OPINION NOTE

From remote control to remote management, and onwards to remote encouragement? The evolution of MSF's operational models in Somalia and Afghanistan

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Abstract

This Opinion Note continues the discussion started in Antonio Donini and Daniel Maxwell's "From Face-to-Face to Face-to-Screen: Remote Management, Effectiveness and Accountability of Humanitarian Action in Insecure Environments", published previously in the Review, by exposing the realities of Médecins Sans Frontières' (MSF) struggle with the issue of remote management. By reviewing MSF's experience with remote management in Somalia and Afghanistan, the authors explore how operational compromise evolves over time, based on specific contextual factors, and highlight the challenges that this form of compromised action poses to MSF's identity and principles.

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Remote management as a form of compromise: What is at stake?

> The strength of traditional humanitarian approaches resided in the proximity and empathy that were at the core of a relationship which, even if it was unequal, stressed the common humanity of those involved. … Without a modicum of presence, empathy and solidarity, the humanitarian endeavour is at risk of losing its meaning.[1]

The statement above is among the conclusions drawn by Donini and Maxwell in their recent article for this publication exploring the implication and the impacts of "remote management" on the aid industry. As remote management becomes more commonplace in insecure environments, opinion on its validity is divided in the aid community, between aid organizations and within organizations themselves. While many of these aid actors consider that remotely managed programming is a logical evolution of the industry, Médecins Sans Frontières (MSF) struggles against this trend. Although MSF resists, reformulates and nuances this discussion in its own terms, it is not above the debate on remote management, and no consensus has been reached on how to handle the many issues surrounding it.

The parameters of the term "remote management" and its implications as established by Donini and Maxwell accurately reflect the way the concept is employed in the industry today, and MSF's understanding of it does not differ in any consequential way from their proposed definition.[2] We have therefore chosen to focus our analysis on the questions of identity and principle that remote management raises for MSF, and we will illustrate the organization's experiences through the case studies of Somalia and Afghanistan. We will argue that this debate is necessary and that this tension between identity, compromise and evolution in the sector is essential to maintaining principled action in the humanitarian endeavour.

MSF's default mode of programming is a "direct action" model which involves mixed national and international teams in every project it runs. Core to our sense of humanitarian action is the notion of "being there" for reasons of principle, identity and quality, and most notably to safeguard impartiality in conflict settings. The organization generally operates with a ratio of around one to ten international to national employees, which is significantly higher than the 3% standard of some other major aid actors.[3] MSF's charter offers a claim to "full and unhindered freedom in the exercise of its functions", and invokes the principles of independence and of bearing witness, which embody MSF's spirit in

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1   Antonio Donini and Daniel Maxwell, "From Face-to-Face to Face-to-Screen: Remote Management, Effectiveness and Accountability of Humanitarian Action in Insecure Environments", *International Review of the Red Cross*, Vol. 95, No. 890, 2014, pp. 383–413.

2   "The withdrawal of senior international or national humanitarian managers from the location of the provision of assistance or other humanitarian action which represents an adaptation to insecurity and a deviation from normal programming practice": *ibid.*, p. 384.

3   Abby Stoddard, Adele Harmer and Katherine Haver, "Providing Aid in Insecure Environments: Trends in Policy and Operations", HPG Report No. 23, September 2006, p. 39.

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direct action.[4] Beyond its charter, MSF has revisited the theme of "direct" engagement in many pivotal documents and assemblies throughout its history. In both the Chantilly Agreement and the La Mancha Agreement – two key documents which formalize the evolution of the organization – MSF reaffirms its commitment to bearing witness with international staff on the ground as well as through "direct control over the use and surveillance of its resources".[5]

With the proliferation of humanitarian crises where humanitarian access is denied or where aid workers and their assets are deliberately targeted, such as in Somalia, Afghanistan, Pakistan, Syria, Libya and Mali among others, the pressure on the organization to "adapt" or experiment with less direct operational models has increased. Following a widespread internal debate, MSF's International General Assembly in 2013 ratified, by an overwhelming majority, a motion that introduced the following paragraph into MSF's vision statement:

> We value direct medical action, proximity and bearing witness by mixed teams of international as well as national staff. Therefore, remote management or the selection of staff based on gender, ethnicity, nationality or religion will only be accepted in exceptional cases, and even then only as a temporary measure.[6]

This statement addressed concerns that an unchecked tendency to compromise, in ways described above, would eventually erode the organisation's identity and values. The organisation thus again reaffirmed a direct implementation model while reserving a margin for temporary adaptation in exceptional circumstances.

