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Unsafe Spaces: Trends and Challenges in Gender-Based Violence

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IMPROVING THE ODDS:
BATTLEFIELD MEDICINE IN IRAQ AND AFGHANISTAN

BY ROBERT BECKHUSEN

During the course of two wars in Iraq and Afghanistan, the U.S. military has faced challenges in treating wounded soldiers on a scale it hasn't witnessed since the Vietnam War. In response, the military has succeeded in reducing the mortality rate of soldiers injured in combat through a radical shift in doctrine, procedures and medical technology. The duration of the two wars has also produced a wealth of research that has informed Tactical Combat Casualty Care (TCCC), which has become the standardized set of procedures used to treat U.S. casualties across active-duty military services. Despite this, the cost has been high: 4,486 U.S. soldiers were killed in Iraq and more than 2,300 killed in Afghanistan. In the early years of the conflicts, the rate of preventable deaths was little different from 30 years prior. But more than a decade later, a wounded soldier is much more likely to survive his or her injuries than in previous wars.

Partly, this is due to the duration of the conflicts. Advances in medical technology and battlefield care can be seen and studied over longer periods. Information technology has made it easier to track, treat and analyze injuries. Developments in neuroscience and prosthetics have also opened up new areas for long-term care, although the causes of traumatic brain injuries (TBI) remain elusive and treatment is often poor. Meanwhile, military practices are being widely adopted in civilian hospitals, by police and by first-responder paramedic teams, and institutions such as the U.S. Army Institute for Surgical Research have also driven a wave of research into treating traumatic injuries, to the benefit of civilian medical providers.

DEVELOPMENTS IN BATTLEFIELD TRAUMA CARE

In a battlefield environment, medics are expected to treat severe injuries with limited supplies in dusty, dirty environments while also risking being shot with bullets or wounded by shrapnel. This confusing and hazardous environment poses enormous challenges not regularly faced by civilian paramedics. Soldiers can sustain catastrophic injuries that can cause sudden death or life-long disability. Does the medic prioritize treating injuries or fighting the enemy? When faced with multiple injuries, how does the medic prioritize which injuries to treat first? And how does the medic treat injuries when different types of treatment pose various other risks?

The most important development in battlefield trauma care has been the creation of the set of doctrines and procedures that comprise Tactical Combat Casualty Care. First developed beginning in 1994 by the U.S. special operations forces community, the goal was to detect the most easily preventable causes of battlefield deaths and train first responders to quickly stabilize such injuries when under fire. This also meant deferring care for injuries that, while still potentially lethal if left untreated, were survivable in the short term. In 1997, TCCC became the standard doctrine for the Navy SEALs, and was mandated for the U.S. 75th Ranger Regiment in 1998 by the regiment's commanding officer, then-Col. Stanley McChrystal. In 2011, TCCC became the standardized set of combat medical procedures used across the U.S. armed forces.

First, TCCC prioritizes reducing casualties over treatment. If a unit comes under attack and one or more soldiers are wounded, the medic—and the injured, if possible—are tasked with returning

fire to suppress the enemy and stop the attack, depending on the tactical situation. This serves to prevent the unit from incurring further casualties, including injuries to medical personnel on the scene or those arriving by helicopter to treat and evacuate the wounded. Next the doctrine calls on medics to employ aggressive use of tourniquets and hemostatic agents to control bleeding, a form of "damage control" that forgoes more complicated procedures, instead emphasizing procedures that are likely to save lives in the hour before the wounded can reach a hospital.

This was a marked change from how the U.S. military treated casualties early on in America's 21st-century wars. When the U.S. military first entered Afghanistan and Iraq, little had changed in medical doctrine since the Vietnam War. Aside from a select few commando units with experience in TCCC, such as the 75th Ranger Regiment—which saw a 3 percent casualty rate from potentially survivable wounds in 2001-2010 compared to 24 percent across the general armed forces—and Navy SEAL teams, the armed services did not train troops to use tourniquets, and in fact cautioned against their use. This has long been a point of controversy among doctors. A tourniquet cuts off the body's blood supply to the wound, which reduces bleeding, but can also result in cut-off tissue becoming oxygenated, which can possibly lead to cell death, nerve damage and amputations. Worse, clotting tissue can then spread to the bloodstream, potentially leading to shock and death. Prior to the implementation of the TCCC, tourniquets were widely thought to be a cure worse than the wound.

The risks of tourniquets are real, particularly if applied improperly or applied after a wounded soldier goes into shock. But as casualties mounted in Afghanistan and Iraq, a new consensus emerged that the risks of using tourniquets had been overstated. A 2007 report by the U.S. Army Institute for Surgical Research studied 232 soldiers in Iraq who had tourniquets applied to wounds and found no link between tourniquets—if used correctly by trained personnel—and increased risk of mortality. The institute's conclusion was that tourniquets can save lives and that discouraging their use "in the current war will increase the death rate." Since these revelations, the U.S. military has gone on to field more than 1 million Combat Application Tourniquets, which use a windlass to secure the band tightly around an extremity, and require only one hand to use. Another development is the introduction to special operations forces units of a specialized tourniquet called the Combat Ready Clamp, which attaches like a vice to the groin region—an area difficult to stabilize with standard tourniquets.

The U.S. military has also improved upon several iterations of hemostatic dressings, which are medical bandages containing chemicals that promote blood clotting. These dressings can be effective when applied together with tourniquets, and in regions that are not amenable to tourniquets such as joints and armpits, which are frequent areas of combat wounds as they are not typically covered by body armor. In 2003, the military largely used fibrin sealant dressings that contained powdered fibrinogen and thrombin, which clotted wounds when pressed for two to three minutes. Over the next several years, the military partnered with the American Red Cross to produce dressings treated with chitosan, a chemical derived from shrimp. The U.S. military experimented with a hemostatic agent known as QuikClot, but this was withdrawn after concerns that the powder caused tissue burns and dissipated before forming a clot. Since 2008, the U.S. Army Institute of Surgical Research has recommended Combat Gauze, a dressing coated in kaolin, a type of clay that uses aluminosilicate nanoparticles to stimulate clotting. It does not have any known side effects.

