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ESSENTIALS Humanitarian medicine addresses the human consequence of crises such as conflict, disaster, or displacement, and serves to assist those whose lives and health are impacted by such events. It is practised in challenging settings where resources are limited and environments unstable, and requires a clinical skillset which is both near limitlessly broad and context specific. The humanitarian sector has expanded significantly during the last two decades as a result of climate-related crises and increasing complex humanitarian emergencies due to protracted and multi- faceted conflicts. The picture today is evolving rapidly to ad- dress expanding humanitarian demands and a changing global sociopolitical reality. Introduction Humanitarian medicine is a discipline in which the overarching aim is to provide relief to those whose lives and health are harmed by crises. This work strives to uphold the core humanitarian prin- ciples of humanity, neutrality, impartiality, and independence, even when the reality on the ground is dangerous and chaotic. Unlike most clinical disciplines, humanitarian medicine is not defined by technique but rather by the setting in which it oc- curs: complicated environments, such as conflict, disaster, or displacement, that are inherently resource-limited and insecure. Within this context, however, its scope is broader than clinical medicine and requires a coordinated effort between multiple dis- ciplines. Moreover, the practice of humanitarian medicine in- volves adherence to principles which go beyond the precepts of the Hippocratic Oath. Humanitarian Medicine has been proposed as a practice that ‘goes beyond the usual therapeutic act and promotes, provides, teaches, supports, and delivers people’s health as a human right, in conformity with the ethics of Hippocratic teaching, the principles of the World Health Organization, the Charter of the United Nations, the Universal Declaration of Human Rights, the Red Cross Conventions and other covenants and practices that ensure the most humane and best possible level of care, without any discrimination or considera- tion of material gain’.1 Humanitarian providers practise medicine in one of its truest forms. Humanitarian medicine occurs in settings with low re- sources, where providers need to rely on clinical skills rather than extensive ancillary tests and imaging. It would be hard to find a practice of clinical medicine that more closely demonstrates Hippocrates’ assessment that ‘the art (of medicine) consists of three elements: the disease, the patient and the doctor’. At a period when Western-trained physicians are becoming increasingly specialized, humanitarian providers often

need to diagnose and treat patients that cross all specialties, including those with rare or atypical pres- entations, and they often conduct their practice without the safety net of referral. Although not a new discipline, the sphere of humanitarian medi- cine has expanded over the last 20 years, primarily in response to an increase in the scale and frequency of humanitarian emergencies. Climate change and natural disasters have become more frequent, violent conflicts are less defined and more protracted, and forced displacement has reached critical levels. With this reality comes the human consequence and the humanitarian needs of those affected. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) estimates that at least 141 million people in 37 countries were in need humanitarian assistance in 2017—the highest level in history (Fig. 2.21.1). The totality of need is staggering, and humanitarian medicine is a practice needed now more than ever. Origins and evolution of the humanitarian sector History of humanitarian response Humanitarian medicine is increasing in prominence (as demon- strated by its new inclusion in this established textbook!). This is related to many factors including increasing global humanitarian 2.21 Humanitarian medicine Amy S. Kravitz 1 Masellis M, Gunn S (2017). International Association for Humanitarian Medicine (IAHM) Brock Chisholm. Iahm.org. http://www.iahm.org/eng/home_ medicinaumanitaria.htm

194 section 2 Background to medicine Democratic Republic of the Congo (DRC) Central African Republic (CAR) Chad Libya Cameroon Nigeria Burkina Faso Senegal Mauritania Haiti Mali Niger Nigeria regional refugee response plan Burundi regional refugee response plan DRC Uganda Chad Cameroon Niger Rwanda Burundi Nigeria Tanzania Sudan Myanmar Afghanistan Occupied Palestinian territory (oPt) Syrian Arab Republic Iraq South Sudan Burundi Somalia Djibouti Yemen Ethiopia Ukraine Syria regional refugee and resilience plan South Sudan regional refugee response plan Sudan Ethiopia Egypt Turkey Iraq Lebanon Jordan Kenya Uganda South Sudan Syrian Arab Republic Countries with humanitarian response plans (HRPS) or other appeals Countries included in regional refugee response plans Fig. 2.21.1 Response plans around the world; Global Humanitarian Review 2017. Reproduced from Global Humanitarian Review 2017, United Nations Office for the Coordination of Humanitarian Affairs (OCHA).

