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Medical Humanitarianism: Anthropologists Speak Out on Policy and Practice

In recent years, anthropologists have become increasingly present in medical humanitarian situations as scholars, consultants, and humanitarian practitioners and have acquired insight into medical humanitarian policy and practice. In 2012, we implemented a poll on anthropology, health, and humanitarian practice in which 75 anthropologists discussed their experiences in medical humanitarianism. Our goal was to move beyond the existing anarchy of individual voices in anthropological writing and gain an aggregate view of the perspective of anthropologists working in medical humanitarian contexts. Responses lead to six inductively derived thematic priorities. The findings illustrate how anthropologists perceive medical humanitarian practice; which aspects of medical humanitarianism should be seen as priorities for anthropological research; and how anthropologists use ethnography in humanitarian contexts. [medicine, emergency, global health, humanitarianism, anthropology]

Introduction

In recent years, medical humanitarianism—or the provision of biomedical, public health, and epidemiological services in conditions of emergency or crisis—has grown to occupy an important area of medical anthropological investigation. Whether living among populations in crisis or experiencing humanitarian aid through their immersion in contexts of violence or disaster, anthropologists have been quick to recognize that medical humanitarianism constitutes an important domain for ethnographic inquiry as well as an important lens for considering development assistance, global health governance, and the "two regimes of global health"—global health security and humanitarian biomedicine (Lakoff 2010). From the intimacy of its health encounters, to the depth and complexity of its operations, humanitarian

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activities carry an immediacy of impact and a moral authority that is apparent to those who encounter it. Further, the history of medical humanitarianism has paralleled the history of the emergence of the modern world system and it has often served as the site for major innovations in medicine and in international law and humanitarian norms.

However, due to their number, breadth, and depth, ethnographic studies on medical humanitarianism can be difficult to navigate, and few such works have been published. To gain a broad perspective on how anthropologists engage with the domain of medical humanitarian practice, we sought to develop a poll that investigated: (1) how anthropologists at the intersection of health and humanitarianism perceive medical humanitarian practice; (2) which aspects of medical humanitarianism should be seen as priorities for anthropological research; and (3) how anthropologists understand the purpose of ethnography in humanitarian contexts. With this in mind, in the summer of 2012, we assembled an international advisory board of prominent academics and practitioners to design an Internet-based qualitative survey. Our initial intention was to implement a Delphi poll–based consensus building process of anthropologists' priorities for medical humanitarian research, but after a trial period, we modified the survey process to capture respondents' views in a single polling step. Our aim was to elicit direct feedback from anthropologists with expertise in medical humanitarian practice so that survey responses could be translated into meaningful insights for humanitarian policy and practice.

Prominent anthropologists (Bornstein 2012; Bornstein and Redfield 2012; Fassin 2011; Fassin and Pandolfi 2010; Feldman and Ticktin 2010; Harrell-Bond 1986; Polman 2010; Redfield 2013; Ticktin 2011) have now joined practitioners (Crombe 2009; Magone et al. 2011; Orbinski 2009) and critical observers (Calhoun 2010; Pattison 2010; Weiss 2012) in challenging the ethical and institutional foundations of humanitarian action. Other anthropologists have entered into the field of medical humanitarian practice as collaborators and interlocutors who work to reform and improve the cultural grounding of humanitarian assistance (Abramowitz and Panter-Brick In press; Ager et al. 2013; Allen and Schomerus 2008; Eggerman and Panter-Brick 2010; Kohrt et al. 2008; Miller et al. 2008; Omidian and Panter-Brick In press; Tol et al. 2011; Tol et al. 2012). Others are drawn into the field of medical humanitarianism inadvertently, as humanitarian crises have found their way into their long-standing involvement in ethnographic field sites (Coulter 2009; Daniel and Knudsen 1995; DelVecchio Good et al. 2008; Farmer 2012; Hammond 2004; Hoffman 2011; James 2010). Some have deployed critiques of humanitarian practice drawn from anthropological critiques of development (Atlanti-Duault and Dozon 2011; Duffield 2001; Olivier de Sardan 2011), while others emphasized engagement and collaboration.

Despite our many efforts at engagement, anthropologists remain unsure about the visibility, relevance, and value of their work to humanitarian practitioners. We have little sense of how the double hermeneutic—"how the 'findings' of the social sciences ... enter constitutively into the world they describe" (Giddens and Cassell 1993:150) and to what extent our own critiques resonate with the public and private concerns of the humanitarian establishment. Our ethnographically informed critiques have often been sharp. They have focused on humanitarian program assumptions and implementation processes, on the dynamics of humanitarian

governance, and on humanitarian ethics and politics. Anthropologists who engage in humanitarian practice are often concerned with the impact of such assistance. They dedicate their careers to building successful programs, leading policy initiatives that ameliorate structural and cultural gaps, and searching for solutions to persistent issues that are often the subject of critique among their peers in academia.

Methods

The Advisory Board on Anthropology, Health, and Humanitarian Practice included 13 international members from Europe, Asia, the United States, and Africa, all experts in both anthropology and medical humanitarian practice. The survey was designed to aggregate diverse views on anthropology, health, and humanitarian practice through the sequenced provision of 26 open-ended questions divided into five sections: (1) respondents' research in humanitarian settings; (2) areas of health expertise; (3) critical issues in humanitarian practice, including ethics, governance, practice (implementation), and resource management; (4) recommendations for improving the study and practice of medical humanitarian aid; and (5) demographic data. The authors submitted drafts for comment and revision to the advisory board in September 2012, and released the survey online, through SurveyGizmo™, from October to December 2012 (see online supplement).

