

Between war and peace: humanitarian assistance in violent urban settings

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Cities are fast becoming new territories of violence.¹ The humanitarian consequences of many criminally violent urban settings are comparable to those of more traditional wars, yet despite the intensity of the needs, humanitarian aid to such settings is limited. The way in which humanitarian needs are typically defined, fails to address the problems of these contexts, the suffering they produce and the populations affected. Distinctions between formal armed conflicts, regulated by international humanitarian law, and other violent settings, as well as those between emergency and developmental assistance, can lead to the neglect of populations in distress. It can take a lot of time and effort to access vulnerable communities and implement programmes in urban settings, but experience shows that it is possible to provide humanitarian assistance with a significant focus on the direct and indirect health consequences of violence outside a traditional conflict setting. This paper considers the situation of Port-au-Prince (Haiti), Rio de Janeiro (Brazil) and Guatemala City (Guatemala).

Keywords: Brazil, gangs, Guatemala, Guatemala City, Haiti, humanitarian assistance, impartiality, intervention criteria, Port-au-Prince, Rio de Janeiro, sub-IHL (International Humanitarian Law), urban violence

Introduction

The theatres of conflict are changing. As the number of cross-border conflicts gradually declines, an increasing number of countries are emerging from full-blown internal conflicts and transitioning into post-conflict phases. At the same time, the number of hybrid forms of conflict within and across state boundaries has risen—that is, violence perpetrated by groups that, usually, are not political in nature, but instead driven by the prospect of criminal economic gain. These new-style conflicts are neither necessarily restricted by classical territorial boundaries nor carried out by clearly defined (and identifiable) actors. Battlefields are no longer only in rural areas. Urban zones are fast becoming new territories of conflict and violence. At the same time—and partially in response to conflicts—there have never been such large concentrations of people living in cities and towns. According to projections by the United Nations (UN), more than one-half of the world's population will soon be urban, and one million people are already living in slums (UN-HABITAT, 2007, p. 9). Many cities are no longer safe havens to which to escape. Indeed, now they often expose their civilian population in ways that make everyone a potential victim of violence.

War-torn cities, such as Baghdad (Iraq), Mogadishu (Somalia) and, to some extent, Kabul (Afghanistan), are currently widely recognised as theatres of conflict. The

framework of International Humanitarian Law (IHL) regulates contexts of international or civil war using provisions for the protection and assistance of conflict-affected civilians (ICRC, 1994). Humanitarian organisations (supported by donor money) strive to maintain a presence there and are traditionally well-equipped to provide assistance to the victims of such conflicts.

Many other cities in a number of countries that are technically at peace are also in need of attention, however. The shocking levels of violence within some areas of those cities and the suffering that it causes to their inhabitants present a serious challenge to humanitarian organisations. In most of those cities, armed gangs hold sway and fight the police to gain and maintain control of territories and key resources vital to their lucrative illegal trade (Harroff-Tavel, 2008). The most frequent expressions of this violence are armed robberies, assaults, beatings, kidnapping, murder and threats. Since most of these situations are classified as internal disturbances, they are not subject to IHL. Consequently, while affected civilians are still protected by International Human Rights Law in such cases, there is no clear legal basis for the presence of humanitarian actors. In these contexts, little if any humanitarian assistance is available to the population affected by the violence.

This paper reflects on the humanitarian and especially medical needs in violent urban settings where IHL does not apply. In addition, it reviews current responses to the violence in such cities and makes a case for humanitarian responses by drawing on the experience of Médecins Sans Frontières (MSF) in a number of cities in Latin America.

Violence is violence

This section analyses violence and its effects in different contexts. Violence can manifest itself in different ways. Extreme forms of violence occur in officially recognised armed conflicts, but also in many settings in countries that are ‘officially’ at peace. Officially recognised armed conflicts are subject to IHL, which, as noted above, contains provisions for the protection and humanitarian assistance of victims. Unfortunately, it appears more challenging to enforce similar provisions in violent contexts where IHL does not apply (but where International Human Rights Law does).

Humanitarian assistance in violent contexts subject to IHL

The World Health Organization (WHO) defines violence as ‘the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or a community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation’ (WHO, 2002, p. 5). As this definition implies, violence is not only a physical act but also a phenomenon that can be embedded in wider social structures. Exploitation, exclusion, inequality and injustice can all constitute violence (Galtung, 1969).

War is the most obvious example of a violent context. International and non-international armed conflicts are subject to IHL,² a set of rules that, for humanitarian reasons, aims to limit the effects of war. IHL not only provides for the protection and assistance of victims of such conflicts, but also seeks to limit the means and methods of warfare employed by the warring parties. Victims of armed conflicts are entitled to medical care and other forms of humanitarian assistance. IHL specifies that impartial humanitarian organisations should be allowed to supply this assistance wherever necessary (ICRC, 1994).³

The principle of impartiality of humanitarian action implies that assistance should be proportionate in scale to and appropriate in nature for the needs of a population in a given situation (IFRC, 1994). Impartial humanitarian actors can operate and offer assistance in a conflict because they are expected to have no interest in the outcome of the dispute. They provide aid regardless of the race, creed or nationality of the recipients and without adverse distinctions of any kind (Darcy and Hofmann, 2003, p. 9).

The International Committee of the Red Cross (ICRC) may well be the prototype of an impartial, neutral and independent humanitarian organisation, but a number of other international humanitarian bodies and non-governmental organisations (NGOs), as well as UN agencies, also extend their services to populations affected by armed conflict. Indeed, with specialised departments, most of these entities are well-placed to respond quickly to emergencies arising from such conflicts. Their services can include assistance with food and shelter, health and medical aid, water and sanitation provision, legal protection, and tracing missing family members. Donor governments are supposed to supply these organisations with the necessary resources for humanitarian assistance in response to humanitarian appeals.

Although not always welcome, a number of international humanitarian organisations are currently providing humanitarian assistance in countries such as Afghanistan, the Democratic Republic of the Congo (DRC), Iraq and Sudan. These countries have been, for years, the scene of complex and horrific wars that generate enormous levels of humanitarian need. Although the funding and resources provided to cater for those needs are often still limited, such contexts are recognised as humanitarian emergencies, besides being subject to IHL. Unfortunately, in numerous other contexts where violence is taking a huge toll on people's lives and where the resulting humanitarian needs are great, the role of humanitarian actors is less well-established. That is the case in violent contexts where IHL does not apply.

