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Mosul Trauma Response: A Case Study Application of Humanitarian Principles

Executive Summary - Part 1: Application of Humanitarian Principles

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Introduction

The battle of Mosul was one of the largest urban sieges since World War II. From October 2016 to July 2017, at least 30,000 Iraqi and Kurdish forces, backed by a U.S.-led international anti- Islamic State of Iraq and the Levant (ISIL) coalition, fought to retake Iraq's second-largest city, which fell to ISIL in 2014. Over nine months, more than 940,000 civilians fled.

As the battle unfolded, the need for trauma care for injured civilians became increasingly evident. In previous wars in the region, coalition military had often provided care for war-wounded civilians; indeed, many of the articles in the Geneva Conventions and Additional Protocols place responsibility for the care of war-wounded in interstate and intrastate conflicts on the warring parties themselves.[1,2] This care largely did not happen in the battle of Mosul. The Iraqi military had few medical units with limited capacity, and U.S.-led coalition forces stated that they were in a supportive role and were unable to supply medical teams to care for civilians. International non-governmental organizations (NGOs), stung by recent attacks on health facilities and workers, initially struggled to find their footing amid the security risks and other programming; moreover, many argued that their role has not and is not to provide frontline care, which should remain the responsibility of warring factions as set out in the Geneva Conventions and Additional Protocols.

The World Health Organization (WHO), as the "*provider of last resort*" for providing health services in the cluster approach,[3] stepped in to fill this void. It led and coordinated what the Humanitarian Coordinator for Iraq described as one of the "*most complex operation[s] the UN has done anywhere in the world*"[4]: a trauma pathway, modeled after military trauma systems, involving several levels of care. This included "*trauma stabilization points*" (TSPs) located ideally within 10 minutes from the frontline, and field hospitals positioned within an hour drive (the so-called "*golden hour*"). Despite requests, the UN and WHO were unable to get the Iraqi military or civilian government medical teams to respond to the need to move forward to care for wounded civilians; nor would the U.S.-led coalition forces. WHO then requested Médecins Sans Frontières (MSF) and the International Committee of the Red Cross (ICRC) to provide these services, but they also declined. Ultimately, WHO contracted other NGOs and a private medical company to manage the TSPs and field hospitals, drawing upon its experience dispatching emergency medical teams (EMTs)[5] in natural disasters and the Ebola response. Funding came from the U.S. Office of Foreign Disaster Assistance (OFDA), United States Agency for International Development (USAID); the European Civilian Protection and Humanitarian Aid Operations (ECHO); and the United Nations (UN) Central Emergency Response Fund.

The Mosul trauma response was novel for several reasons: It was the first time that WHO played the leading role in coordinating trauma care in conflict; the first time a civilian trauma system was attempted in such a frontline setting; and the first time the UN sent humanitarians within minutes of the frontline to deliver trauma care in close coordination with the military. Give the unprecedented nature of this response, as well as the questions it has raised about humanitarian principles and its applicability to other contexts, there is strong interest to better understand what was done, why it was done, and whether this approach represents a model that can or should be used in future conflicts.

This brief summarizes key findings from a larger report funded by a grant from OFDA/USAID to the Center for Humanitarian Health hosted at the Johns Hopkins Bloomberg School of Public Health, focusing on the application of humanitarian principles and implications for future responses. A second executive summary focuses on the quality and effectiveness of the response.

This case study was made possible by the generous support of the American people through the USAID. The contents are the responsibility of the Johns Hopkins Center for Humanitarian Health and do not necessarily reflect the views of USAID or the United States Government.

[1] ICRC. Treaties, States Parties, and Commentaries. https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/WebART/380-600006?OpenDocument

[2] ICRC. Customary IHL. https://ihl-databases.icrc.org/customary-ihl/eng/docs/v2_rul_rule110

[3] https://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach

[4] UN Briefing, July 17, 2017. http://webtv.un.org/watch/lise-grande-unami-on-the-situation-in-iraq-press-conference-17-july-2017/5510054178001/?term

[5] WHO, Emergency Medical Teams. http://www.who.int/hac/techguidance/preparedness/emergency_medical_teams/en/