Another advance has been in treating hypothermia. Cold weather in Afghanistan's mountains is a common cause, but hypothermia can also be hastened by injecting cold intravenous fluids to stabilize wounded troops. The U.S. military has encouraged some makeshift alternatives, including insulating intravenous tubes using bits of cloth, covering the tubes in a sleeping bag together with the patient or storing the fluids close to the body, keeping them warm. Furthermore, soldiers now carry chemically heated blankets and hoods known as Hypothermia Prevention and Management Kits.

A related development was the establishment of the Department of Defense Trauma Registry. This database, created in 2005, established a single system for tracking wounded soldiers and the type

of treatment they receive once they arrive at field hospitals. Such data continues to be tracked as the soldiers are moved to more-advanced treatment facilities in the United States. This gave Pentagon planners access to large amounts of data regarding which treatments were successful, data they then used as the basis for recommendations to the U.S. military's Center for Tactical Combat Casualty Care. The program was later extended to include the Pre-Hospital Trauma Registry Initiative, which tracks treatment given at the tactical level. As part of the initiative, soldiers are issued a card, and if a solider is injured, the field medic can write down the type of treatment given before the casualty is evacuated. This essentially takes the military's practice of recording lessons learned from combat in the form of After Action Reports and applies it to casualties.

DEVELOPMENTS IN FORWARD-DEPLOYED HOSPITAL CARE

Another series of improvements have occurred at in-theater hospitals and, to a lesser extent, during medevac flights from the battlefield to the hospital.

In general, military medical evacuations during the wars compare poorly to their civilian counterparts. U.S. Army medevac UH-60 Black Hawk and CH-47 Chinook helicopters have commonly carried a single medic responsible for treating seriously injured patients while traveling over long distances. By contrast, civilian helicopters often have two paramedics who are better trained and equipped than their military counterparts. According to a 2012 study in the Journal of Trauma and Acute Care Surgery, the military version "remains essentially unchanged since the Vietnam era" despite evidence showing that experiments with medevac units trained along civilian lines reduced 48-hour mortality rates by 7 percent. However, the Pentagon has mandated all flight medics to be trained to civilian paramedic standards by 2017. Medical evacuations have also become more efficient. In 2009, then-Secretary of Defense Robert Gates surged helicopters into Afghanistan to ensure that soldiers could make it to field hospitals within the "golden hour"—the hour after sustaining an injury in which, if treated, the patient is likely to survive. This decision is widely credited with saving lives.

The military has been more innovative at field hospitals. One of the most serious issues facing wounded troops is coagulopathy, a complex condition that prevents blood from clotting. According to the Journal of Trauma and Acute Care Surgery, a quarter of combat casualties with severe bleeding experience the condition, with a mortality rate up to 50 percent if treated with conventional methods. In response, the military has reduced the mortality rate of the wounded to 19 percent by injecting casualties with equal ratios of red blood cells, frozen plasma and platelets. This has meant forgoing substitutes such as cryoprecipitate, which can cause side effects including transfusion-related acute lung injury, which is potentially lethal. Military hospitals also now commonly use tranexamic acid (TXA), which is used to control bleeding during intensive surgeries. Used in civilian hospitals for decades, TXA was introduced to Afghanistan by British forces before entering regular service with U.S. forces.

Moreover, the U.S. has fielded medical-imaging CT machines at the Role 3 Multinational Medical Unit in Kandahar, Afghanistan, the most advanced military medical facility in that country. Prior to the introduction of CT scans at higher-echelon hospitals, the Pentagon mandated that surgeons conduct invasive exploratory surgeries to discover shrapnel embedded by explosive blasts. That mandate has since been dropped, which also eliminates the need for the now-unnecessary surgeries, reducing the risk of fatal complications. The military has also deployed teams of specialized vascular trauma surgeons—first introduced to in-theater hospitals in the past decade—in response to data collected in the DOD Trauma Registry that revealed injuries to veins and arteries were much more common than in previous wars.

One serious form of injury frequently seen in military casualties is severe burns. These are commonly caused by explosive attacks on vehicles. A serious and potentially fatal complication occurs when burn casualties are given too much saline fluid during resuscitation, which can cause pulmonary edema and respiratory failure. This is also a common problem in the civilian world. In recent

years, the military has tried to reduce this risk with a set of procedures adopted from civilian hospitals known as the Rule of 10 and by recording the types and amounts of fluids administered, which was not regularly done during the early years of the wars. Severe burns can also lead to kidney failure. Forward-deployed hospitals had few ways of treating this condition until 2005, when the military began using a therapy known as continuous venovenous hemofiltration, a short-term emergency dialysis treatment, until the patient could be flown out of the country.

PROSPECTS AND SHORTFALLS FOR LONG-TERM CARE

However, despite these advances in battlefield care, the military's record for long-term care is mixed.

Prosthetic legs have improved significantly in the past decade, essentially becoming computerized limbs. At least 2,000 U.S. service members have lost limbs in America's two wars. Many of these veterans now use advanced prosthetics that include built-in gyroscopes and accelerometers that can mimic leg muscles and adapt to changes in elevation. The limbs have also become lighter, thanks to the use of carbon fiber structures as opposed to wood, which was used in prosthetics during the Vietnam War. On the other hand, the more advanced prosthetic limbs on the market such as the Otto Bock X-series—which began as a Defense Advanced Research Projects Agency (DARPA) program—can be exceedingly expensive, at a cost of up to $100,000. Some components, such as a knee with gyroscope and accelerometer, are commonly purchased separately to augment an existing prosthetic leg.

It's likely these advances will continue in the years ahead. DARPA is currently researching a program named Reliable Neural-Interface Technology, which aims to connect nerves in an amputated limb to an interface, potentially allowing a veteran to manipulate a prosthetic arm using brain signals. Several prototypes are being used in military hospitals and include sensors in the fingertips interfaced with the patient's nervous system, which allows the patient to have limited sensations, including feeling heat. However, it's unclear if the interface will be able to perform well over a period of several years—a problem that has plagued previous DARPA prosthetics experiments.

