

MSF

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Aleppo:

Medical Aid Besieged

From Medical Care under Fire to the Near Impossibility of Humanitarian Action

MSF's Account of 2 Years in Aleppo



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Executive Summary

The conflict in Syria has been characterised by brutal violence that does not distinguish between civilians and combatants, nor does it respect the protected status of health personnel and facilities.

Marked by unrelenting suffering of the Syrian people with staggering levels of deaths and injuries, massive disruption of basic needs, and forced displacement of millions within the country and across borders, the dire humanitarian situation has been exacerbated by the violence that has targeted healthcare structures, personnel and assets since the beginning of the conflict, depriving the sick and the wounded from seeking safe access to medical care. One of the major symptoms of the crisis has been the deteriorating healthcare system, which has seen growing shortages of medical supplies and skilled health professionals, not to mention outbreaks of vaccine-preventable diseases and the inability to adequately treat chronic and non-communicable illnesses.

MSF has been providing medical care in opposition-held parts of Aleppo province since August 2012, running health facilities and supporting local medical teams and structures in an extremely hazardous environment. MSF's numerous unsuccessful attempts to obtain official registration in the country limited its access and ability to provide assistance in areas under the Syrian government's control. In addition to ever-shifting battlefronts and changing dynamics amongst armed factions, MSF's access within its area of operations was further jeopardised by lack of security assurances by armed opposition groups.

While MSF did not seem to suffer deliberate violence aimed at destroying its mission in Aleppo, it did face a number of near-missed incidents that had a considerable impact on its operations and on the people seeking medical care; the threat of shelling by government forces was a defining factor in many critical decisions that were made, including reductions of teams and activities and relocation of facilities. Moreover, by virtue of operating in areas under the control of armed opposition groups, MSF witnessed different forms of violations with varying degrees of severity, ranging from a general disregard to health facilities and personnel, to targeted violations mainly affecting the national staff due to their perceived personal ideologies or affiliations – the most tragic being the killing of MSF local surgeon.

With the rapidly changing and unpredictable environment, MSF endeavoured to regularly review its risk assessment and operations, with the aim of mitigating all known and potential risks for its staff, particularly the Syrian personnel who are by definition part of the conflict and have themselves been victims of the changing local context. However, the level of networking and context analysis needed to stay informed and constantly adapt to the evolving context was extremely difficult to attain due to the growing atomisation amongst the armed opposition, with ever-shifting alliances and emergence of multiple uncoordinated factions. While MSF maintained contact with the main coalitions and the strongest groups in its area of operations, one of the main challenges it faced by late 2013 and early 2014 was obtaining reliable security guarantees from the armed groups, particularly those manifesting suspicion and intolerance of what was perceived as 'western' aid.

The heightened violence against foreigners and the abduction of MSF colleagues in January 2014 marked the end of MSF's international staff presence in Syria with the move to remote management with Syrian staff only. Accepting that painful compromises would have to be made, particularly in terms of its proximity and bearing-witness role, MSF acknowledged that it has to rely more on its national staff and share responsibilities, while limiting any potential transfer of risk. It also recognised the significant impact of its support to partner medical networks and health facilities since the beginning of the conflict, as a complement to lack of wider direct presence. This uninterrupted and growing support has been considered to be one of the key contributions of MSF's medical assistance in Aleppo.

Despite the challenging operational context and various violations suffered by MSF since the beginning of its intervention, it is clear that the medical mission was not exposed to the same level and type of violence as witnessed by partner local medical teams and health facilities operating in most of the cities and at the frontlines. From the early phases of the uprising, doctors and medical workers were reportedly threatened, detained and tortured by government security forces and allied militias for providing medical care to injured protesters and for being perceived as sympathetic to the opposition. With the escalation of the conflict and ensuing division of Aleppo, many health facilities in opposition-held areas began witnessing targeted and repeated bombing by the government forces, causing partial or total destruction as well as deaths and injuries amongst medical staff and patients. The situation has only been aggravated by growing interferences and attacks by armed groups and individuals, with many health professionals and patients facing harassment, detentions, torture and executions committed outside any judicial or legitimate structure.

MSF's account of two years in Aleppo is one of immense complexity and adaptation to a highly volatile and constantly changing security context. On one hand, it reflects MSF's choices and decisions made with regards to risk acceptance and mitigation, which has determined the scope of its intervention and its ability to continue providing medical assistance to the Syrian people to this very day. On the other hand, it highlights the high level of uncertainty and unforeseeable threats that materialise in such complex conflict situations, in addition to the challenge of operating in a middle-income dense urban context with sophisticated warfare and dealing with very powerful state and non-state actors.

Introduction

Médecins Sans Frontières (MSF) has long witnessed and condemned various forms of violence against both its medical mission and other healthcare providers. Attacks against medical personnel and facilities put both safe access to and provision of healthcare at risk and result in increased security measures that are detrimental to the populations seeking vital health assistance. Ultimately, they are the ones to pay the heaviest price for measures such as staff reductions, temporary suspension of activities and even closure of health facilities. In some extreme cases like Somalia, MSF has been compelled to close down its medical mission and withdraw completely from a country with dire humanitarian needs due to constant aggression and targeted attacks against its staff, patients and facilities.

Syria provides a dramatic and tragic example of how health systems can become the target of both deliberate and indiscriminate violence.

Nearly four years after what began as peaceful protests, the conflict in Syria continues with no end in sight. The humanitarian situation, which has been underserved since the beginning, continues to deteriorate with civilians bearing the brunt of the violence. By December 2014, an estimated 200,000 Syrians had lost their lives, more than one million had been injured, and nearly half the population had been forced to abandon their homes and flee for their lives, including 7.6 million who have been displaced within Syria and another 3.2 million who have sought refuge in other countries.¹ According to the UN High Commissioner for Refugees, Syrians are now the largest refugee population under the agency's mandate, making it "the most dramatic humanitarian crisis the world has faced in a very long time".²

Since the beginning of the conflict, there have been reports of grave violations of international humanitarian law (IHL) by government forces and non-state actors, including indiscriminate and direct attacks against civilians and civilian infrastructure, use of prohibited weapons, summary killings and taking civilian captives.³ The deliberate targeting of medical facilities, personnel and transports, the obstruction of access to medical care, and ill-treatment of the sick and wounded, has been one of the most alarming features of the conflict.

This report analyses the themes of violence against the medical mission in Aleppo and the surrounding rural area since the beginning of MSF's intervention in 2012. Whilst the situation cannot be extrapolated to the rest of the country, it provides a particularly crude example of the state of health provision in a context where the medical mission has been exposed to constant insecurity.

Whilst the research is centred around the direct experience of MSF, this study also sheds light on the violence suffered by the main Syrian medical networks and facilities that MSF works with, as they are an integral part of MSF operations in Syria and are providing assistance in areas that are either complementary or inaccessible to MSF, or providing different medical services. This part of the analysis is not exhaustive due to the lack of comprehensive and reliable data. However, an inclusion of the medical partners, even from a qualitative perspective, gives a more accurate picture of the difficulties encountered, and the different approaches and alternatives sought.

An analysis of the security incidents alone could easily end up in a victimisation of MSF or medical teams involved, which reinforces the "humanitarian exceptionalism" that prevails in much of the current

¹ WHO, *Syria Response Plan 2015 launched in Berlin, 19 December 2014*, 19 December 2014. <http://www.emro.who.int/syr/syria-news/response-plan-2015.html>

² Remarks by António Guterres, United Nations High Commissioner for Refugees. Conference on the Syrian Refugee Situation – Supporting Stability in the Region, Berlin, 28 October 2014. <http://www.unhcr.org/544fb4189.html>

³ Amnesty International, *Syria: Left out in the cold: Syrian refugees abandoned by the international community*, December 2014. <http://www.amnesty.org/en/library/info/MDE24/047/2014/en>

humanitarian rhetoric⁴ and that has greatly influenced the progressive ‘bunkerisation’ of many actors of the aid system. Hence incidents (or lack thereof) need to be understood not only in light of the external context (evolution of the conflict), but also as embedded in an internal dynamic within MSF and with the understanding that MSF, by being present in an area of conflict, is itself an actor that may influence local dynamics.

Therefore, to avoid ending the analysis and discussion at a ‘blame-game’, we aim to dig deeper and look at “why it happened or did not happen to us” as well as to document the adaptation that resulted from being exposed to such high levels of insecurity.

The study begins by providing a brief background to the Syrian conflict, the ensuing humanitarian crisis and impact on the provision of healthcare, and how MSF-OCBA planned its intervention in Aleppo. It then reflects on MSF’s initial risk analysis and mitigation measures that allowed it to start operating in such an insecure environment. The third section gives an overview of the types of incidents faced by MSF. It then explores the most salient and those that marked a turning point in terms of impact on the medical mission, while looking at MSF’s adaptation of operations, including its growing support to local health facilities and networks. The fourth section shifts the attention from MSF to those facilities and networks that have been operating at the frontline since the beginning of the conflict, focusing on the difficulties they have endured and how they have adapted their medical activities and approaches. The final section highlights the study’s main conclusions while reflecting on the dilemmas that MSF faces, some of which can be overcome while others remain open.

Methodology

The study focuses on incidents that took place since the beginning of MSF-OCBA’s intervention in August 2012 up to October 2014. Research for this report was undertaken between October and December 2014 in Barcelona, Spain, with one trip to Kilis, Turkey. Security limitations did not allow for travel to Syria.

The analysis is therefore based on quantitative and qualitative data compiled from various internal reports and complemented by 30 semi-structured interviews held with MSF field and headquarters staff and some partners from other medical networks in Syria.

As most national staff members interviewed requested to remain anonymous, it was decided to keep all identities anonymous.

Research scope and limitations

The research focused on incidents that took place in and around MSF’s project locations in the Aleppo province in northern Syria.

With regards to incidents perpetrated by government forces, only those that had a direct impact on MSF activities were included and analysed.

It was not possible to conduct a quantitative analysis of the violence against other health facilities and medical networks in Aleppo due to in-existent or poor reporting systems in place. Information acquired in this regard relied primarily on reports received by MSF staff and various human rights organisations, and testimonials obtained through interviews.

⁴ Larissa Fast, *Aid in Danger. The Perils and Promise of Humanitarianism*, University of Pennsylvania Press, 2014.

⁵ Operational Centre Barcelona-Athens.

1 Background

1.1. From Peaceful Demonstrations to Armed Conflict

The uprising in Syria began in March 2011 and was generally considered to be born out of the wave of demonstrations and riots that started in 2010 and spread across the Middle East and North Africa, which became known as the “Arab Spring”. Initially demanding political reform and later calling for the resignation of President Assad, the protests were met with a disproportionate reaction from the Syrian government (GoS) forces and aligned militias (known as Shabiha), with reports of arbitrary arrests, torture and murder of activists.

From the beginning, the government portrayed the emerging uprising as an act of foreign-backed armed gangs and terrorists dominated by Al-Qaida and its allies. The government’s dual approach of offering reforms while continuing to suppress the protests reportedly provoked defections from the Syrian army and militarisation of parts of the opposition between mid and late 2011. This led to the creation of the Free Syrian Army (FSA), which joined the Syrian National Council’s (SNC) political alliance as the consolidated military wing of the opposition⁶.