Violence in contexts not subject to IHL

In a number of Latin American cities, the levels of violence—and the attendant medical humanitarian needs—are often extremely high. IHL may not apply in those urban areas, however, either because the fighting is not of sufficient intensity or because the 'warring parties' are neither clearly identifiable nor adequately organised.⁴ In such cases, the IHL provisions for the protection of civilians and the right of access for humanitarian organisations are not applicable.⁵ Nonetheless, relentless 'routinised' daily violence dominates the lives of the local population in those cities, in turn

contributing to their social, economic and political fragmentation. People live in constant fear and insecurity: a fear that further isolates the poor from the rich in their segregated areas (Moser, 2004).

In major cities in countries such as Haiti, Brazil and Guatemala violence manifests itself in different ways and with different levels of intensity. The following subsections analyse the level of violence and some of its humanitarian consequences in Port-au-Prince, Rio de Janeiro and Guatemala City.

Port-au-Prince

For many years now, Port-au-Prince, the capital of Haiti, has been ravaged by violence inflicted by armed gangs. The city has a population of approximately two million people (Institut Haitien de Statistique et d'Informatique, 2003). For the period between February 2004 and December 2005, the worst phase of the violence, Kolbe and Hutson (2006) suggest that 8,000 people were murdered in the city, with a murder rate of 219 per 100,000 inhabitants per year. The sexual assault of women and girls was common in the same period, with findings suggesting that 35,000 women were victimised in the city, at a rate of 1,698 per 100,000 inhabitants per year. Kidnappings and extrajudicial detentions were also common; physical assaults were rated at 563 per 100,000 inhabitants per year. In a number of individual slums in the city, the mortality rates were significantly higher, however. Ponsar et al. (2009) suggest that, in 2006 and 2007, in the slum known as Cité Soleil, violence (especially gun-related violence) was the primary cause of mortality, causing 30 per cent of all deaths, with a murder rate of 457 per 100,000 per year. Young men aged between 15 and 39 years were most affected by the violence there. For that particular group, the murder rate was 1,109 per 100,000 per year. According to a UN Secretary-General report (UN, 2006), it is estimated that up to 50 per cent of young women living in conflict zones such as Cité Soleil have suffered rape or sexual violence.

The violence has had a wider impact on the city's population at large. According to a retrospective survey in Cité Soleil by Ponsar et al. (2009), approximately 55 per cent of families reported at least one form of non-fatal violence targeting either their belongings or a family member. More specifically, nearly one family in four (22.9 per cent) has been a direct target of physical violence. Blows, threats and intimidation, and gunshot wounds are the most common forms, along with kidnapping and rape. Victims of these violent events experience direct medical ramifications such as fractures, physical pain and wounds. One-fourth (24.6 per cent) of the victims of physical violence continue to suffer the psychological consequences of violent events, underlining the long-term effects of violence (Ponsar et al., 2009). In the language of the WHO's definition, the violence in Port-au-Prince has resulted in 'injury, death, psychological harm, maldevelopment or deprivation'.

Rio de Janeiro

People generally think of Rio de Janeiro as a tourist destination: images of Copacabana or the carnival are on every postcard. After all, Brazil is technically a country at peace.

With a population of approximately seven million people, Rio is also one of several Brazilian cities plagued by criminal violence and drug trafficking, armed gangs and militias (so-called *grupos de extermínio*—exterminators). Rio's violence-related data (including sexual and domestic violence) are alarming. People are killed or disappear on a daily basis: the city amassed 2,993 murders in 2004 (Ministerio da Saude, 2007a). In 2003, the figure was 3,175, and the murder rate for Rio de Janeiro as a whole was calculated at 47.7 per 100,000 inhabitants (Ramos de Souza and Carvalho de Lima, 2006). In the same year (2003), 4,800 people disappeared in the state of Rio de Janeiro (Ramos and Lemgruber, 2004). Violence affects people in the city in different ways, according to their age, class, gender and location. Looking only at the male population, the murder rate was 95.7 per 100,000 inhabitants (Ramos de Souza and Carvalho de Lima, 2006). Breaking down the data by age group, the murder rate for young people between the ages of 15 and 24 was more than 200 per 100,000 inhabitants (Ramos and Lemgruber, 2004), comparable to levels in Port au Prince at the zenith of the conflict in that city. On analysing the geographical distribution of murders in Rio de Janeiro, it transpired that Bonsucesso, one of the *favelas* (slum, in Portuguese) in the north, had a murder rate of 471 per 100,000 inhabitants in 2004 (Small Arms Survey, 2007). The state authorities in Rio have adopted increasingly militarised tactics in their attempt to combat drug gangs, which hold sway over most of the city's shantytowns (Amnesty International, 2007). The number of deaths caused by the police during fighting against gangs was 900 in 2002 and 1,195 in 2003, demonstrating high levels of police violence (Ramos and Lemgruber, 2004).

Guatemala City

Guatemala suffered more than 36 years of internal conflict, which formally ended with the signing of the Peace Accords between the government and the left-wing guerrillas at the end of 1996. Since the war, hundreds of thousands of paramilitary troops have been disbanded, and thousands of guerrillas have been demobilised and resettled and are now being integrated into the political and economic life of the country (GlobalSecurity.org, n.d.). Despite the official peace, the country's capital, Guatemala City, is one of the most violent cities in the Western hemisphere. Like many other places in Latin America, Guatemala City is divided into very rich and secure zones on the one hand and extremely poor and insecure areas on the other. When driving through the streets, one cannot help but notice shop windows completely barred and armed guards with shotguns protecting every commercial building. Criminal violence, drugs and arms trafficking, street crime, gangs (such as *Maras 13 and 18*) and mafia warfare plague certain areas of the city (such as zones 18, 7 and 3). The *maras* are able to operate undisturbed, sharing among themselves control of huge urban (and rural) areas as well as sources of underground economic activity. In the past 10 years, Guatemala City has accounted for more than 35 per cent of crimes committed in the whole country (UNDP, 2007). Paramilitary activities, social cleansing, and political assassinations claim lives daily with almost total impunity.

