

“No patients, no problems”

Exposure to risk of medical personnel working in MSF projects in Yemen’s governorate of Amran

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Abstracts

The paper explores the security incidents affecting medical humanitarian work in Yemen and the ways MSF as well as other health practitioners try to securitize their staff, facilities, patients. This reflection was born out of the high number of security incidents affecting MSF in the past three years, as much as a shared analysis by Yemeni health professionals that doctors in the country are particularly exposed to insecurity and suffer a chronic lack of respect from the patients. ‘What is an incident?’, ‘How to assess a threat?’, ‘How to react to it?’ are some of the questions looked at in the paper. Most specifically, the author studies the link that exists between insecurity and the quality of the medical act, taking into consideration elements such as the patient – doctor relationship as well as the adequacy of the medical activity with the social demand. The study argues that it is both an impossible and irrelevant task of trying to reach all-encompassing conclusions when looking at security of humanitarian work, or a so-called ‘health care in danger’.

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“I was a guard at the entering of the OT. I saw to it that the tribes did not enter or that the families did not attack the doctors.”

A former Yemeni guard working with the ICRC in North Yemen in 1968,

“The sheikhs were driven by motives of greed, not justice, he averred. They had lost all credibility.”

Steven C. Caton, *Yemen chronicle. An anthropology of war and mediation*, 2005.

I – Research project and methodology

The result of an investigation launched in March 2013, this paper aims to provide a better understanding of the various forms of insecurity affecting Médecins Sans Frontières (MSF) projects in Yemen and the ways the organisation and other health professionals adapt their work practices in response.

The high number of security incidents affecting MSF's projects (some 40 documented between April 2010 and July 2013 by MSF's French section alone) prompted these observations and reflections on the ‘*protection of the medical mission*’ in Yemen. A brief analysis of these incidents reveals their extreme diversity, both in terms of origin and manifestation, including, but not limited to: intrusions into medical facilities by security forces and armed men coming for patients and family, tribal revenge against patients or doctors within hospital confines, and the use of threatening behaviour to force doctors to treat family members.

This violence does not occur in a vacuum. Yemen is a country racked with violence: “Religious sectarianism, rebellion in the North of the country, a secessionist movement in the South, and a resurgence of al Qaeda are all growing exponentially against a background of economic collapse, insufficient state capacity and corruption. [...] However, while these challenges are acute, they should be analysed as part of a wider socio political context, where tribal law and patrimonial networks play a major role. [...] Tribalism is at the core of disputes and of their resolutions and remains crucial to understanding the wider eddies of mechanism in Yemen, and in turn, the limits faced by any external actor that tries to interact in this environment.”^[1] A report published in 2010 by YAVA/Small Arms survey states:

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“Violence accompanying land and water disputes results in the deaths of some 4000 people each year, probably more than the secessionist violence in the South, the armed rebellion in the North, and Yemeni Al-Qaeda terrorism combined.”[\[2\]](#)

Focusing on MSF-Operational Centre Paris projects, our research is based on a review of pertinent social science literature focusing on Yemen, as well as numerous interviews and field observations. Several incidents were selected from a field security database, for reasons of the diversity of their alleged causes as well as their manifestations, and this sample led to the compiling of the four short stories featured in the Appendix to this article. We expected that the causes of the insecurity, and the ways MSF and individuals react to it, would be best explored through specific examples. The literature review aimed at gaining an understanding of the social structures in the locations where the organisation works, the principle characteristics of the violence encountered by MSF, and the status of doctors within the country’s society. A total of 55 interviews were conducted with researchers, MSF staff, Yemeni doctors, civil society activists and local leaders in health facilities, MSF offices and interviewees’ homes. The field visit – Sanaa, Amran (North Yemen) and Aden (South Yemen) governorates – took place between July 8 and July 27, 2013 and an English/Arabic interpreter assisted throughout. Most interviews were recorded and then transcribed.

This paper focuses on the Amran project. It attempts to understand both the origins and manifestations of violence against health workers, as well as how they, as individuals, and MSF, as an important employer in the region, respond and adapt. The definition of ‘violence’ or ‘phenomena of violence’ in this study are what the protagonists themselves perceive as violence. I have therefore in no way contested this perception, even if most of the events reported did not involve direct physical harm or material damage.

II – “I would not want to be a doctor here.”[\[3\]](#) MSF in Amran

MSF’s project in Amran governorate (a two-hour drive north of Sanaa) was opened in February 2010 to assist Internally Displaced Persons (IDPs) fleeing the war in the Saada governorate. Given the inadequate secondary healthcare system in the area, the project evolved to address medical and surgical emergencies after the return of most IDPs in 2011. MSF’s current focus is to facilitate access to medical care for people living in outlying areas who are economically and

socially marginalised. The governorate is marked by feuds within and between tribes,^[4] and between tribes and the central government. Sectarian and civil tensions that arose in 2013 as Houthi fighters sought to expand their control over northern parts of the Amran region sometimes further exacerbate the endemic violence.

MSF supports Ministry of Health (MoH) Al Salam hospital in the city of Khamer and the health centre in the town of Huth. Since September 2011, our work has included outreach activities. MSF is in charge of all the hospital's departments, with the exception of the outpatient department (OPD). It runs the emergency room (ER), maternity ward, in-patient department (IPD) and emergency surgery unit. Three Russian and Uzbek doctors working under MoH contract run the OPD and elective surgery activities. After emergency treatment, patients are referred when necessary to secondary healthcare structures in Amran and Sanaa; MSF provides or pays for transport but does not cover medical expenses. The hospital is fairly busy considering the relatively low number of doctors and nurses. Every month, the ER sees between 1,500 to 2,500 patients, the IPD admits around 200 patients, and the paediatric unit over 100. There are also 150 to 250 deliveries and 100 to 250 surgical procedures.