The ensuing violence resulted in growing civilian casualties, massive internal displacement and refugee flows into neighbouring countries, mainly Lebanon, Jordan and Turkey. It also brought to surface an increasingly pronounced factional division; the initially non-sectarian protest movement became dominated by the Sunni majority, while Alawites⁷, Shia and segments of the Ismaili and Christian communities were inevitably bound to the government’s fate, renewing fears of marginalisation and discrimination experienced in the past. Meanwhile Druze and Kurdish minorities appeared to generally support the opposition or tried to remain neutral.

The civilian opposition never managed to retain the leadership and the armed opposition never managed to unite. The fragmentation of the armed opposition, from the FSA to multiple independent battalions (*katiba / kataeb* in plural) or brigades (*liwaa / alweya* in plural) and ever shifting alliances, as well as the emergence of other more powerful Islamist groups such as Al-Qaida-affiliated Jabhat Al-Nusra (JN) and break-away Islamic State of Iraq and Sham (which later called itself the Islamic State)⁸, aggravated the violence in the country.

The splits within the opposition reflect the internationalisation of the conflict whereby various regional and global powers with competing interests have sought to support different armed groups with financial, logistical and military means. This complex geopolitical context and conduct of hostilities has very much shaped the humanitarian needs and their response.

While most armed groups initially adopted a religious though not radical component, the rise of Islamist militancy soon became a prominent feature of the conflict. According to a national staff member, many Syrians felt that their revolution had been “high-jacked” and replaced with the aim of establishing Islamic

⁶ Initially coordinating with the SNC, the FSA later joined the Syrian National Coalition, which was created in Doha, Qatar, in November 2012 to form an alliance of opposition groups in the Syrian civil war.

⁷ Also known as Alawis, Alawites are a Shia Muslim minority group that represents around 12% of Syria’s population, with a few small pockets in northern Lebanon and Turkey. They are known to occupy top positions in the military and intelligence services under the Syrian Baath regime.

⁸ Also known as Islamic State of Iraq and the Levant (ISIL) and “Daesh” in Arabic, the group renamed itself the Islamic State (IS) in June 2014. The group will be referred to as IS throughout the report.

rule, particularly with the growing influence of some Islamist factions who were more resourceful, organised and war-experienced than the mainstream opposition groups⁹.

1.2. Impact on the Civilian Population and Provision of Healthcare

The armed conflict in Syria has been marked by widespread human rights abuses, war crimes, crimes against humanity, and a shocking disregard for civilian lives by both state and non-state actors, as attested by various human rights organisations¹⁰. Not only have civilians suffered all kinds of brutality, including indiscriminate attacks, large-scale deaths and injuries, forced displacement, siege and lack of access to basic needs, but they have been the victims of a blatant and strategic use of violence against healthcare aiming to harm or weaken the opposing side.

1.2.1. Ensuing Humanitarian Crisis: Limitation of Humanitarian Action

From the onset of the conflict, the civilian population saw deteriorating living conditions and disruption of access to basic needs including food, water, electricity, heating and medical care. The urbanised nature of the conflict has had a particularly devastating impact on the inhabitants whereby the fighting has typically involved use of heavy weaponry in densely populated areas, causing massive casualties, widespread destruction and significant displacement of people within the country and across borders¹¹. The estimated figure of 200,000 deaths and five times more wounded gives an idea of the magnitude of the conflict.

The constant movement and evolution of the battlefronts has created a fast-changing context with sudden patterns of displacement and re-displacement leading many families, mostly children, to move several times in extremely harsh conditions¹². Finding no safe refuge within their borders, many have been forced to flee into neighbouring countries, which face enormous strains on their economies, infrastructure and resources after four years into the conflict. With their capacities pushed to the limit, the main host countries are increasingly imposing restrictions on the entry of Syrian refugees, while the response of the international community continues to be inadequate relative to the magnitude of the displacement. As a result, hundreds of thousands are left trapped inside Syria where their basic needs for protection and survival are unmet.¹³

The resulting chaos, insecurity and ever-shifting frontlines have brought challenges to the traditional humanitarian aid system¹⁴, with increased difficulties to access the people most in need of assistance. While some aid actors have only been allowed to operate in opposition-controlled areas and were unable to reach populations affected in GoS-controlled areas, others chose to operate in areas controlled by the government and were therefore unable to reach those with the highest needs: in opposition-controlled areas.¹⁵

⁹ Interview with MSF national staff 1, November 2014.

¹⁰ Amnesty International, December 2014, *op. cit.* See also: UN Human Rights Council, *Report of the independent international commission of inquiry on the Syrian Arab Republic*, 12 February 2014.

<http://www.ohchr.org/EN/HRBodies/HRC/IICISyria/Pages/IndependentInternationalCommission.aspx>

¹¹ François Grünewald, *Cities in conflict: the lessons of Syria*, Humanitarian Exchange Magazine, Issue 59, November 2013.

<http://www.odihpn.org/humanitarian-exchange-magazine/issue-59>

¹² Hugo Slim and Lorenzo Trombetta, *Syria Crisis Common Context Analysis*, Report commissioned by the IASC Inter-Agency Humanitarian Evaluations Steering Group, May 2013.

¹³ Amnesty International, December 2014, *op. cit.*

¹⁴ Refers to UN based western apparatus, which comprises the three pillars of UN humanitarian agencies, Red Cross Red Crescent movement, and international NGOs, along with the main government donor agencies which fund this 'system'. This excludes local governments, foreign state agencies, local non-state organised groups, local communities, diaspora groups and private donors and non-donor institutions (African Union, ECOWAS, etc.).

¹⁵ See: *Open letter: let us treat patients in Syria*, 16 September 2013. <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961938-8/fulltext>

Despite efforts by the Syrian Arab Red Crescent (SARC) and international aid organisations, a significant part of the humanitarian work in Syria and across the wider refugee crisis has reportedly been initiated and managed by local grassroots organisations, religious associations and informal charities, complemented by relief initiatives run by the Syrian diaspora and wider Muslim solidarity groups in the Middle East, Europe and Muslim countries. In areas controlled by the GoS, the traditional state structures, supported by popular committees, provide services although limited due to the conflict. In areas not under GoS control, formal and informal structures have been established to provide basic services and assistance, and are managed either by the community itself, the SNC or some armed opposition groups.¹⁶

All humanitarian aid actors operating within Syria have faced significant operational challenges caused by widespread insecurity, active hostilities, proliferation of checkpoints, targeting of staff and assets, and legal, political and logistical constraints¹⁷. In addition to the polarised aid environment resulting from bureaucratic and access restrictions imposed by the government and armed groups, the employment of siege warfare by both state and non-state actors has entrapped entire communities and hindered the passage of vital humanitarian supplies, including food and medicine¹⁸. As of January 2015, more than 12 million Syrians were reportedly in need of humanitarian assistance¹⁹.

The humanitarian situation has been exacerbated by the violence that has targeted healthcare structures, personnel and assets since the beginning of the conflict, depriving the sick and the wounded from seeking safe access to medical care. In addition to the massive number of deaths, wounded and traumatised people due to the violence, one of the severe symptoms of the humanitarian crisis has been the continuous deterioration of the healthcare system with growing shortages of medical supplies and skilled health workers, not to mention outbreaks of vaccine-preventable diseases and malnutrition, and the inability to adequately treat chronic and non-communicable illnesses and female pregnancy complications, amongst others.

1.2.2. Medical Care under Fire

From the early phases of the uprising in Syria, GoS forces and allied militias have deliberately attacked medical workers, health facilities and ambulances perceived to provide medical treatment to protestors and those opposing the government. While this alarming trend is not new and has occurred in many other conflicts in recent history (if not earlier in time)²⁰, it has very much characterised the wider Arab Spring context in which armed forces (military or police) have blatantly committed violations of medical neutrality in a climate of utter impunity.²¹ To take an example, during the government's crackdown on protests in Bahrain in February and March 2011, security forces reportedly attacked doctors and nurses, lay siege to hospitals and clinics, detained protestors who sought treatment, and arrested dozens of medical personnel, 48 of whom were put on military trial.²²

¹⁶ ACAPS and MapAction, *Relief Actors in Syria: Syria Needs Analysis Project*, December 2013. http://reliefweb.int/sites/reliefweb.int/files/resources/relief_actors_in_syria.pdf

¹⁷ Ibid.

¹⁸ UN Human Rights Council, *Assault on Medical Care in Syria* (A/HRC/24/CRP.2), 13 September, 2013. <http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session24/Documents/A-HRC-24-CRP-2.doc>

¹⁹ OCHA Syria key figures, January 2015. <http://www.unocha.org/syria>

²⁰ In recent years, hospitals in several countries have been invaded by armed parties who have terrorised, kidnapped or killed staff and patients in the occupied Palestinian territory, Afghanistan, the Central African Republic, Ukraine, South Sudan and Yemen, among other places. See: Emily Friedman, *Warning from a Mass Grave: Hospitals Under Attack*, 7 October 2014. <http://www.hnnmag.com/>

²¹ Richard Sollom, *Arab Spring doctors in the crosshairs*, 6 April 2012. <http://www.globalpost.com/dispatches/globalpost-blogs/commentary/after-the-arab-spring-doctors-the-crosshairs>

²² MSF, *MSF Director speaks out against Bahrain crackdowns*, 16 May 2011. <http://www.msf.org.uk/article/msf-director-speaks-out-against-bahrain-crackdowns>

Similar abuses were reported in Egypt, Libya and Yemen, amongst other places. What they all appear to have in common is a systematic government strategy aimed at hindering access to healthcare for the opposition, punishing and intimidating medical professionals treating or suspected of sympathising with protesters and silencing them as they glean first-hand incriminating evidence of abuse, in addition to committing violations based on religious or sectarian discrimination, amongst other causes²³.

Such violations have taken their toll in Syria. According to the findings of a UN-mandated Independent International Commission of Inquiry on the Syrian Arab Republic²⁴, “since the beginning of Syria’s unrest, Government forces have strategically assaulted hospitals and medical units to deprive persons perceived to be affiliated with the opposition of medical care”. Reports of GoS snipers being positioned in front of hospitals, as well as torture and arrests of activists inside hospitals²⁵, led many to avoid seeking medical care in public facilities.

As a result, doctors and paramedics in various parts of the country began treating the injured protesters in clandestine locations with insufficient means in order to stabilise them before referral to a safe hospital. They themselves were putting their safety at risk, as witnessed by MSF local doctor who worked for one of the health facilities in Aleppo at the time:

“During this period, we treated many patients in houses, basements and some private health facilities that belonged to friends and contacts that we trusted. There were spies everywhere; they would monitor who was being admitted and the type of injuries they sustained. Many were later arrested by state security forces. Doctors and medical personnel treating the wounded protesters were not exempted from the violence; some were detained, others were tortured and even killed. I was detained for 27 days on the charge of ‘establishing a field hospital and treating the armed groups’.”²⁶

In addition to targeting health facilities, the general disregard to civilian life and infrastructure by GoS forces was further evident after armed opposition groups gained control of various parts of the country, mainly in the north²⁷. According to the same doctor, efforts of bringing normality to daily life in the opposition-held areas were hampered by repeated shelling of civilian structures in an aim to weaken the opposition. He gave an account of his experience:

“Among the tactics employed by government forces is to drop a bomb at a specific location, usually a densely populated area, followed by another a few minutes later so that rescue teams arriving at the scene also become victims. One of the worst experiences I witnessed was in August 2012 when government forces bombed a crowded bakery. We collected at least 72 bodies from the street and treated over 200 injuries, many of which were critical so the death toll might have been higher. Another devastating feature was the deliberate targeting of hospitals, ambulances and civil defence vehicles.”²⁸

Armed opposition groups have also shown similar disregard to civilian structures in government-controlled areas with reports of mortar bombs fired into densely populated areas in Damascus, including schools, churches and foreign embassies.²⁹ The International Commission of Inquiry documented cases whereby armed factions also attacked medical facilities, such as the assault on the National Hospital in Jurat Al-Shayyah on 14 April 2012, noting that “the Brigade took no precautions to avoid civilian casualties or to

²³ Richard Sollom, April 2012, *op. cit.*

²⁴ UN Human Rights Council, 13 September, 2013, *op. cit.*

²⁵ *Ibid.*

²⁶ Interview with MSF local doctor 2, November 2014.

