was rejected. This caused an unexpected and dangerous delay in the medical evacuation of the Canadian soldier and improvised measures had to be taken. More importantly, this incident was only one in a series of similar episodes that were to follow.

As a result, when a battalion in UNCRO had casualties or other emergency medical conditions which required Level 3 care, the battalion had to provide both the medical crew and the equipment needed during the transport itself. This was unfortunate for all "delivering" units, especially for battalions with rather meager resources, such as KENBAT which only had one physician. As the restrictions of movement imposed by the warring factions sometimes prevented the return of these doctors for more than 24 hours, units could be left in a rather vulnerable situation with regard to medical support. To some extent US national restrictions were understood (but not accepted) as long as it involved US soldiers entering into Serb-held territory. However, once it became clear that they included any medical assistance, even after traffic accidents in HV-controlled Croatia (from Karlovac hospital or collecting patients from Split),

the situation became difficult to understand and impossible to accept.

In winter 1994-1995, following several attempts to have these restrictions lifted, the Force Medical Office (FMEDO) was informed, informally, that US authorities had no wish to stay on in Pleso and that they would withdraw the hospital immediately if the Field Medical Officer did not stop "harrassing" them. To find a replacement at short notice was, however, difficult and the Force Medical Office had reluctantly to accept the intolerable situation. After the seizure of Krajina (Sector North and South) by the Croats, a reorganization of the UN set-up in Croatia was required. As the US hospital was now a surplus requirement, it was suggested by the FMEDO that it should be withdrawn and replaced either by INDOMEDBAT, or alternatively by the Czech Forward Surgical Team. This suggestion was not welcomed by the Americans and, all of a sudden, numerous efforts were made by the US to ensure that their presence at Camp Pleso would continue. They even offered to participate in medical evacuations "as there was no enemy territory anymore!"[9] However, they refused to provide medical evacuation from East-Slavonia which was still the part of the Republic of Serbian Krajina.

US staff officers at the FMEDO, UNPF HQ

At the end of November 1994, existing US restrictions were extended to include any US medical officer regardless of whether they were directly responsible to the Field Medical Office or belonged to the hospital. As this included the Deputy Force Medical Officer (DFMEDO), the Force Hygiene Officer (FHO) and the Medical Supply Officer (MSO) it became next to impossible for these officers to fulfil their jobs. The Field Medical Office raised the issue with the Department of Peacekeeping Operations (DPKO) in New York, both directly with the medical adviser and through the Chief of Staff/Logistics and Administration (COS/Log&Adm) at UNPF HQ in Zagreb (Brig.General), but without any result. The only response was an oral and off-the-record statement from the US ambassador to the UN, Madeleine Albright, requesting that the UN stop insulting the US. As a result, the FMEDO let it be known to both the DPKO in New York and the US authorities through JTFPP in Zagreb, that if the restrictions were not lifted, US officers would have to be replaced by officers from nations without restrictions.[10] After a temporary easing of the restrictions, shortly before rotation, the restrictions tightened again and became not only untenable but also ridiculous; for example, the DFMEDO was unable to attend INDOMEDBAT's medal parade at which he had been invited to hand out the UN medals. This took place long after the area was under the control of Croat forces. When one of the Force Hygiene Officers (from the US) tried to push this issue he was informed, in a meeting with a US admiral based in Naples, that these restrictions were Presidential Orders and that he had to understand that his presence was more complex than simply being a UNPF Force Hygiene Officer.

During the Croatian capture of West-Slavonia, information about the poor conditions in the temporary camps for the Serbs reached the FMEDO. As these camps were outside even the previous demarcation line for Sector West, the acting FMEDO decided to send the Force Hygiene Officer (US officer) on a hygiene inspection. This request was turned down without explanation. If the refusal had come from Croat authorities we might have understood but the request was turned down by US authorities.[11] As it transpired, the Force Medical Officer had virtually no say in how to use the US officers put under his command - an impossible and intolerable situation. Any trip made by these officers had to be planned well in advance (7-10 days) and applications had to be sent to the JTF HQ in Naples. In each case, the request had to be so specific and detailed that it would have been impossible to make any ad hoc decicions or inspections. The majority of these requests were rejected, sometimes on grounds of security, and at others for "professional" reasons (without consulting other medical or public health professionals). No other nation could have behaved in this way without serious consequences.

