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A medical history of refugee camps: medical humanitarianism in Palestinian and Sahrawi refugee camps, 1948-1976

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BA (Hons), MSc

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School of Humanities

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Abstract

This doctoral thesis investigates two refugee camp contexts: the Palestinian refugee camps in Middle East host countries, and the Sahrawi refugee camps in Algeria. From the point in history of their establishment—in 1948 in the Palestinian case and 1975 in the case of the Sahrawi—this thesis will discuss histories of medical emergency and the role of actors and institutions in the delivery of medical humanitarian action.

At the heart of this subject—the medical history of refugee camps—there is an absence of detail and understanding. The grand narratives of humanitarian history describe complex arcs of post-war humanitarian adventure; anthropological scholarship analyses twentieth century and twenty-first century refugee camps whilst reflecting on their longer histories; refugee camp histories detail the broader experiences of life in exile; socio-political scholarship discusses the interplay between camps and humanitarianism. This thesis is a contribution to a multi-disciplinary landscape; and I have taken the opportunity to find, analyse, and illuminate the medical and health history of refugee camps and their inhabitants. The Palestinian refugee camps and the Sahrawi refugee camps became the focus of this thesis because historical documentation of the camps' experience with medical humanitarianism specifically has been uncovered in the archives, and the detail of this action has been under-represented in the historical literature.

This task is important. Medical history is crucial to our understanding of and respect for the human experience—and for the refugee experience. Without detailed discussion of the full, lived experience of refugees and their health, we become increasingly distanced from our understanding of how refugees lived and live. Without detailed discussion of the lived health experiences of refugees, we are in danger of perpetuating an understanding of humanitarian action in the post-war era that lacks nuance.

Here, in the details of refugee health and medical humanitarian action we gain insights into key moments in the arc of humanitarian history, in the post-war period (1945-1953) and as the development century takes hold (1965-1976). During this time, when international humanitarian action was an interplay between global dynamics and local experience, two refugee crises triggered responses of emergency relief from humanitarian actors and institutions, and the foundations were laid for what would become decades of encamped life.

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This thesis is dedicated with hope and gratitude, to my daughter Poppy.

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List of Abbreviations

AFSC	American Friends Service Committee
ASS	Anti-Slavery Society
ARC	Algerian Red Crescent
ASEMCP	African Smallpox Eradication and Measles
BRC	British Red Cross
CICARWS	Commission of Inter-Church Aid, Refugee and World Service
CMC	Christian Medical Commission
EPI	Expanded Programme on Immunization
ESM	United Nations Economic Survey Mission for the Middle East
FIDH	Fédération Internationale des Droits de L'Homme
FLN	Front de Liberation Nationale
GSK	GlaxoSmithKline
ICRC	International Committee of the Red Cross
IFRC	International Federation of the Red Cross
PLO	Palestine Liberation Organization
POLISARIO	Frente Popular de Liberación de Saguía el Hamra y Río de Oro
RD	Rencontre et Développement
SADR	Sahrawi Arab Democratic Republic
SCF	Save the Children Fund
SRC	Sahrawi Red Crescent
TVA	Tennessee Valley Authority (TVA)
UNCCP	United Nations Conciliation Commission for Palestine
UNDRU	United Nations Disaster Relief Project
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Fund
UNISPAL	United Nations Information System on the Question of Palestine
UNRPR	United Nations Relief for Palestine Refugees
UNRRA	United Nations Relief and Rehabilitation Administration
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
League or LORCS	League of Red Cross Societies
League Commission	Middle East Commission of the League of Red Cross Societies
MSF	Médecins Sans Frontières
NCCC	National Council of Churches of Christ (USA)
NEF	Near East Foundation
WCC	World Council of Churches
WHFUSA	World Health Foundation of the United States
WHO	World Health Organization

List of Illustrations

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Introduction

One day before his assassination on 17 September 1948, the United Nations Mediator for Palestine, Count Folke Bernadotte appealed to the international community to accept their responsibility for saving the lives of the Palestinian refugees. He entreated the leaders of nations to act and ameliorate the refugees' misery, stating that humanitarian action was a minimum pre-condition for peace. He presented them with a choice, 'between saving the lives of many thousands of people now or permitting them to die'.[1] At this time, decolonialisation in the Middle East and the subsequent Arab-Israeli conflict ruptured Palestinian lives and forcibly displaced thousands of people across Palestine and into neighbouring countries. The nature and form of the international humanitarian response in the Palestinian refugee camps hinges on this September appeal by Bernadotte, and as such it acts as a starting point for this thesis. From here, the arc of humanitarian history extends into the mid-1970s and the beginnings of a second protracted encampment—that of the Sahrawi refugees, displaced into Algeria by conflict across the territory of the decolonising Spanish Sahara.