Key Findings

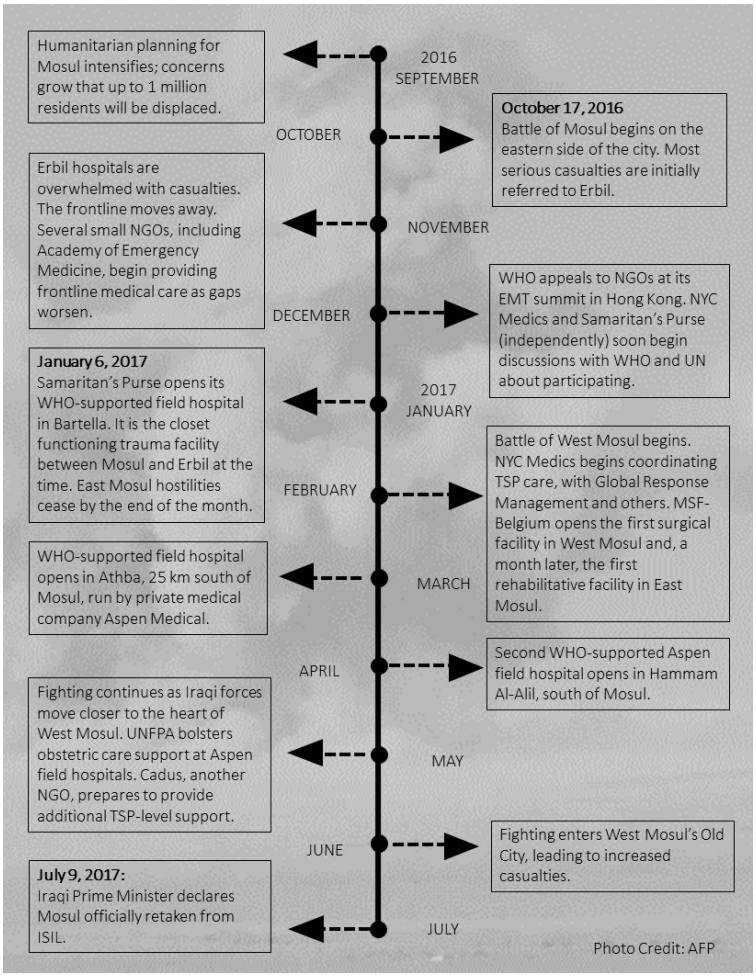
Key Finding #1: **The Iraqi government and its military did not have medical capacity to fulfil their obligations to protect and care for wounded civilians on the Mosul battlefield.**

- The Iraqi military medical corps was largely disbanded after Saddam Hussein's overthrow in 2003, and the few Iraqi medical units that existed at the start of battle of Mosul were inadequately equipped and trained, based upon discussions with NGOs and coalition personnel.
- As the battle progressed, Iraqi forces increased their medical footprint, including setting up at least one field hospital for injured soldiers, but this capacity was largely inaccessible to civilians.
- Most Iraqi civilian doctors had fled the region after ISIS took control, limiting the military's ability to draw upon medical resources from the civilian sector.
- Although the U.S. invested nearly $1.6 billion to rebuild the Iraqi army as part of its Iraq Train and Equip Fund, little of this funding appeared to have had a discernable impact on Iraqi military medical capacity or readiness.

Key Finding #2: **The U.S.-led coalition did not provide substantial medical care for wounded civilians.**

- In the fall of 2016, the UN Humanitarian Coordinator for Iraq approached the U.S.-led coalition and requested additional medical support for civilians, given concerns that civilian casualties were expected to be high and existing capacities were limited.
- The coalition had a limited number of military medical units on the ground, including forward surgical teams and trauma field hospitals; however, these units were operating under restricted rules of engagement (eligibility) that did not allow them to routinely care for civilians.

Battle of Mosul: Timeline of Key Events



- Officially, the U.S. led-coalition stated that it was in an "*advise and assist*" role, and that ground troops were performing largely supportive duties. However, coalition airstrikes played a major role in the battle and had a significant impact on civilian casualties.

Key Finding #3: WHO, as the provider of last resort in the cluster system, and its implementing partners filled important gaps in trauma care.

- When the Iraqi government and the U.S.-led coalition could not or would not provide frontline trauma care for civilians, WHO, as the health agency of last resort, adapted the principles of care from military trauma systems used by well-trained armed forces in conflict zones, which required partners to "*move forward*" to the frontline.
- WHO then requested ICRC and MSF to establish trauma care further towards the frontline, but for a variety of reasons, including security, capacity, and concerns over humanitarian principles, they declined. However, both participated in the overall trauma response and provided much needed medical care.
- WHO turned to governments and organizations certified as WHO EMTs, but these groups all declined as well.
- WHO then cast a wider net, and ultimately contracted two NGOs (Samaritan's Purse for a field hospital and NYC Medics for TSPs), and one private medical company (Aspen Medical for two other field hospitals) to deliver trauma care. Other NGOs, including Global Response Management and Cadus, also operated TSPs.