The military has also struggled heavily with treating a surge of traumatic brain injuries. The wars in Iraq and Afghanistan have resulted in an estimated 200,000 brain injuries, often caused by concussive blast waves from improvised explosive devices, grenades and controlled detonations. The Pentagon has also been beset by numerous, well-documented scandals including widespread neglect of soldiers with brain injuries at military hospitals, months-long delays before wounded soldiers can receive treatment and soldiers being misdiagnosed and denied treatment. Military hospitals can be poorly staffed, with soldiers diagnosed with mental illnesses tasked with overseeing other patients. The military has established mandatory TBI screening programs in the hope of detecting cases, but many cases will likely never be adequately diagnosed and treated. Investigations of the military's screening programs have found that their success rate of spotting TBI is little better than random chance.

The problem is compounded by the fact that a TBI may simply go unnoticed. It may take years for TBI symptoms to emerge, and these symptoms—including dizziness, nausea and headaches—can vary drastically from person to person. New research from the Duke University School of Medicine and the U.S. Department of Veterans Affairs shows that soldiers who have been close to explosions can have discernible injuries to the brain without showing any symptoms. But the science of TBI is still poorly understood. Traumatic brain injury is believed to be a trigger for post-traumatic stress disorder, which can cause symptoms such as major depression and rage. But the exact relationship is unclear. Worse, recognizing that problems with TBI are widespread could call soldiers away from the battlefield, something the military is reluctant to do.

In addition, thousands of veterans have reported chronic respiratory problems as the result of exposure to toxic particulates released from "burn pits"—or open-air incinerators—widely used to dispose of waste at bases in Iraq and Afghanistan. The Pentagon has closed many of these pits,

which have been used to burn everything from discarded clothes to plastic and medical waste. The vast majority of illnesses caused by exposure to hazardous chemicals will also likely never be fully known, as the military did not keep records of the pits and what was burned in them until 2010.

A silver lining to the conflicts has been the spread of military trauma practices to the civilian world. The Pentagon sharply increased funding for trauma research during the wars, and military research institutions have collaborated heavily with their civilian counterparts. After the April 15, 2013, Boston Marathon bombings, trauma treatment developed by the military was used to control bleeding experienced by blast victims. Instead of giving patients whole blood, which risked exhausting the supply, surgeons treating the injured from that incident used a military-style mix of blood, plasma and platelets. The first responders also used tourniquets, again credited to the military, which resulted in no deaths from hemorrhage. Hemostatic dressings pioneered by the military have become more common in civilian paramedic kits. Police first responders to the July 2012 mass shooting in Aurora, Colo., had been recently equipped with tourniquets and military-style Combat Gauze, which was used to control bleeding of several victims. The new wave of advanced prosthetics is also not limited to military amputees—civilians benefit as well. But TCCC cannot be applied evenly across the civilian medical community, as many aspects relate to treating injuries that are comparatively rare outside of battlefields.

Since its development, tactical care in the form of TCCC and its related technologies has improved the survival rate for wounded soldiers. The doctrine was only mandated service-wide in 2011, however, and it's important for the Pentagon to ensure military medical teams receive adequate training under this standard. As U.S. forces withdraw from Afghanistan, it's also crucial to prevent research into trauma from stagnating, as it did during the period after the Vietnam War. This will not only have benefits for civilian providers, but there will likely be a time after Afghanistan when U.S. and partner forces will again be ordered into combat. When they are, they must receive the best possible treatment. □

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Photo: Flight medics from Task Force Knighthawk during a training course, Kandahar, Afghanistan, Jan. 4, 2013 (U.S. Army photo by Sgt. Luke Rollins).

AID UNDER FIRE: HEALTH CARE AND THE COSTS OF CONFLICT

BY HANNAH VAUGHAN-LEE

In recent years, the security threats facing humanitarian aid workers have been the subject of headlines and debates. The humanitarian advocacy community has been filled with discussions of a perceived increase in the politicization of humanitarian aid—attributed in part to declining respect for the humanitarian principles of humanity, neutrality, impartiality and independence—and growing difficulties ensuring operations can be conducted in accordance with those principles. These discussions frequently highlight attacks on relief personnel and assets to show that humanitarian workers are under attack. In the past year, the focus has narrowed to a particular area of humanitarian operations: medical and health care personnel and infrastructure. The image is of an increasing vulnerability for health care providers in countries affected by conflict.

The past year has seen a series of alarming reports on the dangers faced by health workers in some countries. In northern Afghanistan, health workers were reportedly in retreat after killings of aid staff. In Pakistan, polio workers have been targeted with violence. And in Somalia, Medecins sans Frontieres (MSF) withdrew citing violence against its staff.

Subsequent media coverage of these events has painted a picture of a global crisis in health care assistance. Under the headline "Violent Attacks on Health Care Workers a Growing Problem," one writer asserted that "recent reports of violence targeting health care workers provide evidence that the prohibition of violence against health care workers has degraded." Another insisted that "as conflicts around the world multiply and drag on, the respect once accorded to humanitarian workers is eroding. Medical personnel are particularly vulnerable." Accordingly, the "international community" is called upon "to make violence against health care workers in conflict zones a priority."

Despite the depiction of a growing crisis, historically, attacks on humanitarian workers and the politicization of medical assistance in war zones are not new developments. Yet the media coverage of dead and injured medical relief workers, ambulance drivers and vaccination campaigners appears to suggest that this practice is getting worse and that the "sanctity of the untouchable status of health care" afforded to it under international humanitarian law "has been eroded, leaving medical workers increasingly vulnerable to attacks."

In assessing the two aspects of this claim—violence and politicization—what becomes clear is that the trend does appear to be worsening, but only in some contexts. Moreover, even for those countries where targeted violence is rising, while the cause might be broadly attributed to politicization, how it manifests and the extent to which it represents a change varies. As such, available information challenges suggestions of a global shift in the increasing risks and vulnerability of health care workers. The underlying significance of attacks on health care workers and facilities, targeted or otherwise, is not that they may violate the international protections or "sanctity" afforded to medical assistance but the consequences such violence has for the conflict-affected populations. As such, this debate raises a more important and much more complex question in terms of global trends that requires greater attention: Are the costs of conflict now greater for affected populations, particularly when it comes to health?

IS VIOLENCE RISING?