2.21 Humanitarian medicine 195 needs, the expanding size of the overall humanitarian sector, and the role that the mass media have played in raising awareness of global crises and increasing the profile of those who are engaged in the emergent responses. However, the humanitarian concept is far from a new phenomenon: as the Greek historian, Thucydides, wrote in his classical account of the war between Sparta and Athens in the 5th century BCE: ‘If it had not been for the pernicious power of envy, men would not so have exalted vengeance above innocence and profit above justice . . . in these acts of revenge on others, men take it upon themselves to begin the process of repealing those general laws of humanity which are there to give a hope of salvation to all who are in distress.’ (Thucydides, History of the Peloponnesian War) This understanding of human nature and behaviour in crises nearly two and a half millennia ago is one of the earliest discourses on hu- manitarian action. Humanitarian principles have been enshrined in many religious teachings, and limits to warfare, including the acceptable conduct of wars, have been articulated in texts from the time of Thucydides: examples include The Art of War by Sun Tzu. But despite its underlying presence, for millennia the conduct of humanitarian medicine lacked codification and the practical frameworks that it now enjoys. The origins of contemporary humanitarianism are traditionally considered to be rooted in the actions of Henri Dunant, a Geneva- born businessman, who in June 1859 travelled to northern Italy to see Emperor Napoleon III, arriving in time to witness the imme-

diate aftermath of one of the bloodiest battles of the century, the Battle of Solferino in the Second Italian War of Independence. With over 5000 soldiers killed and estimates of over 23 000 left wounded on the battlefield, Dunant's experiences led to the publication of a small book entitled Un Souvenir de Solférino (A Memory of Solferino) in 1862. This book focused attention on the value of having a pre- pared cadre of responders to provide support in emergencies and proposed a plan for the formation of government sponsored inter- national relief societies to care for those wounded in wartime. He put forth the idea that aid workers should be permitted to assist the wounded on the battlefield, unencumbered and unharmed, pro- vided they remained neutral to the conflict. In 1863, Dunant helped to establish The International Committee for Relief to the Wounded, providing the framework for the even- tual establishment of the Red Cross. The following year, on 22 August 1864, 12 nations agreed to the principles of protection for the wounded and the neutrality and independence of medical per- sonnel on the battlefield. By signing the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, now commonly known as the Geneva Conventions, the concepts of rules in war and protection for humanitarian assistance were en- shrined in law. For his efforts, Dunant was awarded the first ever Nobel Peace prize in 1901. From this origin, formal international humanitarian law has been designed to specifically cover the duties of those engaged in armed conflicts as well as the rights of humanitarian organizations involved in relief operations. The laws serve as a careful equipoise between respect for state sovereignty with the recognized rights of inde- pendent organizations to provide aid to those in need. In total, the four Geneva Conventions of 1949, the two 1977 Additional Protocols, and a final additional Protocol in 2005, form the funda- mental basis for international humanitarian law. Derived directly from these laws are the fundamental principles of humanitarian action: humanity, neutrality, impartiality, and inde- pendence. The OCHA summarizes these key principles as follows: • Humanity: Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings. • Neutrality: Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious, or ideo- logical nature. • Impartiality: Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of dis- tress and making no distinctions on the basis of nationality, race, gender, religious belief, class, or political opinions. • Independence: Humanitarian action must be autonomous from the political, economic, military, or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented. International humanitarian law, combined with medical ethics and other legal frameworks for healthcare providers, was intended to de- fend the autonomy of medical personnel, to protect them against interference by security or military personnel, and to ensure that healthcare is provided on the basis of need, and neither refused nor used against groups.