Under the responsibility of an MoH manager, the hospital has multiple employee categories that have the potential to cause friction: staff employed under MoH contract, staff under MoH contract but with MSF incentives, MoH-subsidised volunteers, doctors from the former Soviet Union, and, finally, international and Yemeni staff under MSF contract. But, excluding support and office workers, there are only 10 Yemeni MSF employees – translators, two doctors, a surgeon and nurses working in a supervisory capacity – and most are not from Khamer or Amran. Several used to work with MSF in Saada governorate, while others were recruited from other parts of Yemen. Most hospital employees (around 130 people) are under MoH contract. The MoH-employed hospital manager and his deputy are among those benefitting from MSF incentives. The only member of the international medical team continually present in a unit is the maternity ward midwife. The other two international staff members – the Medical Activity Manager and a non-permanent position intended for a first mission doctor – only have limited hands-on contact with patients. In summary, the number of incidents recorded and the prevalence of threatening behaviour by patients and their relatives have led many among the health personnel to express their uneasiness in working for the project.

“It is horrible for us.”^[5] Threatening behaviour towards doctors is constant

MSF has consistently recorded security incidents since the start of the project. Approximately 23 were documented during the period April 17, 2010 to June 15, 2013 alone. These occurred in areas with few restrictions placed on the movement of MSF employees. Khamer is known as a peaceful city where international personnel can generally live without fear. They are allowed to walk around the town at all times except at night, but this MSF curfew is imposed because of the stray dogs in the area. Within Khamer, the MSF team spends a couple of nights a week in the rather less peaceful town of Huth, where additional restrictions are imposed because of, among other factors, the added risk of stray bullets.

It is important to note that there have been no incidents involving the death or kidnapping of MSF employees. The most serious incident was a revenge killing that resulted in a patient's death at the hospital in 2011. However, in both Khamer and Huth, verbal threats are a daily occurrence and being threatened at gunpoint is commonplace, as are shootings in the hospital compound and carjackings. Such incidents have led Yemeni doctors to leave the projects. There have also been shootings in the hospitals themselves, some targeting individuals who could easily have been killed.

Medical staff members are exposed to high levels of threatening behaviour. One explained:

“Everywhere in Yemen, people fight doctors, but it is not like here, not daily. It's becoming daily, from morning to evening, it is horrible for us.”[\[6\]](#)

It appears to some extent that it is not so much the actual incidents themselves that are the cause of stress but more the doctors' perceptions of insecurity. This is particularly true in the case of the Amran project because, as we will see, the lack of secure working conditions does impact patient management. However, personnel are not equally exposed to threats and risk as the Yemeni medical staff. International employees are not usually affected – with the exception of the midwife – while Yemeni medical staff members in the ER are more exposed than IPD staff, echoing the situation in other parts of Yemen.

A rapid review of the press and interviews with doctors and non-doctors in Sanaa, Amran and Aden reveal the extent of the difficulties with the doctor-patient relationship, which appears prevalent whatever the level of political tension in the country. An article published in *National Yemen* in July 2012 was entitled: ‘Yemeni doctors cause more harm than good.’ Based on patients' personal accounts, it comments:

“Many patients have died or been left disabled due to gross negligence and medical errors that frequently pass unpunished in Yemen. Thousands of Yemenis fall victim to medical errors at the hands of doctors, whose unearned and undeserved titles and certificates are the only things which connect them with the practice of medicine. (...) Many Yemenis have expressed their dissatisfaction with Yemeni doctors, who they say are not good at their jobs and have transformed their sacred profession into a way to earn money. Many have gone so far as to liken doctors to “parasites” which live on human blood.”[\[7\]](#)

A study on the prevalence and associated factors of burnout and stress among doctors in Sanaa concluded that “the prevalence of high degree of burnout as well as emotional exhaustion in Yemeni doctors was higher than those reported internationally.”[\[8\]](#) The article goes further:

“The shortage of necessary diagnosis and treatment equipment in hospitals renders doctors unable to do their job properly and exposes them to blame from patients and their relatives or even violence.”[\[9\]](#)

In many ways, Yemeni health workers’ exposure to occupational violence echoes the conclusions of various studies conducted in other Middle East countries.[\[10\]](#) But, the extent to which Yemeni health workers speak of their security concerns is extreme. An MoH-employed doctor, not originally from Khamer but who describes himself as well-integrated and less exposed to risk than some of his colleagues, said: “there are 20% chances [he] get[s] killed in the hospital, 80% chances [he] stay[s] safe.” Though largely inaccurate, his perception is helpful in illustrating a state of fear shared by other Yemeni doctors.

When questioned about their security, doctors in Sanaa and elsewhere in Yemen often referred to case “0”. This case relates to an anaesthetist who was murdered at the Science and Technology hospital in Sanaa by the relative of a patient who died during surgery. As much urban legend as actual fact, accounts of the episode vary considerably. Some people say the murder was in 2010, others 2006 or 2008, and most say that the perpetrator killed the wrong doctor.[\[11\]](#) Regardless of what actually happened, fear among doctors is tangible and is heightened by a series of incidents that have taken place mainly in public hospitals all over the country.