Only one US officer was permitted to travel with very few restrictions (within Muslim-controlled territory): the Humanitarian Officer (G5) in Sector North-East in Bosnia. The US authorities insisted on this post, regardless of the fact that the officer in question clearly had no intention of ever crossing the front line in order to ascertain humanitarian needs on the Serbian side. This officer was frequently observed along the front line together with high-ranking Bosnian officers. In due course, before the rotation of this position in spring 1995, a letter was drafted by the author and sent by the COS/Log&Adm for DPKO in New York where we underlined the need for the G5 officer, provided by a troop contributing nation with no national restrictions whatsoever that could prevent the officer from crossing the front line, as there was also an obvious need to check the humanitarian and medical requirements of civilians on the Serb side. Otherwise we felt that many basic needs would not be met and that this could also have considerable negative consequences for the UN image of impartiality. Not surprisingly, the next G5 officer in Tuzla was neverthless provided by US.

To sum up, US authorities deployed a medical unit, but did not allow this unit to fulfill its commitments in serving the UN troops. When they were finally asked to withdraw the unit and give way to another lead nation, operating without such obvious restrictions, they were unwilling to do so. Consequently the FMEDO found it difficult to believe, all episodes taken into account, that the prime objective of US deployment was to serve the UN troops. We felt that its prime purpose was to serve as a cover for other US activities related to the Croat and Muslim authorities.[12] As a result, UN requests for support were only met when they did not conflict with US interests, and were at any rate treated as low priority. This "hidden" agenda was difficult to hide and was known to all actors, including the various Serb factions. As a consequence, US soldiers were exposed to greater risk. Medical personnel should, however, in such situations, act in accordance with and claim protection pursuant to the Geneva Convention and Protocols. Moreover, as the helicopter unit operating out of Zagreb was civilian and was used by different nations, US crews were exposed to no more risk than any other medical crew which had to replace them. US restrictions meant that other nations had to take risks on behalf of US officers who had been deployed to do the job. This stands in remarkable contrast to the efforts and actions set in motion to save a single US Air Force pilot trapped in Serb-held Bosnian territory. All in all, US activities in Former Yugoslavia made the situation worse for the UN troops and increased the need for the medical support that the US was obliged, but unwilling to give.

The US battalion deployed in Macedonia had also restrictions. Within its area of responsebility one observation post was manned by Norwegian troops. The reason given was that this observation post was too close to the border of Yugoslavia.

FMEDO and the US officers

In 1993-1994 all positions in the FMEDO (for UNPROFOR as a whole) were held by the US officers. In the spring of 1994, Norway was requested to fill the position of Force Medical Officer (FMEDO) from September 1994. In summer 1994 Norway was also asked by the UN Headquarters in New York to fill the position of Deputy Force Medical Officer at the level of Lt. Colonel. The author accepted a request from the Norwegian authorities to fill this post. Before my arrival in theatre, however, the US had sent, uninvited, a medical officer with the rank of full Colonel. Clearly, the idea was to fill the post before the arrival of the officially invited FMEDO. This failed, and the only other possible position for a full Colonel was the Deputy FMEDO, even though this was listed as a Lt. Col. position. I was then asked to assume the post of Force Medical Operations and Planning Officer instead, as the US Colonel would otherwise have to be sent home. I accepted. The Headquarters in New York was informed about the unfortunate situation created by the US authorities, but considered the incident to be a mishap. It was made clear, however, that during the next rotation of US officers (end of February 1995), such mishaps would not be accepted, the

incoming officer would have to have the rank of Lt. Colonel and would take over the position of Medical Operations and Planning Officer, while I would assume the position to which I had originally been appointed. The name of the incoming officer was then given with the rank of Lt.Col. On arrival, however, it was clear that the incoming officer was a medical doctor who had had the rank of full Colonel for many years. He had also known for some time that he would be sent to UNPF HQ. The actions of the US authorities could no longer be regarded as mere mishaps but rather were seen as an attempt to manipulate the UN system, perhaps only for the sole purpose of complying with the Presidental Declaration that "US soldiers shall exclusively be under the command of US officers". During the next rotation in August 1995, the DFMEDO position was filled by an Indonesian Lt.Col and the US was told not to send anyone. The FMEDO also informed the DPKO in New York that another nation should provide the Force Hygiene Officer in the light of US restrictions. Denmark was recommended. Once again, however, a full Colonel was sent by the US to Zagreb and asked to be admitted to the staff. On this occassion, the UN stood firm and the officer had to return home. The Force Hygiene Officer, however, was replaced by another US officer. None of the US officers seemed to have been fully aware of the restrictions before arrival in theatre, and were caught by surprise. They were highly competent officers and were rather unhappy about this situation, as were the personnel at the US hospital. Nevertheless, they remained loyal to the US Command, ignoring UN orders whenever there was a conflict of interests.