Key Finding #4: The WHO trauma system saved lives, but also created a precedent that needs further examination and debate.

- The WHO trauma system that stressed forward stabilization efforts did save lives, perhaps up to 1,500-1,800 civilian and combatants' lives based upon available data (see full report for details).
- The willingness of the Humanitarian Coordinator for Iraq, WHO, and its partners to "fill the gap" in providing frontline trauma care in Mosul could set a precedent for future conflicts. The UN and NGOs must be careful in the future not to be "*instrumentalized,*" such that parties to a conflict with substantial medical resources expect that they can "*outsource*" their protection and care obligations to humanitarians.

Key Finding #5: WHO and its partners emphasized the humanitarian imperative to save lives above other principles such as independence, neutrality, and some claimed impartiality.

- Interviews with WHO and other UN officials in Iraq and Geneva indicated that a deliberate decision was taken to position medical personnel close to the frontlines in order to save lives. This strategy reflected a strong embrace of the principle of humanity that requires the reduction of human suffering, the protection of life and health, and respect for human beings.
- WHO supported what they called "*co-locating*" of humanitarian medical personnel with Iraqi military units to ensure the safety of the medical personnel and their rapid access to severely injured casualties. Others have labeled this arrangement "embedding." Medical staff that we interviewed who were working at the frontlines confirmed that this arrangement was critical to their ability to access and provide care to wounded civilians.
- The co-location or embedding of medical personnel with Iraqi security forces raised serious concerns regarding the humanitarian principles of independence, neutrality, and some claimed impartiality. Independence requires humanitarians act autonomously from the political, economic, or military objectives or operations of warring parties. Neutrality requires that humanitarian actors do not take sides in hostilities. Impartiality requires the provision of humanitarian action to be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religion, class or political opinions.
- Many respondents were concerned that the co-location/embedding and close coordination of the frontline medical groups with Iraqi security units violated the requirements of independence. Questions regarding neutrality were also raised as UN officials and medical responders talked publicly of "*defeating ISIS*" and were not able to work with all warring factions. This may have been further compounded due to a majority of the Mosul population being Sunni whereas the Iraq security forces are predominantly Shia, raising questions of impartiality of who would choose to come to the TSPs, despite everyone arriving being treated in the same manner.

Key Finding #6: **"*Co-locating*" or "*embedding*" humanitarian actors with militaries may erode local trust in humanitarian groups and could threaten their safety and future work.**

- There was substantial concern that the WHO trauma strategy diminished the principles of independence and neutrality, both of which are intended to provide protection and operational space for humanitarian actors. While the close involvement with the Iraqi security forces were confined to a relatively small group of medical personnel in the TSPs, it can be difficult for populations to distinguish among international humanitarian agencies or UN organizations.
- In this manner, the public perception that the frontline medical personnel and Iraqi military units were functionally integrated had the potential to influence how local populations perceived all humanitarian groups. Consequently, there was concern among many humanitarian NGOs that the WHO frontline strategy undermined the perceived independence and neutrality of all humanitarian groups, thereby eroding the protections conveyed by humanitarian principles.
- Concerns regarding the impact of the WHO trauma strategy on other humanitarian organizations were raised within the Global Health Cluster; minutes from an April 2017 meeting indicate that participants raised questions "*around adhering to principles of neutrality and impartiality, based on concerns that blurring of humanitarian principles can attract attacks on health care*."[6]

Key Finding #7: **The counterfactual: Humanitarian worker casualties could have significantly disrupted the Mosul humanitarian operation**

- The danger to humanitarians, particularly those working in TSPs, was substantial, going beyond what many humanitarian actors in Iraq stated they would accept.
- Interviews with coalition personnel showed they were concerned that humanitarian fatalities could have led to some coalition partners withdrawing support for such activities.
- Although it is very difficult to know what the counterfactual would have been if an NGO medic(s) in a TSP were killed at the frontline, it is possible that a substantial part of the humanitarian response would have been scaled back, or even halted.
- Because most deaths in conflict settings are due to long-term, indirect, rather than direct trauma causes, it is possible that more people would have died from such an interruption in humanitarian aid than were saved by the trauma referral pathway.