Aid architecture The formation of the Red Cross, and the principles upon which it was based, set the standard for the development of subsequent nongovernmental organizations (NGOs). The League of Nations High Commission for Refugees, under the newly formed League of Nations, was founded in 1921 and served as a forerunner of the United Nations High Commissioner for Refugees (UNHCR). This was the first international agency that focused upon legal and polit- ical protections and assistance to refugees. Other humanitarian or- ganizations followed, and by the 1980s the key emergency offices within the United Nations had been formed, followed by the prolif- eration of NGOs. Today, humanitarian medicine is practised within a framework of a larger aid system, with an UN-led coordination mechanism established in 1991 through General Assembly Resolution. Key pillars of the UN-led humanitarian system included the forma- tion of the Inter-Agency Standing Committee (IASC) as the main policy and decision-making body guiding international humani-

tarian response, and the establishment of the OCHA, intended to increase coordination among the multitude of actors now en- gaged in humanitarian relief. No individual organization has suf- ficient capacity to address the comprehensive needs within even a single humanitarian crises, let alone the multitude simultaneously ongoing, and efforts to improve coordination between agencies, as well as with the host authorities, and the affected communities remains an ongoing priority. As part of that effort, the UN intro- duced the cluster system in 2005 to increase accountability, or- ganization, and professionalism within the global humanitarian

196 section 2 Background to medicine community. With health serving as one of the 11 established clus- ters, the purpose of this system was to ensure ‘that international responses to humanitarian emergencies are predictable and account- able and have clear leadership by making clearer the division of la- bour between organizations, and their roles and responsibilities in different areas’. (Fig. 2.21.2). The practice of humanitarian medicine Precipitants and preparations All crises, including violent conflict and natural disaster, can af- fect the health of a population, ranging from injuries and trauma to the exacerbation of underlying medical conditions. These events can weaken already poor infrastructure and affect access to basic services such as healthcare, clean water, and sanitation. Population displacement can result, often precipitating the spread of infectious diseases that are exacerbated by overcrowding. The diseases with the highest epidemic potential in such settings—cholera, dysen- tery, measles, and meningitis—are uncommonly seen in most clin- ical practices today, but where there is displacement they can have devastating individual and population level effects. Humanitarian assistance is essential in any crisis situations where the host government is unable to meet the demands within its own country or is unwilling to provide for the needs of its popu- lation. Before the establishment of a humanitarian space, how- ever, even in emergent situations, assessments, and planning must occur. Most experienced humanitarian organizations have teams of medical, logistics, security, and epidemiological experts on standby to deploy to any affected area to immediately carry out rapid assessments. The inclusion of local partners who can trans- late and provide an understanding of local context is essential, and mapping platforms such as geographic information systems can serve as tools which allow a better understanding of the locations, relationships, and patterns. Logistical considerations can be complex, particularly in un- stable environments, and often require the development of a supply chain with more agility than that required for typical commercial endeavours. Most agencies initially operate by a ‘push’ system, using prepacked and stockpiled kits ready for rapid deployment to an emergency, and switch to a ‘pull’ system, when supplies are requested as per need, within about 2–3 weeks of operations. Humanitarian doctors who join these relief efforts, either in the ini- tial stages or once the programme has become established, should Humanitarian & Emergency Relief Coordinator Early recovery UNDP Education UNICEF & Save the Children Emergency telecom- munications WFP Health WHO Food security WFP & FAO Logistics WFP Nutrition UNICEF Camp coordination and camp management IOM/UNHCR Shelter IFRC/ UNHCR Protection UNHCR Water, sanitation, and hygiene UNICEF Pre ve nt io n Mit ig at io n Pre pa re d n e s s D is as ter Res po ns e Reco ve ry Re co ns tr uc tio n Fig. 2.21.2 UN cluster system. Reproduced from Reference Module for Cluster Coordination at Country Level (revised July 2015), Inter-Agency Standing Committee.