“If we took these threats seriously, we would close everyday.” [\[12\]](#) Documenting and assessing insecurity

At the project level for those whose responsibility it is to document incidents, there is no consensus on what exactly constitutes an incident. In a setting where violence and verbal threats are so prevalent, documenting insecurity represents a real challenge. Should the team only record events they consider to directly impact operations, such as shootings in the hospital, carjackings, etc., or should they try to document all incidents that occur, including minor threats, just to maintain a comprehensive record? The decision on whether to report an incident or not may be rooted in the fact that the person responsible for drafting the report wants to portray the reality in a specific light, whether that be to alert, alarm, or the opposite, reassure headquarters and the coordination team in Sanaa. It is furthermore important to add that the decision to document or not document an incident not only varies with a person's motivations, but also by a person's appreciation and perception of risk. This tends to be a function of the amount of time spent in the field. Additionally, assessing the degree of severity of a threat or incident appears to be equally challenging, particularly for international employees.

The fine line between “a show of violence and the real thing”^[13] is best described by Yemeni employees who feel they are able to “differentiate between real threats and those which are not.”^[14] They base their assessment on the person's profile: where is he from? Is his behaviour often threatening, etc.? The type and severity of incidents occurring in and around Khamer are also perceived very differently. For instance, a *qita* – a tribal roadblock during which tribesmen hold a car or people hostage to negotiate their release in exchange for a variety of demands – is often seen as non-violent, quite normal and commonplace. By contrast, a slap in the face is viewed as the most dangerous. In fact, even a threat at gunpoint is viewed as less serious than a slap in the face; an aggrieved party will consider even a light slap particularly humiliating and deserving of some kind of reaction and severe punishment.

Explaining Insecurity

Discussions with medical staff and MSF employees in general resulted in several theories for the chronic insecurity affecting their work.

“Their mind is like stone.”^[15] Much is attributed to social and cultural aspects

Echoing a common sentiment in Yemen, social and cultural differences are said to be at the root of most threats and incidents. Doctors tend to blame lack of education and an “archaic tribal

system – living off the lack of strict regulation of government – allowing any member of a tribe [to do] whatever he wants.”^[16] MSF staff originally from Saada (also a tribal area), where MSF worked from 2007 to 2011, stressed that “although the doctors are the same, the people are different.”^[17] Doctors and non-doctors alike do not consider all populations as equally deserving of care. People from villages outside Khamer – precisely the primary target population of the project – are said to “make problems”, to be “very aggressive”, mainly because “most of them are not educated”. Health workers, including doctors specifically, attribute the “mentality of tribal people, like Al Osaimat” as being responsible for many of the problems encountered. An international doctor in charge of medical activities at the hospital explained:

“When patients come from communities with whom we’ve had problems, it escalates, and then, the therapeutic decision has no longer any medical and scientific rationality. It is quite common to hear comments such as: ‘this one is from this family’, ‘he is the son of that one’, ‘he comes from this region’, etc. It has a significant impact.”^[18]

“Here, patients are impatient.”^[19] A challenging patient-doctor relationship

While health workers acknowledge the importance of building a good relationship with patients, most of the causes of recorded incidents arise from a poor patient-doctor relationship. This stems partly, but not exclusively, from the social and cultural factors mentioned earlier. A number of reports and interviews point to either the rudeness of health staff towards patients or to the lack of clarity in some aspects of the project’s strategy and medical policy. Several incidents occurred when doctors supposedly denied a patient access to care, behaved badly, or were accused of medical malpractice.

As we saw above, some interviewees said, “doctors are not very friendly, from the beginning, they are hostile.”^[20] MSF’s situation in Khamer reflects that of Yemen in general, where doctors enjoy only limited *symbolic capital*^[21]. Yet, building a positive patient-doctor relationship cannot be achieved purely based upon better communication and appropriate behaviour. Other elements are critical and must be taken into account. These include a lack of clarity in the project’s objectives, selectively choosing patients leading to unequal treatment, and the physical layout of the hospital.

Changes in the political context of Yemen over the past two years have led MSF employees increasingly to question the real purpose of the project: a war ‘justified’ its commencement and

the shortage of medical services in the region ‘justifies’ keeping it going. A MSF-employed doctor expressed his doubts about the organisation’s strategy:

“Patients don’t understand that MSF works in the emergency room only. This is not an emergency place; there are no poor people. I think MSF stays because it is near Saada, in case the war resumes. But how can we discuss that with patients?”

While there are several accessible public and private medical facilities less than a couple of hours drive away, MSF services continue to be restricted mostly to emergency services,^[22] meaning that they do not cover healthcare costs incurred in referral facilities. (The decision to no longer cover these costs was taken after previous security incidents saw patients, dissatisfied with care they received in referral facilities, claiming compensation from MSF). The gap between the services MSF delivers and the expectations of patients leads to much tension. Some patients do not understand why they should or need to be referred. Others require top-of-the-range drugs, transfusions and infusions that do not always comply with MSF medical protocols.

The ER, surgery unit and maternity ward are the sources of most conflicts. Lack of clarity in ER admission criteria (and referral, as we will see below) is often mentioned as a complicating factor and a perception of unequal treatment. The link here with doctors’ routine profiling of patients according to where they come from and family and tribal affiliation needs to be emphasised. This leads to the following important question: what is the point of offering medical services that are not accessible to certain patients?

