The Politics of British Medical Humanitarian Aid: NGOs, the State and the Military, 1988-2014

A thesis submitted to The University of Manchester for the degree of

Doctor of Philosophy

in the Faculty of Humanities

2019

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SCHOOL OF ARTS, LANGUAGES AND CULTURES
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Word Count- 83,297
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CAFOD</td>
<td>Catholic Agency for Overseas Development</td>
</tr>
<tr>
<td>CJIATF</td>
<td>Combined Joint Interagency Taskforce</td>
</tr>
<tr>
<td>CMAM</td>
<td>Community-based Management of Acute Malnutrition</td>
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<tr>
<td>CPA</td>
<td>Coalition Provisional Authority</td>
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<tr>
<td>CTC</td>
<td>Community Therapeutic Care</td>
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<tr>
<td>DEC</td>
<td>Disasters Emergency Committee</td>
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<tr>
<td>DEERF</td>
<td>DfID Emergency Ebola Response Fund</td>
</tr>
<tr>
<td>DfID</td>
<td>Department for International Development</td>
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<tr>
<td>EEC</td>
<td>European Economic Community</td>
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<tr>
<td>ESRC</td>
<td>Economic and Social Research Council</td>
</tr>
<tr>
<td>ETC</td>
<td>Ebola Treatment Centre</td>
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<tr>
<td>FCO</td>
<td>Foreign and Commonwealth Office</td>
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<tr>
<td>GNP</td>
<td>Gross National Product</td>
</tr>
<tr>
<td>GOS</td>
<td>Government of Sudan</td>
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<tr>
<td>HBP</td>
<td>Health as a Bridge for Peace</td>
</tr>
<tr>
<td>HOC</td>
<td>Humanitarian Operations Centre</td>
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<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>INGO</td>
<td>International non-governmental organisations</td>
</tr>
<tr>
<td>INSARAG</td>
<td>International Search and Rescue Advisory Group</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>JEEAR</td>
<td>Joint Evaluation of Emergency Assistance to Rwanda</td>
</tr>
<tr>
<td>JFS</td>
<td>Joint Funding Scheme</td>
</tr>
<tr>
<td>KFOR</td>
<td>Kosovo Force</td>
</tr>
<tr>
<td>KLA</td>
<td>Kosovo Liberation Army</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
</tr>
<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
</tr>
<tr>
<td>NATO</td>
<td>North Atlantic Treaty Organization</td>
</tr>
<tr>
<td>NERC</td>
<td>National Ebola Response Centre</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>---------</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NMCG</td>
<td>NGO-Military Contact Group</td>
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<tr>
<td>OCHA</td>
<td>UN Office for the Coordination of Humanitarian Affairs</td>
</tr>
<tr>
<td>ODA</td>
<td>Overseas Development Administration</td>
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<tr>
<td>ODI</td>
<td>Overseas Development Institute</td>
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<tr>
<td>ODM</td>
<td>Overseas Development Ministry</td>
</tr>
<tr>
<td>OLS</td>
<td>Operation Lifeline Sudan</td>
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<tr>
<td>ORHA</td>
<td>Office of Reconstruction and Humanitarian Assistance</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
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<tr>
<td>PPE</td>
<td>Personal Protection Equipment</td>
</tr>
<tr>
<td>RSLAF</td>
<td>Republic of Sierra Leone Armed Forces</td>
</tr>
<tr>
<td>RUFT</td>
<td>Ready-to-use therapeutic food</td>
</tr>
<tr>
<td>SMART</td>
<td>South Manchester Accident Rescue Team</td>
</tr>
<tr>
<td>SPLM/A</td>
<td>Sudan People’s Liberation Movement/Army</td>
</tr>
<tr>
<td>TBSA</td>
<td>Total body surface area</td>
</tr>
<tr>
<td>TFC</td>
<td>Therapeutic Feeding Centre</td>
</tr>
<tr>
<td>UK-EMT</td>
<td>UK-Emergency Medical Team</td>
</tr>
<tr>
<td>UMEER</td>
<td>UN Mission for Ebola Emergency Response</td>
</tr>
<tr>
<td>UNDAC</td>
<td>United Nations Disaster Assessment and Coordination Team</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNMIK</td>
<td>United Nations Mission in Kosovo</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Abstract

This thesis tells a unique story of Britain’s medical humanitarian response and its politicisation, as the British government attempted to promote its position within a changing international global order. It examines the networks, debates and negotiations that took place between different actors within the British aid sector, and examines their impact on norm-setting and aid delivery. From a sector that is often articulated in terms of human need, this thesis traces the movement of medical humanitarianism into the heart of global politics and its manipulation as a tool of the British state.

Literature that champions France, as the primary medical actor, has led to the marginalisation of Britain’s medical response within humanitarian narratives. The focus of medical humanitarian aid, throughout this thesis, offers a lens through which the relationships between actors within the British aid sector can be explored. By drawing together the work of modern historians, oral histories and grey literature, this thesis showcases the unique nature of British medical humanitarianism. Through the investigation into the impact, and growth, of medical responses, this thesis eschews the institutionally-dominated narratives of British humanitarianism. Rather, it brings to the forefront the key role of smaller, medically-focused organisations, individual aid practitioners and research bodies, often overlooked in current historiography, and explores how they interacted with the British Government and larger British NGOs. In doing so, this thesis examines the distinctive trajectory of British medical aid at the end of the Cold War and explores the impact of neoliberal ideas and the changing global political arena on the British aid sector.

To understand the roles of these many actors, this thesis investigates snapshots of medical humanitarian deployments between the years 1988-2014. Each chapter of this thesis explores a humanitarian response to a different crisis, specifically foregrounding the medical response. Beginning with a study of the Armenian Earthquake in 1988, this thesis explores Britain’s role within the first delivery of international aid to the Soviet Union since the beginning of the Cold War. The second chapter then progresses to examine the British response to the Sudan famine in 1998. It grounds this response in the debates that were taking place, within academia, about the nature of humanitarian response. The following two chapters of this thesis then explores New Labour’s internationalist agenda and its impact on British medical humanitarian response. Chapter 3 investigates the peak of this, identified during the humanitarian response to the bombing of Kosovo in 1999. Chapter 4 examines the consequences of an over-emphasised internationalist narrative, investigating the British response to the Iraq war and its impact on the heavily militarised medical humanitarian response. Finally, this thesis ends with an examination of the biggest medical humanitarian response ever deployed by Britain, the response to the Ebola outbreak in Sierra Leone in 2014. Certain motifs such as: modes of knowledge production, the role of the military and the changing understandings of medicine, are threaded throughout these chapters to draw together these snapshots and to present a narrative of change.

By applying historical methods to a period more often understood through social science lenses and personal narratives, this study extends the existing historiography of British humanitarianism, to demonstrate the shifting relationships, processes, and interactions that influence policy change and shape medical humanitarian deployments.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Acknowledgements

I would first like to thank my supervisors, Professor Bertrand Taithe and Dr. Eleanor Davey. They have been a constant source of encouragement and support throughout the last four years. My PhD experience has been enriched by their guidance, and I thank them both for helping me find my academic voice. I also owe my thanks to the Economic and Social Research Council, without whose funding, this PhD would not exist. The Save the Children Humanitarian Affairs Team has provided me with support throughout this thesis, and I would like to thank its members for giving me their valuable time to discuss my ideas. This thesis has also benefited enormously from the input of Fernando Espada and John Borton, who patiently read each of my chapter drafts. The expansive knowledge and insight that they brought to our meetings, and the patience they showed when sharing it, has greatly enhanced this research. I also show my immense gratitude to my interviewees who were willing to share their stories with me; special thanks goes to Tony Redmond, who went above and beyond to give me access to his private archives.

I have been fortunate to have studied within the University of Manchester for eight years now and have benefitted from the support of many academic staff along the way. I am particularly grateful to Dr. Laure Humbert, Dr. Roisin Read and Dr. Jessica Field, who have always been willing to give me their time, advice and encouragement. When starting my PhD, I was told that it would be a very isolating experience; I have not found it to be so. This is due, in large part, to my brilliant PhD cohort at HCRI. They have provided me with a safe and thought-provoking environment to share my research while also offering friendship and kindness throughout this journey.

Finally, I would like to thank my family, who have been with me for every step of the way. I am profoundly grateful to my parents, who have always encouraged my love of learning. As I have carried out this research, they have shown me unconditional patience, support and love. My thanks also go to Becci and Rich, who on many occasions, have provided me with a haven away from the PhD in their home in London. I am particularly grateful to Becci for proofreading my work, encouraging me to persevere and always being at the end of the phone. A special thanks must also go to Ben, my walking partner, sandwich maker and best friend. He has been unwaveringly supportive throughout this process and has had faith in me and my research from the beginning. I could not have completed this thesis without him.
Introduction

In a survey of British adults carried out in 2016, the National Health Service (NHS) was voted as the top choice when participants were asked what made them proud to be British. With 36% of the vote, for the 2,000 participants, the NHS scored higher than British history, the British sense of humour and the British monarchy. Similarly, in another survey carried out in 2015, 56% of 1,956 British adults voted for the NHS as an “issue that mattered” to them as voters. These two surveys suggest that even in an era of austerity, the NHS is not only understood as a marker of British distinctiveness but that it also holds power over voting choices, with clear political implications. The power of the NHS within the minds of British adults has been such that it has been used repeatedly within party politics. Historian Mathew Thomson has investigated the presence of references to the NHS within political party manifestoes. He has demonstrated that throughout its history, the perceived successes of the NHS have been claimed by both the Labour and Conservative governments during their election campaigns. The integral position that the NHS holds within understandings of British identity was also demonstrated during the 2012 British Olympics opening ceremony, in which the history of the NHS was depicted in a performance by NHS staff and patients from the Great Ormond Street Hospital.

Just as the NHS has been championed as a symbol of Britishness, so too has Britain’s provision of international aid. The presence of international aid within British civilians’ lives has been made prominent by events such as Comic Relief and Sport Relief. These events have, since 1988 and 2002 respectively, annually drawn British celebrities together either in the form of

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2 Ibid.
3 Opinium, *Issues that matter to voters* (Opinium, London: April 2015), Available: https://www.opinium.co.uk/the-issues-that-matter-to-voters [Accessed 30 October 2018]. While the accuracy of these surveys could be debated, when taken at face value, they do offer an insight into the significance of the NHS within the minds of members of the British public.
5 Ibid.
a night of charitable fundraising on Red Nose Day or through sporting events, to encourage the British public to raise money for charities working both domestically and internationally. International relations scholar Vanessa Pupavac has also argued that the idea of giving money for those suffering elsewhere in the world has been ingrained in British children from a young age through the popular BBC children’s programme Blue Peter, which held fundraising appeals every year for those in need. The regular presence of charitable giving within British popular culture highlights its integration within British identity. Furthermore, one can look at the Memorial for Humanitarian Aid Workers, held in Westminster Abbey, as a symbol of the acclaim that is attached to humanitarian work in Britain.

This thesis draws together these symbols of British identity (the NHS and British international aid), within an investigation of British medical humanitarian response during the years 1988-2014. It asks: what can the story of British medical humanitarian response add to existing narratives of British humanitarianism? Both the NHS and British international aid have an important place within the creation of British identity, and yet there has been no research into how these two symbols interact, and the impact of this on British medical humanitarian response.

This thesis uses the lens of medical humanitarianism to provide an insight into the networks and decision-making between the actors that make up the

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8 Whilst recognising devolved institutions-the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly-this thesis takes a London-centric view of the British government and state aid. This thesis will also recognise that the ‘British government’ is an umbrella term for a multitude of departments and that each department had their own agenda and role within the government’s contribution to international aid. To read about the contributions of the Scottish Parliament to international aid, read: Ailsa Henderson, ‘Scottish international initiatives: Internationalism, the Scottish Parliament and the SNP’, Workshop on the Foreign Relations of Constituent Units, Winnipeg, 7, (2001).
humanitarian sector. It argues that during the period of this thesis, the British government took an increasingly active role within the British aid sector. It highlights the encroachment of government power within the aid sector through its increased funding of non-governmental organisations (NGOs), its use of the military as its humanitarian arm and its increased voice within policy decisions. Through the humanitarian medical lens, this thesis showcases the decisive attempts of the British government to situate itself at the centre of British aid delivery, both as a tool of self-promotion within international politics, but also as a method to gain support for its foreign policy decisions. To unpack the change in power relations within the network of actors that make up the British aid sector, this thesis analyses the deployment of British aid to various international humanitarian crises between the years 1988-2014, specifically focusing on the response to international disasters and post-conflict settings.

This thesis recognises ‘British’ responses as being multifaceted and made up of multiple entities. It understands the term ‘British humanitarianism’ to incorporate state responses (and in many of these crises the deployment of the British military as state actors), NGOs and self-organised civilian volunteers. This thesis understands ‘humanitarian response’ to be, the delivery of aid in the immediate period after a crisis. For example, during a famine response, humanitarian aid would be recognised as the delivery of food relief after a state of famine has been declared, or for a conflict setting, it would be the first aid delivered once the initial conflict has ceased. The term ‘humanitarian aid’ was developed throughout the period studied within this thesis.

Historian Eleanor Davey wrote: “there is no homogenous or ‘pure’ and

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9 This thesis will use the term ‘sector’, to describe the different structures and actors that contribute to the delivery of British humanitarian aid. James Darcy and Charles-Antoine Hofmann understood a “humanitarian system” to “to comprise [of] governmental and multilateral donors…the agencies of the Red Cross/ Red Crescent Movement, and International NGOs”. This thesis will understand the humanitarian ‘sector’ in the same way however, it also traces the growing involvement of the British government and the military as actors within this system. James Darcy and Charles-Antoine Hofman, ‘According to need? Needs assessment and decision-making in the humanitarian sector’, HPG, 15 (2003), p. 3.

10 This thesis recognises that the military, whilst also acting on behalf of the British government in many of the crises examined, also had its own agenda, obligations and financial restrictions. For information about the changes that took place within the British military after the Cold War read: Theo Farrell, ‘The dynamics of British military transformation’, International Affairs, 84(4), (2008).

11 This thesis recognises the distinction between a period of conflict and ceasefires are often blurred.

12 The term ‘humanitarian’ was not commonly used in the 1980s and is therefore, avoided in the first chapter of this thesis.
legitimate conception of humanitarian action” and argued that Western understandings of the term had been constructed and reformed by different actors and political agendas. Many humanitarian organisations in Britain choose to understand ‘humanitarian aid’ as defined by principles originally set out by the International Committee of the Red Cross (ICRC) and later recognised by the UN General Assembly in 1991 these being: neutrality, humanity and impartiality, and the addition of independence in 2004. This thesis however, will show the changing importance that actors within the British aid sector have placed upon these principles throughout the period of this study.

The meaning of the term ‘humanitarian aid’ shifted throughout the post-Cold War period and was adapted by different actors to meet their agendas. Similarly, during this period the boundaries between understandings of development work and humanitarian aid became increasing blurred. This thesis will explore the ascription of the term ‘humanitarian’ to actions outside the ICRC definition and will highlight how, both state and non-state, actors manipulated the meaning of ‘humanitarianism’ in mutually-constitutive ways. The widespread, often strategic, use of this term within the aid sector during this period reflects the positive connotations it can bring to an actor or action. Viewing the term ‘humanitarian aid’, and its use, through a historical lens enables this thesis to explore how, by whom and for what purpose, it was used throughout the post-Cold War period within medical responses.

This thesis tells an important story of the expansion of British medical humanitarian response, one that has often been overshadowed by narratives of British famine response, or French medical humanitarianism. British medical humanitarian aid offers a lens through which the story of British humanitarian response can be re-examined. This lens enables the exploration of the discussions and networks behind humanitarian responses. It

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15 This can particularly be seen in debates around New Humanitarianism examined in chapter 3. For a history of the term humanitarian aid see: Rysaback-Smith, ‘History and Principles of Humanitarian Aid’. 
investigates the shifting power balance between the NHS, the State and British NGOs during the 1980s, 1990s and 2000s. In doing so, it will determine the impact of the increased influence of the British government within humanitarian responses.

**Historiography**

This period has inspired the publication of many books, particularly from those who worked as humanitarian practitioners and journalists in the 1980s and 1990s. This literature offers an insight into the challenges and complexities of the humanitarian sector during this period. Books such as Fiona Terry’s *Condemned to Repeat*, which uses her expertise from her time as a humanitarian worker with the French medical relief organisation Médecins Sans Frontières (MSF) to investigate some of the largest humanitarian responses in the 1990s, have become increasingly popular with the British public.\(^\text{16}\) While these narratives offer a critical and informed account of the work carried out by aid practitioners, they often provide little historical context to the decision-making processes behind humanitarian responses. This thesis, therefore, historicises this literature, placing it alongside the work of historians, grey literature, oral histories, medical research and military literature.\(^\text{17}\) This allows for the investigation of the different factors, such as networks, power relations or interactions, that led to the deployments described in narratives like Terry’s. In doing so, this thesis presents a history of the British humanitarian sector during this period, specifically focusing on British medical deployments.


\(^{17}\) The use of ‘grey literature’ has become increasingly common within academia. Though a contested term, ‘grey literature’ is most commonly understood by a definition given at an International Grey Literature Conference held in Luxembourg in 1997 and later expanded at a New York conference in 2004. It stated that ‘grey literature’ was: “Information produced at all levels of government, academic, business and industry in electronic and print formats not controlled by commercial publishing i.e. where publishing is not the primary activity of the producing body”. Within this thesis, the ‘grey literature’ most commonly examined is policy and research papers produced by NGOs. Margaret Mering, ‘Defining and Understanding Grey Literature’, *Serials Review*, 44(3), (2018), p. 238. For more information see also: Samantha Tillett and Elizabeth Newbold, ‘Grey literature at The British Library: revealing a hidden resource’, *Interlending & Document Supply*, 34(2), (2006).
Much of the current literature that examines humanitarian response be it historical, political or international relations literature, fails to demonstrate distinctions between different countries’ responses. Instead, these analyses tend to focus on ‘Western’ humanitarian response, problematically overlooking the distinctive trajectories of British, American or French humanitarian response. This can also be seen in Peter Walker and Daniel Maxwell’s book *Shaping the Humanitarian World* which, despite offering an initial discussion of the diverse roots of humanitarianism found within ancient Egypt and the Chinese Book of Rites, quickly progressed to discuss a generalised ‘western’ humanitarian response.\(^{18}\) By the end of the first chapter, it was clear that the humanitarian response that they refer to was a myriad of different humanitarian traditions.\(^{19}\) Similarly, Jennifer C. Rubenstein’s book *Samaritans and State*, which explored the political ethics within humanitarianism, traced a distinct line of humanitarian evolution within Europe, in comparison to that of charitable societies within the Muslim world.\(^{20}\) Here the commonality of European humanitarian organisations was presented through their Christian background; however, this failed to account for European organisations which trace their influences to Islamic tradition. This presentation again tended towards homogeneity, and in doing so, discounted the unique and varied stories of evolution within different European humanitarian traditions. Historian Thomas Davies also attempted to expand the narrative of western humanitarian response by offering a comparison with eastern humanitarian traditions in his book *NGOs: A New History of Transnational Civil Society*.\(^{21}\) Again, while this proved an illuminating comparison of different traditions, the grouping of “western” or “eastern” humanitarian traditions lead to a loss of recognition of the intricacies of what a “western” or “eastern” response was and the different cultures that combine to produce these dichotomies.\(^{22}\) Davies’ grouping of the western response, while revealing commonalities of humanitarian

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\(^{19}\) Ibid.


\(^{22}\) Ibid.
response from the west, failed to acknowledge and address the distinct histories, ethical backgrounds and political influences of each country’s choice to respond to a humanitarian crisis.

In recent years, however, the investigation into national histories has become increasingly popular within humanitarian research. This can be seen, for example, in Carl Marklund’s work on Nordic Humanitarian action, Julian Irwin’s research on the American Red Cross and American foreign relief, Eleanor Davey’s investigation into the intellectual and political landscape that shaped French humanitarianism, and Hanna Krebs’ exploration of the history of Chinese Humanitarianism.23 Within this school of literature, there has been a rise in research into the history of British humanitarian response. For example, Sarah Roddy, Julie-Marie Strange and Bertrand Taithe’s The Charity Market and Humanitarian Britain, investigated the history of charitable giving within Britain.24 Alternatively, Rebecca Gill’s Calculating Compassion traced the origins of British humanitarianism within responses to war in the late 1800s.25 This thesis contributes to this push back against the ‘western response’ narrative and provides a new contribution to this school of the history of ‘British humanitarianism’, by extending the narrative into the twenty-first century and demonstrating its continued distinctive trajectory.

The field of British humanitarian history has been dominated by one narrative. This dominant narrative examined the colonial background of British humanitarian response and its continued legacy within British international aid. Historians such as Emily Baughan, Andrew Porter and Mark Frost have investigated the impact of the British Empire and its legacies within both humanitarian work and development work in the twentieth

This narrative was also explored by historian Anna Bocking-Welch who, using the Freedom from Hunger Campaign in the 1960s as evidence, determined that the “British public’s transition from imperial to international humanitarianism was not quick, smooth or all-encompassing”. She argued that “imperial philanthropy and trusteeship” did not disappear with decolonisation, but that it continued alongside discourses of humanitarian aid. The impact of the British Empire is also examined within Caroline Shaw’s *Britannia’s Embrace*, which investigated the origins of modern humanitarianism and refugee relief. Though this book begins in the 1700s with an investigation into the aid given to those fleeing religious persecution in French, it too analyses the impact of the British Empire, first by exploring imperial refugee schemes, and then the increasing restrictions placed upon refugees as the Empire began to shrink. These historians highlight the continued legacies from the colonial period within the delivery of humanitarian aid.

This thesis contributes to this literature by highlighting the impact of language and ideas, developed during the colonial period, within government rhetoric relating to international aid during the post-Cold War era. It builds upon the work of Daniel Gorman who explored the inter-war period and the growth of what he termed “humanitarian imperialism”. He argued that “humanitarian imperialism” can be seen in within the work of voluntary associations such as the Association for Moral and Social Hygiene. Gorman described humanitarian imperialism as “moral imperative to improve the social conditions abroad, and the unquestioned assumption that it was their [British

28 Ibid., p.892.
30 Ibid.
voluntary association’s] right and duty to do so”.

Particularly focusing on the role of women activists, he argued that during the 1920s there was shift in thinking that saw the “moral purpose”, that had driven initiatives to combat inequalities within Britain, being applied to “international problems”. This thesis demonstrates that the language of morality, developed within an imperial context, continued to be used by the British government in the post-Cold War period as justification for British interventions abroad and humanitarian responses.

Throughout the histories of humanitarianism which trace the colonial narrative a dominant and reoccurring theme is that of British famine response. This history gained prominence in the late 1980s and early 1990s, in the aftermath of the widely broadcast Ethiopian famine. Historians, however, have traced Britain’s role within famine further back than the 1980s. Kevin O’Sullivan’s work on the humanitarian response to the Biafran famine determined that there was a continuation of colonial paternalistic views within famine response. He wrote that ideas of “donation, dependency, expatriate volunteers and western concepts of ‘needs’ and ‘development’” continued to be prominent in the 1960s.

Historian James Vernon has traced British famine response further back to the British food aid given during the Irish and colonial famines. His work has helped to construct and promote the image of British dominance within the field of famine relief. Writing as a cultural historian, Vernon explored famine as a social issue and examined the changing cultural and social understandings and presentations of famine and famine response. This thesis builds upon his research, exploring the impact that changing perceptions of famine had on famine responses and medical treatments for malnutrition.

The critical role of Britain within famine response has also been reinforced by institutional histories of many of Britain’s largest NGOs. Oxfam, for

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33 Ibid., p.215.
35 Ibid.
example, has determined that its origins can be found in the delivery of food aid to enemy-occupied Greece in 1943.\textsuperscript{37} Similarly, Save the Children UK claims that it was created in response to reports of starving children across Europe after the First World War.\textsuperscript{38} These origins stories not only emphasise the role of famine in the growth and origins of British NGOs but have come to represent the British humanitarian sector as a whole. The dominance of these large NGOs has led to the over-shadowing of other influential actors within the British humanitarian sector.

The presentation of large British NGOs as the epitome of the British humanitarian sector has been created through multiple institutional narratives. These narratives trace the origins of these NGOs, their donors and their roles within international responses. For example, Emily Baughan and Juliano Fiori, a researcher at Save the Children, have traced the origins of Save the Children, highlighting its distinctly political roots.\textsuperscript{39} The dominance of these large multi-mandate NGOs within narratives of British humanitarianism can also be seen in the work of Maggie Black, a former Oxfam employee who wrote \textit{Oxfam: A Cause of our Times}.\textsuperscript{40} These institutional narratives also bring to the foreground the role of large donors. For example, Barrie Ireton, a former Director General of the Department for International Development (DfID), has traced the role of DfID within the aid section since its creation.\textsuperscript{41} These stories, being prominent within British public understandings of British aid, present the British aid sector as one that is dominated by a small number of large multi-mandated organisations and donors. While this thesis has used the institutional narratives of these large NGOs, it places them within a fuller and more varied presentation of the British humanitarian sector, to better understand the shifting relationship, influences and interactions which come together to create the unique identity of British humanitarianism.


\textsuperscript{39} Emily Baughan and Juliano Fiori, ‘Save the Children, the humanitarian project, and the politics of solidarity: reviving Dorothy Buxton’s vision’, \textit{Disasters}, 39(2), (2015).

\textsuperscript{40} Maggie Black, \textit{A Cause for Our Times: Oxfam the first 50 years} (Oxford University Press, Oxford: 1992).

The relationship between large NGOs and the British government has been explored by historians such as Rebecca Gill. Examining the history of the ICRC and British relief work, Gill argued that; “for much of the late nineteenth and early twentieth century, relief workers, inhabited overlapping circles with politics… such that many could be said to be part of the governing establishment”.42 She also wrote that “preoccupation with the independence of the ‘NGO’ from the state is a modern one: the politics of relief in the nineteenth century and early twentieth century were inseparable from the shifting politics of the state”.43 Similarly, Baughan and Fiori’s exploration of Save the Children’s early years highlighted that, by attempting to present itself as non-political and impartial, they actively supported the actions of the British colonial forces in Kenya in the 1950s.44 Such narratives highlight the close relationship that large NGOs had with the British government and the British state agenda. Mathew Hilton has unpacked this relationship further and examined the balance of power between the government and NGOs in his book The Politics of Expertise. Hilton explored the influence that NGOs (in the fields of international development, environment and homelessness) had over British policymaking.45 His work added complexity to the relationship between NGOs and the British government and emphasised the influence that NGOs have over government actions and policies. This thesis builds upon Hilton’s narrative by demonstrating the complex and entangled relationship between the British government and British NGOs. It argues that this relationship is one in which the influence over decision-making and power balance continuously moves back and forth between these actors throughout the post-Cold War period.

Just as large NGOs played a significant role within the humanitarian sector in Britain, so too did the newer humanitarian actors that emerged in the 1980s and 1990s. Historians have traced the “large growth in the number and reach

43 Ibid., p.10.
44 Baughan and Juliano Fiori, ‘Save the Children, the humanitarian project, and the politics of solidarity’.
of humanitarian actors” throughout this period. Randolph Kent for example wrote that; “The post-Cold War order and globalization have opened the way for a ‘humanitarian enterprise’”. He determined that between the 1980s and 2000s, the number of “organizations-including governmental, intergovernmental and non-governmental-that had some recognized expertise in disaster and emergency relief” had “multiplied fourfold.” Scholars, Paul Mosely, Mark Robinson, and Andrew Jones examined the impact of this growth and explored the creation of institutions such as The World Bank or the Overseas Development Administration. This thesis contributes to this literature by examining the impact of new actors within the British humanitarian sector after the Cold War.

By exploring the role of these newer organisations and actors within medical humanitarian responses, this thesis complicates image of British humanitarianism. Unlike older NGOs, these actors did not have a long relationship with the British government. Similarly, unlike the older NGOs and the British government, they had no connection to the ideologies and beliefs of the colonial period. Despite this important distinction, these new organisations worked within a humanitarian sector whose foundations can be found in a colonial context and therefore, were also influenced by the modes of practice and humanitarian norms embedded within this system. Exploring a fuller and multifaceted presentation of British humanitarianism one is better able to understand the shifting relationships, influences and interactions which came together to create its unique identity. This thesis argues that the British humanitarian sector is more than just a collection of several large NGOs responding to famine, and demonstrates this by documenting British medical humanitarian response. Focusing on medicine reveals the presence

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48 Ibid., p.860.
of smaller NGOs, individuals, humanitarian think-tanks and academic institutions within the sector.

Despite strong acclaim and the central place that the NHS holds within the British imaginary, there has been little research on the role that the NHS has played internationally. Alternatively, historians have focused on the distinctive nature of medical care within Britain and the impact of the NHS within this story. Historian George Gosling for example, provided an insight into British health care prior to the creation of NHS in 1948 by examining voluntary hospitals and philanthropic support for health care within Britain between the years 1918-1948. Alternatively, historian Sally Sheard has investigated the different factors that influenced, and catalysts that led to, the creation of the NHS. Reviewing the prominent historiography of the NHS, Martin Gorsky highlighted that much of the literature examining the NHS’s history focused on the political and structural changes within the NHS. These discussions can be seen in the work of Rudolf Klein, who investigated the political history of NHS and the changing impact of policies enforced by successive governments. Moving away from research that explored the influence of government over the NHS, historian Glen O’Hara investigated the NHS in the 1960s and 1970s and examined how the British public interacted with the NHS particularly focusing on the themes of participation and consumerism. Despite the extensive historiography on the origins of the NHS, the impact of the British government on health care policies and the changing ways that the British public have interacted with NHS, there has been little research into the impact of the NHS on the delivery of medical care in other countries.

Prior to the NHS, British medical practitioners played a significant role in the provision of medical care within British colonies and in the development of

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tropical medicine. Historians Helen Power and Michael Worboys, have examined the role that Britain had in the growth of tropical medicine studies by exploring the creation of the Liverpool School of Tropical Medicine and the London School of Hygiene and Tropical Medicine. Alternatively, historian David Arnold researched the role of medicine within colonial projects, specifically focusing on India. He argued that medicine was a tool, used by colonising powers, to both protect colonisers and to impose authority and control over colonial subjects. Historians have however, highlighted the shift within British colonial medicine after World War One that saw the British medical community slowly began to focus on the provision of health care to entire communities and populations, rather than simply the productive workers and colonisers. Moving beyond the colonial period, historians have also investigated the role of the NHS internationally, through the training of international doctors within NHS hospitals. While this history of British medicine during the colonial period and the role of international doctors within the NHS system has been extensively researched there remains a gap in the historiography that fails to examine the influence of the NHS within British medical humanitarian response.

Equally, much of the existing literature surrounding medical humanitarian response does not mention the NHS but instead focuses on two different

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58 Ibid.
59 This builds upon Gorman’s argument of ‘humanitarian imperialism’, insofar as it demonstrates a shift in thinking within medical circles that gave greater recognition to the inequalities in other countries. Furthermore, it indicates the assumption within the British medical community that it was their duty, as a colonial power, to improve the lives of people abroad. Randall Packard, ‘Post-Colonial Medicine’, in Roger Cooter and John Pickstone eds., Companion to Medicine in the Twentieth Century (Routledge, London: 2003), p. 100; Sabine Clarke, ‘A technocratic imperial state? The colonial office and scientific research, 1940–1960’, Twentieth Century British History, 18(4), (2007).
strands. Firstly, the story of MSF, the prominent French NGO which dominates narratives of medical humanitarian response. While recognising the multifaceted nature of French humanitarianism, Philippe Ryfman, determined that the French public still identified “humanitarian NGOs from the stereotype of the ‘French doctor’”. This imagination of French humanitarianism as predominately medical is strengthened through the literature MSF produces. Caroline Abu-Sa’da, then director of the Research Unit of MSF in Geneva, alongside other researchers, both academics and humanitarian practitioners, explored the way that MSF was perceived as an organisation and the impact of this on their ability to deliver humanitarian medical aid. MSF practitioners also published the book Medical Innovations in Humanitarian Situations: The Work of Médecins Sans Frontières, which presented the image of MSF at the heart of humanitarian medical innovation. In light of this, British contributions of medical relief aid have been overshadowed and have little presence within academic and organisational literature.

Alongside the narrative of the French medical humanitarian responses, sits the narrative of the International Committee of the Red Cross and its delivery of medical aid within conflict settings. The ICRC proudly promotes the origins story of the battlefields of Solferino in 1859, with the provision of medical care to wounded soldiers. The ICRC has since its creation played a dominant role in discussions of emergency medical treatment. Within the broad story of the ICRC, however, there is little discussion of the role of the British Red Cross, a national offshoot of the ICRC who is most famous for

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64 Davies, NGOs, p.38.
its domestic work, within British humanitarian response. Gill analysed the origins of the British Red Cross between the years 1870-1906; however, there is little to no research that traces its impact within British medical humanitarian responses after the Cold War.\textsuperscript{66} The Red Cross Movement is distinct from other NGOs due to its relationship with national governments; Thomas Davies argued that this had been the cause of their success and global spread.\textsuperscript{67} This relationship is reflected within the British Red Cross who, in a public-facing document claimed that it “has a special, officially recognised status and role as an auxiliary to its country’s public authorities in the humanitarian field” and that it “retains part of its original support function to the military medical services”.\textsuperscript{68} The ICRC and, specifically for this thesis, the British Red Cross, therefore offered a bridge between national militaries and INGOs within humanitarian settings. Despite this, there has been very little literature investigating the impact of this for British medical response.

Since the 1990s, discussions on the role of the military within humanitarian settings have grown in importance. Scholars of international relations, such as Larissa Fast, David Chandler, Mark Duffield and Marion Birch have investigated the implications of military presence within humanitarian settings and investigated the loss of “humanitarian space” due to an increased presence of the military in humanitarian settings.\textsuperscript{69} This thesis will provide a historical background to these discussions, tracing the steps that led to an increased presence of the British military within humanitarian settings, and specifically, the role of the military within medical humanitarian responses. By examining the role of NHS practitioners and the British military within

\textsuperscript{66} Gill, ‘The origins of the British Red Cross Society’.
\textsuperscript{67} Davies, \textit{NGOs}, p.38.
\textsuperscript{68} Michael Meyer, \textit{The British Red Cross’s humanitarian auxiliary role to the British government and armed forces}, (British Red Cross, London: 2009), Available: file://nask.man.ac.uk/home$/British-Red-Cross-Auxiliary-Role.pdf [Accessed 19 August 2019].
medical humanitarian responses, this thesis challenges the dominant narratives of French medical response and British famine response.

This thesis draws on the historiography of British humanitarianism, political science scholarship and medical literature, creating a space through medical humanitarianism in which they can speak to each other. Scholars tracing a period that expands over multiple decades have commonly used a chronological approach, structuring their research through the artificial division of different decades. This can be seen, for example, in David Sanders, *Losing an Empire, Finding a Role: British Foreign Policy since 1945*, or Michael Barnett’s *Empire of Humanity* and Thomas Davies’ *NGOs: A New History of Transnational Civil Society*. This approach has failed to account for the varying trajectories of different actors and events that have shaped British humanitarianism and themes that transcend decades. Instead, this thesis, through the investigation of different medical humanitarian deployments, uses multiple snapshots taken throughout the 1980s, 1990s and early 2000s, to create a complex image of British medical humanitarian response.

**Methodology**

Studying such a contemporary period using a historiographical methodology enables an exploration of the different drivers of change within the humanitarian system. This methodology provides an insight into the relationships and networks that came together to create British humanitarianism during this period. For example, it offers a greater insight into how different actors negotiated their role within medical humanitarian crises by claiming authority based on their past work within a country. By critically exploring how different actors constructed their own narratives, this thesis examines the importance placed on certain crises and their relationships with other humanitarian actors. Similarly, it enables these responses to be viewed alongside the foreign policies of successive British governments and

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the discussions taking place within academia, to reveal the different agendas that influenced change within the humanitarian sector. By using a historical analysis to explore the sources and examine different documents and oral testimonies alongside each other, this thesis provides an insight into the strategic ways different actors remember their roles within medical humanitarian responses. Furthermore, by using a historical methodology, this thesis is able to critically analyse the development of medical humanitarian policies and practices and question whether they were truly new or have foundations in past modes of practice.

This thesis investigates the British aid sector in the post-Cold War period through an examination of different medical humanitarian responses. The benefits of using an approach have been shown through multiple edited volumes, such as Norbert Frei, Daniel Stahl and Annette Weinke’s study of Human Rights and Humanitarian Intervention, which pulled together numerous research cases to examine the development of humanitarian intervention in the post-Cold War era.71 This method allows for both detailed discussion of particular moments and the study of how key issues and actors have changed over time. In the same way, this thesis uses different cases of medical humanitarian deployment, not only to gain a detailed and close understanding of these responses but also to highlight the continuities, developments and disconnects within the British medical humanitarian sector during the late 1980s, 1990s and early 2000s.

This thesis and the sources that it draws from have been shaped by the time period that it investigates. Much of the literature for British NGOs has been restricted, as their archives have not released any documents later than the 1970s. Similarly, what has been kept is often filed within personal archives of practitioners and hard to obtain. As a historian, therefore, access to what may be perceived as traditional sources for this period is very restricted. Furthermore, many of the documents that would previously have been archived do not exist due to the transition to online communication in the early 2000s. Historian Ravinder Kaur has examined this transition to digital

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communication. He wrote that soon, historians would no longer associate archives with, “dust on the paper documents”. Due to the increasing use of digital media, traditional methods of archiving paper documents is no longer sufficient, rather as Kaur argued, historians need to become their own archivists, gathering information from multiple online sources to create a body of sources from which to research. This thesis has not only faced the challenges that Kaur outlined but also responded to them in a similar way.

To counteract the silence within the British NGO archives and dispersal of documents within personal archives, this thesis draws upon a multiplicity of other sources to glean an understanding of these years. It uses the work of academics writing throughout this period to gain an understanding of the debates that were taking place within academia and within humanitarian and medical think-tanks during this period. By tracing the funding of some of these research projects, this thesis has been able to reconnect links between this research and, in many cases, the state. These networks have enabled the reconceptualisation of the power and decision-making behind the research projects.

This thesis has similarly drawn upon grey literature, often in the form of outward-facing public documents produced by NGOs to promote their work. This provides a clear understanding of the different types of responses that NGOs wanted to promote throughout the period of this thesis. This literature is revealing in both what it focuses on, but also in its silences. These silences are particularly significant within annual reports of their work, as will be seen notably in chapter 1. Alongside this grey literature, the chapters of this thesis have also drawn upon the media to examine how particular crises were presented to the public, for example, chapter 4 highlights the government’s use of the media to gain support for its role in Iraq.

Whilst these sources are revealing, they must be analysed alongside the context in which they were produced and with an awareness of the intentional narrative promoted by their creators. The importance of this is highlighted

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73 Ibid., p.247.
when examining newspapers and their relationships with NGOs. Scholars have documented the complex relationship that British newspapers have with different political parties and the influence of political agendas on their reporting.\textsuperscript{74} British newspapers however, also have long-standing relationships with some of the large NGOs explored in this thesis.\textsuperscript{75} Emily Baughan for example, highlighted Save the Children’s relationship with the \textit{Manchester Guardian} and its use of this newspaper as a platform through which to do fundraising.\textsuperscript{76} The historical relationship between these actors may impact how \textit{The Guardian} presented Save the Children’s work in the post-Cold War period. When examining newspaper articles as a source therefore, this thesis recognises that they were written in the context of their own political agenda and relationships, both with the government and with NGOs.

Despite the abundance of newspaper articles and policy documents, this research still presented many gaps, particularly in the decision-making processes behind each deployment. To counteract this, this thesis has drawn upon semi-structured interviews carried out with humanitarian practitioners. Alessandro Portelli wrote that oral history can “give us information about… social groups whose history is either absent or distorted”.\textsuperscript{77} Similarly, historian Penny Summerfield, who has written extensively about the use of oral histories, highlighted the ability of oral histories to “democratise” history.\textsuperscript{78} The oral histories used within this thesis provide a personal insight into the impact of policy decisions on the work of medical practitioners and the care they were able to provide patients.

Given the nature of this topic, medical humanitarian response, and its potential to be traumatic I took steps during the interview process to avoid the

\textsuperscript{76} Baughan, “Every citizen of the Empire Implored to Save the Children!”.
possibility of retraumatising interviewees. I chose to only ask questions to the interviewees, who were often medical practitioners, about the mechanisms and policy frameworks in which they were required to work. I did not ask about specific medical cases or traumatic events.79 The interviews used within this thesis were often carried out remotely via skype or on the telephone. Having no medical background, I approached these interviews as a site for learning and gave the interviewee the power to dictate the direction of the interview, within the bounds of the humanitarian response being discussed.

These oral histories provide an insight into the experiences of medical practitioners within humanitarian responses and how these crises have been remembered. For some of the interviewees, the crises that were discussed took place more than ten years ago. This distance often enabled them to reflect on their experiences with hindsight. Within crises that particularly divided public opinion, such as the Iraq war, humanitarian practitioners may have adapted their stories to fit into popular understandings of the crisis. These oral histories therefore, need to be understood within the context of a particular crisis and the potential impact of external influences. Summerfield, emphasised that “oral history is about subjectivity”, it offers an insight into how crises are experienced and remembered.80 With this in mind, these oral testimonies are valuable both in regards to what the interviewees remembered and chose to discuss, but also what they did not recall or avoided. These testimonies are used to build upon findings from the available written documents and provide an insight into the experiences of these personnel.

Piecing together such a multiplicity of sources within this thesis has resulted in the need for a different methodology or approach when studying each crisis and time period. Each source has been seen as a product of the time and environment in which it was created, be it oral histories, newspaper reports or academic journal articles. Despite the challenge of limited access to NGO archives, this thesis has drawn on rich and varied sources, enabling the

79 In some cases, interviewees chose to explain the impact of certain policies by providing examples of medical challenges they faced, I however, was careful not to ask for these.
research to move beyond traditional narratives of British humanitarian response and generate new insights into this period.

This thesis, and the methods chosen to research this period, have been influenced by Save the Children UK and the Humanitarian and Conflict Response Institute (HCRI). This thesis was written in collaboration with Save the Children UK’s Humanitarian Affairs Team, as part of a case studentship. This relationship, with one of the large NGOs studied within this thesis, provided privileged access to interviewees such as the Save the Children’s Head of Humanitarian Affairs Gareth Owen. The ability to interview key personnel within the organisation and to gain an understanding of the way this organisation worked had a large influence over which crises were examined within this thesis. I made an active attempt to ensure that the insights provided through this relationship did not result in this research becoming an institutional history of Save the Children’s post-Cold War humanitarian response. While including the role of Save the Children, this thesis places it alongside a multitude of other actors that contributed to British medical humanitarian response.

This thesis was particularly influenced by the contribution of members of the Humanitarian Affairs Team, along with John Borton a Research Fellow for ODI, who provided a supervisory role within this thesis. These members contributed by reading drafts and giving feedback at every stage of research and writing. Throughout this process it was clear that these supervisors, working within or closely connected to the humanitarian sector, emphasised the need for humanitarian events and NGO’s actions to be thoroughly chronicled. The wish for a more chronicled approach highlights the lack of an existing record of the specific actions of different NGOs within such contemporary crises. The call for these to be recorded highlighted the loss of institutional memory that has already taken place within the British aid sector.

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81 The Humanitarian Affairs Team produce research and policy documents for Save the Children UK. They describe themselves as acting as “a counterpoint to programmatic and technical expertise, providing insight into the conceptual and theoretical questions that underpin humanitarian practice”.


82 John Borton now works a freelance consultant focusing on evaluation activities within the humanitarian sector.
and reinforced the need for the intentional archiving of sources from contemporary crises.

I am also a member of the Humanitarian and Conflict Research Institute and this thesis was written under the supervision of its lecturers. This institute and its academics, while sitting within a University, also have strong connections to humanitarian organisations and actors, often contributing to debates and events within the British humanitarian sector. Working within HCRI therefore, has also provided access to actors who straddle both humanitarianism and academia, such as Dr Tony Redmond and Dr Amy Hughes. The ability to access such personnel provided great insight into the crises studied within this thesis. Dr Tony Redmond, specifically, played an influential role by providing oral histories and access to his personal archive. These sources have had a large influence over the choice of humanitarian responses that this thesis examines.

HCRI, as a University institute, faces pressure from funders to demonstrate the impact of its research.\textsuperscript{83} Collaborations such as the case studentship with Save the Children UK, within which this thesis was written, offer a valuable opportunity for collaboration with external actors and the production of demonstrable impactful research. Save the Children’s interest in this thesis came from a wish to reflect upon past humanitarian medical responses in light of the large role that it played within the medical response to the Ebola outbreak in 2014. Juggling both the need for impactful research and the recognition for a need to learn from past responses, these case studentships can benefit both University institutes and NGOs. Such collaborations however, influence the research that is produced. Meeting the research needs of multiple stakeholders, each with different agendas, can at times pull the research in different directions. This thesis therefore, demanded that I had a clear understanding of my research aims and balanced the different expectations of those involved.

\textsuperscript{83} This is demonstrated through an impact agenda and measured by The Research Excellence Framework. For more information about The Research Excellence Framework visit: https://www.ref.ac.uk/about/what-is-the-ref/
Working within HCRI and alongside members of the Humanitarian Affairs Team placed me in the position of participant-observer. This role is one not commonly held by historians, but was made possible by the contemporary nature of this study. This role provided access to sources and gave me a unique insight into the organisational dynamics of both HCRI and Save the Children. The role of participant-observer also presented challenges. Scholar Robert Labaree highlighted that, within participant-observer research, the researcher must distance themselves from the “normative rules and belief systems” of the organisations within which they work.\(^{84}\) Similarly, he wrote that the researcher must work to maintain “objectivity and accuracy”.\(^{85}\) To maintain objectivity whilst carrying out research for this thesis I made an active attempt to distance my research from the relationships that I had with members of each body.\(^{86}\) Using a historical approach was one way in which I was able to maintain this distance. I also chose not carry out oral history interviews with members of the team who provided my supervision, but rather members of the organisation who had no prior knowledge of the research. Similarly, examining sources through a historical lens enabled me to view them objectively, as historical documents, rather than sources with which I had a personal connection.

This thesis must therefore, be read with the recognition of these factors, both in regard to the positive impact that close proximity with both an NGO and academic institution has offered, but also in recognition of the influence that these actors may have had on my decision making and research choices.

**Chapter Breakdown: British Medical deployments**

This thesis begins with a snapshot of late 1980s Britain; a Britain under the leadership of Margaret Thatcher and in the shadow of the impending threat of the Cold War. This first chapter focuses on an earthquake in Armenia in 1988, which sat on the brink of international political change. This response

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\(^{85}\) Ibid., p.107.

\(^{86}\) Ibid., p.107.
was specifically chosen as this earthquake resulted in the first request for and delivery of aid to the Soviet Union from the West since the Cold War began. The aid sent to Armenia was portrayed as a demonstration of the beginning of changes that would lead to the end of the Cold War. This case study, therefore, enables an investigation into the place of humanitarianism within the Thatcher government policy at the end of the Cold War; notably, it will highlight its inferior position to that of development aid. It demonstrates that, despite the financial and institutional growth within this sector, Britain’s ability to respond to humanitarian crises did not improve. This chapter shows that, despite sending an unprecedented amount of money to Armenia, Britain did not have the expertise or the will to send an emergency response team. It argues that the government began to perceive British NGOs as a tool to outsource their aid responsibilities, and as a consequence, development projects (which aligned with government foreign policies) were prioritised over humanitarian response. The lack of development of Britain’s emergency response mechanisms meant that during the Armenian earthquake, British medical humanitarian response was limited to an independent group of doctors who travelled to Armenia to deliver medical care.