2.21 Humanitarian medicine 197 gather information about the context and strive to form a basic framework of the background clinical and epidemiological picture. The setting they will enter may be chaotic and tense, and prepar- ations will serve to align expectations and streamline focus onto

the clinical challenges which lie ahead. Complex realities Simply put, providing clinical care in humanitarian settings is a challenge; resources are limited, advanced diagnostics are not readily available, and the environment is unfamiliar and chaotic. Colleagues may have different backgrounds, cultural norms, and professional practices. Language barriers often require the use of translators. Despite these realities, the breadth of possible caseloads is nearly limitless.
A humanitarian provider may need to manage acute emergencies, respond to victims of sexual violence, treat non- communicable diseases, or support war surgery. A caseload could include ophthalmological, renal, and orthopaedic presentations, while concurrently working to ensure the provision of clean water and support for hospital management. Without extensive adminis- trative or axillary staff, humanitarian providers may have a broad range of duties that stretch their capacity and test their skills to the limit. Humanitarian medicine must be practised with a nuanced under- standing of the specific context in which it occurs; mastery in one setting does not imply universal expertise in another. The skills re- quired for effective working (for example) in the Central African Republic, where there is context of protracted conflict, include an understanding of malnutrition, epidemic control, and of sexual vio- lence. In contrast, providing assistance to Iraqi refugees involves supporting emergency health needs and a shifting focus from war injuries to long-term rehabilitation. In any setting these clinical scenarios would pose a challenge, but working in unstable environ- ments adds further complexity, since before even starting it may be necessary to negotiate humanitarian space with armed combatants, coordinate across agencies, and gain the trust of a broad community. Rather than a ‘simple’ mastery of clinical medicine, effective practice in humanitarian settings demands of the provider that they under- stand disciplines such as security, law, epidemiology, and logistics, and can operate practically in highly politicized domains
Despite the innumerable complexities that present themselves, there is as yet no overarching licensing body or specific clinical review board to instruct and regulate this emerging discipline. There have been coordinated efforts to standardize best practices in humanitarian aid, such as with the Sphere Standards, initiated in 1997, and the Core Humanitarian Standards on Quality and Accountability (CHS), launched in 2014 (Box 2.21.1), but there are clear limitations to the use of universal standards in diversely varied settings. The lack of a definitive training programme to pre- pare the physician for the enormous variability of contexts and scenarios means that humanitarian providers must depend upon their medical education, clinical experiences, and preparations, and be willing to listen and learn from others. National or ‘local’ col- leagues are often the source of indispensable information, and the best humanitarian doctors are those who have the capacity to ac- knowledge their own shortcomings and learn from others. Having ‘gold standards’ might remain the goal, but the reality of circum- stances ensures that these remain at best highly challenging or, in effect, impossible. The humanitarian system Size and economics In response to a changing global landscape there has been an unpre- cedented expansion in the humanitarian sector over the last decade. Between 2007 and 2010, the fieldworker population rose by 4–6% annually, with financial contributions to the international emer- gency response efforts rising nearly threefold. By 2010, there were an estimated 274 000 humanitarian providers who collectively re- sponded to 103 natural disasters and 43 complex emergencies. By 2014, this number had grown to 450 000 humanitarian providers, working across more than 4480 operational aid organizations. Box 2.21.1 Humanitarian response review and sector strengthening Throughout the history of humanitarian action, nearly every major international intervention had raised questions about how to measure the impact and effectiveness of the response and how to make the sector more coordinated, efficient, and effective. When the contextual variability of humanitarian interventions can include sociopolitical con- straints and security limitations, developing a uniform approach to