As mentioned earlier, the ER sees around half of all patients arriving in triage – between 1,500 and 2,500 a month – while the other half are referred to the OPD. Triage is performed in a small room adjacent to the ER and the triage nurse is responsible for referring non-emergency patients to the MoH-run OPD. OPD services, which are not provided free of charge, are run by three doctors from the former Soviet Union whose methods for practicing medicine is apparently very different from those used by MSF employees. Many patients refuse to be referred to the OPD and exert pressure on medical staff to be treated by MSF. As one interviewee explained, “the more vocal the patients are, the better chances they get to be seen by the doctor.” Many people view this medically unjustified discrimination as the source of most of the problems encountered by the hospital’s employees, and this is without taking into account, as a Yemeni MSF doctor explained, “our watchmen, our staff, nurses, nurses assistants, they are taking their friends, their relatives to treat them. Sometimes we, the doctors refuse, and sometimes, we don’t.” Generally, the

arbitrariness in the intake and treatment of patients may contribute to mistrust and the deterioration of patient-doctor relationships.

The layout of the hospital is also a problem, as this contributes to tension, specifically in and around the maternity ward. There are numerous reports of violent and threatening behaviour towards midwives – including the international staff midwife, the most exposed to risk among the international staff members.

“Part of the problem is that there is no waiting room in the maternity – the building is too small. So the families generally wait outside while the women are in labor. Sometimes it can last for hours, during which the family are left in the dark, uninformed about how things are going if the midwife in charge does not take the time to come out and talk to the families.”[\[23\]](#)

However, although tensions run high in the maternity ward, there are few actual acts of reported violence and the midwives believe that their exposure to risk is slight. This is reflective of a tendency found in other studies on workplace violence against physicians in the Middle East, where it is said that “*the prevalent cultural norms [reject] disrespect to female.*”[\[24\]](#)

In addition to the causes of tension described above, the surgical unit has other issues to contend with. One stems from the fact that Yemeni general surgeons perform orthopaedic surgery but are not always perceived as being qualified to do what is required of them. Another is the lack of rigour in patient follow-up and medical files. As an international doctor observed, “every file of patients with whom we’ve had serious problems is practically empty.”[\[25\]](#) Not only is this detrimental to the quality of patient follow-up, it also weakens MSF’s capacity to defend itself in the event of an accusation of malpractice.

“He did all this because he wanted a job.”[\[26\]](#) *Issues over jobs*

Our investigation identified job-related issues potentially leading to tension between MSF and the surrounding community over the competition for and dispute over jobs among the area’s families and tribes.

The hospital staff has more than doubled since MSF’s arrival in 2010. Throughout this period, MSF’s incentive payments have resulted in a significant increase in the average wage. In a region with few employment opportunities, disputes over access to jobs at the hospitals contribute

substantially to an increase in the number of verbal confrontations. While the MoH employs most hospital staff, recruitment is supposed to be handled jointly by MSF and the MoH using a process that includes interviews and tests conducted by both organisations. However, hospital management has the final say on MoH contractors and often favours its own clique. As one of the representatives of the families objecting to this concentration of power explained, “Three families control the hospital, and this is not right.” This places the hospital at the center of disputes. Additionally, some of these disputes are mediated by the hospital director, who is simultaneously accountable to individuals, families and political groups in the region as he needs their support to retain his power.

The “bargaining chip.”[27] Cashing in on MSF and the hospital

Other causes of insecurity affecting the hospital and MSF stem from people seeking means to obtain leverage and subsequently pressure the government or other groups to achieve certain political ends or access to new resources. This phenomenon is analysed by Nadwa Al Dawsari:

“In Marib for example, the tribes started kidnapping people and setting up roadblocks only when they found out that tribes from Sanaa and Amran, areas with a weaker tribal structure, can negotiate winning deals with the government if they kidnap foreigners and block roads. Over time, this becomes a method the tribes use to pressure the government to deliver promised services and fulfil the people’s needs.”[28]

The ambulance hijackings mentioned as part of the case examples highlight this process. According to the ambulance driver in Khamer, there were over 30 such incidents between 2006 and 2013, and most involved demands for money from sheikhs or the government, “because the hospital is like the government”. [29] Patients are usually unaffected because, as one interviewee put it, “these people don’t respect the government, but they respect the patient.” [30] In most cases, the hospital is deprived of its ambulance for up to several weeks at a time before the vehicle is returned after tribal mediation.

Responding and adapting to insecurity

As previously demonstrated, dealing with patients and their families is not without risk. Doctors working in Yemen have therefore attempted to adapt their work practices to help mitigate the incidence of conflict. An MSF international surgeon in Sanaa advised his replacement in 2011:

“Do not tell the patient’s family that you are not going to resuscitate a patient [if] the patient has no hope of recovery. Take the patient up to ICU and allow him to die there. There can be severe consequences if the family thinks that you did not do everything in your power to save their family member.”[\[31\]](#)

Several methods of adapting have thus become commonplace in health facilities. In Yemen, for instance, accounts of doctors trying to avoid treating sensitive medical cases by referring patients to other facilities for security reasons abound. Discussing mechanisms for referring patients adopted by hospital staff confronted with insecurity issues in Khamer specifically serve to illustrate the serious impact that the medical staff’s perception of insecurity has on care management.