Respondents were identified through a process of literature review in Google Scholar™, using keyword searches for the following terms: (anthropology *or* ethnography), (health *or* medicine *or* sickness), and (humanitarianism *or* crisis *or* emergency). This initial search yielded 136 possible respondents with graduate degrees in anthropology and professional experience in humanitarian contexts and 21 non-anthropologists with expertise in ethnography, health, and humanitarianism. We used snowball sampling through the advisory board, through initial respondents, and through calls for participation at the 2012 meeting of the American Anthropological Association to increase the sample to a total of 181 possible respondents, who were recruited via email. From those recruited, 75 (41%) participated in the online survey. Solicited participants were sent email reminders three times to complete the study prior to the survey's closure.

We tabulated the issues identified as priorities by anthropologists from a predesigned checklist (see Table 1 and Table 2), and then undertook thematic analyses of all open-ended responses, and hand-coded all open-ended comments into thematic categories. Through an inductive analysis of poll respondents' lengthy comments, the authors identified six themes that framed the feedback provided through the poll. These included: (1) the Red Cross Principles (The Seven Fundamental Principles); (2) Humanitarian Policy and Coordination; (3) Access and Adequacy of Humanitarian Health Care; (4) Humanitarian Financing and Temporality; (5) Humanitarian to Development Transitions (H2D); and (6) Sustainability. Such themes are introduced in Figure 1a and function as a guiding framework for our presentation of findings and analysis. We also tabulated simple frequency data pertaining to sample characteristics and responses to poll items (to indicate relative importance of issues generating discussion). We limited our quantitative analyses since our sample is small, our response rate modest, and comments were unevenly distributed.

Table 1. Areas of Key Concern for Anthropologists: Humanitarian Ethics and Governance* ($N = 75$)

Area of Concern	Percent (%)
Ethics	
Local knowledge/experience	43.5
Research ethics in humanitarian settings	40.6
Medicalization of suffering/distress	39.1
Ethics of assistance	29
Human rights	29
International/expatriate staff ethics	27.5
Abuse/violations of local populations	21.7
Involvement of local populations in humanitarian activities	20.3
Morality	18.8
Neutrality	13
Governance	
Politics of aid/assistance	40
Empowerment/community participation	35.4
Humanitarian/state cooperation	27.7
Role of foreign experts	21.5
Humanitarian/NGO financing	16.9
Humanitarian independence/autonomy	15.4
Negotiating access	13.9
Liaisons with militaries	12.3
Policy	12.3
Self-governance	10.8

*Totals reflect multiple responses.

Results

Respondent Characteristics

The 75 survey participants showed an impressive breadth and depth of experience working on health issues in humanitarian contexts (see Tables 3 and 4). Eighty-eight percent had academic affiliations, and 42% percent held non-academic affiliations, with the majority having received professional training in public health or public policy (36%) or anthropology (50%) (see Table 3). Twenty percent reported both academic and humanitarian affiliations, 40% reported just academic affiliations, while 8% reported just humanitarian affiliations (for this question, there were data missing from 32% of respondents due to the multi-stage process of poll implementation). All together, they reported having worked in 68 different countries for a mean of 9.7 years (range, 3 months to 35 years), with affiliations to 56 institutions including international NGOs, trans-governmental organizations, and governmental foreign aid institutions. These include: HealthNet TPO, Médecins Sans Frontières, the International Organization for Migration (IOM), Save the Children, World Health Organization (WHO), World Food Program (WFP), UNAIDS, UNICEF, International Committee of the Red Cross (ICRC), IRC, The Carter Center, Oxfam, USAID, and the U.S. Centers for Disease Control. Within these organizations, they

Table 2. Areas of Key Concern for Anthropologists: Humanitarian Practice and Resource Management* ($N = 75$)

Area of Concern	Percent (%)
Practice (Implementation)	
Cultural competency	29.5
Humanitarian to "Development" transitions	24.6
Integration of Research and Practice	23
Monitoring/evaluation	23
Integration with non-humanitarian institutions	21.3
Peace building/reconciliation	18
Humanitarian duration/departure	16.4
Communication	13.1
Logistics	8.2
Material/supply/equipment	8.2
Media representations	6.6
Resource Management	
Access to care	23.3
Foreign experts	18.6
Workforce training	13.3
Health systems integration	10.0
Workforce compensation	6.7
Material supply/equipment	5
Time frame for care	5
Scope of care	3.3
Logistics	1.7

*Totals reflect multiple responses.

listed 28 different roles, including: board member, activist, consultant, director, researcher, manager, technical advisor, translator, writer, and volunteer.

Thematic Categories

We used grounded theory to code all responses into 14 initial categories, which we further refined into the six themes highlighted in this article (see Figure 1a). We detail below respondents' comments regarding each theme in turn, emphasizing respondents' words and phrasings.