A recent article in the Lancet medical journal on the dangers of providing health care in conflict noted that "sometimes the level of violence aimed at health care workers—irrespective of how neutral they are—means that providing humanitarian aid can become untenable." The article cited what has become a commonly used example of the consequences of the increasingly volatile and potentially "untenable" circumstances of medical assistance in conflict-affected countries: the August 2013 withdrawal of MSF from Somalia after 22 years of operation in the country. During the two decades of operation, 16 staff members were killed, and several others were kidnapped or injured in attacks. According to the Aid Worker Security Database (ASWD), since 1997, at least 161 aid workers were killed in Somalia. Some of these certainly worked with medical organizations, including MSF, and some may have been targeted for providing health care, but available information does not indicate that a specific relief sector in Somalia was increasingly intentionally targeted.

Operating in war zones has always come with risks. Initially, attention focused on the general risks associated with operating in conflict-affected areas, such as being caught in the crossfire. More recently this attention has shifted to targeted violence. When MSF reached its "limit" in 2013 and withdrew from Somalia, it was a strong symbol in the debate over the limits of what is acceptable or tenable for humanitarian organizations providing assistance in war zones. But it is not immediately clear that MSF's decision to withdraw is representative of a wider trend in which medical assistance, in particular, is being targeted.

Targeted attacks on humanitarian workers, including those providing medical assistance, have a history as long as the modern humanitarian movement, which is commonly regarded as beginning with the response to the war and famine in Biafra, Nigeria, in the 1960s. In 1969 three International Committee of the Red Cross (ICRC) relief workers were killed when the Nigerian military shot down an ICRC aircraft fully marked with the Red Cross emblem and carrying relief aid to Biafra. Many other medical workers have been targeted since then. In 1996, six ICRC workers were shot dead while sleeping in a hospital in Chechnya—at the time, it was the bloodiest attack on aid workers in the ICRC's 130-year history. In 2001, six ICRC staff members were brutally killed, this time in the Democratic Republic of Congo while traveling in two vehicles marked with the Red Cross emblem. In 2004, five MSF staff members were killed in an ambush in Afghanistan.

In the past 40 years, the movement has expanded not just in the size of its personnel and assets but also in scope, extending "its reach and ambitions into types of conflict and crisis that were previously off-limits." It is therefore perhaps not surprising that the sheer numbers of attacks have also increased. Yet recent headlines highlighting attacks on humanitarian health care workers in South Sudan, Syria, Pakistan and Somalia suggest something new in the pattern of targeted violence. While there is a scarcity of comprehensive data on this question, there are two sources we can turn to for more insight: the ASWD and the ICRC-led Healthcare in Danger project.

The ASWD is one of the most commonly cited data sources in the discourse on attacks on humanitarians. The database records "major incidents," defined as "killings, kidnappings and armed attacks that result in serious injury" affecting international and local staff of the United Nations international and local nongovernmental organizations as well as the Red Cross/Crescent Movement. At first glance, the ASWD statistics appear to support a global trend of rising security incidents involving aid workers, with an annual average of 147 incidents in 2006-2013, compared with an annual average of 64 incidents in 2000-2005. However, the vast majority of the 2006-2013 incidents were concentrated in 10 countries, with the top three—Afghanistan, Somalia and Sudan—accounting for more than 50 percent of all incidents during this period. Afghanistan is the leader for most of the years, accounting for 30 percent of all incidents between 2006 and 2013 and 47 percent of all incidents in 2013 alone. The ASWD does not break down the data by function, so looking for specific trends related to humanitarian health care providers from this dataset is difficult. But one thing is clear: It is more appropriate to speak about trends in a handful of specific countries than a global trend.

Aiming to raise awareness of how medical assistance is targeted in conflict-affected countries, the Health Care in Danger project, spanning 2011-2015, collects information on incidents involving the "use or threat of violence against health care personnel, the wounded and the sick, health care facilities and medical vehicles." Incidents are defined more broadly in this study, which also includes local health care workers in addition to those working for the institutions covered by the ASWD. However, the findings still reflect the principal observation above—that the majority of incidents take place in a handful of countries. For example, in 2012, the study recorded 921 violent incidents affecting health care in 22 countries; these incidents were concentrated in eight countries that each recorded 40 or more incidents. Unfortunately, the Health Care in Danger study does not name the countries, but considering news coverage of incidents and available public data it would be reasonable to assume that there is some overlap with the ASWD top 10. The ICRC study also indicates variation by country as to the perpetrators of these attacks. For example, in one country, 80 percent of the incidents were reported as perpetrated by state security forces, while in another, armed nonstate actors were reportedly responsible for 52 percent of the incidents. Other incidents involve individuals, such as relatives unhappy with patient treatment, and international military or police, while still others involve multiple perpetrators or lack sufficient information to attribute responsibility.

Given the localization of the trend, the question becomes, in countries where there is an increase of violent incidents involving humanitarian medical personnel and assets, are they being specifically targeted because they are providing medical services? Moreover, are there common patterns to be found in the motivations for or drivers of these attacks? For example, there does appear to be a trend targeting polio vaccination workers in some countries, particularly Pakistan, Nigeria and Afghanistan. The motivations for these attacks can vary, however, with examples including accusations that polio workers are U.S. spies, the use of attacks against vaccination campaigns to gain or increase visibility and beliefs in some communities that vaccination efforts are actually part of a sterilization campaign. Though these motivations are context-specific, they can be broadly captured under a common theme: politicization.

In the past decade, there has been a shift away from debates emphasizing the impact of aid on politics to that of politics on aid. But while "politicization" is commonly bandied about as a main cause of the supposedly increasing vulnerability of assistance in times of conflict, including medical assistance, it too is not a new development. Like incidents of violence, politicization spans the history of the modern humanitarian movement. So what, if anything, has changed?

OLD STORY, NEW NUANCE

The shooting down of the ICRC plane in 1969, noted above, was in part the result of the role that humanitarian aid played in sustaining the separatist regime in Biafra and the Nigerian government's response. Discussions around the political effects of humanitarian assistance—direct, indirect, intended and unintended—at first emerged quietly following the Biafra War and later exploded in the wake of crises such as Rwanda, Somalia and Bosnia in the 1990s with the widespread recognition that aid could become entangled in the dynamics of war.