²⁷ The division of Aleppo governorate, the country’s most populated region, between government-controlled and opposition-controlled areas by mid-2012 marked a defining moment in the conflict particularly as armed groups gained access to the Syrian-Turkish border.

²⁸ Interview with MSF local doctor 2, November 2014.

²⁹ Albert Aji, *Damascus in grips of fear as mortar bombs rain down*, November 2013. <http://www.dailystar.com.lb/News/Middle-East/2013/Nov-30/239422-damascus-in-grips-of-fear-as-mortar-bombs-rain-down.ashx>

protect the sick and wounded during the attack”³⁰. By 2013, the increase in the number of armed opposition groups and widespread presence of weapons resulted in heightened insecurity in areas under their control. The emergence of powerful Islamist groups also brought about new threats with growing interferences in civilian life and institutions, including health facilities. Doctors and medical personnel began witnessing various types of violations at the hands of some armed groups or individuals. At best, they were harassed and threatened by disgruntled patients or their caretakers. At worst, they were detained, abducted and sometimes executed due to their suspected political affiliations or perceived religious views.³¹

With fighting erupting between most armed factions and the Islamic State (IS) in January 2014, various violations have been reported, including obstruction of medical care to civilians and fighters, holding medical staff hostage, seizure of ambulances and first aid teams, and executions inside hospitals and ambulances. In some cases, entire hospitals have been taken over by armed groups for their own use or for the purpose of turning them into detention centres.³²

1.3. MSF-OCBA Intervention³³

Given its brief history in Syria and its already established (informal) presence in Damascus³⁴ when the protests started, MSF-OCBA was - in theory - well placed to intervene. Nevertheless, its numerous unsuccessful attempts to obtain official registration in the country³⁵ limited its access and ability to provide direct assistance in areas under government control.

Conducting rapid assessments around end of 2011-early 2012, MSF³⁶ considered supporting Syrian refugees in neighbouring countries, which could pave the way for future intervention inside Syria in terms of acquiring acceptance, establishing networks and gaining a better understanding of the context and security risks. Despite having more contacts from the opposition at the time due to inaccessibility to Syria, MSF’s aim was to continue its efforts to establish networks in pro-government areas to enable it to intervene in any possible scenario, such as supporting minorities or areas on the border between the two opponents.

With many international aid organisations already present in Jordan and Lebanon, MSF turned its attention towards Turkey, which had started to receive many refugees from the Idlib and Aleppo regions. Following a needs assessment that targeted the two biggest refugee camps in the area, MSF decided to support a local NGO, Helsinki Yurttaslar Dernegi - Helsinki Citizens' Assembly (hCa), by initiating a mental health project in Kilis in May 2012. Located by the border and offering a corridor to the Aleppo region, this project enabled MSF to have direct contact with the Syrian population and meet their health needs, while facilitating networking and gaining acceptance necessary for future entry.

Indeed, the opportunity to intervene in Syria crystallised following the fall of the northern rural area of Azzaz district under the control of the armed opposition by July 2012. MSF conducted rapid assessments in the area in August and concluded that the deteriorating humanitarian situation and collapsing health system

³⁰ UN Human Rights Council, September 2013, *op. cit.*

³¹ Interviews with local doctors from medical networks, September 2014 and MSF local doctor 2, November 2014.

³² UN Human Rights Council, *Oral Update of the independent international commission of inquiry on the Syrian Arab Republic*. 18 March 2014. www.ohchr.org/Documents/HRBodies/HRCouncil/CoISyria/OralUpdate18March2014.pdf

³³ Initial discussions regarding OCBA’s intervention in Syria involved a diverse group from different platforms, including direction of operations, regular cell, emergency desk and other staff who have sound knowledge of the area and context.

³⁴ In 2007, MSF-OCBA opened a primary health care project in partnership with the Syrian Catholic Church Charity Organization Migrants Office (MO), a local NGO that serves predominantly Iraqi refugees in Damascus. As per memorandum of understanding, OCBA provided technical and financial support for medical activities and staff.

³⁵ On behalf of the Syrian government, the Syrian Arab Red Crescent Society (SARC) is in charge of coordinating all humanitarian activities, including auditing prior to registration of aid organisations.

³⁶ Unless otherwise stated, ‘MSF’ from now on refers to MSF-OCBA.

warrant an emergency intervention, acknowledging that the security and volatile situation would imply constant adaptation of MSF's strategies and activities.

There were a number of reasons behind MSF's decision to intervene in the Aleppo region, including its size, economic importance and huge population, combined with the intensifying conflict, and considering MSF's limitations due to the security situation and its own capacities. Furthermore, and as it was later seen, focusing on one limited geographical area would allow MSF to optimise its resources, better manage its contacts and networks, and focus on access and security management. Another key aspect that was taken into account was the location of the field hospitals; the approach was to be "close enough to the active conflict zones to be effective (within the golden hour) and far away to be efficient", thus ensuring better care and avoiding constant evacuations and unnecessary or unacceptable risks.

Through its assessments in August 2012, MSF was able to expand its network in the area, particularly with civilian and medical actors, which made its entry less reliant on military or political entities. MSF immediately began supporting existing health facilities in Azzaz, Tal Rifat and Marea towns with medical supplies, focusing mainly on emergency first aid. It also established contacts with the local authorities who agreed to provide space for humanitarian medical activities and facilitated the setup of a field hospital (Al-Salamah) in Sejou village.³⁷

MSF's initial approach was based on an understanding of the trend of heavy politicisation of health facilities. There was an explicit decision to have a standalone health facility rather than embedding teams in other local health facilities. Moreover, based on the assumption that the conflict would be long-lasting and that most initiatives and resources would focus on the war wounded, MSF's strategy was to 'demilitarise' the hospital and focus on the health needs of the civilian population. This meant offering services that were not considered or perceived as a priority, such as maternity care and basic health services, in addition to providing quality life-saving surgical care which facilitated acceptance by armed groups and therefore access to the civilian population. From November 2012, the hospital began receiving patients from over 30 villages.

In January 2013, MSF carried out an assessment in Aleppo city and began establishing contacts with medical networks, acting medical authorities, health centres and hospitals and supplying them with drugs and medical materials. The detection of some measles cases among children in March 2013 prompted MSF to launch a mass vaccination campaign in 49 different sites with over 100 volunteers. This activity was widely perceived to have earned MSF acceptance and trust among the community and various medical networks that MSF later began collaborating with³⁸. It also facilitated the opening of a second project in June with the establishment of a hospital in the Sheikh Najjar industrial city (5 km from Aleppo city centre), which would treat both civilians and combatants in Aleppo city and surrounding areas.³⁹

Looking at MSF-OCBA's overall careful approach in intervening in Syria, it is clear that it had both negative and positive implications. On one hand, its slower deployment meant that MSF was unable to provide urgent and timely medical assistance in the very early stages of the conflict. On the other hand, opting to closely monitor the situation and plan a more calculated entry enabled MSF to gain acceptance among civilian medical networks, which facilitated its intervention while maintaining a high degree of both political and operational independence.

³⁷ Interviews with exploratory mission team: team leader, emergency nurse and national staff 1, Oct-Nov 2014.

³⁸ Interviews with MSF local doctor 2, HoM and OCBA health advisor-emergency unit, Oct 2014-Jan 2015.

³⁹ Interview with HoM, October 2014.

But to what extent has MSF managed to safeguard those principles (as an organisation and through its personnel) or have them acknowledged and respected by the various actors in the conflict? How did MSF respond and adapt to constant exposure to high risk and insecurity throughout its intervention?

2 Assessing and Accepting Risk

2.1. Reflection on Institutional vs. Individual Risk Acceptance

MSF is responsible for determining the possibility to work in tension-ridden areas and war zones, rigorously assessing the threats, designing and implementing mitigation measures and carefully considering if the residual risk is justified in view of the expected operational impact. In places where the level of residual risk remains high, such as Syria, and where the risk of death and kidnapping are real possibilities, the decision to accept the residual risk is a difficult and tricky one both for the organisation and for the individuals, and it raises some difficult dilemmas.

Collectively, severe incidents (both closed, such as the death of some staff as a result of shelling, and open, such as a kidnapping) have a considerable impact above and beyond the human tragedy. Those incidents may have long-term impact on retention of staff, recruitment, programming and reputation. Yet, not accepting those risks would leave large pockets of extremely vulnerable populations trapped in war zones without assistance. In Syria, MSF-OCBA accepted the risks as an organisation, but this is reviewed constantly given the fast evolution of the conflict.

From an individual perspective, all international staff members considering joining the Syria mission are requested to closely examine the risk assessment and to carefully consider if they are willing to personally take the risks. Yet despite this strict policy that applies to all departures to Syria, it is generally accepted that it is difficult to fully realise what it implies prior to going there, as most staff has not previously been exposed to such type of intense urban warfare and thus, full informed consent is hard to obtain. The mission has strived to give its international staff the opportunity to reassess their decision to stay once in mission, as attested by several staff through interviews.

Since the Syria mission was expected to see a significant rotation of staff due to the high level of stress as well as visa period limitations⁴⁰, there was an explicit decision to apply line management in its strictest form regarding security management, with a commitment to have longer mission periods and rotation amongst the same staff members in key positions, such as head of mission and field coordinator. This minimised loss of knowledge and understanding of the context, including contacts and networks.

Staff protection, especially the national staff, was central to MSF's decision-making and programming of activities, and it affected various operational choices. The evolution of the context with heightened insecurity resulted in very dynamic decision-making at both mission and HQ levels, with constant revision of risk analysis and operations aimed at mitigating risk. According to OCBA head of emergency unit, the risk analysis had a big impact on programming and the delivery of services, from the choice of purchasing vaccines in a non-

⁴⁰ Turkish tourist visas were generally obtained for a maximum period of 90 days.

western country, to bringing in specialised medical equipment to gain the trust of both national staff and patients”⁴¹.

2.2. Initial Risk Analysis and Mitigation Measures

From the start, MSF’s decision to operate in such a complex, highly insecure and volatile environment was accompanied by both awareness and acceptance of a certain level of risk, starting with its decision to operate without official permission from the Syrian government.

MSF’s initial risk analysis was formed based on a set of conditions that shaped the prevailing context at the time. In an assessment carried out in October 2012, MSF acknowledged that it was operating in a context that was very likely to change and degrade over the span of its intervention, which would require constant reassessment and risk mitigation.

The main perceived threats at the time included direct conventional GoS military violence such as airstrikes and artillery shelling. While the likelihood of being directly targeted by GoS forces inspired much debate within the movement, MSF-OCBA’s assumption was that this possibility remained low.

Other perceived threats included the possibility of getting caught up in crossfire and open combat, although the probability was perceived to be lower than that of GoS airstrikes and shelling. Meanwhile, risks of arrests, detentions and kidnappings, particularly at unexpected roadblocks or checkpoints, were perceived to be low⁴². The threat of unconventional weapons (chemical, biological, radiological and nuclear) was also discussed but was considered low, noting that this may change in the future.