Theme 1: The Red Cross Principles (The Seven Fundamental Principles)

According to the International Committee of the Red Cross, the fundamental principles include: humanity, impartiality, neutrality, independence, voluntary service, unity, and universality. *The Seven Fundamental Principles* (IFRC 1965) have been enshrined in international humanitarian laws like The Geneva Conventions and The Hague Conventions in that "the laws of war" offer a space for the neutral and impartial provision of humanitarian aid in contexts of violence (Moorehead and ICRC 1998). In addition to providing a legal space of protection for the

Table 3. Sample Characteristics (75 respondents)

Age		Academic Affiliations	
20–35	26%	Graduate Student/Post-doc/RA	22%
36–50	44%	Assistant Professor/Adjunct Professor/Affiliated Scholar	18%
51+	30%	Associate Professor	26%
		Full Professor/Retired/Emeritus	16%
Gender		Other	6%
Male	44%	Missing data	12%
Female	54%		
Professional Training	**%**	**Non-Academic Affiliation**	
Social/Cultural Anthropology	24	NGO/Non-profit Employee	10%
Biocultural/Biological Anthropology	12	State/Federal/Multi-governmental Employee	6%
Applied Anthropology	14	Independent Researcher/Consultant	18%
Medicine/Psychiatry	16	In Applied Fields/Activism/Advocacy	8%
Psychology/Social Work/Counseling	10	Missing data	58%
Public Health or Public Policy	36		
Nursing/Health Sciences	10		
Political Science/Other Social Science	18		

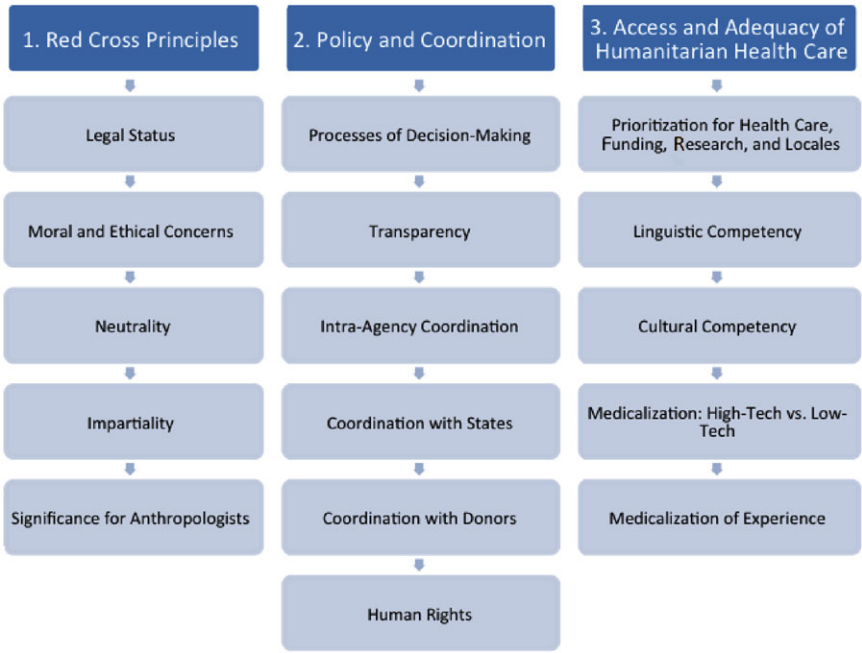

Figure 1a. Issues Raised by Anthropologists, Coded into Six Themes

operation of humanitarian organizations, the Red Cross Principles also offer a rationale for the recognition of special populations like refugees, children, and prisoners of war, all of whom require extra-legal protections. These principles also offer some degree of assurance of a freedom of movement, a freedom to negotiate with local governments and local military leaders, and. above all, access.

Although the concepts of neutrality, impartiality, independence, and volunteerism offer a structuring framework for the practical operations of NGOs like MSF, MDM, World Vision, and others, *The Seven Fundamental Principles*, and their recent successor, *The Sphere Project* (2011), are inconsistently integrated into humanitarian operations around the world. Many humanitarian institutions do not see the principles as consistent with their specific political or religious aims, while others find them to be a barrier to effective operation. Some NGOs that provide aid to populations in the Palestinian Territories, for example, share local agendas regarding settlement and re-territorialization (Magone et al. 2011); others articulate an equally controversial stance of political neutrality (Feldman 2007). Some NGOs like Norwegian Church Aid and The Moslem Brotherhood are sectarian and emphasize traditional objects of charity; still others, like World Vision and Islamic Relief, pursue mainstream secular modes of humanitarian service provision (Benthall and Bellion-Jourdan 2003).

Despite these variances, due to *The Seven Fundamental Principles*' legal and customary significance, and *The Sphere Standards*' growing discursive authority,

Figure 1b. Issues Raised by Anthropologists, Coded into Six Themes

anthropologists regard them as guiding ethical frameworks for analyzing humanitarian conduct (Terry 2002) as well as objects of analysis and critique (see, e.g., Batniji et al. 2006). In our survey, our respondents highlighted particular areas of moral and ethical concern. Respondents focused on the abuse or violation of local "beneficiary" populations and emphasized that humanitarian aid *and* humanitarian research could cause unintended harm among vulnerable, war-affected populations, and children. They also felt that humanitarians showed political naïveté by failing to recognize the "real" drivers of humanitarian crises: political oppression, class oppression, and economic and social injustice.

Anthropologists highlighted issues of impartiality and neutrality in matters of access to food, shelter, and health care. Referring to Didier Fassin, several respondents were quick to note that humanitarian action "is a politics of life" (Fassin 2007) that justifies itself through moral claims, but involves political actions and has political effects. Consequently, our respondents tended to feel that despite its legal, bureaucratic, and moral authority, the Red Cross Principle of neutrality (IFRC 1965) was not feasible.