In settings of armed conflict, remote management and other compromised modes of intervention call into question an aid agency's ability to conduct independent assessments and deliver aid impartially. It is generally understood that in armed conflict, belligerent parties seek to control, appropriate, divert or withhold aid for various obvious tactical and political reasons. It therefore follows that independent needs assessments and need-based programming can be, or rather tend to be, subversive to some degree as they challenge the agenda of one or more of the warring parties. Jean-Hervé Bradol explains:

> Humanitarian action is necessarily subversive, since partisans of the established order rarely empathise with those whose elimination they tolerate or decree. In other words, the first condition for the success of humanitarian action is refusal to collaborate in this fatal selection process.[7]

Outsiders to a conflict, despite having a lesser understanding of the culture and institutions of a context, have the benefit of an external point of reference that

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4   MSF Charter and Principles, available at: www.msf.org/msf-charter-and-principles.
5   The Chantilly Principles, 1995, available at: http://association.msf.org/sites/default/files/rst_library_item/Principles%20Chantilly%20EN.pdf; the La Mancha Agreement, 2006, available at: http://association.msf.org/sites/default/files/rst_library_item/La%20Mancha%20Agreement%20EN.pdf.
6   From Note 2: Compromises to our Modus Operandi, MSF International General Assembly, Brussels 27–29 June, 2013.
7   Jean-Harvé Bradol, "The Sacrificial International Order and Humanitarian Action", in Fabrice Weissman (ed.), *In the Shadow of Just Wars*, C.: Hurst & Co, London, 2004, p. 9.

hasn't already been appropriated by the local political landscape. Additionally, a foreign agency's temporary engagement can somehow act as protection in that a foreign entity would be the culpable party in challenging the established order and thus can shield local engaged and willing personnel from the fallout of being controversial. This commonly occurs in scenarios where a manager is faced with pressure to hire certain personnel, or purchase from certain suppliers within networks of patronage that favour local strongmen; or, on a higher level, when challenging authorities to allow for assessments or provision of aid for those most in need, rather than those in their zone of control. The weight and reputation of an international agency can (but does not necessarily) shield local employees from the repercussions generated by dogged negotiations with potentially dangerous parties. The struggle with authority is touched upon by François Jean:

> [An independent needs assessment] needs to be paired with a more comprehensive analysis of the causes of the target population's deteriorating situation, particularly to determine whether it is the result of any strategy on the part of political authorities … [T]his obligation of fairness is very different from the notion of even-handedness between parties that can be dictated by a false conception of neutrality.[8]

While "direct" operational models can have a clear added value, in an increasing number of conflicts, there are warring parties who consider that certain Western nationalities are by default proxies in the conflict. The public decapitation of aid worker David Haines at the hands of his captors is a tragic and painful example of an armed group enacting vengeance against international armed forces by the simple association of nationality.[9] It is quite commonplace for MSF and other aid agencies to self-censor with regards to nationality in phase with the understanding of local perceptions when certain nationalities are not perceived as neutral (American and British being those commonly restricted by MSF).

In practice, operational managers will use nuanced language to describe the compromises they make, in accordance with the light in which they would like to cast their chosen model of intervention. But at what point do these compromises with the preferred direct intervention model begin to constitute a new norm, and at what point do we begin to feel that they are at irreconcilable odds with humanitarian principles? It is the gradual evolution of compromise and its impact on the aid environment and the organizations acting within it that we must seek to understand when addressing the question of remote management. When MSF's international president, Dr Unni Karunakara, announced the organization's decision to close all activities in Somalia, he likened the evolution of MSF's ever-increasing compromise to the anecdotal frog in boiling water: the

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8   François Jean, *From Ethiopia to Chechnya: Reflections on Humanitarian Action, 1988–1999*, MSF, 2008, pp. 164–165.
9   See "David Haines – Obituary", *The Telegraph*, 14 September 2014, available at: www.telegraph.co.uk/news/obituaries/11095290/David-Haines-obituary.html.

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organization realized it had been pushed too far only when it was too late.[10] While most decision-makers within MSF agreed with this decision, others viewed it as too categorical and believed that despite everything, the organization's operations were of too great a value to the local population to be given up.