The second chapter of this thesis investigates British medical response to a famine in Sudan in 1998, and evolutionary thinking, which began to recognise the failure of famine relief methods. This famine drew contemporary debates surrounding the nature of famine out from academic discussions and into wider political and policy debate. This chapter explores the networks between the Department for International Development and academic bodies and their role in the changing understandings of famine. Clare Short, the Secretary General of DfID, which had been created by New Labour, called for the recognition of the political background of famine crises. This chapter traces the impact of this new understanding within British politics, and by extension, government research funding. By mapping this funding, one can see that new understandings of famine led to the research into, and the creation of, new methods of famine treatment. The Sudan response and the debates it triggered were chosen for the second chapter of this thesis as they indicate a marked change in the role of the government within humanitarian responses.
Specifically, it highlights the new critical nature of government engagement with the aid sector and offers an insight into the impact of this on the treatment for famine victims.

Developing the thread of the role of the British state within humanitarian responses, the third chapter of this thesis investigates the role of Britain within the North Atlantic Treaty Organization (NATO) bombing of Kosovo in 1999, focusing specifically on the British medical humanitarian response that followed. The NATO bombing gives one an insight into British foreign policy, both in terms of the relationship with the US, but also the position that NATO held within the international political order. This chapter investigates the medical response to the food insecurity that followed the bombing, the role of British medical personnel in the immediate delivery of medical aid, and the running of the hospital in Pristina in the direct aftermath of the conflict. While providing emergency medical care, medical personnel working in Kosovo had to carry out a wide array of roles, as the understanding of ‘health’ expanded during this period. This broadened understanding of health drew these medical workers into the political sphere, requiring them to be negotiators between warring parties, peacemakers within the hospitals and actors within the state-building process. The Kosovo response is significant due to its labelling as a humanitarian intervention. This case study therefore not only investigates the impact that expanding understandings of health had for the roles of medical practitioners, but it also examines the implications of the expansion of the term ‘humanitarian’ as a tool within foreign policy.

The fourth chapter, highlights the implications of this, through exploring the blurred role of the military and humanitarian workers within Iraq, both during and after the invasion in 2003. The British army and British NGOs worked alongside each other to deliver what they both termed ‘humanitarian medical aid’. The Iraq war was intentionally chosen as a case study as it demonstrates the implications of unchecked state power and the consequent loss of humanitarian space. This chapter investigates the consequences of the military delivering humanitarian aid under the guise of a ‘hearts and minds’ mission and the specific implications of military doctors providing medical aid to civilians. It argues that this blurring led to the perception of the hospital
as a target for insurgency attacks, preventing British doctors from working within them. The inability of the British and US military to create humanitarian space within Iraq or to provide protection for the hospitals meant that medical staff were restricted in their ability to provide medical care. This chapter, therefore, reveals the complicated and often negative relationship during the Iraq war between the British military and humanitarian medical staff.

Chapter five offers an example of when the military and NHS staff once again worked alongside each other. The Ebola outbreak in 2014, around which this chapter is focused, became the site of medical innovation, as scientists from around the world attempted to create a vaccine to prevent the continued spread of this virus. This chapter will investigate Britain’s important role in this biomedical innovation. This response was chosen as the final chapter of this thesis as it tells an important story of British medical humanitarianism in so far as it was the largest deployment of NHS staff to a crisis overseas. Around 250 NHS staff volunteered to travel to Sierra Leone to support the African medical practitioners. This was an Ebola outbreak on a scale that had never before been recorded, and it resulted in an exceptional humanitarian response to an epidemic. Save the Children UK sat at the forefront of this response, running and coordinating the British response. This thesis will explore the decision of Save the Children to run the response, and will demonstrate the political motives for this decision. The Ebola response led to the creation of a British Emergency Medical Team, something that British doctors lobbied for after the Armenian earthquake in 1988, and therefore provides an appropriate bookend to this story.

These chapters come together to tell the story of British medical humanitarian response. The responses analysed are not evenly spaced across the period of this study; however, they were strategically chosen to highlight the impact of Britain’s changing domestic and foreign policies on humanitarian aid. They trace British aid from the end of the Cold War when British internationalism reached a high point with the response within Kosovo in 1999. The story then progresses to explore the low point of the Iraq war and the impact of inward-facing attitudes that followed the bombing in the US on 11th September
This thesis investigates the impact of this shifting climate of British humanitarian response through investigating British medical humanitarian responses. It traces the shifting understanding of health during this period, from a growing recognition of the socio-political impacts on health in the late 1990s to a regression in this view, back to the view that health was centred solely on physiology during the Ebola outbreak. The British medical humanitarian responses therefore directly reflected changing attitudes towards ‘others’ within Britain, particularly within British foreign policy. We see during this period the use of medical humanitarian response as a state tool, and thus the drawing of medicine and medical response into the political sphere. While medicine has been noted as a political tool within British colonies to ensure control over indigenous populations, its role within contemporary British humanitarian responses has not been researched. From a response that is articulated in terms of human need, this thesis has traced the movement of medicine into the heart of global politics and its manipulation as a tool of the British state to position itself within international political order.

To fully understand the change that has taken place during this period, this thesis starts with the Armenian Earthquake in 1988, a point at which the British government and British NGOs did not prioritize humanitarian response. Rather, it was British doctors released from the NHS that responded to the crisis. The role of the NHS is most prominent within the beginning and final chapters of this thesis. Bookending this thesis, the actions and principles of the British (NHS-trained) medical doctors within both crises varied little during this period. However, this study of the changing actors, networks and power dynamics behind British medical deployments during this period, demonstrates a British medical humanitarian sector that has grown and shrunk having both shaped and been shaped by British government policies, for which it became a tool.

87 This thesis will refer to this as September 11 bombing or September 11 attack.
Chapter One: The 1988 Armenia Earthquake: British Disaster Response under Thatcher’s Neoliberal Agenda

Introduction

The 1980s was a period of significant financial growth for British non-governmental organisations.1 Events such as Band Aid and Live Aid acted as catalysts to an upward trend in British charitable giving, which resulted in the significant growth in the income of British aid organisations. An example of this can be seen in the expansion of Save the Children’s income which, between the years 1984 and 1985 (the years of Band Aid and Live Aid) increased dramatically from “£16.5 million to £42.5 million”.2 This financial growth and its impact on the British aid industry has dominated the literature on British aid during the 1980s. This chapter develops this historiography by examining the consequences of this growth. It proposes that the financial and, by extension, institutional growth of aid organisations in the 1980s, did not translate into commensurate growth of technical or logistical ability in the arena of British disaster response. Rather, the pervasive neoliberal policies of Margaret Thatcher led to a marginalisation of disaster response in the face of development aid.3

This chapter aligns multiple areas of scholarship — British aid in the 1980s, British domestic policy under the Thatcher government, British foreign policy during the Cold War and the study of Thatcher’s neoliberal agenda — to create an image of British aid in the 1980s and the role of the British state. Andrew Jones and Suzanne Franks have examined the impact of Band Aid and Live Aid as focal points for British humanitarian response in the 1980s.

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2 Ibid., p.192.
3 This chapter will intentionally avoid using the term ‘humanitarianism’ where possible. This was because this term did not become widely used until the late 1980s; Katherine Davies, ‘Continuity, change and contest: Meanings of “humanitarian” from the “Religion of Humanity” to the Kosovo War’, Humanitarian Policy Group: Working Paper (2012).
They determined that these events were a catalyst for British public donations and consequently an acceleration of the growth of British NGOs. Jones’ work particularly focuses on the large British NGOs that made up the Disasters Emergency Committee (DEC). Anna Bocking-Welch has attempted to complicate this image and challenge the dominance of the DEC NGOs within histories of humanitarianism through her research of British Youth response to famine in the 1960s. This chapter is influenced by Bocking-Welch’s work and explores the work of smaller organisations and individual actors who worked alongside the larger DEC organisations.

Alongside literature on British aid, this chapter also brings together the work of scholars who have investigated the impact of the Thatcher government on British domestic and foreign policies. The growth of non-state actors during the 1980s sits within a broader realignment of the British state within British society, a realignment that was spearheaded by the Thatcher government. Scholarship examining her 11 years in office, such as the work of Julius Gould and Digby Anderson, has been dominated by analyses of her domestic policies and the relationship between the state and civil society. A central feature of many of these analyses is the role of Thatcher’s promotion of so-called ‘neoliberalism’. Neoliberalism saw the market, specifically market-like governance, as having an influential role throughout all aspects of society. It perpetuated the belief that the development of “private enterprise and entrepreneurial initiatives” was crucial to the creation of wealth and

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5 Gaining her position in May 1979, Margaret Thatcher was the first female Prime Minister of Britain.
8 Peck and Tickell, ‘Conceptualizing Neoliberalism, Thinking Thatcherism’, p.28.
prosperity.\textsuperscript{9} Thatcher’s neoliberal agenda led to the prioritisation of market-led economic theories, free trade, minimal state intervention and the “privatisation of public goods and services”.\textsuperscript{10} The changes made to the British NHS that aimed to improve its performance, such as the introduction of market-based thinking and business practises to its management, are often used as an example of the impact that Thatcherite policies had on state services.\textsuperscript{11} Analysing much of the criticism towards the Thatcher policies, specifically the government’s budget cuts to the state, scholar Florence Sutcliffe-Braithwaite determined that the state under the Thatcher government did not shrink.\textsuperscript{12} She argued that the proportion of government spending remained the same, but that it was re-directed in new ways.\textsuperscript{13} This chapter will develop Sutcliffe-Braithwaite’s work by examining the aid budget and demonstrating the new mechanisms through which the government provided money to NGOs for international development projects.

To create a broader image of Thatcherite aid policies, this chapter will also draw from literature which has examined British foreign policy. Thatcher came to power during a period in which Britain’s place within international politics was uncertain and fragile. The dominance Britain held in previous decades had diminished as Britain lost a vast percentage of its Empire.\textsuperscript{14} Similarly, the threat of the Cold War and the fear of the spread of communism added pressure on Britain “to strengthen its international voice” and to position itself within the West.\textsuperscript{15} Historian Richard Vinen’s work aimed to place the Thatcherite government and its domestic policy within a wider frame of international politics and reconnect the Thatcher government to the broader geopolitical background of the Cold War.\textsuperscript{16} He wrote that “references...
to the Cold War pervaded British politics during the early 1980s — perhaps the time when nuclear annihilation seemed most likely”. Similarly, scholars such as Diana Elles and John Young have examined Thatcher’s use of multinational organisations, specifically the European Economic Community (EEC) and North Atlantic Treaty Organization, to position and maintain Britain at the centre of international politics. As a member of the EEC and NATO, scholars have argued that Thatcher’s foreign policy became “over-extended” as she attempted to manage multiple international relationships against the backdrop of the Cold War. A further line of scholarship has examined Britain’s relationship with the US, particularly Thatcher’s relationship with US President Ronald Reagan. By aligning herself with the EEC, NATO and the US, Thatcher aimed to build up Britain’s defences, while also attempting to rebuild Britain’s position in world politics in the shadow of its declining Empire. This chapter builds upon the work of these scholars and resituates Thatcher’s domestic policies alongside her foreign policies, to gain a greater understanding of the environment that shaped British foreign aid in the 1980s. Through an investigation into the impact of Thatcher’s neoliberal agenda, this chapter examines the increasing role that the British government played within British aid organisations and their policies.

To do so, this chapter will begin with an analysis of the British aid sector in the 1970s, prior to Thatcher’s election. It will examine narratives that promote this decade as one of decline and demonstrate these to be false. While the 1970s was a period of economic decline within Britain, this chapter will highlight the development of British disaster relief mechanisms and a growing interest in disaster relief within academic circles. Despite this development, scholars writing in the 1980s were heavily influenced by the declinist narrative and thus failed to acknowledge the positive changes within

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18 Britain joined the European Economic Community, after having two applications to join blocked by France in 1973. The UK joined NATO as a founding member in 1949. The development of Britain’s relationship with NATO can be seen with the promotion of Lord Carrington, the Secretary of State for Foreign and Commonwealth Affairs (1979-1989), to the role of Secretary General of NATO in 1984. See: Diana Elles, ‘The foreign Policy of the Thatcher Government’, in Minogue and Biddis, Thatcherism: Personality and Politics; Young, Britain and European Unity; Jackson and Saunders, ‘Introduction: Varieties of Thatcherism’.
20 Ibid., p.201.
British aid during the 1970s. In light of this, the 1980s was presented as a period of reform and, as Thatcher promised, a period of economic revival in the UK. This chapter will then investigate the impact of the Thatcher government within Britain, particularly focusing on the impact of her neoliberal ideals. It will examine the prioritisation of a market-based economy within her domestic policy and will provide a lens to explore the changes within the British aid sector. As part of this exploration, this chapter will then investigate the financial and institutional growth of the British NGOs in the 1980s, as demonstrated by the work of Jones and Franks. It will build upon, and expand this scholarship, through analysing the impact of this growth. While much of this chapter examines the effect of large-scale government policies on the British aid system, this chapter proceeds to investigate the official British response to the Soviet Armenian earthquake to explore the impact of these changes on a smaller scale. This earthquake was particularly significant as it took place at the cusp of change within international politics, immediately before the end of the Cold War.

This chapter complicates the narrative that the 1980s was a period of advancement for British aid, by exploring the obstacles to British disaster response; obstacles which resulted in Britain’s minimal medical response to the sudden onset earthquake in Armenia. This chapter will examine the Thatcher government’s focus on development aid, and its growing influence over the British aid sector through the Joint Funding Scheme. Though created by the Labour government in 1975, the 1980s saw the growth of this scheme as a mechanism through which the government influenced and provided funding for development aid indirectly.

The thesis thus begins with an exploration of the British aid industry on the cusp of change, in the final years of the Cold War. It will argue that the 1980s was a period in which neoliberal ideas shifted the focus of the British aid sector onto development aid — specifically, development aid the success of which was demonstrated by economic measures such as GNP — and away from disaster response. It will argue that despite reducing the aid budget, the

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21 Jones, ‘Band Aid revisited'; Franks, ““Please Send Us Your Money””.
British state under the Thatcher government had a significant influence on the British aid sector through mechanisms such as the Joint Funding Scheme (JFS). It will conclude that their promotion of development-focused aid stopped the British humanitarian sector from expanding its disaster response mechanisms.

**Remembering the 1970s**

In the 1970s the British aid sector was preoccupied with the advancement of international disaster response. While this was a significant period for British disaster response, historians have often overlooked this decade, perceiving the 1970s to be “unfashionable”, and to carry a “pervasive feeling of failure”. This section will demonstrate that this narrative was inaccurate and was strategically promoted by the Thatcher government as a foundation upon which their policies could be positively presented.

Historians such as Jim Tomlinson have examined the origins of perceptions that the 1970s was a period of decline and have discovered the origins of this narrative within the Thatcher government. Tomlinson wrote that Thatcher, “constructed a powerful narrative of events of the mid-1970s which turned the traumas of those years into evidence for a story of secular post-war decline.” Tomlinson argued that narrative had an “unprecedentedly powerful effect” and not only helped Thatcher win the election in 1979 but also promoted the ideas of the New Right. This declinist narrative, Lawrence Black argued, was disseminated by accounts that emphasised the “unemployment, energy rationing in 1974, three-day weeks and capitulations to the International Monetary Fund (IMF)” within their work. Black, however, traced the evolution of historians’ understandings of the 1970s, towards an increasingly critical perception of the declinist rhetoric. Examining the work of Niall Ferguson, Black argued that he convincingly placed the 1970s within a longer history and provided figures to demonstrate

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25 Ibid., p.248.
that, “unemployment, inflation and growth” in the 1970s was no worse than in the 1980s.\textsuperscript{27} Similarly, Andy Beckett, writing in 2009, stated that, “unemployment in the 1970s, taken at the time to be a great symbol of political failure, and notorious as such ever since, was actually low by modern standards”\textsuperscript{28} Tomlinson’s thesis, which critiqued the declinist rhetoric of the 1970s and placed the Thatcher government at the origins of the inaccurate perception of the 1970s, has become the dominant narrative within histories of the 1970s. Joe Moran’s work, for example, employed examples from British culture, such as the popularity of punk records, to determine that “ordinary life in Britain was more resilient than the talk of imminent chaos implied”.\textsuperscript{29} He also argued that “histories of the 1970s have been dominated by a Thatcherite narrative presenting 1979 as the year zero”.\textsuperscript{30} Similarly, historian Max Jones has argued that Thatcher presented her “premiership as a crusade to restore national greatness”, using a speech by Thatcher at Cheltenham racecourse to demonstrate this narrative.\textsuperscript{31} During this speech, made in 1982, Thatcher critiqued those who “thought we could no longer do great things which we once did. Those who believed our decline was irreversible”.\textsuperscript{32} By promoting the failures of this decade, the Thatcher government was able to promote its policies as tools that would enable Britain to move beyond this decline.

The presentation of the 1970s as a period of decline influenced how historians have written about the British aid sector. This decade has been presented as an indistinct decade, which is frequently grouped with a wider narrative of decolonisation. This can be seen in Michael Barnett’s *Empire of Humanity*, which failed to distinguish the 1970s as a unique period for disaster response, but rather presented it as part of the continuation of the 1960s.\textsuperscript{33} However,
just as historians have reappraised British culture in the 1970s and recognised it as “a golden age of British television, of pop fiction, of low-tech toys and of club football”, so we too can understand the 1970s as a period of significant consolidation of British understandings of disaster response.\textsuperscript{34}

During the 1970s, the main area of progress within the British aid sector was its response to sudden-onset disasters. For the British public, the image of an NGO responding to international disasters was synonymous with their understanding of British aid as a whole. Much of the British public’s information about sudden-onset disasters came from the Disasters Emergency Committee. This committee was created in 1963 by the British Red Cross, Christian Aid, Oxfam, War on Want, and Save the Children, in collaboration with the BBC.\textsuperscript{35} The DEC launched appeals to the British public and acted as a channel through which these organisations could raise money for a disaster response. It hoped that this would limit the exposure of the public to the growing numbers of television appeals and would prevent the creation of apathy within viewers.\textsuperscript{36} In 1973, the DEC launched an appeal for the Ethiopian famine. This famine appeared to catch the attention of the British public and became the DEC’s largest appeal to date, raising £1,540,000.\textsuperscript{37} Similarly, in 1973 the British children’s television show, Blue Peter, launched one of its first international appeals, calling for British children to collect stamps to raise money for the starving populations in Ethiopia.\textsuperscript{38} Pupavac determined that Blue Peter was “one of the primary introductions British children [had] to humanitarianism through its documentary reports and annual appeals”.\textsuperscript{39} As international disasters became increasingly recognised by the British public, and images of disaster victims continued to appear on their TV screens, the British public began to demand an aid response from their government.

\begin{itemize}
\item[\textsuperscript{35}] CAFOD joined the DEC in 1973, and War on Want left the DEC in 1979.
\item[\textsuperscript{36}] Jones, ‘The DEC and Humanitarian Industry’, p.573.
\item[\textsuperscript{38}] BBC, ‘Blue Peter appeals from the last 36 years’, BBC (2008) [online], Available: https://www.theguardian.com/media/gallery/2008/nov/06/blue-peter-appeals-bbc [Accessed 07 February 2018].
\item[\textsuperscript{39}] Pupavac, ‘Between Compassion and Conservatism’, p.129.
\end{itemize}
The disaster response also grew in prominence within research. This can be demonstrated through the creation of the London Technical Group in 1971. This group brought together scholars from London University and aid practitioners with the aim of building and developing the field of disaster studies. In March 1977 they produced the first volume of the journal *Disasters*, with its first article investigating the rebuilding of the Sahel region. Similarly, in 1974, the British government created the Disaster Unit that was to sit within the Ministry of Overseas Development as a response to “growing concern at the scale and incidence of disasters… and the inadequacy of international relief”. The Unit had two purposes, firstly to supervise the “rapid mobilisation of supplies and personnel from Britain in readiness for, and in the event of, a disaster in a less developed country” and secondly to be “responsible for general pre-disaster planning” and monitoring. Jones argued that the creation of the Disaster Unit signified “a new level of official significance being attached to humanitarian aid”. The London Technical Group and the Disaster Unit represent the development of an intellectual community built around studies of disaster and disaster response. It also demonstrates the recognition within the British government and British academic circles of the need to reappraise and improve the field of British emergency aid.

The recognition of the need for greater effectiveness in disaster response can be seen throughout western countries during the 1970s. Agencies like the Disaster Unit were also created within other western governments such as Canada which, in 1978, created the International Humanitarian Assistance Division, which sat within the Canadian International Development Agency. Similarly, in 1975 the Netherlands created the Emergency and Humanitarian Affairs Section under their Ministry of Foreign Affairs and in 1972 Switzerland created the Directorate for Cooperation Assistance and

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43 Morton, ‘Developments in British Aid’, p.27.
Humanitarian Aid within their Federal Department of Foreign Affairs. These examples indicate that disaster relief during this period gained widespread recognition within many western governments. This growth was in part due to the increasing presence of humanitarian disasters within western consciousness and pressure from civilians on governments to respond to the emergencies shown in the media. Randolph Kent, a former UN official, however also argued that the growth in disaster units in Britain was due to “institutional insecurities” within the government. He determined that the presence of NGOs highlighted the failings of governments to respond effectively. In conjunction with this, one cannot overlook the international political dynamics during this period and the need for western countries to project a positive image to the world but also to their own citizens.

During the 1970s, the British government, while creating its Disaster Unit, began to recognise the utility of NGOs and their ability to cross political lines—something that their own Disaster Unit could not do. Brian Walker, Director of Oxfam between 1975 and 1985, provides an example of Oxfam’s ability to cross political lines in his description of their response to refugees that were fleeing the Khmer Rouge in Cambodia in 1979. Oxfam headed an initiative called the Consortium for Cambodia, which was made up of 33 NGOs from countries within the Western Bloc. This consortium, championing its foundations in “independence and integrity”, was able to cross the geopolitical impasse and deliver aid to populations within the Eastern bloc. Brian Walker described the actions of Oxfam as “humanitarian diplomacy with a sledgehammer”, due to their controversial decision to fly into Phnom Penh and offer their assistance without prior arrangements having been made. NGOs, such as Oxfam, were increasingly recognised by the British government for their ability to cross the lines drawn by the Cold War, and to

47 Ibid., p.51.
48 Ibid., p.51.
49 The Khmer Rouge led a brutal regime in Cambodia in 1975-1979. The Khmer Rouge has been remembered for their violence, with figures estimating the number of people murdered varying from 1 million to 3 million; Brian Walker, ‘NGOs break the Cold War impasse in Cambodia’, in Larry Minear and Hazel Smith eds., *Humanitarian diplomacy: practitioners and their craft* (United Nations University Press, Tokyo: 2007).
50 Ibid., p.147.
51 Ibid., p.142.
do what governmental organisations could not. The recognition by the British government that NGOs had the potential to be political tools had an increasingly significant role within the Thatcher government as the Cold War continued.

Episodes such as the Oxfam response in Cambodia demonstrate the politically polarised environments in which NGOs were drawn to work during the Cold War. With the increasing recognition of the political nature of many of these crises, NGOs began to extend their remits to work on longer-term projects. War on Want, for example, chose to leave the DEC in 1979 and focus exclusively on development and long-term aid.52 Thatcher, therefore, came to office during a time in which the British aid industry was conflicted. One school of thought emphasised a need to build and improve British disaster response, while simultaneously, there was a growing recognition that longer-term development aid could help to reduce the number of crises. As Thatcher came to power, her neoliberal agenda caused the government to champion the growth of development aid and side-line disaster response.

While the 1970s was a period of institutional and academic growth within the field of disaster relief, the declinist narrative influenced the recollections of those writing in the 1980s and their perceptions of British aid in the 1970s. One narrative that was dominant in the declinist rhetoric was the presentation that Britain had lost its power on the international stage. In a report written for the Overseas Development Institute in 1980, Vincent Cable wrote: “Britain is, quite simply, becoming relatively less important, as a market or a provider of resources”, and that “as an aid donor, for example, Britain has fallen, in terms of a ranking based on absolute magnitudes of net aid flows, to sixth-in 1962 it was third”.53 The fear that Britain no longer held a dominant position within international politics was a central theme of the declinist rhetoric. The emphasis on economic challenges also contributed to the declinist trajectory, supposedly shaping aid in this narrative. For example,

52 Jones, ‘The Disasters Emergency Committee (DEC) and the Humanitarian Industry in Britain’, p.581.
Cable wrote that Britain’s economic decline had “affected Britain’s relations with developing countries and their perception of them”. Cable suggests that Britain’s loss of importance as a donor was due to Britain’s poor economic situation. This report demonstrates that the declinist rhetoric strongly influenced Cable’s perception of the 1970s aid sector.

In contrast to this, Randolph Kent, writing in 1987, highlighted the positive developments within the aid sector during the 1970s. Writing more broadly about western aid, he highlighted the move towards professionalisation within the aid industry during the 1970s, and the attempts to improve coordination between different actors within disaster response. Despite highlighting these developments, Kent’s work also emphasises the continued flaws in the aid sector; for example, he asked: “why, if such potential exists, disaster relief remains so often unpredictable and inappropriate”.

Similarly, he remarked “despite the very positive developments to which one can point, there remain profound structural constraints upon the functioning of an effective international disaster relief system”. Kent’s presentation of the 1970s, and his suggestion that the 1980s offered a chance for improvement, demonstrates how the declinist narrative could dovetail with the call for future improvements even for those who did not dismiss the legacies of the 1970s.

It is clear from the origin of this declinist rhetoric within the Thatcher government that this rhetoric rests heavily on periodisation and the superficial division of the 1970s and 1980s as disconnected decades. The Thatcher government, and successive British Prime Ministers, used the image of the 1970s, as a decade of decline, as a political tool. The choice to view the 1970s as a disconnected decade enabled the Thatcher government to promote its time in office as a period of complete reform and positive transformation within Britain. For historians however, this view prevents reflection on both the positive developments that took place within the British aid sector during

54 Cable, British Interests and Third World Development, p.8.
55 At the time of writing Kent was a visiting Research Fellow at the Refugee Studies Programme at the University of Oxford.
56 Kent, Anatomy of Disaster Relief, p.175.
the 1970s and continuities that were carried into the 1980s. The inability to see these connections inhibits one from seeing the networks and relationships that continue to influence the aid sector across both the 1970s and 1980s. O’Sullivan et al. instead argue that histories of humanitarianism should be understood “less in terms of ruptures or breaks, and focus more on the moments of acceleration and the continuities”. While this chapter uses these decades as markers, it sees the division between the decades as porous and aims to investigate the points of acceleration and deceleration across these two decades. It is clear, therefore, that the 1970s was not solely a decade of decline, as suggested by Thatcher, but rather, for British disaster relief, was a decade of learning and progress. The acceleration of British disaster relief, however, did not continue under the Thatcher government.

Neoliberalism in Britain and Internationally

The Thatcher period is often remembered for the central role that the neoliberal agenda played in the government’s domestic policy and foreign policy; however, the impact of this agenda on Thatcher’s aid policies has often been left unexplored. An investigation into these policies offers an insight into the changing dynamics of the British aid sector, in particular, the increased role that the British government played within the decision-making processes of British NGOs. Compartmentalising the Thatcherite government, historians Ben Jackson and Robert Saunders have argued that Thatcher’s first term can be perceived as one dominated by “economic changes, particularly the macro-economic policy”, which they believe resulted in a shrinking of GNP and an escalation of unemployment. Furthermore, they argue that her second term was one in which “Privatisation… emerged as a central component of Thatcher policy”.

60 Kevin O’Sullivan describes moments of acceleration as “bursts of activity that refreshed the sector whilst carrying with them the baggage of what had come before”; O’ Sullivan, Hilton and Fiori, ‘Humanitarianisms in Context’, p.6.
63 Ibid., p.7.
government terms showcases their distinct nature, it fails to highlight the continuities across Thatcher’s time in government. One of these continuities was their promotion of the neoliberal agenda.

The promotion of neoliberal ideas by the Thatcher government can be seen with the 1976 Conservative manifesto, *The Right Approach*, which championed the shrinking of the welfare state and liberalisation of the market economy.64 Thatcher’s continued commitment to these ideas throughout her time in office is reflected in a speech she made in 1990, 14 years after *The Right Approach*. In this speech, she stated that “wealth is not created by regulation and instruction but by ordinary enterprising people”.65 As a Prime Minister, Thatcher did not deviate from neoliberal ideas and continued to promote the role of the free market as a tool to reform the British economy.66 Her government promised to end the economic decline within the UK and increase employment levels. The Thatcher government’s neoliberal policies had broad implications throughout British domestic policy but were particularly felt within the public services.

The National Health Service was a key target of Thatcherite reforms due to its symbolic position as an embodiment of “British-ness” and due to the Keynesian belief system on which it was built.67 The impact of Thatcher’s policies can be demonstrated through the significant structural and managerial changes that took place within the NHS.68 In 1989, the government produced a White Paper called *Working for Patients*. One of the changes that this paper introduced was the creation of NHS Trusts which, managed individual groups of hospitals, enabled greater private sector involvement, and were expected to be run in a “business-like” manner.69 The

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67 Kyriakides and Virdee, ‘Migrant Labour, Racism and the British National Health Service’, p.288; Keynesian ideology was developed by John Keynes who lobbied for the ‘big’ state in which there would be a lowered tax rate and increased government support of public systems.
British Government believed that this would encourage competition, and by extension, increase standards and efficiency. Many of the new models introduced to the NHS were based upon those found within the private sector, which led to the treatment of health care and medicine as a commodity, rather than a right. Thatcher believed that the competition introduced through an internal market would ensure that standards were kept high and that costs would be cut. The successes of these aims are hard to measure, however during the 1980s the government had to use £100 million from the Treasury to support the NHS, or as journalist Jeremy Laurance wrote, to “bale [sic] it out”.70 The critical language within Laurance’s article, written for the Independent in 2013, highlights the negative connotations that some still associated with Thatcher’s health policies. The initial outcomes of these changes resulted in the movement of decision-making away from doctors and into the hands of business practitioners. Furthermore, the shift to run the NHS as a business took the attention away from the patients and towards the prioritisation of finance.

Recent scholarship has shown that Thatcher’s policies did not succeed in shrinking the proportion of the budget that was being spent on the welfare state but rather shifted funding from supporting the welfare system to the provision of employment benefits. Matthew Hilton wrote, “though she did succeed in changing the balance of spending on different elements of the welfare state, she did not permanently shrink overall government spending as a proportion of GDP”.71 Florence Sutcliffe-Braithwaite also determined that by the time Thatcher left office in 1990, “there was no real change in the proportion of GNP devoted to social security compared with 1979, with social security absorbing just over 10% of national income in both years”, highlighting that there was not a reduction in the size of the welfare state.72 Journalist George Eaton’s examination of Thatcher’s public spending highlights the continued interest in this topic in 2013. Eaton offered an explanation as to why there was not a reduction in state spending on welfare

72 Sutcliffe-Braithwaite, ‘Margaret Thatcher, individualism and welfare state’. 

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when there were cuts to institutions like the NHS. He determined that, “while Thatcher squeezed spending on public services such as health and education, mass unemployment and the consequent increase in spending on benefits… ensured that total expenditure remained high”. As a piece of journalism, Eaton’s work demonstrates the dominant place that economic policies hold within memories of the Thatcher government. While historians have demonstrated that the Thatcher government’s neoliberal agenda did not shrink government spending, it did enable the devolution of some aspects of the welfare state, such as the independent management of NHS Trusts.

During this period, just as one can trace Thatcher’s attempts to spread neoliberal ideas throughout her domestic policy, one can also see neoliberalism embedded within her attitude towards international development. Raewyn Connel coined the phrase: “Neoliberalism is a missionary faith: it seeks to make existing markets wider and to create new markets where they did not exist before”. Western governments, including Britain, used multilateral organisations such as the International Monetary Fund and World Bank as a mechanism for spreading their neoliberal agenda internationally. Susan Koshy argued that such economic policies were a form of neocolonial power. She wrote that after the Cold War, “neocolonial power operate[d] less through military force than through economic domination”. By attempting to influence the development of international

75 Neoliberal development policies were propagated internationally by organisations such as the World Bank and the IMF using mechanisms such as Structural Adjustment loans. These loans came with conditions which aimed to develop recipient countries’ economic policies along the line of the neoliberal agenda. A country tied to the conditions of a Structural Adjustment loan had little room to dissent from the ideas that underpinned the World Bank and IMF’s understandings of development. The policies embedded within the IMF and World Bank tell a story of western governments’ unwavering faith in the neoliberal agenda during this period and its ability to be utilised not only within domestic economic policy but also within international development. For more information read: Alexander E. Kentikelenis, ‘Structural Adjustment and health: A conceptual framework and evidence on pathways’, Social Science and Medicine, 187, (2017), p.297; John Pender, ‘From “Structural Adjustment” to “Comprehensive Development Framework”: conditionality transformed?’, Third World Quarterly, 22(3), (2001), p.399; William Easterly, ‘What did structural adjustment adjust? The association of policies and growth with repeated IMF and World Bank adjustment loans’, Journal of Development Economics, 76(1), (2005). For a history of the origins of the IMF and World Bank see: Paul Krugman, ‘Dutch Tulips and Emerging Markets’, Foreign Affairs, 74(4), (1995).
76 Susan Koshy, ‘From Cold War to Trade War: Neocolonialism and Human Rights’ Social Text, 58, (1999).
77 Ibid., p. 1.
economies through the promotion of the neoliberal agenda, the Thatcher government used the economy to assert power over other countries. Similarly, as new geographies opened up with the collapse of the Soviet Union, NGOs were used by the West as a tool to control the development of these countries and to spread the neoliberal agenda. For example, anthropologist Laëtitia Atlani-Duault investigated the use of aid, particularly development aid for those with HIV, as a tool through which the West encouraged what they determined to be ‘good governance’ practices. She highlighted the concern of “the West” to ensure that these regions developed into liberal states rather than fall back upon the communist models. She argued that aid to these countries, and particularly aid that encouraged the creation of local NGOs, was rooted in the goal, “to create a strong countervailing force against state power and thereby ensure the success of political and economic liberalism in that period of the Cold War political incertitude”. NGOs were perceived as a channel for actions of a vocal civil society, deemed essential in a liberal state.

Under the Thatcher government, neoliberal ideas had a large influence on domestic policies. While not shrinking government welfare spending, it introduced market-based thinking and competition to different state institutions such as the NHS. As the Cold War came to an end, Western governments turned to multilateral organisations and NGOs as crucial actors in the development of new states and the spread of neoliberal economic policies internationally. The influence of the neoliberal agenda, however, is often left out of narratives of British humanitarian aid during the 1980s but will be explored in the final section of this chapter.

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78 This highlights the continued legacies of colonialism within Thatcher government foreign and economic policies.
79 Whilst recognising the multiple, and shifting, understandings of the term Governance, this chapter understands it through the United Nations Development Programme (UNDP) description cited in Atlani-Duault’s book. It describes governance as: “the exercise of economic, political and administrative authority to manage a country’s affairs at all levels. It comprises the mechanisms, processes and institutions, through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences”. Atlani-Duault proceeds to explain the multitude of moral guidelines that have been used to explain good governance. UNDP cited in Laëtitia Atlani-Duault, *Humanitarian Aid in Post-Soviet Countries: An Anthropological Perspective* (Routledge, London: 2007), p.22
80 Atlani-Duault, *Humanitarian Aid in Post-Soviet Countries*, p.32.
81 Ibid., p.3.
82 Ibid., p.13.
The Growth of the British NGO sector

Analyses of the British NGOs during the 1980s are dominated by narratives of their growth, which has often been linked to the widely publicised Ethiopian famine in 1984, and the extraordinary support it received from the British public.83 This growth, however, is presented primarily in terms of financial and institutional growth, and there is little examination of the impact that this growth had for the delivery of aid during this period.

The British public’s recognition of international famine escalated in October 1984, when Michael Buerk presented a story on the Ethiopian famine for the BBC news. Reporting from a refugee camp in Korem, Buerk described the famine as being of “biblical proportions”, and showed images of the starving population lining up for irregular or often non-existent food deliveries, and images of families mourning their deceased relatives.84 Jones pin-pointed this broadcast as the catalyst that “gripped the conscience of the public and elevated the story into a major international issue”.85 The widespread knowledge of Ethiopia was then furthered by the release of the Band Aid single “Do they know it’s Christmas”, in November 1984, the proceeds of which went to the famine relief efforts.86 Following the success of this single, Bob Geldof organised the Live Aid concert in July 1985 in stadiums in London and Philadelphia. Live Aid brought together some of the biggest names in the music industry to play at concerts, again intending to raise money for famine relief. 87 Live Aid had a live audience of an estimated 1.9 billion people from across the world and raised £150 million.88 Jones wrote that the “sudden influx of income” for the Ethiopian famine response “fuelled a period of rapid and sustained institutional growth” for the DEC

86 Ibid., p.584.
87 Ibid., p.584. Historian, Suzanne Franks, using the lens of the media and celebrity fundraising, has argued that Live Aid and the television appeals for the Ethiopian famine were the start of the regular use of celebrities within fundraising campaigns, which then grew in popularity after the Live Aid and Band Aid movements. See: Franks, ‘Please Send Us Your Money’; Louise H. Davis, ‘Feeding the World a line?: Celebrity activism and ethical consumer practices from Live Aid to Product Red’, Nordic Journal of English Studies, 9(3), (2010).
organisations. These events drew international disaster relief into the British consciousness and led to the large financial outpouring of the British public which, in turn, resulted in the growth of aid organisations such as Oxfam and Save the Children.

Vanessa Pupavac’s work complicates Jones’ analysis of public consciousness, insofar as she examines the domestic events taking place within Britain and their influence on the British public’s response to the famine. She wrote that Live Aid coincided with the government’s success over the miners’ strike that had been taking place over the previous 12 months, and determined that this resulted in an environment in which “British humanitarianism became burdened with unfulfilled hopes for justice and peace as progressive political visions contracted”.90 The reaction of the British public to Band Aid and Live Aid has also been assessed by Maggie Black, who worked as an editor at UNICEF in the 1980s. She argued that the £100 million donated to famine response by the British public was an expression of “dismay that such a small proportion of the official aid budget was similarly spent on measures to prevent hunger and starvation”. 91 This work presents Live Aid and the famine response as an outlet for the frustrated British population. This frustration was rooted in the government’s failure to respond to the famine appropriately, but also in response to British domestic economic policies. These events, therefore, offer an example of a point in which domestic policy and international aid converge, and demonstrate the public’s use of international aid as an outlet for their frustration in the Thatcher government’s domestic policies.

While the significance of these events has been analysed in terms of financial and institutional growth of British NGOs, historians have failed to critically examine the impact of this financial growth on the delivery of emergency relief aid during this period. Randolph Kent described international disaster response during the 1980s as being demonstrated through “the chaos, the pandemonium–run-riot that marked the humanitarian response”.92 This

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91 Pupavac, ‘Between Compassion and Conservatism’, p.140.
92 Black, A Cause for Our Times, p.265.
statement, when placed alongside the work of scholars Andrew Jones, Suzanne Franks and H. Louise Davis, who analysed the growth of British NGOs in the 1980s, suggests that despite being a period of financial and institutional growth for NGOs, the 1980s may not have been a period of development within disaster response. The case study of the Armenian Earthquake demonstrates that, despite the increase in funding to British aid organisations in the 1980s, the British aid sector did not develop its logistical and technical capacity to respond to sudden-onset disasters.

The British Response to the Earthquake in Armenia 1988

At 11.41 am on Wednesday 7th December 1988, three years after Band Aid, an earthquake measuring 6.9 on the Richter scale hit Armenia, a territory of the Soviet Union. As news of the earthquake spread around the world, the estimations of the numbers dead rose. On 10th December 1988, three days after the earthquake, The Times reported the death of an estimated 170,000-200,000 people.93 When the earthquake hit, Mikhail Gorbachev, the General Secretary of the Communist Party of the Soviet Union, was making a state visit to the US.94 Upon receiving the news of the earthquake from Margaret Thatcher, Gorbachev cancelled his planned visit to the UK and flew back to the Soviet Union, arriving in Armenia on 8th December. In a letter to Gorbachev, Thatcher wrote, “I hope you will let me know if there is any way at all in which the United Kingdom can help in relief efforts. We shall also be encouraging the European Community to offer assistance”.95 Britain’s assistance was in the form of financial and material aid. After initial predictions that the death toll was in the hundreds of thousands, in the days that followed the earthquake it was determined that an estimated 25,000 bodies were retrieved from the rubble, and an estimated 15,000 people had been recorded injured.96 This was an unusually high death to injury rate and

94 During the late 1980s Thatcher particularly worked to build her relationship with Mikhail Gorbachev, who in 1989 became the Chairman of the Supreme Soviet of the Soviet Union. His trips to the US was part of a larger state visit, in which he had also been scheduled to come to Britain.
was something that has dominated many of the reports written after the
earthquake. The aftermath of the earthquake, however, still presented
significant challenges for survivors. With temperatures regularly falling
below zero, and most of the buildings in the cities of Spitak and Leninakan
having been flattened, shelter, access to water, and warm clothing became an
immediate need.

The British response to the Armenian earthquake was indicative of the British
aid sector in the 1980s. When the Soviet Union appealed to the international
community for help, Thatcher determined that Britain’s contribution would
be predominately financial. Britain’s commitment of £5 million to Armenia
was the first commitment of British government-sponsored aid into the Soviet
Union since the beginning of the Cold War, and the largest sum it had given
to any natural disaster response. This sizeable financial response had
political motives, as Thatcher believed that a good relationship with
Gorbachev was crucial to improving relations with the Soviet Union. This
financial contribution, however, was also indicative of the British
government’s limited ability to contribute operationally to a disaster response.

British NGOs mirrored the government and responded to the earthquake by
providing financial aid. While historians have emphasised, in O’Sullivan’s
words, the “emergence of an internationalised, professionalised aid industry
that took centre stage in the mid-1980s”, the presence of British NGOs within
Armenia was distinctly lacking. The response in Armenia was, on the
request of Soviet officials, coordinated by the Red Cross Societies. The
British Red Cross supported this by launching an appeal which raised £1
million within two days. In addition to this fundraising, Tear Fund UK

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97 It was determined that this high death-to-injury ratio was predominately due to the poor building
materials used within Spitak and Leninakan. As way of comparison, this earthquake measured the
same as the Kobe Earthquake in Japan in 1995, which killed 5,502 people and injured approximately
41,000 people.
98 McEwen, ‘World unites to help Armenia; Armenian Earthquake’, The Times (10 December 1988),
p.1.
100 The Times, ‘Experienced emergency squads ready to help devastated areas; Armenian
raised $10,000, and Armenian Musicians UK raised $668,508.\textsuperscript{102} The British Red Cross, in collaboration with the UK government and British Airways, supported nine relief flights carrying medical equipment, food, 27,000 blankets, and 980 tents.\textsuperscript{103} Despite the British Red Cross’s response, the other four DEC organisations did very little in the way of response, and within their annual reports of the year 1989, there is little or no mention of the Armenia Earthquake. Reflecting the inaction of many British organisations, the DEC chose not to launch an appeal.\textsuperscript{104} Unlike France, who sent the first trained international responders into Armenia within 60 hours of the earthquake, the British government and British NGOs did not send an official qualified disaster response team.\textsuperscript{105} This was because, despite the increased funding and growth of the British aid sector during the mid-1980s, an official response team of this nature did not exist.\textsuperscript{106}

The gap in physical response to the earthquake created by the inaction of the government and British NGOs was filled by ad hoc teams of skilled British professionals who chose, independently of NGOs and the government, to travel to Armenia to provide assistance. Despite the lack of a DEC campaign, the earthquake was widely publicised within the British media. Historian Jo Laycock has investigated its publicity within British media and demonstrated that newspapers in Britain published “Lists of aid sent by various countries to the Soviet Union”.\textsuperscript{107} Laycock investigated the impact that the delivery of aid to Armenia had on the British public, arguing that: “the idea of the iron curtain dissolving in the face of humanitarian need was central to media coverage of the earthquake”.\textsuperscript{108} The West was assisting the Soviet Union for the first time since the start of the Cold War, and it was at the request of the Soviet authorities. Laycock argued that “providing aid to the Soviet Union had

\textsuperscript{103} UN Department of Humanitarian Affairs, ‘USSR Earthquake’.
\textsuperscript{104} This may have been due to their attempts to avoid what they perceived to be political crises. For more information about these discussions read: Jones, ‘The DEC and Humanitarian Industry’.
\textsuperscript{105} Frechette, ‘Rescuing Earthquake Victims in Armenia’ p.838.
\textsuperscript{106} This may have also been due to the increased recognition, within the NGO sector, of the ineffectiveness of international relief teams within earthquake responses.
\textsuperscript{108} Ibid.
become a source of international pride”. This pride can be particularly seen in the newspaper reports that told the story of British civilians who independently responded to the earthquake.

One group of civilians, whose activities were proudly reported within local newspapers, was a group of firefighters from Lancashire. These newspapers referred to them as the “mercy team” and the “heroes of the Armenian earthquake disaster”, omitting their inexperience in earthquake response. They were the largest group, amongst the firefighters from across the country, who volunteered to help with the search and rescue mission. Team leader and Assistant Chief Fire Officer, John Liversey recorded his experiences of Armenia in a local newspaper. He wrote that the day after the earthquake, and without receiving final approval from the British fire service, he and his team began to gather volunteers. The firefighters left for Armenia from Heathrow Airport on 13th December 1988 with members of mountain search and rescue teams and “expert pot-holers”. Liversey recalled the challenges they faced when transporting their equipment from the UK, through Moscow and finally to Yerevan. For example, they were held in Yerevan for three days as they waited for their thermal imaging cameras and other equipment to arrive. Despite having access to specialist equipment, such as this thermal imaging equipment, the British firefighters were unable to retrieve anyone alive from the rubble. They were, however, able to contribute to the response by recovering the bodies of eight people and creating a map of the town of Spitak post-earthquake, which could be used by other rescue workers. The earthquake had a considerable influence on the British firefighters who, upon their return to Lancashire, continued to raise money

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109 Ibid.
112 Ibid.
113 Ibid.
114 Ibid.
115 Ibid.
117 Liversey, Lancashire linguists.
for the Armenian population. They also collected ten tons of equipment for people with disabilities, such as “electric beds, wheelchairs and bath cranes”. This was a distinctly grassroots response by communities in Lancashire.

Alongside these firefighters, a team of doctors also attempted to deliver aid and provide their professional expertise to Armenia. The South Manchester Accident Rescue Team (SMART), led by doctor Tony Redmond, recognised the need for medical personnel within Armenia in the aftermath of the earthquake. SMART was created in 1988 to provide medical support to the Manchester ambulance service in the event of a disaster within the UK. The Armenian earthquake is a significant point in their history as it was SMART’s first international response. Despite their willingness to help and their mobilisation within 24 hours of the disaster, they, like the fire brigade in Lancashire, had to await official approval. Redmond in a radio interview recalled that it “took several days for Soviets to communicate necessary authority for us to leave for Moscow”; however, in a subsequent interview he indicated that this hold-up came from the British government who were initially unwilling to allow them to respond. Once they finally gained approval from both the British government and Soviet officials, the SMART team headed to the town of Leninakan, roughly the size of Manchester, which had been completely flattened.