The murder rate for Guatemala City as a whole in 2006 was 108 per 100,000 (5,885 murders) (UNDP, 2007). Assaults and thefts accounted for 81.1 per cent of crime in the first semester of 2007 (UNDP, 2007, p. 38). The city (like the rest of the country) has also seen an alarming increase in violence against women, including rape, torture and extrajudicial killings. Sexual violence (including domestic violence) is definitely an increasing problem (Amnesty International, 2006). For the majority of women in poor urban areas, sexual abuse constitutes their first sexual experience. Countrywide statistics for 2007 point up approximately 10,000 cases of sexual abuse (PAHO, 2007, p. 379), of which 4,200 took place in and around Guatemala City (MSF, 2008a). Data from January to September 2008 for Guatemala's metropolitan area reveals 723 cases of sexual violence, of which 231 involved girls and boys under the age of 11 (MSF, 2008b).⁶

Analysis

A word of caution regarding the accuracy of the data for all three cities is necessary. The coverage and the quality of the data vary, making it harder to interpret them. In addition, the data often come from official sources, being complaints filed with the police. One should note that, in fact, people often do not report crimes to the authorities. Most women are reluctant to report sexual violence to health facilities or the police. For example, it is universally accepted that rape is the most underreported crime in the world (WHO, 2007, p. 1). According to McGregor et al. (2000), an estimated 94 per cent of sexual assaults never come to the attention of the criminal justice system. Similarly, Amnesty International highlights that around 4,800 men were murdered in Guatemala in 2005. These cases also appear not to be investigated effectively: press reports indicate that only four per cent of cases end with criminal sentences (Amnesty International, 2006). One can assume, therefore, that the indicators and rates cited here are equally underreported. For a more comprehensive picture, data from mortuaries, hospitals and emergency departments are essential, but such data frequently do not exist or are not made available. More rigorous and complete data collection systems would be of great help in analysing data and conducting assessments.

Looking at the indicators of violence used for the three cities discussed here, one can say that the levels of violence are extremely high. As mentioned, the murder rate of Port-au-Prince was calculated at 219 per 100,000 inhabitants per year (with peaks of 457 per 100,000 in some areas). Similarly areas of Rio de Janeiro report murder rates of 471 per 100,000. By contrast, the murder rate in New York City in 2006 was seven per 100,000 inhabitants (UNDP, 2007, p. 23). Wallensteen and Sollenberg (2001) define war as any armed conflict with at least 1,000 battle-related deaths during any given year. If one applies that definition to the number of deaths in Port-au-Prince (where 8,000 people died over three years), Rio de Janeiro (with 3,175 murders in 2003, of which 1,195 occurred during fighting with the police) (Ministerio da Saude, 2007b) and Guatemala city (with 5,885 murders in 2006), one could argue that each of those cities is in a state of war, albeit undeclared.

In many violent urban settings it is often difficult to differentiate between guerrilla warfare and violent common crime. As Bourgois (2004, p. 428) notes: ‘. . . violence operates along multiple, overlapping planes along a continuum that ranges from the interpersonal and delinquent to the self-consciously political and purposeful’. Especially in Latin American countries, strategies for the control of territory and drug-trafficking routes, including counter-insurgency tactics and extortion, are used, irrespective of their political or criminal nature. In fact, some of the most powerful armed gangs in these countries could potentially be considered ‘armed groups’ as understood in the context of IHL. Indeed, many of the gangs (such as the *Commando Vermelho* in Rio de Janeiro) are under a responsible command and exercise control over parts of a country (or a city) territory, enabling them to carry out sustained and concerted military operations—as required for the application of Additional Protocol II to the Geneva Conventions (ICRC, 1994, p. 270). Criminal violence is not immune to political conflict tactics: cleansing of recruitment-age youth, active recruitment (also of children), rape, terror campaigns (including signature killings), abductions, control of organised crime for income generation, and illicit trade (involving and/or abusing the urban community).

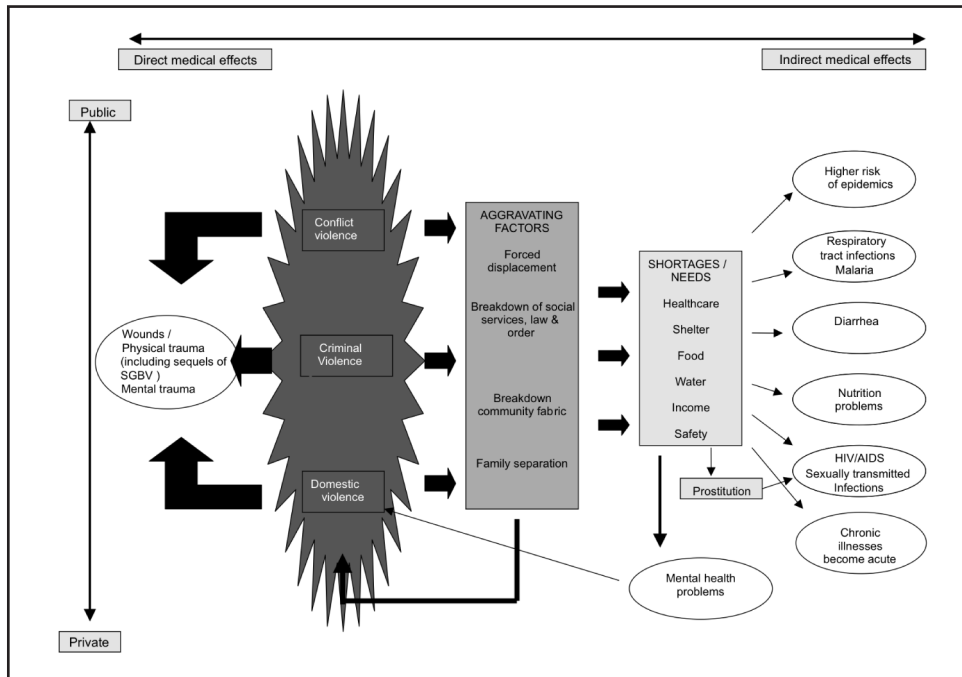
Different forms of violence persist and overlap in urban contexts. Besides being a concrete concern in terms of security and the protection of human rights, violence also produces humanitarian needs. Indeed, the distinction between armed conflicts subject to IHL and violent contexts that are not subject to IHL does not relate to the scope and intensity of violence in a particular setting. One can argue that making a distinction between legally-defined and non-legally-defined armed conflicts means ignoring the real issue: what matters is not who is fighting but rather the suffering of the people affected. This distinction also has consequences for the availability of humanitarian assistance and donor funding in the way that ‘official’ labels and definitions, rather than actual needs, seem to define responses (as shown below in the section entitled ‘Different responses to violence in urban contexts’). Where governments fail to provide protection and assistance to their own citizens, humanitarian organisations have yet to define response criteria for these challenging new situations. At the same time, the humanitarian imperative and its resulting moral obligation to assist people on the basis of their needs and their needs alone, and to respond to their suffering, is also being challenged. Despite the horrendous impacts of violence in these ‘unofficial’ theatres of conflict, the resulting humanitarian needs often remain underserved and the humanitarian response is limited. The various players in the humanitarian system (governments, donors and organisations) need to remedy this situation.