Regarding the Red Cross Principle of impartiality, anthropologists observed that the nature of contemporary humanitarian financing gives rise to partnerships with militaries, for-profit institutions, host-country governments, and donor governments and other non-neutral actors. Such parties have the ability to shape the humanitarian agenda. One respondent, who worked in Sri Lanka, noted: "A strong military

Table 4. Respondents' Areas of Health Expertise and Experience in Humanitarian Contexts

Areas of Health-related Research	%	Experience in Humanitarian Contexts	%
Access to Care	70	Pre-crisis Emergency	28
Global Health	56	War/Conflict	56
Violence	52	Post-conflict	44
Psychosocial Well-being	52	Natural Disaster	28
Mental Health	50	Environmental Disaster	6
Women's Health	44	Refugees/Forced Migration	62
Infectious Disease	42	Famine/Drought	20
Health Systems	40	Epidemic Disease	40
Health Equity	40	Extreme Poverty/Deprivation	58
Maternal/Infant Health	34		
Child Health	36		
Health Governance	30		
Displacement	28		
Health Education	26		
Medical Workforce	24		
Food and Nutrition	22		
Chronic Disease	20		
Pharmaceuticals	18		
Health Financing	16		
Prevention	16		

*Totals reflect multiple responses.
**List excludes $n<15\%$.

strategy can 'steamroll' humanitarian objections"; another disagreed, and called for greater coordination with security forces in contexts of disaster management to mitigate the impact of security forces' behaviors and activities (for medical humanitarianism within military institutions, see Gordon 2014).

Theme 2: Humanitarian Policy and Coordination

In our poll, anthropologists often noticed that the claims of global humanitarianism exceeded their legal and material abilities to provide care and protection to populations in need. As a result, respondents used our questions regarding humanitarian policy to voice frustrations about the lack of transparency surrounding the methods and terms of aid allocation. One said:

> Based on my experiences in Kenya, it seems we have failed to examine the ways in which local governments use aid or encourage aid agencies to provide relief as a means for pacifying communities. The seemingly random way in which communities are chosen for food and medical aid deserves some scrutiny. In drought circumstances the process is fairly clear but in circumstances where internally displaced people congregate, there is no predictable formula for which community will receive assistance versus who will not.

Some of the problems in humanitarian policy stemmed from coordination with other humanitarian bodies. Respondents commented: "Communication channels are often unclear," which creates "confusion" over "the relationships between state, local, and NGO organizations (and how they are forged)."

Respondents criticized the integration of human rights into humanitarian practice. Some felt that too many NGOs neglected human rights; others worried that NGOs had co-opted human rights into humanitarian discourse. One observed: "Human rights have been so ignored by so many systems in Afghanistan and Pakistan. The heavy use of militarized aid, and a blatant disregard for human rights, is evident. It has never been a priority, though it should be." Another called for "the establishment of human rights, institutions for arbitration, and norm-establishment." However, one respondent did comment that humanitarian aid could function subversively to conceal the introduction of rights-based language while advocating for basic needs.

Several argued in favor of the principle of "health as a human right," and called for a better integration of global health policy and humanitarian policy. They called on NGOs to consider "the right to health understood in a broad sense, and not only as the right to health care." One argued that, "policies to study and address great health disparities, SES determinants, surveillance mechanisms, and [the] regulatory issues for global medical technologies and treatments [that] directly involve humanitarian actors and funds" were needed.

Humanitarian policies, especially the "top-down" processes of post-conflict peace building and reconciliation, generated a range of critiques. Some anthropologists contended that the Truth and Reconciliation Commission (TRC) "model . . . fails in more contexts than it succeeds," and turns peace-building activities like TRCs and war crimes tribunals into "cultural performances" that "remain largely symbolic," that fail to attend to the material needs of post-war populations, or that they have become a commoditized industry. One noted:

> In the post-conflict interventions I have seen oriented toward "peace-building," . . . too often the focus is on "interethnic hatred" when it needs to be on the foundations of human security, without which scapegoating and ethnic tensions are easily exacerbated. People complain most often of needing jobs, health care, childcare, and other basic needs met, and only turn to blaming other groups or to long historical grievances when they can see no other explanation for these needs going unmet. Seminars on civil communication, trauma, peace-building are good when the base needs have been met.

Overall, anthropologists held radical views with regard to humanitarian policy. Many called for "the democratization of policy making processes, and equality as the main goal for health policies," and demanded a pathway, "to create meaningful, flexible, sustainable, effective, and ethical policies." Several argued that the humanitarian world needed to "move from a conception of top down humanitarian assistance to a conception of human rights and the rights to politics," while "conceptualizing human rights as a social, and not only juridical phenomenon."

Theme 3: The Access and Adequacy of Humanitarian Health Care

Our survey respondents were concerned with how humanitarian intervention intersected with health care provision, and it was a top priority in their responses. Issues of access and adequacy often overlapped directly with anthropologists' fieldwork projects and led them to critique "the politics of prioritization" and humanitarian motives. Their comments highlight the rift between humanitarian heath policy and direct health care service provision and the bioexpectations (Redfield 2012a) in humanitarian crises.