The Palestinian refugee crisis resulted in a ¾ million refugees, scattered across multiple territories and states. The United Nations (UN) adopted General Assembly Resolution 181 and the Plan of Partition with Economic Union on 29 November 1947, ending the British Mandate for Palestine and drawing up a two-state plan with a special regime for the City of Jerusalem.[2] From this point, up to and past the departure of British troops and the declaration of the State of Israel by its first prime minister, Ben-Gurion, on 15 May 1948, violence flared and forced people from their homes and land.[3] By May 1948, around 380,000 Palestinians had fled or been forced from their homes by conflict and violence.[4] The subsequent Arab-Israeli conflict saw

[1] UNISPAL (United Nations Information System on the Question of Palestine) United Nations General Assembly Official Records: Third Session, Supplement no.11 (A/648), 'Progress Report of the United Nations Mediator on Palestine', Count Folke Bernadotte, 16 September 1948. <https://uniteapps.un.org/dpa/dpr/unispal.nsf/0/AB14D4AAFC4E1BB985256204004F55FA> [Accessed Online: 2 May 2019]. UNISPAL documents will henceforth be footnoted as UNISPAL, abridged locator e.g., UN call reference).

[2] UNISPAL, A/RES/181 (II), 'Resolution 181 (II). Future government of Palestine', 29 November 1947.

[3] Dawn Chatty, *Displacement and Dispossession in the Modern Middle East* (Cambridge: Cambridge University Press, 2010), pp. 202-203.

[4] Nancy Gallagher, *Quakers in the Israeli-Palestinian Conflict: The Dilemmas of NGO Humanitarian Activism* (Cairo, 2007; online edn., Cairo Scholarship Online, 14 Sept. 2011), p. 7. [Accessed 17 May 2023].

protracted battles through the year, displacing '750,000 Palestinians, equivalent to half the estimated Arab population of Palestine'.[5] Military operations including the Israeli capture of Jaffa and Haifa (April 1948), and Lydda and Ramle (9-13 July 1948) (two towns which were already shelter to around 15,000 encamped refugees) significantly increased the number of Palestinian refugees and led to the exodus of between 50,000 and 70,000 civilians.[6] Conflict in Acre forced greater numbers into Lebanon, Syria, and Transjordan.[7]

At the time of the Palestinian refugee crisis, humanitarianism was crystallising into an international system with the UN at its heart. With momentum and impetus from the First and Second World Wars, the UN, non-governmental organisations, international agencies, and the Red Cross movement began to coalesce into a system linked by finances, operations, personnel, and values.[8] The medical humanitarian response to the Palestinian crisis was correspondingly complex, but the United Nations Relief and Works Agency for Palestine Refugees in the Near East (henceforth, UNRWA) became a centre-point. The roles of other institutions present in the camps, including the United Nations International Children's Fund (UNICEF[9]), the League of Red Cross Societies (the League) as a pivotal element of the Red Cross 'non-governmental humanitarian agencies'[10], and the World Health Organization (WHO) interplayed with the emergency UN organisations set-up to support the refugees. Through the 1950s, and into the 1970s, humanitarianism globalised as rapid decolonisation and conflict produced hundreds of thousands of refugees, and shaped new responsibilities, opportunities, and forms of control for states and citizens.

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[5] Peter Gatrell, *The Making of the Modern Refugee* (Oxford: Oxford University Press, 2013), p. 125.

[6] G. Daniel Cohen, 'Elusive Neutrality: Christian Humanitarianism and the Question of Palestine, 1948-1967', *Humanity*, 5 (2), (Summer 2014), p.186; and Benny Morris, 'Operation Dani and the Palestinian Exodus from Lydda and Ramle in 1948' *Middle East Journa*l 40 (1), (Winter, 1986), p. 85.