The evolution of MSF remote control in Somalia between 2008 and 2011: From security necessity to political imposition

On 28 January 2008, Victor, Damien and Billan were killed in Kismayo by a roadside bomb which hit their car close to the hospital where they were working for MSF.[11] Although the motivation for this attack was never conclusively established, it soon became apparent that it was deliberate and targeted. The three MSF workers were not victims of an unfortunate incident: they were murdered. MSF's immediate reaction was natural: all expatriate personnel were immediately evacuated from Somalia. What was surprising to most people not directly managing the operation was not the decision to evacuate, but the scale of the evacuation: more than 120 expatriate staff left the country the next day.

While it is common for MSF to have so many (or even more) international staff on the ground in a crisis, people were alarmed that this was also the case in Somalia, where it was notoriously difficult to work. Since 1997, the number of agencies working with expatriate staff based inside Somalia had steadily declined,[12] and Somalia gained the reputation of a "no-go" zone for foreigners. Many aid agencies in 2008 managed their operations by "remote control", later rebranded as "remote management", using Nairobi as the base for international staff for the Somalia projects, and "managing" operations inside the country by phone and Internet. Where possible, aid agencies would make unannounced and unpredictable "flash visits" to the project locations, so as not to become completely disconnected from the operational reality while minimizing the risk of targeted attacks.

Even though MSF had 120 international staff on the ground, its "direct action" model of operations was already converging with the "remote management" model adopted by most other aid agencies, even before the attack in Kismayo. There was a brief window of opportunity in 2006, when the Islamic Courts seized power in Mogadishu and large parts of Southern and Central Somalia and established brutal but effective control over the warlords, removing all checkpoints and guns from the streets. MSF and other agencies were able to expand rapidly in the six months during which the Islamic Courts ruled, including the project in Kismayo where three of its staff later died. This period of relative security and access was brief, however, as the country was plunged into

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10 Andrew Gilligan, "Is Foreign Aid Just Money Down the Drain?", *The Telegraph*, 17 August 2013, available at: www.telegraph.co.uk/news/politics/10248706/Is-foreign-aid-just-money-down-the-drain.html.

11 MSF, "Three MSF Aid Workers Killed in Fatal Incident in Kismayo", press statement, 28 January 2008, available at: www.msf.org/article/three-msf-aid-workers-killed-fatal-incident-kismayo-somalia.

12 Mark Bradbury, *State-building, Counterterrorism, and Licensing Humanitarianism in Somalia*, Feinstein International Center, Tufts University, Medford, MA, 2010, p. 8.

fragmented chaos after the intervention of Ethiopian troops. Although MSF had medical projects in sixteen locations throughout the territory by the end of 2007, security was so bad in many of them that the expatriate teams spent more time in Nairobi than on the ground due to repeated evacuations. In some locations this occurred so frequently that the actual time spent on the ground meant the operation differed very little from the "flash visits" used by other agencies. To the untrained eye, MSF expatriates were not flying "out" of their project for an evacuation; they were flying "in" for a visit. Consequently, MSF had already started to debate whether it should be more honest about the operational reality in these projects and formally switch to a remote management model.

These discussions came to a rapid conclusion following the Kismayo killings. The targeted nature of the attack, combined with the already tenuous presence prior to the incident, made the choice inevitable. MSF would join the rest of the humanitarian agencies and adopt a remote management approach to Somalia. This was the second time MSF had adopted this policy structurally – the first time was in Chechnya in 2001 – and in both cases it was triggered by a serious security incident and considered as a temporary measure.

However, in Chechnya, remote management was still firmly in place seven years later, and the teams immediately suspected that the situation would be the same in Somalia for the long haul. MSF was able to benefit from its long history in the country, where over the years it had created a large pool of experienced and well-trained Somali staff who could continue to provide medical services in much the same way, in the absence of the international managers. This pool included staff from the neighbouring countries – Kenyan and Ethiopian nationals with an ethnic Somali background who quickly made up a third category, wedged in between expatriate and national staff: the so-called "regionals". It was thought that concerns regarding a loss of impartiality would be mitigated as these regionals did not have direct economic, political or family links to the project locations they supervised.[13] With the exception of Kismayo, which was formally closed, almost all projects resumed activities according to this new model within weeks. In a few locations in the north, expatriate presence was still judged possible and so MSF's overall ability to manage its operations seemed strong.