Based on the risk analysis, MSF defined specific threat and vulnerability reduction measures to be taken, which were to be reviewed on a regular basis throughout the operation.⁴³

Acceptance and Perception

Acquiring acceptance for its work from the community and all relevant parties is an essential prerequisite for MSF to operate in such a sensitive and volatile environment. One of the main threat reduction measures taken initially and throughout the operation was to ensure knowledge by all parties of MSF’s presence and activities as well as respect for medical ethics and impartiality.

The acceptance and positive perception enjoyed by the MSF team with the local community and authorities relied primarily on the relevance of its medical services and its principled approach⁴⁴: independent, neutral and impartial. This was also crucial for MSF’s security and ability to operate in the area. Threats of crime, disgruntled patients or infighting between armed opposition factions were all considered possible yet minimal at the early stages of the intervention.

Establishing good communication with the local authorities also helped MSF understand the local context and take necessary security measures.

The opening of a second hospital in Aleppo’s industrial city was similarly welcomed by the local community and medical and civilian authorities. From its initial assessment in January 2013, MSF began building

⁴¹ Discussion with OCBA head of emergency unit, February 2015.

⁴² In order to mitigate risks due to the prevailing political and social climate, staff profiling was applied throughout the reporting period, leading to restrictions based on nationality, gender or religious background.

⁴³ Interviews with HoMs and FieldCos, backed by internal reports, revealed that risk analysis and mitigation measures were reviewed on a constant basis due to the ever-changing context and in response to certain incidents.

⁴⁴ This was confirmed through interviews with several MSF expat and national staff members.

relationships and providing medical supplies to various hospitals, health centres and first aid points. The launch of a mass measles vaccination campaign in April and May 2013 was instrumental in achieving acceptance and trust among opposition groups, medical associations and the population, although it did not achieve sufficient coverage from the public health perspective.⁴⁵ This activity allowed MSF to contact 49 different teams active in the city's health initiatives, revealed the risks that MSF was willing to take to serve the people, and expressed much needed support to medical staff desperately battling for the health needs of their communities. This acceptance was also motivated by the deteriorating healthcare system in Aleppo marked by shortages of medical supplies, flight of skilled personnel, destruction of facilities and transport means, in addition to an increase in chronic conditions and vaccine-preventable diseases⁴⁶.

Securing acceptance from the government authorities was clearly more challenging. Notwithstanding numerous efforts to obtain official access to government-held areas – though with little success, MSF's provision of assistance in areas de facto administered by opposition groups was evidently regarded as 'aiding the enemy'⁴⁷. This both compromised MSF's perceived impartiality and neutrality and put its security at risk. It was therefore crucial that MSF, both as a Movement and through operational centres, continues its communication endeavours with the Syrian authorities, informing them of their presence and activities, offering medical services to government-held areas, and requesting respect and protection of the medical mission⁴⁸.

Location of Field Hospitals

The decision to set up the Al-Salamah hospital in Sejou village was based on both security and operational considerations. In comparison to other towns that were assessed in the district (some of which were subjected to shelling during MSF's exploratory missions), it was considered the safest possible location for both staff and patients; there had been no armed group bases at the time, which reduced the risk of shelling⁴⁹. Moreover, given its proximity to the border, the village was less likely to be bombed, and it also offered the best and most direct patient referral route to Turkey and was well placed for evacuations if need be.

In agreement with the local authorities, it was decided to rehabilitate a school in the village to set up the hospital. Despite being in an acceptable condition, MSF's risk assessment concluded that the building structure would need to be reinforced. The question of protecting⁵⁰ the facility was discussed although it was noted that this level of overt protection was not deemed required at the time.

Another issue that sparked debate within MSF-OCBA and other sections was whether MSF facilities should be visibly marked on the roof with a medical or MSF emblem and whether their geolocation should be communicated to the Syrian government. The assumption was that this knowledge might increase deterrence, as targeting MSF would then be easily defined as a violation of IHL. Although opinions were divided, directors of operations concluded that the risks outweighed the benefits, and it was ultimately

⁴⁵ Interviews with HoM and OCBA health advisor-emergency unit, December 2014 and January 2015 respectively.

⁴⁶ MSF assessments revealed an over-burdened healthcare system that was struggling to meet the needs of the population, including the war wounded who were generally prioritised. There was a clear need for assistance in stabilisation of trauma cases, inpatient and post-surgical care, emergency obstetric care, primary healthcare, vaccinations, and a functioning referral system. Source: MSF Spain proposal for Sheikh Najjar, 19 May 2013.

⁴⁷ During discussions with GoS authorities in Damascus to inform them of the generic presence of MSF teams in opposition-held areas, clear threats were conveyed by GoS officials, stating that MSF facilities may be considered as military targets.

⁴⁸ Communication efforts with the Syrian authorities were led by MSF International and individual sections on several occasions prior to and during the current conflict and were on-going at time of writing this report.

⁴⁹ MSF also agreed with the armed battalion present in the area not to open an office in the same location.

⁵⁰ This refers to strengthening key features such as shielding windows and doors, constructing a safe room, amongst other protection measures.

decided against this option⁵¹. Generic statements of MSF presence in the districts were communicated to GoS authorities but not exact locations, in fear of ‘facilitating’ the targeting of the medical facilities.

As for the location of the second hospital in the Sheikh Najjar industrial city, the same approach was followed in terms of safety (the area had not witnessed any bombing or fighting during 18 months), proximity to Aleppo city (6 km northeast), and direct access to the patient referral route. As for the hospital structure, an existing building designed to host a health centre with a basement was identified, although much rehabilitation work was required to make it a fully operational hospital. This was to prove challenging in the months to come.⁵²

2.3. Where We Are Today

Today, MSF-OCBA continues to run two health facilities in Sejou village (Al-Salamah) and in Maskan, although the nature of its intervention has evolved since its initial assessments and start of medical activities in October 2012. Over 30 other medical teams and facilities are supported from those two points.

While the threat of shelling and increased risk of exposure has meant constant withdrawals, evacuations and relocations of MSF facilities and personnel, the multiplication and growing fragmentation among armed opposition groups brought to surface threats that had a grave impact on the medical mission. Up to 38 independent armed groups were identified in the Kilis-Aleppo corridor and the city itself. It has proved impossible to contact and negotiate access with all of them. Only the major coalitions, the strongest groups and those located closer to the facilities were contacted in order to be informed of MSF’s presence and activities and to mitigate the possible threats. Moreover, the growing presence of Islamist groups brought challenges to acceptance and perception with increased suspicion and intolerance of what was perceived as ‘western’ aid, making negotiated access more challenging. The campaign of systematic kidnapping of foreign journalists since summer 2013, the kidnapping of eleven colleagues from MSF Bernas hospital in January 2014 and the growing threat of abduction of foreigners, led to a complete withdrawal of MSF international staff from Syria by early 2014. Activities continued to run with Syrian staff only.

The next section seeks to explore this evolution and the extent to which MSF’s intervention has developed, adjusted and reached its limits in the face of the deteriorating security situation and changing conflict dynamics. It will give an overview of the types of incidents faced, while focusing on those that had a decisive impact on the medical mission and the provision of healthcare.

3

Adapting to the Violence: From Bunkerisation to Shared Management

3.1. Overview of Security Incidents

⁵¹ Interview with director of operations, December 2014.

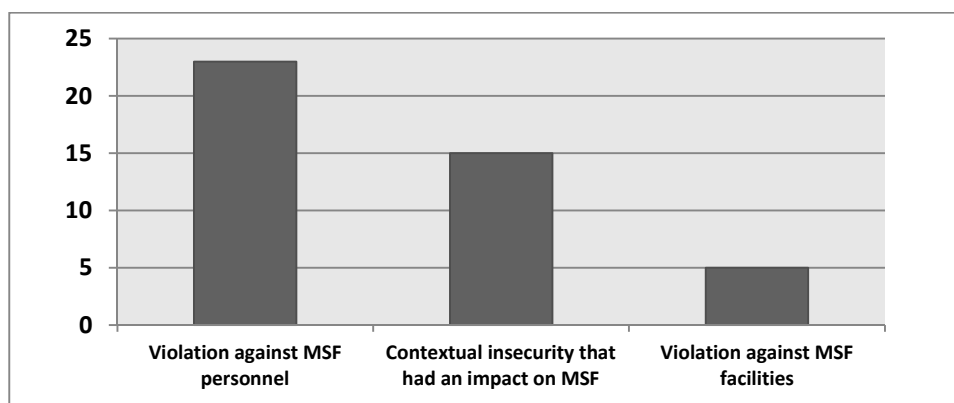
⁵² Interview with HoM, October 2014.

Between August 2012 and October 2014, MSF reported a total of 43 security incidents that had an impact on its operations, including 33 formally registered in the standard 'security incident report' format and 10 reported in other types of documents or records. In 28 of the 43 incidents, MSF was directly affected whereby its personnel, facilities and assets were violated, irrespective of the motivation. The remaining 15 incidents were linked to contextual violence mainly caused by GoS shelling and in some cases fighting or insecurity perpetrated by various armed groups; these 'near-missed' incidents had a significant influence on MSF's decisions and motivated change or adaptation in its operations.

While there is a general perception that MSF was not targeted in any of the incidents reported, some 'near-missed' incidents where GoS shelling came very close to MSF facilities generated doubts among some national staff and local residents. When the facilities in the outskirts of Aleppo city were established, the perception of increased risk of targeting due to harbouring a medical facility was widespread amongst the authorities and those consulted (see section 3.2).

Out of the 43 incidents, 23 were perpetrated against personnel, 15 were linked to contextual insecurity and 5 affected healthcare facilities (of which 2 can be regarded as collateral damage). There were no incidents reported specifically against patients or medical vehicles, although on two occasions MSF ambulance was detained with the personnel.

Figure 1: Incidents by Type



As indicated above, the vast majority of incidents occurred against personnel, almost exclusively national staff (only one incident involved international staff), although none were perceived to be linked with their work with MSF. More than half of those incidents (13 out of 23) were linked to individual staff members' political affiliations or religious views and behaviour. While the violence took different forms with varying degrees of severity, the two most recurrent types of incidents reported throughout the analysis period involved staff being threatened or detained by armed groups. The most critical and tragic of such incidents was the targeted killing of MSF local surgeon by an unknown⁵³ armed group or individuals after having received threats on a number of occasions⁵⁴. Other types of incidents involved interferences by armed groups with human resources, medical procedures and intrusions to health facilities demanding preferential medical treatment or complaining about the services.

⁵³ The perpetrators were not caught and remain unknown to date.

⁵⁴ See section 3.3 for more details.

Figure 2: Consequences of Incidents

Violations against personnel	
Detention/arrest	18 national staff (8 incidents)
Attempted detention/abduction	2 international staff, 2 national staff
Threat (individual)	13 national staff (11 incidents)
Killing	1 national staff
Violations against health facilities and assets	
Intrusion	5
Robbery	2 (1 severe, 1 minor)
Detention	2 ambulances
Damage to facilities	Bullets in structure, damage to windows and water tank (3 incidents)

With regards to the perpetrators, different armed groups were responsible for 31 incidents⁵⁵, 10 of which the perpetrators were difficult to identify as they sought anonymity. The remaining 12 incidents were occasioned by GoS forces, noting that only those that had a direct influence on MSF activities were reported.