“Some patients are dangerous, we know it.”[\[32\]](#) Referring patients for security reasons

Patients are referred to health facilities in Sanaa and Amran for three reasons. The first, and most obvious, is a referral on medical grounds for cases that cannot be treated at the hospital because of the lack of appropriate expertise. Patients, however, are not always referred on medical grounds. The second reason indeed comprises of a referral in situations calling for exceptional measures, particularly in the case of hostile patients who may put the hospital in immediate danger (conflicts within the hospital confines, revenge killings, etc.). This policy has led to the emergence of a third category of referral, which affects patients with *profiles* perceived as dangerous. There is very little disagreement among Yemeni and international staff and the hospital management on, as an MSF-employed doctor put it, “if there is a security risk, it is better to refer.”[\[33\]](#) As we saw earlier, risk assessment is not an exact science and the fates of patients are left to a subjective evaluation. Health workers acknowledge that, in some cases, the decision is at the discretion of the night supervisor, a non-medical staff member who “knows everything and everybody.”[\[34\]](#) In such situations, the Project Coordinator and Medical Activity Manager may not even be informed, meaning that there is little room left for medical rationale.

While this practice is a reaction to insecurity, it is itself a factor of insecurity, as it is only natural that patients react to such discriminatory practices.

“Here, it is too much.” [\[35\]](#) Staff comments on MSF security management

In the past year, no less than three MSF-employed Yemeni doctors have left the Amran project after an incident or as a result of receiving threats. A surgeon left after being verbally threatened by the relative of a patient he had operated on; a doctor in Huth left after being forced at gunpoint to treat a patient; and, the third doctor left after he was slapped. Two switched to the project in Aden. Yet another two MSF-employed doctors openly admitted to seeking alternative employment or to facing pressure from their family to leave, and both gave the same reasoning – a general malaise at work stemming from insecurity. MSF itself and the way it has adapted its activities or reacted to incidents are seen as direct sources of insecurity.

In an attempt to resolve disputes with patients and/or their relatives who exert pressure on MSF after what they see as medical malpractice on the part of the organisation, a Head of Mission recently decided to either partly reimburse medical expenses incurred by patients in Sanaa or abroad, or to fast-track their referral to the MSF surgical programme in Amman. Mainly Yemeni doctors, but also international staff, often mentioned this as having potentially serious consequences for the future of the project. And, in a region where most people possess arms, MSF's decision to remove its armed guards from the hospital gate was viewed by many as bordering on foolhardiness. But it is the debates that take place after an incident on whether or not to suspend activities that appear to elicit the most animated responses from the staff.

MSF widely portrays the suspension of its medical activities – an action that some claim needlessly deprives a population of the very care it is supposed to benefit from – as a direct consequence of individual security incidents. The rationale for this strategy is for each suspension to be understood as a necessary response to security issues rather than an action made after long discussion and consensus.

Suspensions are therefore often portrayed as key elements in advocacy efforts aimed at protecting the medical mission. Examination of how such decisions are taken is also of particular interest in the context of the Amran project as it has seen several suspensions, varying from one day to five months. But there are also suspensions of hospital activities within the wider context of Yemen that demonstrate the widespread use of this protocol. Just before our investigation, MoH hospital management in Amran decided to suspend activities after a doctor was slapped. Early in 2013, ER doctors and nurses at Aden's Al Jomhori MoH hospital stopped working for two weeks after a series of incidents.

Lasting five months, the most notable project suspension occurred in February 2011 after a patient died in the operating theatre and international employees were threatened. A few days after the team returned, a patient was killed in the ER and MSF suspended activities for just a couple of days. And more recently, in February 2013, the project was suspended for two weeks after a patient's relative slapped a doctor. Activities were suspended yet again for a few days in July after an MSF car was hijacked and the teams received death threats via text message.

There have been other incidents after which activities were not interrupted by suspensions. Examining why some incidents resulted in suspensions while others did not demonstrates the complexity of making this decision. In most cases, the decision on whether to suspend or not is preceded by discussions – deontological and socio-political – and occasionally heated debate between field, Coordination, “Desk Team” and, at times, hospital management. The lack of a clear-cut policy on suspension is not without its own problems, even if establishing one is widely acknowledged to be an impossible task. Justifying or extending a suspension of activities is often therefore multi-layered. This is made even more complicated by the fact that interviewees, both arguing for and against suspension, frequently tended to view suspending hospital activities as a ‘collective punishment’. The decision-makers therefore need to consider the gravity or perceived gravity of an incident, the type and relevance of the services provided, and the reaction of the community, population, and local leaders.

Apart from when a hospital is damaged or destroyed, suspending an activity is thus rarely only a direct consequence of the trauma caused by the incident itself. It is often a decision taken by MSF. As such, it is important to emphasize again the apparent randomness of these decisions: some incidents lead to a suspension, while others do not, and it is left solely to the judgment of the team, the Coordination or the Desk to make the decision.

A nurse observed, “Doctors are left alone sometimes. MSF should stand between them and the patients and their relatives.” Given the lack of protection doctors can expect from the various local institutions (the state, tribal systems, etc.), staff demand that MSF play a vital role in maintaining safety. While nobody expects MSF to provide full protection, in the eyes of its employees, it is the responsibility of the organisation to acknowledge the riskiness of their situation and demonstrate a real determination to institute better working conditions. Here we see the opportunity to establish a contract between MSF and its employees, whose terms would, in turn, require respect for and adherence to professional standards and medical ethics.