For the first year, the remote management model did not change much on the ground. Flash visits by expatriates were still possible, and activities remained largely the same. Some suggested that, in retrospect, it actually made things easier and there was less friction as it signalled increased trust and commitment to the staff and community. There was, however, a tangible change in the decision-making process, most notably in decisions taken through direct negotiations with the armed groups.[14] As noted in the introduction to this piece, in a direct action approach one of the main tasks of the expatriate staff is to front negotiations with

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13 Abby Stoddard, Adele Harmer and Jean S. Renouf, "Once Removed: Lessons and Challenges in Remote Management of Humanitarian Operations for Insecure Areas", *Humanitarian Outcomes*, February 2010, p. 27.
14 A. Stoddard, A. Harmer and K. Haver, above note 3, p. 33.

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armed actors; this cannot be maintained when operating on a remote model. As most of these negotiations concern small, daily issues, most of them go unnoticed by the nominal supervisors based in Nairobi. Slowly, however, the distance between the expat staff and the daily reality grows.

Over the course of the same year, the frequency and length of the flash visits diminished. This reduced presence on the ground was the result of a perceived increase in security risks, but this was hard to verify without independent risk assessment. The security risks on the ground were reported by national staff, who may have had an interest in minimizing the presence of expatriate staff as this brought complications and tensions. This implies that national staff had a natural tendency to err on the side of caution, and to recommend more often than not that expatriate staff could not travel to the project location, which further increased the distance between them and the operational reality on the ground.

MSF began to question the national staff's overly cautious approach, especially in project locations firmly controlled by Al Shebab. Al Shebab had evolved from the Islamic Courts, and its methods of control were similarly brutal and highly effective. Clans, warlords and criminal groups, which had brought so much insecurity to many regions of Somalia, could not operate freely under the Al Shebab administration. In a sense, Al Shebab-controlled locations tended to be some of the safest locations. Discussions regarding whether or not to engage again with expatriate staff on the ground were cut short when Al Shebab decided to ban all foreigners from its territory in mid-2009.[15] For a period, regional staff – Kenyans and Ethiopians with a Somali background – were still allowed to work, so there were still some, more impartial or independent international personnel on the ground, and the MSF projects were consequently branded "remote control – light". By 2010, most of the local commanders had also banned these regionals from their territory. All MSF projects in Al Shebab-controlled areas were now under full remote control.

Major investments were made in this period to mitigate the expected negative aspects of this model. One of the main concerns was around the quality of the medical services, so a huge investment was made to improve the training of national staff: regular flights bringing senior staff to Nairobi were organized, and hardware was put in place to improve phone and internet connections in order to facilitate video links for "telemedicine" and remote medical consultations by doctors based in Nairobi. To mitigate the expected pressures on impartiality, a management model was developed to allow national staff to credibly defer sensitive decisions to the hierarchy in Nairobi. Finally, to counter concerns about accountability, remote monitoring tools were developed to reduce the risk of resources being diverted or misappropriated. There is no doubt that the investments in training have resulted in the continuation of high-standard medical services. The success of the other measures, however, is less clear, as impartiality is hard to quantify and accountability has been a problem in Somalia regardless of the intervention model.

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15 A. Donini and D. Maxwell, above note 1, p. 399.

Over the same period, in locations that were outside Al Shebab control, such as Mogadishu and Galkayo, MSF slowly brought expatriate staff back in. Although never to the level of a formal permanent presence, flash visits increased and there were longer periods of expatriate presence. Ironically, this meant that MSF had no international staff in the safer locations controlled by Al Shebab, but had a resumed expatriate presence in the more insecure areas outside of Al Shebab's direct control. Not surprisingly, this triggered a fundamental and emotional debate inside MSF on the legitimacy of remotely managed humanitarian interventions. For some, remote management is as legitimate as any other operational model, as long as the final objective of delivering quality medical assistance is achieved. Proponents of this argument were backing up their position by showing the medical output, numbers of lives saved, people cured and medical data to prove that quality standards were met. Those that argued against this model said that MSF's identity and principles were at stake, and questioned the impartiality of the medical interventions, the reliability of the (near-perfect) data and the lack of proximity to the patients. They emphasized that even if one can measure the outcomes for patients in the hospital, there was no real understanding of the situation of people outside of the hospital and no data on those who may not have been able to access it in the first place.