Medical consequences of violence

The numerous health consequences of violence vary according to its intensity, its purposes and the tools used to perpetrate it, regardless of the context in which it occurs.

Figure 1 shows how violence can have both direct and indirect medical consequences. Violence always has a decisive impact on living conditions, in particular because it

Figure 1 Medical consequences of violence



Source: Humanitarian Affairs Department, MSF, Amsterdam.

jeopardises a person’s physical integrity and survival and it produces suffering and disease. Besides the loss of life (partly visible through murder rates), violence can lead to direct medical effects such as wounds, physical trauma (including the ramifications of sexual violence) and mental trauma.

In addition to the often more obvious direct medical effects of violence, indirect medical effects sometimes result from aggravating factors such as displacement, the breakdown of the social fabric, the separation of families, and the breakdown of social and health services and law and order. Besides being theatres of violence, cities also frequently become the destination for those who have been forcibly displaced from the countryside or for victims of violence seeking refuge and safety. These new populations are likely to put an additional strain on existing urban resources and available services, when they are in need of healthcare, shelter, food, water, income and safety. These needs can generate further medical consequences such as (depending on the context) epidemics, malnutrition, respiratory tract infections, malaria, intestinal infections, diarrhoea, sexually-transmitted infections (STIs) and nutrition problems. Furthermore, people may resort to alcohol and drug abuse to escape their problems. Due to the lack of access to and availability of healthcare, chronic illnesses can become acute and emergencies can go unattended.

Violence also affects the provision of healthcare: governmental health structures are not always able to cope with all the various medical needs produced by violence. These additional needs represent a burden for the healthcare system: not only in

relation to the treatment of injuries resulting from aggressive behaviour, but also with regard to demand in other areas fundamental to health, such as physical rehabilitation and psychological care (Cruz, 1999). The entire health system may collapse due to violent events, and healthcare professionals might stay away from certain areas of the city (slums) for fear of violence.⁷ Other forms of structural injustice, such as neglect, exclusion, discrimination and corruption by the authorities, might be the cause of the lack of proper infrastructure (for example, functioning health centres and a sewage system) and resources in the slum communities. These communities often have no access to clean water for drinking or washing and sanitation facilities (for instance, latrines) may not be available, increasing their vulnerability to water-borne diseases. In these circumstances, structural injustice also has health consequences. The following subsections consider some of the indirect affects of violence in the cities of Port-au-Prince, Rio de Janeiro and Guatemala City.

Port-au-Prince

The indirect medical consequences of violence in Port-au-Prince are manifold. In Martissant (a slum of Port-au-Prince), one-third of families (36 per cent) reported that they had to move (forcibly displaced) at least once during the 2006–07 period because of insecurity (Ponsar et al., 2009). The houses of some families were burned down, destroyed or seized. Such displacement, even if unique, will certainly have had ramifications for the economic situation and living conditions of the families concerned.⁸ Food insecurity and chronic malnutrition as a result of continued violence is still affecting the most vulnerable. Some people often have only one meal per day; others eat mud cakes made out of dirt, shortening and salt, which are sometimes their only means of sustenance (Carroll, 2008).

The crisis situation in Martissant has hit a population that was already marginalised, extremely poor and vulnerable in a context in which access to basic social services, including healthcare, is almost non-existent. The population of Martissant has been rendered fragile by years of crisis during which the violence has affected morbidity and mortality within families. In such circumstances, there are significant medical needs. Martissant is one of the poorer areas of Port-au-Prince, but has no Ministry of Health (MoH) facilities. Most of the health facilities elsewhere in Port-au-Prince have suffered from insecurity in the past few years: some have been the target of armed robberies or caught in crossfire, or their staff have been directly threatened at gunpoint or attacked. Some are still suffering due to a lack of healthcare personnel, among other things (MSF, 2008d). Some health centres had to close down or relocate outside the slums for months during the worst periods.

Haiti has the highest maternal mortality rate in the Western hemisphere: it was estimated at 670 deaths per 100,000 live births in 2005 (in the Dominican Republic, by comparison, it was 150 per 100,000 live births) (UNICEF, 2008a, 2008b). For pregnant women living in the violent slums of Port-au-Prince, it is not easy to find healthcare. Some antenatal care is available in the healthcare structures within slum communities, which are mostly run by churches and NGOs, yet none of those

structures provides care during actual delivery of the baby. Seventy-five per cent of maternal deaths occur during delivery or the subsequent few hours. Some women told shocking stories of being stranded at home during labour while fighting was raging in the streets; others recounted the terrifying experiences they endured on their way to the hospital (MSF, 2008d). Being surrounded by violence and insecurity has been a collective experience of women in Port-au-Prince.

Rio de Janeiro

Communities in Rio de Janeiro face similar problems due to violence. Some communities are almost completely cut off from the rest of the city; barriers isolate them, so that police cars and other vehicles cannot get in (MSF, 2008e). Most communities do not have efficient or effective health services nearby, and many people have complained that health workers were reluctant to enter their communities because of fear or prejudice. Residents often have to travel considerable distances (frequently through shootouts) to get to a hospital. If they do manage to get there, they regularly face discriminatory treatment and have to queue overnight to have any chance of receiving treatment (Amnesty International, 2008).

In some communities in Rio de Janeiro, women are unable to visit a health centre as it is located in a neighbouring community, which is controlled by a rival drug faction; the women would be killed if they were seen going there. Women living in areas dominated by criminal gangs have great difficulty accessing effective and secure healthcare when they are physically abused or raped. The attackers, especially if they are members of criminal gangs, threaten not only the women themselves, but also the health centre workers, nurses and doctors who try to help them. Violence and insecurity are the main reasons cited for the lack of health workers in this neighbourhood. Medical teams are afraid, and emergency vehicles (ambulances) are unable to manoeuvre through the narrow streets of the *favelas* (MSF, 2008d). The obvious outcome of this situation is that fewer health professionals are prepared to become involved in cases of women abused by criminal gang members (Amnesty International, 2008).

