Commentary

Defining the Limits of Emergency Humanitarian Action: Where, and How, to Draw the Line?

Nathan Ford*, Médecins Sans Frontières
Rony Zachariah, Médecins Sans Frontières
Ed Mills, University of Ottawa
Ross Upshur, University of Toronto

*Corresponding author: Nathan Ford, Médecins Sans Frontières, 49 Jorrisen St, Braamfontein 2001, Johannesburg, South Africa.
Email: Nathan.ford@joburg.msf.org.

Decisions about targeting medical assistance in humanitarian contexts are fraught with dilemmas ranging from non-availability of basic services, to massive demographic and epidemiological shifts, and to the threat of insecurity and evacuations. Aid agencies are obliged, due to capacity constraints and competing priorities, to clearly define the objectives and the beneficiaries of their actions. That aid agencies have to set limits to their actions is not controversial, but the process of defining the limits raises ethical questions. In MSF, frameworks for resource allocation are subject to constant reflection and reiteration, and perspectives are sought at all levels, from implementers at the programme level to the operational directors at headquarters. The perspectives of the programmes staff hold considerable weight as they have the knowledge and experience with particular communities to assess the degree of vulnerability and need, and are also the people who ultimately have to give explanations to beneficiaries when changes or closures are going to be instituted. Humanitarian agencies have a responsibility to ensuring that their workers are prepared to reflect on these dilemmas, and challenge the status quo when it costs lives.

For doctors used to practicing medicine in the well-resourced Western world, humanitarian emergencies are extraordinary situations. Health professionals who normally rely on a panoply of routine diagnostic tests, therapeutic options and specialist colleagues are transported to highly impoverished areas with collapsed health services, limited human resources and an excessive burden of infectious and chronic diseases. In extreme situations of isolation and insecurity, a modest team of expatriate health workers equipped with a limited supply of essential medicines and clinical algorithms may represent, for the limited duration of their presence, the only health professionals in the area. In zones of active conflict—the traditional terrain of humanitarian assistance—the provision of relief is further complicated by unpredictable violence and insecurity. Decisions about how to target medical assistance are fraught with dilemmas ranging from non-availability of basic tools, to massive demographic and epidemiological shifts, to the possibility of having to evacuate at any moment.

The starting point for any decision about how, where, and when to intervene in a humanitarian crisis is the institutional mandate that defines the scope of humanitarian assistance provided by a particular organization. Mandates can vary enormously in the breadth of activities they lay out, from the all-encompassing to the specific. So while Oxfam aims to 'find lasting solutions to poverty and injustice' Médecins Sans Frontières (MSF) defines itself as an organization that 'delivers emergency aid to people affected by armed conflict,

epidemics, healthcare exclusion and natural or man-made disasters'.

From an operational perspective institutions are obliged, due to capacity constraints and a multiplicity of competing priorities, to select specific sites of intervention and clearly define their objectives and the beneficiaries of their actions. This is essential to ensuring that operations are focused and have the best chance of achieving the expected results, while ensuring maintaining capacity to intervene in other crises. Operational interventions are thus clearly guided by a priori choices before getting to the field. For an international humanitarian organization, a decision to assist cholera patients in Juba is not only a decision to single out a particular disease (Devakumar, 2008). It is also a decision to intervene in Juba (a region in Sudan), as opposed to other areas in Sudan; to deploy human and financial resources in Sudan instead of other counties in crisis; and to provide health care as opposed to other humanitarian services (water, shelter, nutrition).

At what point does a crisis become a humanitarian intervention? The science is far from perfect. A decision to intervene is often based on little more than a crude measurement of population-level mortality; a doubling of existing mortality rates is often used as an arbitrary threshold for declaring an emergency situation (Sphere Project, 2004). But often, mortality per se provides insufficient justification for a particular NGO to intervene in a given context, and the presence of other associated factors, e.g., vulnerable groups (children, the elderly), exclusion from access to health care, media or donor pressure and political choices can all influence the decision to intervene (Checchi *et al.*, 2007).