“Promises are not followed by acts.” [\[36\]](#) *Dealing with the sheikhs*

After an incident, the Project Coordinator usually meets with sheikhs from the Khamer region reputed for their alleged power and influence. The field team is thus excluded from these discussions and simply awaits the outcome. In most cases, after a period varying from one day to six months, mediation is successfully concluded, compensation is paid – money, cows or guns – and an *apology ceremony* takes place. As a way of obtaining closure for the February 2011 incident, in which a family threaten to kill the international team, no less than 45 sheikhs gathered in Khamer to sign an agreement reaffirming the need to guarantee the hospital’s security and define rules (such as a ‘no weapon’ policy) and sanctions (slaughtering of cows, payment of a fine, imprisoning offenders). In this as in most cases, however, MSF was not privy to the exact details of the transaction, or to whether the issue was definitively or only temporarily closed.

This reactive approach to insecurity also merits critical analysis. While appearing to mirror local practices and, potentially helping to maintain a low prevalence of life-threatening incidents, these sheikh-led negotiations that end in an apology ceremony have not led to a significant reduction in exposure to risk. A Yemeni doctor formerly employed by MSF commented:

“The only thing we’ve been doing lately is incident, apology ceremony, incident, apology ceremony, incident, etc. We have to think about it in a different way it.”

MSF project team’s somewhat culturally-driven approach may be partly responsible. Identifying with an environment, getting accustomed to and accepted by it, also requires the adoption its societal values and practices – in this case, tolerating violence and focusing on crisis resolution rather than on prevention.

The international team seem to believe that the sheikhs are all-powerful, assuming the appropriate one with the greatest influence can be identified. “He can do whatever he wants with his people,” commented an international staff member. However, some academics question this assertion. In her paper on tribal governance, Nadwa Al Dawsari explains:

“Traditional rules that stem violence, such as the prohibition against harming disarmed men and the protection of public facilities as conflict-free areas, are also crumbling. These days, tribes are more reluctant to protect public places because they fear they might be dragged into a conflict in the process of protecting those safe havens. This happened in Marib, when a few men from Aal

Yaslem subtribe invaded the al-Joobah hospital, seeking to kill a man there. The hospital is protected by the Aal Mesli subtribe as a safe haven, and in the process of protecting the safe haven, Aal Mesli entered into a conflict with Aal Yaslem. That conflict led to the killing of at least two people from each tribe.”[\[37\]](#)

Yemeni staff acknowledge the limits of the sheikhs’ ability to resolve disputes. They cite two problems: firstly, that the sheikhs only exert power over their own ‘people’, and secondly, that the sheikhs are principally based in Sanaa. These facts explain, at least partially, their lack of influence over certain conflicts, making the sheikhs’ role in conflict resolution rather unreliable. There is no cast-iron process where a superior authority is in a position to impose its rule on a conflict between two parties.[\[38\]](#) Who the sheikhs are, how they interact with each other and the rest of society, and other such questions, are all subjects of an immense academic corpus. While we will not attempt to summarise it here, we must call attention to the complexity of the concept.[\[39\]](#) Sheikhs are local leaders and social figures with “various degrees of power, influence, and wealth and are usually not “chiefs” who have authority over their “followers.”[\[40\]](#) These so-called figures of authority, who “gain their legitimacy and accreditation through their ability to resolve conflicts and safeguard the tribe’s interests without resorting to coercion,”[\[41\]](#) only exist *in association* with other forms of power. As such, even though tribal relations often take precedence, sheikhs interact and coexist with state authorities [\[42\]](#) as much as they are influenced by local and national politics.

Laurent Bonnefoy suggests that violence is indeed endemic, saying “violence is always present, even if it is contained. There is coexistence of regulation and acceptance of violence.” [\[43\]](#) Building on this view, it would appear that controlling violence in North Yemen is based first and foremost on ‘mitigation’ and ‘regulation’ rather than on ‘prevention’ in an effort to ensure that conflicts do not get blown out of proportion and stay contained within acceptable limits. While acknowledging the indisputable role of tribal authorities, the teams need to be encouraged to better understand the limitations of the sheikhs’ power and to work towards instituting a stronger political base with a more diverse panel of stakeholders. This shift in focus is particularly crucial if the organisation is looking to not only contain incidents but also to improve the working environment.

III – Conclusion

MSF's project in Amran and its activities in Huth and Khamer confront several major constraints: health facilities (and their staff) are jointly managed by the organisation and Ministry of Health representatives; the facilities host a range of activities that MSF does not fully control; and, the project is not only a provider of health services, but also serves most likely as the largest employer in a region with very few official employment opportunities. The rapport with the social demand is marked by ambiguity: services are contested, at times for what they deliver, and at others, for what they do not. In any event, an emergency care provider in an area with alternative healthcare solutions is vulnerable to threats of violence. Furthermore, the project has to rely on doctors with a relatively low social status and whose medical and social skills are mistrusted. The combination of these factors results in a high rate of exposure to tension and risk for health workers. In order to protect themselves, or to simply improve their working environment, they have developed – as elsewhere in Yemen – coping mechanisms, which can in turn become aggravating factors of the very situation they want to contain.

The type and level of threat that medical workers are subjected to are unacceptable. However, the expectations of MSF are framed, for the most part, within demands that are very comparable to what MSF and health professional strive for in hospitals all over the world:[\[44\]](#) a quality relationship between patients and health personnel. At Al Salam hospital, MSF operates in a setting where this expectation may be in conflict with the reality on the ground; the surrounding region features a high degree of violence that generally appears to be socially accepted, and intimidation is used as an integral part of social regulation. No measure – apart from MSF withdrawing from its project – could ever fully protect its employees. However, the research shows that humanitarian organisations do not have to see themselves as passive victims, nor do they have to view Yemeni patients as inherently dangerous. In the case of Khamer, improving medical practices and instituting a stronger political base as well as a more robust security management plan would all contribute to a safer and more effective work environment.