Like Port-au-Prince, Rio is also failing to provide adequate maternal care. Women in socially excluded communities face discrimination and extremely low levels of services in this fundamental area of healthcare. The statistics on maternal mortality in the city make for a shocking reading: 120 per 100,000 live births in 2006 (Ministerio da Saude, 2007a). The four main causes of maternal mortality in Brazil, according to the MoH, are hypertension, haemorrhaging, post-partum infection, and abortion (largely as a result of an illegal or self-inflicted procedure). All of these conditions are easily preventable or treatable with adequate healthcare provision (Amnesty International, 2008).

MSF's experience in Rio de Janeiro shows that many severe clinical emergencies, such as asthma, complicated pregnancies, drug overdoses, heart attacks and strokes, are also aggravated by the isolation of communities and the lack of access to healthcare. These are medical needs that warrant an appropriate response.⁹

Guatemala City

Besides being heavily hit by violence, Guatemala City is the main receptor of migrants from the countryside. Most of them live in illegal settlements built in very precarious security conditions. They form a good source of recruitment for *maras* (gangs) and organised crime. Increasing levels of widespread violence are taking their toll on public health resources: the main reasons for admissions in hospitals are fractures or injuries due to violence or accidents. This ‘epidemic’ of violence subtracts funds from normal medical care. HIV (human immunodeficiency virus) prevalence is growing (UNAIDS, 2008, p. 229); although government investment to counter the epidemic is uncertain and insufficient (UNAIDS, 2008, p. 254). In 2006, an MSF exploratory mission found that healthcare services are not evenly distributed throughout the city and few health structures are offering appropriate treatment to survivors of sexual violence, that is, comprehensive medical and mental healthcare. In addition, services suffer from several shortcomings, full treatment is not always available, and medical attention is not available at all times without interruption (MSF, 2006). MSF patients often present symptoms of post-traumatic stress, acute depression and anxiety due to violent events. In turn, symptoms such as these are often the cause of high levels of domestic violence. Violence creates a vicious circle, producing more violence. Not having enough money can also be a problem for people in urgent need of healthcare.

Analysis

Examples of indirect medical consequences of violence—including its effects on the healthcare system—in Port-au-Prince, Rio de Janeiro and Guatemala City show that violence and its aggravating factors can result in needs that greatly affect already marginalised, poor and vulnerable communities. These populations are exposed to higher health risks and often enjoy little, if any, access to healthcare.

On analysing these different violent urban contexts, it is clear that people living in these places are in need of humanitarian assistance. In that sense, they are no different to armed conflicts with a high level of violence that are subject to IHL. Yet, little or no attention is paid to affected communities residing in locations that are not considered as full-blown conflict zones, except when they are hit by natural disasters, as is unfortunately often the case in Haiti (due to hurricanes). As Darcy and Hofmann (2003, p. 5) argue, the way in which needs are defined and prioritised has real-world implications for millions of people. Indeed, the needs of people suffering in these cities (and many others around the world) often go almost overlooked and unattended by humanitarian agencies, as well as by the governments that are supposed to provide protection and assistance to their own citizens. For this very reason, the principle of impartiality of humanitarian action should be reaffirmed. Humanitarian assistance in violent contexts should not depend solely on the ‘legal existence’ of a conflict, but rather on what people’s needs are. Darcy and Hofmann (2003, p. 11) add: ‘the key concern is whether the most urgent cases are being funded – and more generally, whether resources are being allocated based on a clear sense of

relative priorities. This question must be asked at the global, regional, country and local level: and it must be asked between different sectors of humanitarian activity'.

As explained in the next section, the existing responses to violence mainly focus on preventing and reducing violence via security and developmental approaches. A humanitarian response is not yet considered a real priority.

Different responses to violence in urban contexts

Violence in urban contexts is increasingly being recognised as a serious security and developmental concern. Various governments and NGOs are promoting and implementing different approaches to the prevention and reduction of violence mainly from a governance or developmental perspective. The following subsection considers some of these approaches: some are sector-specific, others focus on particular communities or target populations, while still others aim to achieve more integration among different policies (Moser, 2004). Most of these approaches foresee long-term interventions. Very few of them concentrate on the medical-humanitarian consequences of violence in the type of setting under consideration here. Two of the main reasons for this gap are the current funding mechanisms and the artificial division created between relief and development aid. Another factor is that humanitarian organisations still perceive violent urban contexts as unexplored territories.

Current responses and funding mechanisms

One of the most popular approaches to urban violence to date is the so-called human security approach, which aims to deter and control violence through law-enforcement measures. Usually sponsored by donor governments and UN agencies, the interventions utilising this approach support training and capacity-building for police and military forces (depending on the particular context) (humansecurity-cites.org, 2007). The 'human security' approach often seeks to reform the justice system, has a strong human rights agenda, and is frequently combined with urban disarmament, demobilisation and reintegration (DDR) programmes with the goal of reducing the availability of firearms among the population in general and among gang members in particular (International Crisis Group, 2007, 2008). One shortcoming of this approach is that it does not address or act on the causes of violence (that is, the grievances), nor does it respond to the needs of communities affected by the direct and indirect consequences of violence.

Another more long-term developmental and community-oriented approach aims to reduce violence by focusing on particular population groups that may resort to or be affected by violence due to a lack of opportunities in life (such as poorly educated young males in the slums) (Briceño-León, 2005). Many such programmes endeavour to reduce vulnerability by establishing opportunities for job creation, education and vocational training. Others focus on conflict resolution (or transformation) and on building social capital, trust and cohesion in both informal and formal social

institutions. In addition, some programmes look to resolve inequality and exclusion by improving infrastructure and water and sanitation facilities for the entire population living in the slums. Yet other public health-focused programmes seek to prevent violence by reducing individual health risk factors and by trying to decrease drug and alcohol dependence (Moser, 2006). The impact of such programmes is, however, difficult to assess. Moreover, their long-term perspective is hardly an adequate response to the immediate needs of violence-affected populations.

A number of violence-affected governments and local and international NGOs (as well as churches or religious groups) provide some form of remedial assistance to individuals and groups, such as displaced populations and children or female victims of violence. This can include legal or social support, family tracing and sometimes the provision of shelter or food. While this kind of assistance is of great importance to people directly affected by violence, its shortcoming is that it is usually provided only for the short term and often it does not encompass healthcare.