The impact of humanitarian assistance on political groups and structures or the politicization of aid, in which assistance is deliberately manipulated to serve political purposes, can take many forms. For example, aid may serve as a financial resource for the state or armed nonstate actors to sustain or fuel conflict. It may legitimize armed nonstate actors as an unintended consequence of access negotiations or providing services in areas under their control. Or political actors may deliberately and directly co-opt humanitarian action, such as by using humanitarian assistance as a reward for peacebuilding or strategically in military campaigns, including relying on or preventing access to assistance.

Syria and Somalia have both recently appeared in headlines citing the increased vulnerability of medical assistance in conflict. Somalia has a 40-year legacy of humanitarian politics, while Syria

is a recent entrant into the fray. Yet they are both examples of how medical assistance can be politicized and consciously made part of military strategy.

In Syria, the role of medical assistance in military strategy has come front and center since the war broke out in 2011. The country is a recent addition (2012) to the ASWD top-10 list, yet news reports tell us that among the dead are ambulance crew volunteers, doctors and, as of January 2014, 34 Syrian Arab Red Crescent volunteers. In September 2013, the U.N. Human Rights Council published a report raising alarm at the "deliberate targeting of hospitals, medical personnel and transports, the denial of access to medical care and ill-treatment of the sick and wounded." The report continued, "The denial of medical care as a weapon of war is a distinct and chilling reality of the war in Syria." That it is "chilling" is by no means in question, but is it new? Or more specifically, does it represent a new pattern in conflict modalities?

The case of Somalia, where over the decades assistance has been entangled in the politics of the conflict in almost every conceivable way, including military strategies, suggests the answer is no. For example, since the 1980s, refugee camps have served as recruiting grounds for the government and armed nonstate actors, and warlords and other armed actors have benefitted from—and sometimes consciously sought out—the financial support and legitimacy afforded as an unintended consequence of humanitarian aid. More recently, access to medical assistance has formed part of the military strategy of the principal armed nonstate actor in the conflict, al-Shabab. It has been reported that al-Shabab made an effort to have international NGOs working in the health sector operate in areas under its control in order "to guarantee that its wounded fighters would get adequate treatment."

The significance of this medical support did not go unnoticed by either Somalis or international observers. And while some NGOs providing medical assistance were expelled from Shabab-controlled areas following accusations of spying for the U.S., other medical humanitarian agencies remained. One of those organizations was MSF, which has been relatively open about its operations in Shabab-controlled areas. Speaking in 2010 about an MSF-supported hospital in the capital, Mogadishu, an MSF spokesperson remarked how "from the rebels' point of view, it was in their interest to support assistance for their wounded and displaced populations and to encourage the aid organizations to attest to the crimes by the Ethiopian army with the support of the government militias. . . . We are sometimes seen by some political players, the African Union mission officers, for example, as the opposition's war surgeons."

Some actors were reportedly frustrated by the support they perceived MSF to be providing to al-Shabab, which may have made the organization more vulnerable to attack. Yet although the Mogadishu hospital mentioned above was hit by gunfire and shelling in 2012, the incident came amid renewed fighting in the capital; available evidence does not suggest the hospital or health care workers were specifically singled out. Medical personnel and facilities may have been subject to violent threats and attacks during the course of the conflict, but violent targeting of medical staff and facilities because of the medical services they provided does not appear to have formed an explicit part of the military strategy—and certainly not to the extent witnessed in Syria.

When MSF pulled out of Somalia in 2013, the decision was based on the culmination of events over several years as well as recent incidents. One of those recent incidents was the 2011 killing of two staff in Mogadishu. While in no way trying to diminish the seriousness of this incident, the killing was reportedly motivated by a human resource grievance, not because of the medical services the staff were providing.

NEW COSTS OF CONFLICT

While both Syria and Somalia provide evidence of medical assistance being instrumentalized in war, the cases offer different answers to the question of whether there is an increasing vulnerability for humanitarian health care workers and the assistance they provide. In Syria the answer

is clearly yes. In Somalia, it is much less clear. These admittedly brief examples reinforce the need to pause before concluding there is a global shift underway in the risks to health care providers in conflict.

But what if we look at the issue another way—rather than rising risks to health workers, examining instead the rising costs for the conflict-affected populations' health in these countries. That is, the perceived rise in threats to health workers may be a symptom of a larger phenomenon, that of the rising health costs of conflict overall, which leave health systems particularly damaged.

Chronic conflict and state failure in Somalia, and the accompanying political, economic, social and security challenges, have left the country with 0.4 doctors for 10,000 inhabitants—compared with an average of 28.7 doctors per 10,000 inhabitants for the five permanent members of the U.N. Security Council. In the year before MSF pulled out of Somalia, the organization had provided more than 624,000 medical consultations, admitted 41,100 patients to hospitals, cared for 30,090 malnourished children, vaccinated 58,620 people and delivered 7,300 babies. Other NGOs have tried to fill the void left by the organization's withdrawal. But in a country where MSF had become one of the main health care providers, it is a big role to fill.

We see similar figures for health care workers in some of the other ASWD top contenders, most of which are also countries affected by chronic conflict: In Afghanistan there are 1.9 doctors per 10,000 inhabitants, while in Sudan there are 2.8. While the duration of the conflict does not match that of Afghanistan or Somalia, the public health sector in Syria already lies in rubble. Conflict has a devastating effect on the health of a population. Contemporary conflicts include battle-related deaths and injuries, as Syria has illustrated with estimates of more than 140,000 civilians killed to date. But they also include extensive indirect effects of war on health, which can lead to death tolls in the millions from disease, malnutrition and the inability to access medical care.

Humanitarian medical assistance in conflict-affected countries provides vital assistance both for battle-related injuries as well as the indirect health effects stemming from the destruction of public health sector, epidemics accompanying mass population movements, and restricted or no access to basic services such as water, to name only a few. A recent MSF study on health care in the Democratic Republic of Congo observed, "Violence, or the threat of it, forces medical staff to flee and health facilities to suspend activities. Often, people in the affected areas have no other health care providers to turn to—and it is those people who suffer most." The inference from the debate on violence against health care workers and the politicization of humanitarian medical assistance is that the health of conflict-affected populations is becoming more vulnerable, and that people are suffering more, as a result.