The development of the humanitarian environment in Somalia in March 2011 posed the greatest challenge to proponents of the remote model. Reports of drought, displacement and malnourishment began to arrive from the rural heartland of Southern and Central Somalia,[16] a region that was primarily under the control of Al Shebab. MSF made some attempts in the spring of that year to launch an exploratory mission into the regions reported to be the worst affected, but access continued to be denied. Not only international and regional staff but also local personnel from nearby MSF projects were forbidden from entering these regions. In other words, all potential independent needs assessments were banned and MSF was unable to operate there. Although staff in some of the MSF projects were proactive and creative in their attempts to address this emergency, many other projects fell into a "trap" or "rut"[17] – i.e., they tended to maintain the status quo. While external reports on the drought and displacement became harder to ignore, many remotely managed MSF projects, although based around the same region, did not report anything at all and continued to churn out routine medical reports, again raising doubts about the impartiality of the response.

The upshot of this was that MSF did very little in terms of emergency response until large numbers of displaced people entered accessible areas like Dadaab refugee camp in Kenya and the outskirts of Mogadishu in July of that year. As the emergency response geared into action, international personnel were deployed *en masse* to these locations, complete with full charter cargo planes to support the rapid deployment of nutrition and measles treatment centres for

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16 "Drought-Hit Somalia on Brink of Humanitarian Disaster, Warns UN Expert", UN News Centre, 2 March 2011, available at: www.un.org/apps/news/story.asp?NewsID=37660#.VBq4Y_mSy9o.
17 A. Stoddard, A. Harmer and K. Haver, above note 3, p. 33.

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hundreds of thousands of people. Operating under the paradigm that direct action works best in emergencies, MSF paid a heavy price for this massive scale-up in its activities. In October 2011, two expatriate members of staff were kidnapped in Dadaab refugee camp in Kenya, and two months later, in December, two others were shot dead inside MSF's compound in Mogadishu. The two hostages would be held captive for some twenty-one months. Shortly after their release in July 2013, recognizing that there was no longer any respect for aid workers among any of the parties to the conflict, MSF decided to close down all of its medical programmes in Somalia, including those in the autonomous regions of Somaliland and Puntland.[18] MSF made the announcement on 14 August, and within days, work was under way to organize the closure of all projects, including the management of remaining patients, outstanding payments and the donation of medical stocks. Although plans allowed one month for the projects to manage all these matters properly and safely, the process took less than twenty-four hours in most of the remotely managed projects in Al Shebab-controlled zones. Al Shebab officials arrived at the gates of the MSF compounds immediately after the announcement, confiscated the keys, expelled the MSF staff and all the patients, even those who were in mid-treatment, and took over the structures and all their assets. The speed and ease with which this transition took place begs the question: how much did MSF really "manage" in these remote management projects in the first place?

The Somalia case raises questions regarding impartiality and independence, and the progressive nature of MSF's compromise in its operations demonstrates how rational decision-making in the moment brought the organization to an untenable position over time. In turn, this evolution poses deeper questions about MSF's identity. The attacks conducted on its international personnel, the complicity of local authorities and the fundamental compromises required to continue to work remotely left MSF with no other option but to leave.[19]

MSF returns to Afghanistan, 2009–2011: Remote control rejected against the conventional wisdom of the aid community

On 2 June 2004, Helene, Willem, Egil, Fasil and Besmillah, all working for MSF, died when the clearly marked MSF ambulance in which they were travelling to an MSF clinic in Badghis province, northern Afghanistan, came under gunfire.[20] As in Somalia, although the motivation for this attack was never conclusively established,

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18   MSF, "MSF Forced to Close All Medical Programmes in Somalia", press statement, 14 August 2013, available at: www.msf.org/article243/msf-forced-close-all-medical-programmes-somalia.

19   *Ibid.* To the surprise of many, this closure also affected Somaliland (where no incidents took place) and not Dadaab in Kenya (where the two Spanish staff were abducted). The rationale behind this was that the authorities accused (Al Shebab, TFG) were allowed to freely circulate in Somaliland, and not in Kenya. In practice, of course, they freely circulate in both places, hence the controversial nature of this decision.