Like the experiences of the Lancashire firefighters, the SMART team also faced great difficulty in ensuring their equipment got to Armenia. When they arrived in Moscow, “all the medical equipment belonging to SMART was

121 Ibid.
Redmond later discovered that it was removed from the plane in London to make space for other equipment and, despite reports that it had been despatched at a later date to Yerevan, the SMART team were never able to locate it. Without their equipment, the SMART team were wholly dependent on other aid organisations for shelter and transportation. Despite this, the team decided to continue by bus to Leninakan. Redmond recalled his experience entering the city, where “coffins lay in large piles with severed limbs and corpses uncovered in the streets”. After spending a few days in Leninakan, the team travelled to Yerevan to the main hospital receiving patients where they worked with Russian doctors to improve the treatment of patients with crush injuries.

The narratives of these responses hold a clear place within the memory of both Lancashire firefighters and the SMART team. The Lancashire fire brigade remembers the work of these volunteers through an online archive, to which retired firefighter Bob France added his memories of his time in Armenia. Similarly, the website of UK-Med heralds the work of the SMART team in Armenia as the catalyst for its reforming into an international medical response team, and holds their experiences as evidence for the gap that UK-Med fills within British humanitarian medical response.

The modest scale and limited success of these contributions may encourage an assumption that the significance of the British response to Armenia was minor, however it was precisely these attributes that made the Spitak earthquake influential in the years that followed. Crucially, Tony Redmond lobbied for the building of British capacity to respond to future sudden-onset disasters. In a radio interview at the time, he said that “the thing that struck

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125 Ibid.
126 Ibid., p.167.
127 Ibid., p.167.
128 Ibid., p.168; The medical response required after an earthquake is like that of military medicine. Britain has a history of developing this field, for example British navy personnel developed early forms of the triage system. See: Kenneth Iserson and John Moskop, ‘Triage in Medicine, Part I: Concept, History and Types’, *Annals of Emergency Medicine*, 49(3), (2006), p.277.
130 UK-Med became a registered charity in 1995.
us most was that Britain should be able to organise a coordinated disaster response in the same way other countries do”.131 Despite the existence of small civilian-led teams such as SMART, Britain did not have the skills to deploy either an NGO or an official, government-supported, group of medical teams to respond to such disasters. The teams who did respond were made up of volunteers who, having seen images of the earthquake in the media, felt compelled to act. These teams were held back by logistical challenges throughout their response and resorted to relying on the support of other international teams within the country. The lack of a well-trained, official British disaster response team was felt by others active in transnational relief in this period, such as Nicholas Mellor and Dr Christopher Besse, who would go on to create the medical organisation Merlin after they responded to the civil unrest in Romania in 1989.132 Mellor articulated their critique in a letter to The Times in 1990 in which he wrote:

The Romanian crisis highlighted for us the inadequacies of British emergency medical aid. In the first days of the conflict, when emergency aid was desperately needed, we found not a single British organisation working in the field. Rapid deployment of health workers was frowned upon by British development agencies, and the highly effective ‘French Doctors’ [MSF] group of relief workers were unfairly criticised.133

While Mellor and Mark Dalton (who would become the third founder of the medical NGO Merlin, alongside Besse and Mellor), envisaged the establishment of a ‘British MSF’, Tony Redmond petitioned for a British government-funded medical response team. After his experiences in Armenia, Redmond began to actively appeal for a British response team like the French teams they saw in Armenia. In a report to the Prime Minister’s office, he wrote that there was a need for the UK to work with the US, who had recently developed a national disaster team, to gain information on how “their team is run” and that “active dialogue [should be] encouraged”.134 He highlighted the importance of the role of doctors within disaster response and

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131 Redmond, ‘The Response of the South Manchester Accident Rescue Team’.
the need to create an organised and trained team of readily deployable medical staff. Many of these ideas came from his recognition that the UK was far behind countries such as France in their disaster response abilities.

While the government did not commit to the creation of a British response team until the creation of the official UK-Emergency Medical Team (UK-EMT) in the 2000s, the organisation UK-Med continued to grow and would come to host and maintain the UK-EMT. UK-Med is significant to this story as it played a crucial role in the recruitment and coordination of NHS staff during the Ebola outbreak. Armenia has also been cited by Wilson Li, Consultant Orthopaedic Surgeon, and Tony Redmond as the origin of the International Search and Rescue Advisory Group (INSARAG) founded in 1991, and The United Nations Disaster Assessment and Coordination Team (UNDAC) created in 1993.\textsuperscript{135} Li and Redmond have singled out Armenia as “the time when the current trend towards the dispatch of many foreign medical teams to sudden-onset disasters began”.\textsuperscript{136} INSARAG’s own organisational story also clearly claimed the Armenian earthquake as the foundation on which it was built.\textsuperscript{137} INSARAG’s primary purpose was to “facilitate coordination between various international Search and Rescue Teams”, with a particular focus on urban environments.\textsuperscript{138} A booklet written to celebrate its 20\textsuperscript{th} anniversary claimed that the inaugural meeting of INSARAG in December 1991 was “instrumental in creating the United Nations Disaster Assessment and Coordination system”.\textsuperscript{139} These organisations marked the start of the professionalisation of disaster response internationally and in particular, the standardisation of humanitarian medicine. In 2003, for example, the World Health Organisation (WHO) issued the “first substantive policy… regarding international medical relief

\textsuperscript{136} Ibid., p.92.
\textsuperscript{137} INSARAG, Our Background, Available: https://www.insarag.org/about/background [Accessed 14 March 2018].
\textsuperscript{139} Ibid., p.16
standards”, which focused on Foreign Field Hospitals. The Armenian earthquake, and the lobbying of relief workers such as Tony Redmond, led to the professionalisation and standardisation of humanitarian medicine. This enabled disaster response, with the inclusion of humanitarian medicine, to carve out its place within international aid programmes.

The Armenian earthquake has also been recognised as a site of learning, particularly within medical developments. In Nikolaj Wolfson, Alexander Lerner and Leonid Roshal’s (eds.) *Orthopaedics in Disasters*, the Armenian earthquake is used as a case study within multiple chapters. It is cited as a place of learning for the role of sonographic screenings of mass causalities for abdomen injuries, the treatment of fractures and crush injuries, and understandings of paediatric trauma. These lessons also go beyond the specific treatment of different injuries and touch on other aspects for the response, such as the use of telemedicine and earthquake preparedness. Within medical literature, the earthquake is remembered as a site of medical learning; however, for members of SMART, the earthquake signified the need for a British, government-funded, Emergency Medical Team. The inability of Britain to send trained a response team to Armenia, despite the growth in British NGOs in the 1980s, also tells an important story of the British aid sector.

**Prioritising development: the British Aid sector in the 1980s**

There is conflict between the narrative of growth within the British NGO sector in the 1980s and Britain’s lack of disaster response to the Armenian earthquake in 1988. To understand this, we must look at the British aid sector as a whole, investigating the relationships and networks between NGOs, the Overseas Development Administration (ODA) and the government more broadly. The declinist narrative presents the 1980s, in contrast to the 1970s,
as a period of advancement and growth. The Armenian earthquake highlights that while this was a period of progress for British development aid, it was a period in which the British disaster response mechanisms and institutions were neglected by the government and by NGOs. Helen Milner, a professor of politics and international affairs, stressed the importance of looking at the domestic policy to determine how the construction of national interests impacts government decisions about international agreements.\footnote{Helen Milner, ‘International Theories of Cooperation Among Nations’, in Alain Noel and Jean Philippe Therien, ‘From domestic to international justice: the welfare state and foreign aid’, \textit{International Organization}, 49(3), (1995), p.546.} Using this as a foundation, one can also examine British domestic policy to gain an understanding behind British international policy during this period, and specifically British foreign aid. The neoliberal focus of the Thatcher government, which had such a large impact on domestic policy, offers one explanation as to why British disaster relief was side-lined during this period.

This chapter has previously highlighted that Western governments perceived NGOs and multilateral organisations as potential tools to develop former communist states after the Cold War. Within Britain, the Thatcher government was an advocate of this movement and saw aid as a potential tool to encourage the development of market economies within other countries. Geoffrey Howe, a Member of the Treasury, wrote to Lord Carrington in January 1981, saying, “We should seek to make development aid as effective as possible to help countries to move towards reliance on private finance”.\footnote{Geoffrey Howe, ‘Development Policy’, \textit{Treasury Chambers} (21 January 1981), Available: http://86e87754c1530cd7c4a7-873dc378ab15d5cbeb1e3fe4dbee9b4.r88.cf1.rackcdn.com/810204%20crrngtn%20min%20PREM19-0859%20f92.pdf [Accessed 28 April 2018].} Within letters such as this, it is clear that members of the Cabinet had a narrow view of development which focused solely on the growth of a country’s free-market economy. This also mirrored the domestic policies within Britain that saw restrictions on trade. In a letter to the Prime Minister, Lord Carrington wrote:

There was a need to put aid in the wider perspective of total financial flows to developing countries: private investment and financial flows had an important and growing contribution to development, and this should be recognised.\textsuperscript{146}

It is clear Lord Carrington believed that the encouragement of private investment would lead to the growth of a market economy within developing countries and that this could be a key factor to a country’s overall development.

The commitment of British policy to development aid can also be seen within Thatcher’s attitude towards the Overseas Development Administration. One of the early policies of Margaret Thatcher moved the ODA under the umbrella of the Foreign and Commonwealth Office (FCO).\textsuperscript{147} This position was not new for ODA, as its position either within or alongside the FCO demonstrated the polarised views of the Conservative and Labour governments since its inception.\textsuperscript{148} Reinstating ODA under the FCO in 1979 reduced the decision-making power of the ODA. Tim Lankster wrote that this repositioning had negative effects on the ODA as an aid donor, as its policies were tied to the aims of the Foreign and Commonwealth Office.\textsuperscript{149} This move blurred the distinction between British foreign policy and British foreign aid. Historian Peter Byrd, writing in 1991, recognised that the ODA under Thatcher pursued “aid policies consistent with its foreign-policy objectives”.\textsuperscript{150} In the aftermath of the Cold War, development aid was used to encourage the growth in a country’s market economy and can, therefore, be seen as part of the process, termed by Atlani-Duault, of “exporting democracy”.\textsuperscript{151} The ODA became a tool in this process. Political scientist Peter Burnell wrote that “the late 1980s


\textsuperscript{147} The Overseas Development Administration, formally called the Ministry of Overseas Development, was created in 1964. It had various positions, both under the umbrella of the Foreign and Common Wealth Office (FCO) under conservative governments, and as an independent ministry under Labour governments.


\textsuperscript{149} Tim Lankester, \textit{The Politics and Economics of Britain’s Foreign Aid: The Pergau Dam Affair} (Routledge, London: 2013).

\textsuperscript{150} Peter Byrd, ‘Foreign Policy and overseas aid’, in Bose and Burnell, \textit{Britain’s Overseas aid since 1979}, p.59.

\textsuperscript{151} Atlani-Duault, \textit{Humanitarian Aid in Post-Soviet Countries}, p.13.
saw the ODA regaining its morale as a development force”. The utility of foreign aid as a tool to support the economic development of weaker countries was promoted throughout the Thatcher era, during which Gross National Product (GNP) “became the most widely used indicator of progress”. An aid policy review undertaken in February 1980, had two dominant themes. It highlighted: “first that in future greater weight would be given to political and commercial considerations in the allocation of aid, and second, that careful scrutiny would be given to new multilateral aid commitments”. The commercial considerations of aid were a direct reflection of domestic and foreign policies that supported market liberalism.

The ‘scrutiny’ of multilateral aid commitments became a central theme of many of the debates surrounding aid within the House of Lords. These debates took place throughout the Thatcher government. In a debate held in the House of Lords in 1985, about Overseas Aid Policy, Lord Blake addressed the Minister of State for Foreign and Commonwealth Affairs, Baroness Young, saying;

In 1979, when fighting the general election, one of the planks of the Conservative Party platform—a minor one, perhaps and possibly not one that would have commanded an enormous amount of attention by the public at large—was that aid should be channelled more as bilateral aid, and less as multilateral aid, than it had been in the past.

He then proceeded to ask whether it was “the case that the emphasis has now shifted the other way because there are many figures to suggest that the emphasis now is more towards multilateral aid and less towards bilateral aid”. This financial prioritisation of bilateral aid was examined by Oliver Morrissey, Brian Smith and Edward Moresh, who highlighted that “In 1979, 69% of net UK aid was bilateral, and 31% went to Multilateral Aid Agencies; whilst the Conservatives espoused the policy of reducing multilateral aid, its

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154 Ireton, *Britain’s international development policies*, p.124-125.
156 Ibid.
share of total net aid had risen to 41% by 1989”.\textsuperscript{157} In response to Lord Blake’s question in 1985, Baroness Young highlighted that, “our membership of these agencies does give British industry access to substantial business opportunities. But most multilateral commitments are only spent over many years: thus, the effect of our policies will only bear fruit in future years”.\textsuperscript{158} While highlighting the positive impact that contributions to multilateral agencies may have had, she does not explain why the proportion of British multilateral aid increased.

The movement towards a higher percentage of government aid channelled through multilateral organisations, such as the World Bank and IMF, in the 1980s was a significant change for British aid policy. The work of Gordon Cumming, a scholar of modern languages and development, demonstrates this change. He determined that “the distinctiveness of Britain’s aid arose out of her colonial past. British assistance was primarily bilateral and heavily tied to the procurement of goods and services in the UK”.\textsuperscript{159} Under the Thatcher government, as more aid flowed through multilateral organisations, the direct financial benefit to the UK was reduced. Concern for the loss of this financial gain and, by extension, influence, can be seen in a letter by Lord Carrington, the Secretary of State for Foreign and Commonwealth Affairs, to Thatcher in 1981. He wrote, “that each multilateral commitment must be examined critically in the light of its cost and possible benefits”.\textsuperscript{160} Despite the increasing shift of British aid to multilateral organisations, Britain’s economic stability continued to be paramount. While supporting the development of a country’s economy Thatcher, however, refused to “subsidise uncompetitive exports”, and therefore continued to place the British economy at the forefront of her priorities.\textsuperscript{161} Much of Britain’s aid before the 1980s had been given bilaterally to the Commonwealth countries


\textsuperscript{159} Gordon Cumming, \textit{Aid to Africa: French and British policies from the Cold War to the New Millennium} (Ashgate, Aldershot: 2001), p.78.

\textsuperscript{160} Lord Carrington, ‘Development Policy’.

\textsuperscript{161} Ireton, \textit{Britain’s International Development Policies}, p.126.
and Dependent Territories. Barrie Ireton, former Director General of the Department for International Development, determined this figure to be as much as “two-thirds of the bilateral budget”. The new commitments to multilateral organisations such as the EEC and the World Bank put a large strain on the aid budget. Scholar Anuradha Bose highlighted that the aim of the government in the 1980s was to “reorient aid policy, by giving more weight in the allocation process to commercial and industrial considerations”. Despite an increasingly stretched aid budget due, in part, to new multilateral aid commitments, the Thatcher government continued to prioritise Britain’s economy and the development of market economies.

Cuts in funding further exacerbated the pressure on British aid spending during the 1980s. John Mitchell wrote that during Thatcher’s time in office “aid went from being the fastest-growing area of public expenditure to one of the fastest shrinking”. He determined that Britain’s aid shrank from “0.52 per cent of GNP in 1979 to 0.37 per cent in 1982”. Scholar Tim Lankester determined that this was because the government had the “desire to cut the budget deficit and pay for reduced taxes”. These cuts led to pressure and strain on Britain’s multilateral commitments. The impact of this can be seen in the cutting of British aid to the United Nations Development Programme (UNDP) between the years 1979-1982. In a debate in the House of Commons, Labour MP Tom Clarke, queried the cuts highlighting:

We contributed £25 million in 1978, £28.5 million in 1979, £15 million in 1980, £17.5 million in 1981 and £18.5 million in 1982….we read that France, America, and Japan substantially increased their contribution in dollars, yet Britain's contribution decreased from $47 million in 1978 to $28 million in 1983.

162 Ibid., p.157.
166 Lankester, The Politics and Economics of Britain’s Foreign Aid, p.11.
The response from Mr Whitney, the Under Secretary for Minister of State for Foreign and Commonwealth Affairs, indicated the diminished aid budget as a reason for Britain’s drop in financial commitment to UNDP. He responded: “Again, we are totally committed to the great work… and the effectiveness of UNDP programmes, but as always it is a question of striking a balance between the variety of commitments and pressures which there are on a necessarily limited aid budget”.

British historian Mark Curtis, however, identified another reason behind this cutting of aid to a UN agency. He proposed that there was a “general contempt for the UN throughout the post-war era” within the British government as it “fought tooth and nail to keep the UN out of its colonial affairs”. Alternatively, historian Robert Ledger argued that during the Thatcher period, “The government…felt the British taxpayer should have a tangible return for the money spent on overseas aid”. He also argued that “the government believed the money should benefit British firms, help them win contracts, and guarantee market share in the recipient country.”

Britain’s contribution to UN agencies would not have delivered this result.

Within debates in both the Houses of Lords and Commons, the official line repeatedly pointed towards the aid cuts more generally and the British economy. Lord Trefgarne argued that it “was part of an overall reduction in the aid programme which, like other government programmes, had to bear its share in the public expenditure cuts necessary to reduce inflation and to strengthen the economy”. During the Thatcher period there were cuts within the aid budget that put pressure on the bilateral and multilateral aid

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170 Ibid., p.57.

171 Ibid., p.57.

commitments of the government and as a result of this, Britain’s aid contributions to the UNDP went down. In 1980, with the reality of Britain not reaching its aid target and the decision to cut the aid budget, Lord Carrington wrote that “particular care” would be needed when presenting their aid figures, and that “work [was] now being put in hand on how best to explain the change. In the eventual presentation, we should make as much as we can of increasing flows of private finance”.173 This demonstrates the British government’s reliance on private funding to bridge the gap in government aid funding. Andrew Jones’s work recognised the significant cuts to the aid budget made between the years 1979 and 1990; however, he highlighted that alongside these cuts one can trace the government putting money into the aid sector in different ways, specifically through the increased funding of the Joint Funding Scheme.174

During the Thatcher government, there was an increase in the availability of government grants made available to British NGOs through the Joint Funding Scheme. This scheme, developed in 1975 by the Labour government, targeted NGOs who wanted to carry out “small-scale poverty-alleviating projects”.175 The funding available within this scheme grew an extraordinary amount during Thatcher’s time in office, from £290,000 in 1976/77 to £2.5 million in 1981/82.176 Mark Robinson, a research fellow at the Overseas Development Institute, demonstrated that this figure stagnated during the early 1980s due to government aid cuts, but that in the late 1980s it grew again to reach £16.2 million in 1989/1990.177 These grants, however, did not come without conditions. Robinson described some of these conditions and stated that they had to be “developmental”, and that “short-term relief, welfare projects, and major construction programmes” did not fit under the remit of the scheme.178 This money was similarly not allowed to go to countries that had been denied British aid (such as Argentina in 1989).179 Thus, the JFS demonstrates the government’s desire for aid to be aligned with its foreign policy goals. These

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173 Lord Carrington, ‘Development policy’.
176 Ibid., p.161.
177 Ibid., p.162.
178 Ibid., p.163.
179 Ibid., p.163.
grants enabled the government to have greater control over the work of NGOs who competed for these grants and acted as a tool to promote the neoliberal agenda. British NGOs embraced this agenda during the 1980s and believed that development aid would lead to resilience within communities. The JFS and neoliberal ideas directly impacted the type of aid that these organisations focused on, through the championing of development programmes.

At the same time, there was greater dialogue between NGOs and the British government, as NGOs began to be recognised for their expertise. Maggie Black highlights this increased dialogue through an example of Oxfam. She claimed that Oxfam’s 1987 White Paper *Hunger for Change*, which critiqued the clear link between aid giving and British commercial interest, was met with openness from the British government. 180 The White Paper demonstrated that “as much as 79% of the UK aid budget had been spent on UK goods and services”. 181 Black argued that the government’s reaction to this paper represented their increased “willingness” to “seek common ground” with NGOs. 182 Similarly, Hugo Slim believed that during this period, NGOs began to gain the ability “to exert extraordinary and quite asymmetric pressure on government and corporations alike”. 183 This influence over government policy, however, must not be over-emphasised; Black recognised there were limits to the new dialogue by highlighting an investigation by the Charity Commission of Oxfam in 1990, after their role in lobbying against Israel’s actions against the Palestinian liberation forces in Lebanon. 184 This example, Black argued, demonstrates a willingness to interact and have an active dialogue with NGOs; however, there were clear topics on which the ODA were unwilling to engage or compromise. The Chief Charity Commissioner Robin Guthrie, who was appointed in 1988, was said to have a “robust view of matters concerning overlaps of charitable with political activity”. 185 The engagement in activities deemed to be political led to

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181 Ibid., p.269.
182 Ibid., p.269.
185 Ibid., p.273.
“Christian Aid and Oxfam frequently [having] their activities monitored”. Therefore, alongside an increase in government funding, through the JFS, NGOs in the 1980s were burdened with an increased number of restrictions and were placed under greater scrutiny than ever before.

The encroachment of the government control on NGOs was reflected in the bureaucratisation of the NGO sector. Mirroring the impact that neoliberal ideas had on the health sector, one can see the arrival of business models within the running of NGOs. The 1980s has been recognised as a period in which log frames and methods of evaluation were introduced into the British NGO sector. Slim highlighted that this period saw the growth of “strategic planning and strategic management” of emergencies and that this “came to symbolise this new managerialist organisation”. The increased pressure from the government to record and evaluate the performance of development programs and disaster relief can be demonstrated through the creation of the first conference on ‘evaluation’ organised by the ODA in 1984. Tracing the development of evaluation mechanisms within the aid sector, historians Angela Jacklin and Colin Lacy characterised the 1980s as “a time when increasing awareness brought with it an increasing realisation of the inadequacies of the approaches and methods used”. Writing in 1990, David Sanders determined that “for the political right, what mattered most in international affairs was the maximisation of the economic and security interests of the entire developed capitalist world”. The encouragement of economic development, along neoliberal lines, of ‘Third World’ countries can be seen within the British ODA, through its foregrounding of development relief, within its JFS grants. However, this rhetoric can also be seen within international policies of the multilateral aid organisations, the IMF and the World Bank.

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189 Ibid.
190 Sanders, *Losing an Empire, Finding a Role*, p.293.
Following her belief that the state should pay a minimal role within society, Thatcher’s government funnelled money for development projects to NGOs through the Joint Funding Scheme. These grants came with conditions set by the government, therefore allowing the government to influence the aid projects carried out by NGOs. The increased power of the government within the aid sector during the 1980s, through mechanisms such as JFS, encouraged NGOs to focus on development projects. As such, the disaster response fell from the priorities of both the government and British NGOs. This had a negative impact on Britain’s ability to response to sudden-onset disasters, such as the earthquake in Armenia.

Conclusion

This thesis begins with an investigation of the Thatcher period, specifically during the 1980s, as Britain sat at the cusp of change before the end of the Cold War. This chapter has examined the significant shifts within international politics and British foreign policy during this period, which saw neoliberalism take centre stage. This resulted in a promotion, by the British government, of a form of development which championed free-market economy, individual entrepreneurship, and the movement away from state-led response. This chapter has built upon scholarship that viewed the 1980s as a period of growth and advancement for the British aid industry. While still recognising the financial and institutional growth of many aid organisations during this period, this chapter has shown that this did not result in a growth of technical ability and learning within disaster response. Instead, the 1980s saw the influence of Thatcher’s neoliberal beliefs within international aid and the promotion of development aid. This chapter has demonstrated that, during the 1970s, one can see knowledge creation within the field of disaster response through think-tanks such as the London Technical Group and the government’s Disaster Unit. The influence of think tanks and academics on policy decisions within the British aid sector will continue to be discussed throughout this thesis. During the 1980s, the research on disaster response, by these think-tanks, was marginalised by the Thatcher government. The implications of this were seen in the 1988 Armenian earthquake, during which neither the British government nor British NGOs had the technical and
logistical ability to respond. Thus, despite the 1980s being a period of financial growth for British organisations, it was not a site of growth within the field of disaster response.

The Armenian earthquake offers an example of the impact of changes within the British aid sector during the 1980s. It has demonstrated that despite the discourse of positive change and growth promoted by the British government throughout the 1980s, this rhetoric was not a genuine representation of the British aid sector during this period. The focus on development aid by the British government, as a tool for the spreading of the neoliberal agenda, led to the marginalisation of disaster relief mechanisms and research. Therefore, when Soviet Armenia asked for international support following the earthquake, the British government and British NGOs were unable to provide expertise. Rather, groups of British civilians chose to respond despite being “ill-equipped and ill-prepared”.

The roles of British civilians within Armenia (and their lobbying after the crisis) directly influenced the development of international disaster response mechanisms, led to the creation of devices such as the UN Disaster Assessment and Coordination Team and have been cited as the origin of British medical response teams such as UK-Med. The role of medical doctors within humanitarian settings is a central theme of, and one that will be examined throughout, this thesis, particularly in the fourth and fifth chapters. Lessons from the Armenian earthquake also continue to be referenced within medical and humanitarian literature. This chapter has begun to investigate the complex and intertwined relationship between the British government and the multiple actors within the aid sector. This was a relationship that evolved to become increasingly integrated as government funding of British NGOs continued throughout the period of this study.

Within Britain, John Major’s government, which took office in 1990, continued to focus on development aid, and it was not until the late 1990s that a need to reform disaster response mechanisms began to be recognised by the New Labour government and British NGOs. The following chapter will

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191 Ireton, Britain’s International Development Policies, p.105.
demonstrate that in the 1990s, members of the British government and individuals within NGOs began to recognise the lack of growth in the humanitarian sector. It will investigate the role of individuals, such as Clare Short, in advocating a need for reform. This chapter has highlighted the distinct nature of disaster relief and development aid during the 1970s and 1980s however; this distinction did not continue. The following chapter of this thesis will trace the blurring of these distinctions within New Labour’s aid policies. It will again use a localised example, in this case, the famine in Sudan in 1998, as a tool through which to explore the impact of the changes taking place within the British aid sector.
Chapter Two: Rethinking Famine: The British response to the 1998 Sudan famine and the demedicalisation of malnutrition treatments

Introduction

Britain has had a long relationship with famine response, a relationship that historian James Vernon has traced back to the 1840s. He mapped the evolution of different understandings of hunger, from hunger as a class issue within Britain, to the recognition of hunger as a humanitarian cause within colonial India and the formation of British organisations such as Oxfam. Vernon argued that “British-based non-governmental organisations neatly repackaged the old imperial conceits of the civilising mission, by leading the now global war against hunger”. Vernon also suggested that Britain’s “role in shaping the history of hunger” diminished after the 1940s; this chapter, however, will demonstrate Britain’s continued influence on understandings of famine and famine response during the 1990s. The British response to the 1998 famine in Bahr el Ghazal, in the south of Sudan, is emblematic of a diversion away from lessons learnt within colonial famine response and towards a new understanding of famine. This understanding recognised, and responded to, the socio-political causes of famine. This chapter will argue that new understandings of famine led to a movement within British aid towards the demedicalisation of famine response. By exploring the networks between academics and policymakers, this chapter will demonstrate the process by which academic debates influenced government discussion and led to policy change. Specifically, it will examine the early stages of change within Britain’s response to severe malnutrition. This change moved the famine treatment from a short-term centralised medical response to long-term care.

1 Vernon, Hunger.
2 Ibid., p.4.
4 Vernon, Hunger, p.272.
5 This chapter will understand demedicalisation as the moment at which “a problem is no longer defined in medical terms and medical treatments are no longer deemed to be appropriate solutions”; Peter Conrad, ‘Medicalization and Social Control’, Annual Review of Sociology, 18(1), (1992), p.224.
within the community. This chapter will, therefore, examine how changing understandings of famine within academia led to changes in famine treatment policies, specifically, the shift towards the demedicalisation of famine response.

The previous chapter of this thesis has examined British humanitarian response at the end of the Cold War and under the Thatcher government. This chapter moves the narrative of this thesis into the post-Cold War period to Britain under the New Labour government. This period represented a shift from the conditional aid seen within Conservative neoliberal policies towards a Labour development agenda. The latter, while still influenced by neoliberal ideals, placed greater emphasis on the moral duty of the British government towards developing countries. For international politics, the end of the Cold War (commonly dated to the reunification of East and West Germany on 3rd October 1990) was a period of realignment and reconfiguration, in which the power of the state was unclear, and the number of intra-state civil wars grew.

Within the British aid sector, the post-Cold War period led to new understandings of humanitarian disasters and the complexity of their origins. Johannes Paulmann determined that the term “complex emergency” was coined during the 1990s. However, in 1994, Mark Duffield argued that the term “emerged in Africa in the late 1980s”, and that it became increasingly common during the first Gulf War. Despite the disputed origins of the term “complex emergency”, Duffield’s work demonstrated its use within the humanitarian sector through its presence within UN rhetoric in 1993. The UN, he demonstrated, described a “complex emergency” as “a major humanitarian crisis of a multi-causal nature that requires a system-wide

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6 This language of ‘moral’ duty mirrors the ideas, highlighted by Gorman in what he termed ‘humanitarian imperialism’. New Labour policies that emphasised Britain’s moral duty to help those less fortunate abroad, highlights the continued legacies of imperial thought within Britain. Gorman, Empire, Internationalism, and the Campaign against the Traffic in Women and Children in the 1920s.


10 Ibid., p.38.
response. Commonly, a long-term combination of political, conflict and peacekeeping factors is also involved”. The growing recognition of the complex nature of emergencies led to greater involvement of western militaries within aid settings. This is something that will be further explored in the following two chapters.

Within this setting of internecine wars and complex emergencies, humanitarian organisations began to re-examine their roles. One example of this re-examination concerned the delivery of food aid by NGOs within politicised environments. Within the famine in Bahr el Ghazal in 1998, British aid organisations responded by delivering material, food and medical aid and using aeroplanes to reach inaccessible areas and using medically-focused Therapeutic Feeding Centres (TFCs) to treat individuals with severe malnutrition. Despite these familiar methods of response, British aid organisations received criticism from members of the newly formed Department for International Development which replaced the Overseas Development Administration in May 1997. Heading this criticism was Clare Short, the General Secretary of DfID, whose public denouncement of NGO fundraising for Sudan made headline news in the UK.

This chapter will examine the criticisms of Clare Short and situate them within broader discussions taking place within British academia about the nature of famine itself. Recognition of the shifting understanding of famine during the 1990s requires a consideration of the different understandings of the term ‘famine’. The word ‘famine’ was originally a biblical term; Alex De Waal, one of the major voices in famine scholarship, traced the word from its origins, to what he termed “an English understanding”. De Waal argued that

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11 UN quoted in Duffield, ‘Complex Emergencies’, p.38.
14 DfID was the only new department created by the Blair government when it first came to office. The creation of this department moved aid away from the control of the Foreign and Commonwealth Office and separated it as a distinct entity.
this understanding is grounded on the work of Thomas Malthus.\textsuperscript{17} Writing in
1789, Malthus argued that, “since populations grew at a faster rate than their
food supplies, there would necessarily be times when the food needs of the
population exceeded its resources... in such cases; famine would act as a
natural check on population levels”.\textsuperscript{18} Malthus presented a population’s
suffering as a natural and inevitable result of a lack of resources. This chapter
will critically analyse the movement away from this understanding in the late
1980s and throughout the 1990s. It will trace the growing recognition, within
the British aid sector, of the socio-political causes of famine. Using the lens
of medical famine response, this chapter will explore the impact of the new
understandings of famine on the delivery of medical aid. This chapter
proposes that, against the background of intra-state wars and emergencies in
increasingly complex arenas, DfID pushed for a reconceptualisation of aid
that responded to the long-term effects of disasters.

Using government papers, grey literature, the work of academics during this
period and medical literature, this chapter will explore the steps that led to the
reconceptualisation of famine and the subsequent change in medical famine
response. This chapter will first examine the transition from the Thatcher and
Major Conservative years to a New Labour government in 1997. It will
analyse the impact that this change had for British aid policies, particularly
highlighting the importance of the creation of DfID. During this period,
within British humanitarianism, there was a movement towards the
standardisation of humanitarian aid; this chapter will explore the role of
British individuals in the creation of the universal Sphere Standards.

This chapter will then proceed to examine the role of British NGOs and the
UN within Sudan, as contributors to Operation Lifeline Sudan (OLS), and
will analyse their role within the 1998 famine response. It will highlight that,
despite responding to the famine in a way typical of NGOs at the time, the
British NGOs began to face criticisms. This chapter will place these criticisms
within wider discussions taking place across the UK between the government,
think-tanks and academics, which reconceptualised famine. Finally, this

\textsuperscript{17} De Waal, \textit{Famine that Kills}.
chapter will analyse the impact on this reconceptualisation of famine through an exploration of the changes that took place within the medical humanitarian response, specifically the creation of Community Therapeutic Care (CTC). It will demonstrate that CTC gained support for its ability to target a larger number of patients than Therapeutic Feeding Centres. It will explore the integration of development methods in humanitarian responses and will observe the implications of this integration, specifically the movement towards a demedicalisation of famine relief.

From Thatcher to Blair

The movement from the Conservative governments of Thatcher and Major to the New Labour government brought with it a significant change to the British aid sector. This section will discuss some of the internal and external factors that shaped British aid. It will investigate the impact of the Rwandan genocide on the recognition of the need for accountability within the aid sector, and the role of British individuals in the creation of the Sphere Standards. British aid was also influenced by the internal changes that came with the New Labour government. This government placed aid at the forefront of its agenda and worked to gain more influence within the aid sector. Before the election of Tony Blair and the New Labour government in 1997, there was a continuation of Thatcherite policies within the Conservative government under John Major. This continuation is clear within the Major government’s foreign policies, which were “dominated by Euro-Atlantic issues, specifically, the health of the so-called ‘special relationship’ with the United States”. Major, like his predecessor, also focused on strengthening the British role within NATO and attempted to continue to build “Britain’s relations with the European Community”. Alongside these foreign policy commitments, the government continued to follow Thatcherite policies on international aid.

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19 Conservative MP John Major succeeded Margaret Thatcher in November 1990. Historian Michael Foley argued that during Thatcher’s third term (which began in 1987), members of the Conservative party had become exasperated by her uncompromising nature. Foley argued that this was as a major factor in the resignation of the Deputy Prime Minister Sir Geoffrey Howe. After a failed leadership challenge by Conservative MP Michael Heseltine on 14th November 1990, Thatcher stepped down as Prime Minister. For more information see: Michael Foley, John Major, Tony Blair and a conflict of leadership: collision course (Manchester University Press, Manchester: 2002).


21 Ibid., p.3.
Specifically, Major continued to develop the JFS. For example, the amount given to aid organisations by the government through the JFS in 1989/1990 was £16.2 million. By 1993/1994, the official funding of NGOs had risen to £68.7 million, with the majority of this being awarded through the JFS.

Perhaps the most significant event concerning the British aid sector during Major’s time in office was the Rwandan genocide in 1994 and Britain’s delayed response. Linda Melvern, an investigative journalist, and Paul Williams, a scholar of security studies, determined that the Major government was too preoccupied with the ongoing war in Bosnia, following the break-up of the Soviet Union, to recognise the implications of events taking place in Rwanda. In a book chapter, Williams further suggested that, like the Thatcher government, Major’s government placed a significant emphasis on Britain’s economy within their aid policy decisions. He wrote that, for the Major government, “British aid, trade, investment and interests have been concentrated, at times almost exclusively, on Commonwealth Africa”, and thus events taking place in countries outside the Commonwealth, such as Rwanda, were met with “indifference”. While the delayed British response to the Rwandan genocide may have multiple explanations, it demonstrates the British government’s preoccupation with countries that they could develop international trade links with. During Major’s time in office, the British government continued to imitate and develop Thatcherite policies which promoted Britain’s position within international politics and the continued growth of the British economy.

While British foreign aid policies under Major followed the pathways laid out by Thatcher, the aftermath of the Rwandan genocide led to significant changes across the aid sector internationally, most notably the creation of the
Sphere Standards. In response to the widely acknowledged failures of international governments and aid organisations during the Rwandan genocide, Danida (a section of the Danish government’s Ministry of Foreign Affairs which focused on the delivery of aid) proposed that an evaluation of the response should be carried out. This evaluation was called The Joint Evaluation of Emergency Assistance to Rwanda (JEEAR). The Overseas Development Institute (ODI), based in London, carried out the most extensive study within JEEAR, Study 3, which examined the humanitarian response within Rwanda.28 This study, headed by the British researcher John Borton, a Research Fellow for ODI, was published in March 1996. The report outlined recommendations for the humanitarian sector, which aimed to “improve NGO performance” through the creation of a universal “set of standards” and to improve the accountability of NGOs.29 Margie Buchanan-Smith and Peter Walker have both argued that the Rwandan evaluation was the “impetus to the embryonic Sphere initiative”.30 As a product of the recommendations made by Study 3, the Sphere Standards were created, which set out the “minimum standards” for aid organisations working in humanitarian settings.31 Alongside the work of John Borton, Buchanan-Smith highlighted the notable contributions of British former aid practitioners, Peter Walker (ICRC) and Nick Stockton (Oxfam), in the launch of Sphere.32 The creation of the Sphere Standards was influenced by individuals, many of whom were British, who believed that the standardisation of the humanitarian sector would enforce more accountability within humanitarian organisations.33 The launch of the Sphere Standards, in March 1998, marked a shift within the humanitarian sector within the 1990s which placed greater

29 Ibid., p.10.
31 The Sphere Standards came out of widespread discussions and working groups within the humanitarian sector, “involving more than 700 people and over 200 agencies” and members from IFRC, Oxfam, ICRC, Save the Children Fund-UK and InterAction; Buchanan-Smith, ‘How the Sphere Project Came into Being’, p.12.
32 Buchanan-Smith, ‘How the Sphere Project Came into Being’, p.vii.
33 For more information on the creation of the Sphere Standards, see: Denis Kennedy, ‘Humanitarianism Governed: Rules, Identity, and Exclusion in Relief Work’, Humanity, 10(2), (2019).
prioritisation on the outcomes of humanitarian response and the responsibility of aid actors to take account of this.34

The creation of the Sphere Standards coincided with changes within the British government, which led to an acceptance of the government’s moral duty within international crises.35 In a speech made in 2001 John Major’s successor, Labour leader, Tony Blair argued that “in retrospect, if nearly a million people were murdered in Rwanda today, as they had been between April and July 1994, the British government would have both a political and moral duty to prevent or suppress the killing”.36 Blair’s speech presumed that the role of the government within the British aid industry in 2001 had significantly changed since 1994; however, this change should not be over-emphasised.37

Many of New Labour’s policies were not dissimilar from those of the Thatcher government. Lewis Minkin, who examined the management structures of New Labour, determined that Blair adopted many Thatcherite policies, such as the “neo-liberal economic framework of Thatcherism”.38 Minkin’s argument, however, highlights New Labour’s attempt to “dilute” the “most offensive aspects of Thatcherism… [by] introducing elements of social justice and in establishing social democratic objectives in the public sector”.39 Minkin argued that New Labour’s policies were “post-Thatcherite”, because they built upon, but adapted, Thatcherite policies to include moral elements.40 Historian Duncan Watts argued that Blair made changes to the Labour Party Constitution which reflected aspects of the Thatcher government, while also adding emphasis on “community values such as equality of power, tolerance and respect [and] rights and duties”.41

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34 The Sphere project, which began in July 1997, launched the Sphere Standards document in March 1998; Walker and Purdlin, ‘Birthing Sphere’.  
37 Tony Blair became Prime Minister in 1997 in what Ian Adams called “one of the biggest victories in British electoral history”; Ian Adams, Ideology and politics in Britain today (Manchester University Press, Manchester: 1998), p.150.  
38 Minkin, The Blair Supremacy, p.125.  
39 Ibid., p.125.  
40 Ibid., p.125.  
Blair therefore, while adopting many of the Thatcherite policies, also attempted to improve them by adding a “moral dimension, with references to personal responsibility, the family and our duty of care to each other”.

Blair’s party emphasised the moral responsibility of the government, both towards the British public and populations internationally.

While some of New Labour’s ideas mimicked the language of the Thatcher government, one can see the impact of Blair’s emphasis on moral duty in the Blair government’s prioritisation of international aid. Blair not only created DfID as a separate department but he also placed Clare Short, who was described as “a powerful advocate of development policy within government”, at the head of this new department. Under Short’s leadership, DfID gained a significant and influential voice within British politics. Senior members of the Labour party, such as Chancellor of the Exchequer, Gordon Brown, gave their backing to DfID which, in part, led to budget increases for aid. The budget for aid rose from 0.26% of gross national income in 1997 to 0.32% in 2000. To further increase the influence of DfID within the government, Short created an “Inter-Governmental Working Group on Development” in November 1997. In the same month (November 1997), DfID produced the first White Paper on aid since 1975 titled, Eliminating World Poverty: A Challenge for the Twenty-First Century. DfID had influential power within the government, in the early years of New Labour, as international aid became a key policy focus.

The White Paper was a marker of New Labour’s commitment to international aid, and specifically, it highlighted DfID’s prioritisation of development aid that was independent of trade considerations. Short, in her autobiography, recalled what she believed to be the importance of DfID’s aims, writing:

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42 Watts, British Government and Politics, p.246.
48 Ibid., p.250.
The reshaping of our development programme on the reduction of poverty might sound obvious, but there was such a muddle of motives and programmes in the international development system, that the UK clarity of focus became influential.\textsuperscript{49}

The 1997 White Paper laid out DfID’s prioritisation of poverty eradication through the reduction of Third World Debt and by working in partnership with recipients.\textsuperscript{50} Oliver Morrissey argued that it highlighted a movement towards a “results-oriented perspective”.\textsuperscript{51} Short also focused on decreasing the use of tied aid, which was finally abolished by the government in 2001.\textsuperscript{52} Her commitment to this was said to have caused tension between DfID and the Department of Trade and Industry, as she pushed for the government to stop using aid as a form of “support [for] British exporters”.\textsuperscript{53} Alongside these goals, DfID also aimed to “increase the effectiveness of multilateral agencies in poverty reduction and responding to humanitarian crises”.\textsuperscript{54} The commitment of the government to this aim can be seen in the decision to once again become a member of the United Nations Children’s Fund and the United Nations Industrial Development Organization.\textsuperscript{55}

The prioritisation of development aid and active distancing of past aid policies that supported British businesses, seen in DfID’s first White Paper, were also captured in DfID’s first Annual Report. Short wrote the opening to the report, stating that DfID was created “to bring development considerations into the mainstream of government thinking” and that as a department it was “no longer subject to short term political and commercial considerations”.\textsuperscript{56} In contrast to schemes such as the JFS grants seen within the Thatcher government, DfID claimed that its development aid would prioritise human rights, work with partner governments, and would avoid

\textsuperscript{50} Young, ‘New Labour’, p.249; Morrissey, ‘British Aid Policy in the “Short-Blair” years’, p.166.
\textsuperscript{51} Morrissey, ‘British Aid Policy in the “Short-Blair” years’, p.162.
\textsuperscript{53} Morrissey, ‘British Aid Policy in the “Short-Blair” years’, p.166.
\textsuperscript{54} Ibid., p.180.
\textsuperscript{55} Young, ‘New Labour’, p.250.
“crude conditionality” within its partnerships.\textsuperscript{57} DfID’s change in the allocation of funds towards development-oriented goals demonstrated its commitment to long-term aid. The distribution of funding for “Africa (including the Middle East)” increased from £257 million in 1995/96, to an estimate of £444 million in 1998/99; however, this funding was not for humanitarian responses.\textsuperscript{58} Instead, the allocation for “emergency aid” dropped from £142 million in 1995/96 to an estimated £22 million in 1998/99.\textsuperscript{59} It is clear that there would be an increased presence of DfID funding within Africa, this funding did not support emergency aid. When placing these allocation estimates alongside Short’s opening address, it is clear that during its early years, DfID prioritised the long-term development focused aid policies.

The changes within British aid and specifically British government-sponsored aid had both external and internal factors. The insufficient response to this genocide, by the international community, led to the creation of the Sphere Standards in which many British aid practitioners played a significant role. The changes taking place within the wider aid sector, particularly those which emphasised accountability, were mirrored within the British government's aid policies. The shift from Thatcher to Major and then to Blair saw the continuation of development-focused aid approach by the British government. However, the emphasis on morality and accountability seen within the creation of mechanisms such as the Sphere Standards set the Blair period apart. Within the creation of DfID, the British government gained a stronger voice within the British aid sector.

\textbf{Famine in Sudan}

In 1998, famine returned to Bahr el Ghazal, a province in the south of Sudan, which had a long history of food insecurity.\textsuperscript{60} This famine, which took place a year after the creation of DfID, provides a lens to analyse the British aid sector and Britain’s humanitarian medical response under the new New

\textsuperscript{59} Ibid., p.12.
Labour government. This section will examine the humanitarian response to the famine and specifically investigate the role of British actors within this famine. It will demonstrate that, though the mechanisms used to respond to this famine were not unusual, they faced increasing criticism in light of new results-driven agendas promoted by DfID.

The Bahr el Ghazal famine was a clear example of a complex emergency in which a natural cause of famine, two years of failed harvests, was exacerbated by an ongoing civil war within the country. This war was between the Government of Sudan (GOS) based in Khartoum and the Sudan People’s Liberation Movement/Army (SPLM/A) in what is today South Sudan. At the height of this famine in July 1998, “one in every three people [in the Bahr el Ghazal region were] labelled as severely malnourished”. Modes of warfare on both sides of the civil war, such as the killing of livestock, the burning of grain stores and the internal displacement of communities, had destroyed traditional coping mechanisms for food shortages and further increased the medical needs of the population. Furthermore, poor infrastructure, government restrictions and insecurity hampered the delivery of aid.

Neither famine nor civil war was new to Sudan. The civil war in Sudan had its origins within the colonial period when England and Egypt governed Sudan through an Egyptian governor-general who was appointed with British consent. When Sudan gained its independence from Anglo-Egyptian rule in 1956, the divisions between the north and south, which began under colonial rule, continued. Sudanese independence notwithstanding, the British continued to play a significant role within its former colony through the provision of humanitarian relief. One example of this was the British

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65 From 1899, the Anglo-Egyptian alliance ruled Sudan. Under this rule there were strong divides between the Arabic population in the north, who were predominately Islamic, and the southern population made up predominately of Christians and African tribes such as the Dinka and Nuer. The divides between the north and south continued throughout the process to independence which began in 1956 and was completed in 1983; J. Millard Burr and R. Collins, Darfur: The long Road to Disaster, (Markus Wiener, Princeton: 2006), p.55; Taylor-Robinson, ‘Operation Lifeline Sudan’, p.49.
humanitarian response to a famine between the years of 1983-85. The origin of this earlier famine can also be found within the civil unrest between the north and south, political instability and failed harvests. Alongside the aid given by the British government, British NGOs (Oxfam and Save the Children) also responded to the 1983 Sudan famine. During the 1998 famine, therefore, NGOs came to Sudan with some prior knowledge of the challenges they could face.

The famine in Sudan during the years 1983-85 killed an estimated 250,000 people in the south and triggered the creation of what was called Operation Lifeline Sudan. Formed in 1989, this operation brought UN agencies, NGOs, and INGOs into a negotiated agreement with the GOS and SPLM/A, to provide humanitarian assistance to populations in Sudan. Tom Rhodes described OLS as “an unprecedented initiative as a neutral humanitarian operation that works within an internal war”, which prioritised the “right to humanitarian assistance”. OLS was created under the following terms:

1. The UN has to deal with all the parties to the conflict that control territories through which relief items pass or to which they are delivered
2. The parties to the conflict commit themselves to the safe and unhindered passage and delivery of relief items to the needy population
3. The UN, as a neutral body, was to co-ordinate the operations with the parties to the conflict.