A lesson from an earlier round of debate on humanitarian politics comes to mind here. When the political effects of aid came under heavy scrutiny in the 1990s, case studies from Somalia, the Democratic Republic of Congo, Liberia and Sudan were heavily influential in what became a generalized discussion on how aid fueled conflict. That aid has unintended effects and could fuel conflict was not and has not been disputed. However, arguably, when taking into consideration the many factors that fuel and influence conflict, the significance of aid varies extensively between contexts. The "new orthodoxy" of aid fueling war may have been too reliant on a generalization based on extreme or outlying cases.

Within the current discourse on the risks to health care in conflict, not only is there a strong focus on a specific set of countries, but much of the available information on so-called new trends focuses on the health care providers rather than a thorough analysis of the effects violence has on affected populations. Understanding context-specific patterns of violence against medical assistance is important, and opportunities should not be missed to identify and learn lessons that could diminish these attacks. But in terms of global trends, the focus on allegedly growing attacks on medical assistance or changes in how it is politically instrumentalized seems to be misplaced. The evidence suggests potentially more important questions: Are the effects of conflict on health

care greater than they once were? And why? These are difficult questions, and understanding what influences the health of a population is a complex endeavor. But the answers may provide greater insight into the changing vulnerabilities of health in conflict. □

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Photo: Haitians receiving cholera treatment, L'Estere, Haiti, Oct. 26, 2010 (U.N. photo by Sophia Paris).

UNSAFE SPACES: TRENDS AND CHALLENGES IN GENDER-BASED VIOLENCE

BY JANIE LEATHERMAN AND NADEZDA GRIFFIN

There is not sufficient evidence on the use of sexual violence in conflict to determine whether it is increasing or decreasing in prevalence or institutionalization. However, evidence indicates it is widespread. Conflict-related gendered violence can range from a tool of economic exploitation, oppression and violence, especially during conflicts, disasters and their aftermath, to the systematic use of sexual violence as a strategy in armed conflict. Gender-based violence (GBV) is defined in humanitarian contexts as "an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females."

Many conflicts encompass different formsof GBV, the escalation of which is fueled by pre-existing gender inequalities, discrimination, abuse and lack of respect of human rights. Despite common assumptions, gendered violence in conflict is not limited to women and girls, but can also target men and boys, as well as persons of all ages. There is evidence of widespread use of sexual violence in contemporary conflicts, including in Somalia, Mali, Sudan, Syria, Colombia, Guatemala and Honduras, and including against men, for example in Syria and the eastern Democratic Republic of the Congo.

Despite the prevalence of sexual violence in conflict today, we are no longer living in an era of silence and impunity. This changed definitively when the Rome Statute of the International Criminal Court (ICC) came into force in 2002. Building on previous international criminal tribunals, the ICC expands international law on war crimes and crimes against humanity to encompass forms of sexual violence such as rape, sexual slavery, enforced prostitution, forced pregnancy and enforced sterilization, and also to consider sexual violence as an element of genocide. These developments have challenged prevailing norms that treated sexual violence in warfare as a corollary to looting, in which the woman was seen as the property of another man, rather than in terms of her own bodily integrity and human dignity.

Nevertheless, the risks of sexual violence are also shifting along with changes in the patterns of conflict and the spaces in which it takes place. This requires new kinds of programming to support affected members of communities. Of particular note, refugee and displaced populations are becoming more urban as opposed to rural, while localized violence is also increasingly intertwined with crime and economic exploitation embedded in globalized networks. Climate change and disaster also intersect with crime and conflict to further heighten risks.

CONFLICT TRENDS AND SEXUAL VIOLENCE

Despite major shifts in the global patterns of warfare over the past century, more than 1.5 billion people currently live in areas affected by state fragility from the intersections of violence, crime and conflict. Contemporary conflicts are also internationalized through the blurring of illicit and licit economies, or what Carolyn Nordstrom calls the "extralegal" movement of goods and people. As Reece Jones has documented in "Border Walls," states are increasingly walling up their borders to further militarize control of extralegal activity—for purposes of both profit and interdiction—and as part of their strategies to limit asylum seekers and facilitate deportation.

These developments in state border practices have to be seen against the backdrop of historic highs in numbers of displaced people along with four related trends. First, the balance of refugees is shifting from rural camp settings to urban locations. Second, threats of human displacement from climate change are rising, with related potential for environmentally driven conflicts around the world and elevated gendered vulnerabilities. At the same time, rapid urbanization is also projected to greatly enhance exposure to disaster risks. Third, the interface between migration and humanitarian crises is producing "mixed migration." And fourth, the numbers of stateless people are high—the United Nations High Commissioner for Refugees identified 3.5 million stateless persons in 64 countries in 2012, but estimates that there may be over 12 million stateless worldwide. All these trends heighten the vulnerability of displaced populations, including through the rising numbers of unaccompanied minors, to the risks of GBV and exploitation.

These shifts create new spaces for GBV that need to be addressed. For example, the shift of refugee populations from rural camps to urban settings introduces different security and safety challenges. In camp settings, women refugees and displaced persons face such risks as limited camp monitoring for security; ill-considered placement of latrines along with lack of lighting and locks; absence of male family or community members to provide protection; and risks of sexual assault while collecting firewood or selling goods at the local market, among others. Along with rape by gangs, rebel groups, government armed forces, local police or even humanitarian workers, survival sex poses some of the greatest gendered risks. Indeed, some women refugees in Mafraq, Jordan, who had fled Syria indicated that they knew of cases where sex had to be exchanged for aid. Humanitarian programming should provide equal access to economic opportunities for men and women, and ensure safety consistent with the principle of "do no harm." But for women, these opportunities may in fact be limited.

In urban settings, the displaced are often unregistered and undocumented refugees who lack rights and face persecution. While they may attempt to blend into the local setting, refugees face gendered risks from inadequate shelter, physical insecurity and exploitation in informal markets—for women especially in domestic labor or prostitution. In urban settings and post-disaster contexts, vulnerabilities to human and sex trafficking increase, including for children, especially as displacement destroys livelihoods and people are forced to find new means to support their families.