The Norwegian Hospital

Norway's hidden agenda was less obvious and did not have the same grave consequences as the US agenda. Nevertheless, it was there. The deployment of the Norwegian hospital was part of a Nordic agreement and it was therefore decided that it should be located in the vicinity of Nordic forces. In terms of providing the most effective support for UNPROFOR operations throughout Bosnia, the hospital should ideally have been more centrally located. Three requests were made for redeployment, all of which were rejected on political grounds. The decision to stay in Tuzla was clearly dictated by the desire to ensure the best possible medical support for Nordic troops. However, there were no other limitations on the use of the hospital's assets. Medical evacuation by air and on ground, as well as humanitarian assistance on both sides of the front line, were conducted to the complete satisfaction of the FMEDO.

More disturbing, however, was the fact that after comprehensive withdrawal plans for UNPROFOR had been drawn up, conflicting instructions on how to use the Norwegian hospital and its personnel during a withdrawal were discovered. Furthermore these instructions were only available in Norwegian. In the event of a withdrawal they could have jeopardized the lives and safety of the other UN soldiers. Nordic soldiers were clearly given a higher priority than other UN contingents in the withdrawal plans. Fortunately, we never had to experience the practical consequences of this hidden agenda.

German-French Hospital

The German-French hospital had no obvious hidden agenda, but its establishment highlighted that UN top officials were equally influenced by political considerations, as by the medical needs of the troops. It was clear that another hospital was needed in the southern part of Bosnia, preferably in the Support Region Split. Belgium had originally been asked to provide a suitable unit, to serve both as a holding station for the transfer of patients, and as a Level 3 hospital for Support Region Split. A MEDEVAC function was also included. They were also asked to provide a hygiene team to cover the southern part of Bosnia. In early1995, Germany had already offered a hospital unit for UN peacekeeping operations in the Former Yugoslavia, provided that personnel did not have to enter Bosnia or any Serb-held territory. This was refused by FMEDO as it was of paramount importance that any additional medical asset complied

fully with the UN Support Manual and the Operational Procedures outlined in FCPD 20. But, in the late spring of 1995, it became clear that, for political reasons, Germany had been asked to provide a unit (not necessarily medical) for UNPF after all. The request was accepted by Germany, but only a Field Surgical Hospital would be deployed. Details of this agreement were discussed thoroughly in a meeting between UNPF and the key nations in Paris. The FMEDO, however, was not invited! Despite our strong recommendation against such a deployment (see Level 3 medical support), based on an assessment of needs and as a matter of priniciple, FMEDO was overruled. In order to bolster the German unit, France accepted to provide a unit for the hospital, to perform all functions not covered by Germany, notably MEDEVAC Teams and a Hygiene Team. When France finally deployed the unit, it became clear that they were only prepared to establish a holding station for French soldiers awaiting repatriation for medical reasons. They never fulfilled their commitment as promised to the FMEDO and no political pressure was put on them to do so. As a result, we had another Level 3 unit incapable of meeting the minimum requirements laid down in written agreements and the Force Commanders Manuals.

Conclusion

This paper examines how the medical and humanitarian support services in the Former Yugoslavia were both politicised and hijacked at certain crucial stages of the conflict. Medical support has long been used as a means of gaining access to more or less closed areas, as well as to monitor violations of International Humanitarian Law (comprising the Geneva Convention of 1949, its Additional Protocols of 1977, and the Hague Convention of 1907). Medical support, such as that provided by the International Committee of the Red Cross (ICRC) during conflict, has also been an important means of monitoring human rights violations. Whenever medical support is provided, the Physicians Ethical Code and International Humanitarian Law have been, and should remain, non-negotiable principles. In the Former Yugoslavia, however, an unfortunate amalgamation of politics and medical "power" was observed both on the part of the UN but even more so on the part of troop contributing nations, especially the United States. Any such dual approach to conflict, as I attempted to show using the management of conflict in Former Yugoslavia as an example, is inconsistent with an impartial and objective approach to conflict. A troop contributing country, in particular, cannot be both inside and outside the UN system at the same time.

