

Blurred lines

Warfare and health care

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Abstract

The neutrality of medicine and health care professionals in different conflict settings in the Middle East have come under scrutiny in recent human rights reports, and should be seen as part of the broader fallout of the US-led ‘global war on terror.’ The last two decades of US military attacks on health infrastructures in Iraq and the use of polio-vaccination campaigns to track down ‘terrorists’ are acts of war that have further blurred the lines between health care and warfare. The failure of international legal processes and institutions to prevent such assaults or to prosecute those responsible raises questions about the Eurocentric system of checks and balances that shape international humanitarian law and its invocation as a ‘legal’ and ‘moral’ framework.

Keywords

infrastructure, conflict, war, humanitarian war, sanctions

Global war and the systematic assault on health care

The increase of reported attacks on healthcare professionals and facilities has raised many red flags about the immunity of medicine and health care professionals in different conflict settings. According to a recent report, there have been close to 1,800 incidents reported between the years 2012 and 2013 alone (Human Rights Watch 2014). Many have taken place within conflicts in the Middle East where the US-led ‘global war on terror’ has given way to militarized geographies of protracted conflicts and unprecedented scales of violence (Dewachi et al. 2014). Under this global war, assaults on civilian populations and healthcare systems have become increasingly normalized.

For more than 150 years, international humanitarian law (IHL) has shaped the ethics and politics of wars in the Global North. The set of internationally ratified customary rules endorses the notion of ‘distinction’, particularly between combatants and noncombatants, as one of its main organizing principles. The law prohibits the targeting of civilians or civilian structures and defines ‘medical and religious men’ – even those serving in the armed forces – as noncombatants (Henckaerts 2005). On the ground, many of these distinctions have not fully respected, as the scale of violence targeting cities during the World Wars demonstrates.

The principle of distinction never really applied to Europe’s colonial wars of the nineteenth and twentieth centuries, where no distinction was made between combatants and noncombatants (Wilke 2014). The local populations were seen as hostile, and violence was deployed as a ‘civilizing force’ to terrorize the ‘uncivilized’ into submission. The British *Manual of Military Law* used in 1914 stated that rules of war applied only to ‘civilized nations’ and that ‘they do not apply in wars with uncivilized states and tribes’ (Godley and Edmonds 1914). The British government used air strikes against tribes in the south of Iraq to impede the revolt against British policies (Omissi 1991). The aim of these strikes, which resulted in thousands of Iraqi deaths, was to demonstrate military might and instill fear in the local population.

These colonial wars echo today in the logics of contemporary warfare: the distinctions between ‘terrorist’ targets and ‘civilian’ ones are continuously muddled. The destruction of the ‘terrorist’ comes at any cost and civilian targets are seen as mere ‘collateral damage’. In Pakistan, Yemen, and Afghanistan, attacks on suspected terrorists have claimed many civilian lives including those of first responders (Zenko 2012). Intentionally targeted with ‘double-tapping’ strikes, in which a second attack is launched on the same site a few minutes after the first, first responders are significant risk (Greenwald 2012; Kelley 2012). This is the same tactic used by double suicide bombers in Iraqi cities to target rescuers and create a higher death toll and greater carnage.

Health care has become not only a target but also a tactic of war. The infamous vaccination campaign in Pakistan, where the instrumentalization of public health campaigns in the war on terror has had serious repercussions on global health, was devised by the CIA in 2011 to capture and kill the United States' most wanted terrorist, Osama Bin Laden (Shah 2011). With the help of a local Pakistani doctor and international nongovernmental organizations, the CIA orchestrated a door-to-door vaccination drive months before the attack in Abbottabad in order

to locate Bin Laden (Shah 2011). This fake campaign has had a serious effect on the Pakistani health system, triggering a backlash in Taliban-controlled areas where the militant group has banned polio vaccination (Edwards 2014). Since the perfidious vaccination drive, there have been scores of attacks on polio vaccination teams, who are accused of being 'Western spies' (Edwards 2014). Areas in Pakistan have seen an increase in polio cases, raising concerns about efforts to eradicate this global pest that thrives under conditions of war and poverty.

Iraq's health systems have been tremendously weakened through US military interventions. During the military campaign of 1991, the US maximized its destructive might using an array of high-tech weaponry and experimenting with depleted uranium warheads on both military and civilian targets (Dewachi 2013). Electricity grids were bombed, water sanitation systems were destroyed, and communication networks were left in shambles. While the 'allied forces' rationalized these acts as a means to cut the Iraqi regime's supply lines, the attacks also destroyed the life support and infrastructure necessary for the everyday survival of the entire population.