20   MSF, "Five MSF Workers Killed in Serious Incident in Afghanistan", press release, 2 June 2004, available at: www.msf.org/article/five-msf-workers-killed-serious-incident-afghanistan.

it was soon evident that it was deliberate and targeted. MSF immediately evacuated its personnel from some project locations, reduced numbers in others and put many projects on hold. What followed, however, was unprecedented in the history of MSF. Less than a month after the incident, MSF announced that it would completely close all its projects in Afghanistan, and leave the country.[21] After previous incidents in other countries, MSF had usually closed the project where the incident occurred, and sometimes the MSF office responsible for the project would leave the country. For the entire MSF movement to withdraw, especially from a country where it had such a long history and so many projects – at the time of closure MSF was responsible for health care in thirteen of Afghanistan's provinces – was exceptional. Publicly the justification for this decision was based on the collusion of all the parties in the Afghan conflict in the killing of the five staff members. On the government side, it quickly became clear that a local policeman was involved in the killing, but his bosses in Kabul were unwilling to hold him to account. Meanwhile, the Taliban claimed responsibility for the attack. Although it was unlikely that they were actually involved, some commanders were quite willing to claim responsibility to boost their image of influence and reach. Privately, there was also a significant emotional element to MSF's decision. MSF had a long history of engagement with Afghanistan, and had remained present during some of the worst periods of its history. The brutal assassinations, followed by the government and opposition's indifference towards punishing the perpetrators, triggered a strong feeling of betrayal, which fed into the decision to leave.

Our analysis of remote management in the Afghan context begins four years later, in mid-2008, when MSF was ready to re-engage in the country. Since its departure, the situation had deteriorated dramatically in terms of security, while humanitarian needs, in a country that had already been at the bottom of health, poverty and development tables even in peaceful times, predictably increased. In addition, the ICRC had started discussions with MSF to encourage a return to Afghanistan, as it was struggling to find health actors willing to work in the more insecure regions of the country. This had put pressure on the ICRC to engage in general health activities well beyond its mandate and capacities.

MSF deployed an exploratory team to Kabul to see if a return was feasible. The outcome of this visit was a clear yes, but with a recommendation to follow a model of operations which was "low profile" and "relying on senior national staff". In other words: remote control. This was hardly surprising, as the conventional wisdom of the aid community in Kabul was "less is more" when it came to expatriate presence. The United Nations, in its Humanitarian Action Plan for 2009, observes that: "In areas where insecurity prevents access, there has been an increased reliance on programme delivery and monitoring through local partner organisations."[22]

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21 MSF, "MSF Pulls Out of Afghanistan", press release, 28 June 2004, available at: www.msf.org/article/msf-pulls-out-afghanistan.
22 UN Office for the Coordination of Humanitarian Affairs, *Humanitarian Action Plan for Afghanistan*, Geneva, 2009, p. 1.

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The kidnapping of foreigners had grown into an industry, road travel was all but impossible except for Afghans with sufficiently long beards, and large parts of the south were controlled by the Taliban, who did not allow foreign staff into their regions. On the development side, where working through local partners is the preferred model, a similar assessment was made for monitoring health-care indicators. The Afghan Ministry of Health (MoH) channelled all health-related overseas development funding through NGOs for implementing the ambitious goals that were defined in the Basic Package of Health Services (BPHS). In its 2009 document, the Afghan MoH notes that:

> Insecurity is still another challenge which reduces the population's access to the health care services. It also limits monitoring visits to the provinces where BPHS is being implemented. This may result in a compromise of the quality and possibly a lack of transparency in terms of quality services provision.[23]

This meant that even local health officials could no longer reach their structures, and had to rely on remote control. In this environment the recommendation to MSF to consider remote control was logical. Moreover, this model of operations would resemble MSF's projects over the border in Pakistan at the time, where security in the Pashtu areas had deteriorated.

MSF's team arrived in Afghanistan in January 2009 with a clear brief to restart medical activities, concentrating on the conflict regions outside Kabul, and with a firm recommendation to copy the Pakistan mission's "national staff-driven, low-profile model". At the time, the reality of the reigniting conflict was readily apparent within the aid community, who were beginning to adapt their intervention mode accordingly, yet the health sector remained entrenched in the development logic outlined in the BPHS, channelling all funds through the MoH in Kabul.