Conflicts unfold both over time and space. The post-Cold War approach to conflict interventions has been driven by a phase model of conflict, with programming geared to challenges arising over a timeline defined as pre-crisis, crisis and stabilization/recovery—a framework clearly articulated, for example, in the 2010 "Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings." However, local conflicts are often linked to global political economies of violence. A spatial analysis can help GBV programming by illustrating the patterns and scale of these risks and enabling factors, determining where these occur in the daily lives and livelihoods of those most vulnerable and identifying options to enhance gendered safety.

For example, displaced populations settling in camps for refugees or the internally displaced integrating into an urban environment may find themselves in less of a "community" context than they would in traditional villages. While this makes it possible to report cases of GBV in a more anonymous way, the lack of community also makes it more difficult to encourage local support and incorporate local and culturally accepted practices into healing GBV-related trauma. Therefore, programs may consider creating communities of survivors and those working with them to enable support and long-term economic opportunities, rather than relying on geographically oriented communities as a support structure. Survival Girls, a theater group for Congolese girls aged 17-22 in Nairobi's slum of Kangemi, is a safe space that serves such purposes.

SEXUAL VIOLENCE AS A CONFLICT WEAPON

Sexual violence is an affront to humanity, ripping apart bodies, families and communities. The impact of any possible form of assistance to survivors pales in contrast to the trail of destruction left

in the wake of sexual violence. Sexual violence casts a long shadow over its victims—whether men, women, war orphans, rape babies or child soldiers—through physical and psychological trauma and social mechanisms of exclusion, shame, stigmatization and blame. Reverberations endure through subsequent generations by means of the transmission of trauma, the long arc of war memories and the shunning and marginalization of affected families and community members. In conflicts such as the genocide in Rwanda and the ethnic cleansing in Bosnia, rape has been used as a weapon of war to block as much as possible any future for the enemy.

Historically, strong taboos have created a veil of silence about the role of sexual violence in peacetime and war. The global women's movement that gained momentum in the 1990s began to empower women to overcome this silencing. As evidenced by key United Nations Security Council resolutions such as 1325 (2000), 1820 (2008), 1888 (2009), 1889 (2009), 1960 (2010), 2106 (2012) and 2122 (2013), along with other U.N. reports, such as the 2012 U.N. secretary-general's report on conflict-related sexual violence, most of the attention has focused on violence against women and girls. Yet male victimization has been documented in a vast array of conflicts, most recently in Syria, even if the extent of it is only slowly coming to light.

Sexual violence is a "runaway" norm that intensifies social harm through many overlapping and egregious subversive strategies and practices. It is also a pervasive element of conflict, posing risks through all phases of conflict. Risks for women and children's safety in the aftermath of conflict remain high, too, because of the breakdown of social norms, a climate of impunity, a culture of violence against women in both domestic and public spheres, a collapse of law and public authority and the resulting lack of accountability, increased banditry and criminality, and retribution.

Sexual violence is efficient because it is a cheap, practically inexhaustible weapon that can be used to simultaneously cross numerous thresholds of violence. It is also a powerful weapon for cultural reasons related to its force as a taboo violation. Sexual violence encompasses atrocities that subvert the traditional social order and elevate horror.

There are at least four elements that help explain the particular viciousness of sexual violence. The first aspect concerns the egregious forms or acts of violence that sexual assaults entail. As more thresholds are broken, it seems that perpetrators pursue increasingly depraved forms of sexual violence and combinations of them in an attempt to continuously escalate the threat.

A second aspect of sexual violence as a runaway norm concerns the targets of the violence, especially victims with special standing in society, such as pregnant women, the elderly, children, mothers, fathers, grandparents, doctors, nurses, teachers and religious leaders. A third element that propels the runaway normative character of sexual violence concerns the use of forced agency, such as children who are compelled to commit acts of sexual violence, and child soldiers—many of whom may have themselves been abducted—who are drugged or indoctrinated to carry out war crimes and crimes against humanity.

A fourth characteristic that fuels sexual violence as a runaway norm concerns the place where it is committed, which is almost always significant in its own way. This point also underscores the importance of understanding the spatiality of sexual violence in conflict as perhaps an incomparable weapon—and a force multiplier—for the production of unsafe space. It is used to threaten communities and drive community members to flee violence, while placing them at new risk. This in turn enables opposing armed groups to capture the abandoned territory and assets, control access to them and use displaced and vulnerable populations for forced labor—including for smuggling arms, drug production and trafficking, mining and other activities.

Sexual violence in conflicts occurs in all manner of locations, including in homes, gardens and fields, as well as at work and in many places considered safe havens, such as hospitals, clinics, schools and religious sites. It also occurs in refugee or internally displaced person camps. In many instances, sexual violence in armed conflict appears not to be systematically organized at

the highest levels nor limited to individual acts of terror. Rather, it occurs somewhere along such a continuum as part of local strategies of control, exploitation and domination, such as reports suggest is the case in Syria.

CURRENT AND FUTURE POLICY DIRECTIONS

The programs addressing GBV-related issues typically involve coordination, response and, to some extent, attempts at prevention. Such programs are integrated or addressed through a number of sectors, including health, rule of law, food security and livelihoods, education and so on. Stakeholders in the area of GBV-related issues range from international organizations such as the U.N. Security Council, the International Criminal Court, the U.N. Department of Peacekeeping Operations and the U.N. Special Representative on Sexual Violence in Conflict, to regional organizations, such as the African Union, governments—including relevant ministries, such as for health—and to regional and local municipalities and community-based organizations.

The United Nations Children Fund and the United Nations Populations Fund are the lead agencies for the GBV area of responsibility within the interagency Global Protection Cluster, while U.N. Women spearheads international initiatives on women, peace and security, gender equality and development work. Governments have elaborated national action plans (NAPs) on women, peace and security, many of which the Network of Women Peacebuilders monitors and reports on in its annual publication "Women Count." NAPs are also tracked on Peace Women. In addition, some countries have developed special programming on violence against women. The United States, for example, has launched a program under the Secretary of State's Office of Global Women's Issues, and the British government has done so under its Preventing Sexual Violence Initiative. International nongovernmental organizations working in the field of GBV include agencies such as the International Rescue Committee, the American Refugee Committee, Save the Children, International Medical Corps, Oxfam, Handicap International and Plan International.