Given the number and nature of incidents reported during the analysis period, it was not possible to identify any significant trends or peaks. However, interviews with some field staff revealed that since late-2014, there has been an increase in arrests and detentions of national staff by armed groups. This was mainly explained by the divisions among armed groups, the confrontation between the mainstream moderate armed groups with JN on one hand and IS on other hand, and increased suspicion of espionage or collusion, particularly among staff members who reside in areas controlled by a rival armed group.⁵⁶

3.2. Providing Medical Care under the Shelling

Al-Salamah Project

When Al-Salamah hospital opened its doors to the community in October 2012, the area was still generally regarded as safe in terms of shelling by GoS forces due to its proximity to the border and absence of armed groups headquartered around. Nevertheless, the period November 2012 - February 2013 saw an increase in GoS targeting of armed opposition strongholds within the Azzaz district, with an intense battle unfolding over a government military airbase (Menegh) located 11 km south of Sejou village (Al-Salamah). The shelling, mainly in the form of surface-to-surface rockets, resulted in large-scale civilian casualties and increased displacement of people towards the Turkish border. It also resulted in a few 'near-missed' incidents, which increased the risk of collateral damage to MSF staff and premises⁵⁷. MSF field coordinator noted:

"We will never know whether the shelling had targeted MSF or not. What was certain was that the residual risk had increased and additional mitigation measures needed to be taken."⁵⁸

MSF's response was to reduce the team during most of January 2013. However, the continued shelling - whereby missiles landed very close to MSF house on a number of occasions - led to a further reduction to a skeleton team until the end of February. Although MSF was able to maintain an appropriate level of activities through a reduced team, it was clear that the increased risk of exposure to staff and patients demanded more measures of protection to be taken.

⁵⁵ In cases where they were clearly identified.

⁵⁶ Interviews with MSF expat and national staff, Nov-Dec 2014.

⁵⁷ There was a common perception that GoS shelling was not very precise.

⁵⁸ Interview with FieldCo, November 2014.

As a response, MSF reduced activities for a few weeks in March in order to reinforce the hospital structure with defensive sand barriers and bomb shelters. This meant temporarily pulling out the international team and operating through remote management during the construction period. It was also decided to introduce a 24-hour rotation system amongst teams to reduce the risk and stress levels. Other mitigation measures included engaging in dialogue with the authorities in Damascus to try to obtain security assurances, and issuing a press release 'asking all parties to respect medical facilities', which received international coverage.

Both international and national staff members interviewed noted that the hospital reinforcement achieved its purpose and provided necessary protection to the personnel and patients. In addition to physical protection, it also provided them with a feeling of safety, which was one of the key aspects considered when the decision was taken⁵⁹. According to MSF field coordinator, "MSF's analysis of the situation was that the possibility of the hospital receiving a direct hit was low. With the construction of [sand barriers], all staff members considered that the level of risk was acceptable and agreed to stay. Understanding the risk of peer pressure, combined with staff members' commitment to their work, we made sure to regularly hold individual meetings with both national and international staff to discuss the security risks and give them the choice to leave".⁶⁰

The following months witnessed an intensified bombing campaign, which marked a shift from surface-to-surface rockets to air strikes. The sound of airplanes flying and explosions were reportedly heard on an almost daily basis for six weeks. On 26 June 2013, the hospital got hit for the first time. Although the material damage was minimal (some bullets were found in the sand barriers), this incident indicated a serious development in the security situation and made it clear that the residual risk had further increased, particularly with the hospital being the biggest and only significant structure in the village. This led to additional fortification of the hospital compound and a reduction of the team overnight with continued rotations.

It was noted that some staff members did not feel comfortable, while others accepted the increased level of risk due to the protection provided by the defensive barriers and bomb shelters, combined with the significant impact of MSF's intervention. It was also noted that the national staff expressed their willingness to continue working despite the increased risk of exposure, pointing out that the situation in their villages, mainly Tal Rifat, Marea and Azzaz, was subject to heavier bombing. This was also the case for staff who worked with other medical teams and for other health facilities at or closer to the frontline.⁶¹ Many expressed that they were exposed to severe risks during their daily lives as Syrian civilians and considered themselves well sheltered inside the MSF facility. One national staff member stated that they had gone "from being afraid at the beginning to getting accustomed to the shelling, like a routine"⁶².

On the medical care side, it was noted that the reduction of the international team overnight made it difficult for the national staff to cope on their own. It was therefore decided to continue with a reduced international team until skilled local staff was hired. The main challenge, which became increasingly difficult to tackle, was retaining and finding qualified local medical personnel. Skilled doctors and medical staff easily found opportunities abroad, which implied better living conditions for their families, better salaries and professional promotion, and overall safer conditions without constantly risking their lives.

Aleppo Project

From Sheikh Najjar Industrial City to Fafeen

The dire health needs in Aleppo prompted MSF to open a second project in Sheikh Najjar industrial city. While this was facilitated by the level of acceptance achieved locally, setting up the hospital and achieving

⁵⁹ Interview with OCBA head of emergency unit, November 2014.

⁶⁰ Interview with FieldCo, November 2014.

⁶¹ Interviews with several MSF expat and national staff members, Nov-Dec 2014.

⁶² Interview with MSF national staff 3, December 2014.

high medical coverage proved to be a challenge. According to the head of mission, “opening a real hospital with a fixed structure and heavy equipment took a long time to complete and proved to be ill-adapted to respond to the volatile context where we could have expected the security situation to worsen... We were already receiving bombs before the [Operational Theatre] was ready”⁶³.

Despite on-going rehabilitation work, MSF began medical activities in July 2013 with the opening of services in the outpatient department (OPD), paediatric department (PD), emergency room (ER) and later inpatient department (IPD). Two security incidents in August⁶⁴ led MSF to evacuate the international team with a provisional period of remote management, followed by regular visits at the end of October and throughout November.

From 19 to 24 November, GoS forces began an intense barrel bombing campaign on the industrial city, which resulted in a high number of casualties and destruction. MSF hospital received 88 wounded and activated a mass casualty plan. Exposed to very close shelling, MSF took protection measures, asking staff to hibernate in the basement and reducing activities to ER.⁶⁵

On 6 December, repeated bombing brought some damage to the hospital, which led MSF to suspend all activities except life-saving, reduce the national staff team to skeleton and move the office and ER to the basement. At this point, the international team reportedly expressed that the exposure of national staff was unacceptable despite the mitigation measures taken. Moreover, the impact of the medical activities was severely reduced due to the massive displacement of people that had taken place as a result of the bombings (the hospital was receiving 20 consultations per day as opposed to 150-200 prior to the first airstrike). There was also little value in using a heavily bombarded area as a stabilization hub for referrals outside the city, other roads were considered safer at that time. While most staff believed it was ‘wrong time wrong place’ due to the shifting battlefield as the industrial city was included in the offensive to siege Aleppo, some national staff thought that the hospital was targeted.⁶⁶

The increased risk and reduced medical impact, together with repeated shelling throughout December, led MSF to evacuate indefinitely from Sheikh Najjar industrial city and find an alternative location. Learning from this experience, MSF re-adjusted its strategy and opted for a lighter and movable health structure that could be relocated more rapidly should the security situation deteriorate.

From Fafeen to Maskan

Following assessments at the end of 2013, MSF decided to relocate its medical activities to Fafeen town, situated 8 km from Sheikh Najjar north of Aleppo city. The location met MSF’s approach of being close enough to the frontline to receive the war wounded and far enough to offer quality service without having to constantly evacuate. Fafeen was located along the same referral route as the one used for the industrial city, and the area had not witnessed any incidents since the takeover of an infantry school by the Al-Tawheed brigade in 2012, although it was noted that the security situation could change. On the medical side, a small health centre was identified and set up to temporarily run ER, OPD and small-scale IPD services and referrals with the intention of finding a bigger facility in the future.⁶⁷

According to MSF local doctor, “Although MSF’s health facility was welcomed by the local authorities and armed opposition groups, opinion among residents was divided; some were happy about having a free medical

⁶³ Interview with HoM, December 2014.

⁶⁴ In August 2013, MSF faced 2 critical incidents that highlighted the degree of uncertainty in the changing operational environment and affected its reading of the context. These include the detention of a national staff member and risk of detention or abduction of a team of national and expat staff. See section 3.3.

⁶⁵ Internal reports November 2013 and interviews with field staff.

⁶⁶ Internal reports December 2013 and interviews with MSF expat and national staff, Nov-Dec 2014.

⁶⁷ Internal reports and interviews with MSF local doctor 3 and FieldCo, Oct-Dec 2014.

service while others opposed the presence of any medical point due to the perception that hospitals and medical facilities attracted insecurity”⁶⁸.

Within three weeks of opening the facility, the armed opposition stronghold in the area was subject to air strikes. On 2 February 2014, several barrel bombs were dropped close to MSF facility, while three car bombs linked to armed groups exploded by the infantry school base. Operating through remote management⁶⁹, MSF international team maintained constant communication with the national staff and decided to suspend activities and immediately evacuate from Fafeen⁷⁰.

The infighting amongst armed groups, mostly IS against Islamic Front and others, and the intensified barrel bombings by the GoS led MSF to completely evacuate the facility by the end of February and relocate to the town of Maskan by March. Located in the countryside close to Aleppo city and along the patient referral route, Maskan was chosen based on a set of protective measures, including absence of armed groups, checkpoints and history of bombings or armed clashes.⁷¹

For the third time and within a period of 4 months, MSF had to redeploy its Aleppo operation to another location due to the shifting frontline and heightened insecurity. Movements were restricted, teams were reduced, and health services offered to the population were limited to ER, IPD, OPD and referrals. Set up entirely by the national staff, the health facility in Maskan began activities in April 2014.

Reports by MSF staff and partners revealed that the shelling and barrel bombing of civilian areas and armed opposition strongholds in and around Aleppo continued up to the end of the analysis period (and at time of writing this report)⁷². Despite facing two ‘near-missed’ incidents in May and August 2014 whereby its facility was exposed to close air strikes, MSF managed to continue running medical activities in Maskan. Unfortunately, this was not the case for many local health facilities that MSF collaborates with, which witnessed partial or total destruction as well as deaths and injuries among their personnel and patients (see section 4).

While the threat of shelling and air strikes were determining factors in most of the decisions that were made by MSF (such as location and relocation of activities and composition and size of teams), and continues to be a major concern, analysis of security incidents revealed that the majority of violations against MSF facilities and personnel were perpetrated by local armed groups. Nevertheless, the attacks against the medical mission cannot only be evaluated by the number of incidents it incurs, particularly in a context where MSF is sharing the same space with the armed opposition groups and is therefore not alien to the dynamics on the ground.

Issue of Illegal Chemical Weapons

MSF in Aleppo received reports of several chemical weapons attacks in 2013. In March, an attack involving the use of chemical agents was reported in Khan Al-Asal in the southern suburbs of Aleppo. In April another alleged attack with chemical weapons occurred in the Kurdish-majority neighbourhood of Sheikh Maqsoud. Following this attack, MSF visited Afrin hospital⁷³, which reported to have received some of the victims that were affected. MSF did not manage to reach any of the victims. In other regions of Syria similar attacks were subsequently reported, the deadliest occurring in Ghouta, Damascus, in August 2013. A UN fact-finding mission confirmed the use of chemical agents and presented evidence indicating that the perpetrators likely

⁶⁸ Interview with MSF local doctor 3, December 2014.

⁶⁹ By then, MSF expat staff had withdrawn from Syria due to the increased risk of kidnapping. See section 3.4.

⁷⁰ Internal reports February 2014 and interview with FieldCo, November 2014.