Respondents were concerned that research, funding, and labor are funneled into targeted areas like HIV/AIDS and post-traumatic stress disorder but neglect non-target issues like chronic diseases, water-borne diseases, and malnutrition. One respondent critiqued: "Some diseases receive disproportionate funding and attention due to transnational interest, while others, at least as pressing, continue to lack basic epidemiology and treatment access." On matters of violence, too, "war and disaster receive attention for research and funding, whereas chronic forms of violence . . . receive inadequate attention." Humanitarian institutions needed to develop broad policies that offered "equal access to health care services," while providing "access to food, shelter, health care, and hope."

The occlusion of local populations' evaluations' of their own health needs from humanitarian health care prioritization processes was attributed to failures in cultural and linguistic competency. Discussing health care providers who could not speak local languages, one person wrote: "There seems to be far, far less emphasis on [linguistic competency] in the treatment of infectious disease, despite the complexity of interactions around treatment, especially for chronic conditions that must be regularly monitored." Bureaucratic language was described as confusing and misleading, and respondents demanded that beneficiaries be given clearer definitions of categories like "need" and "victim," with an explanation of the consequences of gaining those designations.

Cultural competency, in general, was hailed as an important failing among medical humanitarian institutions, but our respondents reflected conflict within the field of anthropology over the appropriate integration of cultural competency into humanitarian and development practice. The following quote is emblematic of advocates of cultural competency: "Humanitarian organizations often have difficulty understanding what local populations perceive to be critical health and social issues, and addressing them in a meaningful and timely way. They place too little value on local populations' own estimations of risk and vulnerability." Some felt that expatriates poorly understood the meaning of "aid, protection, need, deservedness, duration, reliability, and self-help"; others criticized emergency medical NGOs for failing to include or recognize legitimated non-Western forms of healing. As a result, respondents saw cultural *incompetency* in NGOs' health care performance, which often culminated in the decision to fund duplicative services and then shut down soon after, having effectively disrupted parallel local health care markets. All of these issues have resulted in the transformation of cultural competency into a bit of a spectacle when it is introduced in the humanitarian scene. Respondents made the following comments:

> Culture (always someone else's) is either an obstacle, a mystery, or a grab bag.
> Cultural competency turns into pithy, reductionist stereotypes of locally affected populations.
>
> Cultural competency, in itself, can become an ethnocentric enterprise.
>
> The critique that humanitarian practices are not sufficiently culturally competent was not true in the organizations where I worked, where most of the actors doing humanitarian work were locals. However, I think what needs to be looked at is the impact of humanitarianism on those actors (how it affects their local competence).

One critical aspect of cultural competency addressed by anthropologists was the dubious treatment of local staffs by medical humanitarian organizations. They noted that local staffs were overlooked as a resource for managing the cultural and linguistic challenges of humanitarian health care (see Carruth 2014). One said: "Rather than using their own employee base as a crucial source of knowledge about local contexts, norms, morals, values, and needs, local staff are turned into tactical service delivery personnel fulfilling agendas set elsewhere." Another anthropologist acknowledged the tensions that emerged for local staffs through humanitarian health care labor—like the pressure to emigrate, unequal compensation, and risky living and working conditions.

Medicalization, including the use of medical technologies and the application of biomedical epistemologies, was a contentious issue between respondents. Some demanded the expansion of health technologies (including medications) to all populations, but others worried that technology dependence was unsustainable. Some prioritized "low-tech interventions that save lives," arguing, "there is a well-known emphasis on techno–scientific approaches ... yet alternatives to pharmaceuticalization, care projects, clean water initiatives, infrastructural improvement, etc. often have less public appeal than drugs and cutting-edge science." One example offered was WHO's Mental Health Gap Action Programme (mhGAP), which is seeking to expand basic mental health services worldwide through local clinical care contexts. Our respondent worried that MhGAP might universalize psychiatric treatment through medication, rather than "developing, adapting, and promoting context-specific, non-medication treatments."

Respondents were concerned that through the process of "medicalization," lived experience was being subordinated to biomedicine, clinical labeling, and diagnoses. They worried about "an overemphasis on Western biomedical approaches," and expressed concerns that the provision of humanitarian health services showed a "lack of understanding about social and political factors linked to suffering and distress," and failed to ask: "When and how does a particular form of suffering become a humanitarian problem, and to what extent does the medical response to it determine its meaning?"

Along with calls to "avoiding unnecessary medicalization," many contended that "the imposition of Western categorical diagnoses [might] preclude observation of, or replace, local ways of understanding." They believed that "biomedicine selects out and deals with social issues as diseases," and had the power to "undermine

existing systems of coping" and "overwhelm already limited resources." One person commented: "Most of the humanitarian workers think that giving pills is effective in managing the suffering, and hence, unnecessarily medicalize the social suffering which I think [can easily be solved] with some social intervention."

Theme 4: Humanitarian Financing and Temporality

Poll respondents were concerned with the financing and temporality of humanitarian health services. Anthropologists called for research about "the political ecology of aid, how it is disbursed, and how it is received" and for research that could illustrate the power relations involved in program funding, including relations of dependence and obligation with donor institutions.

However, anthropologists differed in their perceptions of the scale of aid financing available. Some regarded humanitarian financing as available but as somehow inaccessible, as this quote shows: "Where to get it! There's little money for routine care, compared to special initiatives" (e.g., The Gates Foundation). The fact that funding was tied to short-term projects with measurable outcomes, all driven by donor interests and values, engendered the following comment: "We need open and honest discussions that bring together donors, implementing organizations, analysts/critics, and most importantly, 'target communities' (however these can be represented), to develop and share better practices for ensuring that there is as much accountability to community priorities built in to funding as there is to donor interests."