The primary causes of mortality—violence, malnutrition and infectious diseases—may define the initial operational response, but when other life-threatening conditions are confronted, and if the means are available, it would seem fairly clear that a health professional is duty-bound to respond. But again, the means that are available are often conditioned by organizational a priori choices. The case study from Juba accepts that certain interventions like surgery could not be done, but is this any more acceptable than referring non-cholera cases? How much surgical disease is required before the lack of surgical care becomes an ethical dilemma and should this automatically become the responsibility of an NGO who may be in the area with a completely different operational mandate? An emergency intervention can become even more complicated when health teams are faced with a pressing burden of chronic disease. In most humanitarian contexts in Africa, health care workers will inevitably be confronted with HIV, a life-threatening disease requiring treatment for life. In the absence of some limiting criteria, a time-bound emergency cholera intervention could evolve into a programme providing surgical care and anti-retroviral therapy. Health professionals reacting to the 'moral duty' to treat could rapidly exceed the organizations' technical and financial capacity, preventing action in other crisis areas.

The reality is that there is very poor guidance for decision-making about resource allocation at a public health level (Kass, 2001). Because of this, health workers most often appeal to medical ethics, viewing these dilemmas exclusively at the level of the doctor–patient relationship. But when a doctor working for an international agency in a remote part of Africa is confronted with a pathology they cannot respond to for technical reasons, or reasons of limited mandate, this situation is not simply a medical ethical dilemma. Rather, the situation is conditioned by dynamics that run from the micro-level (bedside) to the meso- and macro-level (institutions and health systems) (Sreenivasan and Benater, 2006).

These dynamics can run in both directions. It is not only a matter of a doctor in a remote area situating themselves within the broader landscape of international humanitarian needs—the stream of influence can run from the bottom up. It was the voice of frustration of doctors not being able to treat HIV that convinced MSF to launch treatment programmes across Africa. To be able to treat patients on the ground, the organization had to first engage in a considerable number of macro-level fora, including lobbying pharmaceutical companies to lower the price of their drugs, convincing UN agencies that treatment should be provided as well as prevention, pushing donor governments to put money into HIV programmes, and convincing national governments to allow pilot programmes to proceed. Indeed, it is often this advocacy work that allows humanitarian workers to live with the relative imperfections of operational decision-making. NGOs can often not do more than make a temporary contribution to saving lives and restoring the dignity of a small number of individuals, but by demonstrating that action is possible, and holding others to account, it may be possible to ensure that a broader, more sustainable improvement in peoples' lives is made.

The provision of anti-retrovirals in Africa provides one of the few examples where attempts have been made to define criteria for decision taking on resource allocation at the international public health level (Daniels, 2005). The decision of who to treat rests primarily on clinical grounds, with patients with lower immunity prioritized. While the use of clinical criteria as a basis for rationing care appears to make sense at first glance, clinical criteria have been used in the past to mask moral and

social judgments made in the rationing of penicillin, liver transplants and renal dialysis (McGough *et al.*, 2005). Any single criterion is going to be imperfect, so the process of defining criteria, and the involvement of a broad range of stakeholders is essential (Rosen *et al.*, 2005). But as the cholera case study notes, community members are generally not parties to MOUs and rightly perceive the possibility of care when they see red crosses and other indicators of the presence of health care providers. Raising community awareness on the rationale and mandate for a given humanitarian intervention particularly when it is selective (in this case cholera) would seem a minimum and worthwhile responsibility. Communities should not be the agents bearing responsibility for any misperception of mandates.