On their own, each one of these approaches is, without doubt, useful and necessary. And given the complex and multifaceted nature of violence in urban settings, an integrated response is certainly appropriate. Nonetheless, some gaps remain in the response to the humanitarian impacts of violence. When taking into account the direct and indirect medical consequences of violence, in both the short and the long term, some additional needs come to mind. As mentioned above, acts of violence have both physical and mental health consequences that require immediate attention and proper treatment. Particularly during the peaks of violence, appropriate patient care needs to be provided, wherever and to whoever needs it.

Physical violence as well as exclusion and deliberate neglect can also result in the disruption and collapse of whatever health system is in place. Therefore, those systems cannot offer the necessary basic or specialised medical care, nor are they either accessible or available to those populations that are affected by violence and need healthcare (at any given time). It is vital that (medical) humanitarian organisations respond to these unaddressed medical humanitarian needs.

Unfortunately, humanitarian aid in violent urban contexts has yet to become a priority for all parties concerned. This is clear from the list of financial commitments, contributions and pledges that the UN Office for the Coordination of Humanitarian Affairs, Financial Tracking Service (OCHA-FTS) compiled on the basis of data from donors and the appealing organisations. The lists for Haiti, Brazil and Guatemala for 2006 and 2008 were analysed for the purpose of this discussion.

In 2006, Haiti received 38 financial contributions from donors, of which only three were clearly devoted to projects in Port-au-Prince (although the words 'violence' or 'conflict' do not appear in the descriptions of any of them). In 2007, donors contributed to 63 projects for the whole country. Only seven of these projects were clearly implemented in Port-au-Prince. The word 'violence' (or 'conflict') appears only eight times, as most of the contributions in 2007 related to the response to hurricanes and natural disasters, as well as food security. In 2008, Haiti was first affected by a food crisis (which also resulted in violent riots) and then hit by tropical

storms and hurricanes (Fay, Gustave, Hanna and Ike). Most of the humanitarian contributions for that year were in response to the consequences of those natural disasters. Nevertheless, before a second appeal was initiated after the storms of 2008, 75 contributions had been made to humanitarian interventions in Haiti, only seven of which were clearly implemented in Port-au-Prince. The words 'violence' or 'conflict' do not appear in any of the descriptions of these contributions.

The situation regarding humanitarian contributions to Brazil is slightly different. In 2006, Brazil received three contributions, of which one was for human security, but it is unclear if that was earmarked for Rio de Janeiro. In 2007, five humanitarian contributions were made to Brazil, one of which was for a 'conflict prevention and resolution, peace and security' project in Rio. In 2008, humanitarian contributions for Brazil were made to support four interventions related to the January and November 2008 floods. It remains a question whether, besides being officially at peace, Brazil is receiving very little humanitarian assistance because it is considered a middle-income country and is therefore supposed to respond to the humanitarian needs of its own population by itself.

There were 22 humanitarian contributions to Guatemala in 2006, six in 2007 and 14 in 2008. Most of these contributions related to natural disasters (either in response to them or for prevention) and the word 'violence' does not appear in the descriptions of these projects. There was only one contribution (in 2006) clearly earmarked for an 'urban' project (disaster preparedness for Guatemala City).

The poor provision of humanitarian aid in these contexts has different origins. One of the main reasons is the current funding mechanism. With the exception of natural disasters, donor governments still generally provide little financial support to humanitarian efforts that aim to alleviate immediately the suffering of people affected by crises in countries that are not officially at war. Current funding mechanisms distinguish between developmental, humanitarian and post-conflict assistance. The contexts in question are scrutinised and classified into one of those categories, and the money from the donor governments is distributed accordingly. As Darcy and Hofmann (2003) note, the way in which situations are classified determines the source of funding, the scale of resources allocated, the form of the response, the planning time frame, and the way in which organisational roles are determined. Humanitarian organisations and developmental NGOs implement projects depending on the resources made available to them. The problem of combining humanitarian and development agendas in places where people face chronic poverty as well as violence and insecurity is well known.¹¹ In particular, the violent urban contexts described in this paper do not easily fit in just one of those categories, being instead relatively complex and multifaceted. As they are most likely to be included in the realm of development (or post-conflict in the case of Haiti), the funding for developmental projects can often take priority over any funding for humanitarian assistance.

Another important reason for the inadequate provision of humanitarian assistance in such contexts is often to be found in the organisational culture of the service providers. Humanitarian organisations frequently consider the violent urban contexts

in countries that are officially at peace to be unexplored territories for which appropriate operational models have yet to be created.¹² Particularly the ‘hard-core’ ones have trouble finding an appropriate role for themselves in these ‘unofficial settings’—as explained above, contexts that are subject to IHL are more likely to attract the attention of (and therefore a greater presence by) humanitarian organisations. A number of organisations think that they have no expertise in such ‘unofficial’ contexts. Such considerations can nevertheless endanger the provision of and access to the necessary medical care in the slums during the peaks of violence. Communities are then left with the scant assistance provided by state agencies that often have few resources and are not always impartial or are equally endangered when entering these areas.

Although humanitarian organisations somehow view the response to crises in violent urban settings as an unfamiliar field, the experience that they have gathered by working in traditional armed conflict settings is of significant added value that should not be underestimated. The fact that, until now, violent urban settings have not been considered appropriate environments for humanitarian organisations to work in—and the lack of set standards or accepted ways of doing things in such locales—does not detract from the magnitude of the basic medical and humanitarian needs that have to be fulfilled.

Violence in urban settings: a role for humanitarian organisations?

Humanitarian assistance is the aid and action designed to save lives, alleviate suffering and maintain and protect human dignity during and in the aftermath of emergencies (Development Initiatives, 2008, p.3). As discussed above, humanitarian organisations and their donors too often think of criminally violent urban settings as something essentially different from armed conflict zones. As a result, they are failing to respond to the medical–humanitarian needs that arise because of the violence in those urban contexts. What they fail to recognise is that those who have seen family members killed, wounded or raped are equally affected, regardless of the perpetrator (be it an army soldier, a state agent or a gang member) (Harroff-Tavel, 2008).

Considering the severity of both the direct and indirect medical consequences of violence in the urban contexts described above, a humanitarian response is much needed when the governments themselves fail to provide for their own citizens. This subsection outlines the challenges to and opportunities for the provision of humanitarian assistance in such violent urban settings, and it sets out examples from MSF’s own experience.

Challenges to and opportunities for humanitarian organisations

Humanitarian organisations can play a vital role in violent urban settings, especially by supplying healthcare to communities that are unable to access public health services. The lack of access to healthcare could be due to a collapsed health system or discriminatory policies. In such circumstances, the provision of healthcare or any humanitarian assistance is not without its obstacles.