Some were frustrated with their inability to penetrate the humanitarian donor world and to gain insight into financing mechanisms. They recognized that financing shaped many operational decisions, but lamented that they lacked "insider status" and were thus unable to overcome the "opacity/secretiveness of donor decisions/processes." They called for greater transparency. One said:

> I think that the pathways between donors and service delivery need to be made clearer in humanitarian contexts. It should be easier for both NGO workers and international observers to track funding from their source to the outcome so as to be able to evaluate the impact of funding source upon outcome (transparency).

Others called for radical efforts to "decommodify health care" and permit "logistical transparency" while reining in corruption and nepotism. The lack of funding, the inconsistency of funding, "ruptures of service and care," and the seeming randomness of funding and time-frame decisions proved frustrating. It is perhaps remarkable that, given a mean of 10 years of experience in humanitarian contexts, experienced anthropologists had still not found a way to penetrate the financing barrier.

The timing and duration of medical humanitarian aid was another important area of concern for anthropologists. There was concern that it took a long time to establish locally aware, culturally sensitive interventions, which was the preferred alternative to rapid "global one-size-fits-all models of intervention." The timing of humanitarian aid can be connected to a temporality of emergency that is defined by

humanitarian perceptions of time, urgency, and significance (Calhoun 2010). One person, reflecting on population health care needs, wrote: "The scope of care goes beyond the timelines and missions of emergency medical aid."

Anthropologists addressed the end of humanitarian funding and humanitarian withdrawal and expressed concern over the lack of monitoring surrounding medical humanitarian departure. One wrote: "I am concerned about the bolus of funds that goes into countries and regions, but little of this seems focused or extendable to system building." Others described how "'handover' exposed systematic and structural issues," and noted that "departure is the most sensitive part of the practice, since it is so rarely a happy 'success.' At the same time, when the present is defined as an emergency, then prolonging it is no better."

Theme 5: Humanitarian to Development (H2D) Transitions

One anthropologist, reflecting on matters of health sector transitions, commented: "In the 1990s, there was too much overlap and lack of fit. Now, perhaps, there is too good a fit, and thus dependencies are created which cannot be sustained in the long term." Our respondents were concerned about how and when "humanitarian to development" transitions—or the transition from humanitarian aid, to development aid, to state-level self-sufficiency in the health care sector—should take place. One noted: "How humanitarian organizations make decisions to stay or leave or to involve themselves in various ways to support or challenge state institutions, is a murky area that is often being negotiated behind closed doors." To explain decisions made in the course of planning a transition from humanitarian assistance to development assistance, one said: "Since in certain settings the transition ... takes years, at times it becomes complicated to decide if a situation still requires humanitarian assistance. In such situations, the decision is normally taken at the political level."

In health sector transitions, medical humanitarian institutions were confronted with a limited range of choices: (1) stay in country and transition to long-term, remote support for local health care initiatives to sustain a paradigm of emergency; (2) remain *in situ* in a "development" capacity; or (3) engineer a complete withdrawal. Poll respondents wanted NGOs to expand their focus from specific diseases or immediate needs to the development of local institutions, sanitation, and infrastructure systems, and to strengthen public health care sectors *prior* to transitions. They called on NGOs to "find ways to work with state governments to facilitate integration with local/state governance, and facilitate self-sufficiency" while avoiding any agreements that would "reinforce coercive structures," facilitate "corruption," or "support the erosion of the welfare state model."

Respondents were alternately hopeful and cynical about the prospect of transitions from humanitarian to development. They identified factors that might complicate transition (e.g., "forcing development in contexts where humanitarian problems are rampant"). Humanitarian departure raised concerns (e.g., the manner in which the exit is conducted, the timing of exits, the transition to local health care services during exit, and the ongoing presence of violence, poverty, or conflict at the time of exit). Another explained:

> Humanitarian withdrawal is a major problem, and highlights the degree to which humanitarian work is often as much or more about soothing Western consciences as it is about long-term benefit to communities. The short-term project-based nature of many interventions means that many communities benefit a great deal from a burst of goods and services that disappear as suddenly as they arrive—leaving a vacuum of services and often great unrest and grievance than existed previously. The "temporality of aid" must be addressed in a way that makes it clearer to donors and humanitarian actors that long-term responsibility is what is required—and that if they want quick fixes that make them look good, they are in fundamental breach of humanitarian ethics.

Theme 6: Sustainability

Respondents agreed on several key features of health care sustainability (e.g., "integrating services into the government health system, and adapting care to more local scales, is considered critical for a sustainable system"). They concurred that: "Programs should focus on sustainable financial processes for the long-term development of mental health services" and that "funding should be ensured after temporary injections of aid money." Humanitarian institutions should play an important role in "building local capacities," "expanding high-quality trainings," and should "use sustainable practices that are grounded in local as well as global realities" and focus on "translation" into local scales.

To build sustainable health systems through transitions, interventions must include "systems thinking" and system building, although funding for promoting sustainability was often unstable. Two specific proposals to facilitate sustainability were offered: (1) provide governments with support to collect and analyze their own data; and (2) support institutionalized consideration of the health impacts resulting from climate change and population migration (see also Asad and Kay 2014; Mbacke 2013; Pfeiffer 2008).