Key Finding #8: **Specific factors and context that allowed humanitarians to move forward in the Mosul theatre may not be replicable in most other conflict settings.**

- Although Mosul was a highly insecure environment, humanitarian actors benefited from organizational support that may not be found in other austere environments.
- TSP providers relied heavily upon the Iraqi special forces, who in turn were heavily supported by coalition air forces and, in some cases, nearby special operations ground troops.
- In interviews, the coalition indicated that it dedicated resources to avoiding humanitarian casualties. Additionally, the UN Officer for the Coordination of Humanitarian Affairs (OCHA) CivMil group played a critical role in coordinating information sharing between humanitarians and military.
- Whether such coordination is possible in contexts without extensive intelligence and security resources and cooperating militaries deserves careful reflection and is discussed more in the key recommendations below.

[6] http://www.who.int/health-cluster/about/structure/GHC-Partner-Meeting-Apr2017-NFR.pdf?ua=1

Main Recommendations

Recommendation #1: **Warring factions, and allied government/militaries supporting them, need to enhance the medical capacities of the former to enable them to fulfill their obligations under the Geneva Conventions and Additional Protocols.**

- High-level discussions and intensified advocacy are needed to emphasize the responsibilities of governments and allied militaries providing operational support to strengthen their medical capabilities to provide adequate care for wounded combatants and civilians.
- In the case of Mosul, not only did the Iraqi military not have capacity to care for wounded civilians, they appeared not to have sufficient capacity and skills to care for their own soldiers. Many respondents stated this was a failure of the Iraqi government as well as the U.S.-led coalition. If the appropriate training and capacity building had occurred, WHO would not have needed to act as the "agency of last resort" to coordinate such care in Mosul, which would have been preferable.

Recommendation #2: **Medical teams working directly with a combatant force should not be identified as "*humanitarian*" groups.**

- If non-military frontline medical services are to be provided to injured civilians, great care should be taken to distinguish these services from the broader humanitarian effort.
- The language and public representations used to describe these groups should purposefully differentiate them from other humanitarian organizations operating in more neutral and independent postures.
- The goal would be to insulate the larger humanitarian enterprise from the work being performed by medical groups who are "*co-located*" or "*embedded*" with combatants.

Recommendation #3: **How humanitarian actors can apply standards of care that require them to move towards the frontline to save lives, and still adhere to longstanding humanitarian principles, needs debate at senior levels such as at the Inter Agency Standing Committee or at the intergovernmental level.**

- Given the changing nature of warfare, increased attacks on humanitarians, and pressure upon organizations to accept greater risks, there needs to be a reconsideration of the relationship among humanitarians, combatant forces, and governments who support such forces. These considerations include the following:

a. Humanitarian principles

Given the diverse international and technical roles of humanitarian organizations, there may be a need for purposeful plurality in how humanitarian principles

- are emphasized by different humanitarian organizations in the field according to their mandate and context.

A deliberative process should be initiated to assess the continued applicability and potential revision of humanitarian principles in emerging, complex political

- and security environments.
- These deliberations should include organizations with deep experience in conflict areas as well as representatives of the communities most directly impacted by violent conflict.

b. Provision of medical services by contractors

- The Mosul experience has, for better or worse, outlined a potential new "market" for contracted medical-support services either by the military themselves or through the UN as was done in Mosul.
- Given the special security and technical requirements of medical personnel working in combat environments, it is reasonable to consider the development of organizations specifically established to operate in such settings; they could draw upon

medical personnel with combat training and experience, such as former military medical providers, and function explicitly in coordination with a combatant force.

- While this approach raises its own set of ethical and pragmatic concerns, it would respond to the dual requirement of ensuring the technical capabilities of frontline medical personnel and distinguishing such personnel from other humanitarian actors.
- An objective analysis of this business model, as well as the corresponding humanitarian ethos, cost effectiveness, and adaptability, needs to occur.

Recommendation #4: **All partners in the future, whether humanitarian or not, need training in international humanitarian law and humanitarian principles (IHL).**

- Only organizations and professionals with conflict experience, international humanitarian law training, and a strong understanding of the high-risk environments in which they will be working should be deployed.
- This training, and a greater awareness of IHL in general, is critical for humanitarian organizations to avoid being utilized inappropriately or "*instrumentalized*" by governments, militaries, and other combatant groups.
- Training courses could be developed with academic institutions, donors, NGOs, and other humanitarian-focused groups to prepare such groups for such missions.