Perhaps the most important challenge is to identify the needs that can be linked to physical violence and abusive use of power and to separate them from the issues affecting the general well-being of the population in any resource-poor urban setting (such as poor sanitary conditions, inadequate healthcare, higher demand on social services, illegal housing, a lack of planning and poor roads). A key question—and one that remains unanswered—is how to target assistance to meet the needs that stem from violence, but still avoid becoming too removed from the ‘humanitarian’ role that the organisation has chosen to play.

In medical terms, deciding how big a health package to provide in these settings is another important dilemma. For example, the treatment of chronic conditions, such as asthma, diabetes, drug overdoses, heart attacks, hypertension and strokes, is no less important than dealing with gunshot wounds, as these conditions also can be life-threatening. An emergency response that focuses solely on the direct medical effects of violence might not be sufficient. This dilemma once again raises the question of how to address long-term structural problems that coexist with temporary but critical problems, such as emergencies.

A third significant challenge in attempting to provide assistance in an impartial manner is how to manage the scale and volume of potential beneficiaries and how to identify and appropriately target the most-affected communities within a wider, densely-populated urban population base. A key issue for the implementation of programmes in urban contexts, for example, is why and how to target urban internally displaced persons (IDPs) when they live in the same abject living conditions and suffer essentially the same problems as the urban poor around them. The following questions continue to challenge the logic of humanitarian interventions in these urban settings:

- which individuals qualify as IDPs?;
- how long will that status remain valid?;
- what are the direct and indirect consequences of the displacement for their health?; and
- why is it necessary to duplicate or substitute health services in countries where most healthcare is concentrated in urban settings?

The challenge of targeting people in urban settings is not limited to distinguishing between IDPs and the urban poor. With a programme that focuses on HIV care or the reduction of maternal mortality, strategies need to be found to limit or filter the assistance so as to reach people who really have no alternative means to access other services. Within urban slum settings, it is important to identify who is most marginalised, affected by violence or living in extreme conditions. Yet, once such groups have been identified, it is also of paramount importance not to stigmatise them, and not to increase their sense of insecurity.

A fourth significant challenge pertains to the fact that the distinction between victims and perpetrators, civilians and combatants seems even less clear in violent

urban settings than in traditional conflicts. The proximity of ‘genuine civilians’ to gang members, weapon carriers, or resource providers within the community make civilians even more vulnerable to becoming direct targets of violence. To earn a living, some people have little choice but to become part-time informers, to hide weapons for the gangs, or to cook food, carry information and/or form family ties with urban ‘combatants’ or criminals. Many of the perpetrators of violence in Haitian slums have themselves been the victims of violence; many will now continue to be victims of the new urban conflicts. Former perpetrators, such as demobilised gang members, are among those with the greatest need of mental healthcare (but will rarely be considered as civilians). This blurring of identities presents challenges to humanitarian agencies that aim to distribute aid in an impartial and neutral way among communities that resent each other (in much the same way as in militarised refugee or IDP camps in ‘official’ armed conflicts).

A fifth challenge for humanitarian organisations in terms of working in violent urban settings is that interventions in these areas present some security concerns linked to the proximity to the communities concerned and the higher degree of unpredictability and complexity of the violence—also due to the invisibility of the ‘conflict’. In addition, the multiplicity of armed actors (in all their forms) can make negotiating access and obtaining security guarantees difficult, particularly when those charged with protecting citizens and providing security are very often the perpetrators themselves (although this is not a uniquely urban problem, of course). Interpreting the risks that such dynamics pose to both the beneficiaries of assistance and the humanitarian organisations, and figuring out how to limit these dangers—while securing reasonable access to and for target populations—are difficult tasks.

Given these challenges, accessing populations in distress and implementing programmes in urban settings can take a lot of time and effort to achieve. Approaches often need to be cautious and proceed step-by-step, requiring a significant investment of time and resources before the outcomes are realised that can justify such programmes.

Yet another particularly challenging aspect is establishing exit criteria (in chronic settings) or deciding when to stop or close down a project in a violent urban setting. For most projects, any exit strategy will be linked to an improvement in the provision of healthcare by the MoH in the country concerned (or to the possibility of handing over the project to other capable actors)—and this will depend on external factors that are often beyond the control of the humanitarian agencies themselves. Exit strategies are often frustratingly difficult to define or even to develop over time, given the frequently chronic nature of the types of problems encountered in those settings. Responding to needs in such locales requires a commitment of time (longer than a typical emergency intervention) and resources.

Finally, preventative public health measures, such as securing potable water and carrying out sanitation interventions, can be daunting for humanitarian organisations in urban settings as they often depend on establishing structural change and infrastructure in illegal settlements.

Despite all of these challenges, there are also a number of opportunities for humanitarian assistance to violent urban contexts. The primary added value of a humanitarian response in violent urban settings no doubt pertains to its impartial and neutral nature. The blurring between civilians and those who bear arms, the existence of frontlines within cities, and the isolation and neglect of the communities caught in the middle make it that much more important to provide aid in ways that are non-discriminatory and need-based. In particular, just as in recognised war zones that are subject to IHL, the impartiality and the neutrality of humanitarian action are paramount if organisations are to gain the confidence of all parties involved, and in the process, acquire access to communities in distress under the control of armed gangs.

Delivering humanitarian relief is certainly achievable in violent urban settings such as Port-au-Prince, Rio de Janeiro and Guatemala City. In the Port-au-Prince slums of Cité Soleil and Martissant, for example, thanks to the work of humanitarian organisations, the victims of violence are now receiving basic and emergency health-care, as well as clean water due to the rehabilitation of the water tower of Cité Soleil. Neither would have been possible without the trust of all of the armed groups as well as of the governmental forces. In Guatemala City and Rio de Janeiro, MSF ambulances are now allowed to enter and exit isolated violent areas to provide emergency care to patients and to refer them to secondary-care hospitals.

Another important opportunity for medical humanitarian organisations working in violent urban contexts is that existing specialised MoH structures offer the possibility to refer patients to them. Their presence underscores the importance for humanitarian organisations to work in partnership with the MoH of the respective country. However, the same MoH presence can also represent a challenge when certain patient groups or categories are not granted access to free healthcare to begin with, and/or where corruption is rampant, limiting the possibilities for referral. An additional related challenge for humanitarian organisations concerns the need to work ‘within’ the system without duplicating (or substituting) it or being seen to be complicit with it.