Upon arrival, the team was inundated with reams of reports and megabytes of data showing in detail health structures, population figures, prevalence tables, mortality and morbidity figures and treatment outcomes. Such forthcoming and positive data was suspect. The monitoring system deployed by the BPHS was outsourced to the John Hopkins University in the US, who employed the system known as "the balanced scorecard", which produced health data in colour-coded spreadsheets, with green indicating that targets were achieved or exceeded. On first glance, these sheets were a sea of green with an occasional yellow or red dot. This seemed improbable in a context where even the MoH admitted its own staff could hardly travel, newly displaced people were arriving in Kabul fleeing the intensive fighting, and very few qualified health staff dared to work in the countryside. As no expatriate and very few senior national staff could travel outside of Kabul, most of the data were collected by the local health workers whose continued financing depended on a positive outcome of the monitoring exercise. Faced with this quandary, MSF decided that any assessment had to be

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23 Ministry of Public Health, Islamic Republic of Afghanistan, *A Basic Package of Health Services for Afghanistan*, Kabul, January 2009, p. 10.

conducted by an expatriate team to guarantee a disinterested and impartial overview, even if the organization still considered remote management to be the most feasible mode of running the project.

In May 2009, MSF sent an expatriate-led assessment team to Helmand province, which at the time was at the centre of the conflict between international forces and the Taliban. On paper in Kabul, the main hospital for the province in its capital Lashkar Gah was a successful 150-bed facility with general surgery capacity, sufficient medical staff and good to excellent health outcomes, according to the "balanced scorecard". What the MSF team found on the ground was this:

> The hospital is beautiful, spacious, well designed with an almost perfect infrastructure, but is has 53 doctors who run it like a butcher shop mostly aimed at marketing their own private clinics. The few patients that are admitted (the register showed 39 on the day of assessment) hang around on the ward a bit lost as most of the nurses seem to be continuously occupied drinking tea in their offices. Between 10 and 11 AM, all of the Doctors and a large part of the Nurses rush off to their jobs in the numerous private clinics in town, the biggest one of which is owned by the Provincial Health Director.[24]

The impact of this assessment on the decisions around operational models was profound, and the following operational discussions were animated by a simple logic: if numerous NGOs with similar expertise and capacity to MSF have not been able to provide a relevant outcome with the remote management approach, it would be irrational to assume this would be different for MSF. The idea of employing remote management was instantly taken off the table and a direct management model was considered essential for meaningful impact on the ground.

A direct model of intervention with mixed international and national teams in the heart of the conflict zone went completely against the grain of the conventional wisdom of the aid community in Afghanistan. Only a handful of organizations maintained an expatriate presence in the south, and they were able to do so because they were either protected by an armed force or by agreement with opposition forces active in the region. As military protection was not an option, such an agreement was therefore also required for MSF, and negotiations with the opposition forces started the same month. These discussions with the central leadership of the Taliban (the so-called "Quetta Shura"), had an unexpected outcome. Permission to start medical activities in Helmand was relatively easily obtained, in contrast with MSF's failed access negotiations with Al Shebab in Somalia. MSF ascribed its quick success in Afghanistan to the good reputation it had built between 1996 and 2001, when the Taliban had been in power in Kabul. Many of the current members of the Shura had occupied ministerial posts in Kabul before, including the crucial ("shadow"[25]) minister of

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24 MSF, "Helmand – Lashkar Gah Assessment", internal report, 2 May 2009.
25 The official name of the Taliban is "Islamic Emirates of Afghanistan", which is the old name used during their rule in Kabul. From their point of view, they are the legitimate government of Afghanistan, currently in exile, driven out by foreign invaders. Following that logic, their man is the legitimate, not the "shadow",

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health. When the details of the *modus operandi* were discussed, they had a final demand: the doctors MSF brought to run the hospitals had to be expatriate doctors, because they said they "didn't trust any of the local doctors". Moreover, these expatriate doctors, and their cars and compounds, had to be clearly marked with MSF logos. This last precondition was basically so that their fighters could recognize which foreigners not to kill.

This logic is in sharp contrast with that expressed by Al Shebab in Somalia, indicating that remote management is not the *de facto* future of the industry, even in a context where Western armed actors are engaged. The decision to reject remote control was at first a choice made by MSF, but later this approach was actually imposed as a condition and locked into the deal with the dominant armed group. Five years on, MSF is working in four locations, three of which are conflict zones in Helmand, Khost and Kunduz, each with a large, highly visible expatriate team. For now the deal is holding, but there are clear limitations. Safe travel by road remains unreliable and difficult for foreigners, so MSF locations are limited to where a plane can fly. Despite the Taliban's request that MSF open projects in five remote locations in the heartlands of their constituency, the organization has only managed to travel to assess one of them. The others were never reached as local Taliban commanders were never able to overcome their fear of a Trojan horse. Although the leadership considered that humanitarian assistance was vital in these locations, when it came to negotiations on each checkpoint, the local commanders could not be convinced that not *all* foreigners attract drones. To some this may suggest that alternative operational models should be considered in order to reach these distant regions with no access to supplies or services, but so far this has not been explored.