⁷¹ Maskan assessment - site protection, 10 March 2013.

⁷² See MSF report: *Aleppo's Reality: Daily Life under Barrel Bombs Voices from Eastern Aleppo*, April 2014.

⁷³ OCBA Report on Afrin visit: chemical weapons alert, 15 April 2013.

had access to the chemical weapons stockpile of the Syrian military, although it did not have sufficient evidence to identify the perpetrators.⁷⁴

Faced with this new threat, and with limited experience in dealing with the consequences of the use of biochemical weapons, MSF invested in preparedness both in its own facilities and to support the other key health structures and staff in the region. The approach (considered too shy by some members of the team) was mainly passive, and focused on making sure that staff would be able to protect themselves, as well as patients admitted to the hospital and the victims of biochemical agents should they arrive at an MSF or MSF-supported facility. MSF developed a protocol and supplied protection packages, installed decontamination stations in the three main hospitals in the area, providing them with technical advice and introducing them to sentinel surveillance so that they would have a minimal capacity to respond. Beyond that, MSF decided to not take the lead on the management of the cases and samples.

3.3. From Open Conflict to Increased Fragmentation amongst Armed Groups: Limitations of Acceptance and Networking

The power vacuum left by the Syrian government in areas that had fallen under the opposition control was filled by the emergence of local councils to run civil affairs, including education, health and public services, closely monitored by the armed opposition groups. Different armed groups continued to watch the areas that they had taken under control ensuring a minimum of security. However, the escalation of the conflict into a full-fledged civil war, with growing divisions within the armed opposition groups and emergence of a plethora of armed actors with varying levels of power and influence, led to increased insecurity on the ground.

On one hand, the abundance and accessibility of arms and light weapons inevitably resulted in increased banditry and criminal acts. Controlling resources, from wheat silos to border-crossing passages and from running industries to distributions of basic goods, became a key motivation for most of the groups. On the other hand, the rise of Islamist militancy had a significant impact on the evolution of the local context, bringing further challenges to the provision of humanitarian aid.

While MSF continued its efforts to build acceptance with all different actors, it was almost impossible to keep up with the increased number of brigades and rapidly changing dynamics amongst them. It also found it difficult to develop reliable local networks to negotiate access and obtain sufficient security guarantees for its staff and operations. This was manifested by the numerous interferences and violations perpetrated by armed groups, some of which had severe consequences on the medical mission. While the motivations behind incidents were not always clearly determined, two broad categories were identified from the analysis:

- Staff threatened or detained due to perceived personal views or behaviour
- Disrespect and abuse of health facilities, staff and assets

Staff Threatened Due to Personal Views or Behaviour: Killing of MSF Local Surgeon

As is the case in diverse war contexts, one of the recurrent motives of targeting medical staff is the perception that they are not neutral or taking sides in the conflict. The civil war in Syria has created a polarised situation with growing intolerance towards any perceived association or collaboration with the 'enemy'. In areas under the control of the opposition, being suspected of being counter-revolutionary or supportive of the government has led to threat, detention, torture and death.

⁷⁴ UN Human Rights Council, 12 February 2014. *op. cit.*

During the analysis period, MSF recorded at least 13 incidents whereby national staff were either threatened or detained due to their perceived or suspected political affiliations (including support to a rival armed group).

Similarly, with the growing influence and military might of Islamist factions, the conflict gradually adopted a strong religious element that characterised both the external context as well as the internal dynamics within MSF. Consequently, staff members who did not conform to the changing environment in their religious views or behaviour were exposed to threats and insecurity.

One of the first incidents that reflected this evolution was in April 2013 where an unidentified militant came to MSF hospital and rebuked three female national staff members due their alleged 'non-Islamic' behaviour, threatening to take them to court. Discussions with various team members and local authorities brought to light the increased conservative behaviour in the community and within the hospital; many did not consider the incident to be serious and agreed that the female staff should 'behave better' in light of the changing context. Taking into account that individual behaviour or ideologies could result in such incidents, MSF chose to take precautionary measures and ask the staff members in question to be more discrete⁷⁵ in their behaviour and requested staff members to avoid political or religious discussions inside the facility.

The extent and gravity of such threats was not fully grasped until the tragic abduction and killing of MSF local surgeon in September 2013. It was reported that four masked armed men entered MSF dormitory in Sejou village and abducted the doctor, sparing his two colleagues. His body was found the following day near Tal Rifat, bearing bullet wounds and marks of torture. Although different groups or individuals were suspected, no one claimed responsibility.

There had been previous threats made against the young surgeon who was known to be vocal about his atheism and criticism of Islamist extremists. In May 2013, he informed the field coordinator that he had received a "fatwa"⁷⁶ for not behaving "as a good Muslim". MSF took protective measures accordingly until the issue was resolved and after confirming the fatwa had been lifted on the condition that the doctor 'behaves'. He was requested by MSF, as well as friends and colleagues, to keep a low profile and avoid any provocative behaviour.⁷⁷

Although many believed his outspoken beliefs would get him into trouble, the doctor's tragic fate was alarming to both national and expatriate staff. In response to the incident, MSF held meetings with the local authorities who expressed dismay and committed to launching an investigation with the Sharia council in Tal Rifat. Immediately evacuating its expatriate team from both projects, MSF was faced with the dilemma of whether or not to temporarily close the hospital or suspend operations to send out a strong message of outrage. Given that the likely motivation behind his murder was linked to his personal life and ideology, not his work or who he worked for, it was difficult to justify halting critical medical assistance to the population of Al-Salamah and surrounding villages.

This tragic incident marked a defining moment for the medical mission with the realisation that there were no limits to actions taken by some armed groups against anyone opposing their causes or ideologies, including acting outside any judiciary structure with impunity. It also highlighted the total disregard of the perpetrators to the fact that the young surgeon had been risking his life on a daily basis to save the lives of others, including those who might have occasioned his death. Within MSF, the mission coordination team acknowledged that a better reading of the situation, including timely knowledge and understanding of the changing local context, might have prompted MSF to take stricter measures in response to the initial threats.

⁷⁵ This decision generated different opinions in the team. Some did not agree that MSF should tell staff how to behave while others accepted that the protection of the staff and facility justified the 'interference' with personal liberties when inside the facility.

⁷⁶ Fatwa in Islam refers to a legal opinion or interpretation of Islamic law. However the limited use and understanding of the term has led to its general interpretation as 'death sentence' particularly by western media.

⁷⁷ Internal report September 2013 and interviews with various MSF field staff, Nov-Dec 2014.

This however sparked an internal debate on how far MSF can control staff members' personal lives and prevent such incidents, particularly in a highly sensitive conflict situation.⁷⁸

In addition to the sad atmosphere in the hospital and low morale of staff, the incident was followed by the departure of the remaining two surgeons, following the trail of many local doctors and medical personnel⁷⁹. Given the difficulty of finding skilled local surgeons, MSF was forced to temporarily suspend surgical operations. The field coordinator at the time noted:

“This became one of our biggest operational challenges. We spent most of our time contacting medical and diaspora networks in order to find staff, while making sure all medical resources were fully utilised. At some point, MSF was able to perform surgical procedures twice or three times a week but not as an emergency service.”⁸⁰

Aware that similar incidents could happen in the future, MSF developed a protocol to deal specifically with these sensitive situations and take strict measures to minimise exposure of its staff, patients and facilities.

Within one month, MSF faced a similar situation in its hospital in Sheikh Najjar whereby a local doctor was death-threatened by an armed faction group due to an incident he had faced in another health facility back in March 2013. In agreement with MSF, the doctor resigned for his own safety and to avoid exposing the mission. As a result MSF lost the most senior local doctor in the hospital, putting further strain on the project's medical activities and in terms of finding qualified medical staff.

Disrespect and Abuse of Health Facilities, Staff and Assets

In addition to threats and detentions by armed groups, MSF also faced a number of incidents whereby armed groups showed disrespect and aggression towards the medical personnel and facilities. In November 2013 a group of armed men raided MSF hospital demanding an ambulance, stretchers and two medical personnel to accompany them to the location of the wounded. One of the men had a grenade and threatened to blow up the hospital. The personnel were forced to comply with the order and were later returned unharmed. A similar unsuccessful attempt occurred a few days later. Likewise, in April 2014, a group of armed men came to Maskan facility and demanded home treatment for an injured relative and started shooting in the facility. They also complained about the quality of the services.

In the face of such incidents, MSF did not have a choice but to comply with the orders so as to avoid harm to the personnel and patients, and to communicate the incidents to the armed groups to remind them of the need to respect the medical mission. On occasions where the perpetrators were identified or suspected, the armed groups took responsibility and apologised to MSF. In the second case, MSF acknowledged that it needed to improve the quality of its services and took some measures in this regard (see section 3.4).

Interviews with both international and national staff revealed that MSF's approach, based on humanitarian principles, had a positive impact on both the running of the health facilities and behaviour of armed groups. It was noted that with time, the national staff adopted a more 'neutral and impartial' discourse reminding armed groups of MSF's principles and hospital rules. This resulted in a slightly more responsible approach of armed groups, such as leaving weapons at the entrance as opposed to initially storming the facilities fully armed. Similarly, some national staff members noted that explaining MSF's mission and activities to armed groups during incidents that occurred outside MSF premises (checkpoints, detentions, interrogations, etc)

⁷⁸ Interviews with HoM, FieldCo and HQ staff, Oct-Dec 2014.

⁷⁹ According to Physicians for Human Rights (PHR), an estimated 15,000 doctors had fled the country by December 2013. As of May 2014, there were only 40 doctors serving the population of 2.5 million in Aleppo, with only 10 to 15 surgeons available to perform the necessary 1,500 surgeries in the city each week. https://s3.amazonaws.com/PHR_other/Syria%27s-Medical-Community-Under-Assault-October-2014.pdf

⁸⁰ Interview with FieldCo, November 2014.

also contributed to their release.⁸¹ It was also observed that this principled approach was increasingly embraced by other local medical facilities and networks that MSF collaborates with, due to growing violations by armed groups (see section 4).

Growing Threat of Kidnapping

The growing atomisation among armed opposition groups may be linked to various aspects, including differences in ideology, tactics, organisation, capability and funding, amongst others. However, with time, a clear distinction emerged between those with a national focus and those with a global 'jihadist' agenda. The situation fundamentally changed following the rift between Jabhat Al-Nusra and the Islamic State in spring 2013⁸². Since then, relations between IS and the different armed opposition groups, including JN, have severed with mounting rivalry leading to full fighting amongst them. By the end of 2013, IS had grown to become one of the most powerful factions in opposition-controlled areas, evoking respect, fear and animosity among other opposition groups⁸³.

While it was impossible for MSF to contact and negotiate with all newly-emerging armed factions (there were up to 38 different non-coordinated factions in Aleppo by mid-2013), MSF maintained contacts with the main armed groups in its area of operations, including the Sharia Council, the Islamic Front and Jabhat Al Nusra. It also continued its endeavours to communicate and negotiate access with IS.

The growing exposure to kidnapping became evident in August 2013 when an MSF national staff member was detained by IS militants before being released three weeks later. Shortly after the incident, 2 national and 2 international staff members faced an attempted detention while commuting between Aleppo city and MSF hospital in Sheikh Najjar⁸⁴. These events highlighted an important shift in the context. Aware of the need to take stock and reflect on the implications, all international staff were temporarily evacuated. The rapidly changing and unpredictable environment made it difficult to obtain sufficient and timely knowledge of potential risks, such as kidnappings and executions of locals and foreigners committed by IS and other armed groups and the team acknowledged the need to expand and strengthen MSF's networks⁸⁵. The same observation was made with regards to the targeted killing of MSF local surgeon, which occurred around the same period (see section 3.3).