UNICEF was chosen to co-ordinate the delivery of aid through OLS. Violation of the agreements made by the SPLM and the GOS with OLS significantly impacted the humanitarian response in the 1998 famine.

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68 Ibid.
69 Ibid., p.2 + 3.
71 Donors fund OLS by contributing to the Annual Consolidated Appeals of the UN. These donors comprised of NGOs, State governments and UN bodies. Between the years 1993-1995, the US provided the largest state contribution of $75 million. For more information about funding read: Ataul Karim et al., Operation Lifeline Sudan-A Review, (United Nations: 1996).
In February and March 1998, the GOS enforced a flight ban over southern regions of the country, restricting the delivery of humanitarian aid and exacerbating the food security challenges within this area. Iain Levine argued that the government’s use of flight bans was an example of the government’s power over OLS. A flight ban to the southern region in the south of Sudan was significant, as the poor infrastructure and challenging terrain in this area had led to the reliance on aeroplanes by OLS for the delivery of food aid.

The delayed response of humanitarian organisations to the Sudan famine dominates the evaluations of the aid response. The British Disasters Emergency Committee launched its Sudan Famine Appeal on 15th May 1998; however, reports of a potential food crisis in the Bahr el Ghazal region date back to 1997. An evaluation carried out by Luka Biong Deng stated that at the end of 1997, field workers from both Oxfam and Save the Children UK had raised concerns about the Bahr el Ghazal region to their offices in Lokichogio and Nairobi. Deng, however, highlighted the failure of these field offices to report back to their respective headquarters in the UK. In a different article, Deng argued that the slow recognition of the famine in Sudan was due to an international perception that “Africans do not starve, but they cope”. This chapter will suggest that problematic early warning systems also contributed to the slow response. The severity of the situation within Sudan was not apparent to the British government or British NGOs in the first four months of the food crisis. When the British response did begin the British government and British NGOs contributed financially to OLS projects and worked both within and alongside their operations.

72 Rhodes, ‘OLS Relief Operation’, p.11.
74 Save the Children, Sudan Bulletin One.
75 DEC, DEC Evaluation: Sudan Crisis Appeal.
77 Luka Biong Deng works as the Director of the Centre for Peace and Development Studies at the University of Juba. He held roles as both a Minister in the Office of the President of South Sudan and as a National Minister of Cabinet Affairs of the Sudan until he resigned in May 2011; L. B. Deng, ‘Famine in the Sudan: Causes, Preparedness and Response: A political, social and economic analysis of the 1998 Bahr el Ghazal Famine’, IDS Discussion Paper, 369, (1999), p.101.
OLS acted as the coordinating body of many of the aid organisations during the 1998 famine. One of the leading organisations within this response was the UN World Food Programme (WFP), who delivered food aid across the country. In a report from July 1998, Save the Children recorded that, through the OLS co-ordinated programmes, “2.6 million people [were] now being targeted for food aid”. Three months before this report, however, despite the efforts of the organisations within OLS, the famine in Sudan did not appear to be slowing, and it gained greater recognition within international media. This, in turn, led to an influx of aid, which Save the Children championed in its July report.

In response to media coverage of the famine, international governments pledged more money to the cause. Irish aid, the Irish government’s international development aid programme, for example, provided a total Ir£884,000 for “various emergency assistance projects in Sudan through UN agencies and non-governmental organisations”. Irish Aid also worked closely with the EU and particularly members of the British government, to push for a ceasefire between the GOS and SPLM. Similarly, the Canadian International Development Agency supported the ICRC, UNICEF, and various Canadian NGOs. Their money was used for “air transportation of relief supplies” and, specifically in Bahr el Ghazal, for “medical assistance, clean water, and cooking supplies to people”. By August, the Canadian government had given $11.3 million to the humanitarian response in Sudan. The international response to the Sudan famine focused on responding to the immediate needs of communities and displaced people in the south.

The British government and British NGOs also contributed to this response. British NGOs raised a total of £14 million to support the humanitarian effort in Sudan, making Britain the third-largest donor behind the USA and the

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82 Ibid., p.221.
84 Ibid.
EU. A report by the Select Committee on International Development stated that by June 1998, the UK government had also committed £25.23 million to the crisis in Sudan. It determined that the funds would be distributed in the following way:

- £16 million to WFP
- £1.83 million to NGOs (including Save the Children, MSF, World Vision and Care)
- £1.0 million to ICRC
- £0.8 million to UNICEF
- £0.4 million to OLS Logistics
- £0.2 million to the UN Humanitarian Coordination Unit in Khartoum
- £5 million still to be allocated as new needs emerge in the north and south.

The Disasters Emergency Committee appeal for the famine raised £6.4 million within three weeks. The table below demonstrates the division of this money between 12 of the 15 DEC members who responded to this famine.

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>AMOUNT (£)</th>
<th>Share (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Red Cross</td>
<td>1,089,280</td>
<td>17.02</td>
</tr>
<tr>
<td>Catholic Agency for Overseas Development (CAFOD)</td>
<td>322,600</td>
<td>4.65</td>
</tr>
<tr>
<td>Care International UK</td>
<td>371,200</td>
<td>5.80</td>
</tr>
<tr>
<td>Christian Aid</td>
<td>556,800</td>
<td>8.70</td>
</tr>
</tbody>
</table>

87 DEC, DEC Evaluation: Sudan Crisis Appeal.
Concern Worldwide 147,200 2.30
Help the Aged 117,760 1.84
Médecins Sans Frontières 118,960 1.39
Merlin 112,680 1.37
OXFAM 1,949,320 31.63
Save the Children 1,155,200 18.05
Tearfund 197,000 4.25
World Vision 192,000 3.00
TOTAL 6,400,000

Table: ‘Final Allocation of Funds from the Sudan Crisis Appeal’. 88

These DEC members worked within and alongside OLS in the south of Sudan, often providing their expertise to OLS operations. An evaluation of the DEC agencies highlights the different ways that these NGOs were able to support OLS. It stated that:

Oxfam provided general management, SCF provided analytical capacity for WFP’s food economy studies, CARE provided logistical capacity…, and World Vision increasingly provided storage management for strategic general rations in southern Sudan. Concern operated as a member of an informal peer group to help steer WFP operations and provided food monitors. 89

Alongside the operational support provided by DEC organisations to OLS, these NGOs also delivered material and practical aid, both independently and in coordination with OLS, a church consortium and the ICRC. 90

88 DEC, DEC Evaluation: Sudan Crisis Appeal.
89 Ibid.
90 Ibid.
Some of these organisations were working within Sudan before the
pronouncement of the famine; others came with prior knowledge of
past famine relief projects in the area. The British Medical NGO Merlin, for
example, had been working in the Bahr el Ghazal region since February 1998,
attempting to combat a sleeping sickness epidemic.\textsuperscript{91} When it became clear
that there was a food shortage within Bahr el Ghazal, they set up several
Therapeutic Feeding Centres which provided immediate care for severely
malnourished children, gave vaccinations against malaria, and distributed
vitamin A supplements.\textsuperscript{92} Similarly, Oxfam, who had prior knowledge of
famine response within Bahr el Ghazal, returned to “provid[e] clean water,
improv[e] sanitation, distribut[e] seeds, [and] giv[e] health support and health
education”.\textsuperscript{93} While the WFP was in charge of wide-scale food distribution,
the DEC organisations provided logistical support within OLS and more
targeted aid to communities and vulnerable groups.

A large proportion of the British response in Sudan was medical, as NGOs
provided clinical care through Therapeutic Feeding Centres. Oxfam set up
and ran “therapeutic and supplementary feeding programmes” which worked
alongside food distribution” programs.\textsuperscript{94} The NGOs “Oxfam, [Save the
Children], Tear Fund and MSF felt that the existence of high malnutrition
rates necessitated the establishment of Therapeutic and Supplementary
Feeding centres”.\textsuperscript{95} The organisations Oxfam and Merlin, who took the lead
in the British medical response, worked to provide medical and nutritional
care to children under the age of 5 suffering from malnutrition. Using
guidelines created by organisations such as the WHO, NGOs used Mid-
Upper Arm Circumference (MUAC) bands to categorise patients and determine who

\textsuperscript{91} Merlin, \textit{Famine in South Sudan}.
\textsuperscript{92} Borton, \textit{Merlin 1993-2013}.
\textsuperscript{94} Oxfam, \textit{Emergencies Bulletin: Sudan, June 1997} (Oxfam, Oxford: June 1997), Available:
\textsuperscript{95} Pierson R. T. Natta, Participation by the affected population in relief operations: A Review of the
experience of DEC agencies during the response to the 1998 famine in South Sudan (ALNAP,
London: 1999), Available:
http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.458.2200andrep=rep1andtype=pdf
should be admitted into the TFC. Using the MUAC band as a measure, aid workers divided patients into categories of severe malnutrition, moderate malnutrition and healthy; symbolised by the colours of, red, orange or green. Those who fell into the red section of the band were sent to the TFC. Once a child had been categorised, those with severe malnutrition were admitted into the Therapeutic Feeding Centres where they would stay for approximately one month, or until they had moved into the orange section of the MUAC band. During the Sudan famine TFCs were used as the medical response against severe malnutrition amongst children. While they were able to provide to a high level of care within the centre, due to the large scale of the famine and the poor infrastructure in the south of Sudan, many children were unable to access the TFCs.

The methods of response used within the Sudan famine faced criticism from academic institutions and independent evaluators. Within these critiques, there was a conflict between the need to target as many of the population as possible while simultaneously ensuring that responses were both effective and accurate. These critiques, within academic journals and evaluations, were targeted at both the MUAC band and TFCs. Historian Joël Glasman, who has written about the history of the MUAC band, argued that it had faced opposition since its creation, with many medical professionals determining that the Upper Arm Circumference alone was not an accurate enough measure to determine a child’s nutrition status. Glasman analysed the methods of the supporters of the MUAC band who, despite never contradicting these criticisms, continued to successfully promote the use of the band, emphasising its usability and its ability to “make hunger commensurable on a global scale”. He argued that its success in the 1990s was grounded in the “the trend toward ‘evidence-based humanitarianism’”. The MUAC band not only provided a quick and easy measure to diagnose a child but also

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96 These measures were initially based on research carried out on Polish children in 1964. However, in 1997 the WHO released a new universal reference of measure. See: Joël Glasman, ‘Measuring Malnutrition: The History of the MUAC Tape and the Commensurability of Human Needs’, Humanity, 9(1), (2018), p.29 + 33.
99 Ibid., p.19.
100 Ibid., p.20.
produced data that was internationally comparable and enabled practitioners to quantify success rates for TFCs easily. The MUAC bands are also used to determine “the need for food relief” within a community. Alex De Waal, however, argued that this was “useless” as the MUAC band promoted a narrow conception of famine as merely a “nutritional deficit”. This same criticism can be used to challenge the use of the MUAC band as a way of determining medical pathways for patients, as it failed to recognise the other medical problems that may arise due to a lack of nutrition. Despite these criticisms, MUAC bands were used throughout the Sudan famine in 1998, alongside height and weight measures, to categorise children.

Within the literature discussing TFCs, a central tension exists between their ability to deliver excellent patient care and their ineffectiveness on the scale of population response and reliance on international staff. These centres, often set up within a hospital, temporary field hospital or other health facilities, offered individual medically focused care to its patients. Within the TFCs, therapeutic feeding would take place under medical supervision, and patients received personal medical care. The Sphere Standards set out clear guidelines for the treatment of malnutrition, however as these were in the early stages of creation in 1998, the 1999 WHO guidelines give us a more accurate view of the standards that may have been used within the TFCs in Sudan. According to WHO guidelines: “Each centre should include, as a minimum, one part-time doctor, three nurses and ten nursing aides. The mothers or carers of the children may also provide assistance”. These centres relied upon external medical staff to provide training, support and personnel to ensure that they followed and maintained high standards of patient care. This meant that these centres were not self-sufficient and therefore, without international support, were not sustainable.

101 De Waal, Famine that Kills, p.31.
102 Ibid., p.31.
Another challenge that TFCs faced was the limited number of patients they were able to support. A report about the 1998 Sudan famine noted that “in many cases, these centres [TFCs] were not able to accommodate the large numbers of patients, there was one report of a therapeutic centre exceeding the guidelines of 100 people per centre”. During the famine reports of concerns that TFCs were being “overwhelmed by the demand” were common. Deng, in an evaluation of the response, wrote,

According to UNICEF, the majority of malnourished children-including some severely malnourished cases-did not receive the care they needed at feeding centres. The limited number of feeding centres coupled with their low admission capacities, attracted people and encouraged unusual population movements and a high concentration of people around feeding centres. Despite these concerns, the TFCs have been celebrated, even by their critics, for the individual care they offered patients. Writing in 2009 and reflecting on the criticisms directed towards TFCs, Ben Ramalingam et al. highlighted that, despite these challenges, treatment given within these centres was “on the whole very good”. Though their ability to provide a good level of care to individual patients was noted, evaluations of the Sudan famine response criticised TFCs for being ineffective due to the large percentage of the population suffering.

One of the critical medical responses set up by British NGOs within Sudan was the Therapeutic Feedings Centres. While the TFCs delivered individual medical care, they were unable to provide support to severely malnourished children on the scale needed. The evaluations that followed the Sudan famine response focused not on the availability of support from the

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107 Deng, ‘Famine in the Sudan’, p.75.
international community, or the amount of food aid, but rather on the methods used to deliver this aid and the impact of this on the population. The criticisms of the response highlight tension between the need to respond on a large scale while also ensuring the delivery of effective aid. This tension existed against a background in which the British aid sector was becoming increasingly results-focused. The critical evaluations of the use of TFCs reflect discussions taking place within Britain during this period, which demanded long-term results from humanitarian aid.

**Responding to a Complex Emergency**

Criticism of the famine response entered the public sphere when Clare Short publicly criticised the use of airdrops within this famine as a method of aid delivery. Her argument was two-fold. She both criticised the methods of delivery, but she also highlighted the failure of the international community to engage with the long-term political causes of the famine. She openly condemned the large deliveries of material and financial aid and argued that priority should be placed on attempts to achieve a cease-fire between the GOS and the SPLM. While Operation Lifeline Sudan tried to maintain corridors of aid, as a neutral party within the conflict itself, Short pushed for a political response that promoted a country-wide ceasefire and a negotiated settlement. The criticisms of Clare Short mark a changing dynamic within the British aid sector as a whole, insofar as they highlight an example of the government, a donor within this famine response, holding aid organisations accountable for their policy choices.

One of the significant challenges to the delivery of aid within the Bahr el Ghazal region was access; though OLS had negotiated safe pathways for aid, the continued conflict and the poor infrastructure in the south of Sudan meant that a large proportion of aid was delivered through airdrops.\(^{111}\) Airdrops were a standard method of aid delivery, particularly to hard-to-reach regions; however, Short publicly criticised the use of them within Sudan. In a statement to the House of Commons in July 1998, she highlighted that “the

\(^{111}\) Levine, ‘Promoting humanitarian principles’.
90% of the aid budget being spent on airdrops” was a “terrible overspend”.

Criticising the financially wasteful use of aeroplanes, Short argued that lobbying for a cease-fire was a better way to help the Sudanese population. She condemned NGOs’ seeming disregard of the political dynamics behind the famine and their focus on the delivery of material aid. In June 1998, Short told the House of Commons:

I have wanted the public… [to] not be misled into thinking that, if more money could be found, the women, children and old people we have seen starving on our television screens would necessarily be saved. That is simply not the case. The problem is much more difficult than has been portrayed by the media, and I believe the public deserves to know this.

Short criticised the media for not giving the British public a full understanding of the political background behind the famine and argued that British NGOs and the media should not present increased funding as the answer to the suffering. She also suggested that further fundraising was not needed as the British government could provide enough money to support the cause. In a statement to the House of Commons the following month, Short again argued that Britain should “encourage ceasefire and press for a negotiated settlement”.

Short lobbied for the recognition of the long-term implications of the famine and called for a response that addressed them. She argued that the temporality of material relief would not end the food insecurity that had been a reoccurring problem in Sudan since its independence. Short’s criticisms highlight a shift within the British aid sector in which DfID (a donor) began to call for the accountability of aid actors and demand measurable impacts from the projects it funded. In short, DfID tried to micro-manage the aid response. Short’s criticisms of the failure to address the long-term underlying causes of this famine, specifically the civil war, highlight her

113 Ibid.
114 Select Committee on International Development, Memorandum from the Secretary of State for International Development.
115 Short, ‘Sudan’.
recognition that famine was not merely caused by a lack of food and thus her belief that the delivery of food aid was an inadequate response.

Clare Short’s criticisms of the Sudan response were widely publicised throughout the British media and not well received by her fellow politicians who feared that her comments would prevent the British public from donating to the famine.\(^{117}\) In a BBC report titled “Short’s Sudan comments baffles MPs”, she was criticised for being “premature… to announce in such bald terms that there was no lack of money or resources for Sudan”.\(^{118}\) Similarly, Jenny Tonge, the Liberal Democratic Development Spokeswomen stated that “Clare Short’s intervention has made the situation worse. It was the wrong time to spark up a debate on wider development law”.\(^{119}\) The Conservative Development Spokesperson, Gary Stricter went even further to state that Short was “prejudiced against private fundraising”.\(^{120}\) Most of the criticism for Short’s statement did not oppose her call for aid organisations to work towards a ceasefire, but rather her suggestion that more financial aid would not benefit the people of Sudan.

The reporting of this famine within the British media and the debates that surround Short’s criticisms of the response indicate that actors within the British aid industry were unsure what their role should be within the arena of political unrest in Sudan. Throughout the famine response, aid organisations continued to emphasise the need for material and food aid. A report within the *Independent* in May 1998 quoted the Deputy Director of UNICEF saying “unless other food supplies arrive in time, starving people will eat the seeds rather than planting them”.\(^{121}\) The *Independent* also quoted Mark Bowden, the Regional Director of Save the Children for East Africa, saying that “there is a lack of clarity. The media are getting into quite broad definitions of what is going on”.\(^{122}\) Bowden’s comment is representative of the reporting of the


\(^{118}\) BBC News ‘UK politics Short’s Sudan comments “baffle MPs”’, *BBC News* (07 August 1998).


\(^{120}\) Ibid., p.8.


famine as a whole. The debate about the correct way to respond to the Sudan famine, either through the delivery of material aid or the attempt to create a ceasefire, required a clear definition of the role of aid in a post-Cold War world. This definition was, for many British aid actors, still unclear.

The DEC decision, to launch a Sudan appeal, was similarly marked by this debate. On 3rd May, the *Independent on Sunday* clearly stated that the DEC decided against launching the emergency appeal. They framed this decision in two ways, on 3rd May saying that it was due to the lack of access for aid delivery, and on 7th May stating that it was because famine had not been declared but rather the crisis was termed a food shortage. Despite the DEC’s initial decision not to launch a Sudan appeal, Christian Aid, a member of the DEC, launched its independent appeal. In a statement from a Christian Aid spokesman, their position was clear: “Why wait till there is a famine? We want to do something now to prevent it from happening”. While these public statements suggest that the hesitation of the DEC to launch a Sudan appeal was due to a lack of knowledge of the scale of the crisis, the political dynamic of the famine may also have had an impact on this choice.

Suzanne Franks’ work offers another example of when the DEC debated the decision to launch an appeal. Using the 1982 civil war in El Salvador, Franks shows the unwillingness of the DEC to work within a civil conflict “on the grounds that it was not a natural but complicated, political and clearly manmade disaster”. Despite changes made in the DEC guidelines in 1983, which determined that the “DEC could in some circumstances support appeals for victims of ‘man-made’ disasters”, Franks highlighted the continued resistance to responding to disasters of a political nature. The political dynamic of the famine in 1998, as publicised through Short’s criticisms may, therefore, have added to the DEC’s reluctance to launch an

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123 Mark Bowden proceeded to hold multiple positions within the UN, such as the UN Resident and Humanitarian Coordinator and the Deputy Special Representative of the Secretary-General for Afghanistan in the United Nations Assistance Mission in Afghanistan.

124 Whitaker, ‘Only two weeks to head off famine’, p.19.


128 Ibid., p.108.
appeal. When the decision was finally made to launch a DEC appeal on 15<sup>th</sup> May 1997, the DEC distanced their appeal from the political dynamics within Sudan. Using the celebrity figure Martin Clunes, the DEC appeal made little reference to the civil war and instead emphasised the need for monetary donations to buy food, medical and material aid for the Sudanese people. Clunes’ appeal continued to present the famine as having a simple answer, the delivery of more aid.

While British NGOs opposed Short’s statements that criticised their fundraising, many of them supported her push for the recognition of the political nature of the famine. In October 1998 Oxfam, Save the Children UK, and MSF released a statement. It said:

> The current civil war is only the latest phase of ongoing conflicts over the past forty years. The war has caused millions of civilian deaths, massive displacement, the depopulation of the South of Sudan, the collapse of the rural economy, the collapse of local governance, increasing local instability and ethnic hostilities and the collapse of political accountability of the government and rebel movements of the Sudan to their citizens.

While each of these organisations had a varied political background, and different beliefs regarding the role NGOs should play in political crises, they came together to produce a Joint Statement to recognise the political causes of the famine. Alongside this public recognition of the political dynamics of the famine, some NGOs, such as Oxfam, demanded political action. In June 1998, in an Emergency Update from Oxfam, it stated that:

> Oxfam is calling for international pressure for a negotiated peace settlement. The only hope for a long-term solution is an end to the war between government forces in the north and rebel forces in the south. The aid agencies cannot bring this about. What’s needed is political action from the major international powers, including the United Kingdom.

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131 Oxfam, Oxfam Sudan Appeal.
This statement highlights Oxfam’s recognition of the need for a peace settlement, but also their belief that state actors should negotiate this. Similarly, an MSF report stated that “peace is the necessary pre-condition for a sustainable solution to the current level of human suffering in southern Sudan”.\footnote{MSF, Fighting Hinders Humanitarian Assistance (MSF, Geneva: 08 July 1998), Available: https://reliefweb.int/report/sudan/fighting-hinders-humanitarian-assistance [Accessed 01 June 2019].} Clare Short’s attempt to emphasise the political causes of the Sudan famine was part of a broader debate about the role of aid actors and appropriate aid responses to disasters, specifically famine.

The response to the Sudan famine and criticisms of airdrops demonstrates a sector-wide recognition within Britain of the need for long-term sustainability within aid programs and accountability for the actions of aid organisations. There was a clear agreement between British NGOs and DfID that the political dynamics of famine crises could not be ignored. Furthermore, the criticisms publicly voiced by Clare Short also demonstrate a shift within the British humanitarian sector regarding the role of the government, and specifically DfID’s critical reaction to the humanitarian response. As a donor within this response, there was a clear imbalance in power between DfID and the humanitarian organisations that competed for its funding. DfID during this response held organisations to account for how DfID money was being spent and therefore, as a critical donor, gained increasing power over the decisions made within the delivery of aid.

**Rethinking Famine**

A prominent voice within this conversation, which influenced DfID’s criticisms of the Sudan response, came from British academia. During the late 1980s and early 1990s, British academics began to re-conceptualise famine. The belief that humanitarian work (of which famine response was an important element) should be concerned with “the immediately present space of humanitarian crises to the exclusion of past and future” began to face criticism.\footnote{Walker and Maxwell, Shaping the Humanitarian World, p.53.} The changing conversation within academia reframed famine from being a natural event to an event that had political foundations. The reframing of famine within academia influenced government understandings
of appropriate famine responses. This was due to the close connections that DfID had built with think-tanks.

Experts in nutrition and food security, Daniel Maxwell and Nisar Majid traced the change in understandings of famine during the early 1990s, whereby scholars suggested that famines were “the result of intent, not just accident and that some groups in society actually profit from famine”.134 This challenged the widely accepted Malthusian view (that had a strong influence over British famine response) in its claim that famine was not caused naturally by a lack of food as a population grew but rather was the result of an active choice to deprive people of food. Conversations about the causes of famine were prompted by the work of Amartya Sen in the 1980s.135 Sen’s work reassessed the Malthusian view of famine and determined that “famine was not a question of food supply—a purely technical concept, but of food ownership—a question that is socially constituted”.136 Sen argued that “starvation [was] a function of entitlements and not food availability”.137 Through his recognition that famine may be caused by more than a lack of resources, Sen re-politicised the notion of famine. Development scholar Paul Howe, writing in 2002, argued that Sen’s work influenced how famine was perceived, moving it from an “essentially ‘natural’, [to a] predominately ‘political’ phenomenon”.138 The debate surrounding the nature of famine sat within the wider recognition of, and use of the term, “complex emergencies”.139 Following Sen’s work, academics began to question old understandings of famine, as an economic challenge, and instead began to understand it to be a multi-faceted crisis.

For these academics, famine was no longer an inevitable feature of a growing population. Stephen Devereux and Paul Howe, scholars of the Institute of Development Studies, and Luka Biong Deng argued that “every famine that

135 Amartya Sen is a Professor of Economics and Philosophy at Harvard University and has also held the position of Honorary President of Oxfam. Amartya Sen, *Poverty and Famines: An Essay on Entitlement and Deprivation* (Oxford University Press, Oxford: 1982).
139 Duffield, ‘Complex Emergencies’.
occurs in our globalising world represents either a catastrophic failure or a malevolent exercise of political will”. Similarly, writing in 2000, Devereux problematised the humanitarian aid system, highlighting competing narratives within the sector. He wrote:

One views famine as a natural disaster or economic crises…, the second views famine as a political pathology which should be analysed in terms of local power struggles, state repression of afflicted population groups… and a refusal by the international humanitarian community to enforce the fundamental human right to food.

During this period understandings of famine moved from being seen as an “event” or “that ‘moment’ when a group’s normal access to food so completely collapses that mass starvation occurs” to a complex socio-political process which no longer demanded a quick-fix but a long-term response.

The progression of the understanding of famine during this period is particularly striking when comparing this understanding with a report produced after the 1985 Ethiopian famine. This report stated that the “relief community seeks to be judged on the technocratic standard of its efficiency in delivering emergency supplies, not its role as a social engineer”. The recognition of the socio-political causes of famine challenged the assumption that famine relief does not have a role as “a social engineer”. Famine, in the 1990s, began to be seen as, as Sen had described, a socially constituted phenomenon which required a multifaceted response. Short’s attempt to engage politically with the Sudan famine in 1998, therefore, sat parallel to contemporary academic debates. These debates questioned the role of humanitarian relief and sat within an environment in which development was being pushed to the forefront of British responses by DfID.

143 Ibid., p.51.
144 Ibid., p.51.
The influence of academic discussions upon government thinking was a result of DfID’s connections with academia. Three academics became prominent voices in debates about famine and famine response during this period: Stephen Devereux, Paul Howe and Luka Biong Deng. These writers published separately on the subject of famine and also published work together. Each of these scholars’ work was published by the Institute of Development Studies. This institute had strong links with DfID, indicating that the academic challenges that these authors were posing to famine response would have travelled further than the academic circles in which they were generated. DfID’s annual report from 1998/99, stated that DfID would focus on “working more closely with the private and voluntary sectors, and the research community”. This research community appears to include IDS through which these academics were publishing their work. In a history of IDS written for its 40th anniversary, Richard Jolly wrote that “for years the IDS bulletin has been routinely circulated within DfID” and that “DfID’s support for development research has grown and broadened, to the point where development thinking and research in the UK is probably stronger than in any other developed country”. While the role of IDS in DfID’s decision-making may be over-emphasised by Jolly in his celebratory piece, it is clear that there is a relationship of information sharing between both DfID and IDS and other research tanks within Britain. This collaboration gives some indication of the movement towards a development-focused famine response within both academia and DfID.

The debate about the role and modes of famine response was also a central theme in a 1999 special issue of Disasters, which focused on the role of Public Nutrition in famine response. This journal issue, based on a workshop in June 1999, promoted the introduction of what its authors termed Public Nutrition within humanitarian responses. The authors of this issue argued that Public Nutrition “contrasts with clinical nutrition, which focuses on individuals”, but instead accesses populations and the “dynamic processes that proceed [the]
end-stage, or wider health risk factors that contribute to famine mortality”.147 Anuradha Harinarayan, in a workshop summary, explained that “Public Nutrition recognises that food insecurity is only one of the determinants of malnutrition in emergencies, and interventions need to address both the health and social environment to have an impact on malnutrition”.148 This workshop built upon new understandings of famine and determined that famine response needed to go beyond simply the delivery of food aid. While the term Public Nutrition does not seem to have a significant presence within humanitarian rhetoric, the existence of it as the theme of the special issue of Disasters highlights its role within debates about famine response, and nutrition during this period.149 The call for a Public Nutrition-led response signifies the demand for a change within famine response that would engage with the broader long-term implications of famine. These demands speak to the debates taking place within the British government and within British NGOs.

The changing perceptions of famine, seen within academia, humanitarian evaluations and the British government led to changes in the modes of famine response; however, while these debates took place in the 1980s, they did not impact famine response policies until the early 2000s. During 1998, British humanitarian actors who responded to the famine in Sudan conceptualised the emergency as a shortage of food and thus used policies that responded to the immediate material and food needs. The continued narrow perception of famine also influenced the early warning systems used in 1998. Early warning systems were created in the 1980s and 1990s, to track both economic patterns and levels of production to pre-empt a food shortage and thus respond before a famine began. In 1998, these systems framed the crisis in Sudan as a short-

term issue of food security as the result of a failure of the economic systems of Sudan. The inability of these early warning systems to recognise potential socio-political causes of famine led to the slow recognition of the severity of the food crisis in Sudan in 1998. Xavier Crombé highlighted the same issue during the 2005 famine in Niger. He argued that the narrow indicators of early warning systems failed to recognise the famine. Despite changing perceptions of famine within academia and the government, early warning systems, in 1998, had not yet adapted to this new understanding of famine and the new recognition of the multiplicity of famine causes.

Clare Short’s call for the need for a political response did not take place in a vacuum. Rather, these criticisms were part of a broader evolution in understandings of famine causation. The close relationship that DfID attempted to build with British think-tanks ensured that new perceptions of famine were carried across into their understanding, thus bridging the gap between academia and policy decisions. Within these discussions, academics began to call for a change in famine response, such as the inclusion of nutritionists within famine responses. Increasingly they called for sustainable responses that targeted the broader causes, and longer-term implications, of famine. Within medical aid specifically, they highlighted the need for aid to target the socio-political causes of malnutrition. Despite these discussions, their impact on policies for famine response did not happen immediately.

**An Evolving Medical Response**

An examination of feeding centres set up during the 1998 famine highlights a gap between the discussions that were taking place within academia and government, which championed long-term aid responses to famine, and

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151 Today the term famine is used only when a food shortage has reached a threshold set out by the Integrated Food Security Phase Classification. This classification system was designed in 2004 and was publically released in 2006, with an updated version having been published in 2012. This system outlines the different phases a food security crisis goes through before reaching the highest phase of a famine. See: IPC Global Partners, *Integrated Food Security Phase Classification: Technical Manual 1.1* (The Food and Agriculture Organisation of the United Nations: 2008), Available: http://www.fao.org/3/i0275e/i0275e.pdf [Accessed 20 August 2019].
153 Ibid.
organisational policies, which instructed the way that medical aid was delivered. Therapeutic Feeding Centres used during the Sudan famine focused on the delivery of short-term aid and were not created to manage long-term socio-political factors that may affect famine victims. It was only in the early 2000s that policies directing the delivery of aid to famine victims began to recognise and respond to the socio-political causes of famine. These changes were a step towards the demedicalisation of famine response.\textsuperscript{154} Peter Conrad, who has written extensively about demedicalisation, described it as “a problem that no longer retains its medical definition”.\textsuperscript{155} He wrote that demedicalisation occurs when “a problem is no longer defined in medical terms, and medical treatments are no longer deemed to be appropriate solutions”.\textsuperscript{156} Regarding famine response, therefore, demedicalisation is the process through which those suffering from famine are no longer treated as patients, their interaction with medical staff is diminished, and their malnutrition is no longer seen through a medical lens. After the Sudan famine, new methods of delivering aid to recipients began a process of demedicalisation insofar as it moved famine treatment away from centralised medical institutions and into the community.

During the Sudan famine, as discussed earlier, the predominant treatment for severe malnutrition was Therapeutic Feeding Centres. TFCs, like those run by Merlin, served large populations. MSF Holland, for example, set up TFCs in the Bahr el Ghazal region in the areas of Wau, with a population of 150,000 and in the villages of Panthou, Ajak and Terialiet which had a combined population of 5000-10,000 people.\textsuperscript{157} Steve Collins and Tanya Khara wrote that to run a TFC effectively one should follow “the high-quality manuals that agencies such as MSF…have produced”.\textsuperscript{158} Despite the good individual care

\begin{flushleft}
\textsuperscript{155} Conrad, ‘Medicalization and Social Control’, p.224.
\textsuperscript{156} Ibid., p.224.
\textsuperscript{157} Andre Griekspoor and Steve Collins, ‘Raising standards in emergency relief: how useful are Sphere minimum standards for humanitarian assistance?’, \textit{BMJ}, 323(7315), (2001).
\end{flushleft}
provided in Therapeutic Feeding Centres, they began to face criticism in the early 2000s.

During the Sudan famine, one of the major criticisms placed on TFCs was their restricted coverage. People would have to travel many miles, often to arrive at a centre that was over-run with patients and ill-equipped for such numbers. The collection of people in one area was problematic. Medical doctor Steve Collins has spoken openly about his experience in Liberia, in which the feeding centre became the epicentre of a cholera outbreak. Collins wrote that “despite clear progress at the individual level, TFCs have achieved little improvement in the population-level impacts of nutrition interventions, and every year acute food insecurity and famine still kills thousands of children and adults”. Writing in 2004, Collins’ statement makes it clear that the stories of individuals who were treated in these TFCs were not a strong enough indicator of their success. In a humanitarian environment, where success is measured by the numbers of people helped and the impartiality of aid actors when doing so, the failure to reach all communities was a significant problem. Collins, reflecting the debates taking place within Britain, argued that there was a need to treat famine as a public health issue, rather than a medical, clinical problem. Academic Tom Scott-Smith noted that there was a “broader trend in the world of relief, towards the assessment of interventions according to biological efficiency and their impact on the population”, the challenges posed to TFCs reflects this. The TFCs, which focused on the treatment of individual patients, fell short when effective treatment was quantified in terms of numbers treated.

Therapeutic Feeding Centres provided a short-term treatment and failed to have an impact on the long-term causes of malnourishment. Collins highlighted that TFCs require a “large number of highly qualified – often

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160 Steve Collins was instrumental in the creation of community-based treatment of severe acute malnourished patients. This offered an alternative treatment plan to the traditional TFC system; Collins, ‘Changing the way we address famine’, p.498.
expatriate-staff and entail large-scale external resources”. Not only was this expensive but required a large amount of external help. Similarly, when children stayed in a TFC, it was expected that a parent or guardian would stay with them. This led to the removal of a patient and their guardian from the community for approximately 30 days and often negatively impacted the community and individual family units. In many cases, parents were unable to remain with their child due to other responsibilities at home. In Sudan therefore, it was reported that “the numbers of individual children without families who presented themselves to supplementary and therapeutic centres led to problems about the responsibility of the agencies for orphans after successful treatment.”

The use of the word “orphans” within this report is problematic. The demand for a parent or guardian to stay with a child may not have always been possible, and therefore, the treatment of all unaccompanied children as orphans is inaccurate. A report investigating alternatives to TFCs, written in 2004, highlighted that Tearfund “had been questioning the effectiveness of the traditional, centralised Therapeutic Feeding Centre” in part due to the “length of time mothers spent in centres, and the long-term dependency impact on the community”. These centres did not work within communities but were distinct from them. They were dependant on international organisations and funding and did not provide a sustainable answer to the challenge of protracted famines.

NGOs used TFCs within emergency settings as an immediate answer to children suffering from severe malnutrition; however, they were not designed to provide long-term care. The shifting perception of famine as requiring a long-term, widespread response, brought to light the failures of the TFC system, and it is from these perceived failures within Sudan that new treatments of severe malnutrition within communities were developed. Collins wrote that “during the South Sudan famine in 1998, the TFC model clearly could not deliver substantial population support”, and that it was this

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163 Collins, ‘Community-based Therapeutic Care’, p.3.
164 Collins, ‘Changing the way we address famine’, p.499.
165 ETC, Disasters Emergency Committee: Sudan Crisis Appeal, p.29.
that led him first to formulate what he termed Community Therapeutic Care. 167

Community Therapeutic Care, today called Community-based Management of Acute Malnutrition (CMAM), was seen as a new way to “treat people in a resource-scarce environment”. 168 This new response to famine allowed communities to “maintain their livelihoods” and was a movement “towards more sustainable programmes implemented by local health workers”. 169 The main aim of this new method of treating severe malnutrition “took therapeutic treatments out of the clinic and into the community”. 170 Collins took inspiration for these community-based methods of care from a development model of Hearth Groups, an idea coined by Save the Children in the 1970s. 171 The approach taken from the Hearth model was to provide mothers with the means to treat severe malnutrition at home (at the hearth), thus enabling them to remain within the community. The Hearth model uses mothers within the community to “educate other mothers and treat malnourished children in their own villages”. 172 This model, therefore, was situated within the community, and its sustainability was not dependent upon expatriate staff. 173

This new model became possible through the development of ready-to-use therapeutic food (RUTF), one example being the product Plumpy-nut. 174 Plumpy-nut, a peanut-based food substitute high in nutrients and protein, was developed in the late 1990s by French paediatric nutritionist André Briend and began to be used as a comprehensive treatment from severe malnutrition in the early 2000s. 175 Plumpy-nut and other therapeutic foods developed during this period were created to replace the traditional dry powdered substances used to treat malnutrition. These dry substances, often in the form

168 DfID, Promoting innovation and evidence, p.20; Collins, ‘Community-based Therapeutic Care’, p.8.
169 DfID, Promoting innovation and evidence, p.8.
172 Collins, ‘Changing the way we address famine’, p.499.
173 Ibid., p.500.
175 Scott-Smith, ‘The Fetishism of Humanitarian Objects’.
of powdered milk, required access to clean water and a trained hand to measure out the quantities of nutrient-based powders. RUTF, however, was a pre-made treatment for malnutrition in the form of a paste that could easily be administered by mothers without the need for clean water or measuring techniques. Despite its ability to be administered by a patient’s carer within their homes, Plumpy-nut was still presented as a medical treatment and was governed by medical policy. Scott-Smith highlighted that, when it was developed, the New York Times “described it as ‘an immunisation’ against malnutrition”. Patients were no longer required to stay in the Feeding Centres for long periods, and it was said to minimise the “alienation, disempowerment and undermining of community spirit often associated with externally-driven interventions”. Patients were able to take their treatment home, and local health workers and volunteers could be trained to distribute the Plumpy-nut. The practice of Community Therapeutic Care, using RUFTs, moved away from the short-term delivery of aid by external actors and towards a long-term response to malnutrition using development practices.

There have been several critiques about Plumpy-nut and the fetishisation of it, and other humanitarian objects. Humanitarian organisations promoted Plumpy-nut and the MUAC band as the best examples of “technological fixes” in the 2000s. Despite the movement towards CTC, it was the simple and uncomplicated product of Plumpy-nut that was promoted. Scott-Smith critiqued what he believed was the “fetishism” of Plumpy-nut and argued that it was “no substitute for concerted political action”.

However, critiques of these technological fixes and their reception by NGOs risk oversimplifying the practices in which these technologies are situated. For example, in arguing that Plumpy-nut was not a satisfactory replacement

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177 Ibid., p.918.
179 Scott-Smith, ‘The Fetishism of Humanitarian Objects’.
for TFCs and that it had become an “increasingly indispensable and inflexible approach to relief”, Scott-Smith ascribed it too much power and failed to recognise its role within a broader community-based response.\textsuperscript{182} In an interview, Steve Collins explained that the use of RUTFs worked alongside TFCs.\textsuperscript{183} He indicated that Plumpy-nut alone would not create a successful response, without the work of community support workers and highly trained anthropologists.\textsuperscript{184} Similarly, Scott-Smith failed to recognise that, alongside the development of CTC and the use of Plumpy-nut, TFCs remained open for those patients that had other medical problems or medical complications that may have developed once they began to gain weight.\textsuperscript{185} Rhetoric, such as that of the \textit{New York Times}, which promoted Plumpy-nut as a fix for famine victims, appears to have influenced Scott-Smith’s perception of Plumpy-nut. While he described the “fetishisation” of the product, humanitarian workers continued to use existing fortified powdered milk in conjunction with Plumpy-nut. Humanitarian practitioners did not perceive it as the “immunisation” against famine as Scott-Smith’s work suggested.\textsuperscript{186}

While not being a ‘magic bullet’ for famine response, the creation of Plumpy-nut enabled the creation of CTC.\textsuperscript{187} Plumpy-nut, as part of the CTC management of malnutrition enabled famine responses to target a larger number of recipients, be less dependent on international organisations and work alongside local healthcare systems to help rebuild trust between communities and their local healthcare facilities. Collins, in an interview with the \textit{Independent}, argued that “the treatment of severe malnutrition has been over-medicalised”.\textsuperscript{188} The development of CTC programmes provided an alternative to the intensive short-term medicalised Therapeutic Feeding Centres, and towards a famine treatment that could target larger numbers,

\begin{footnotesize}
\begin{enumerate}
\item Steve Collins, Interview by Jennifer Chapman, Personal Interview, via Skype, (09 January 2017).
\item Ibid.
\item Young, et al. ‘Public nutrition in complex emergencies’, p.1904.
\item Scott-Smith, ‘The Fetishism of Humanitarian Objects’, p.918.
\item Plumpy-nut was only given to patients without other medical conditions, and who were able to swallow solid foods.
\end{enumerate}
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worked within communities and wasn’t reliant on the influx of international medical staff seen within an emergency.

An investigation into the funding of research on CTC demonstrates a connection between humanitarian policies and the changing understanding of famine within Britain during this period. Alongside the knowledge-sharing relationship between DfID and IDS previously highlighted, one can see DfID working with the Overseas Development Institute. DfID’s Annual Report from the year 2000 stated that they were developing a “multi-year integrated programme of research, advisory and dissemination work of the ODI Humanitarian Policy Group”, which would address “the emerging humanitarian policy agenda and the critical link between policymakers and field practitioners”. That Collins himself also published and presented his research about CTCs through ODI highlights the importance of the relationship between ODI and DfID in enabling the dissemination of practice-related thinking. Collins highlighted that, despite gaining initial funding for research from Irish Aid, gaining funding and support from DfID was initially problematic. He stated that Britain took advice from the WHO and that the WHO was reluctant to move away from its tradition of clinical response during famine. British interest in this method, however, began in 2003, when DfID funded a trial of CTC in Bahr el Ghazal. This may be due to DfID’s commitment to “innovative projects”, or perhaps due to the use of developmental methods such as Hearth groups, within CTC programming. The example of the move towards CTC response directly highlights the relationship between humanitarian work in the field and discussions within government policy and academia.

189 The link between DfID and think-tanks is further strengthened by the careers of people such as Joanna Macrae, who worked in both ODI and then DfID. DfID, Annual Report 2000, p.87.
191 Steve Collins, Interview by Chapman.
192 The WHO and the UN officially endorsed the use of CTC in 2007. Steve Collins, Interview by Chapman; Collins, ‘Community-based Therapeutic Care’.
193 Khara and Collins, ‘Community-based Therapeutic Care’, p.29.
The use of Community-based Therapeutic Care moved away from the medicalisation of famine response, which prioritised the care of individual patients within a clinic. CTC responded to severe malnutrition as a public health issue that should, where possible, be treated within the community. Writing in 2004, academic Peter Salama stated that “because of the close interaction between malnutrition and communicable disease, food-based interventions must be accompanied by public health interventions”. The development of CTC after the 1998 Sudan famine highlighted the movement towards a developmental approach to the treatment of famine. An investigation of the funding behind the research into the CTC model demonstrates that its use of developmental models made it attractive to DfID and their growing focus on innovation.

Conclusion

In conclusion, the Sudan famine sat at a point of fluctuation both within international politics after the Cold War and within British aid after the election of a New Labour government. This chapter has argued that a significant outcome of these changes was the recognition of the complex nature of emergencies. This chapter has demonstrated a shift in understanding away from the Malthusian concept of famine towards an understanding influenced by Sen within British academia. Famine was no longer perceived, by academics, as just a food shortage but rather, part of a web of broad socio-political factors of which lack of access to food was the result. This chapter has traced the development of these understandings within academia, and by demonstrating the relationship between British academia and DfID, has highlighted their impact on perceptions of famine response. Clare Short personified these perceptions through her public criticisms of the 1998 famine response in Sudan. Short argued that the delivery of food via airdrops, which focused only on filling a gap in food availability, was unacceptable. DfID and British NGOs began to recognise the need for responses that would view famine as a long-term crisis and would respond accordingly. This call for a new response led to funding which was used to publish research by Steve

Collins and his team who developed Community Therapeutic Care. CTC enabled children suffering from malnutrition to be treated at home. This movement, away from traditional Therapeutic Feeding Centres, moved these patients away from the heavily medicalised centres. Rather, the demedicalisation of famine response enabled communities to be less reliant on international staff, ensured that a wider population could be targeted, and rebuilt relationships between communities and their local health care centres.

By tracing the impact of government debates within medical policy decisions on the ground, this chapter has showcased the networks and relationships between multiple actors that make up the British humanitarian sector. It has particularly focused on the role of British academia and think-tanks and their influence within the process of decision-making within the medical humanitarian sector. This chapter has also demonstrated, however, the important role of the newly created DfID in building and strengthening these networks. It has highlighted DfID’s focus on international development aid and its power within the government that led to a promotion of aid within the government agenda. The following chapter will build upon this story by exploring the further growth in power of DfID over the humanitarian sector.

We have seen the ability of individuals within DfID to critique humanitarian response and to fund research into new policies; the following chapter will examine the development of this as DfID began to actively use medical humanitarian aid as a tool for peacebuilding and state-building within Kosovo after the NATO bombing.
Chapter Three: Medicine as a tool for peacebuilding and state-building: The Humanitarian Intervention of Kosovo, 1999

Introduction

On 24th March 1999 the British and US military, on behalf of the North Atlantic Treaty Organization, began an air campaign against the Federal Republic of Yugoslavia. The British Defence Minister, George Robertson, stated that this bombing aimed to “lessen the degree of violence towards civilians in Kosovo”. This violence primarily targeted the ethnic Albanian population, which made up 90% of the 2 million people living in Kosovo in 1990. The British government presented its decision to intervene in Kosovo, as part of NATO, as a humanitarian intervention. They argued that in light of failed peace talks between the government of Slobodan Milosevic and the Kosovo Liberation Army (KLA), and the continued reports of human rights abuses against the Albanian population within Kosovo, physical intervention by NATO forces was the answer to stop the violence. The bombing by NATO forces led 800,000 civilians to flee Kosovo; the flight of these civilians, in addition to those who had left due to the human rights abuses before the intervention, led to a humanitarian crisis in the neighbouring countries on a scale that had not been anticipated by humanitarian organisations or NATO governments. The British relief response to this refugee crisis saw the convergence of actors from DfID, the British military and British NGOs and raised the questions of who is a legitimate humanitarian actor and what activities fall under the umbrella of humanitarian aid.