Moreover, where certain specific services do not exist (mental healthcare services, as well as HIV care and post-rape treatment are rare), the presence of medical humanitarian organisations can be useful as a way of demonstrating a ‘model of care’. In Guatemala City, for instance, having an international NGO assertively take the lead on providing care to survivors of sexual violence is considered an important step towards getting the society there to acknowledge sexual violence as a medical emergency and towards establishing proper and confidential services.

Local partnerships—or at least fairly elaborate networking with local authorities and other entities (such as churches, civil society groups and NGOs)—are more commonplace in urban settings and provide ways of avoiding a completely substitutive role. Strong partnerships with civil-society activist groups to further common advocacy objectives are key to the success and sustainability of these programmes. Links with legal departments, social security services and other structures that offer (legal or physical) protection are also of fundamental importance in supporting victims of violent acts or those who are under direct threat.

Finally, in such settings, operational responses should go hand-in-hand with advocacy efforts. Given their proximity to the communities they work with, humanitarians can advocate for change as well as provide accounts of how people are suffering. Advocacy targets can be local authorities, health authorities, governments and the international community. Advocacy objectives can vary: from introducing new protocols for care, to the provision of health services in neglected areas, to the provision of more and better aid by international donors in a particular setting. Raising awareness of the suffering of violence-affected populations is equally important to increase the protection of vulnerable population while addressing the underlying causes of suffering. Speaking out is also meant to avoid complicity with the perpetrators of violence while trying to alleviate the suffering that they produce (MSF 2008c, 2008d, 2008e, 2009; Ponsar et al., 2009).

Conclusion

As the theatres of conflict change, those who provide humanitarian aid need to adapt to the new contexts of violence. The humanitarian consequences of ‘sub-IHL’ violence in urban settings are often comparable to those of the violence that occurs in ‘IHL’ armed conflicts. Both involve large numbers of people who are killed, raped, kidnapped, tortured, forcibly displaced or otherwise attacked. In addition, the breakdown of the social and health services that results from the violence in urban settings aggravates the vulnerability of poor urban communities and increases the scope of their needs.

Violence in urban settings has various causes and a broad range of ramifications. Some causes might well be effectively addressed through a human security approach with increased policing, law enforcement and conflict resolution, or through more developmental approaches, including job creation and education. Likewise, some impacts (such as food shortages, inadequate housing and poverty) might be addressed—often on an ad hoc basis—by local charities or governmental agencies. But the fact remains that violence in urban contexts also produces immediate humanitarian needs that must be addressed even as the crisis is unfolding.

Despite the intensity of the needs generated by ongoing violence in urban settings in countries that are technically at peace, the provision of humanitarian aid in such locations is limited. The distinctions between armed conflicts regulated or not regulated by IHL, as well as between emergency and developmental assistance, can lead to the neglect of populations in distress. This is especially the case where both donor governments and humanitarian organisations feel less ‘entitled’—and less compelled—to offer their assistance to those in violent urban settings in countries that are officially at peace. The current funding mechanisms cannot adequately respond to situations that do not easily fit into one category or the other. The organisational culture and structure of humanitarian organisations also play a part in the decision-making process when defining interventions in violent urban settings. Those settings

are generally considered to be unexplored terrain for which appropriate expertise and operational models have yet to be developed. The way in which needs are defined and prioritised fails to do justice to the problem of violence, the suffering it produces and the populations affected by it.

As long as those in power do not introduce the necessary measures to reduce violence and to provide health services and assistance to neglected populations, an impartial humanitarian response to the suffering of people in violent urban contexts is unfortunately going to remain necessary. While such a response presents many challenges and opportunities, experiences so far in Port-au-Prince, Rio de Janeiro and Guatemala City show that it is possible to develop and justify relevant programmes with a significant focus on both the direct and indirect health consequences of violence. Humanitarian organisations can alleviate much of the suffering of populations in distress in violent urban contexts.

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Endnotes

- ¹ This paper was written in a personal capacity. The views expressed herein are the personal opinions of the author and are not intended to reflect those of Médecins Sans Frontières.
- ² IHL is applicable in all cases of armed conflict, although the exact law applicable in each case will depend on a number of factors, most significantly whether the conflict is international or non-international in character.
- ³ Article 9 of the Geneva Convention (GC) I, as well as Article 9 of GC II, Article 9 of GC III and Article 10 of GC IV, state: '*The provisions of the present Convention constitute no obstacle to the humanitarian activities which the International Committee of the Red Cross or any other impartial humanitarian organization may, subject to the consent of the Parties to the conflict concerned, undertake for the protection of wounded and sick, medical personnel and chaplains, and for their relief*'. In addition, the Common Article 3 of the Geneva Conventions, 1949 states that: '*An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict*'.
- ⁴ Haiti has been a controversial case in terms of the applicability of IHL. Given the intensity of the confrontations, a number of agencies made the case for the applicability of IHL during the peaks of the conflict (2004–06). The situation has largely improved since. Today, Haiti is largely considered to be a fragile/post-conflict state.
- ⁵ International Human Rights Law applies in these settings. This body of law imposes an obligation on the state to ensure that essential healthcare is made available to its citizens, but, different to

IHL, it does not make a strong case for humanitarian agencies to provide their medical services to populations affected by violence.

- ⁶ Statistics released to MSF by Ministerio Publico.
- ⁷ David Souza, MD, MSF, personal communication, 21 May 2008.
- ⁸ A member of the community reported that several houses abandoned temporarily by families were taken over by gang members. On their return, these families were forced to pay rent to the latter in order to reoccupy their homes (MSF, 2008c, p. 17).
- ⁹ David Souza, MD, MSF, personal communication, 21 May 2008.
- ¹⁰ Such lists can be downloaded by country and by year at <http://www.reliefweb.int/fts>. This information is likely to be incomplete because some humanitarian organisations (as with MSF) have their own private funds that are not recorded as contributions. Another shortcoming of the information provided by the UN Office for the Coordination of Humanitarian Affairs is that the location for the humanitarian assistance within the country is often omitted. Hence, there might be more projects in the capital cities that are not listed as such.
- ¹¹ An attempt to plug this gap is the recently introduced (2006) early-recovery cluster managed by the United Nations Development Programme. This initiative is trying to link immediate responses to disasters with medium- and long-term recovery efforts. More information is available at <http://www.undp.org/cpr/disred/english/earlyrecovery/earlyrecovery.htm>.
- ¹² Paul Mcphun, Operational Manager, MSF, personal communication, May 2008.

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