Beyond these critiques of development interventions, respondents contended that considerations of sustainability requires a nuanced account of how humanitarian institutions regulate themselves, coordinate with each other, and coordinate with national governments. Our respondents noted examples where "intersectoral approaches to humanitarian assistance fostered local participation and community ownership" and insisted that humanitarian institutions avoid "destroying self-governance capacities." Others noted how erratic coordination between NGOs, donors, and local and national governments could be, emphasizing the strength of the host country in the relationship:

> On the one hand, the state needs the infrastructure the agencies provide; on the other hand, they are quick to kick out INGOs when their moral, ethical, or other standard don't align with the position of the state. Red Cross in Indonesia, Doctors without Borders in Papua. Both were kicked out with deleterious impact on local conditions. Not to say these INGOs necessarily do great work, but the moral conflicts resulted in negative outcomes at the local level.

In contrast to this example, some worried about states' financial dependence on NGOs. These relations of dependency appeared to be supported at the level of legislation and policy:

> In situations in which weak states "farm out" activities to others (common around conflict/post-conflict situations), NGOs are sometimes asked to write policy for governments, that seems to (uncannily) support the missions of the NGO doing the writing. And, of course—as others have pointed out, when NGOs act semi-autonomously, this creates a space in which government can remain non-accountable to the people.

On the other hand, some demanded increased external inputs into building sustainable infrastructures while advocating against "mission creep" or "blurring of the boundary between NGO and state (and their respective responsibilities)." Citing Giorgio Agamben (1998, 2005), some warned against "the state of exception becoming the rule—e.g., easing the state's withdrawal from responsibility." Indeed, some felt that humanitarians saw themselves as saviors, and that "there is an assumption on the part of humanitarian organizations that whatever the state does is going to be inept and inefficient (and probably corrupt)." Particularly in "failed states," "NGOs have essentially replaced the state and undertaken its roles and responsibilities," but without any structural accountability to the population or the government. In one person's view: "Much of humanitarian biomedicine, paralleling the rise of NGOs, have become surrogate states charged with filling in the gaps in the universal provision of care—where it existed." However, the linguistic subtleties of the concept of "humanitarianism" emerged in these discussions: "I'm loath to assume that the privately funded organizations supporting Botswana's HIV/AIDS treatment program are humanitarian while the public health system is "'non-humanitarian.'"

Relations between expatriates and locals, and matters of status, placement, and professionalization of a local health care workforce were intensely scrutinized. Poll respondents critiqued humanitarian organizations for inciting "tensions over expertise among some health care workers," and for discrediting local health care agents as insufficiently trained or educated. NGOs were also blamed for rapidly promoting talented health care workers, and for "siphoning off the sharpest personnel from state to non-state organizations."

Although they work in close proximity, expatriates and locals live in different conditions, earn unequal salaries, and are offered different benefits. Expatriates and locals are protected and kept safe from violence to varying and unequal degrees, and are unequally included in policy and programming decision-making. Their relationships can become "a site where inequality becomes most visible and embodied." Respondents cited abuses of local health care workers including, "nepotism in the selection of local staff for NGO positions" and "differing valuations of the lives and health of expatriate versus national workers" as well as a general culture of condescension (see Redfield 2012b). One person commented: "Practitioners and patients (and everyone else) come to regard foreignness as a sign of expertise in itself." However:

> [T]he categories of "international/expatriate staff" and "locally affected populations" need more nuance. . . . I conduct my research in a clinical environment characterized by a high degree of expatriate health professions, only some of whom (and under certain conditions) count as "international" in the same way. One of the critical issues in this site has been the bumpy integration of new institutions and new kinds of expatriates with existing ones, with ensuing contests over expertise, training, professional standing, space, etc., and conversations about similarities between these inter-institutional "partnerships" and colonial occupation.

The potentially dangerous character of short-term medical missions also arose:

> Many have recently noticed a trend of U.S. and European short-term volunteers practicing abroad in ways that exceed their level of expertise and would be illegal in their own countries. There are contexts where this can be dangerous and unnecessary. Also, in short-term interventions, medical advice and powerful drugs are at times distributed by visiting humanitarian groups without information, follow-up, or documentation of injuries/fatalities caused by iatrogenic effects of treatment.

Issues of local participation and community empowerment were regarded as common failings. As one anthropologist exclaimed: "Involvement and capacity-building are buzz-words!" They observed that people, culture, language, and customs were left out of assessments, implementation practices, humanitarian policy, and bureaucratic management. Our respondents described how locals were disengaged in the policy-making process and argued for "meaningful" community participation, "meaningful" research, and "meaningful engagement."

> The most successful projects I have seen have been those which have been set up and are maintained by local community volunteers. There are organizations working with such community groups, giving trainings, providing small amounts of assistance, or organizing gatherings, and this sort of cooperation appears to be very successful. NGOs that do not work through such networks of local actors make limited contributions with respect to the numbers of people impacted as well as the behavioral changes sought

Many reported on structural barriers to local involvement. Put starkly: "The role of many donors undermines empowerment," and "the structures of accountability follow money more than people." In humanitarian interventions, there is "too little communication and collaboration between beneficiaries and benefactors, too many top-down interventions and imposing of 'expert knowledge' which perpetuate disempowerment, exclusion and oppression and do not address causes." Some attention was paid to the fact that "new forms of communication" and media complicates how organizations manage relationships on the ground (Grayman 2014).