The actions of NATO have been widely discussed throughout different academic fields, as scholars question their legality and the implications of this

intervention for ideas of sovereignty and human rights. Professors of European politics and international relations respectively, Mary Buckley and Sally Cummings, determined the Kosovo crisis to have been “the most important development in international relations at the close of the twentieth century”. Similarly, scholars Peter Salama, Bruce Laurence and Monica L. Nolan highlighted the perception within academia that the NATO intervention “set an important precedent: human rights were given priority over the rights of a particular state, a challenge to the notion of the absolute inviolability of state sovereignty”. Another line of scholarship has investigated the position of Kosovo in the political ideology of the government under Blair, particularly his moralistic focus. As highlighted in the previous chapter, Blair’s government emphasised their moral responsibility to both British and international populations. Scholars have described Blair’s foreign policy decisions during this period as “ethical foreign policy”. Dan Bulley, a scholar of international politics, for example, argued that the Kosovo intervention was “a relatively clear-cut expression of Britain’s ethical foreign policy: the international community protecting citizens of a state from human rights abuses”. Similarly, David Chandler argued that “an important motivation for British high-profile involvement in Kosovo lay in the unsullied cause of the victims of Milosevic’s Serb regime”. Chandler argued the government used the intervention to promote Blair as a moral authority through international responses.

8 Daniel Gorman wrote that during the 1920s within Britain there was a “growing conviction amongst liberal imperialists… that it was permissible to intervene in sovereign affairs of other states or colonies on moral grounds”. This suggests again, that Blair’s emphasis on the language of ‘moral authority’, used to promote British intervention in Kosovo, was in part an exercise in rebranding imperial ideas. Gorman, ‘Empire, Internationalism, and the Campaign against the Traffic in Women and Children in the 1920s’, p. 216.  
Within humanitarian studies, the Kosovo intervention raised questions about the role of different actors within the humanitarian response. Thomas Weiss, a scholar of international relations and global governance, investigated Kosovo’s significance concerning the role of the military within humanitarian settings. Others have used the humanitarian response within Kosovo as a base upon which to discuss peacebuilding within humanitarian settings. Much of the literature surrounding the events within Kosovo, including the examples mentioned above, was written closely after the bombing, as scholars grappled with the impact and significance of this event.

The Kosovo intervention sat within a wider re-thinking of humanitarianism that took place within Britain during the late 1990s and early 2000s. The previous chapter has demonstrated the increasing demand from the government, academics and policymakers for a humanitarian response that reflected the complex nature of emergencies and recognised the long-term impact of aid. The need for developmental relief, or what Fiona Fox has termed ‘goal-oriented’ humanitarianism, was a central theme of debates within Britain around New Humanitarianism. New Humanitarianism was a school of thought that questioned the humanitarian principles, perceiving them to be “politically naïve”. It argued that the humanitarian principles were no longer appropriate in the post-Cold War world, where the distinction between civilians and military actors had become blurred. Particularly under threat was the principle of neutrality, understood by humanitarian practitioners as “not taking a political position in relation to the conflict”. Fiona Fox, who explored the debates surrounding this concept demonstrated that advocates of New Humanitarianism believed that the promotion of human rights should have priority over access to recipients and that NGOs should no longer turn a blind eye to human rights abuses to maintain their

16 Ibid., p.275.
neutrality.\textsuperscript{18} Instead, New Humanitarianism called for NGOs to engage within the political dynamics of a humanitarian crisis. Critics, however, argued that rejection of humanitarian principles, created to distinguish humanitarian organisations for other actors, would lead to the loss of humanitarian space. Within Kosovo, the humanitarian space was occupied by both humanitarian actors and the military.

These debates surrounding New Humanitarianism are relevant to the medical humanitarian response within Kosovo as NGOs, working alongside military actors, had to determine their role against that of the military. Advancing the previous chapter, this chapter will explore the progression of DfID’s view of medical humanitarian aid, as a mechanism for the delivery of relief that should be aligned with development aid, to a tool that can actively be used to support peacebuilding and state-building projects. This chapter will argue that the British government actively used medical humanitarian aid as a tool, both to promote their role in Kosovo and as a tool for peacebuilding and state-building. The Kosovo crisis demanded British organisations decide their view of New Humanitarianism and the humanitarian principles, as they worked alongside the British military.\textsuperscript{19}

This chapter will first examine the role of the British army within the initial humanitarian response both in countries that received refugees from Kosovo and within Kosovo itself. The humanitarian needs after the bombing proved a much larger task for the international community than was initially anticipated.\textsuperscript{20} This lack of anticipation enabled the British military force to play a significant role within the humanitarian response, as they were able to mobilise much faster than the UNHCR and British humanitarian organisations to deliver aid. This chapter will demonstrate how the British government, after the bombing, used the delivery of medical aid by the military to promote the British image within Kosovo and internationally. Within the Kosovo response, one can see the influence of New Humanitarian

\textsuperscript{18} Fox, ‘New Humanitarianism’, p.278
ideals as humanitarian workers began to do more than simply deliver aid. Utilising medical research carried out after the bombing campaign, this chapter will then proceed to examine the role of medicine within peace-building attempts. Finally, this chapter will investigate the British government’s use of medicine within their state-building projects. It will investigate the role of humanitarian actors in the rebuilding of the Kosovo healthcare system.21 Writing in 2001, Mark Duffield wrote that “NATO’s humanitarian ‘intervention’ in Kosovo… marks the collapse of the divide between humanitarians and politics”.22 This chapter will investigate how humanitarian aid, specifically medical humanitarian aid, enabled the British government to have an active role within this response; both in the delivery of humanitarian aid and within the state-building agenda.

The Kosovo Crisis

The bombing of Kosovo, after failed peace talks and escalating violence within the country, led to a level of human need beyond expectations of humanitarian responders. An aspect of the humanitarian crisis that was a particular shock for NGOs was the number of refugees that fled into neighbouring countries. This lack of preparation by NGOs and UN organisations resulted in a gap within the humanitarian response that was filled by NATO forces. The delivery of aid by an active member of the conflict led to a politicisation of aid within the refugee camps surrounding Kosovo. Despite the implications that came with military personnel delivering aid, the British government publicly promoted the presence of the military within the aid efforts in response to public criticisms of the bombing and to reinforce the presentation of their presence in Kosovo as a humanitarian intervention.

The intervention by NATO forces aimed to provide a resolution to violent political and ethnic divisions within the country between the Albanian

Kosovar population and the Serbian population. Historian Stephan Schwartz has shown how the death of Josip Broz Tito in 1980 and the break-up of Yugoslavia acted as a catalyst to the violence seen between these groups in the 1980s. The instability that followed Tito’s death led to war within the federation and was a precursor to the independence of Croatia and Slovenia in the early 1990s. In 1987 Serbian Slobodan Milosevic gained power over Serbia, and held de facto power over Kosovo. During his time as Yugoslav President, mirroring events in Croatia and Slovenia, a civil war began, and the Albanian Kosovar population attempted to gain independence. The political divide defined by ethnicity between the Albanian and Serbian communities, was exacerbated during the 1990s by Serbian forces who “dismissed all Albanian political institutions in Kosovo”, shut down the Albanian newspaper *Rilindja*, and “restricted the use of the Albanian language” in schools and the University of Pristina. In September 1991 the outlawed Kosovo Assembly held a referendum which voted in favour of independence. This referendum placed the Democratic League of Kosovo and its leader, Ibrahim Rugova, in power. Milosevic however, did not recognise the results of the referendum and the divisions between these ethnic groups became more pronounced. For example, following the referendum, many Albanian professionals, such as police, judges, doctors, civil servants and doctors were removed from their positions by the Serbian government. Despite the restrictions placed upon the Albanian population by Serbian forces, Rugova aimed to respond peacefully, believing that the international community would recognise the referendum and by extension, Kosovo’s independence. The Dayton Agreement in 1995, however, failed to recognise Kosovo as autonomous and recognised Milosevic as an interlocutor with the
international community. This led to a violent response from members of the Albanian community, as they resisted Serbian control, and to the creation of the Kosovo Liberation Army. The KLA demanded not only autonomy but complete independence. They initially carried out small-scale guerrilla attacks upon the Serbian police force within Kosovo; however, as their numbers grew, the KLA turned to and was met with increasing levels of violence. Attempts to break up the pro-independence movement became fierce.

As the violence increased, so too did international awareness. This awareness triggered the beginning of an international response through sanctions. In late 1998, Milosevic ordered a “massive military offensive against the KLA”, which resulted in initial threats from the UN of a ‘stern response’ by NATO if the violence against the Albanian population within Kosovo did not stop. The UN attempted to gain a peaceful settlement in February 1999 through the Rambouillet Peace Agreement. Representatives from both sides of the conflict attended this meeting; however, they were unable to agree on conditions for a peace settlement. Diplomatic efforts appeared to be having little impact on the violence and forced displacement taking place within Kosovo and, despite warnings in March 1999 of airstrikes by the US envoy, Milosevic continued to resist an internationally negotiated peace deal.

NATO commanders believed that a bombing campaign would end the human right abuses reportedly taking place within Kosovo; however, the airstrike exacerbated violence against the Albanian community and led to the forced migration of an estimated 1.5 million people. The plans for a potential

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28 The Dayton Agreement was signed after a peace conference attended by Milosevic, the President of Bosnia and Hercegovina and the President of Croatia. Also in attendance were international representatives such as those from the US, the EU, the UK and Russia. This peace agreement marked the end of the civil war between Bosnia and Hercegovina. British Prime Minister John Major witnessed its signing.


30 Booth, ‘NATOs republic’, p.89.


32 Ibid., p.178.

33 Ibid., p.180.

intervention were first discussed within the British House of Commons on 14th January, the day before a massacre in the village of Racak in which Serb forces killed an estimated 40 Albanian Kosovars. In the shadows of Rwanda and Srebrenica, this ethnically motivated attack against seemingly innocent civilians, triggered an emotive response within the UN and members of NATO (many of whom faced criticism for their insufficient response in Rwanda). NATO, after three months of deliberation and after waiting for a peace agreement that never came, acted without a UN mandate and launched an airstrike against the Federal Republic of Yugoslavia. This attack, against a sovereign country, was later deemed by the UN to be illegal but legitimate. The bombing began on 24th March 1999 and, though predicted to be a short-term response, continued until 10th June 1999. The air attack proceeded to “accelerate [Milosevic’s] campaign of systematic terror and forced migration” against the Albanian population. By the end of May 1999, estimates suggested that 1.5 million people, roughly 90% of the Kosovo population, had been displaced both inside Kosovo and within its neighbouring countries. By the time that the NATO bombing campaign ended in June, an estimated 200,000 people had been displaced within Kosovo. An additional 800,000 people are estimated to have fled Kosovo: 460,000 travelled to Albania, 250,000 to the Republic of Macedonia and 70,000 to Montenegro. This mass movement resulted in huge demand for humanitarian aid, in the form of shelter, food, water and medical assistance.

NATO’s airstrikes resulted in a large international humanitarian response which first began in Kosovo’s surrounding countries and then, following the bombing, within Kosovo itself. Duffield wrote that humanitarian interventions “result [in the] blurring of the civilian/ military interface”.

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36 Buckley and Cummings, Kosovo, p.2.
39 Harvard University and NATO Joint Analysis and Lessons Learned Centre, The Kosovo Case Study, p.4.
40 Ibid.
Within the humanitarian response that followed the Kosovo intervention, one can see the blurring of the role of the NATO military forces and NGOs in the delivery of aid, as they jostled to play a role within Kosovo and the surrounding refugee camps.

NATO’s humanitarian intervention in Kosovo took place amidst debates around New Humanitarianism and the importance of the humanitarian principles. While there was resistance to, and fear of the implications of, New Humanitarianism during the late 1990s and early 2000s, DfID was a strong and influential advocate for it.\(^{43}\) Supporters of New Humanitarianism called for the merging of humanitarian aid and development aid; as highlighted in the previous chapter, Clare Short was a strong supporter of this. Subscribers of New Humanitarianism, recognising the delivery of humanitarian aid as a political action, also called for it to be used as a tool within peacebuilding activities. James Fennell, in a paper presented at a conference run by the Disasters Emergency Committee in 1998, argued that “agencies and donors alike have downgraded the humanitarian imperative in favour of conditional assistance linked to peacebuilding processes”.\(^{44}\) Duffield writing in 2001 also determined, “The New Humanitarianism… implies a drive for coherence where humanitarian action become[s] part of a comprehensive political strategy”.\(^{45}\) The bombing of Kosovo was justified by the British government as a humanitarian intervention insofar as it was intended to stop the intentional targeting of civilians within the conflict and to prevent a humanitarian crisis. DfID’s support of New Humanitarianism led aid further into the political sphere as part of Britain’s political strategy.

**The Humanitarian Response**

The humanitarian response during and after the NATO intervention had two parts: the response within the refugee camps in neighbouring countries and the humanitarian response in Kosovo. Within the refugee camps, there was a notable blurring of the role of the military and humanitarian organisations. As

\(^{43}\) Macrae, ‘The Death of Humanitarianism?’.


the first responders, the army went beyond the provision of logistical and security support, delivering humanitarian aid such as shelter and food. They also played an active role in attempts to create a peace agreement that, in the words of one British commander, “involved humanitarian operations on the one hand, but also the preparations for force entry into Kosovo on the other”. In the context of British domestic criticism of the Kosovo bombing, targeting both its rationale and its methods, the positive associations between the military and the relief effort were beneficial to the government’s efforts to present the operation in a positive light.

The first stage of the humanitarian response focused on providing aid to refugees who had fled into neighbouring countries. The UNHCR, in charge of coordinating the relief efforts, quickly realised that their aid preparations were inadequate for the scale of need and the number of refugees. As the bombing campaign began, the number of refugees grew. Estimates suggest that the Republic of Macedonia received between 250,000-350,000 refugees. On 3rd April, the overwhelmed UNHCR officially accepted an offer from NATO of support within the humanitarian relief operations. This support came in the form of military personnel from the NATO countries that made up the Kosovo Force (KFOR). The scale of the emergency thus resulted in military actors supporting the humanitarian response.

While the UNHCR had accepted help from the KFOR forces, recipient countries of refugees also had to accept their support. During the first week of April, the British army, as part of KFOR, arrived in Blace, Macedonia, where large numbers of refugees were gathering, and their humanitarian needs were overwhelming the government. In what the British Army termed

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47 Ibid., p. 18.
48 Alongside co-ordinating a humanitarian response, the UNHCR worked closely with the Macedonian government to develop the ‘temporary humanitarian assisted persons’ status. During this period Macedonia had no asylum law and thus this status would become crucial for the many refugees who crossed the border. See: D. Donev, Silvana Onceva, Ilija Gligorov, ‘Refugee crisis in Macedonia during the Kosovo Conflict in 1999’, *Croatian Medical Journal*, 43(2), (2002), p. 184.
49 Figure 1 taken from DEC, *Kosovo Crisis: Lesson Learning Study*, p. 7; Figure 2 taken from UNHCR, ‘The Former Yugoslav Republic of Macedonia: at a glance’, *UNHCR Global Report* (1999), p. 348.
51 Cross, ‘Comfortable with chaos’, p. 4.
‘operation AGRICOLA’ a base called Tac HQ was set up, with the support of DfID funding, to provide logistical support within the Blace area. Tim Cross, Commander of the Logistic Brigade in Macedonia, wrote that when KFOR arrived in Macedonia, the humanitarian organisations were not yet in the position to provide aid. KFOR, funded by DfID, therefore, became the first humanitarian responders. Clare Short recounted her experience when visiting Macedonia; she wrote that, upon her arrival members of the British military were already supplying food for the refugees and body bags for those who died before receiving aid. Seeing that the military was already present and providing relief, Short made a deal with the Macedonian government to allow the British military to build a refugee camp and get it running.

From Tac HQ, the British military began to provide food, shelter and emergency medical care to the refugees. Cross explained the choice of the military to provide humanitarian support; he wrote: “we could not stand idle…it was clear to me that the Macedonian government needed KFORs strength”. Cross proudly highlighted the speed with which the British military responded to the needs of refugees, in comparison to the NGOs and the UN. Cross presents the British military response in a very positive light; however, his role in the response as a British Commander must not be overlooked when analysing his commentary of the response. An evaluation carried out by the Humanitarian Practice Network demonstrated that the UN, NATO, and the NGOs who responded were all unprepared for the speed and numbers of refugees that fled Kosovo in March 1999. This evaluation suggests that the KFOR forces may not have been the capable rescuing force presented by Cross, but that they too may have been unprepared for the scale of humanitarian need. As NGOs began to respond within these camps, the military handed over some of their projects, for example by the end of April

52 Short, An Honourable Deception?,
53 Tim Cross was awarded the title of Commander of the Order of the British Empire (CBE) for his work in Kosovo.
55 Short, An Honourable Deception?, p.94.
56 Ibid., p.94.
57 Cross, ‘Comfortable with chaos’, p.5.
58 Ibid.
the British Army had withdrawn from the camp in Blace and had handed medical support over to MSF and the Red Cross.\textsuperscript{60} They also took a step back from their other roles, leaving, by 19\textsuperscript{th} April 1999, only a military liaison team.\textsuperscript{61} Within this humanitarian response, the first responders were not NGOs or UN organisations. Instead, KFOR forces (with funding from DfID) provided the first aid to this refugee camp.

Following the initial delivery of aid by military personnel, British NGOs began to work alongside, and take over from, the military within the refugee camps. The response of British NGOs was significant, with the organisations Merlin, Save the Children, Oxfam, and Help the Aged providing aid to camps in Macedonia, Albania and Montenegro. These NGOs gained a large proportion of their funding from the British public. The DEC’s Kosovo Appeal, launched on 6\textsuperscript{th} April 1999, generated over £40 million, the largest ever appeal at that point.\textsuperscript{62} An independent evaluation of the appeal highlighted that it generated an excess of money, so much so, that Oxfam chose to redirect 30\% of its funds to other emergencies that were being overlooked.\textsuperscript{63} By April 1999, Oxfam was providing water to an estimated 23,000 refugees and distributing hygiene kits within the camp Brazada (also known as Stankovic I) in Macedonia.\textsuperscript{64} CAFOD, who were working primarily in Albania, had set up programmes within the communities to support families hosting refugees.\textsuperscript{65} Alongside this, Save the Children, Children’s Aid and Help the Aged, were working across each of these countries to meet the particular needs of the young, elderly and disabled.\textsuperscript{66} Healthcare was provided by the military initially and then through humanitarian organisations such as

\begin{footnotesize}
\begin{enumerate}
\item Cross, ‘Comfortable with chaos’, p.6
\item Ibid., p.6
\item Wiles, ‘Independent Evaluation of Expenditure of DEC Kosovo Appeal Funds: Phases I and II’, p.78.
\item DEC Report, Kosovo crisis appeal record response.
\end{enumerate}
\end{footnotesize}
Merlin. They found that the primary medical needs of the refugee population were the treatment of chronic diseases, mental health illnesses and antenatal care. Within Macedonia, “two-thirds of the consultations in camps were due to untreated or poorly controlled chronic diseases”. This was a reflection of the poor quality of medical services available to this population within Kosovo before the NATO intervention, something that will be examined later within this chapter. As the bombing continued, and the number of refugees continued to rise, the role of British NGOs within this camp and others in the neighbouring countries increased. By May Oxfam were supplying 80,000 refugees with water at Blace transit centre, Stankovic I and II and Cegrane camps. They had also set up community hubs within several of these camps, to provide electricity to their occupants. After the initial response by the British military, many of the projects within refugee camps were handed over to humanitarian organisations.

As the aerial campaign came to an end on 10th June 1999, the refugees began to flood back into Kosovo, creating a new challenge and the second phase of the humanitarian response. Like the swift departure of the refugees, the speed of the refugees’ return took the humanitarian community by surprise. By the end of July, 85-90% of refugees who were living with host families had returned to Kosovo. Expatriate staff working for NGOs, who had been evacuated from Kosovo during the bombing, also returned. Humanitarian organisations were faced with the challenge of reuniting families, providing

67 The scale of this response can be demonstrated by the number of medical aid agencies that responded; over 300 NGOs worked to respond to the medical needs of the population. See: Hilary Bower, ‘Learning to pull in one direction to improve Kosovo’s health’, The Lancet, 354(9189), (1999), p.1538.
68 Donev, Onceva and Gligorov, ‘Refugee crisis in Macedonia during the Kosovo Conflict in 1999’, p.186.
69 Ibid., p.186.
71 Ibid.
materials to reconstruct damaged homes, re-establishing access to clean water and providing electricity to critical buildings such as hospitals. Within Kosovo, one of the main restrictions to the delivery of aid was insecurity and damaged infrastructure. The British military provided engineering and logistical support for the humanitarian response; for example, they helped provide fire-fighting services and organised and controlled the Kosovo railway system. They also focused on creating a “secure environment for returning refugees” by setting up a civilian detention centre in Lipljan. The success of the British military’s work in providing security can be seen in July 1999, in KFOR’s announcement that “all principle towns and roads” were now safe from armed groups and mines.

With the presence of both the NGOs and the KFOR forces within Kosovo, the humanitarian response was confused and disjointed. One reason for this was the inability of the United Nations Mission in Kosovo (UNMIK), which managed the co-ordination of the humanitarian response, to efficiently create a registration system of aid workers. It was not until November 1999 (5 months after the end of the bombing campaign) that UNMIK finally set up a system for NGO registration within Kosovo. Prior to this registration, there was minimal and sporadic co-ordination between NGOs and with UNMIK. Their job, to juggle the multiple actors within Kosovo and ensure that the actors within this arena had a clear and distinct role, was an ongoing challenge. This lack of distinction between the role and position of different actors within Kosovo can be seen in the close geography of the British military headquarters (Tac HQ) and the offices of Save the Children Fund UK.

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75 Cross, ‘Comfortable with chaos’, p.7.
76 The team working on this project were: Dr. Vanessa Bradford Kerry, Harvard Medical School, Department of Global Health and Social Medicine; Dr. Margaret Bourdeaux, Harvard Medical School, Division of Global Health Equity Brigham and Women’s Hospital; Commander Dr. Christian Haggenmiller, German Navy, NATO Joint Analysis and Lessons Learned Centre Project Manager (to September 13); Lt. Colonel Laurent Zych, French Army, NATO Joint Analysis and Lessons Learned Centre Project Manager (from September 13); Commander Luigi Ceppodomo, Italian Navy, NATO JALLC, Kosovo Case Study Manager; Captain Brad Holt, US Navy, NATO–Allied Command Transformation (to December 2012); Ms. Jodie Lazell LLM, JALLC Consultant; Mr James Collins, NATO Civilian (to November 2012) Mr Kenneth Pye, NATO JALLC Consultant (to May 2013); Harvard University and NATO Joint Analysis and Lessons Learned Centre, The Kosovo Case Study, p.4.
77 Save the Children, Kosovo Emergency: Bulletin Seventeen.
which sat next to each other in Pristina.\textsuperscript{79} Within the refugee camps and, to a lesser extent, Kosovo, there was little distinction between the role of NGOs and the KFOR forces.

The blurring of roles between the humanitarian organisations and military forces had implications for the delivery of aid to recipients. Tim Cross claimed that the “British soldiers…[could] switch easily from one role to another, and psychologically had no difficulty with helping refugees one day and preparing to fight their way into Kosovo on another”.\textsuperscript{80} Literature produced by military personnel, such as the work of Cross, failed to examine the implications of the military’s role within the humanitarian response. Within debates about New Humanitarianism and the importance of the humanitarian principles, critics argue that a loss of impartiality by humanitarian actors would lead to a hierarchy of aid recipients, in which some may be deemed undeserving.\textsuperscript{81} The presence of the military within Kosovo appeared to have this effect. In July 1999, the UNHCR began to collect requests from members of Roma and Serb populations within Kosovo for assistance to leave the country.\textsuperscript{82} This, in part, may have been due to the presence of the British Forces within the country. Aleksandar Jokic argued that, as the conflict within Kosovo continued, the use of the term “Serbian nationalist sentiments” became increasingly prominent both within British government rhetoric.\textsuperscript{83} This term, he argued, presented Serbian populations as holding “collective guilt” for the violence in Kosovo.\textsuperscript{84} This language presented all Serbians as opponents to the British intervention. Military personnel, delivering aid on behalf of the government, may have held a similar attitude and thus perceived some aid recipients as more deserving than others.

The presence of the military within the hospital and refugee camps militarised these spaces in which the divisions of the war continued. British medical

\textsuperscript{79} Save the Children, \textit{Kosovo Emergency: Bulletin Seventeen}.
\textsuperscript{80} Cross, ‘Comfortable with chaos’, p.19.
\textsuperscript{81} Fox, ‘New Humanitarianism’.
\textsuperscript{82} Save the Children, \textit{Kosovo Emergency: Bulletin Seventeen}.
\textsuperscript{84} Jokic, ‘The Aftermath of the Kosovo Intervention’, p.177.
Doctor Tony Redmond, head of the largest hospital in Kosovo, the Pristina University Hospital, recalled the military presence within the hospital and stated that, after a week or so, he sent them away. He described the reaction of his fellow physicians as one of relief, recalling one doctor saying that the hospital “now felt like a hospital again”. Dr Redmond’s recollection suggests that he, and his fellow physicians in Kosovo, felt that the hospital and its ability to deliver medical aid were challenged by the presence of the military. Another example of a militarised space was the refugee camps surrounding Kosovo. Within these refugee camps, KFOR was deployed to do more than guard humanitarian centres and protect the civilians; NATO also used them as a tool to “provide a secure environment, emergency medical care and assistance with the refugee crisis”. Bruderlein and Leaning wrote that “the neutral status for medical relief... rests on the reciprocal assumption that those who deliver this relief are practising in accord with their professional ethics and will take specific steps to maintain their neutral posture vis a vis the warring parties”. This would have been impossible for the KFOR forces delivering humanitarian aid as belligerent within this conflict.

The disorganised nature of the humanitarian response and the indistinguishable roles of the NGOs and some of the KFOR forces enabled the British government to promote the humanitarian role of the British military within Kosovo. Within the refugee camps in Macedonia, Short actively chose the British army to provide DfID funded aid. This was in part due to their presence within this area; however, it may also have been a strategic choice to promote the humanitarian nature of this intervention in the face of opposition to the military operations. For example, on 8th May 1999, 25,000 people were reported to have marched in London alongside the Committee for Peace in the Balkans, against the continued bombing over

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85 Pristina University Hospital was the largest hospital within Kosovo, hosting 2,000 beds. This hospital often took on difficult cases referred from other hospitals and can be seen as central to the health system within Kosovo. Dr Tony Redmond was asked to run the hospital by Mukesh Kapila the head of Conflict and Humanitarian Affairs in DfID.
86 Professor Tony Redmond, Interview by Chapman, (07 June 2017).
87 Harvard University and NATO Joint Analysis and Lessons Learned Centre, The Kosovo Case Study, p.15.
Kosovo”.\(^{89}\) In parallel, Professor of Defence Studies, Michael Clark, noted that challenges were also coming from within the Labour government itself, regarding the methods used during the bombing.\(^ {90}\) During the aerial attack, the Royal Air Force used indiscriminate cluster bombs, which had a failure rate of 5-12%.\(^ {91}\) This type of bomb was much more likely to hit civilians and to add to the number of deaths within Kosovo. This challenged the image, promoted by the British government, that this military intervention took place to put a stop to human suffering and was a humanitarian war.\(^ {92}\) Criticism also came from academics such as Richard Falk, an international law scholar and former UN Special Rapporteur, who argued that “in its first fifty days, the Atlantic Alliance failed in everything it set out to do”.\(^ {93}\) Similarly, scholar Ken Booth argued that “it is difficult to believe that the bombing saved one life in Kosovo—while there is plenty of reason to suppose that it ensured many more dead in the Balkans”.\(^ {94}\) Their criticisms were based on the number of deaths of civilians during the prolonged bombing.

Throughout the response, however, the British government actively promoted the humanitarian nature of this response. For example, Tim Cross recalled Clare Short visiting the refugee camp in Blace, Macedonia, and said that she was photographed handing out materials to the waiting refugees.\(^ {95}\) These images sent an important message to the British public that the British government was acting alongside British NGOs and the British Army to provide humanitarian support to the displaced people of Kosovo. From the initial discussions about the possibility of bombing, the British government had always promoted this bombing as a humanitarian intervention. In a speech made by Tony Blair to the House of Commons, he said; “We must act: to save thousands of innocent men, women and children from humanitarian

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91 Failure Rate means that they hit the ground without exploding and therefore, continue to pose a risk to civilians; Clarke, ‘British perceptions’, p.88.
92 Mark Duffield challenged understandings of the term humanitarian war, he argued that it “is not one in which militaries intervene for humanitarian reasons” as the British government promoted, “but rather, an alliance with non-governmental humanitarian community to contain the humanitarian effects of western military actions”. This chapter will use Duffield’s definition to understand NATO’s intervention in Kosovo. Duffield, Macrae and Curtis, ‘Politics and Humanitarian Aid’, p.272.
94 Booth, ‘NATO’s republic’, p.92.
95 Cross, ‘Comfortable with chaos’, p.5.
catastrophe, from death, barbarism and ethnic cleansing by a brutal dictatorship”. The British government justified the bombing as a tool to stop the violence against the Albanian Kosovar population. For the British government, the military needed to be shown to support the humanitarian response after the bombing. The importance of the public image of the war was noted in Clare Short’s book; she said that during the Kosovo intervention, “Blair… honed [his] PR machine and… image as a humanitarian war leader”. MSF personnel, writing in 1999, recognised NATO’s use of aid as a tool to promote their intervention; they wrote, “by assuming a so-called humanitarian role, NATO was trying to improve its public image”. Duffield also wrote that for western governments there was a realisation that when fighting wars, “they might lose the public relations war if the humanitarian consequences of their actions are not contained”. The British government provided humanitarian aid to the populations seeking refuge from the bombing in neighbouring countries to promote an image of the British military as a humanitarian actor.

The number of refugees that left Kosovo during the bombing and their humanitarian needs, both before and upon their return to Kosovo, overwhelmed NGOs and the UNHCR. NATO forces were the first actors able to support the host governments of the refugees and provide much-needed aid. The British military, as part of KFOR, set up the first refugee camp on the border of Macedonia. Once NGOs were able to respond, military forces handed over their projects. The military’s role within the delivery of aid continued after the bombing within Kosovo, as they worked alongside NGOs to support the aid delivery. The distribution of aid by an active participant of the conflict, the British military, led to the politicisation of aid within Kosovo. Despite this, the British government publicised the role of the British military within the aid response, in an attempt to subdue criticisms of the intervention itself. Thus, the delivery of aid by the military was used as a

97 Short, An Honourable Deception?, p.93.
98 MSF, Kosovo: Aid under siege once again.
tool by the British government to promote the image of war in Kosovo as a humanitarian intervention.

**Medicine and Peacebuilding**

Despite an end to the bombing in June 1999 and the return of refugees in July, the violence between groups of Albanian and Serb populations continued and thus the need for peacebuilding became clear. This prolonged violence challenged the British government’s rhetoric which had previously argued the bombing would end the violence and questioned the legitimacy of their choice to bomb Kosovo. Peacebuilding, therefore, became a key focus for NATO countries in the aftermath of the bombing. The recognition that the term health could also be expanded to mean the health of a community-led to its use as a tool for peacebuilding activities.

With the expansion of understandings of medicine during the 1990s, as demonstrated in the previous chapter, one can also see an extension in understandings of the health of an individual during the Kosovo crisis. Doctors Vincent Lacopino and Ronald Waldman, who wrote about the changing role of the physician, convincingly demonstrated an evolution during this period, in which medical humanitarian response came to include “individual and community mental health concerns” and a re-conceptualisation of health to include the recognition of physical, social and mental well-being. Lacopino and Waldman traced the ideas behind this change to its origins within the Declaration of Alma-Ata in 1978. The expansion of understandings of medicine and individual health during this period can be seen within the internal evaluation of the WHO’s response in Kosovo, in which they explained that some of their respondents “argued that health should be a cross-cutting issue”, and that health played a role within all aspects of the international response. The health of a patient was perceived to include a social element, and the medical response was no longer

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101 Ibid., p.479.
deemed appropriate if it didn’t also take into account the socio-political impacts of a patient’s health. Within the international response in Kosovo, as seen in Sudan, medicine was recognised as having a role not just for individuals but within the community as a whole. Within the Kosovo response, the British government pushed understandings of medicine further, to actively use it as a tool within peacebuilding and state-building projects and implicating medical personnel in the political dimension of the crisis.

The Kosovo humanitarian response was not the first time that medicine and health were perceived to be potential tools for peacebuilding. Simon Rushton and Colin McInnes demonstrated this in their work on an initiative funded by DfID called ‘Health as a Bridge for Peace’ (HBP). They wrote that following the election in April 1997, “the UK was at the forefront of the development of the HBP concept within WHO”. They described HBP as:

A multidimensional policy and planning framework which supports health workers in delivering health programmes in conflict and post-conflict situations and at the same time contributes to peacebuilding. It is defined as the integration of peacebuilding concerns, concepts, principles, strategies and practices into health relief and health sector development.

DfID encouraged and funded HBP and the consultation processes, in which it was developed. HBP was based on the belief that “health” affected all parties within a conflict and could “transcend political differences”, and thus, peacebuilding initiatives should be incorporated into health programmes. While recognising health’s ability to transcend political differences, HBP brought medicine into the political sphere, as a tool for peacebuilding. Rushton and McInnes argued that HBP lost the support of DfID and that, during the Kosovo response, DfID’s focus was not on HBP but instead on the “provision of technical assistance and funding for the reconstruction of health infrastructure”. While one can see examples of this new focus within DfID

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104 Ibid., p.95.
105 Ibid., p.98.
106 Ibid., p.96.
107 Ibid., p.102.
reports, and an absence of the term HBP, health and medicine still played a role within peacebuilding efforts.

Notwithstanding the decrease in support for HBP that Rushton and McInnes identify prior to Kosovo, the use of medicine as a tool for peacebuilding can be seen within the Kosovo response. Much of DfID’s funding went to the WHO, 48.5% of which was “designated to public health and environmental health”.¹⁰⁸ This reflects an understanding of the broader aspects of health beyond the physical health of an individual. Similarly, within a DfID and UNICEF evaluation “health protection”, was presented as the “direct intervention to reduce the consequences of social or environmental stressors, such as by providing child-friendly spaces”.¹⁰⁹ This demonstrates the continued recognition of health as a term that incorporates social well-being.

The medical system within Kosovo reflected the ethnic segregation of the country under Milosevic’s presidency. Prior to the NATO bombing, the health care system within Kosovo was divided along ethnic lines. The Semashko system was the official system within Kosovo, which was built on a model seen throughout the Soviet Union, that was “characterised by heavy centralisation; the state was both the purchaser and provider of care and placed emphasis on specialist rather than primary care”.¹¹⁰ This system was top-heavy, made up of multiple clinics specialising in different types of medicine. Dr Tony Redmond, in an interview in 2017, described the lack of respect given to General Practitioners within Kosovo.¹¹¹ Rather than using General Practices and referral systems, patients often went directly to the specialist centres. This centralised and specialist-based system provided health care for the Serbian population within Kosovo.

Alongside this system was the unofficial Mother Theresa Society, set up by doctors from the Albanian population as an alternative health care system in the early 1990s, after Milosevic removed Kosovo’s autonomy and took

¹⁰⁸ de Goyet and Sandorp, WHO response in Kosovo, p.10.
¹¹⁰ Harvard University and NATO Joint Analysis and Lessons Learned Centre, The Kosovo Case Study, p.6; Percival and Egbert Sondorp, ‘A Case Study of health sector reform in Kosovo’, p.3.
¹¹¹ Professor Tony Redmond, Interview by Jennifer Chapman, Personal Interview, Manchester, (14 December 2017).
control of the health care system. In this take-over, many of the Albanian medical staff lost their jobs, others chose to leave due to unfair treatment, and those who remained were required to write in Cyrillic and speak in Serbian.\textsuperscript{112}

In response to this, Albanian doctors formed the parallel Mother Theresa Society. Those who went through medical training within this system gained a strong theoretical background; however, due to restrictions in access to healthcare facilities, their training was incomplete, disorganised and outdated. After the bombing, many Albanian doctors returned to the state hospitals; however, their integration alongside remaining Serbian doctors was not always successful.

In this context, medicine was used as a tool for peacebuilding to bring together Albanian and Serbian doctors. This can be seen within the work of Dr Tony Redmond and his treatment of his staff within Pristina University hospital. One of the main focuses within medical literature after Kosovo highlighted the role that training played in the attempt to bring all doctors up to the same standard, through technologies such as telemedicine.\textsuperscript{113} This training not only improved the standard of healthcare within Kosovo but was also used to encourage doctors from different ethnicities to work together. Theresa Agovino highlighted the challenge that Tony Redmond faced. She wrote that “Redmond has to devise a plan to get Albanian and Serbian doctors to work together as he determines what services the hospital can reasonably provide”.\textsuperscript{114} Redmond’s answer was to establish a hospital board, funded by DfID, on which both Serbian and Albanian doctors sat.\textsuperscript{115} A Serbian doctor remarked, “we have to get politics out of the hospital”.\textsuperscript{116} While this may not have removed politics from the hospital, projects like this were intended to alleviate the conflict between the doctors from these two communities. Though this offers a small example of a much broader peacebuilding response within Kosovo, one can see the intention of using health as a peacebuilding mechanism within the hospital to bring doctors from different ethnicities.

\textsuperscript{112} Percival and Sondorp, ‘A Case Study of health sector reform in Kosovo’, p.4.
\textsuperscript{115} Ibid., p.927.
\textsuperscript{116} Ibid., p.927.
together. Health was, therefore, a tool within the broader British peacebuilding agenda.

While the case of Pristina hospital offers an insight into small-scale peacebuilding activities, one must also be careful not to over-emphasise the impact of doctors from different ethnicities working together. A WHO report produced in November 1999 described Serb and Albanian doctors coming together to provide an immunisation programme for children in ethnically mixed villages.\textsuperscript{117} Though deemed “successful”, the doctors on arrival at the villages split into two groups and treated children from their ethnic background.\textsuperscript{118} This label of success, therefore, points towards the immunisation programme itself, rather than the long-term peacebuilding possibilities that may have come with this programme. Similarly, while the doctors worked side by side in Pristina hospital, the same cannot be said for all healthcare facilities. Within the Mitrovica Children’s Hospital, the Serb Deputy Director Dr Milan Ivanovich refused to allow returning Albanian physicians to enter and work. While this particular instance led to Ivanovich’s suspension, more broadly, resistance to the return of the Albanian doctors eventually saw the WHO abandon its attempts to reintegrate them.\textsuperscript{119}

The inclusion of medicine, and the use of medical practitioners, within peacekeeping projects was criticised by NGOs. An article produced by MSF in 1999 critically stated that within Kosovo “humanitarian action was essentially part of military and political strategy”.\textsuperscript{120} The use of medicine as a peacekeeping tool worked to support the political strategy in the aftermath of NATO’s bombing. Doctor and scholar Alex Vass argued that this could lead to a situation in which “health professionals could lose their status of neutrality and impartiality”.\textsuperscript{121} There was potential for supporters of Milosevic to perceive the actions of Dr Tony Redmond, in creating a hospital board which included members from both ethnicities, as supporting NATO’s

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\textsuperscript{118} Ibid., p.4.
\textsuperscript{119} Ibid., p.1.
\textsuperscript{120} MSF,\textit{ Kosovo: Aid under siege once again}.
\textsuperscript{121} Alex Vass, ‘Peace through health: This new movement needs evidence, not just ideology’,\textit{ BMJ}, 323(7320), (2001), p.1020.
\end{flushleft}
peacebuilding strategy.\textsuperscript{122} Scholars Graeme MacQueen and Joanna Santa- Barbara recognised this challenge and questioned the “role of health workers in preventing and mitigating destructiveness” and argued that this “raised questions regarding constraints to their achievement of such objectives”.\textsuperscript{123} A doctor’s primary aim was to provide medical assistance to populations, not to act as a NATO peacebuilder.

Within Kosovo, medical aid was thus used in efforts to build peace between members of different ethnicities, but the success of this was variable. It is clear, however, that the use of medical humanitarian practitioners within peacebuilding activities directly challenged the humanitarian principle of neutrality. Thus, just as humanitarian NGO work was uncomfortably drawn alongside the relief provided by the military, so too was medicine, both successfully and unsuccessfully used as a tool for peacebuilding.

**Health and State-building**

Just as medicine was used as a tool for peacebuilding within Kosovo, so too was health care a significant part of NATO’s state-building initiatives. This chapter understands state-building as defined in a 2010 joint report commissioned by the World Bank and the United Nations Development Programme. This report defined a fragile state as one which has “weak institutions and governance systems, a fundamental lack of leadership, political will and/or the capacity to deliver on key public goods, especially in terms of protecting the poor”.\textsuperscript{124} This report proposed that state-building was “a direct policy response to these conditions”.\textsuperscript{125} In the aftermath of the Kosovo bombings, health was a significant part of the state-building agenda. This can be seen through funding statistics. Money towards the health care system constituted the second-largest proportion of the Kosovo Consolidated

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\textsuperscript{122} Redmond recalled negotiating with the KLA to ensure that both sides in the conflict accepted the hospital board members that he had chosen. Professor Tony Redmond, Interview by Chapman, (14 December 2017).

\textsuperscript{123} Graeme MacQueen, and Joanna Santa- Barbar, ‘Peace building through health initiatives’, *BMJ*, 321(7256), (2000), p.293.


\textsuperscript{125} Ingram, ‘State-Building’, p.2.
Budget, with 80 million euros being spent on the health sector between the years 1999 and 2002.\textsuperscript{126} At the beginning of the bombing, UNMIK appointed the representative of the WHO (which had been present within Kosovo since 1997) as the coordinator of the health programmes of the UN.\textsuperscript{127} Though suspended during the bombing period, representatives of the WHO made a substantial impact on the planning and reform of the health sector within Kosovo. The significant proportion of money spent on the health sector highlights its importance within wider state-building plans within Kosovo.

After the NATO bombing, UNMIK was greeted by a divided health care system, a loss of staff through the flight of many Serbian doctors, and a cohort of Albanian doctors with incomplete and disjointed medical training. This proved a significant test for the WHO and medical NGOs whose job it was to reopen the hospitals and provide medical assistance to the returning refugees. This challenge was compounded by the damage that health care infrastructure sustained during the conflict. In an investigation of the medical systems within Kosovo, Lacopino and Waldman determined that, within their group of interviewees, “1 in 5… had seen medical facilities that had been destroyed or had witnessed Serbian police or soldiers expelling patients and medical personnel from medical facilities or using medical facilities for military purposes”.\textsuperscript{128} An estimated 70\% of the health clinics within the rural areas were destroyed.\textsuperscript{129} Though the main hospitals suffered little damage to their buildings’ infrastructure, they experienced a loss of staff, the looting and damage of medical equipment and the loss of electricity.\textsuperscript{130} Dr Redmond described the challenges he faced when first entering the hospital in Pristina. He recalled seeing dogs roaming the halls, a lack of access to medicine, a lack of electricity (which had caused significant problems for refrigeration in the morgue), and a poorly and unevenly trained workforce.\textsuperscript{131} Alongside these challenges, the violence continued outside, requiring the hospital to have a

\textsuperscript{126} Percival and Sondorp, ‘A Case Study of health sector reform in Kosovo’, p.6.
\textsuperscript{128} Iacopino and Waldman, ‘From Solferino to Kosovo’, p.480.
\textsuperscript{129} Harvard University and NATO Joint Analysis and Lessons Learned Centre, \textit{The Kosovo Case Study}, p.8.
\textsuperscript{130} Ibid., p.8.
military guard initially. It was clear, therefore, that the creation of a new healthcare system within Kosovo was a mammoth undertaking.

The crucial link between the healthcare system and the politics within Kosovo were presented by Dr Tony Redmond. He described the challenge that the KLA posed to every decision he made for the hospital. He highlighted that all parties of the conflict recognised the powerful tool that the healthcare system had in gaining the population's support. He argued that both the NATO forces and the KLA attempted to gain power over the hospitals as they saw them as a tool to promote their actions and as a way of gaining political sway. One way in which Britain attempted to control the medical system was through the funding that DfID provided to the pay the doctors, whose wages from Belgrade had stopped in the aftermath of the bombing. Similarly, the perceived importance of the rebuilding of this healthcare system and the provision of medical care can be seen within an entry by Clare Short in The Lancet. Within this article, she praised the UK for being a “main sponsor of the work now initiated to deal with the problem of the quality in health”.

When a new emergency centre was built within Pristina University Hospital, under the direction of Dr Tony Redmond and with funding from DfID, Clare Short publicly opened the new unit. Her presence at this opening and the funding provided by DfID both for this centre and for the doctors' wages, demonstrated Britain’s attempt to present themselves as successfully working towards the renovation of the healthcare system, and thus as an indication of the success of state-building programs throughout Kosovo. Healthcare has always been and continued to be used as an indicator of a country’s level of development, with a Long and healthy life being one of the three dimensions of the UN Human Development Index, and the often referred to health indicators within World Bank or IMF reports. The political power attributed

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132 Professor Tony Redmond, Interview by Chapman, (07 June 2017).
133 Professor Tony Redmond, Interview by Chapman, (14 December 2017).
to the Kosovo health care system was manipulated and utilised by Britain to present a clear message that they were taking an active role in rebuilding the hospitals and health care system, and by extension, the state at large.

The health care system after the NATO bombing became the responsibility of the international community. Within a few weeks of entering Kosovo, new policies were created by the WHO and implemented by international actors, such as Dr Tony Redmond. By September 1999, these policies had been developed by the WHO, into health guidelines for Kosovo, or what they termed the ‘blue book’. The blue book aimed to “not only to provide a framework for emergency work but also to use these effects to bring about sustained reform” within the Health care system. The WHO has been praised by academics, de Goyet and Sandorp, for producing these and providing a standard guide for international organisations within Kosovo. Alongside this, the WHO placed international individuals within the leadership teams of the five leading hospitals within Kosovo.

Despite being praised in 1999, there have since been criticisms of the WHO’s methods of rebuilding the Kosovo healthcare system. Writing in 2016, David Chandler criticised what he termed the “solutionist cause-and–effect model” of humanitarian interventions during this period. Chandler determined that during the 1990s there was a belief in a “universalist understanding of good policymaking”, the belief in one size fits all policies. This, he argued, could be seen within Kosovo in which there was no “holistic engagement with society as a collective set of processes, interactions and inter-relations”. Rather than building upon the healthcare system that existed, and working with those within the health care system, the WHO plans aimed to start anew, as if with a blank slate. The Kosovo health system, however, did not provide

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136 Alongside the implementation of Dr Tony Redmond as manager, an NHS team had been created to help build a partnership between the hospital in Pristina and the NHS; de Goyet and Sandorp, WHO response in Kosovo, p.2; Redmond, ‘How do you eat an elephant?’, p.1653.
137 de Goyet and Sandorp, WHO response in Kosovo, p.6.
138 Bower, ‘Learning to pull in one direction to improve Kosovo’s health’, p.1538.
139 de Goyet and Sandorp, WHO response in Kosovo, p.1.
140 Agovino, ‘Pristina: Sensitively restructuring health services in Kosovo’, p.927.
142 Ibid., p.40.
143 Ibid., p.41.
the blank slate hoped for but rather a complex, divided and broken system. Valerie Percival, a scholar with expertise in the reconstruction of health systems after conflict, and Egbert Sondorp, an expert in health planning and policy, examined the failure of international actors within Kosovo to build upon the existing systems and knowledge. They indicated that medical practitioners in Kosovo felt that, rather than being allowed to provide their input into health care plans, the WHO’s plans were “pre-formulated” and that as stakeholders, they were simply being “sold” these plans during meetings. They also critiqued the rapid speed in which these plans were implemented, and argued that it led to a system “in chaos”. Rather than attempt to rebuild the healthcare system based on the knowledge of local physicians and health ministers, or attempt to reconstruct and develop the old health care system, the WHO guidelines enforced a brand new system. J. D Bloom et al., who wrote about the post-war health care system in Kosovo, argued that this lack of integration and the fast speed of application had a negative impact on the Kosovo health system.