Limit setting is one of the greatest ethical challenges in health care delivery (Coulter and Ham, 2000). The fact that humanitarian organizations have to set limits to their actions is not controversial; rather, the process of defining the limits raises ethical questions. It has been proposed that such a process should take into account the following issues: limit setting should be discussed in the context of practice, and not in isolation; they can give rise to true ethical dilemmas, where the best available option is the 'least worst' and not an ideal solution; and they can give rise to disagreement and this should be respected given the absence of a universally accepted ethical framework (Hurst, 2005). All three conditions are present in MSF's operational decisions-making processes. Frameworks for resource allocation, for example to help determine how much operational activity should be devoted to responding to conflicts versus chronic diseases like HIV/AIDS, are subject to constant reflection and reiteration, and perspectives are sought at all levels, from implementers at the programme level to operational directors at headquarters. While decisions regarding resource allocation are ultimately taken by headquarters, the perspectives of programmes staff tend to hold considerable weight as it is understood that they have the best necessary knowledge and experience with particular communities to assess the degree of vulnerability and need, and they are also the people who ultimately have to give explanations to beneficiaries when changes or closures are going to be instituted (Fuller, 2006). Thus, debate and disagreement is actively encouraged, but the objective is to ensure transparency, accountability and justification in decision-making; consensus seeking does not supersede the need to act.

Finally, humanitarian agencies have a responsibility to ensuring that their workers are better prepared to reflect on these dilemmas and challenge the status quo when it costs lives. Global health has matured to the point that developed world clinicians working on the front line in the developing world should not be surprised by the vast health needs outside the mandate of their program. Indeed, planning for interventions in under-resourced areas should now factor in such possibilities as part of their interventions, and providers need pre-departure briefing on expected conditions informed by epidemiology in order to mitigate, to some extent, the distress caused by the mismatch between the organizational mandate and the ground realities. While this issue has been ethically problematic in research contexts as witnessed by the debate on ancillary care obligations, it bears thorough foresight on the part of organizations pledged to serving health needs in humanitarian crises.

Institutional mandates are important for managing resources and setting limits for action, which is an essential way to ensuring that an organization maintains capacity to respond to a range of crises. But ultimately, mandates are self-endowed and therefore revisable. If they repeatedly fail to stimulate or even hinder an adequate response to the priority health needs of populations in crisis, then they should be called into question.

References

Checchi, F., Gayer, M., Freeman Grais, R. and Mills, E. (2007). *Public Health in Crisis-Affected Populations. A Practical Guide for Decision-Makers.* Humanitarian Practice Network, Network Paper 61. London: Overseas Development Institute.

Coulter, A. and Ham, C. (2000). *The Global Challenge of Health Care Rationing.* Buckingham: Open University Press.

Daniels, N. (2005). Fair Process in Patient Selection for Antiretroviral Treatment in WHO's Goal of 3 by 5. *Lancet*, **366**, 169–171.

Devakumar, D. (2008). Cholera and Nothing More. *Public Health Ethics*, 1–2.

Fuller, L. (2006). Justified Commitments? Considering Resource Allocation and Fairness in Medecins sans Frontieres-Holland. *Developing World Bioethics*, **6**, 59–70.

Hurst, S. (2005). What Limits to the Responsibilities of Humanitarian Medicine? A Few Pointers for Difficult Ethical Questions. In: *My Sweet La Mancha.* Geneva: MSF, 2006.

Kass, N. (2001). An Ethics Framework for Public Health. *American Journal of Public Health*, **91**, 1776–1782.

McGough, L., Reynolds, S., Quinn, T. and Zenilnian, J. (2005). Which Patients First? Setting Priorities for

Antiretroviral Therapy Where Resources Are Limited. *American Journal of Public Health*, **95**, 1173–1180.

Rosen, S., Sanne, I., Collier, A. and Simon, J. (2005). Rationing Antiretroviral Therapy for HIV/AIDS in Africa: Choices and Consequences. *Plos Medicine*, **2**, 1098–1104.

Sphere Project. (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*. Geneva: The Sphere Project.

Sreenivasan, G. and Benater, S. (2006). Challenges for Global Health in the 21st Century: Some Upstream Considerations. *Theoretical Medicine & Bioethics*, **27**, 3–11.