IV. Appendix

Short Stories: case studies of security incidents in Amran in 2012-2013.

Incident number 1

Huth Health Centre, September 2012.

One night, two armed men tried to enter the Health Centre in Huth. One was wounded and his friend was probably under the influence of khat^[45] and drugs. When the watchman asked them to leave their guns and traditional Yemeni daggers (*jambia*) outside, one of the intruders shot at him but he deflected the gun with his arm and the bullet missed. Then, the uninjured intruder told the midwife and nurse on duty he wanted to see the doctor. Asleep in the staff quarters behind the Health Centre building, the doctor did not come immediately and the intruder became even more agitated. When the doctor eventually turned up, the gunman threatened to kill him if his friend died or even suffered any pain. The doctor had to treat the patient with a Kalashnikov held to his head. Once his condition was stabilised, the patient was referred to Khamer. His friend stayed on the premises for a while, threatening to kill all three staff if his friend died, and finally left.

As a result, the MSF doctor and the MoH employees suspended their activities. The MoH employees resumed a couple of months later but MSF only six months after the incident. And while the MSF doctor left with a financial package and psychological support, the organisation appears to have shown scant regard for either the nurse or the midwife during the period of suspension.

Incident number 2

Khamer hospital, February 2013

A family transporting a patient suffering from severe burns crashed their car through the main gate of the hospital. The patient was treated immediately in the ER. Deeming she was not taken care of quickly enough, her family became very upset and threatened the doctor and nurses on duty. Once her condition was stabilized, the patient was transferred to the IPD. While the doctor on duty was calling a surgeon to treat a head wound, the patient's brother slapped him. The doctor hid for a while in the kitchen, and then left the hospital. The relatives calmed down and agreed to leave.

The decision was taken to suspend activities. The MSF team – international staff and personnel not from the region – was sent to Sanaa. The suspension lasted for two weeks while the problem was sorted out.

Incident number 3

Amran to Khamer road, June 2013

Two MSF international staff travelling by car were held up at gunpoint between Amran and Khamer and forcibly detained for a couple of hours by the relatives of a patient who had undergone surgery in the Khamer hospital in September 2012.

An MSF surgeon had operated on the patient and, dissatisfied with his post-operative care, his family sent him to Egypt in March 2013. The patient's leg did not recover full mobility, for which the family accused MSF of mismanagement. They sent a number of messages to MSF via staff saying that their patience was running out. They warned that something would happen if nothing were done in response to their complaint. The Project Coordinator and Medical Activity Manager visited the family, who gave them two weeks to come up with a solution; the incidence, however, occurred just one week later. During the couple of hours the team were detained, the family explained they wanted the MSF car in compensation for the cost of treatment in Egypt. After some discussion, the MSF team was able to keep their car and they drove off unharmed. An investigation into the case by the Head of Mission and Medical Activity Manager revealed that there had indeed been failings in the management of the case, and the patient was fast-tracked to MSF's surgical project in Amman.

Incident number 4

Khamer, May-July 2013

Given the developments in this incident over a three-month period, this example is the most involved of the four.

In May 2013, two members of a family heretofore referred to as "Family A" brought an old man to the hospital who, in critical condition, had previously been referred for further tests and treatment to Sanaa by an ER doctor. A doctor saw him and advised him to return to Sanaa. There are reports that the doctor grabbed a prescription from the patient and threw it away, which the doctor denies. Family A left and returned a few minutes later armed with Kalashnikovs. The watchmen would not let them in and one confronted them, breaking a tooth in the struggle. Family A entered the compound, and one member said he was going to kill the ER doctor. He subsequently fired shots in the air. Some people took him outside the hospital gate, which was locked behind them, and they hung around for a while. Activities were suspended for half a day. The ER doctor was not pleased by the day's events, as he viewed MSF's reaction to the incident as inadequate.

The injured watchman happened to be a member of a prominent Khamer family, heretofore referred to as “Family I”, who owns the land the hospital was built on. The dispute between Family A and MSF progressed into a feud between Family A and Family I, with the hospital director also becoming involved. After several sheikhs interceded,^[46] Family A apologised to Family I and presented them with a Kalashnikov in recompense. It appeared as if the dispute between the two families was finally settled, but this was not the case. For days the hospital served as the scene of a standoff between the two families, who successively surrounded the hospital with armed men. It was claimed that the watchmen from Family I behaved particularly badly as Family I attacked Family A with the gun they had been given to them. MSF and the hospital director agreed to suspend the two watchmen from work for a few weeks after Family A repeatedly explained that their quarrel was with Family I, not with MSF. Supposedly busy with more important matters – doubtless more murderous tribal conflicts – the sheikhs lost interest and did nothing.

Three weeks after the first incident, members of Family A hijacked the hospital ambulance from in front of the hospital gate. The driver was removed at gunpoint and shots were fired in the air. The driver was unharmed and the ambulance was returned ten days later. This may have been an attempt to pressure the sheikhs into resolving the issues the family had with the hospital management and Family I. It was then believed that the incident was indeed closed as for several weeks as there was no news of the family feud.