As part of the state-building process, this focus on health drew physicians into new roles. Some, such as Dr Redmond, had to act as peacebuilders and mediators within their hospitals, others were drawn into the politics of the conflict and were required to promote human rights. Vincent Iacopino and Ronald Waldman, writing in 1999, highlighted that within the complex emergencies and humanitarian interventions, “the nature and extent of human suffering has compelled health care professionals to redefine their understanding of health and the scope of their professional interests and responsibilities”. Doctors were now required not only to provide medical aid, they were also called to be or utilised as peacebuilders and state builders.

144 Percival and Sondorp, ‘A Case Study of health sector reform in Kosovo’.
145 Ibid., p.7.
146 Ibid., p.7.
147 Harvard University and NATO Joint Analysis and Lessons Learned Centre, The Kosovo Case Study, p.11.
149 Iacopino and Waldman, ‘From Solferino to Kosovo’, p.480.
Conclusion

Whilst politics and humanitarianism are inherently linked, Fiona Fox wrote that “the political manipulation of humanitarian aid is entirely different to the conscious use of humanitarian aid by agencies to pursue political ends”.150 During the Kosovo response, British medical aid was politicised as it was used as a tool within peacebuilding and state-building mechanisms in Kosovo.

Within the refugee camps that were created following the bombing, DfID chose to deliver a humanitarian response through the British military, in the hope that it would re-enforce their message that this was a humanitarian war. The role of the military within refugee camps, whilst only temporary, had a negative impact of politicising the refugee camps and the aid they delivered. The distinction between the agenda of humanitarian workers and the agenda of the British government was further blurred by the role of medical practitioners within peacebuilding activities. Despite the loss of support for the DfID funded initiative ‘Health as a Bridge for Peace’, before the Kosovo intervention, the ideologies behind it remained. The role of health within peacebuilding mechanisms in Kosovo is clear, and the example of Pristina hospital and the training of doctors have demonstrated attempts to bring both ethnic groups together through health.151 Health also played a central role within the state-building agenda. The failure of the WHO to build upon the existing health care system within Kosovo and collaborate with the country’s medical professionals in this process is indicative of the whole state-building agenda within Kosovo. By working behind the veil of medicine, the British government was able to use funding and its military to have an active presence within each of these arenas. Within the Kosovo response, one can see the manipulation of medicine and the health care system, as a tool to promote not only the British role within the humanitarian response but also within the peacebuilding and state-building activities that followed.

151 The development of Pristina hospital was funded by DfID.
The following chapter examines the British humanitarian response to the NATO bombing of Iraq. While the New Labour government promoted its role in the Kosovo intervention as part of its broader ethical foreign policy programme, the legitimacy of claims of ethical foreign policy began to be questioned during the Iraq invasion. Bulley, who explored the British government language of ethical foreign policy, argued that in Iraq “ethical and humanitarian concerns were not at the forefront of justifications for the invasion of Iraq in 2003”. Similarly, Chandler argued that, in a speech made by Tony Blair after the September 11 attacks, one can see the manipulation of the language of ethical foreign policy. He wrote of the “ease with which the ethical framework could legitimate the projection of power abroad on the basis of acting on behalf of others”. Chapter 4 builds upon themes explored within the Kosovo case, particularly the growing role of the British state within humanitarian response. It explores the active use of humanitarian aid in Iraq to promote a political agenda, the resistance of British NGOs to this, and the implications this had for the delivery of medical aid. Within Iraq, relations between actors within the response were pushed to the extreme. Unlike within the refugee camps surrounding Kosovo, the British military did not hand over their humanitarian activities to NGOs. The following chapter examines the outcome of the attempts by the coalition governments, belligerent forces within the continuing conflict, to co-ordinate and control the humanitarian response.

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Chapter Four: The Loss of Humanitarian Space and the Consequences for Aid Recipients during the Iraq War, 2003

Introduction

In February 2003 the US and UK submitted a resolution to the United Nations stating that an invasion of Iraq was necessary. They argued that, despite the sanctions that had been levied against Iraq by the UN since the 1990s, Iraq had failed to disarm itself. Since its conception, members of the British government and the humanitarian sector had criticised the invasion of Iraq. Humanitarian aid agencies appealed to the UK and US governments to stop the plans for an invasion in fear of the humanitarian consequence and high human cost of war.1 Save the Children UK, for example, stated that "Save the Children has joined with other humanitarian organisations in urging the US government, Iraq and the international community to continue to seek diplomatic solutions to the war".2 For many British NGOs, the poor conditions already experienced by the Iraq population signified the severe suffering that an invasion would inflict. This opposition was not, however, limited to humanitarian organisations and government personnel. On 15th February 2003, “hundreds of thousands” of the British public took to the streets in London to protest the potential war in Iraq.3 Despite this opposition and the failure of the appeal for a UN resolution for the invasion of Iraq, Britain joined the United States in an attack that began on 20th March 2003. As predicted by its opponents, the invasion had significant and negative consequences for the civilians in Iraq.

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2 Ibid.
This chapter will investigate the response of British and US humanitarian organisations to plans that the US government would run the humanitarian response. It will also examine the US’ attempt to use humanitarian aid as a tool to win ‘hearts and minds’. This chapter will argue that British organisations, in light of the government encroachment on the humanitarian arena, found a renewed reliance on the humanitarian principles as a tool to redefine their work against that of US and UK militaries. Antonio Donini wrote that the “Iraq crisis has resulted in a dangerous blurring of the lines between humanitarian and political action and in the consequent erosion of the core humanitarian principles of neutrality, impartiality and independence”.4 The political nature of the humanitarian arena within Iraq forced British NGOs to redefine themselves as distinct actors.

Scholars, military personnel and humanitarian organisations have researched different aspects of the Iraq war. Some scholars, such as Alex Bellamy, investigated the justifications given by both President George Bush and Prime Minister Tony Blair for the invasion of Iraq.5 Clare Short’s memoir highlighted the close relationship of Bush and Blair in which she determined they stood “shoulder to shoulder” during their times in office.6 Scholar Katy Parry has also researched the relationship between these two governments. Parry argued that while the “Bush doctrine” was distinct from the “internationalist and moralistic values of the Blair doctrine”, the War of Terror and the “humanitarian ideals of liberation” brought these governments together under the same justifications of the war against Iraq.7 Investigating the legality of the war, Didier Fassin has argued that Iraq marked a point in which the “legitimacy of interventions was… displaced from the legal sphere (since they did not have the support of the United Nations) to the moral sphere (the defence of human rights and even, more restrictively and more specifically, the humanitarian right)”.8 The British government used

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humanitarian narratives to justify its actions in Iraq. T.G Weiss, for example, argued that the Iraq invasion had “nothing more than a humanitarian veneer”.9 Similarly, Bulley argued that the War on Terror caused humanitarian aid to have “fallen down the West’s list of strategic priorities, far below the desire for security”.10 In the aftermath of the September 11 attacks, humanitarian organisations feared co-option by the British government as a tool in their War against Terror. The chapter will build on this literature by examining the relationship between the coalition forces and NGOs and the implications that this had for medical aid.

Existing scholarship on the humanitarian response following the invasion of Iraq has demonstrated the limitations that NGOs faced due to “insecurity, a lack of coordinated funding, limited operational capacity and patchy information”.11 Some scholars, such as Larissa Fast and Mark Duffield, have focused on the impact of insecurity within humanitarian responses and the movement towards a “Bunkerisation” of aid organisations.12 Unlike the Kosovo crisis, within which the British military was able to hand over the refugee camps to be run by humanitarian organisations, insecurity in Iraq meant that the military remained a primary deliverer of aid. This chapter builds upon the work of Paul Dixon, whose research investigated British ‘hearts and minds’ missions, and will offer an examination of both the US and UK army’s use of aid as a tool to gain support within Iraq.13 At the centre of much of the research surrounding civil-military relations are questions about the role of the humanitarian principles, particularly impartiality and neutrality. After Rwanda, as shown in the previous chapter, the concept of New Humanitarianism encouraged a critique of aid principles and the spread of humanitarian aid into areas outside the umbrella of relief aid, such as peacebuilding and state-building. Within the significantly politicised and insecure environment in Iraq, however, these aid principles became a tool for humanitarian organisations to distance themselves from the military.

10 Bulley, ‘The politics of ethical foreign policy’, p. 444
The information available regarding the different roles of humanitarian actors within the Iraq war is distinctly lacking. One reason for this was the security challenges they faced within the country during this period. After the bombing of the ICRC and UN headquarters within Baghdad, in August 2003, humanitarian organisations restricted access to detailed information about their projects in Iraq. For example, a report published by Oxfam stated that Oxfam had chosen to withhold certain information due to security fears.14 Alongside this challenge, much of the literature written about the Iraq war and the role of the British and US militaries was written in the form of propaganda-like reports produced internally.15 The Iraq war was a “uniquely politicised and dangerous humanitarian landscape”, and thus the literature produced during and after this war is equally polarised.16 In light of this, this chapter will rely on both written sources and semi-structured interviews with both military and humanitarian personnel. Alessandro Portelli wrote that oral history could, “give us information about… social groups whose history is either absent or distorted”.17 Within this chapter, these interviews will be used to fill in the missing information regarding the humanitarian response. The absence or addition of specific stories within oral histories also offers an insight into what was deemed significant, both at the time when a specific memory was created, but also during the period in which it was recalled.

Using these sources, this chapter will be broken down into three sections. It will first investigate the pre-war period in which the US and UK governments planned the humanitarian response. During this period, the US government attempted to control the humanitarian response through the creation of various coordination mechanisms. This chapter will examine the response of both the British and American humanitarian organisations to these plans and will demonstrate the different relationship that British NGOs had with the UK

government, in comparison with their US counterparts. This chapter will then proceed to investigate the humanitarian response after the invasion. The coalition’s initial unwillingness to accept their role as occupiers had negative implications for the security and stability of Iraq. This chapter will argue that the lack of security within Iraq enabled military forces to monopolise the humanitarian response as humanitarian actors were forced to distance themselves from aid recipients. Finally, this chapter will investigate the implications that the militarised humanitarian response had for the delivery of medical humanitarian aid. It will determine that the poor quality of Iraqi hospitals problematically led many civilians to seek care within the military hospitals. By investigating the relationship between military forces and humanitarian organisations within a post-war setting, therefore, this chapter shows that the presence of the military within humanitarian space in Iraq had a significant impact on civilians’ ability to access medical aid.

Pre-war Humanitarian Planning

Aid agencies’ policy documents, press releases and discussions within the UK government in the months leading to the invasion all reveal concern for the potential Iraq invasion and the probable humanitarian crisis that would follow. This foresight enabled the coalition governments and humanitarian actors to plan for the possible humanitarian consequences that this war could bring.18 Oxfam, for example, predicted that in the event of war “more than 11 million people could be in immediate need of humanitarian assistance”.19 Similarly, the World Food Organisation estimated that a war would result in “400,000 civilians [being] at risk” of cholera and other diarrhoeal diseases”.20 Such predictions were used by British NGOs to both denounce the war and prepare for a potential humanitarian crisis that could follow. Recognising that they may have to work alongside the coalition forces within Iraq, British NGOs also produced clear guidelines and policy documents that outlined their distinct roles from those of the military.

18 Kirkbride, Bailey and Omar, Rising to the humanitarian challenge.
Prior to the invasion, the US government created new groups within the US Department of Defence to directly manage and coordinate the humanitarian response. The first of these was the Humanitarian Planning Team, which was instructed to “conduct pre-war planning of the military central command humanitarian response”. The government also created the Office of Reconstruction and Humanitarian Assistance (ORHA), a network of intergovernmental and interagency organisations which also worked within the US Department of Defence, under the command of retired Lieutenant General Jay Garner and his deputy Tim Cross, who had previously responded to the crisis in Kosovo. ORHA aimed to co-ordinate and run the humanitarian effort in Iraq, overseeing the work of the coalition militaries, international humanitarian organisations and the Iraq government. Scholars Keith Baker and Ellen Rubin, writing in 2011, have described ORHA as “a mechanism that would allow the Department of Defence to control Iraq policy and activity”. Whether the US government had initially envisioned it as such is unclear; however, it is clear that the US government, through these organisations, planned to place itself at the centre of the humanitarian response. The US government then created the Humanitarian Operations Centre (HOC). This was run by both the coalition military and the Kuwait government and aimed to be another point of “liaison and coordination of civilian and military organisations providing humanitarian assistance”.

The US government planned for the Office of Reconstruction and Humanitarian Assistance, based in Baghdad, and the Humanitarian Operations Centre, based in Kuwait City, to manage the humanitarian response. British humanitarian organisations became the leading opponents to ORHA and HOC. They actively resisted the proposition that their work would be coordinated by the US government, through an organisation that sat within

the Department of Defence. British NGOs saw these plans as a direct challenge to their humanitarian principles. They argued that the planned coordination of the humanitarian response by a coalition government would challenge their principles of impartiality and neutrality. An Oxfam report, written in 2003, recognised that, “throughout the 1990s, the United States and several other countries increasingly regarded the provision of humanitarian assistance as an integral part of their military strategy”. British NGOs resisted the attempts of the US government to use humanitarian aid as part of their military strategy in Iraq. In response to these plans, the British medical agency Merlin released a statement saying that “NGOs shall endeavour not to act as instruments of government foreign policy”. Merlin also publicly appealed to the government stating that “Merlin is urging the British government and their allies to do all they can to ensure that in the aftermath of war assistance to Iraq is coordinated and distributed by civilian, neutral and impartial means”. These statements are representative of the fear that British NGOs had of a government co-ordinated humanitarian response. British NGOs thus began to use the language of the humanitarian principles to resist the direct encroachment and attempted control of the humanitarian arena by the US military.

Alongside fears of the co-ordination of the humanitarian response by the US Department of Defence, British NGOs also resisted the planned use of the military within the humanitarian response. As the British and US militaries

28 Merlin, *Iraq: Aid agency’s concern over military control*.
29 Ibid.
30 This was not the first time that the British and US militaries had delivered aid to Iraq. In 1991 UK and US governments, as part of a larger coalition of countries, used their militaries to work alongside humanitarian organisations to provide aid to communities within Kuwait, in what the US termed Operation Provide Comfort. Dr Ramey Wilson, an Officer and Physician in the US Army perceived the collaboration between NGOs and military personnel as a success and described it as having “heralded... a new model of civil-military interaction”. In light of the perceived success of this cooperation, the US governments prepared for the role that the military could play within the humanitarian response in 2003. Ramey L. Wilson, ‘Disasters and Conflict Zones Around the World: The Roles and Relations of the Military and Nongovernmental Organisations’, in Paul A. Gaist eds., *Igniting the Power of Community: The Role of CBOs and NGOs in Global Public Health* (Springer, London: 2010), p.110.
were active combatants in the war, British NGOs feared the impact that association with the militaries would have on their ability to deliver aid. Opponents to New Humanitarianism argued that the loss of humanitarian principles could endanger humanitarian workers. Within complex emergencies in which there were no clear lines between military personnel and civilians, the need to remain impartial became paramount. Mark Duffield highlighted a clear trend within academia in the early 2000s, which presented the “main threat facing aid workers [as stemming] from the local backlash to the politicisation of Western aid”. This fear of co-optation, (exacerbated by the US government-headed War on Terror in the aftermath of September 11), became a central point of resistance for NGOs during the planning stage for the Iraq war.

As an alternative to ORHA, British NGOs persistently advocated for the UN to coordinate the humanitarian response. Their position was summed up by Julian Forsyth, then Head of Policy in Oxfam, who stated:

> We are worried that the US believes and acts like it can replace the UN in delivery of humanitarian aid and reconstruction. We don’t believe they have the skills or the legitimacy. We don’t want our aid equipment to be offloaded off the back of a US military lorry, because if we were to do that, we would be seen as a part of a belligerent force.

Many British NGOs saw the UN as the preferred alternative to this planned US-led humanitarian response. Save the Children stated that the “UN’s contribution through elements of inclusiveness, transparency and legitimacy” could not be replicated by other actors. Furthermore, Oxfam demonstrated its support for a UN-coordinated response within a briefing paper published in 2003, which stated that “the UN alone has the international mandate to coordinate humanitarian response”. It reasoned, “any association between

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31 Christian Aid, *Preparing for the humanitarian consequences*.
32 Fast, ‘Securitisation’.
humanitarian agencies’ activities and those of military forces in Iraq could increase security risks faced by aid workers worldwide”. 37 Within the British humanitarian sector, there was a clear rejection of the US government’s plans to coordinate the humanitarian response in Iraq, and there was a common belief that the UN should hold this role.

Despite the lobbying of British NGOs, in the planning stages of the humanitarian response, it was unclear as to whether the UN would support the Iraq war, and subsequently whether it would have a role within the humanitarian response. The UN Office for the Coordination of Humanitarian Affairs (OCHA) released a statement on 2nd March 2003 saying:

UN humanitarian assistance in Iraq will not depend on a Security Council decision relating to a possible conflict. However, the capacity of UN agencies might be impeded with the Security Council support [sic] to war in Iraq. Should a Security Council resolution be passed, UN agencies will have to make sure that they remain perceived as neutral. 38

Though unsure of their role within the Iraq response, it is clear from this statement that the UN feared the loss of their neutrality within the conflict. Writing in 2004, aid veterans and analysts Antonio Donini, Larry Minear and Peter Walker determined that the lack of a “clear UN mandate” in the planning stages of the humanitarian response left a vacuum for coordination that the US government willingly filled by the creation of ORHA and HOC within the Department of Defence. 39

The rejection of ORHA and HOC by British NGOs was not mirrored by many American NGOs. Rony Brauman and Pierre Salignon argued that the evident lack of resistance from US NGOs was due to their fear of losing their funding from the US government. They wrote that, “in the United States… most NGOs accepted government funding, [and therefore] refrained judgement on the forthcoming war”. 40 This choice to refrain from judgment came not only

in the form of a lack of criticism of the US-led humanitarian response but also of the war itself. Donini et al. determined that “US NGOs feel that they have been coerced into supporting US foreign policy objectives”. 41 Many US aid agencies during this period were reliant on the funding they received from the US government. This had significant implications for their ability to distance themselves from the government and its plans for Iraq. Barnett demonstrated this lack of distance between NGOs and the US government, highlighting that, “in 2003 U.S. AID administrator Andrew Natsios told humanitarian organisations operating in Iraq that they were obliged to show the American flag if they took U.S. funding”. 42 Furthermore, Greg Hansen argued that after the invasion, the “exercise of neutrality, impartiality and independence in Iraq, had come to be understood as ‘anti-Americanism’”. 43 The acceptance of government funds by US NGOs limited their ability to challenge the war or the plans for the humanitarian response. There was clear pressure on US NGOs to accept government funding as by denying government funds and thus protecting their neutrality NGOs were perceived to be anti-American.

Funding figures of the UK NGOs in 2003 demonstrate that they received large sums of money from the government, however many British NGOs chose not to use government money for their Iraq relief projects. Before the war, DfID committed £3.5 million to the United Nations, later promising to double that contribution. 44 Alongside this, DfID offered £3 million to NGOs for projects that would help prepare for the humanitarian consequences of the war. 45 Writing in 2003, prior to the invasion, Nick Cater stated that the “Catholic fund for Overseas Development is considering making an application [for DfID money]…, but is ‘very unlikely to accept funding’ during any hostilities”. 46 CAFOD, Save the Children UK, ActionAid and Oxfam made a joint declaration stating that they would not take any money from the British government for their Iraq response as “such aid would be inappropriate while

45 Ibid.
46 Ibid.
fighting continues’’.\footnote{David Batty, ‘Aid for Iraq timeline: Week Two’ The Guardian (07 April 2003) [online], Available: https://www.theguardian.com/society/2003/apr/07/1 [Accessed 17 April 2017].} This denial of government funds demonstrates the fear within British NGOs that, by accepting money from a belligerent party within the conflict, the Iraqi population would perceive them as a tool of the government.

The attitudes of the different branches of Save the Children demonstrate the different relationship that the UK and US branches had with their governments. According to an investigation by The Guardian newspaper, Save the Children US received 60\% of its income from ‘government grants and contracts’, “whereas Save the Children UK received 49\% from ‘grants and gifts in kind from institutional donors’, including the government’’.\footnote{Kevin Maguire, ‘How the British Charity was silenced on Iraq’, The Guardian (28 November 2003) [online], Available: https://www.theguardian.com/society/2003/nov/28/charities.usnews [Accessed 10 April 2017].} Despite the large proportion of funding from the British government, Save the Children UK set itself apart from its American counterparts by refusing any government funding for their response in Iraq. In November 2003, The Guardian released leaked internal emails between the two sections. The US branch criticised its UK base for “accusing the coalition forces of breaking the Geneva Convention by blocking humanitarian aid” and asked for their name to be removed from the statement.\footnote{Ibid.} According to the article, the US branch was worried about the effect that this statement would have on its donors. These emails reveal the impact and power that government funding had on the independence of these branches. British NGOs denial of government funding for their projects within Iraq prevented them from suffering the restrictions placed upon US NGOs. By refusing funding from the UK government, British NGOs were able to voice their concerns both regarding the war itself, but also to the plans of the US (and by extension the coalition) plan for coordinating the humanitarian response.

The role of the British military and the need for a handover of the humanitarian response to NGOs was a familiar rhetoric within discussions in the British government. In the months leading to the Iraq invasion, in debates in the House of Lords, there was general recognition, both of the need to
divide the military and NGO response, but also that NGOs were the best placed to deliver aid. For example, in a debate within the House of Lords on 10th April 2003, Baroness Valerie Amos, (who took up the role of International Development Secretary after the resignation of Clare Short in May 2003) stated that “there will be the immediate post-conflict phase when our military has… responsibilities in relation to humanitarian assistance. Once security is established, it will be possible for humanitarian workers to come in”. The Director General of Corporate Communications for the Ministry of Defence wrote that it was “arranged, in conjunction with the US, for UK forces to provide emergency humanitarian aid in southern Iraq until such time as civilian aid agencies could take over”. These statements presented the image of collaboration between the British military and humanitarian organisations. The British government planned a clear hand-over of work from the military to the humanitarian organisations. This was not the case however, within the US’ preparations.

The records of British government cabinet meetings, which were declassified during the Chilcot Inquiry, demonstrate that the government was critical of the US government’s creation of ORHA and feared the power it may hold. One paper taken from the Inquiry demonstrates that the UK government feared that the US “could move ORHA beyond the UK’s understanding of an occupying power’s rights and obligations”. Furthermore, it concluded that “ORHA is in many ways a sub-optimal organisation for delivering the UK’s Phase IV objectives on the ground in Iraq”. Within military responses, “Phase IV” refers to the Stabilisation and Reconstruction phase. This paper recognised both the limits of ORHA and challenges that it could pose within the humanitarian response. In an attempt to counteract this potential power of the US through ORHA and later the Coalition Provisional Authority (CPA),

51 Director General Corporate Communication, Operations in Iraq, p.34.
52 Unlike the Kosovo crisis, the instability of Iraq after the war meant that there was never a clear handing over.
54 Ibid.
the British government worked to place UK civilian personnel into CPA’s offices, increasing their number from 6 in March 2003, to “over 70, including secondees from MOD, FCO and DfID” by mid-June 2003. The UK Government feared the US power over Iraq’s “political or economic governance such as constitutional reform; substantive decision on oil market strategy and the attraction of foreign investment in the oil sector”. The UK government saw the humanitarian response as a potential tool that the US could use to have significant power over Iraq and its economy after the war and thus mirrored British NGOs in their resistance to an ORHA coordinated humanitarian response.

Despite this resistance to the planned coordination of the humanitarian response by the US government, the UK government did not fully support the need for a military-free humanitarian response. In the years preceding the Iraq war, questions about the role of militaries within humanitarian settings divided British NGOs. A leading advocate of the development of Civil-Military Cooperation policies within NGOs was the British Red Cross. In 1999 the NGO-Military Contact Group (NMCG) was created after a conference in Oxford. Chaired by the British Red Cross, this contact group aimed to “improve and strengthen communications between NGOs, the British Armed Forces and relevant government departments, addressing policy, technical and operational issues and civil-military relations in humanitarian response”. While the objectives of these meetings may not always be clear, whether the aim was “to improve co-ordination in anticipation of joint activities or develop an understanding that will re-enforce separate roles”, they provided a space of encounter between military and British NGOs.

British NGOs published multiple policy documents in the months prior to the Iraq war that set out their roles within humanitarian response alongside

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56 Inter-parliamentary Union, Iraq.
military actors. Oxfam, for example, produced a policy paper in March 2003 stating; “our experience shows that civilians are best assisted when civilian humanitarian agencies provide this assistance, even during conflict situations”. It went on to state that the role of the military within humanitarian crises should be “to create conditions secure enough” for humanitarian organisations to deliver aid and that it was “only in extreme circumstances, where civilian organisations cannot work, that military forces should directly provide humanitarian aid”. The Humanitarian Practice Paper, written in 2003 shows that there were discussions, during this period, regarding the benefits of the military within humanitarian settings. It stated that “the simplistic perception that barriers between humanitarian organisations and the military are based on misunderstandings and cultural clashes gloss over much greater intrinsic differences between core aims and principles”. The military’s aims were political; the NGOs aims were not. The creation and continued meetings of the NMCG demonstrates a fundamental difference between the British and American government during this period. The British government recognised the importance of dialogue between themselves, the military and humanitarian actors. They also acknowledged that, when possible, humanitarian organisations were the best placed to deliver humanitarian aid. This is distinctly different from the US government who planned to run the humanitarian response and did not appear to recognise the implications that this may have had for the work of humanitarian organisations. The creation of policy documents by British NGOs prior to the Iraq war, outlining the civil-military roles within humanitarian settings, demonstrates both their concern for the blurring of boundaries between their work and that of the military, but also their recognition of the necessity to work alongside the military.

The UN’s failure to clearly define its role within Iraq left a void in the coordination mechanisms of the humanitarian response. The US government’s plan to coordinate and control the humanitarian response

60 Ibid., p.11.
directly challenged the principles of neutrality and impartiality. In the context of a war in which the actors in the conflict proposed that they would co-ordinate humanitarian aid, this led British NGOs to re-emphasise the humanitarian principles, which, in the year before the Iraq conflict, they had begun to dismiss. Their objections also represent wider discussions taking place within the British humanitarian community regarding the danger that close relationships with governments, such as those proposed by the US government, might have. The different responses of UK and US aid organisations to these plans demonstrate the power that funding had over humanitarian organisations. It also, and perhaps more importantly, represents the differential relationship that these US aid agencies had with their government. However, as the Iraq war proceeded, the humanitarian field grew in complexity, and the British government lost recognition of a need to separate military and NGO delivered aid.

**From Liberators to Occupiers, The invasion and its aftermath**

On 20th March 2003, after months of preparation by military and humanitarian actors, the coalition forces launched a bombing campaign on the capital of Iraq, Baghdad. Though there was no official declaration of war, this date is now commonly used to mark its beginning. The bombing of Baghdad served as a precursor for a land invasion termed, by the US military, Operation Iraqi Freedom, and by the UK military, Operation Telic. Though initially planned as an invasion from the North, the Coalition forces entered Iraq from the South through the Al-Faw peninsula. After securing the south of the country, in particular, the Um Qasr port, which would be controlled by the British military, the coalition forces moved northwards. The British moved to take over Basra and the US to invade the capital Baghdad on 5th April 2003. Four days after the capital’s invasion, images of the destruction

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62 Hugo Slim notes a movement with NGOs in Britain that “saw them rediscovering the principles and practice of formal, classical humanitarian action”. This chapter examines the context of Iraq and the militaries infringement upon the humanitarian space, to offer a justification for this. Slim, ‘Establishment Radicals’, p.37.


of Saddam Hussein’s statue, which stood in the centre of Baghdad, were projected across the world’s news channels. President Bush declared victory over Hussein's Ba'ath regime on 1st May 2003. The coalition military forces and governments believed that the swift invasion and defeat constituted a “remarkable military victory”. 65 If one interprets this war as merely having the objective of overthrowing the Ba’ath regime, this claim of a victory is justified; however, it is clear that the immediacy of this victory was soon overshadowed by the months and years of instability that followed. This section will examine the impact of this instability on the humanitarian response within Iraq.

Following the military victory, the Coalition Provisional Authority took over the role of the interim government of Iraq. As part of this transition, the coalition forces disbanded the government of Iraq and the Iraqi army and arrested members closely connected to the Ba’ath regime. With the fall of the Ba’ath regime, however, came a collapse of the social fabric of Iraq. The planned quick handover to Iraqi civilians now seemed unfathomable and the predictions for the post-invasion phase, such as USAID’s Wendy Chamberlin’s claim that, “It's going to be very quick….We're [the coalition forces are] going to meet their immediate needs., We're going to turn it over to the Iraqis. And we're going to be out within the year”, appeared naive. 66 Baker and Rubin criticised the coalition forces, arguing that “the assumption that a viable Iraqi state would survive the invasion proved to be unfounded as the Iraqi army collapsed, the government ceased to function, and the country descended into anarchy”. 67 An example of this anarchy was the widespread looting that took over the cities of Baghdad and, to a lesser extent, Basra. With a lack of government to enforce law and order and “British and allied armed forces [inability to] immediately fill the power and admin vacuum left by the collapse of civic authority”, violence throughout the country grew. 68 The breakdown of civil society and the challenges that this brought with it

were not, however, a surprise to all parties within Iraq. For example, on 30th January 2003, the International Rescue Committee “publicly warned that breakdown of law and order was likely”.\(^69\) Despite this warning, both humanitarian organisations and ORHA planned to respond to a humanitarian crisis as they would a natural disaster, predicting the mass displacement of people, a potential breakout of disease and possible food shortage.\(^70\) This preparation, however, did not appropriately prepare for the challenges that would face communities.

The predicted disease breakout and food shortages did not materialise after the invasion, and the numbers of those displaced were fewer than the coalition governments and NGOs had predicted. Instead, the initial challenge that faced the populations of Iraq was the damaged infrastructure that was the result of the air attacks. Baghdad for example, is geographically very flat and therefore it relied on a pumping system to ensure the city had access to freshwater and that sewage was moved out of the city, these mechanisms suffered substantial damages during the war. Power lines were also significantly damaged, resulting in a lack of electricity for both Basra and Baghdad. The main challenges, therefore, that Iraqi communities faced, alongside the injuries that some civilians incurred during the invasion, were a lack of clean drinking water, damaged sewage systems and a lack of electricity.\(^71\) Following the invasion, many NGO projects changed to respond to these infrastructure challenges. Oxfam worked in Baghdad to deliver clean water and attempt to rebuild sanitation systems.\(^72\) Save the Children worked to ensure populations had access to food, water, medicines and shelter.\(^73\) While the rebuilding of infrastructure was not an unusual challenge for humanitarian organisations, the continued violence within the country compounded the challenge.

As violence within Iraq cities grew, the question of whose responsibility it was to stabilise the country became pressing. When the CPA disbanded the

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\(^{70}\) Kirkbride, Bailey and Omar, *Rising to the humanitarian challenge*.

\(^{71}\) Ibid.

\(^{72}\) Ibid., p.23.


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Ba’ath government and the Iraqi military, there was a breakdown of services such as the police force, the fire service and the ambulance service.\textsuperscript{74} Within the first month of the coalition control of Iraq, reports of violence and looting began to arise from both Baghdad and Basra. Social geographer Derek Gregory highlighted that this “surge of looting… was the understandable result of sheer material deprivation”.\textsuperscript{75} This looting had a significant impact on the continued running of civil services, such as the hospitals, something that will be discussed in further detail in section 3. Alongside this looting, there was a rise of insurgent groups who fought against the control of the coalition in Iraq. The coalition’s inability to secure Iraq and restart mechanisms of civilian control resulted in public disorder and the damage of public facilities such as hospitals; the implications of which will be discussed later within this chapter.

After the invasion and the removal of the Ba’ath regime, there a gap within the country’s governance structure that the coalition governments, who did not wish to present themselves as occupiers, were unwilling to fill. ORHA, which was initially designed to run and coordinate the humanitarian effort in Iraq, was unfit for the challenge of sustaining and supporting civil society.\textsuperscript{76} Not only was ORHA not created to fill this role, but there was a distinct lack of commitment from the coalition forces to create this stability. Donald Rumsfeld, the US Secretary of Defence, was asked on 11\textsuperscript{th} April 2003, why coalition forces had failed to stop the looting, he responded, “Freedom's untidy and free people are free to make mistakes and commit crimes and do bad things. They're also free to live their lives and do wonderful things, and that's what's going to happen here”.\textsuperscript{77} This response echoes the coalition’s belief that they were not in Iraq to rebuild the country.

Throughout the planning stages and initial months after the invasion, the US and the UK governments regularly used the term ‘liberators’, when discussing their role in Iraq. They believed that they had fulfilled their role in providing

\textsuperscript{74} Baker and Rubin, ‘Understanding Accountability and Governance in post-invasion Iraq’.
\textsuperscript{76} Baker and Rubin, ‘Understanding Accountability and Governance in post-invasion Iraq’, p.523.
the Iraqi population with this freedom. Frederick Burkle, who worked as the interim Minister of Health of the Coalition Provisional Authority in Iraq until April 2003, argued that despite the increasing instability the coalition demonstrated a continued commitment to their role as liberators, “not occupying forces”.

This choice relieved the coalition of any responsibility to work to rebuild the civil society structures within Iraq. This lack of acceptance of the role of ‘occupiers’ left what Alistair Mack, a serving officer for the US army, has coined a “theatre-level power vacuum”.

Paul Bremer, who replaced Lt. General Jay Garner as the Director of ORHA on 11th May 2003, argued that there were “about 40,000 coalition forces in the capital, but their very restrictive rules of engagement did not allow them to use force to stop the looting”.

Thus, in the months following the Iraq invasion, Iraq was left with no national military, no police force and no one willing to fill the role of managing the cities.

The label of “occupiers” carried with it both restrictions and obligations for British and US governments within Iraq. Legal scholar Gregory Fox highlighted that within the bounds of the traditional understanding, “occupiers are assumed to remain only for the limited period between the cessation of hostilities and the conclusion of a final peace treaty...[furthermore]an occupier exercises mere de facto power. For that reason, it enjoys no general legislative authority to make permanent changes to legal and political structures in the territory.” This directly contradicts the actions of the CPA who, after the removal of the Ba’ath party, “undertook reforms in six major areas and significantly altered pre-existing Iraqi law and governing institutions”.

Fox highlights the “obvious and troubling

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81 As ‘occupiers’, the coalition was drawn into obligations under both the Hague regulations and the Fourth Geneva Convention. These were created to ensure that civilians had access to services such as healthcare and ensured the protection of civilian persons in the time of war, placing the responsibility of civilian welfare into the hands of the coalition forces.
83 Ibid., p.201.
implications for the sweeping reform agenda pursued in Iraq”.

The debate regarding the de-Ba’athification of Iraq, its legality and the way that it was managed, cannot be discussed within the bounds of this chapter. However, the implications of the Ba’th regime’s removal by allied forces, and the subsequent refusal of the coalition to take responsibility for civil order, led to substantial ramifications for the delivery of humanitarian aid, both within Baghdad and across the rest of the country. The dismissal by the US and UK governments of their responsibilities as occupiers stopped when the UN Security Council passed Resolution 1483. This resolution, Derek Gregory argued, mandated that the US and UK, as occupiers, administered post-war Iraq. It stated that the “council acknowledges the US and UK and describes the two states as ‘occupying powers under unified command’.” With the lack of objection to this, the coalition forces accepted the responsibility of ensuring that civilians had access to basic services and security.

The pressing obligation to protect civilians meant that the military delivered aid whilst continuing to fight against insurgent forces. Lieutenant Colonel Conrad Conrad justified this by explaining that “Phase IV [the Stabilisation and Reconstruction phase] usually begins soon after the advent of combat…[and] significant fighting can still occur during Phase IV”. In Iraq, the US and UK military’s delivery of aid took place alongside their fighting. Humanitarian workers were also pushed, by the insecure environment in Iraq, to deliver aid alongside the coalition forces.

As the war in Iraq progressed, the tension between government control and NGO resistance continued. In April 2003, the role of ORHA in the coordination of the humanitarian response was handed to the Coalition Provisional Authority. In resistance to CPA and other attempts by the military to control the humanitarian response, a network of international

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84 Fox, ‘The Occupation of Iraq’, p.199.
NGOs created the NGO Coordination Committee in Iraq. Though this group aimed to create “a co-ordinated system of delivery”, outside of ORHA/ CPA. Despite the resistance of UK humanitarian organisations to the presence of the US government within the humanitarian arena, many organisations continued to work through the government-run bodies. USAID’s Disaster Assistance Response Team, for example, was located within the Humanitarian Operations Centre (which was managed by the coalition governments). During the response, the Humanitarian Operations Centre had the “authority to confer (or deny) permission for entry into Iraq by aid agencies”. The US government, through CPA and HOC, maintained its strong command over the humanitarian response.

The creation of the Commander’s Emergency Response Programme also highlights the growing presence of the US military within the humanitarian arena in Iraq. This programme offered a “pool of discretionary cash available to field commanders for quick-response civic action or ‘hearts and minds’ activities”, in which they included humanitarian assistance, and by 2006 had amassed $753,000,000 in funds. Despite holding a lesser role within both the CPA and HOC, the UK government, like the US, used its military to deliver humanitarian aid. The Ministry of Defence, for example, “allocated £30M for immediate humanitarian aid to meet our national obligations in the interim period before the security situation stabilised enough to allow agencies to take on humanitarian responsibilities”. Reports also promoted the delivery of “30 WHO health kits provided by DfID to the Central Drugs Supply Depot in Basra and sufficient drugs and medical equipment to provide primary health care for 300,000 people for three months” by UK forces. The occupying militaries, whilst continuing fighting, used aid as a tool within their

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90 Kirkbride, Bailey and Omar, Rising to the humanitarian challenge, p.3.


92 Ibid., p.43.

93 Director General Corporate Communication, Operations in Iraq, p.37.

94 Ibid., p.35.
‘hearts and minds’ projects in the hope to gain support from the Iraq population.

Images of the British military delivering humanitarian aid were used within the British media to counter opposition to the war. Investigating the iconography of the Iraq war within the British press, Katy Parry noted that “the pro-war press in Britain largely embraced and perpetuated the theme of the humanitarian motivations for war, with The Sun and The Telegraph positively framing humanitarian-like activities in over 14 per cent of all their Iraq-related photographs”.95 Parry wrote that images which provided a “humanitarian-led frame” of the war played a “legitimating function”.96 The image of the military as a humanitarian response was used strategically to promote the invasion as a humanitarian act.

Notwithstanding its limited role, the UN was not absent within the humanitarian response. In May 2003 the UN Security Council Resolution 1483 stated that “the UN should play a vital role in humanitarian relief”.97 In June 2004, another Security Council Resolution (1546) enforced the need for “commitment of all forces promoting the maintenance of security and stability in Iraq to act in accordance with international law”.98 Within the response itself, the UN acted through the World Food Programme and UNICEF.99 In August 2003, the UN created the United Nations Assistance Mission for Iraq, which had the task of “exhortation and information seeking… to assist the Iraqi people in achieving their goals”.100 The UN remained distant from the war through its lack of involvement in the military aspects, however as the war continued it engaged with the humanitarian response and took on the role of reminding the coalition of its legal

95 Parry, ‘Images of liberation?, p.1192.
96 Ibid., p.1198.
100 UN, Security Council resolution 1483.
obligations through various Resolutions.\textsuperscript{101} The UN, like the British humanitarian organisations, aimed to keep its distance from CPA and HOC.

Despite the recognition, by NGOs, of the risks of civil-military co-optation, British humanitarian organisations were unable to escape the bounds placed upon them by the insecurity in Iraq. Some members of the NGO community, in recognition that the division between NGOs and the military was increasingly difficult, welcomed the collaboration. Rob MacGillivray, from Save the Children UK, contested the seemingly territorial nature of the humanitarian space and argued that humanitarian organisations did not have claim over humanitarian space.\textsuperscript{102} He determined that, rather than objecting to the delivery of aid by the military, aid agencies should offer their expertise to enable the military to deliver aid effectively.\textsuperscript{103} One can see the beginning of this collaboration in the role that British NGOs played in lobbying for the occupying forces to fulfil their legal obligations. Oxfam wrote, “it is particularly important to emphasise the particular responsibility that any occupying power bears under the Fourth Geneva Convention to ensure the supply of food and medical necessities, and the maintenance of hygiene and public health during armed conflict and its aftermath”.\textsuperscript{104} MacGillivray argued that the delivery of aid by the military was not going to stop, but NGOs could inform the way in which this aid was given.\textsuperscript{105}

Reflecting on their time within Iraq, a British humanitarian aid worker (who asked not to be named) recalled the difference between the British and US delivery of aid. They stated that the difference was “like night and day”.\textsuperscript{106} They explained that the US military would remain in full-body combat armour when working within Iraq communities, whereas the British military would wear soft caps and roll up their sleeves.\textsuperscript{107} They also gave one example of a US tank which had written on it “Baghdad Widow Maker”.\textsuperscript{108} While recognising the problematic delivery of aid by military forces, there were

\textsuperscript{101} Gordon, ‘Reforging Certainties?’.
\textsuperscript{102} Rob MacGillivray, Interview by Jennifer Chapman, Personal Interview, via Skype, (19 June 2017).
\textsuperscript{103} Ibid.
\textsuperscript{105} MacGillivray, Interview by Chapman.
\textsuperscript{106} British Humanitarian worker, Interview by Chapman.
\textsuperscript{107} Ibid.
\textsuperscript{108} Ibid.
distinctions between the ways in which the UK and the US military decided to deliver this aid. It is therefore unsurprising that, “the British did not meet the degree of resistance and hostility faced by the US forces in central Iraq”. The implications of the military’s delivery of humanitarian aid, however, became apparent in August 2003.

As the fighting continued after the war, the insecurity within the country made it increasingly challenging for NGOs to deliver aid. Throughout the initial post-invasion phase, the UK government continued to ensure that their “intention [was]…to hand over responsibility for humanitarian assistance to civilian aid agency experts …as soon as possible”. This handover never took place as insecurity within the country increased. The British military, rather than providing the security that would enable humanitarian workers to access to communities, delivered humanitarian aid themselves and began to monopolise the humanitarian space. The continued violence within Iraq and the inability of the military to create neutral humanitarian spaces led to a blurring of roles of actors within Iraq and loss of distinction between humanitarian organisations and the military. The fear that British NGOs held, prior to the invasion, of the consequences of this conflation was justified.

The implication of this can be seen in the targeting of aid organisation by insurgents. On 19th August 2003, a truck bomb exploded in the UN headquarters in Baghdad, killing 23 people including the UN Special Representative in Iraq Sérgio Vieira de Mello. Following this, on 27th October 2003, 12 people were killed in a bomb targeting the ICRC headquarters, also in Baghdad. This attack was the first suicide bomber to target the “famously neutral” ICRC. From October 2003, the aid arena in Iraq dramatically and irrevocably changed. Many NGOs working in the

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110 Director General Corporate Communication, Operations in Iraq, p.34.
111 Kirkbride, Bailey and Omar, Rising to the humanitarian challenge.
country moved their international staff and headquarters to Jordan. Following these attacks, Hansen argued, “the security of humanitarian actors has dominated discourse and decision-making on the humanitarian response in Iraq...to the extent that security restraints routinely trump the humanitarian imperative”. The insecurity pushed humanitarian organisations into the fringes of the delivery of humanitarian assistance and as a consequence, left space for aid to be delivered by the military within their ‘hearts and minds’ projects.

**Medical Humanitarian Aid and the role of the Military Medic**

One of the main victims of the coalition’s failure to provide security in Bagdad and Basra was the Iraq healthcare system. Years of sanctions had already weakened the healthcare system in Iraq, which was further damaged by the heavy looting of hospital facilities after the invasion. Nicholas de Torrente, former executive director of Doctors without Borders, wrote that “immediately after the fall of Saddam Hussein’s regime, emergency relief efforts were paralysed as basic services collapsed due to looting, political upheaval and in hospitals admin chaos”. When fighting with insurgents began, the ICRC wrote that the “bombing [was] hindering the delivery of medical supplies and water to the capital's hospitals”. These reports paint an image of crippled health care service and an unorganised and poorly-protected response. In this insecure setting, the poor-quality of care and inaccessibility of state hospitals led some civilians to turn to military hospitals for aid, resulting in differential care for civilians and military personnel in these hospitals.

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119 For information on military medical personnel or the different groups within the Royal Army Medical Corps see: *Royal Army Medical Corps*, Available: https://www.army.mod.uk/who-we-are/corps-regiments-and-units/army-medical-services/royal-army-medical-corps/ [Accessed 20 September 2019].
The health care system of Iraq in the 1980s was deemed one of the best within the Middle East; however, sanctions in the 1990s had damaged it significantly and had led to a loss of medical staff. British medical students who worked in Iraq before the invasion determined that the sanctions had “affected almost every aspect of medical care”. The sanctions resulted in a failure to maintain facilities, to replace broken equipment and to maintain training for medical staff. Examining the Iraq healthcare system prior to the war, Bassim Irheim Mohammed Al Sheibani a lecturer physician and his colleagues argued that emergency medicine had not developed to meet the needs that the war required and that “emergency departments… [were] staffed by doctors who do not have proper experience or skills to manage emergency cases”. Les Cannon, a British Military orthopaedic surgeon, working in Basra in 2004, also highlighted that when the war began, “those with money left the country” and he determined that a large majority of those were health care professionals. Figures from the Iraq Medical Association suggest that by 2003, “50 per cent of the 34,000 doctors registered… [had] left the country”. The war in Iraq exacerbated the already damaged health system through the heavy looting of hospital facilities and a further loss of doctors. Hansen, reflecting on the response in 2008, argued that the implication of the insecurity within Iraq on the medical system was that “there is no doubt that needs surpassed access and delivery in Iraq between 2004 through 2006”. The lack of security within Iraq worsened the already compromised Iraq health care system and further restricted the population’s access to health care.

The war also brought with it the challenge of injured Iraqi civilians. The Director General of Corporate Communication for the UK Ministry of Defence stated that the coalition had an “extremely effective targeting policy”. A report on civilian causalities, however, contests this. In May

122 Mr Les Cannon, Interview by Jennifer Chapman, Personal Interview, via Skype, (14 June 2017).
123 Kirkbride, Bailey and Omar, Rising to the humanitarian challenge, p.12.
125 Director General Corporate Communication, Operations in Iraq, p.34.
2003 the Project by Defence Alternatives produced a report mapping the instances of civilian casualties since the beginning of the airstrikes. An ICRC figure within this report, on 10th April, predicted that in Baghdad alone there had been 4,200 civilian causalities. An ICRC figure within this report, on 10th April, predicted that in Baghdad alone there had been 4,200 civilian causalities. Alongside these figures, this report speaks of individual instances of bombings, such as the bombing of a market place that “killed almost 60 civilians”. Furthermore, the British media also released reports of the bombing of Baghdad’s trade fair building which, having been next to a Red Crescent maternity hospital, “injured at least three doctors and nurses” and “damaged the windows and roof of the hospital”. Thus a crippled health service and inexperienced emergency departments were faced with civilian injuries in the continuing conflict. The coalition forces and humanitarian organisations faced the problem of supporting Iraqi staff in both the rebuilding of a fractured national healthcare system, while simultaneously providing a medical humanitarian response to those injured during the fighting.