Negotiated access with IS and JN in Aleppo was difficult and mined with mistrust between September 2013 and early 2014, with discussions marked by growing intolerance and suspicion towards foreigners, while a campaign of kidnappings against foreigners escalated. Moreover, numerous local journalists and aid workers, including medical staff, faced detentions, torture and executions during the withdrawal of IS to Ar-Raqqa city (160 km east of Aleppo).

On 2 January 2014, thirteen colleagues from MSF Bernas hospital were abducted by IS militants from their project base in the province of Latakia. National staff members were released the same day and, after months of negotiations, three international staff members were released in April, while the remaining two were released in May. This incident constituted the main turning point for MSF with severe consequences on the medical mission. Not only did it force MSF to close four hospitals and health centres in Al-Raqqa, Idlib, Aleppo and Latakia, it also meant a de facto end of almost all international staff presence in Syria with a shift to management with Syrian personnel only. MSF decided in August 2014 to end all visits of international staff inside Syria so long as the context remained unchanged and security guarantees offered by

⁸¹ Various internal reports and interviews with national staff, December 2014.

⁸² A disagreement over their fusion was followed by Al-Qaida officially disowning IS and declaring Jabhat Al-Nusra as its representative in Syria. This led to significant defections from JN to join IS.

⁸³ International Crisis Group, *Rigged Cars and Barrel Bombs: Aleppo and the State of the Syrian War*, Middle East Report N°155, 9 September 2014. <http://www.crisisgroup.org>

⁸⁴ They were immediately released when the driver identified one of the members of the armed group, which was suspected to be IS.

⁸⁵ Interviews with several HoMs and FieldCos, Oct-Nov 2014.

the armed groups remained unreliable. Meanwhile, negotiation attempts with IS have to date been unsuccessful.⁸⁶

MSF national staff, like the rest of the community, was not exempted from the growing threats of extremist Islamist groups. Several staff members interviewed noted that the conflict entered a new phase with the growing dominance of IS, particularly when IS militants took over Azzaz and gained control of the main road used to commute to Al-Salamah hospital. This prompted MSF to temporarily suspend medical activities and evacuate the national staff in February 2014 until the armed group's withdrawal from the area.⁸⁷

3.4. Remote Management and Partnerships

3.4.1. From Remote Management to Shared Management

The decision to move to remote management modus operandi is an extremely difficult one for MSF. The delivery of humanitarian aid through mixed teams (international and national staff) and the proximity to populations are crucial aspects of MSF's identity and values. A model of remote management was put in place in which the expatriate team was based in Turkey to support the daily business of the field hospitals.

With the absence of reliable negotiated access, this 'forced' adaptation was the only remaining option that would allow MSF to continue providing critical healthcare in Aleppo, while accepting that important compromises would have to be made.

Both international and national staff needed a period of adjustment, with the former having a tendency to micro-manage, while the latter was suddenly overwhelmed with increased reporting and administrative tasks. One national staff member described this change:

"When the expatriate team was present, decisions were taken and issues were resolved in a faster and more efficient way. There is more paperwork and administrative processes that lengthen and weaken decision-making. Although staff performance has seen a decline mainly due to lack of direct supervision, we have a good medical team in place, which has allowed us to continue providing a good level of services."⁸⁸

Likewise, international staff expressed frustration with regards to losing direct contact with their field colleagues and projects, in addition to decision-making constraints and difficulty to assess or control the quality of services. Recruiting and retaining qualified personnel, particularly surgeons and anaesthetists, was also reported to be increasingly difficult. This prompted MSF to 'soften' some of its rules and accept measures such as hiring medical students in Al-Salamah hospital. However, there continued to be gaps in skilled surgeons, gynaecologists, midwives and specific specialities.⁸⁹

Throughout 2014, MSF received a number of complaints from the community and local authorities over the decreased quality of health services, particularly in Al-Salamah hospital, which had enjoyed a good reputation in the region during the presence of the international team. According to the head of mission⁹⁰, the temporary presence of IS in the Azzaz area in January-February also isolated Sejou village, which led to a sharp decline in the hospital's services and attendance for a few months. In Aleppo, the changed nature of MSF activities from a full hospital in Sheikh Najjar to an advanced emergency medical centre in Maskan led to initial false expectations and disappointment.

⁸⁶ Note: MSF is not currently providing medical assistance in areas under the control of IS due to the failure to obtain reliable security guarantees after the kidnapping incident in January 2014.

⁸⁷ Interviews with MSF national staff members, December 2014 and internal report February 2014.

⁸⁸ Interview with MSF national staff 3, December 2014.

⁸⁹ Interviews with several expat and national staff, Oct-Dec 2014.

⁹⁰ Discussion with HoM, January 2015.

MSF took several measures to tackle those issues, including holding regular meetings with the national staff and the local authorities in both projects areas to obtain feedback and share information. As there was no intention or need to turn the Maskan facility into a hospital, MSF reinforced its referral system between Maskan, Al-Salamah and other health facilities, with the medicalization of two ambulances. It also introduced a sexual and reproductive health activity in June in response to a strong request by the community, although the service has faced shortages of midwives.⁹¹

Despite the challenges of remote management, all staff members interviewed agreed that the medical needs in the Aleppo region justified the continuing of operations through national staff. They equally agreed that there was room for improvement, particularly if MSF was to continue having the same relevance and acceptance that it has enjoyed since the beginning of its operations. To do this, MSF acknowledged that it would need to give up its 'expat-centric' approach and rely more on the national staff.

By the second half of the year, it was decided to implement a 'shared management' model whereby responsibilities are clearly defined and shared between international and national staff. By creating 'mirror positions', national staff members are trained and managed by their supervisors in Turkey, so that they disseminate MSF principles, implement protocols and supervise activities on the ground⁹². Decisions related to sensitive areas, such as security, financial control and human resources remain under the responsibility of the expatriate team to minimise transfer of risks and organisational responsibility.⁹³

With the plan to implement this model by early 2015, the impact is yet to be seen although many interviewed expressed a degree of optimism, noting that its success would very much depend on trust, flexibility and ability to retain skilled staff.

3.4.2. MSF's Support to Local Health Facilities and Networks: From Necessity to Choice

With no exception, all staff members interviewed noted that one of the biggest added values of MSF's intervention in Syria has been its uninterrupted support to local health facilities and medical networks that have been working at the frontline under extremely dire conditions.

With the setting up of Al-Salamah hospital, MSF immediately engaged in a support programme and began providing a number of health facilities in the Azzaz district with medical supplies and equipment. This intervention was expanded with the opening of the second project in Aleppo whereby MSF strengthened its partnerships with local medical networks and began supplying standard first aid kits to several health facilities. The emergence of vaccine-preventable diseases together with intensified bombing led MSF to include Expanded Programme on Immunisation (EPI) and blood bank supplies in the donation packages. As mentioned previously, MSF started activities in Aleppo city with donations of medical supplies and materials as well as the mass vaccination campaign that took place in April and May 2013, which meant interacting with 49 different health teams. By the end of 2014, MSF was supporting 10 hospitals, 3 health centres and 6 first aid points in Aleppo city, and another 3 hospitals and 3 health centres in the Azzaz district (see Annex 3).

In addition to providing regular medical supplies and equipment, MSF's support to local facilities and networks has also included a capacity-building component. This has ranged from the provision of training on

⁹¹ Interviews with HoM and OCBA health advisor-emergency unit, January 2015.

⁹² MSF national staff members holding 'mirror positions' spend 40% of their time in Turkey and 60% in the field.

⁹³ Interviews with HoM, FieldCos and OCBA Head of Emergency Unit, Nov-Dec 2014.

triage, mass casualty and 'scoop and run'⁹⁴ approaches, to support in maintenance of biomedical equipment. Running costs, including staffing, were considered out of the scope since the beginning.

Over 2012 and 2013, MSF teams were able to conduct regular visits to the health facilities to assess the needs and meet with the personnel. Several staff members noted⁹⁵ that those visits were crucial for obtaining feedback and building trust, particularly as most facilities had little or no reporting systems in place. With the deteriorating security situation, the visits discontinued and the facilities began picking up the donations from MSF premises. Trainings were also reduced or limited to MSF facilities, with difficulties of holding trainings in Kilis due to bureaucratic constraints imposed by the Turkish authorities⁹⁶.

Both field and headquarter staff deem these interventions to have a high impact and deliver an acceptable quality of care. At the same time, it was the only means for MSF to enhance its support, as the intervention in Syria must be considered modest since it started. It was noted that this collaboration has allowed many health facilities to continue running and also extend their services to the wider civilian population; initially focusing on the war-wounded, many facilities now include maternity care, paediatrics and treatment of chronic diseases. Establishing a solid referral system between the different facilities also helped to provide services that were missing, as most of the medical teams were unable to provide all range of medical services on their own.

4 Violence against Partner Medical Teams and Health Facilities in Aleppo

Despite the challenging context and significant number of incidents suffered by MSF since the beginning of its intervention, it is clear that the medical mission was not exposed to the same level and type of violence witnessed by other local medical teams and health facilities operating in most of the cities and at the frontlines.

While it has been difficult to gain an accurate insight of the numbers, nature and frequency of the attacks against local health facilities, various reports and testimonies received by MSF and other humanitarian and human rights organisations reveal a tragic reality: not only has there been a blatant disregard to civilians and civilian structures since the beginning of the conflict, but there has been a deliberate use of violence against health workers, medical facilities and ambulances perpetrated primarily by the government and, to a lesser extent, by armed groups asserting their power and control.

As mentioned in the first section of the report, this reality was evident from the early phases of the uprising, whereby doctors and health personnel were reportedly threatened, detained and tortured by government security forces and allied militias for providing medical care to injured protesters. In some cases, their families and relatives were also targeted. In a report published in June 2014, Violations Documentation

⁹⁴ Also known as Advanced Medical Post, this activity refers to delivering first aid and stabilising the wounded before referring them to hospitals by ambulance.

⁹⁵ Interviews with several FieldCos and MedCos, November 2014.

⁹⁶ Discussion with HoM, January 2015.

Centre in Syria (VDC) reported that more than 53 doctors and medical staff in Aleppo have been detained by government forces, many of whom remain under arrest while some have disappeared without trace.⁹⁷

Their inability to treat the injured protesters in public and private hospitals led many doctors and medical personnel to establish secret medical points to avoid arrest or mistreatment by the government forces. In many cases, those makeshift field hospitals were stormed by the government forces and both the injured and their caregivers were arrested or assaulted.