From remote management in Somalia to "remote encouragement" in Syria: A compromise too far?

Casting a broader focus beyond these two case studies, we must note that similar struggles exist in a proliferating number of contexts today. In Mali, MSF responded to the kidnap risk posed to Western expatriate staff by imposing restrictions not just on nationality, but even on the skin colour of its international staff, resulting in teams mostly staffed by regional nationalities. This recalls the early decrees by Al Shebab, which initially restricted access to staff with a Somali ethnic background from the region, but eventually deteriorated into the banning of all foreigners. In the case of Syria, MSF tried many avenues of intervention, but eventually concluded that most regions controlled by the opposition were too dangerous for international staff. Access to areas controlled by the government was outright denied to the agency. As the intensity of the conflict is extreme and the resulting needs immense, MSF has taken the unusual

minister of health. However, the term "shadow" was widely used to refer to members of their parallel administration.

measure of supporting local networks of medical actors who provide desperately needed medical care in areas which the international NGOs cannot reach. While this helped build the trust and confidence required for working directly on the ground in some parts of opposition-controlled northern Syria, the kidnapping of five of MSF's personnel in early 2014 led to the eventual withdrawal of its entire international staff, and there is no clear prospect of a meaningful return.

As the remaining programme is largely donations of medical supplies to third parties, what is left, at best, is a concept of "remote encouragement". The point of departure is the failure of the organization to be relevant if it sticks to a classic direct intervention model. This additional step, even farther from the field than in remote management, simply enables groups to do what they would do anyway without MSF's "encouragement". Any true pretence of control is absent in this model, as is the idea of "management", since these groups are not even employed by MSF. However valid, useful or life-saving, can we still consider that the aid is humanitarian – in the proper sense of the industry's definition of the term – or has it become more a form of philanthropy? "Without a modicum of presence, empathy and solidarity, the humanitarian endeavour is at risk of losing its meaning" is one of the conclusions of Donini and Maxwell. If this is considered valid, what does this mean about the organization's identity?

Beyond Syria, debates on replicating this third-party model are ongoing for other seemingly impenetrable contexts where needs are great and direct access is not possible. For a "Dunantist" organization like MSF, direct action remains the preferred model as the focus on immediate humanitarian needs requires a level of impartiality that is difficult to maintain in other operational models. Also, whilst concerns about quality and accountability can be largely mitigated by different management models, more principled issues like the dilemma of "outsourcing" the risk to national staff are less easy to fix.

Also, remote management, usually conceived as a temporary adjustment, tends to become a self-perpetuating situation. National staff have little incentive to reintroduce the risk associated with expatriate presence to their projects, and armed groups or other authorities have little reason to invite back nosy foreigners once the resources are secured. The case studies discussed in this paper show that there is no "one size fits all" model for managing operations in highly insecure contexts. What works well for one organization can be unacceptable to others in the same context. Each organization will adapt its intervention model to the local requirements and needs. For MSF, the evolution from remote control, to remote management, and finally to merely "encouraging" activities of third parties, may well be a step that pushes us to the limits of "humanitarianism" in the classical sense of the term. Yet it may also be the right thing to do considering the enormous needs and impossibility of intervening in a more direct manner in contexts like Syria.

While MSF may still decide what mode of operation is valid when the international system itself fails, organizations like MSF should never concede that

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this evolution is inevitable unless we acknowledge that humanitarianism, as we have known it, is to some degree obsolete. While MSF's *modus operandi* will remain dynamic and will continue to evolve in accordance with the operational reality on the ground, debates around these issues will continue to shape and challenge the organization's identity in the coming years.

CORRIGENDUM

From remote control to remote management, and onwards to remote encouragement? The evolution of MSF's operational models in Somalia and Afghanistan – CORRIGENDUM

Michiel Hofman and Andre Heller Pérache

The text of the above article by Michiel Hofman and Andre Heller Pérache has been amended since it was first published online.

The original version of this text represented the vote taken by MSF's International General Assembly as having been divided, rather than a resounding majority decision.

The article has now been corrected in order to assure historical accuracy.

Reference

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