NGOs, while not working directly within the hospitals, attempted to help with this rebuilding. There is little information within humanitarian organisations’ annual reports on the actions of NGOs within Iraq; for example Save the Children, in its Annual report from 2004, states only that “more than a year [after entering Baghdad], STC employs more than 250 Iraqi humanitarian workers and completed more than 600 grassroots community projects”. It fails to tell the reader where their staff were working or what they were doing. However, Rob MacGillivray working for Save the Children in Baghdad highlighted that one of their projects centred on attempting to restock hospitals with medical equipment that had been looted after the invasion. MSF had also contributed to restocking surgical equipment and other medical supplies within Iraq hospitals. In the aftermath of the Iraq war, the British charity Merlin released a report documenting its work within Iraq. It wrote

130 Rob MacGillivray, Interview by Chapman.
131 Kirkbride, Bailey and Omar, Rising to the humanitarian challenge, p.11.
that “the charity is now focussing on rehabilitating 137 clinics and 2 Paediatric units in Al Rasafa and Al Karkh health directorates in Baghdad”, it also highlights its role in training Iraqi staff.\textsuperscript{132} Similarly, in July 2003, Merlin met with the Iraqi Interim Director of Preventative Medicine “who stated how embarrassed he, as a health professional, was to be sitting in the looted building, with no resources to offer other than his extensive healthcare knowledge which no one had asked him about”.\textsuperscript{133} Merlin, unlike CPA and the coalition forces, made a distinct effort to work directly with Iraqi medical staff such as the Interim Director of Preventative Medicine. The CPA has been criticised by Linda Doull for supporting “private health contractors unfamiliar with post-conflict health service provision, and the CPA’s lack of transparency about health sector reform plans”.\textsuperscript{134} In reaction to the lack of inclusion of the Iraq Ministry of Health in planning the rebuilding of the health care system, the International Committee of the Faculty of Public Health organised a workshop for WHO, DfID, INGOs and the Iraqi Ministry of Health.\textsuperscript{135} This represented an alternative to the coalition-led humanitarian response and an attempt to bring the Iraqi Ministry of Health into the planning of the Iraq health care system. Though there was an immediate need within hospitals, the insecurity led humanitarian organisations to work with the Ministry of Health to develop a longer-term plan, while supporting the hospitals remotely.\textsuperscript{136} In light of this, many of the hospitals were understaffed, being run by some of the few remaining Iraqi doctors. Civilians in need of medical treatment had to choose between seeking care in these civilian hospitals or attempting to get treatment within military medical facilities.

The study of two military hospitals, one run by the US and one by the UK, highlights both the role of the military and the implications that a military-run hospital as the main facility for care has for the treatment of civilians. Within Baghdad, the US military set up the 31\textsuperscript{st} Combat support hospital

\textsuperscript{134} Ibid., p.12.
\textsuperscript{135} Andrew Furber and Paul Johnston, ‘Rebuilding Health Care in Iraq’, \textit{Journal of Epidemiology Community Health}, 58(888), (2004).
\textsuperscript{136} Murphy and Conetta, ‘Casualties in the 2003 Iraq War’, p.4.
within the damaged and looted Ibn Sina hospital.\textsuperscript{137} This was situated within the international zone in Iraq and was run by the US army between 2003 and September 2009.\textsuperscript{138} This hospital was staffed by US military medical personnel and by rotating combat support hospitals, resulting in a regular change of hospital staff.\textsuperscript{139} It had operating rooms and an intensive care unit that treated coalition forces, Iraqi military and civilians. The hospital focused on the treatment of injured US military personnel.\textsuperscript{140} Similarly, on the outskirts of Basra, the British army set up a field hospital for injured British troops, which specialised in orthopaedic and general surgery.\textsuperscript{141} Mr Cannon emphasised that this hospital was primarily for British and coalition soldiers and that only on rare occasions would they treat civilian patients.\textsuperscript{142} Mr Cannon described the field hospital in which he worked as being better than an NHS hospital as patients had direct access to Consultants.\textsuperscript{143} In 2008 the Healthcare Commission determined that military trauma care was of an “exemplary” standard and suggested that the NHS could learn from them.\textsuperscript{144}

Given the poor state of the healthcare system in Iraq, these two military hospitals were among the few remaining and successfully functioning hospitals in Iraq. The lack of both hospital staff and facilities elsewhere in Iraq meant that civilian patients who were critically injured were often brought to these military hospitals.

The treatment of civilians within these hospitals aimed to get them out of the critical stage, and well enough to be transferred to a national hospital. Major James Sebesta of the US army stated that “Iraqi patients stayed until they were near ready for discharge and were transferred to Iraqi facility to arrange follow-up care”.\textsuperscript{145} However, Mr Cannon described the treatment of civilians

\textsuperscript{139} Ibid.
\textsuperscript{141} Rosenfeld, Rosengarten and Paterson, ‘Health Support in Iraq’, p.3.
\textsuperscript{142} Mr Les Cannon, Interview by Chapman.
\textsuperscript{143} Ibid.
\textsuperscript{144} Baker, ‘Care and Conflict’.
within the military hospitals in a less optimistic manner. He described an incident where military doctors, having treated civilians with severe head trauma due to a car accident, decided to move them to an Iraqi national hospital despite the knowledge that the hospital did not have the facilities to care for them. The doctors made this decision despite knowing that these two patients would most likely die if transferred. Cannon argued that the doctors made this choice based on the justification of the beds and equipment within the military hospital were primarily for the treatment of soldiers. Alternatively, when a coalition soldier was critically injured, they were stabilised and then transported by “critical care air transport teams for evacuation”, or what Les called “flying intensive care units”. These patients were flown “to higher echelons of care in Germany and state-side locations”. The US army praised itself for its ability to reduce “mortality rate for war wounds of US troops down to 10%” between the years 2003-2005. However, one can assume that these rates did not apply to civilian casualties. The differential care of Iraqi civilians and military personnel within the military hospital demonstrated that medical treatment was not impartial.

The discrepancy of care within the military hospitals is particularly evident within cases of burn victims, as these patients placed an unusually large strain on medical resources. Within the military hospitals, military doctors were aware that the Iraqi hospitals could not effectively treat a patient with more than 50% total body surface area (TBSA) burns and could not provide them with the specialist long term treatment they would need. Therefore, if a civilian patient entered the military hospital with over 50% TBSA burns, they would be treated as “expectant” and were only given pain control and basic wound care. The mortality rate for “non-coalition burned patients with 50% TBSA burns... was 100%”. In contrast to this, if a coalition...

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146 Mr Les Cannon, Interview by Chapman.
147 Ibid.
148 Rosenfeld, Rosengarten and Paterson, ‘Health Support in Iraq’, p.3.
149 Sebesta, (Major) ‘Special Lessons Learned from Iraq’, p.712.
150 Rosenfeld, Rosengarten and Paterson, ‘Health Support in Iraq’, p.5.
152 Ibid., p.160.
153 Ibid., p.160.
soldier arrived at the hospital with the same level of burns, their treatment would be significantly different. Christian Lundy highlighted their different treatment pathways, explaining that the coalition soldier would be “rapidly resuscitated and evacuated to higher levels of treatment”.\textsuperscript{154} This example, from a medical research paper on burn victims written after the war, demonstrates the differential treatment of civilians and military patients within the coalition’s military hospitals during the Iraq war. The coalition military hospitals, such as those used as examples above, were built with the main objective of caring for the coalition forces. The inability of the British military to take control of the Iraqi hospitals, therefore, had a direct impact on the treatment of civilian patients. One can hypothesise that if civilian hospitals were secured, the medical humanitarian organisations such as Merlin could have had a greater role within these, both supporting the Iraqi medical staff but also delivering the needed equipment and medicines to provide treatment to the patients. Instead, the lack of security within the national hospitals resulted in the delivery of many critically injured civilians to the military hospitals in which they were treated as a secondary priority and thus received different care.

Military physicians in Iraq were required to make hard ethical decisions in regard to patient treatment, and the prioritisation of military patients. The example of the patients injured in a car accident, given by Les Cannon, demonstrates the difficult choices he witnessed as a military physician within Iraq.\textsuperscript{155} These decisions challenged military physicians’ roles as medical doctors. Ramey Wilson, who has investigated in-depth the role of the military physician, determined that they sit in a distinct category, where they are “officially non-combatants [and] provide medical care for wounded, regardless of patient’s nationalities”.\textsuperscript{156} However, Wilson’s assessment fails to recognise the seemingly opposing roles of the soldier and the doctor. The instruction to prioritise coalition soldiers over Iraq civilians did more than “generate harsh choices for military physicians”, but also challenged the

\textsuperscript{154} Lundy et al., ‘Intensive Care Unit in Ibn Sina’, p.160.  
\textsuperscript{155} Mr Les Cannon, Interview by Chapman.  
\textsuperscript{156} Wilson, ‘Disasters and Conflict Zones Around the World’, p.115.
ethical standards of British medicine. Lisa Schwartz et al. wrote that “clinical ethics has traditionally focused on the best interests of an individual patient”; however, within the military hospital, this may not always have been the case. For the military physician, the decision to transport patients to the national hospitals with the knowledge that they did not have the facilities to care for them represents theforegrounding of their identity as a member of the military rather than that of a doctor. The examples above highlight the impact that this could have for patient care. For the military physician, the decision to treat a civilian is, Stuart Gordon argued: “as much a product of medical ethical considerations as they were an expression of ‘soft power’ in pursuit of ‘hearts and minds’”. It is clear that the doctors working within both the US and UK military hospitals in Iraq were trained and employed with the purpose of the “treatment of their own wounded and ill so as to maintain combat effectiveness”, and therefore, this was the priority for the military physicians working within these hospitals.

A report by the NGO-Military Contact Group in 2009 states that the role of the military within humanitarian settings should be that of “logistics, or impartial medical care”, however, case studies from within medical hospitals in Iraq question the parameters of this impartiality. Gregory, who viewed the Iraq war as a continuation of Britain’s colonial power, argued that one could see colonial attitudes within the reporting of the treatment of Iraqi civilians. He wrote that that just as the number of Iraq troops killed were not quantified, neither was the number of civilian deaths: “the principle that if they had not been counted, they did not count applied with equal force to civilian causalities”. In the aftermath of the 2003 invasion, a website called *Iraqbodycount* was created to monitor civilian casualties. This website suggests that the number of killed civilians is not insignificant and that by

160 Ibid., p.426.
2004, an estimated 6,087-7,798 civilians had been killed.\textsuperscript{163} The failure of the coalition governments to record civilians’ deaths reinforces previous conclusions within this chapter that argue that civilians treated by the military as second class citizens to that of army personnel.

Despite the requirement under international humanitarian law that the coalition forces ensure civilian populations had access to healthcare, many of the hospitals within Iraq remained insecure and poorly resourced.\textsuperscript{164} The inability to secure the hospitals within Iraq resulted in the degradation of the care that they could offer to the injured civilians during the Iraq war. Hansen determined that “as the proximity to communities in need decreases, so does the quality of humanitarian data, safe access and aid effectiveness”.\textsuperscript{165} This was certainly the case within the medical humanitarian responses in Iraq. Due to the insecurity of the hospitals, NGOs moved to work to develop and reconstruct the health system from a top-down level. The insecurity within Iraq, therefore, led to a lack of support for national medical staff and the civilian hospitals, many of which had infrequent access to electricity and water. In opposition to this, military hospitals were able to provide world-class treatment. This disparity meant that for many critically ill Iraq patients, the military hospital was their only option for treatment. The implication of this, however, was that they were not treated as the priority, and this directly impacted the care that they received. The goal of better treatment was unattainable.

**Conclusion**

This chapter has explored the relationship between British humanitarian organisations and the US and the UK governments during the Iraq war in 2003. It has argued that the attempt of the US government to use humanitarianism as a political tool within this war, and the humanitarian crisis that followed, led to a re-claiming of the humanitarian principles by British NGOs. The previous chapter showed that during the 1990s, there were

\textsuperscript{165} Hansen, ‘Operational Modalities of Iraq’, p.1.
debates between British academics and NGOs about the appropriateness and utility of the humanitarian principles. This chapter, however, has argued that the attempted politicisation of the humanitarian space in Iraq by the US, led to resistance from British NGOs and the increased use of the language of humanitarian principles.

This chapter has first examined the preparations for a humanitarian crisis before the Iraq war and the resistance of both the British government and British NGOs to a humanitarian response coordinated by new agencies within the US Department of Defence. The failure of the UN to clearly define its role within Iraq led to the creation of coordination mechanisms that sat within the US Department of Defence. Unlike the US government, which aimed to run the humanitarian response, the British government intended, as it had done in Kosovo, to hand over their humanitarian projects within Iraq to British NGOs as soon as was possible. This possibility was tied to the creation of stability within the country. Despite the extensive plans for the humanitarian response, the crisis that followed the war was greater than the coalition governments and NGOs has planned. The instability caused by the removal of state actors within Iraq led to a continuation of fighting between the coalition militaries and insurgents. The insecurity within Iraq prevented the creation of neutral humanitarian spaces, which were devoid of military actors. This meant that NGOs worked alongside militaries and delivered their aid alongside the militaries ‘hearts and minds’ campaigns. The fears of British NGOs of becoming “a largely owned subsidiary of the superpower” were exacerbated by the US government and the context of ongoing violence within Iraq. Due to this violence, NGOs were required to distance themselves from their aid recipients and were pushed into the work of reconstructing the health care of Iraq remotely.

Finally, this chapter has used the lens of medical humanitarian aid to assess the implications of the militarised humanitarian response. The inability of the coalition to create stability within both Basra and Baghdad resulted in the loss of many health care facilities within these cities, and thus the increasing

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166 Donini, Larry Minear and Peter Walker, ‘Between Cooptation and Irrelevance’, p.260.
number of civilians looking for treatment within the military hospitals. These hospitals were created to treat coalition soldiers, thus implicating the care given to Iraqi civilians who were second-in-line to the coalition forces.

The Iraq war had a significant negative impact on Blair’s reputation within Britain.167 Despite this decline in popularity, he remained in parliament for a further five years, resigning as Prime Minister in June 2007.168 Blair’s successor, Gordon Brown, who held the position of Chancellor of the Exchequer within the Blair government, could not distance himself from associations with Britain’s decision to go to war. Despite his prominent role within New Labour government, his supporters perceived him to be more “authentically Labour” than his predecessor and hoped he would push Labour party policies further to the left.169 Despite these hopes, as leader of the Labour Party, Gordon Brown’s policies show a lot of continuity with the Blair government, this is particularly clear within his policies to do with international aid.170 Kevin Theakston argued that given Brown’s role as “co-architect of New Labour”, it is unsurprising that his policies were not radically different from those of Blair.171 Throughout his three years as Prime Minister, Gordon Brown faced criticism for his inability to communicate a clear direction for government.172 His successor Conservative leader David Cameron, however, did not have this problem. Defining himself as a “liberal conservative”, Cameron, who became Prime Minister in May 2010, attempted to distance his policies from those of previous Conservative governments.173 Cameron aimed to present a Conservative party that supported all members of society in the hope to challenge the view that the Conservative party did not care for “those most vulnerable” both within Britain and

During his time in office, Cameron’s claims of supporting vulnerable international populations were put to the test during the West African Ebola outbreak in 2014. The following chapter examines the role of British actors in the humanitarian response to the Ebola. The British government, under Prime Minister David Cameron, was a key player in this response.

174 Robert M. Page, ‘David Cameron’s Modern Conservative approach to poverty and social justice: towards one nation or two’, *Journal of Poverty and Social Justice*, 18(2), (2010), p. 148. Once again one can see continuities of imperial humanitarian thought, this time within David Cameron’s Conservative government rhetoric, specifically the continued belief that it was Britain’s “right and duty” to improve the lives of those abroad. Gorman, ‘Empire, Internationalism, and the Campaign against the Traffic in Women and Children in the 1920s’, p.216.
Chapter Five: A Government-Led Response: 
Britain and Sierra Leone Ebola Outbreak, 2014

Introduction

The West African Ebola outbreak began in December 2013, when a young boy in Guinea became infected by the virus. By 7th April 2014, the Ebola virus had been recorded in three countries: Guinea, Sierra Leone and Liberia. Within Sierra Leone, despite early attempts of the government to contain the virus, through awareness-raising and the surveillance on the country’s borders, Ebola rapidly spread throughout the country. In May, the government created the National Ebola Task Force and began to train health workers to manage cases of Ebola. Despite the government’s attempts to implement measures to control the spread of the virus, such as the closure of schools and borders, the numbers of Ebola cases continued to rise. On 30th July the Sierra Leonean President, Ernst Bai Koroma, declared a state of emergency.

The epidemic rapidly outstripped both national and international efforts. By August, Sierra Leone had recorded 717 cases of the Ebola virus, and the death toll had reached 282. The Sierra Leone government, despite receiving support from the World Health Organisation and Médecins Sans Frontières, could not control this outbreak without further help from western governments. On 8th August the WHO, who had been coordinating the response across Sierra Leone, Guinea and Liberia, declared the outbreak had

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2 SEM Contributor, ‘In Sierra Leone, as more Ebola cases are confirmed, mixed messages and alarmist media reportage tend to derail the efforts of health officials to contain the virus’, *Sierra Express Media* (28 May 2014) [online], Available: http://www.sierraexpressmedia.com/?p=67698 [Accessed 06 July 16].
3 Ross, ‘Command and control’, p.3; The first Ebola treatment centre was set up by the Sierra Leonean Dr Khan, the second my MSF, who had been working within Sierra Leone since 1968.
4 The Ebola virus attacked a body’s circulatory system, causing haemorrhagic symptoms or excessive bleeding. The main cause of death for Ebola patients was loss of blood which would result in shock; Ross, ‘Command and control’, p.3.
become a “Public Health Emergency of International Concern”. In the following month, and in response to criticisms that the WHO had not responded early enough, the UN created the UN Mission for Ebola Emergency Response (UNMEER), whose aim was to provide “overall leadership and direction to the operational work of the United Nations System”. As western governments divided their aid between the affected countries, Britain, as a former colonial ruler, supported the response in Sierra Leone.

This chapter will examine the British response within Sierra Leone and argue that the presence of this outbreak within the international psyche and the fear surrounding its spread enabled the British government to spearhead the British humanitarian response. The control of this response, by the British government, specifically the MoD and DfID, resulted in a failure to prioritise patients suffering from Ebola. Rather these government departments prioritised the containment of the disease and the promotion of Britain as a leading figure within the international response. Scholars who have examined government policies during this period highlighted the Prime Minister David Cameron’s attempt to pursue what he called Compassionate Conservatism. Danielle Beswick and Mattias Hjort, scholars who have researched political parties’ engagement with international development, investigated the Cameron governments’ use of international aid to “modernise” the Conservative party. They highlighted that DfID had brought international development onto the map as a policy issue and that the UK had “established a leadership role in international development”.

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5 This outbreak was the first time that the Ebola virus had crossed borders with such a high infection rate, and more importantly, and as an explanation for its fast spread, it was the first time Ebola had been recorded in large urban settings. WHO Ebola Response Team, ‘Ebola virus disease in West Africa—the first 9 months of the epidemic and forward projections’, New England Journal of Medicine, 371(16), (2014), p.1481.


7 France also supported its former colony Guinea and the US supported its former colony Liberia.

8 Page, ‘Cameron’s Modern Conservative approach’.


development with conservative values as a way to promote the image of the party as compassionate.\textsuperscript{11} The actions of the government during the Ebola outbreak, however, do not follow this narrative of compassionate conservatism. Whilst Britain did respond to the outbreak, it was not solely driven out of compassion for the suffering of others. Instead, the British response was shaped by two dominant and interwoven understandings of the outbreak. On the one hand, the MoD portrayed Ebola as an international threat and therefore a security threat to the UK; on the other, DfID cast Ebola as an opportunity to present Britain at the forefront of humanitarian response internationally.

This chapter examines the role of each of the different actors that came together within the British response. It will first investigate the role of the British military within the response and will highlight the central position that British military personnel held within the coordinating bodies in Sierra Leone. It will also examine the origins of the securitisation of the Ebola outbreak, including the Sierra Leone government’s decision to use quarantines, and explore the ways that the British government responded to this narrative.\textsuperscript{12} One of the primary roles of the British military was to help build the Kerry Town Ebola Treatment Centre (ETC), which was funded by DfID and cost £89.10 million to build and run. This chapter will investigate the role that DfID, and the British organisation Save the Children, played in the running of the ETC and will argue that DfID used the ETC as a tool to promote itself as a leading figure within the international response. By providing a comparison between DfID’s response and the response of non-governmental aid organisations, this chapter will show that British NGOs built upon their experience of working in communities within Sierra Leone and focused on projects that targeted the socio-economic challenges that Ebola posed. The following section of this chapter will then proceed to discuss the role of NHS medical staff within the ETCs. It doing so, it will recognise the challenges medical personnel faced when treating Ebola patients due to the lack of a proven treatment or vaccine for the virus and

\textsuperscript{11} Beswick and Hjort, ‘A missing link in understanding Party policy change?’, p. 564.
\textsuperscript{12} This thesis refers to securitisation as “the ways that states and other actors use relief and development assistance to promote security objectives”. Fast, ‘Securitisation’, p.314.
enforced policies that aimed to stop the spread of the virus. This chapter will argue that the British government’s prioritisation of containment restricted the ability of medical personnel to deliver quality care to patients. Finally, this chapter will investigate the role of British research within the Ebola response. It will demonstrate how the prestige-seeking actions of DfID and the research bodies led to a focus on finding a clinical answer to the virus’ spread and the neglect of other avenues for research.

The Ebola outbreak has been chosen as the final study for this thesis as it reveals the impact of the heavy involvement and power of British government ministries within a humanitarian response. It also demonstrates the influence of this involvement on the framing and decision-making within a response. Furthermore, it highlights the power of the government to mobilise large numbers of actors and funds quickly. This chapter argues that the prestige-seeking nature of DfID, which failed to build upon others’ knowledge of past epidemics, and the prioritisation of security fears by the MoD, negatively impacted the care given to Ebola victims.

The British military and securitisation of the outbreak

In an investigation of the term ‘global health’, Didier Fassin examined two semantic networks that built this term, one of ‘compassion’ and one of ‘security’.\(^\text{13}\) He wrote that during situations such as viral outbreaks, there is a convergence of these two networks which can lead to the “confusion between humanitarian and military interventions”.\(^\text{14}\) The events of the 2014 Ebola outbreak support Fassin’s theory. Much of the literature produced by military personnel, after the outbreak, celebrated the role of the military within the Ebola response, presenting them as the only group “trained, equipped, manned and available to rapidly deploy and operate a complete medical


\(^{14}\) Ibid., p 104.
unit”. The securitisation of this response by the British government led to the deployment of a disproportionate ratio of military personnel to civilian medical staff. Previous chapters of this thesis have discussed the implications of the role of the military within humanitarian settings and the delivery of medical treatment. This section will demonstrate that the military’s prioritisation of the control of Ebola was to the detriment of patient care within Sierra Leone.

The British response to the Ebola outbreak was indicative of the securitisation narrative that surrounded the outbreak. On 8th August 2014, the WHO declared that the outbreak had become a “Public Health Emergency of International Concern”. This announcement led to the widespread fear, throughout the US and Europe, that the Ebola virus might travel beyond the continent of Africa. Historian Marks Honigsbaum argued that it was only when Ebola posed a threat “beyond West Africa and the extent of death and suffering within the tri-border zone became too visible” that international global health actors responded. The presentation of this threat was also examined by Gian Luca Burci, a former member of the Legal Office of the WHO, who argued that the presentation of Ebola as a threat to the international community was entrenched by the Security Council resolution 2177. This resolution, created on 18th September, determined that Ebola was an unprecedented threat to “international peace and security”. Burci argued that this understanding was the result of a long process of the securitisation of health, which had begun in the 1990s, and led to infectious diseases being treated as a “security threat to be addressed primarily by security, military and intelligence authorities”. The WHO’s announcement, and the following

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19 Ibid., p.27.
20 Ibid., p.33.
Security Council resolution, shifted understandings of the outbreak from being a crisis affecting West Africa, to a potential threat to the West.

Within Britain the media propagated this fear. Newspapers from a diverse range of political backgrounds emphasised the danger that Ebola posed. The Daily Mail, a right-wing tabloid newspaper, used headlines such as “Truth about incurable virus that’s just one plane ride from Britain”, which emphasised the threat that Ebola posed to the UK. Similarly, The Guardian, a left-wing newspaper asked: “What is the risk of Ebola in UK? Ebola experts outline NHS contingency plans in the event of an outbreak in Britain”. Though it is hard to assess the impact of such headlines on the British public the emphasis on the ‘threat’ of Ebola, seen within newspapers of both political backgrounds, demonstrate the significant presence of this language within the public arena. These headlines were not however, unfounded. The existence of such contingency plans and the delivery of information about Ebola by Public Health England (PHE) demonstrates that the NHS and PHE believed that Ebola did pose a potential threat in the UK. The language that discussed the threat of Ebola was also used by David Cameron when he spoke about the outbreak. In a speech that he made at the Lord Mayor’s banquet in November 2014, he determined that Ebola sat “alongside ISIS and Russia as one of the biggest threats to Europe”.

Media reports, that highlighted the threat that Ebola posed to the UK were not unfounded; they reflected a real narrative within the government that emphasised the danger this virus posed to Britain.

The fear that Ebola could spread to the UK was exacerbated when British nurse Will Pooley was flown back to the UK on 24 August 2014, having contracted the Ebola virus in Sierra Leone. In 1998 sociologist, Sheldon

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24 Russia Today, ‘ISIS, Ebola, Russia: Cameron shortlists threats to Europe’, YouTube (11 November 2014) [online], Available: https://www.youtube.com/watch?v=k8hQdZlqs8s [Accessed 12 February 2016].
Ungar, who researched the power of the media and communications, published an article that investigated the role of media during an outbreak of Ebola in Zaire in 1995. He argued that the western press heavily relied on the “othering” of Ebola victims to reduce the fear of the threat of the virus to the West. During the 2014 outbreak, the ability of the British media to present the “othering” of Ebola victims, was inhibited by the arrival of British Will Pooley and the Ebola virus into the UK. His arrival challenged British public perceptions which understood Ebola as something happening to others and further reinforced fear of the threat that Ebola posed to Britain. This fear, of the spread of the virus, led to the securitisation of the Ebola outbreak. Simon Wright, the Head of Child Survival in Save the Children UK stated that the fear of Ebola led to “global panic”, which in turn led to questionable decisions such as “cancellation of flights to the countries affected by Ebola”. The fear of the further spread of the Ebola virus led to a heavily militarised response in Sierra Leone. In early September the WHO and the British government met to discuss plans for Britain’s response and determined that the British military were the “entity most likely” to be able to “instil crisis management capabilities and operational capacity”. This was also not the first time that the British military had worked in Sierra Leone.

The narrative of the security threat of Ebola and the need for protection was inflected by the post-colonial relationship between Britain and Sierra Leone. After Sierra Leone’s independence Britain continued to play a role within the country, supporting Structural Adjustment policies in the 1980s and then sending British military to support Sierra Leone troops during the civil war that took place between the years 1991-2002. The British army had direct involvement in reforming the Republic of Sierra Leone Armed Forces

26 Ungar, ‘Hot Crises and Media Reassurance’, p.52.
28 Ross, ‘Command and control’, p.4.
(RSLAF) and providing training and policy guidance, in what was called Operation Palliser.\textsuperscript{30} Between the years 2000-2002, the UK provided an estimated US$37 million to support the RSLAF.\textsuperscript{31} Emma Ross, an expert in health communications, argued that the long history between these two countries enabled Britain to maintain a high “level of influence” within Sierra Leone.\textsuperscript{32} This relationship also continued after the civil war as Britain played a significant role in supporting the post-conflict reconstruction of Sierra Leone.\textsuperscript{33} Britain was both financially and politically invested within Sierra Leone. The history between these two countries provides insight into why Britain took a leading role, and specifically the British military, within the Ebola response.\textsuperscript{34}

In light of the long relationship between Sierra Leone and the British military, and the fear of the spread of the virus to the UK, it is unsurprising that the military dominated Britain’s initial response to the Ebola outbreak. The British army’s response to Ebola, called Operation GRITROCK, was launched in October 2014, following an initial deployment of British soldiers on 21\textsuperscript{st} September 2014.\textsuperscript{35} The deployment of the military was the first action taken by the British government in support of the Ebola outbreak in Sierra Leone.\textsuperscript{36} The MoD committed 750 military personnel to Sierra Leone, to provide logistical support and to build Ebola Treatment Centres. On 16\textsuperscript{th} October, Britain sent 91 military doctors to Sierra Leone, followed by a further 150 military personnel five days later. By November, two months after the initial deployment, “around 900 [military] personnel had arrived” in Sierra Leone.\textsuperscript{37} Though there were medical military staff among this number, protocols

\begin{itemize}
\item \textsuperscript{30} Operation Palliser saw the deployment of 1,300 British troops to support the Sierra Leone troops; Adrian Horn, Funmi Olanisakin and Gordon Peak, ‘United Kingdom-led Security Sector Reform in Sierra Leone’, \textit{Civil Wars}, 8(2), (2006), p.112.
\item \textsuperscript{31} Horn, Olanisakin and Peak, ‘Security Sector Reform’, p.120.
\item \textsuperscript{32} Ross, ‘Command and control’, p.11.
\item \textsuperscript{33} A. J. Grant, ‘Diamonds, Foreign Aid and the Uncertain Prospect for Post-conflict Reconstruction in Sierra Leone’, \textit{The Commonwealth Journal of International Affairs}, 94(381), (2005), p.446.
\item \textsuperscript{34} This colonial legacy was also seen in the responses to the outbreak in Liberia by the US and the response to the outbreak in Guinea by France.
\item \textsuperscript{37} Brosnan, ‘How the British Armed Forces Helped Fight Ebola in Sierra Leone’.
\end{itemize}
restricted them to the provision of medical care to healthcare workers. The size of this deployment, comprising of 900 military personnel, is strikingly big when compared to the 250 NHS staff that also travelled to Ebola to support the response. While the disparity in these numbers may have been due to the increased availability of deployable military personnel, it is also a reflection on Britain’s emphasis on the control of the disease. Martin Bricknell, the MoD Head of Medical Operations and Capability, along with colleagues, argued that the government prioritised the military response because they were the only ones able to respond at the speed, and with the numbers, required. As leading figure within the MoD, Bricknell presented the military as the best actors to respond to this crisis, rather than emphasising their ability or experience in responding to contagious viruses, he stressed their ability to deploy quickly. Bricknell’s work reinforced the government’s prioritisation of containment, which, as this chapter will later demonstrate, had negative consequences for individual patients with the virus.

Upon arrival within Sierra Leone, British military asserted their dominance through the creation of the Combined Joint Interagency Taskforce (CJIATF), which was made up of “various UK government agencies involved in the response” and led by the British military. Following this, the Sierra Leone President, along with British personnel, created the National Ebola Response Centre (NERC) to manage the response. NERC replaced the National Ebola Taskforce, created during the early stages of the response, and was “manned by [the] British military and civilian members of the CJIATF, the Republic of Sierra Leone Armed Forces” and members of the Sierra Leonean diaspora. The dominant position that British military personnel held within these groups demonstrates the authority that the British government asserted within the Ebola response in Sierra Leone. As discussed in the previous chapters, the presence of the military within humanitarian medical responses

38 Brosnan, ‘How the British Armed Forces Helped Fight Ebola in Sierra Leone’.
40 Ross, ‘Command and control’, p.4.
41 Ibid., p.5.
42 Ibid., p.5.
impacted the medical care given to recipients. During the Ebola outbreak, the large presence of the British military also affected the delivery of aid.

The British military prioritised the containment of the disease; however, they did not introduce the securitisation narrative to Sierra Leone. The Sierra Leone government had chosen to focus on the control and containment of the Ebola virus before the arrival of the British military, as is demonstrated through their use of quarantines. When the British military arrived, an estimated 1 million people were affected by quarantines, and the majority of Sierra Leone’s 14 districts were subject to quarantine. As the outbreak continued, “nearly 50% of Freetown [the capital of Sierra Leone] was placed under quarantine”. Despite the lack of evidence that quarantines controlled the spread of disease and ALNAP’s recognition that the use of “quarantine does violate human rights”, the Sierra Leonean government imposed them across the country.

Exploring the effectiveness of quarantine, Donna Barbisch, Kristi L. Koenig and Fuh-Yuan argued that “quarantine should be reserved for situations in which it is supported by scientific evidence”. In the case of Ebola, while the use of isolation had proven effective in past outbreaks in rural Uganda, there was little evidence that quarantine would slow the spread of the virus within urban areas. Similarly, the definition of ‘quarantine’, given by ALNAP, highlights some of the ethical implications of the decision to implement such policies. It defined quarantine as: “The separation and restriction of movement of healthy people who have been exposed to a contagious disease

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but do not (yet) exhibit symptoms”. These “healthy people” may be quarantined alongside those with the early stages of the virus, increasing their chances of developing the virus. This was particularly dangerous in the case of the Ebola virus as it had an incubation period of up to 21 days. The choice to quarantine, therefore, placed the need to control the spread of the disease ahead of the potential threat it posed to healthy individuals within the quarantined community.

The use of quarantine within Sierra Leone was supported by the British military, who also prioritised the containment of the virus. A British military official was reported to have remarked: “There needs to be a clampdown on human movement inside Sierra Leone and possibly to and from the country”. Similarly, this official perceived the British military’s response to Ebola to be like that of a response to a biological warfare attack. The Sierra Leonean President used similar imagery when speaking about Ebola; for example, he promised to “overcome and free our land from this evil virus”. His personification of the virus and his description of it as “evil” presented Ebola as an enemy that needs to be fought. Kristin Bergtora Sandvik examined the use of militarised language through the response and argued that the emphasis on the threat of Ebola might have helped rationalise the “forceful enforcement of quarantines, particularly of slums and poor people’s dwellings”. Researchers based at and linked with the Overseas Development Institute, including former Executive Director of MSF-UK, Marc DuBois determined that policies such as quarantines were the result of “fear, panic and politic”.

The Sierra Leone government and the British government both prioritised the

51 Ibid.
containment of the Ebola virus. With no widely available cure or vaccine for Ebola, their policies enabled the rights of individuals who were quarantined to be superseded by the need to control the spread of the virus.

NGOs working within Sierra Leone strategically used the rhetoric of containment to appeal for military support in the hope that western militaries would provide personnel for their medical responses. Sandvik highlighted that, in September, MSF’s International President Joanne Lui, “re-emphasised the global public understanding of Ebola as an existential threat” and called for a “civilian and military medical capacity to be deployed to deal with the growing crisis”.

Liu strategically used the narrative of an international threat to demand support from international military personnel. Liu hoped that the military would support the medical care of Ebola victims and would provide knowledge on bioterrorism and “highly contagious diseases”. However, the support that the military gave to the medical capacity within Sierra Leone was minimal. A Chatham House report, which investigated the role of the British military during the Ebola outbreak in 2014, stated that:

> While military personnel did treat patients in the health worker Ebola unit, they were unable to perform certain other high-risk tasks that civilians calling for their involvement had initially hoped they would take on, such as the handling of dead bodies, community patient care and patient evacuation.

The deployed military medical staff were unable to provide the medical support that Liu had hoped for. The British military, after commissioning risk

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54 This was not the first time that British actors had enforced quarantines within Sierra Leone. During the late 1890s and early 1900s colonial governments used authoritarian methods, such as quarantine, to manage public health within Sierra Leone (with varying levels of success). Though the quarantine in Sierra Leone in 2014 was initially imposed by the Sierra Leone government, the British military’s enforcement of this authoritarian measure indicates that certain colonial modes of practice have endured. For more information about colonial public health measures in Sierra Leone read: Festus Cole, ‘Sanitation, Disease and Public Health in Sierra Leone, West Africa, 1895-1922: Case Failure of British Colonial Health Policy’, *The Journal of Imperial and Commonwealth History*, 43(2), (2015).


56 Sandvik, ‘Evaluating Ebola: the politics of the military response narrative’


assessments, devised “protection protocols and... mission parameters”, which confined military personnel to only providing medical care for health workers.\textsuperscript{59} The Chatham House report critiqued the military’s protection protocols arguing that they were risk-averse and that “risk assessments, which informed blanket force protection standards, were calibrated to the lowest-qualified individual”.\textsuperscript{60} While the British military was able to provide logistical support, their protocols prevented military medical staff from providing medical care to the Sierra Leone population. Rather the military’s role within Sierra Leone was primarily to shore up the disciplinary regime and prevent the further spread of Ebola.

Fear of Ebola and the lack of a widely available cure led to a heavily militarised response that championed the containment of the disease. The British military presence within Sierra Leone during the outbreak was not the first interaction that the British military has had within this country. Paul Williams, writing about a civil war within Sierra Leone, stated “as a former colonial power... expectations naturally turned to Britain”, and though he was speaking about the civil war, the same can be said for the Ebola outbreak.\textsuperscript{61} As the narrative of Ebola as a ‘global threat’ grew, the outbreak was drawn further into the British frame of interest.\textsuperscript{62} In the months following the Ebola response, the British government awarded medals to the healthcare workers for their dedication to their efforts within the response. These distinctly echoed those medals given to soldiers on return from war. The ‘global threat’ narrative in Britain enforced the view of Ebola as something to ‘fight against’ rather than something to treat. The militarisation of the response resulted in the prioritisation of the control of the virus over the health of quarantined communities and the delivery of medical care to Ebola victims.

\textsuperscript{60} Chatham House, The Next Ebola, p.4.
\textsuperscript{62} Ungar, ‘Hot Crises and Media Reassurance’, p.52.
British NGO Response

In conjunction with the deployment of military personnel, Britain committed £427 million to the response.\(^63\) The government channelled a significant proportion of this money through DfID’s Emergency Ebola Response Fund (DEERF), which aimed to fill the “essential gaps” in Ebola response.\(^64\) This section will investigate one of the first projects of DEERF, the Ebola Treatment Centre in Kerry Town.\(^65\) The treatment centre encapsulated the interrelated roles of British Ebola responders, as it was funded by DfID, built by the British military, managed by the organisation Save the Children and staffed (in part) by NHS volunteers. This section will investigate DfID’s humanitarian response within Sierra Leone in comparison to projects run by British NGOs and funded by the Disasters Emergency Committee.\(^66\) Through this comparison, one can see a significant difference in the way in which these groups responded to the outbreak; the rushed response of the DfID-funded and Save the Children-run ETCs, and the broader community-based projects funded by the DEC and run by other British NGOs. DfID failed to acknowledge and respond to the wider socio-economic impacts of the Ebola outbreak within communities. It will be argued that these were overshadowed by DfID’s rushed attempts to contain the disease and, as a result, focus on the physiological effects that Ebola had for patients. The quick and visible response, showcased by DfID’s ETC, failed to recognise the lessons learnt within the 1990s that saw health as having broader socio-economic roots and impacts.

The mobilisation of humanitarian actors to the Ebola outbreak has been remembered for its slow response. Academics, humanitarian organisations

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\(^65\) Money from DEERF was also used to develop WASH programs, support the Ebola ambulance service, construct 6 treatment centers and 200 community care units. It also helped to facilitate the deployment of more than 250 UK aid staff; Aid Works, ‘Evaluation of the DfID Ebola Emergency Response Fund’, p.6; Polygeia, *Lessons from Ebola Affected Communities: Being prepared for future health crises*, (Commissioned by African APPG and Funding from Royal African Society, 2016), p.24; DfID, *The End of the Ebola Epidemic*.

\(^66\) Save the Children is a member of the DEC, despite this, during the Ebola outbreak its primary funding source was not the DEC, but DfID.
and newspapers have each explored the reasons behind this.\textsuperscript{67} Criticism has often been targeted at the WHO for failing to manage the early stages of the outbreak successfully.\textsuperscript{68} By the time the WHO declared Ebola to be a “Public Health Emergency of International Concern” on 8\textsuperscript{th} August 2014, 961 people had died from the virus, and it had spread across three countries.\textsuperscript{69} The Saving Lives report determined that the slow response may have been due to the WHO’s choice to frame the outbreak as a health crisis instead of a humanitarian crisis.\textsuperscript{70} By doing so, the Saving Lives report argued, the WHO failed to trigger humanitarian mechanisms such as the cluster system.\textsuperscript{71} While it is likely that multiple factors impacted the pace of the response to the Ebola outbreak, many actors, including DfID, explain their failings by describing the outbreak as ‘unprecedented’, therefore suggesting that they could not have been prepared for the speed and distance of the virus’ spread.\textsuperscript{72}

When DfID began its response within Sierra Leone, with the funding of the Kerry Town ETC, it ensured that the British media championed its work. DfID sent a stream of press officers to Sierra Leone to ensure that the British media showcased their work. The government Communication Service stated that DfID was “working with the MoD and FCO to show British nationals, from medics to military, delivering life-saving support in an unprecedented outbreak overseas” in the hope that it would promote the image “that intervention was in the UK national interest”.\textsuperscript{73} The government wanted to


\textsuperscript{69} WHO Ebola Response Team. ‘Ebola virus disease in West Africa’, p.1481.

\textsuperscript{70} Kamradt-Scott, et al., Saving Lives.

\textsuperscript{71} Ibid.


ensure that the press would document their role within Sierra Leone, to gain support for their response from the British public, but also to ensure that the international community was aware of its activities within the outbreak.

The use of the media to promote the role of British civilians and military personnel within Sierra Leone was part of a broader attempt of the British government to promote itself as an international leader of disaster response. On 5th November 2014, Britain opened its first Ebola Treatment centre in Kerry Town, which had the capacity of 80 beds, and a further 12 for staff. The building of this centre was coordinated by the British army, the running of it was managed by Save the Children, and its Sierra Leonean medical staff were supported by NHS volunteers. In the month preceding the opening of the ETC, David Cameron promoted Britain as a leading figure within the Ebola response. In a speech at the European Council in Brussels, he claimed that he was “absolutely determined that Britain, with other countries, will lead the way in dealing with this [Ebola outbreak]” and that Britain was “playing a leading role here in Europe”.74 Throughout Cameron’s time in office, one can see his promotion of the narrative that Britain was a leader within the humanitarian response. This is clear in his decision to make Britain the “first G7 country to meet the target to spend 0.7% of its income on aid”, and Cameron’s determination that a Briton would hold the position of Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator within the UN.75 Writing for The Guardian in 2015, Jamie Doward wrote that had they lost this title, it would have been “a major diplomatic snub” as Britain had “positioned itself as a champion of disaster relief”.76 Within the Ebola response, the British government used the DfID-funded ETC as a symbol of their commitment to the Ebola response.

British humanitarian organisations, however, were ill-equipped to run the

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DfID funded ETC. Members of the Sierra Leone government challenged DfID’s decision to fund Save the Children to run the ETC. Their primary criticism was that “Save the Children do not have the expertise” to run an ETC of this scale. 77 Michael von Bertle, the Global Humanitarian Director of Save the Children, defended DfID’s choice by claiming that “we were the only charity that said ‘yes we will do it’. The Sierra Leone government knew this”. 78 He argued that someone responding was better than nobody, regardless of their level of experience. 79 Humanitarian Director of Save the Children UK, Gareth Owen had a similar belief, he recognised Save the Children’s lack of knowledge but argued that “even if [Save the Children] didn’t have the skills” or experience, it was “not a reason not to” respond. 80 Gareth Owen also suggested that Save the Children did not respond due to its knowledge of Ebola treatments, but rather for financial incentives. 81 He said the choice to respond to the Ebola outbreak was “very strategic” and was a way for SCUK to gain “more of the [British government’s] money”. 82 One must also question why, if Save the Children had no experience of responding to an epidemic of this scale, DfID appealed to them to run their response. Dr Amy Hughes, who led a Quality Control Unit during the outbreak in Sierra Leone, suggested that the government did not choose certain organisations because of their expertise, but rather because of their political position. 83 The choice to fund Save the Children was also a strategic decision for DfID, as it offered them an opportunity to work directly with a large British NGO. In 2011, DfID stated its wish to “establish a new mechanism to partner with the strongest performing British NGOs to improve the timeliness and quality of responses to humanitarian crises through competition and linked to performance”. 84 Both DfID and Save the

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78 Ibid.
79 Ibid.
81 Ibid.
82 Ibid.
83 Amy Hughes, Interview by Chapman, Personal Interview, Manchester, (27 April 2016).
Children benefited from this collaboration. Save the Children gained funding to run the ETC and publicity for their significant role within the response, and DfID gained the ability to collaborate with a large NGO and, through the provision of funding, have a stake in the humanitarian project.

The fear of the spread of Ebola impacted DfID’s decisions surrounding the creation of the ETC. An evaluation, commissioned by Goal, of DfID funded projects during the Ebola outbreak, listed DfID’s key aims for its Ebola response.\(^85\) It determined that DfID’s principal objectives were: “1. To reduce transmission rate of Ebola to less than 1 in Sierra Leone initially, then zero; 2. To prevent spread to the wider region; 3. To stimulate global public goods to tackle this and future epidemics; and 4. To tackle wider consequences of Ebola in Sierra Leone”.\(^86\) Though these were important objectives, none of these aims directly link to the care given to patients with the virus. This again suggested that the fear of the spread of Ebola was a fundamental reason behind the rapid creation of DfID’s ETC, and the choice to place Save the Children, the only NGO who said yes, in control of it. Furthermore, Gareth Owen stated that the NHS would have been the best people to respond but that Save the Children were “good at a fast-paced response”, and therefore it was they who took the lead.\(^87\) The UK government promoted the need for a quick response within a press release, which stated that “we are in a life and death race against time”.\(^88\) Within the creation of the DfID funded ETC, one can see two aims, neither of which prioritise the delivery of care to Ebola patients: firstly the aim to providing a quick response to prevent the further international spread of the virus; secondly, the aim of presenting a visible response, both to the British public to reduce fears, but also to the international community to promote Britain as a leader in the international Ebola response.

While the staff in the Kerry Town ETC worked extremely hard and helped save the lives of many Ebola patients, the running of this centre did not escape

\(^{86}\) Ibid., p.1.  
\(^{87}\) Gareth Owen, Interview by Chapman.  
criticism. The Sierra Leone government criticised the time it took the ETC to be fully functional. They were frustrated that, by December “most of its 80 beds [were] still empty despite the worsening epidemic”. In response to this criticism, Save stated that they staggered the opening of this ETC to ensure that the 250 local staff they had trained were able to run the centre successfully. The global humanitarian director of Save the Children, Michael Von Bertele, indicated that they had: “made it absolutely clear that this was new business for [them]” and that they, therefore, chose to open the ETC slowly planning to “tak[e] just two or three patients in the first week”. Thus, while they may have been the only option for DfID when looking for an NGO to partner with and while there were few other organisations with experience dealing with Ebola (and none on this scale), the rushed choice of using the self-proclaimed, inexperienced Save the Children, did not come without consequences for the patients themselves.