In various meetings with MSF, a head of Family A explained that their quarrel was mostly with the hospital management, not with MSF. He particularly contested what he saw as three specific Khamer families having a monopoly on jobs at the hospital. Two days later, in the early evening, a MSF car was seized at gunpoint in the market by the members of Family A who had hijacked the ambulance. The international team decided to suspend activities without consulting the Coordination. Perhaps the carjackers were seeking jobs at the hospitals and money to pay for their father’s burial, but this has not been confirmed. Two weeks later, after the intervention of several sheikhs and the local authorities, the car was returned. At the same time, the team received death threats by text message, and the decision was taken to send the entire team to Sanaa. They were allowed to return a few days later.

The dispute between Families I and A and the hospital management was seemingly settled after the intervention of local sheikhs and an *apology ceremony*.

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- [1] T. Fabbri. *Health care in danger, the case of MSF in Yemen*, MSc Political Economy of Violence, Conflict and Development, SOAS, London: September 2012.
- [2] YAVA, *Under pressure: social violence over land and water in Yemen*, Issue Brief No.2, October 2010.
- [3] Project coordinator, Amran.
- [4] The concepts of ‘tribe’, ‘sub-tribe’ and ‘family’ in the context of Yemen are the subject of academic debate. As P. Dresch puts it in “Tribalisme et démocratie au Yémen” (*Arabian Humanities*, 2, 1994), tribes are ‘evidently, not [...] very solid group’. Although central in the understanding of social and political dynamics, it is a malleable concept: ‘a very important flexibility in term of conflicts and alliances potentially exists.’
- [5] Yemeni doctor, MSF, Khamer.
- [6] Yemeni doctor, MSF, Khamer.
- [7] “Yemeni doctors can cause more harm than good”, *National Yemen*, 18 July 2012.
- [8] Al Dubai S. and K.G. Rampal, “Prevalence and associated factors of burnout among doctors in Yemen”, *Journal of occupational health* 52 (2010); 58-65.
- [9] Ibidem.
- [10] See M. Alameddine et al., “Occupational violence at Lebanese Emergency Departments: Prevalence, Characteristics and Associated Factors”, *Journal of Occupational health* 53 (2011); 455-464 ; Abbas M.A.F. et al, “Epidemiology of workplace violence against nursing staff in Ismailia governorate, Egypt”, in *Journal of the Egyptian Public Health Association* 85 (1 – 2) (2010) ; 29 – 43.
- [11] “With no specific law to protect them, health care workers are at risk”, *Yemen Times*, September. 10, 2013.
- [12] Yemeni staff, MSF, Amran.
- [13] Steven C. Caton, *Yemen chronicle. An anthropology of war and mediation*, New York: Hill and Wang, 2005, 69.
- [14] National staff, Amran.
- [15] Yemeni doctor, MSF, Sanaa.
- [16] Hospital director, Sanaa. Interview conducted in English; quotation in original English..
- [17] Yemeni staff, MSF, Amran.
- [18] International doctor, Khamer.
- [19] Ministry of Health, Khamer.
- [20] International doctor.

- [21] Bourdieu, P. 1984. *Distinction: A social critique of the judgement of taste*, Cambridge, MA: Harvard University Press.
- [22] The maternity, paediatric and adult medical departments admit non-emergency patients; patients with leishmaniasis and rickets are also provided with non-emergency treatment.
- [23] International midwife, Amran.
- [24] M. Kitaneh and M. Hamdan, “*Workplace violence against physicians and nurses in Palestinian public hospitals: a cross-sectional study*”, *BMC Health Services Research* 12 (2012) ; 469. doi:10.1186/1472-6963-12-469.
- [25] Interview, International doctor, MSF, Khamer.
- [26] Yemeni staff, MoH, Khamer.
- [27] See Adam Baron, “Hostage for a day. How I became a bargaining chip in Yemen’s tribal maze”, in *Foreign Policy*, 19 February 2013.
- [28] N. Al Dawsari, *Tribal governance and stability in Yemen*, Carnegie Endowment for International Peace, 2012.
- [29] Yemeni staff, MoH, Khamer.
- [30] Yemeni staff, MoH, Khamer.
- [31] “Hand over surgeon Sanaa”, 27 June 2011, MSF internal report.
- [32] Ministry of Health, Khamer.
- [33] Yemeni doctor, MSF, Khamer.
- [34] Yemeni doctor, MSF, Khamer.
- [35] Yemeni doctor, MSF, Khamer.
- [36] Yemeni doctor, former MSF
- [37] N. Al Dawsari, op. cit.
- [38] P. Dresch, op.cit.
- [39] Issues such as the relevance of ecology for understanding Yemeni tribes are the subject of academic debates. See Shelagh Weir, *A tribal order: Politics and Law in the Mountains of Yemen*, London: British museum press, 2007 and its review by Paul Dresch, in The British-Yemeni Society, <http://www.al-bab.com/bys/books/weir07.htm>.
- [40] N. Al Dawsari, op.cit.
- [41] N. Al Dawsari, op.cit.
- [42] Baudoin Dupret, “Legal Traditions and State-Centered Law: Drawing from Tribal and Customary Law Cases of Yemen and Egypt”, in D. Chatty (ed.), *Nomadic Societies in the Middle East and North Africa: Entering the 21st Century*, Boston: Brill, 2005.
- [43] Interview, June 2013.

[44] See for instance Rapport Annuel 2012, Observatoire national des violences en milieu de santé, Ministère des Affaires sociales et de santé, French Ministry of Health and Social Affairs.

[45] Khat, or qat, is a tree with leaves that are chewed as a stimulant. It is widely used in Yemen.

[46] See infra for a brief analysis of the role of the sheikhs in regulating conflicts.