improvement can be difficult to achieve. Despite the challenges, over the past two decades, great strides have been made to further the ef- fectiveness of humanitarian action, and the evaluation of humanitarian responses, such as that to the 2010 earthquake in Haiti, remain an im- portant component driving this effort. After the devastating 2010 earthquake in Haiti, which killed more than 220 000 people and affected nearly a third of the Haitian population, almost $9 billion in aid was donated in what amounted to one of the largest emergency relief responses ever mounted. Countless lives were saved in the immediate search-and-rescue efforts and medical response, and in subsequent relief efforts which reduced food insecurity and con- trolled an ensuing cholera epidemic. Despite such a large financial com- mitment and global response, by 2013, acute vulnerabilities persisted with over 10% of the population remaining displaced in camps and 30% continuing to have chronic and acute health needs. A review of the international response to the earthquake showed that, significantly, the Government of Haiti, was estimated to have received only 1% of the immediate humanitarian aid, and between 15 and 21% of the longer term recovery funding for reconstruction and develop- ment. NGOs and private contractors were the primary recipients of the aid in Haiti, and despite building extensive infrastructure with the use of public funds, had limited accountability to the national health authorities and lacked transparency as to quality and services offered. Further, with limited infusion of funds into the existing public health system, Haitian clinics and hospitals continued to lack the necessary resources to func- tion. With this in context, the 2014 Haiti Humanitarian Action Plan, developed through OCHA, sought to address the ongoing critical hu- manitarian needs but also focused at strengthening national capacities. The review of the response also demonstrated inconsistent capaci- ties and performance between agencies, and, (as concluded by Sir John Holmes, former Under-Secretary General for Humanitarian Affairs and Emergency Relief Coordinator) ‘the influx of many hundreds of hu- manitarian organizations, many of whom, while well-meaning, were not necessarily professional and well-informed in their approach, posed a huge challenge to coherence’. In addition to reforms aimed at coord- ination, the review highlighted the need ‘to develop principles, cri- teria and standards for medical teams that respond to emergencies and disasters’. This led to the development of the Classification and Minimum Standards for Emergency Medical Teams in sudden-onset disasters, and fed into the formation, in 2014, of the Core Humanitarian Standards on Quality and Accountability.

198 section 2 Background to medicine Although international actors receive the most media attention, local and national agencies and authorities actually deliver the greater assistance in conflict and disaster situations, particularly in the critical initial phase. Over 80% of operational aid organizations are local NGOs that work only within their home country. These na- tional providers are the ‘first in’ and ‘last out’ and form the backbone of the aid delivery system, but they are often underrecognized and excluded from much of the available funding. Despite a consensus on the essential role that national and local NGOs play within the humanitarian sector, recent data suggest that these sectors receive only a meagre share of global funding—0.3% in 2017. Funding of the sector has risen in absolute amount, but the growth has not kept pace with need, indeed the increase in need has stretched the capacity of the sector to its apparent limit. In 1992, the first interagency humanitarian appeals by OCHA requested (US) $2.7 billion, a figure which, by 2007, had only risen to $5.5 billion. The International Red Cross and Red Crescent Movement (RCRC) set out its requirements separately, maintaining independ- ence from the UN-coordinated appeals. By 2016, the UN joint ap- peal was for $20.5 billion yet yielded only $12.4 billion in committed funding, a 40% shortfall, and—irrespective of any shortfalls—needs have continued to increase (Fig. 2.21.3).