> Despite numerous critiques over the last several decades, from anthropology and beyond, the incorporation of "local knowledge" and "community empowerment" into humanitarian approaches still seems superficial to me. "Empowerment" and "community participation" can easily become "magic bullets" in their own right when they are not conducted in a way that allows the community to substantially revise the values and procedures of an intervention.

Limitations

We highlight three important limitations to this study. First, the methods of participant selection—specifically, snowball sampling, the use of Google Scholar (a database of published scholarship), and recruitment at the annual meeting of the American Anthropological Association—may have biased our sample toward academic anthropologists connected to the United States. We did make efforts to overcome recruitment bias, but we have no way to assess our recruitment bias or the extent of under-recruitment of anthropologist–practitioners working globally within the humanitarian sector. Second, our survey may have encouraged academic critiques rather than canvassed the voices of anthropologists who lead humanitarian efforts. Third, the study was unable to fully examine what value ethnography, anthropology, or the social sciences more generally add to the study of medical humanitarianism.

Discussion

As Figure 1a demonstrates, the poll reaped a great diversity of responses, reflecting a range of perspectives across the space of engagement between anthropology and humanitarianism, which may reveal as much about the current state of anthropology as it does about medical humanitarianism. Given the diversity of responses, we see the need for a research agenda that is comparative—clearly, medical humanitarian practice is comprised of *both* locally contingent institutional practices with tremendous variation *and* transnational networks that have important cultural, financial, and bureaucratic continuities. Understanding that anthropologists were speaking "to their own," our poll respondents made a series of recommendations to improve medical humanitarian practice, and to focus anthropological research on medical humanitarianism. To advance medical humanitarian practice, anthropologists suggested a "bottom-up approach," the "creat[ion of] safe institutional spaces for documenting and denouncing abuses," and the development of "ways of disseminating information nationally and internationally in an effective and persuasive ways . . . to promote political/institutional/legal pressures for reform or regime change."

Anthropologists raised difficult questions regarding humanitarian knowledge and expertise. Our respondents asked, "How does an agency involve 'the community?' Who is the 'community?' What obligations do we—as anthropologists or other outside observers—have to the 'community'?" "Who is constructing policies?" "How is it linked to the local world?" "Whose interests are being represented?" "Who is

marginalized and erased?" "How is the technical rationality of large international agencies distorting the moral world?"

Despite our respondents' long involvement in humanitarian practice, anthropologists lack awareness of *where* or *how* humanitarian practitioners engage in processes of self-critique. Anthropologists sense that their voices are missing in current debates. They seem unaware that anthropological concerns *have been* heard and addressed in formal and informal humanitarian literatures and in landmark humanitarian protocols. Important examples include WHO's *Building Back Better* (2013), the Inter-Agency Standing Committee (2005, 2006, 2007) guidelines on human rights, gender-based violence interventions, and mental health and psychosocial support (Abramowitz and Kleinman 2008; de Jong 2002), and interdisciplinary partnerships to define the agenda of humanitarian practice over the next decade (Barnett and Weiss 2013; Tol et al. 2011; Tol et al. 2012).

There are significant challenges confronting those who want to do research on medical humanitarianism's financing, logistics, and labor systems. Although many anthropologists have gained prolonged access to humanitarian contexts, they are still excluded from observing the operations of power in the humanitarian theater. Given the deep backgrounds of our poll respondents, it is puzzling that issues of policy formation, financing, program development, and structural reform continue to remain beyond ethnography's reach. As one respondent reported, there is a lack of "access by anthropologists to areas defined as humanitarian zones, and access to humanitarian organizations and personnel. Many humanitarian organizations do not collaborate with researchers, and limit access to researchers." Anthropologists who are not "on the inside" have difficulty understanding how humanitarian financing works as a site of ethics and negotiation and how issues of culture, sovereignty, and governance pertain.

The responses to this survey traced a diverse and complex humanitarian space that is in the midst of transition, and an anthropological line of inquiry that is on the cusp of a new direction. The next generation of anthropological research into medical humanitarianism needs to recognize that it constitutes a distinct space of inquiry that brings together important phenomenological concerns with the need for transnational and local structural analyses. New ethnographies of medical humanitarianism might benefit from an explicit comparative perspective that seeks to build a theory of humanitarian intervention across case and contexts, rather than pursuing theory from within specific cases (Abramowitz and Panter-Brick In press). We may wish to shift our focus from medical humanitarian *ethics and politics* to medical humanitarian *policy and practice*, so as to become more adept at directing our insights toward the shaping of non-anthropological lines of inquiry in fields far removed from our own (like emergency medicine, economics, international relations, health sector development, and logistics).

We also need to improve our ability to identify sites of humanitarian institutional memory, self-critique, and self-reform, so that we can better understand the social architecture of humanitarian memory, learning, and knowledge. We have yet to chart the cultural delineations of medical humanitarianism as a space of global practice or understand its commonalities and variations across sites of intervention. We borrow from our respondents by noting that:

> [It is] critical to move away from thinking of humanitarianism as a dyad (giver/receiver, expatriate/local, NGO/state, donor/beneficiary) and to analyze more complex landscapes of humanitarian intervention, including a diverse array of actors. This scope will allow for richer analyses of the politics of humanitarianism. It will allow us to recognize that it's not the presence or absence of politics in humanitarian intervention, but how particular forms play out.

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