For more than twelve years, the US pursued an unprecedented regime of international sanctions that further debilitated Iraq's once robust health care system. Under the blockade, hospital supplies and medicines became limited, and the country's medical system was overwhelmed by rapidly increasing rates of afflictions (Gordon 2012). The effects of the war became especially visible among the country's most vulnerable. According to UNICEF, the deaths of close to half a million Iraqi children were related to the sanctions (Ali, Blacker, and Jones 2003). Iraq recorded a 150-fold increase in infant mortality rates, surpassing the impact of HIV/AIDS on infant mortality in sub-Saharan Africa (Ali, Blacker, and Jones 2003).

The sanctions represented a direct assault on the country's medical professionals. Overwhelmed by the preventable mortality and morbidity, doctors were incapacitated by the embargo. During the sanctions, medical-related items requested by the Iraqi government were either blocked or 'held' by the UN sanctions committee, including critical medical supplies, such as cancer medications and equipment that were listed as 'dual use' (considered

to have both military and civilian uses) (Arbuthnot 1998). During the 1990s, thousands of health professionals escaped the country in search of security and careers elsewhere (Amin and Khoshnaw 2003). Those who stayed behind grappled to preserve life under this everyday assault on Iraq's social body.

The invasion and occupation of Iraq (2003–2011) under the guise of the 'global war on terror' defined a new scale of violence on the country's health system. The occupation forces transformed Iraqi cities into a theatre of war and cultivated the emergence of a militant sectarian political system. Inside highly populated cities, occupation forces became a moving target for attacks by different militant groups, jeopardizing the lives of the local population. The US military established checkpoints and built neighborhood walls, limiting mobility and humiliating citizens.

While the Iraq Body Count project estimates that 108,000 Iraqi civilians were killed between 2003 and 2011, representative surveys estimate that more than one million Iraqis have died from the direct and indirect consequences of war and occupation in Iraq (PSR 2015, 15). The scale of injuries, disabilities, and morbidities is unimaginable. Militant political parties instrumentalized hospitals and the Ministry of Health for kidnappings and killings (Paley 2006). Patients were abducted from their hospital beds or transported by ambulances only to show up a few days later as corpses floating in the Tigris River.

Since 2003, hundreds of Iraqi doctors have been killed or kidnapped (Reif 2006). Thousands more have been threatened by militia groups or by patients' relatives for retribution (Donaldson et al. 2012). More doctors have simply sought refuge outside the country along with the more than two million Iraqis who became externally displaced because of the war. As a result of the destruction of the country's health infrastructure and the exodus of many of its doctors, many Iraqi patients now seek health care from other countries in the region, where therapeutics are being redefined along the precarious geography of the conflicts in the Middle East (Dewachi et al. 2014).

The Iraqi case is part of a broader trend that speaks to the long-term consequences of the US-led war on terror. The effects of more than twenty years of direct American military engagement in Iraq has both overwhelmed and incapacitated the country's health care system and doctors' ability to preserve life. The failure of Iraq's health care system to recover, even after the official end of the occupation, shows how the repeated violence to Iraq's health care infrastructure has become nearly insurmountable.

Contemporary war, manifested in the 'global war on terror', has further blurred the lines between health care and warfare. Attacks on civilians and health systems have become imbricated in acts of war, leading to the further militarization of medicine in different

conflict settings. The failure of international legal processes and institutions to prevent such assault or to prosecute those responsible for it raises questions about the Eurocentric system of checks and balances. While reporting individual incidents is an important process that needs to continue to document all violations, a more systematic approach to understand how these attacks are entangled in broader questions of war and violence is required.

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Omar Dewachi is an assistant professor of anthropology and global health at the American University of Beirut (AUB). He trained as a medical doctor in Iraq during the 1990s and received his PhD in Social Anthropology from Harvard University in 2008. He recently co-authored 'Changing Therapeutic Geographies of the Iraqi and Syrian Wars' (*Lancet*, January 2014), and his book, *Ungovernable Life: War and Mandatory Medicine in Iraq*, is forthcoming from the Stanford University Press (2016). Based on archival and ethnographic research, the book chronicles the story of medicine and statecraft in Iraq. Dewachi is currently conducting research on the politics of wounds and wounding in the eastern Mediterranean. He leads the War and Global Health Working Group at AUB and is one of the contributors to the Costs of War Project at Brown University.

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