The field hospitals were sustained by a number of local and diaspora-based networks (often working independently), which supplied them with drugs and medical material. This was done in coordination with pharmacies and local drug factories, and later through cross-border smuggling operations when resources became scarce. The networks also provided support by sending personnel and vans to protest areas in order to evacuate and transfer the injured to the field hospitals.⁹⁸

After the armed opposition gained control of north-eastern Aleppo around mid-2012, it did not take long before the government forces retaliated with a heavy and repeated bombing campaign that did not spare civilian structures or health facilities. MSF local doctor who worked in another health facility in Aleppo at the time stated:

“In addition to schools and bakeries, almost every hospital and health centre in Aleppo suffered partial or significant damage due to the shelling. Dar Al-Shifaa hospital was deliberately targeted due to the presence of an armed opposition faction in the same building. It was subjected to a series of airstrikes until it was completely destroyed, killing four of my colleagues and injuring seven others. Having a hospital in the same location as an armed group was a reckless mistake. We understood that more security measures needed to be taken thereafter to protect our staff and patients.”⁹⁹

Some representatives of local medical networks observed that the shelling by government forces has generally been more intense and deliberate in Aleppo city than the surrounding rural areas. A local doctor from the Aleppo City Medical Council (ACMC) told MSF:

“The situation in Aleppo is different than in the reef. Airstrikes are more frequent and hospitals have been clearly targeted by the government forces since the early days of the conflict. Zarzour hospital has been shelled numerous times. For the government forces, a doctor is more dangerous than a fighter. By targeting medical personnel, they want to deprive the wounded combatant from receiving care as well as punish the population in the area.”¹⁰⁰

According to data compiled by partners¹⁰¹, attacks on medical facilities in opposition-controlled areas increased significantly in 2014, with 26 attacks reported in the Aleppo governorate causing at least 39 deaths amongst medical personnel. Attacks by barrel bombs¹⁰² have also intensified and have had a particularly devastating effect on healthcare, in addition to other civilian structures. Physicians for Human Rights and VDC¹⁰³ documented at least 14 barrel bomb attacks against medical structures in Aleppo since end-2013 causing widespread destruction, deaths and injuries.

⁹⁷ Violation Documentation Center in Syria, *A Special Report on the Medical Conditions in Aleppo Including the Violations against the Medical Cadres*, June 2014. <http://www.vdc-sy.info/pdf/reports/1401644133-English.pdf>

⁹⁸ Interview with MSF national staff 1, November 2014.

⁹⁹ Interview with MSF local doctor 2, November 2014.

¹⁰⁰ Interview with local doctor from Aleppo City Medical Council (ACMC), September 2014.

¹⁰¹ Physicians for Human Rights (PHR), *Anatomy of a Crisis, A Map of Attacks on Health Care in Syria*. Accessed in February 2015. https://s3.amazonaws.com/PHR_syria_map/web/index.html

¹⁰² See MSF report, *Aleppo's Reality: Daily Life under Barrel Bombs Voices from Eastern Aleppo*, April 2014.

¹⁰³ VDC June 2014, *op. cit.*

Amongst the trends revealed by the data compiled are repeated attacks against the same health facility in an effort to render it dysfunctional, such as Dar Al-Shifaa, Al-Daqaq and Al-Sakhour hospitals, which were shelled several times. Some were completely obliterated such as Al-Huda SKT Welfare hospital, which was hit by a rocket on 2 August 2014, killing 6 medical personnel and injuring another 15 people, including patients.¹⁰⁴ This hospital provided the only neurosurgical service in the north of the country. Aleppo's only functioning pharmaceutical factory was also struck by a missile on 16 August, injuring one staff member and putting the facility out of service¹⁰⁵.

The conflict has also seen a growing shortage of skilled doctors and medical personnel, particularly surgeons, anaesthesiologists and female reproductive health professionals. Low salaries and lack of a foreseeable resolution of the conflict has led many to flee the violence and seek a better future for their families abroad. PHR reported that by May 2014, there were as few as 40 doctors left in Aleppo to serve its population of 2.5 million¹⁰⁶.

Like MSF, local health facilities have sought ways to adapt to the violence including moving underground and running activities out of basements as well as using protective measures such as sandbags. With the growing shortages of medical supplies and staff, compounded by the threat of shelling, hospitals began resorting to early discharge of patients and referral of those requiring post-operative care or more complex treatments. Other uncommon practices included hiring and training volunteers with no previous experience and transporting up to three patients in the same ambulance. MSF local doctor explained that they "had to adapt and resort to doing what was possible, rather than what was standard medical practice"¹⁰⁷.

Another approach that became increasingly adopted by local doctors and health personnel was to promote compliance with humanitarian principles. At the early stages of the conflict, most of the medical staff did not give much importance to adhering to principles of impartiality, independence and neutrality. Over the course of the conflict, many evolved in their position but found it difficult to sustain due to the enormous pressure from armed groups and the personal political stance of most of the staff that remained in opposition-controlled areas. Even ethical medical principles were at stake as revealed through recruitment interviews where medical candidates expressed they were ready to deny help to soldiers or militia from the government. A doctor from Physicians across Continents (PAC) highlighted the difficulty of maintaining neutrality and independence in this type of conflict while noting that, with time, it became the best protective method:

*"The problem is that medical personnel often see their work as an act of resistance, linked to their commitment to the revolution. They are too often part of the conflict, because they are related or connected to one side against the other. After having been very outspoken and targeted from all sides, medical staff have realised that they are paying the price of the politicisation of their profession. Being seen as neutral is the best protection possible to be able to work in a very tense and hazardous environment. In some hospitals, the personnel started displaying posters to raise awareness and promote respect for humanitarian principles."*¹⁰⁸

In addition to constant bombing by GoS forces, medical facilities, personnel and patients have witnessed growing violations committed by armed opposition groups with varying motivations and degrees of severity. Many have been attributed to the prevalent presence of weapons and increase in acts of banditry.

Islamist groups, who have grown in power and influence over the span of the conflict, have been responsible for numerous severe violations against health workers and patients, from reported detentions and kidnappings, to decapitations inside health facilities and executions of patients while being transferred in

¹⁰⁴ Statement made by Al-Huda Hospital, 2 August 2014 (reported by MSF staff).

¹⁰⁵ PHR, February 2015, *op. cit.*

¹⁰⁶ Physicians for Human Rights (PHR), *Syria's Medical Community Under Assault*, October 2014.

¹⁰⁷ Interview with MSF local doctor 2, November 2014.

¹⁰⁸ Interview with local doctor from Physicians Across Continents (PAC), September 2014.

ambulances. MSF local doctor, who was himself detained by one of the armed factions while working for another health facility in Aleppo, noted that having different political or religious beliefs to the armed group is enough to get you arrested, tortured, kidnapped or killed. He added that some of the wealthier doctors have been abducted, while others have disappeared.¹⁰⁹

In response to repeated violations by some of the armed factions, a number of medical facilities in Aleppo city undertook a strike in August 2014, demanding an end to such acts of aggression and to bring the perpetrators to justice. This was followed by an agreement endorsed by the local medical council and a number of armed factions in conjunction with the Sharia law, pledging to protect medical facilities and ensure the rights of the health personnel are respected by the armed groups. In return the medical council pledged to receive and treat all sick and injured military personnel, without exception, and provide them with the best possible medical care.¹¹⁰

On a number of occasions, armed groups have been responsible for bombing or shelling health facilities in Aleppo. In 2014, PHR reported four such attacks by armed groups, including the shelling of the Armenian Relief Society clinic in June, the shelling of the cardiac centre at Aleppo University hospital in September, a suicide bomb that damaged a field hospital in Ayn Al-Arab and a car bomb that detonated near Al-Kanana hospital in Dar ta Izzah in December.¹¹¹

Despite local and international pressure and condemnation, all parties to the conflict in Syria continue to disregard their international legal obligations to respect the safety of medical facilities and vehicles, health workers, and patients.

5 Conclusions

The conflict in Syria has shown how medical care can become the target of both deliberate and indiscriminate violence and how humanitarian principles can become extremely difficult to uphold in a context of total war. Since the onset of the crisis, government forces have strategically attacked doctors, hospitals and ambulances with the aim of harming the opposition; an alarming trend of impunity that has characterised the wider Arab spring context. Like the rest of the civilian population, health facilities and workers have also faced indiscriminate attacks, simply because they are not spared from the violence and are not offered the protection to which they have the right. Similar violations against both civilian structures and healthcare providers have been committed by non-state armed actors with the same level of impunity. This has brought unspeakable suffering to the Syrian people.

The number and nature of incidents faced by MSF-OCBA in Aleppo throughout the research period tell a story of immense complexity and adaptation to a highly volatile and ever-changing security context on one hand, and an increasingly contracted humanitarian space on the other.

While MSF did not seem to suffer deliberate violence targeted against its mission in Aleppo, the threat of shelling was a determining factor in many crucial decisions that were made, including reductions of teams

¹⁰⁹ Interview with MSF local doctor 2, November 2014.

¹¹⁰ Interviews with local doctors from medical networks, September 2014 and report of Aleppo Media Center (AMC), 29 August 2014.

¹¹¹ PHR 2015, *op. cit.*

and activities and relocation of facilities, which had a considerable impact on its operations and on the populations seeking medical care. Moreover, operating in the same area as armed opposition groups exposed MSF to various violations, ranging from a general disregard to the protected status of health facilities and staff, to targeted violations perpetrated mainly against national staff due to their personal ideologies and affiliations - the most tragic being the killing of MSF local surgeon. This raised an important dilemma for MSF in how far it can control staff's behaviour in their personal lives in order to protect them, particularly in such a sensitive and highly politicised conflict scenario.

This dilemma fed into a larger challenge whereby MSF, aware of the complexity and volatility of the conflict, endeavoured to carefully design and regularly review its operations, weighing every decision against all known and conceivable potential risks, particularly with regards to national staff, reaching levels of detail and intricacy like no other MSF mission. With the growing fragmentation amongst armed groups, the level of networking and context analysis needed to stay informed and constantly adapt to the ever-changing context was nearly impossible to attain. Likewise, establishing contacts and negotiating access with anti-western armed groups became an increasingly arduous task.

The heightened violence against foreigners and the kidnapping of MSF colleagues in January 2014 marked the end of MSF's international presence in Syria. With the move to remote modus operandi, MSF accepted that compromises would have to be made, particularly with regards to its proximity and bearing-witness role; a painful compromise but one that has enabled MSF to continue providing critical medical assistance in Aleppo to this very day. A major component of this assistance has been its uninterrupted support to local health facilities and medical networks that have been operating at the frontline since the beginning of the crisis, facing constant bombing and various violations by armed actors. MSF did not take long to recognise the significant impact of this support as a substitute to lack of direct presence, and has increasingly focused on strengthening this collaboration.

The nature of the Syrian crisis, where all forms of brutality against the civilian population have clustered in one context, poses serious challenges to international humanitarian action, which many agree has failed the Syrian people. Operating in middle-income dense urban contexts with sophisticated warfare and dealing with very powerful state and non-state actors pushes MSF to overcome various barriers (including international vs. national staff) and engaging with local and regional networks as well as actors that are new to the 'traditional aid system'. This means accepting that a degree of flexibility and adaptation is not only necessary but perhaps the only means to be able to respond to Syria-like humanitarian contexts.

List of Acronyms

ACMC	Aleppo City Medical Council (ACMC)
AFAD	Turkish Disaster & Emergency Management Provincial Directorate
EPI	Expanded Programme on Immunisation
ER	Emergency Room
Expat	Expatriate
FieldCo	Field Coordinator
FSA	Free Syrian Army
GoS	Government of Syria
HoM	Head of Mission
IHL	International humanitarian law
IPD	Inpatient department
IS	Islamic State (also known as ISIL/ISIS/Daesh)
JN	Jabhat Al-Nusra
MCUF	Medical Care Under Fire
MedCo	Medical Coordinator
MTL	Medical Team Leader
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
OCBA	MSF's Operational Centre in Barcelona and Athens
OPD	Outpatient department
OT	Operational Theatre
PAC	Physicians across Continents
PHR	Physicians for Human Rights
SARC	Syrian Arab Red Crescent
SNC	Syrian National Council
UN	United Nations
UNHCR	The Office of the United Nations High Commissioner for Refugees
VDC	Violations Documentation Centre in Syria