As of June 2017, the UN joint appeal estimated a total requirement of $23.5 billion, to target 101.2 million people across 37 countries. Changing humanitarian picture The dizzying increase in global humanitarian needs show no signs of abating. Today, the primary cause of human suffering and the re- sultant humanitarian response is intricately linked to conflict, par- ticularly those which are increasingly complex and protracted. With comparison to the historic precedence, today's crises are increas- ingly referred to 'complex humanitarian emergencies', defined by the World Health Organization as 'situations of disrupted livelihoods and threats to life produced by warfare, civil disturbance and large- scale movements of people, in which any emergency response has to be conducted in a difficult political and security environment'. Modern conflicts increasingly occur in urban rather than rural settings, and now affect middle income countries as often as poorer ones. The impact of such conflicts includes a massive surge in displace- ment, a regression on development, and a general increase of human suffering. The humanitarian consequences are massive and persistent. The International Committee of the Red Cross (ICRC) spends most of its budget on protracted conflicts, and in 2013, two thirds of the hu- manitarian aid from the Development Assistance Committee (DAC) donors was spent in countries which had been recipients of substantial humanitarian support for at least the previous 8 years. Protracted conflicts and other man-made crises have already con- tributed to unparalleled levels of displacement and 2016 marked an unprecedented challenge for the humanitarian community. UNHCR reported 65.6 million people forcibly displaced due to persecution, conflict, violence, or human rights violations, exceeding even the levels seen after the Second World War (Fig. 2.21.4) This equates to nearly 1% of the global population and the rate of new displace- ments is calculated to be 20 people every minute. Most refugees ori- ginate from the three zones of continued violence, Syria (5.5 million), In billion US$ 20 15 10 5 0 2004 2016 2014 Funding Gap Requested 2012 2010 2008 2006 Fig. 2.21.3 Funding trends 2004-2016. 97 0 10 20 30 40 50 60 70 Displaced population (millions) Proportion displaced (number displaced per 1000 world population) 98 99 00 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 0 1 2 3 4 5 6 7 8 9 10 Refugees and asylum-seekers Internally displaced persons Proportion displaced Fig. 2.21.4 Trends in global displacement and proportion displaced (1997–2016). From Global Trends: Forced Displacement in 2016, © 2017 United Nations High Commissioner for Refugees.

 Afghanistan (2.5 million) and South Sudan (1.4 million). Despite the predominance of news coverage on the European refugee influxes, the reality is that the least wealthy countries are actually hosting the vast majority of those displaced. In 2016, 84% of the refugees were hosted in developing countries, with Turkey assuming the lar- gest number worldwide for the third consecutive year (2.9 million). Lebanon, meanwhile, hosted the largest number of refugees relative to population size, and current estimates are that one out of every six people in that country is a refugee. Pakistan, Iran, Uganda, and Ethiopia were the other primary countries of asylum for refugees. The challenges of displacement for the humanitarian community relate not simply to the sheer magnitude of the issue but also to the changing contextual picture. Displacement today no longer adheres to traditional precedents that were set in rural areas or in camp set- tings. Today's response requires evolving practices, approaches, and interventions, in particular those that recognize and are sensitive to often dire historical contexts. Current crises in settings such as Yemen and Syria, where prewar health systems were functional, means that humanitarian providers must adapt traditional responses and con- sider the voids left by previously-existing tertiary level or specialist care. The expectations placed on humanitarian providers in such set- tings can be untenably high. Requests to support dialysis units or ter- tiary