Alongside money given to Save the Children by DfID, British and Irish NGOs also accessed funding through a DEC appeal which raised £37 million. For many of these organisations, this was not the first time they had worked in Sierra Leone, and therefore, they were able to utilise their previous connections to gain access to communities. For example, the Irish organisation, Concern Worldwide (Concern), had been working within Sierra Leone since 1966, on projects to do with “health, education, food, income and markets”. Concern’s response initially focused on the immediate needs of the population; for example, they increased the access to water and sanitation within primary health care facilities and holding centres in Tonkiolili District. Concern also delivered wellbeing support for members of burial teams and provided Ebola patients with discharge packs to help with their reintegration into communities after their treatment. As the outbreak progressed, their work shifted to longer-term projects, such as support of burial team members.

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89 Connor, ‘Sierra Leone criticizes Save the Children’s running of Ebola Treatment’.
89 Ibid.
91 Ibid.
“through comprehensive psychosocial support and support for reintegration into communities”. Concern’s work covered several different areas, from food security, to WASH, and livelihood support. An evaluation of Concern’s use of DEC funds stated that Concern had helped sustain “quarantined households… [within Freetown and Tonkolili District] through a difficult period of enforced quarantine”. Throughout many of their projects focused on helping individuals and communities cope with the broader and longer-term impacts of Ebola.

Long-term focused projects were also carried out by British NGOs such as Age International, which joined with Restless Development, to create a joint project in Sierra Leone in November 2014. Funded by the DEC appeal, Age International and Restless Development worked together on projects “targeted towards the elderly and vulnerable groups”, such as “community-led social mobilisation” and activities to reintegrate Ebola survivors into communities. They worked within communities to highlight the importance of hygiene and the danger of the practice of washing the bodies of the dead. Similarly, Oxfam, also funded by the DEC, established community mobilisation projects, case finding, and interventions “including emergency food security and vulnerable livelihoods”. Alongside these organisations, the DEC also funded projects run by Care in the north of Sierra Leone, and projects run by CAFOD, Plan UK and World Vision and Tearfund Collective Initiatives Ebola report. While many of these organisations also received money from DfID, the funding they received from the DEC enabled them to work on community-based projects in which many had previous

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95 Ibid., p.5; The need for humanitarian support for quarantined communities highlights the negative impact that quarantines had and again, demonstrates how fear of the spread of disease had negative consequences for health of communities within Sierra Leone.
97 Ibid.
98 Ibid., p.11.
experience. Their work didn’t directly prioritise the containment of the Ebola virus, but instead focused on giving support to communities, playing a significant role in helping these communities continue to function despite the ongoing outbreak.

A comparison of the DfID funded ETC with the projects carried out by DEC funded organisations demonstrates the different priorities of these projects. DfID’s aim of responding quickly to the Ebola outbreak resulted in the building of a crucially required ETC however, with few alternative options, it also resulted in the choice to allow Save the Children to run the ETC despite their lack of experience. DfID’s prioritisation of containment and the wish to promote Britain’s response internationally resulted in a rushed response that failed to recognise the wider consequences of the Ebola outbreak in Sierra Leone. Within the projects funded by the DEC, however, there was a clear focus on sustainable and long-term projects within communities. It was, for example, left to these NGOs to deal with the impacts of patients returning from ETCs or the containment policies such as quarantine.102

**NHS Staff and the Treatment of patients**

The Kerry Town ETC was predominately staffed by Sierra Leonean medical personnel; however, it was also supported by British NHS staff.103 The Ebola outbreak saw the deployment of 250 NHS medical staff, the largest recorded deployment of NHS personnel to one crisis. Some reports suggested that more than ten times that number volunteered to go to Sierra Leone, however the need to cover volunteers’ usual roles within the NHS, known as back-filling, restricted how many people could be released from their duties.104 DfID funds supported this deployment, which was managed through the medical organisation UK-Med. The NHS staff, many of whom were first-time volunteers, arrived in Sierra Leone to a health system in crisis and national

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103 A team of Canadian doctors also supported the Kerry Town ETC; Polygeia, *Lessons from Ebola Affected Communities*, p.25.
medical staff who were overwhelmed by patients. While the NHS staff brought with them advanced training and knowledge of patient care and infection control, compared to the Sierra Leone volunteers, many of the NHS staff had little or no experience of treating Ebola. The level of care that they were able to provide patients was restricted by the limited equipment and facilities available to them within the weak Sierra Leone health care system and the restrictive protocols in place within the ETC, which prioritised the health of the medical staff and the containment of the virus over the individuals they treated. These restrictions were also exacerbated by the lack of proven treatment or vaccine for the Ebola virus.

A significant challenge for medical staff responding to the outbreak was the poor state of the Sierra Leone health care system. Before the outbreak, Sierra Leone had one of the highest mortality rates for pregnant women and “there was a lack of medical staff and of an institutional capacity to design and implement health policies”. According to World Bank figures, in 2007, Sierra Leone had “67 medical officers and 225 nurses for a population of more than 5.5 million”. In 2007, when President Koroma came to power, he said, “I inherited a health sector that was in shambles, a health sector that was giving us terrible health indicators, where one out of eight women were dying in childbirth”. Hospitals were inadequately equipped, hospitals and health care centres were understaffed and existing healthcare staff were poorly paid.

Neoliberal reforms, which took place after the civil war, and were supported by DFID under the Blair government, offer one explanation behind the poor development of the health care system within Sierra Leone. Wilkin and Conteh argued that the neoliberal policies carried out by Sierra Leone after 2002 led to restricted access to health care for the Sierra Leonean population. These neoliberal policies transformed the health care system into a market-led system which was inaccessible to the poorer members of

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107 Ibid., p.1394.
the Sierra Leone population. They concluded that these reforms introduced “conditions for the generation of the Ebola virus emerge”. With limited access to health care, many people turned to traditional healers who had inadequate knowledge of the Ebola virus and the mechanisms through which it spread.

DFID also funded government-led health care reforms in Sierra Leone in 2010. On 27th April 2010, coinciding with the 49th anniversary of Sierra Leone independence, the President Ernst Bai Konoma, declared the introduction of free healthcare for pregnant women, new mothers and children under the age of 5 years. This program, which saw reforms across Sierra Leone’s health care system, such as the increased pay and availability of health care workers, was perceived by DFID as a success. In the first three years of the programme, DFID helped to fund the rise of staff salaries by paying “22% of the costs”. DFID also committed “$16 million over five years and $8 million for drug and supplies over the first year” of this free healthcare policy. Despite these reforms within the health care system, and the increased pay for the medical staff, between the years of 2005-2010, the number of “disease control staff dropped over the period from 250 to 189”. Large sections of Sierra Leone’s health care system remained underdeveloped and inadequate for the needs of the Sierra Leone population.

Alongside DFID’s financial support of Sierra Leone’s health system, the King’s Sierra Leone Partnership offered a pathway through which British medical staff could work alongside their Sierra Leonean counterparts. This partnership aimed to “build the capacity of individuals, institutions, and systems to improve health outcomes”. This was a partnership between King’s College London, King’s College Hospital, Guy’s and St Thomas’, and

110 Ibid., p.428.
113 Donnelly, ‘How did Sierra Leone provide free Health Care?’, p.1396.
South London and Maudsley NHS Foundation Trusts with three medical institutions in Sierra Leone: the Ministry of Health and Sanitation, The College of Medical and Allied Health Services, and Connaught Hospital, the primary teaching and adult referral hospital in Sierra Leone’s capital Freetown. Partnerships between British hospitals and those abroad are not new, and the NHS has a long history of training international medical staff. Writing in 1972, Brian Maegraith, an affiliate of the Liverpool School of Tropical medicine, wrote: “the reason for teaching tropical medicine in the school has changed somewhat over the years” from training “doctors destined for the tropics particularly for the British colonies” to “training doctors who have come from abroad”. While the reasoning may have changed, partnerships such as the King’s Sierra Leone Partnership offered a platform of collaboration between medical institutions in different countries.

When the Ebola outbreak began in Sierra Leone, the King’s Sierra Leone Partnership had been in-country working with the MOHS since January 2013, on health system strengthening projects. British doctor, Oliver Johnson, who led the partnership, highlighted the ease with which this partnership shifted from a development focus to a humanitarian focus when the Ebola outbreak began. Receiving £1 million from DFID, the partnership set up the first Ebola holding centre in the country and went on to create another five holding centres in the western area of Sierra Leone. Alongside this, the King’s Sierra Leone partnership provided care protocol pathways and training to Sierra Leone medical staff in infection control. Unlike the NHS staff within King’s Sierra Leone Partnership, many of the NHS volunteers arriving in Sierra Leone in 2014 had never been to the country before. Therefore, the

116 Kings Sierra Leone Partnership, Our Vision.
120 Ibid.
121 Ibid. These holding centres had space for 60 patients, used existing infrastructures, and could be set up within a week.
122 Ibid.
challenge of responding to an Ebola outbreak was intensified by the contrast in conditions from an NHS hospital to a Sierra Leone ETC.

The NHS staff were a crucial support in filling the gaps in staffing that Sierra Leone medical staff could not. Adding to the challenge of their limited numbers, “health workers [had] been amongst the main victims” in the early stages of the outbreak.123 WHO doctor, Tim O’Dempsey spoke of the struggles faced by staff within the Ebola centres, noting that “of the 60 or so patients being treated in Kenema ETC in the later-half of July 2014, 15 were healthcare workers”.124 Similarly, reports determined that more Health Care Workers “were infected and died within Sierra Leone than in any other country, both in absolute numbers and relative (proportion of cases) terms” during this outbreak.125 Despite these challenges, a Quality Control Unit worked to ensure that the clinicians within Sierra Leone were well trained, that they provided the best quality of care possible and that a high standard of protection for medical workers was maintained.126 Dr Amy Hughes, who worked within this Quality Control Unit, described the high “standards [of care] and high levels of training” that the NHS staff brought with them.127 This training, however, was challenged by restrictive protocols which limited medical staffs’ ability to deliver a high standard of care and required them to make difficult ethical choices.

When comparing the care pathway of the British nurse William Pooley who contracted the virus in Sierra Leone, to the care given to Sierra Leonean civilians, the differential treatment they received is striking. On 24th August 2014, Pooley was flown to back to the UK by the Royal Air Force and under the care of an expert doctor who escorted him. While it is unclear the exact day that Pooley was diagnosed with Ebola, even his parents stated they were

126 UK-med is an organisation funded by the British government that recruited and trained medical staff from the NHS to respond to the Ebola outbreak in Sierra Leone.
127 Amy Hughes, Interview by Chapman.
“astounded by the speed and way which the various international and UK government agencies… worked together to get Will home”.128 When he arrived back in Britain, Pooley was given a police escort to the Royal Free Hospital in London which had an isolation unit on standby.129 The “high-level isolation unit” was equipped with a polythene “patient isolator”, a “specially-designed tent with controlled ventilation [which] allow[ed] the staff to provide clinical care”.130 While in this unit Pooley recalled that he “was outnumbered by health care workers”, and highlighted that this was in opposition to his experience in Sierra Leone where “the patients were outnumbering [him]”.131 While in the unit, Pooley’s doctor, Dr Jacobs, prescribed him with the newly developed treatment—the ZMapp drug. Jacobs recognised that the services offering care were “limited in our knowledge about the medicine” but that “they wanted to give him the best care possible” and “there was sufficient reason to go ahead”.132 Pooley was discharged from the Royal Free on 3rd September, just ten days after arriving back into the UK. In interviews after his recovery, Pooley said: “I had a better chance because I had that treatment, that care”.133 Within Sierra Leone, however, limited beds within ETCs meant that some patients were unable to access any form of medical assistance. Those who did enter ETCs did not enter a state-of-the-art facility; they were not offered the experimental ZMapp treatment, and they were not outnumbered by medical staff. Within Sierra Leone, despite the best efforts of both the national and international medical staff, patients did not receive, and could not be offered, the same level of care as Will Pooley.

NHS staff who volunteered in Sierra Leone have documented the challenges

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faced when treating Ebola patients. Long hours, limited numbers of beds and equipment, and the restrictive Personal Protection Equipment (PPE) were all recorded as challenges that created barriers to the delivery of care to patients. In several interviews, the PPE used to keep the medical staff safe, was highlighted as a particular challenge when giving medical care. International President of MSF, Joanne Liu regretted that for patients who were dying the last person they saw was often someone dressed in PPE, or as she described in a “spacesuit”. Sebastian Stein, an MSF coordinator who oversaw the morgue in an MSF ETC in Sierra Leone, used this same imagery. He said, “We come in dressed as spacemen, and we can try and say nice things but the fright and the terror of being in alone as a child in the hospital, especially in these circumstances, it’s too much for any small child”. Staff recognised that the delivery of medical care was more than the administration of drugs, but also included the provision of emotional support to a patient. The PPE, while protecting the medical staff from contracting the virus, inhibited their ability to give a high standard of care and created distance between the medical staff and their patients. The protocols that were in place to protect the NHS and Sierra Leone medical staff prevented them from delivering the quality of care they had hoped to provide.

Another challenge that medical staff faced during the Ebola response was policy restrictions which limited the medical treatments they were able to give patients. Lieutenant Colonel Andy Johnston, a Consultant in Respiratory and Critical Care Medicine who volunteered in Sierra Leone, highlighted that specific treatment was withheld from patients in fear that it would put the health workers at a higher risk of contracting the virus. In an article published in The Lancet, Johnston wrote that within some ETCs, staff were restricted from using intravenous (IV) fluids due to the risk of needlestick injuries to the health workers. Similarly, A WHO guide for clinicians treating Ebola

produced in 2014 stated that dehydration should initially be managed with oral rehydration salts. The delivery of IV fluids is a crucial treatment for viruses such as Ebola, where one of the main symptoms is severe dehydration due to vomiting and diarrhoea. Therefore, Johnston’s article suggests that the prevention of virus spread was prioritised above the basic treatment of individual patients. Similarly, Dr Oliver Johnson said that much of his “experience [was] going completely against what [he] would expect”, and that he often faced “a series of impossible choices that scream against what [their] instincts are as health workers”. The restrictions placed upon medical staff within the Ebola outbreak prevented them from giving the care they were trained to provide. Scholars Leach and Hewlett wrote that “outbreaks have been foci for rapid and sometimes draconian international policy responses and control measures”, this is demonstrated in the prioritisation of virus control over patient care.

The use of IV fluids was not the only restriction placed upon medical staff within ETCs in Sierra Leone. Dr Ian Roberts from The London School of Hygiene and Tropical Medicine and Dr Anders Perner, an expert in intensive care, wrote an open letter to The Lancet, highlighting other clinical measures should be adapted to prevent more deaths within ETCs. Roberts and Perner termed the dominant approach “therapeutic nihilism”. They wrote:

It is often stated that there are no proven therapies for Ebola Virus Disease but that potential treatments, including blood products, immune therapies and antiviral drugs, are being evaluated. This view is inaccurate.

These doctors argued that “dehydration and electrolyte abnormalities are

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important causes of death for which there are proven treatments”. They suggested that a failure to create “practical protocols for managing fluids and electrolytes” had negative consequences for the number of deaths. They argued that ETCs should not be used as a setting for quarantine. This letter provides examples of ways in which the treatment of Ebola patients could be improved, and its existence suggests that more patients may have been saved in 2014 had there been better clinical provisions.

An internal letter to MSF staff confirmed these criticisms. Within this letter, signed by members of MSF-France, MSF-Switzerland and the research centre MSF-CRASH, signatories recognised a question faced by MSF in 2014: ‘how they could best intervene in an epidemic with such an extremely high mortality rate?’ and argued that the answers given by MSF during the Ebola outbreak were lacking. They argued that MSF had failed “to demonstrate that — even in an Ebola outbreak — the survival of every individual patient is a battle worth fighting for”. Other NGOs often used the care given by MSF staff as a yardstick or something to aim for; they argued that this was problematic because the care provided by MSF doctors and nurses was limited by “the rigorous and restrictive protocols”. They wrote that their protocols, “propagated a standard of care that ironically perpetuate[d] non-assistance to persons in danger”. The fear of staff contamination led to a failure to treat individual patients with a higher quality of care. They argued that “the way MSF dealt with many patients was inconsistent with good medical practices”. If, as this letter suggests, other NGOs used MSF care protocols, then it can be assumed that the care for many patients, across the whole Ebola outbreak, was also “inconsistent with good medical practices”.

The narrative of ‘Ebola as a disease’ or an epidemiological challenge presented Ebola sufferers as carriers of the virus rather than patients. The Ebola response and the treatment given to patients in ETCs prioritised the

144 Ibid., p.2001.
146 Ibid., p.2.
147 Ibid., p.3.
148 Ibid., p.3.
149 Ibid., p.3.
control of the disease and the safety of medical staff, over the treatment of patients. The delivery of antibiotics and fluids is often a baseline of treatment within Western hospitals; however, within Sierra Leone ETCs, this baseline was not met. Despite this, the vital role that the NHS staff played within the Ebola outbreak cannot be disregarded. NHS staff worked in hard conditions and were asked to make daily decisions that challenged their medical ethical training. It is clear, however, that these ethical dilemmas were made harder by policies, perpetuated by DfID and the MoD, that emphasised the containment of disease above the care of individuals. This narrative impacted the patient care protocols that restricted the use of IV treatments due to the fear of needle prick injuries. The differential care given to the UK staff who contracted Ebola, over that of individuals of the Sierra Leone population, demonstrates that the highest quality of care was not, and perhaps could not be, afforded to them.

**Research and Vaccines**

The role of British researchers, often overlooked in narratives of humanitarian response, was brought to the foreground during the Ebola crisis. One of the most significant challenges that faced medical staff who responded to the Ebola outbreak was the lack of a clinically-approved vaccine for the Ebola virus. Yet the International President of MSF, Joanne Liu criticised the priority given to the search for a vaccine, arguing that the testing of vaccines may be something to investigate for future outbreaks, but that “for this epidemic, it is unlikely to solve this epidemic”.\(^{150}\) Within the shifting power dynamics of the international response, which saw the UN take control of the response from the WHO, lessons learnt from previous outbreaks (which had been managed by the WHO) were lost. The narrative that positioned this outbreak as exceptional, and saw the creation of the new body UNMEER, resulted in a lack of knowledge transfer and thus the loss of protocols and research. Within DfID, the Wellcome Trust and British research councils, the aim to remain at the forefront of vaccinology and epidemiology led to the promotion of research into a vaccine ahead of anthropological research.

The first recognised outbreak of Ebola was recorded in 1976. Since then, there have been multiple Ebola outbreaks within Africa, such as the 425 cases recorded in Uganda in 2000, and the 351 cases recorded in Angola in 2005. Despite the numerous outbreaks of Ebola, pharmaceutical companies have never prioritised a vaccine for the virus. The British pharmaceutical company, GlaxoSmithKline, stated that one of the reasons behind their failure to develop an Ebola vaccine was that the market for the vaccine was too small. Within the Ebola outbreaks before 2014, it was rare that there would be more than 500 cases at a time; this was a significantly lower caseload than other virus outbreaks, such as malaria.

A report from the House of Commons in 2016, recognised that there was “not a huge incentive for pharmaceutical companies to invest in drugs and vaccines for Ebola and similar diseases”. During the 2014 Ebola outbreak, however, DfID and the Wellcome Trust began to offer large grants for research projects that aimed to find a vaccine.

Following the outbreak, DfID committed £20 million to a “fund for research and development to combat infectious diseases”. Similarly, the Wellcome Trust, which has a long history in epidemiological research, released £10 million to fund research into finding a vaccine for Ebola. In August 2014, it released a call for “researchers doing clinical trials to test vaccines and drugs that could impact the current epidemic”. The Wellcome Trust believed that this research was crucial, and reduced the normal eight-month process of funding applications down to two months, enabling research into a vaccine to begin in October.

Professor Peter Piot, the Director of the London School of Hygiene and Tropical Medical and the Chair of Her Majesty’s Government’s Strategic Coherence of ODA-funded Research Board, argued the research carried out during the outbreak in 2014, was the “first time that

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151 Leach and Hewlett ‘Haemorrhagic fevers’, p.46.
154 House of Commons Science and Technology Committee, ‘Science in emergencies’, p.41.
157 Ibid.
158 Ibid.
trials for vaccines and treatments had taken place ‘in the midst of an epidemic’.”159 By the end of 2014, five separate teams had been funded and were ready to begin their trials of potential drugs.160 The Ebola outbreak was understood, by the Wellcome Trust and the Medical Research Council, as an exceptional case and they, therefore, released funding at an unprecedented speed.

Some scholars such as Jeffery Drazen and his colleagues championed the Wellcome Trust for their involvement in the Ebola outbreak and their search for a vaccine. Others however, have been more critical. Drazen and his colleagues wrote that the Wellcome Trust “has helped pave the way for their personnel to fight Ebola and deserve praise”.161 While recognising the impressive ability of the Wellcome Trust to release funding at such short notice, many have questioned the ethics of this research and whether the creation of a vaccine would help the ongoing crisis. A report by the House of Commons Science and Technology Committee highlighted the struggles that drug trials faced when they took place during an ongoing outbreak. One such challenge was the resistance, which researchers during the 2014 outbreak faced, to the use of placebo drugs in randomised trials. This resistance was over the ethical and physical implications of using a placebo drug during an outbreak in which the mortality rate was very high.162 Research projects which aimed to find a vaccine, such as those funded by the Wellcome Trust, were also criticised by Dr Roberts and Dr Perner. In their open letter to The Lancet, Roberts and Perner criticised this focus on finding a vaccine, stating that “the potential for benefit from anti-viral drugs is likely to be limited without better critical care”.163 They argued for the need for research into the critical care of Ebola patients and referred to the restrictions on patient care, such as the limited use of IV fluids. Similarly, Dr Oliver Johnson from the King’s Sierra Leone Partnership recalled that medical staff within Sierra Leone, wanted answers to questions

159 Peter Piot quoted in House of Commons Science and Technology Committee, ‘Science in emergencies’, p.23.
160 House of Commons Science and Technology Committee, ‘Science in emergencies’, p.22.
162 House of Commons Science and Technology Committee, ‘Science in emergencies’, p.24
such as: “which was more effective: oral fluids versus intravenous fluids?”.

Despite the divided opinion on the vaccine research within the medical community, DFID and the Wellcome Trust continued to fund medical trials. Government press releases also stressed the need for a clinical answer to the outbreak. Within a speech made by David Cameron, the British government’s prioritisation of finding a technical fix, a drug, to treat Ebola victims is clear. In this speech, Cameron said: “as a world, we must be far better prepared with better research, more drug development and a faster and more comprehensive approach to how we fight these things when they hit”.

The British government’s plan for future outbreaks also emphasised the biomedical factors of Ebola. It stated: “The UK will establish a new group of 6 to 10 expert staff, mainly epidemiologists, infection control specialists and infection control doctors, who will be on permanent standby, ready to deploy to help countries respond to disease outbreaks.”

In 2014, initial reports from the WHO presented the Ebola outbreak as a health crisis rather than a humanitarian crisis. This resulted in the response operating within a particular set of rules which placed the epidemiological focus at the forefront of response, and can be seen to follow the pattern of, what scholar Priscilla Wald has termed, an ‘outbreak narrative’.

Wald wrote that the outbreak narrative “follows a formulaic plot which begins with the identification of an emerging infection, includes discussion of the global networks throughout which it travels, and chronicles the epidemiological work that ends with its containment”. This ‘outbreak narrative’ dominated the research that was funded by the Wellcome Trust and DFID, which traced the outbreak to Patient Zero, a two-year-old Guinean boy named Emile Oumnouno, and focused on epidemiological

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164 House of Commons Science and Technology Committee, ‘Science in emergencies’, p.22.
166 Gov.UK, ‘wake-up to the threat from disease outbreak’.
169 Wald, Contagious: Cultures, Carriers and the Outbreak Narratives, p.2.
research to find a vaccine.¹⁷⁰

Britain was celebrated for its ability to release emergency funds for research into a vaccine and scholars have praised the Wellcome Trust stating that it had “encouraged academic institutions to join the fight”.¹⁷¹ DfID wanted to ensure Britain maintained its place at the forefront of epidemiological research. During the meeting that resulted in the House of Commons Science in Emergencies report, Dr Jeremy Farrar from the Wellcome Trust and Professor Chris Whitty from LSHTM and the former Chief Scientific Advisor at DfID highlighted Britain’s “world-leading role” in both vaccinology and tropical epidemiology.¹⁷² Therefore, whilst the initial framing of the outbreak as a health crisis may have resulted in an epidemiologically focused response, the prestige of finding a vaccine for the Ebola virus, and its potential to re-enforce Britain as a ‘world leader’ within epidemiological research, was a strong incentive behind DfID and the Wellcome Trust’s funding of vaccine focused research.

In the later stages of the outbreak, however, there was a shift to recognise the need to integrate the international response with communities’ own efforts. Funding bodies began to incorporate anthropological research in their work, and in November, the Wellcome Trust joined with DfID, the Enhancing Learning and Research for Humanitarian Assistance, and the Economic and Social Research Council (ESRC) to create the Ebola Response Anthropology Platform, through the Research for Health in Humanitarian Crises program.¹⁷³ The Ebola Response Anthropology Platform aimed to investigate the spread of Ebola through an anthropological lens in a hope to provide other methods of containment. The methods would not be clinically focused, but instead would focus on the socio-economic factors that impacted the transmission of the virus. From November onwards, the platform produced multiple

¹⁷² House of Commons Science and Technology Committee, ‘Science in emergencies’, p.15.
¹⁷³ The Wellcome Trust initially supported technical research; however, as the epidemic progressed, they began to fund wider research projects such as the Ebola Response Anthropology Platform; ESRC, Ebola Response with local engagement (June 2016), Available: https://esrc.ukri.org/news-events-and-publications/impact-case-studies/ebola-response-with-local-engagement/ [Accessed 13 August 2019].
publications that aimed to inform practitioners on the importance of anthropological factors in the spread of the virus.\textsuperscript{174}

The use of anthropological research within an Ebola outbreak was not new: the WHO had used anthropologists within responses to disease outbreaks in the mid-1990s. In this research, the WHO came to the “realisation that ‘culture matters’, … [and the recognition] that Ebola responses are fundamentally ‘not just about a virus’ and that Western-style responses were often culturally inappropriate, provoking local fear and anxiety”.\textsuperscript{175} The WHO’s use of anthropologists in the mid-1990s is striking in its similarity to the research written during the 2014 Ebola outbreak, which highlighted the potential importance of a “community-owned strategy for Ebola control”.\textsuperscript{176} The recognition of the role that anthropologists could play within an outbreak, therefore, had a longer history than the creation of the Ebola Response Anthropology Platform. The research undertaken in the mid-1990s led to “the incorporation of anthropologists [within] integrated outbreak responses teams” who were deployed by the WHO.\textsuperscript{177} These policies, created in the mid-1990s, were ignored in the early stages of the 2014 Ebola response. The belief that this outbreak was exceptional led the WHO to disregard old Ebola response policies. The use of anthropologists within an outbreak, though presented and believed to be a new initiative in 2014, can be traced back to the 1990s.

In the years following the outbreak, Britain has again used research funding as a form of soft power to position itself as a leader in infectious disease research. In a report produced one year after the end of the outbreak, the government stated that it “has announced new research funding for infectious diseases through the establishment of the Ross Fund”.\textsuperscript{178} It said that: “Over the next five years, the Fund will invest £1bn to target infectious diseases including

\textsuperscript{175} Leach and Hewlett ‘Hemorrhagic fevers’, p.56.
\textsuperscript{176} Pronyk et al., ‘The Effect of Community-Based Prevention and Care’, p.730.
\textsuperscript{177} Leach and. Hewlett ‘Haemorrhagic fevers’, p.60.
diseases with emerging resistance, such as malaria; diseases of epidemic potential, such as Ebola; and neglected tropical diseases”.

Similarly, the government claimed that “the UK Vaccine Network has also convened an expert sub-group to prioritise known infectious diseases and ensure that funding is prioritised for the key risks”. While this funding may have a significant impact on the ability to develop drugs and vaccines against viruses such as Ebola, it appears that there has again been a lack of recognition of lessons learnt from the 2014 outbreak that re-emphasised the importance of anthropological research and the recognition of the social-political nature of disease transmission.

**Conclusion**

Despite the large response from the international community, by the time that Sierra Leone was declared Ebola-free in November 2015, 3956 people had died, and there had been a further 8706 confirmed cases of the Ebola virus.

This chapter has explored the different perspectives of various ministerial departments with the British government and their alternative solutions to the Ebola outbreak. The prominent role of the MoD within the response and its fears of the threat that Ebola could pose for the UK led to a prioritisation of the control of the Ebola virus and the securitisation of the British response. The narrative promoted by the MoD, of the virus as a threat to the UK, presented patients as, first and foremost, hosts of the virus pathogen. This led directly to protocols that ensured that the British military only delivered care to medical personnel. This two-tiered level of care, created by the presence of the military, was discussed within the earlier chapter on the Iraq war.

Within the Ebola outbreak, the British military was unable to respond to calls from MSF for medical support; instead, their primary role was to support

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180 Ibid., p.9-11.
efforts to contain the disease. Restrictive protocols were also placed upon the large NHS cohort who volunteered in Sierra Leone. The NHS staff that did volunteer faced both physical and ethical challenges to their ability to deliver a good quality of care; this was, in part, due to the safety protocols enforced upon them. Again, patient care was placed secondary to the containment of the virus.

This prestige-seeking by DfID aimed to present Britain as a humanitarian leader by running the Kerry Town ETC, which they promoted as being at the forefront of Ebola care. In actuality however, this ETC and the choice to use Save the Children to run it, faced strong criticism from the international community and the Sierra Leone government. Critics particularly highlighted the time that it took to open and begin to treat patients. Similarly, DfID’s humanitarian response failed to recognise or respond to the wider socio-political impacts of Ebola. In contrast to this, the projects that were funded by the DEC and ran by NGOs placed these socio-economic impacts of Ebola centrally within their response. The long relationship that British aid organisations had within the country enabled them to work closely with members of the Sierra Leone population to deliver a coherent Ebola response.

Within DfID, the Wellcome Trust and British research councils, the aim to remain at the forefront of vaccinology and epidemiology led to the promotion of research into a vaccine ahead of anthropological research. While the research carried out within Britain had little impact for the 2014 Ebola outbreak, its results have made a greater impact on the more recent outbreak. In the 2018 Ebola outbreak in the Congo, medical personnel were all offered an Ebola vaccination. Similarly, the critical care mechanisms were enhanced, to ensure patients got the correct access to the IV fluids, antibiotics and oxygen.\(^\text{182}\) The WHO has worked with the British Department of Health and DfID to produce a “blueprint for research and development for infectious diseases with epidemic potential”, to be used during future outbreaks.\(^\text{183}\) Didier Fassin hypothesised that in the future there would be “epidemiological homogenisation”, this being the “expansion of infections in the west…and

\(^{183}\) House of Commons Science and Technology Committee, ‘Science in emergencies’, p.29.
the progressive recognition of mental health problems that were until recently ignored in poor countries”. If Fassin is correct, and epidemiological homogenisation does take place, the lessons from the 2014 Ebola outbreak will become increasingly important.

By examining the different government actors and NGOs involved within the British response within Sierra Leone, this chapter argued that the government’s control of this response, which reflected their aims of protecting Britain from the virus, and their need to promote Britain as an international leader in humanitarian aid, resulted in a failure to prioritise the care of individuals within Sierra Leone. The needs of Britain were placed above the care for Sierra Leonean patients with the Ebola virus.

184 Fassin, ‘The Obscure Object of Global Health’, p 102
Conclusion

This study asked: what can the story of medical humanitarian response add to existing narratives of British humanitarianism? It has argued that this story exposes the power dynamics between the multiple actors that made up the humanitarian sector and the mechanisms that influenced the delivery of aid between 1988 and 2014. It has traced the increasing power and interventionist nature of the British government within the decision-making process of the humanitarian sector. The lens of medical humanitarian aid demonstrates the diverse ways in which actors have interacted and influenced humanitarian norms, often not to the benefit of medical-aid recipients. The different humanitarian responses analysed have demonstrated the impact that changing policies and norms had on medical responses. The cross-sections of British humanitarianism, provided through the crises and responses studied, have highlighted the following themes and role of certain actors which will be discussed below: medical aid as a political tool, the challenging of political mythologies, the British government as a critical donor, the role of military medical personnel, the ethical dilemmas for NHS personnel and the role of researchers.

Medical aid has taken many forms throughout this period, such as becoming a tool for state-building or as a mode of promoting government foreign policy choice. The many different guises that medical humanitarian aid has taken reflect the attitudes of the decision-makers at the time and the weight of new norms and policy practices. The medical lens of this thesis has therefore provided a way to trace the fast-changing ideas and priorities behind humanitarian responses. Within the context of famine treatment in Sudan, government funding drove a change in the treatment of famine victims from the biological treatment of malnutrition (a medical response) to a response that managed broader socio-political factors that lead to malnutrition (health care). The dominance of health care, which aimed to treat the cause, not just the symptoms, took precedence. This was seen in the Kosovo response when medical humanitarian spaces became part of peacebuilding efforts. However,
the biological challenges of Ebola, explored in chapter 5, reveal a change in the dominance of these terms. During this pandemic crisis, the outbreak took precedence and those infected were no longer treated as patients, but rather were treated as carriers of the disease themselves. The focus shifted from individuals to populations, as the intervention focused on the need to stop the virus. The medical lens, which shed light on such fluctuations, therefore enabled an investigation into the sequences of changing ideas behind the large deployments of humanitarian aid. This thesis has traced the evolving understandings of health during this period, from a growing recognition of the socio-political impacts of health in the late 1990s, back to the view that health was centred solely on physiology as seen during the Ebola outbreak. The shifting nature of the terms medicine and health reflected academic discussions prevalent within specific periods of this study and their influence on understandings of medical aid. It is important to recognise that this is not a linear process of ever-improving knowledge but a series of negotiations in which the range of actors’ advocate and adopt different ideas according to contemporary needs, ideologies, and pressures.

This perspective, in turn, aids understanding of the position of institutions in the humanitarian sector. In contrast to institutional histories, such as those produced by Oxfam or Save the Children, which focus predominately on the role of large British NGOs, this study has attempted to unpack the role of these organisations as members of a broader, more dynamic, and continually growing sector.¹ The medical lens highlighted the impact of smaller actors, who work alongside large NGOs. The role of individuals, research bodies, think-tanks and NHS staff all contribute to the story of British humanitarianism. Challenging previously established historiography, which regarded the 1980s as predominately a period of financial and institutional growth from the large NGOs within Britain, chapter 1 explored the lack of growth within British expertise in disaster response.² It examined the role of individuals within this response and their drive, after the Armenian earthquake, to create a British disaster response team. Chapters 2 and 5 have

¹ Black, A Cause of our Times; Baughan and Fiori, ‘Save the Children, the humanitarian project and the politics of solidarity’; Slim, ‘Establishment Radicals’.
also expanded NGO-centred narratives of British aid by examining the role of think-tanks and British academia. The role of researchers grew with the creation of DfID in 1997 as the British government aimed to work closely with researchers to improve their aid programmes. This was particularly evident within the Ebola outbreak, where the search for a vaccine dominated the investment in research. While the large organisations that collaborate in the Disasters Emergency Committee dominate British public perceptions of humanitarian aid, they represent but one aspect of the multifaceted British humanitarian sector.

This thesis has examined the political narratives of successive governments between the years 1988 to 2014. It has built upon literature which explored political mythologies such as Thatcher’s promotion of her small state ideology, New Labour’s attempt to present their decisions as a form of ethical foreign policy and Cameron’s attempt to present his policies as a form of compassionate conservativism. Each of these political narratives reflected ideas developed within the colonial period. They demonstrate the continued impact of colonial thought in the successive government’s understanding of their role internationally. For example, neocolonial power through economic control, as described by Koshy, can be seen the Thatcher governments’ attempt to control the development of other countries through the promotion of neoliberalism. Similarly, echoes of Gorman’s ‘humanitarian imperialism’ can be traced within the Blair and Cameron governments’ emphasis on the moral duty of Britain to help vulnerable international populations and their efforts to as present Britain as a moral authority internationally. This thesis has added to historiography that has examined British domestic and foreign policy during this period, such as that of Gould and Anderson and Richard Vinen, to investigate the influence of these factors on British humanitarian aid. Adding to these narratives, this study has explored the use of humanitarianism within the British government, particularly by DfID and the FCO, as a tool of self-promotion both within international politics and

3 Pierson, Dismantling the welfare state?; Gaskarth, ‘Interpreting Ethical Foreign Policy; Beswick and Hjort, , ‘A missing link in understanding Party policy change?’.
4 Koshy, ‘From Cold War to Trade War’, Gorman, ‘Empire, Internationalism, and the Campaign against the Traffic in Women and Children in the 1920s’
domestically. At the end of the Cold War, the role of Britain within international politics was uncertain; over the following 20 years, it used international aid as a tool to reposition itself within the global political sphere and promote its foreign policy decisions. In chapter 2, for example, the New Labour government is shown to have used humanitarian aid to present the Kosovo intervention as a humanitarian action. Similarly, chapter 4 has revealed the British government’s attempt to publicise the British military’s role in the delivery of humanitarian aid in response to the criticisms of their invasion of Iraq. The British government actively publicised its role within the humanitarian responses in Kosovo and Iraq in an attempt to promote and gain support for their foreign policies.

The government’s relationship with the aid sector changed as it became a critical donor. Chapter 1 examined the mythology of the shrinking of the British state under the Thatcher government and examined the impact of government policies on the delivery of aid. It determined that the government’s aim to spread neoliberal ideas had an impact on the types of aid projects they would support through grants. However, the role of the government as a critical and influential voice within the humanitarian sector particularly grew within the New Labour government under Tony Blair, as explored in chapters 2, 3 and 4. One of the first changes Blair made within the government was to prioritise aid through the creation of DfID. Clare Short, the General Secretary of DfID, was a prominent voice amongst critiques of the British response to the 1998 Sudan famine. Her criticisms, which demanded a political response, demonstrate the movement of the British government towards the position of a critical donor. Though DfID policies faced resistance at times from other branches of the British government, they enacted change within the British aid sector. DfID in this early period combined high-profile critique of short-termism with an attempt at micro-managing the delivery of aid. From this time, the British government became increasingly interventionist and took the position as a critical donor and, by-extension, gained greater voice with policy creation and norm-setting. This influence, both positive and negative at different times
throughout this thesis however, did not go unchallenged and the power within this sector fluctuated between the different humanitarian actors.

Alongside gaining a critical voice within the humanitarian responses, the British government also used humanitarian aid not just to promote, but as a tool within, its foreign policies. During the Kosovo response, explored in chapter 3, the British government actively began to use humanitarian aid as a method for carrying out its foreign policy agenda. The political environment, within which medical personnel worked in Kosovo, had an impact on the work of these personnel. During the Kosovo response, British medical personnel were drawn into DfID's peacebuilding and state-building activities. While the Kosovo intervention has often been used as an example of New Labour’s ethical foreign policy, the Iraq war has challenged this narrative. Following the September 11 bombing in the US, Britain’s foreign policy refocused on the War against Terror. This had an impact on the British humanitarian sector as it got drawn further into Britain’s political project. Despite the resistance of NGOs to the invasion of Iraq, the fourth chapter showed the disparity of power within the humanitarian sector, as the government proceeded with its plans and then, following the bombing, used the delivery of aid as a tool to win 'hearts and minds'. The government's use of humanitarian aid and medical personnel contributed to the politicisation of British medical humanitarian aid.

As the British government has had an increasing influence within norm-setting, it has also had a physical presence within humanitarian contexts in the form of the British military. Though the imperatives of the military may not always have aligned with those of the government, within the crises studied in this thesis, the military worked on behalf of the government. The UK has a distinct relationship with its military in humanitarian settings. The British NGOs had a more open and communicative relationship with the military, in comparison to the US. This in part was due to a greater cultural recognition of the different roles of the military and humanitarian workers, seen within British government debates and supported by platforms which

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6 Bully, 'The politics of ethical foreign policy'.
enabled dialogue between these actors. Despite this, the presence of the British military still had an impact on the delivery of medical humanitarian aid. The collation of military literature, medical research and oral histories has provided a new analysis of this impact. During the Kosovo response, for example, access restrictions resulted in DfID funding the British military to set up refugee camps on the border of Kosovo. Though these camps were handed over to NGOs to run, the use of the military within this context blurred distinctions between these two actors and challenged perceptions of NGOs as impartial. Similarly, within Iraq, the use of the military to provide aid as part of a broader 'hearts and minds' project drew NGOs into the political sphere as the boundaries between their work and the work of the military became unclear. The expansive boundaries of what has been labelled 'humanitarian' enabled the British government and military to adopt the term, as they attempted to promote a positive and moral picture of their actions. During the Iraq invasion, British NGOs actively resisted this; however, they were unable to reclaim the humanitarian terrain for their own, as is still seen within popular depictions of military action. The increasing presence of the military within humanitarian crises resulted in the distancing of NGOs from their aid recipients.

Health care personnel and the ethical dilemmas they face have been a central part of this story, often representative of the complex nature of the humanitarian crises studied. As seen in the Iraq response, this is particularly the case for military medical staff. Oral history interviews highlighted the complex ethical challenges army medical staff faced while juggling their role both as a doctor and as a member of the British army. Accounts of the instability of post-invasion Iraq have showcased the failure of coalition forces to demilitarise civilian hospitals. This resulted in civilians turning to military field hospitals to receive medical care. These civilian patients provided ethical dilemmas for military personnel who both had to follow NHS medical training which dictated they responded to those in need, while also

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7 Lundy et al., ‘Intensive Care Unit in Ibn Sina’; Schwartz et al., ‘Western Clinical Health Ethics’; Martin Bricknell et al., 'Operation GRITROCK: the Defence Medical Services' story'.
8 For example, in the BBC drama Our Girl, the British military is depicted as carrying out a 'humanitarian' mission in Bangladesh during which the military medics worked in Bangladeshi hospitals.
recognising their military orders to prioritise the care of military personnel. The challenges for military personnel were also evident in chapter 5. Restrictions placed upon medical workers within humanitarian settings, by governmental policies that directed their work, influenced the level of care they were able to provide. During the Ebola crisis, MSF international called for the presence of military personnel to support the care of patients during the outbreak. While the British government sent over large numbers of the British military, including many medical staff, government— and military—dictated policies restricted the care that they were able to give. Thus, although the limitations of working in austere environments should not be underestimated, this thesis has demonstrated that the involvement of the military medical personnel within humanitarian settings has a detrimental effect on the medical care given to civilians.

This study began with a discussion of the place of the NHS within British political culture. Scholarship on the history of the NHS has, however, failed to adequately explore its role within Britain’s medical humanitarian response.9 The first chapter began within British doctors on a nominal scale, voluntarily delivering medical aid to Armenia. Their ill-equipped and unprepared team, however, inspired the creation of the UK-EMT team and the UK-Med charity which organised the deployment of over 250 NHS staff to Sierra Leone. This study has begun to draw the NHS into the story of British medical humanitarian response, and while more research needs to be done on the issue as archives open fully for the 1990s, it has demonstrated the increasing role of the NHS within this sector and the increasing role that the British government took in medical humanitarian responses. More widely, the study has brought together medical literature and personal accounts to examine the impact of government-influenced policy decisions on the work of medical practitioners within humanitarian settings. Within Sudan, for example, these policies led to a demedicalisation of famine response and a distancing of patients from medical practitioners. Similarly, during the Ebola outbreak, many NHS personnel who worked in Sierra Leone highlighted that

9 Gorsky, 'The British National Health Service 1948-2008'; Ham, 'Improving NHS performance'; Smith, Overseas Doctors in the National Health Service; Johns, Green and Powell, 'Diversity in the British NHS'.

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the restrictive protocols prevented them from giving the quality of patient care that they aimed to provide. During this outbreak, the life that was prioritised was not those infected with the virus, but rather those who had yet to be. NHS personnel gained an increasing role within medical humanitarian response during this period; however, their ability to deliver aid was restricted by government policies that often failed to prioritise medical care of patients.

Just as the role of the NHS personnel has grown within humanitarian settings, so too has the role of researchers. The British government gave researchers a greater platform within humanitarian discussions; however, through funding, it also had a strong influence on the nature of this research. Studying the dialogue between think tanks (such as the Overseas Development Institute or the Wellcome Trust), academics and the British government has revealed the increasing role of research within British humanitarianism. This thesis has shown that while think-tanks such as the London Technical Group existed in the 1970s, such research only gained significant recognition by the British government in the 1990s with the creation of DfID. From its creation, DfID committed to working with researchers to bring Britain at the forefront of international aid. The link between DfID and think-tanks is strengthened by the careers of individuals such as Joanna Macrae, whose work has been used within this study, which has seen her work both for the Humanitarian Policy Group within ODI and as the Head of the Humanitarian Policy Team at DFID.

Chapters 2 and 5 have explored the government’s role in strategically funding research and the direct impact that the relationship between the government and researchers has had in changing the policies that directed the delivery of aid. This can be seen after the Sudan famine when DfID helped to fund research that supported its focus on long-term aid responses, specifically the creation of Community Therapeutic Care for individuals with severe malnutrition. This is also demonstrated during the Ebola outbreak during which the government, along with the Wellcome Trust, funded research into a vaccine for the Ebola virus. In both cases, the British government influenced the type of research being carried out through funding and attempted to ensure that British research was at the forefront of humanitarian narratives.
This thesis has added to existing histories of the British humanitarian sector by extending the period of study into the 2000s. Using a historical lens to examine this period highlighted both the continuities with older forms of humanitarian practice and the influence of different actors in the development of the humanitarian sector. Such a contemporary history, however, has not come without challenges. Access to archives was a large determinant of both the crises studied and the narrative of this story. If this research were to be replicated in the future, this access would change the story that has been told. However, the restrictions placed on many contemporary documents within institutional archives directed this study away from being a reproduction of existing institutional histories. Rather, it has enabled a unique exploration and assembly of material from personnel archives, oral histories and grey literature. Due to access restrictions, therefore, this thesis tells a more varied and colourful story of the British humanitarian sector. The contemporary nature of this history has also highlighted the challenges that come when researching a period during which paper records moved to online databases and physical correspondents move to emails. The loss of data that came with this transition has been clear throughout this research and has emphasised the importance of the continued active archiving.\(^{10}\) Furthermore, the contemporary nature of this thesis has re-enforced the notion that history does not have an endpoint, many of themes and challenges drawn out of this study continue to arise in the complexity of British politics today.

The exploration of different actors within the British humanitarian sector has revealed the distinct nature of the British humanitarian sector and challenged narratives of a homogenous Western humanitarian system.\(^{11}\) Instead, adding to the historiography of country-specific aid, this study has exposed the particular trajectory of British humanitarian response.\(^{12}\) By applying historical methods to a period more often understood through social science lenses and personal narratives, this study extends the existing historiography

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\(^{10}\) Such as that carried out by Matthew Hilton and Nicholas Crowson in the creation of the online Database of Archives of NGOs (DANGO); DANGO Available: http://www.dango.bham.ac.uk/ [Accessed 20 September 2019]; Kaur, ‘Writing History in a Paperless World’.

\(^{11}\) Walker and Maxwell, *Shaping the Humanitarian World*; Davies, *NGOs: A New History of Transnational Society*.

\(^{12}\) Davey, *Idealism beyond Borders*. 
of British humanitarianism, to demonstrate the shifting relationships, processes, and interactions that influence policy change and shape medical humanitarian deployments.\textsuperscript{13}

\textsuperscript{13} Ireton, \textit{Britain's International Development Policies}; Bose and Walker, \textit{Britain's Overseas Aid Since 1987}. 
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