As set forth by the Interagency Standing Committee (IASC) guidelines, GBV programs typically focus on the needs of the survivor, providing medical, psychosocial, legal, economic and social resources. In order to reduce GBV cases, most programs include advocacy and training efforts, thus encouraging governments to create adequate GBV-related policies, educating communities about the cases occurring in their localities and sharing the impact on the victims in hopes of reducing the number of cases. Yet the existing stigma when it comes to reporting GBV often impedes those efforts. For instance, a 2013 Interagency Assessment report on child protection among Syrian refugees in Jordan indicates that there is very limited awareness about services available to victims of GBV. It is generally accepted that GBV cases are underreported, while the full scale of it is unknown. According to the same report, 83 percent of those asked were not aware of services offered in their communities.

Meanwhile, some countries do have policies to combat GBV and are aware of a multitude of GBV cases, but the enforcement of those policies remains a challenge. Victims or their families may report GBV cases in a variety of ways—such as through family, medical professionals or law enforcement—but in a number of instances the victim is further victimized by the resulting process. For example, a rape victim may be forced to marry the perpetrator, blamed for the violence that occurred or forced to remain in marriage for the sake of family stability. In addition to widespread problems with impunity, the 2012 "Women Count" report also revealed a lack of health care services and capacity and a lack of gender-sensitive resources for the police and judicial systems.

As data from numerous reports on the substantial numbers of sexual violence victims among men and boys reflect—including recent reports from Syria—there is also space for adjusting interventions to develop awareness of physical symptoms of sexual assault of male victims and to destigmatize the reporting of such violations. There also need to be medical and psychosocial programs and longer-term economic solutions to support men and aid them in recovery, including within family and community support structures. Prevention, monitoring and advocacy programs

need also to consider the risk factors and causes that predispose men and boys to sexual violence in contemporary conflicts, including in the context of state fragility and the linkages between conflict and crime.

A range of programs consider GBV in conjunction with the safe space issue. In considering shelter or construction programs, these approaches may involve building the camp so that families are given relative privacy and so that single, widowed or separated women are not exposed to greater risk when they have to take on more responsibilities for the household and—when possible—for generating income. In other instances, projects may include improving the safety of the actual shelters. Similarly, the programs that focus on economic strengthening, including those with various training programs, income-generation activities, cash transfers, grants, agricultural development and so on, may consider GBV problematic in the design and implementation of those projects, while other projects specifically target GBV survivors. The failure to do so reflects widely held assumptions that economic recovery and infrastructure are gender-neutral, that is, that women and men will benefit equally, though that is rarely the case.

There are many large international nonprofit organizations leading GBV programs around the world in conflict, post-conflict or relative peace environments. To date, there is no complete overview of the scale of such programs, though more country-level information may be available via the protection cluster in the locations where it is established. However, this overview often does not take into consideration a substantial number of local, community initiatives and organizations that often have limited visibility and funding and yet provide important services to women and girls in those communities. For instance, a Southern Sudanese NGO, Confident Children out of Conflict (CCC), provides a safe space for girls that are at high risk of exploitation and abuse, including GBV. CCC provides a safe place to stay along with access to basic education and vocational training. The binational Kino Border Initiative in Nogales, Arizona, and Nogales in the state of Sonora, Mexico, similarly provides safe space in a region of violent border risks for migrants deported from the United States, including a safe house for women fleeing domestic and drug-related violence from Central America and Mexico.

While the field of GBV programming in humanitarian emergencies has developed rapidly over the past decade within and across many sectors, methods of evaluating effectiveness and evidence of learning from good practices are emerging more slowly. Such learning has been propelled by organizations such as The Active Learning Network for Accountability and Performance in Humanitarian Action, founded in 1997, and DARA, founded in 2003, which both aim to improve quality and effectiveness of humanitarian action. Nonetheless, in the present context it is difficult to pinpoint to what extent the currently implemented programs would help prevent gender-based violence. Moreover, given the number of potentially underreported cases it is hard to identify the depth of the problem, and yet making assistance available is critical in emergencies. However, going forward, integrating GBV programs into the community is essential in preventing GBV cases. Eventually, community-based efforts can be further developed into larger civil society impacts with the involvement of women's organizations for effective monitoring, and also mobilizing and advocating for policy implementation.

To such ends, a key initiative is the 2014 pilot of revisions to the 2005 IASC Guidelines, which will be followed by feedback and further refinement. These revisions will stress the importance of multifaceted programing on GBV rather than a focus on sexual violence in emergencies, cover natural disasters along with conflict settings, give guidance to both short-term programming to improve protection as well as interventions for longer-term structural changes to eliminate GBV, and include accountability mechanisms. Guidance documents on GBV programming may benefit from further categorizing different forms of violence, target groups, contexts and relevant responses to foster the exchange of lessons learned.

Nonetheless, among the challenges for moving forward is the lack of consensus on defining and applying gender-based violence concepts. A second issue concerns new demands for programming to

support a wider range of survivors, such as men and boys; gay, lesbian and transgendered people; and the disabled. A third set of challenges arises from changing contexts, such as risks in urban versus rural settings or conflict versus disaster response and, increasingly, their intersections.

There are also different challenges for assessing success or failure in risk prevention or mitigation versus outcomes of GBV programing to assist survivors. Prevention strategies are more complex, less tangible and more difficult to measure, especially strategies that target structural causes of violence, such as programming to address discrimination against women or develop the rule of law encompassing women's rights. The impact of these strategies on social transformation is long-term and complex. In addition, it is difficult to prove counterfactuals, for instance that a particular preventive measure—such as lighting for latrines in refugees camps to provide greater protection for women—averted specific outcomes, such as a certain number of rapes. In contrast, response programs can tabulate numbers of persons given medical care, food, water, shelter and so on.

GBV is a widespread "runaway" norm that operates both temporally and spatially. Though no longer abetted by silence and impunity, it is in some ways adapting along with shifts in conflict itself. Our efforts to respond to it, and prevent it, must do so as well. □

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Photo: A clinic for vicitims of gender-baseded violence in Zambia, Nov. 27, 2012 (U.K. Department for International Development photo).

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