Recommendation #5: **Planners must carefully consider whether the conditions that (1) necessitated this response and (2) kept humanitarians safe are applicable in other contexts.**

- Certain elements may not be easily replicated in other settings, particularly if coalition assets are not available.
- Key elements that planners should critically assess in future conflicts are detailed below:

Considerations for Future Conflicts	
Preclusion of Neutrality	The inability of humanitarians to reach civilians—and create a "humanitarian space"—in areas controlled by extremist groups may be relevant to many conflicts, although ISIL is a particularly extreme example.
Limited local capacity	Many militaries and civilian counterparts in low- and middle-income countries may lack medical capabilities for adequate trauma care.
Military protection and intelligence assets	Coalition partners had assets in theatre to track humanitarian movements, and at least one coalition special ops unit was working in close proximity to an NGO TSP. This capability and security assurance likely will not exist in many conflict settings.
Civilian-Military Coordination	Tight communication between military, UN OCHA CivMil, and forward-positioned humanitarian components was likely essential in avoiding strikes on humanitarian facilities and personnel.
Risk Tolerance of Leadership	UN and WHO leaders in Iraq had a high-risk tolerance, which allowed a response that saved lives, but could have jeopardized other efforts if medical team members had been killed.
Donor Interest	The U.S. and EU provided significant funding reflecting political and foreign policy interests in Iraq. Such support may be absent in other conflicts.

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Annex: Humanitarian Principles Overview

This annex provides a very brief overview of key aspects of International Humanitarian Law (IHL) and humanitarian principles that underpin the findings and discussion in this summary.

Care for the Sick and Wounded: IHL

- The Geneva Conventions and Additional Protocols affirm that all wounded and sick individuals must receive timely medical care to whatever extent possible.
- The Conventions and Additional Protocols are clear about who bears primary responsibility for providing this care. As the ICRC summarizes, "The wounded and sick must be collected and cared for by the party to the conflict which has them in its power."[7] This principle is clearly spelled out in Common Article 3 of the Geneva Conventions and Additional Protocols.
- Article 3 also allows—but does not compel—impartial humanitarian bodies such as the ICRC to offer medical services to parties of the conflict.
- The Geneva Conventions and Additional Protocols additionally state that the wounded and sick should be treated based upon medical need alone; no distinction should be made based upon the identity of the injured.[8]

The Role of Humanitarian Principles

- Humanitarian principles derive from IHL and provide guidance for humanitarians in conflict settings, theoretically protecting humanitarians and the populations they serve.
- In many conflicts, military and political pressures can expose humanitarians to substantial risk if they are viewed as supporting one party over another. Historically, acting in accordance with the principles has been seen as essential for access, safety, and population acceptance.
- The four main humanitarian principles are outlined in the table below:

Core Humanitarian Principles

PRINCIPLE	DESCRIPTION
Humanity	Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.
Neutrality	Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.
Impartiality	Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religion, class or political opinions.
Independence	Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.

Source: UN OCHA[9]

- In practice, some pragmatic balancing of these principles is often required, e.g. using armed convoys to reach civilians in insecure locations.

Principles Under Attack

- Humanitarians are facing repeated attacks. In 2016, WHO recorded 207 attacks on health facilities, resulting in 418 deaths.[10]
- In Syria alone, more than 200 attacks were recorded in 2016.
- Attacks have forced many actors to scale back operations or withdraw altogether.
- In Oct 2017, ICRC drastically scaled back in Afghanistan after seven workers were killed.

[7] ICRC. War and International Humanitarian Law. https://www.icrc.org/eng/war-and-law/overview-war-and-law.htm
[8] Footer, K and Rubenstein, L. A Human Rights Approach to Health Care in Conflict. Intl. Review of the Red Cross, 2013, 95(899): 1-21.
[9] OCHA. What are Humanitarian Principles? https://docs.unocha.org/sites/dms/.../OOM-humanitarianprinciples_eng_June12.pdf
[10] WHO. Health Attacks Dashboard: 2016 http://www.who.int/emergencies/attacks-on-health-care/attacks_dashboard_2016_updated-June2017.pdf?ua=1