specialist care are totally different propositions from traditional refugee responses, factors which have substantially increased the complexity of humanitarian programming in recent years. Further, working in dense urban areas poses different challenges with regard to shelter and housing, water and sanitation, engagement with es- tablished municipal and governmental systems, and even locating marginalized or displaced populations. Despite years of operational experience, humanitarian practices are currently, and rapidly, being adapted to today's picture. But this takes time, and the humanitarian community may not have the desired resources for this investment as the needs of millions are generally urgent and pressing. Instability and insecurity in humanitarian space Addressing the humanitarian consequences of today means engaging in a sector that is more complex and hazardous than ever before. With increased involvement of nonstate actors, conflicts can often no longer be considered to be between two recognizable sides. Fragmented structures can mean it is often difficult to know who is in charge, and the laws of war and the associated humanitarian pro- tections are often forgotten. Perhaps the most fundamental issues facing humanitarian pro- viders today is a decrease in respect for and enforcement of humani- tarian principles. Violations against humanitarian law, including a lack of respect for the protections of civilians, humanitarian, and medical workers, has risen to unprecedented levels and become a threat to the foundations of the sector. Analysis of data by the World Health Organization (WHO) showed that within the 2 year period of 2014 and 2015, there were 594 reported attacks on health care facilities or personnel across 19 different countries with emer- gencies, resulting in 959 deaths and 1561 injuries. Médecins Sans Frontière (MSF), meanwhile, reported attacks on 63 of their facil- ities in Syria in 2015, resulting in the total destruction of 12 facilities and the injury or death of more than 80 MSF-supported medical staff in that year. There has been an appalling lack of accountability against the perpetrators of such crimes, allowing violations of inter- national law to occur with seeming impunity. The campaign #NotATarget was launched by MSF in 2015 to stand in solidarity with those targeted and to demand the 'right of humani- tarian workers to provide humanitarian care to people in need, par- ticularly in conflict zones'. The laws to provide these protections are already in place, but without enforcement they hold little power. When nations and warring parties disregard the international ob- ligations and the protections in place for the impartial provision of healthcare, humanitarian action itself is threatened. Now more than ever, efforts must be made to strengthen and protect this system, and those who work within in it. In May 2016, UN Security Council Resolution 2286 passed, which condemned the attacks on medical facilities and demanded compliance with international law. At pre- sent, however, global leaders have not provided much substantive action to support the rhetoric. Political change and forward uncertainty Humanitarian Medicine has grown in prominence because it is im- portant, indeed essential. Those who practise humanitarian medi- cine have the fundamental ability to reaffirm humanity and help relieve human suffering. Yet the humanitarian sector now appears to be at a crossroads, with capacity stretched to a limit and insufficient funding, and today's geopolitical context portends uncertainty. Throughout modern history, humanitarian principles have played a critical role in the geopolitical sphere, from Britain's commitment to end the slave trade in early 1800s to the international response for those affected by the Northern Chinese Famine of 1876-1879. In 1904, United States President Theodore Roosevelt used the op- portunity of his Annual Message to Congress to reaffirm a place in politics for humanity, stating that: ' . . . there are occasional crimes committed on so vast a scale and of such peculiar horror as to make us doubt whether it is not our manifest duty to endeavor at least to show our disapproval of the deed and our sympathy with those who have suffered by it . . . (and) . . . in extreme cases action may be justifiable and proper'. After the Second World War,

these commitments were repeated and appeared firmly rooted in the foundations of liberal governance, but these sentiments appear disconnected with the realities of the present day, and today's global world order no longer conveys any semblance of solidarity. The predominant views from leaders is often decidedly more inward-looking and self-centred. Decisions made in response to the refugee influx in Western countries include the tightening of entry of refugees to the point of near stranglehold. The EU-Turkey deal, signed by 28 European Union Heads of State in March 2016, agreed to the return to Turkey of 'all new irregular migrants' arriving on Greek shores, despite concerns about poten- tial violations of both EU and International Humanitarian Law. The traditions of humanitarian principles, which once ran deep in world politics, now appear reduced to strategic interest. The moral respon- sibilities of today's world leaders can no longer be assumed. At this profoundly transformative time, those practising hu- manitarian medicine continue to uphold moral imperatives. They are demonstrating a commitment to medical excellence, with a broadening and strengthening of their capacities to meet the de- mands of those in need. But it is crucial that these and other active groups realize that the practice of a humanitarian provider should

200 section 2 Background to medicine go well beyond the therapeutic acts of relieving suffering and saving lives, as it serves to exert the general principles of humanity. The mere presence of humanitarian providers indicates a solidarity with those in need and helps to restore dignity for those impacted by crises. By bearing witness and demanding accountability, they re- ject the placid acceptance of suffering. Through their actions the capacity of compassion and the potential of humanity displayed, which at this particular time in history, perhaps more than ever be- fore, is imperative. FURTHER READING Bradol J-H, Vidal C (eds) (2011). Medical interventions in humanitarian situations: The work of Médecins Sans Frontières. Translated by Christopher Brasher, Nina Friedman, Philippa Bowe Smith, Karen Stokes, and Karen Tucker. Médecins Sans Frontières (MSF), Geneva, Switzerland. Kravitz A (2019). Oxford handbook of humanitarian medicine. Oxford University Press, Oxford.

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