Any action which threatens to undermine the impartiality, honesty and ethical integrity of UN personnel in a peacekeeping operation, represents a danger to the mission as a whole. It will inevitably generate mistrust in the UN system, especially on the part of the warring factions, but also on the part of those who provide resources for the mission in good faith. This in turn will make it increasingly difficult to find nations or persons willing to serve in UN missions. If the safety and security of UN troops, as well as the protection of basic human rights and adherence to International Humanitarian Law become bargaining chips, we will inevitably be fighting a loosing battle for the future of UN peacekeeping. Abusing the medical support system for political reasons is both unethical and illegal. It must be vigorously opposed by all those who are anxious to preserve UN peacekeeping as an instrument for mitigating and, where possible, resolving conflicts.

Abbreviations

AIREVAC	Air evacuation
COS/Log&Adm	Chief of Staff, logistics and administration
DETALAT	The French detachment for air ambulance and transport
DFMEDO	Deputy Force Medical Officer
DPKO	Department of Peacekeeping Operations (New York)
ECMM	European Community Monitoring Mission
FCPD	Force Commanders Policy Directive
FHO	Force Hygiene Officer
G5	Humanitarian Officer
HVO	Bosnian Croat forces
ICRC	International Committee of the Red Cross
INDOMEDBAT	Indonesian Medical Battalion
KENBAT	Kenyan Battalion
MEDCOY	Medical Company
MSO	Medical Supply Office
NGO	Non-governmental organisation
NORHOSP	Norwegian hospital, Tuzla
NORLOGBAT	Norwegian Logistic Batallion, Tuzla
POW	Prisoner of War
SRS	Support Region Split
UNCRO	United Nations Confidence Restoration Operation (Croatia)
UNMO	United Nations Military Oberver
UNPF	United Nations Peace Force
USHOSP	United States Hospital

Notes

[1] P. 10. Sadly, harassment and human rights violations by members of the Croatian military and police against the remaining Serb population in the Krajina and Western Slavonia regions continue to his day. See, SC/6267, Presidential Statement concerning Croatia's Failure to Execute Arrest Warrants of the International Tribunal on Former Yugoslavia, 20 September 1996.

[2] FCPD 20 was the Standard Operational Procedure (SOP) for all medical activities in UNPROFOR (UNPF after April 1, 1995).

[3] The sentence in brackets (italics in this paper only) was added to the latest version of FCPD 20 (September 1995). In the 1994 version this exemption was not included.

[4] Due to the impractical location of the Norwegian hospital (in Tuzla) several patients from the southern parts of Bosnia-Herzegovina were evacuated to US hospital at Camp Pleso instead of transporting them to Tuzla.

[5] This was communicated by an HV medical officer to a German medical officer in Split. The HV officer, who had dual citizenship (German and HV) had participated in the recapturing of Knin. Later this was openly confirmed in *Time Magazine*, August 14 1995 (p. 15-18). In *Time Magazine* January 15, 1996 a system of civilian US military advicers is outlined. There is reason to believe that a similar system also existed earlier.

[6] There were some indications of such activities Otherwise it is difficult to explain how Croatia could be able to build up such a well equipped and well functioning army from scratch during an extremely short period of time (less than three years) during a wepaon embargo. There are also indications that the Krk International Airport served as a port of entry for illegal weapons import.

[7] This information was given by a UN military observer who strongly felt that the ethical commitment and impartiality of the UN was suffering to the extent that he was considering terminating his contract. According to his information, UNMO had checked the landing site of the shell after the special group had withdrawn and their conclusion was that it was impossible to state exactly from where the granade had been launched. This conclusion was also supported by the first oral report from the mortar radar unit which had not identified any origin of a shelling.

[8] See, in particular, ECMM (European Community Monitoring Mission) report from September 1995.

[9] Statement given in a meeting, September 13 1995, chaired by COS/Log and Adm.

[10] The FMEDO wrote numerous letters regarding this issue. Written responses were, however, few and far between.

[11] On the whole, we did not know at what level the requests were refused as these, almost without exception, were communicated by phone, in spite of the FMEDO demanding to have them in writing.

[12] There was some indication of such activities. High-ranking US officers were observed being transported with high-ranking Bosnian offiser in Bosnia.