[7] United Nations Archive, New York City (Henceforth UNA, NYC), AG-022/S-0616, 'Minutes of Disaster Relief Project', 7 December 1948.

[8] Eleanor Davey, John Borton, and Matthew Foley, *A history of the humanitarian system: Western origins and foundations*, Humanitarian Policy Group (HPG) Working Paper (June 2013), Overseas Development Institute.

[9] UNICEF was officially re-named the United Nations Children's Fund in 1953.

[10] The Red Cross and Red Crescent movement has defined itself as "Non-Governmental Humanitarian Agencies (NGHAs)" a term coined to encompass all the components of the International Red Cross and Red Crescent Movement including the International Committee of the Red Cross (ICRC), the International Federation of Red Cross and Red Crescent Societies (IFRC) and its member National Societies: IFRC/ICRC, 'The Code of the International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGOs) in Disaster Relief', 1 Jan 1994: *ALNAP*, <https://www.alnap.org/system/files/content/resource/files/main/code-english.pdf>[Accessed 16 May 2023].

In 1975, as Spain retreated from its hold over the Spanish Sahara, conflict ensued between Morocco, Mauritania, and the POLISARIO (abbreviated from the Spanish: Frente Popular de Liberación de Saguía el Hamra y Río de Oro, referring to the northern and southern geographical regions of the former Spanish Sahara) in conjunction with the Sahrawi state-in-exile, the Sahrawi Arab Democratic Republic (SADR). Fighting caused waves of displacement within the former Spanish Saharan territory and pushed people across the border into Algeria, creating mass refugee camp settlements near Tindouf. The humanitarian network had evolved into a complex mesh of organisations, including organisations from the emerging sans frontiérism (without borders) movement.

The Palestinian and Sahrawi refugee camps became home to refugees from two of the world's last unresolved post-colonial states, and as such share an important conceptual space. Palestine was accorded non-Member State Observer Status to the UN in 2012,[11] and remains fractured by conflict. On 26 February 1976, Spain formally relinquished administrative responsibility for the Spanish Sahara and the UN has listed the Western Sahara as an anomalous non-self-governing state since 1963,[12] sharing the same category as a scattering of islands still administered by the UK, USA, France, and New Zealand. In both geographical and political contexts, violence and mass displacement has led to protracted refugee camps existing across borders from contested states.[13] Palestinian and Sahrawi refugees became exceptional in their 'stateless' identities, living in exceptional environments, experiencing unique connections with the humanitarian system and its foot soldiers. And as humanitarianism became bonded with Western agendas of development and advancement, the refugee camps and the refugees became tethered, inter-connected with the actors and processes of both.

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[11] The State of Palestine was accorded non-Member Observer Status by UN General Assembly resolution on 29 November 2012, receiving a standing invitation to participate as observers in UN General Assembly sessions, whilst maintaining permanent observer missions at UN Headquarters: United Nations, Meetings Coverage and Press Releases, 'General Assembly Votes Overwhelmingly to Accord Palestine 'Non-Member Observer State' Status in United Nations', 29 November 2012, <https://press.un.org/en/2012/ga11317.doc.htm> [Accessed 31 October 2023].

[12] *UN, The United Nations and Decolonization,* 'Western Sahara', <https://www.un.org/dppa/decolonization/en/nsgt/western-sahara> [Accessed 16 May 2023]. In 1990, the UN General Assembly reaffirmed that 'the question of Western Sahara is a question of decolonization which remains to be completed on the basis of the exercise by the people of Western Sahara of their inalienable right to self-determination and independence': *UNHCR (Refworld),* '*Question of Western Sahara: resolution/adopted by the General Assembly,* 20 November 1990, A/RES/45/21' < https://www.refworld.org/docid/3b00efe510.html> [Accessed 16 May 2023].

[13] Chatty, *Displacement and Dispossession in the Modern Middle East*, p. 181. For a study that juxtaposes the British failures with the Palestine mandate with a more successful record in Trans-Jordan: D.K. Fieldhouse, *Western Imperialism in the Middle East 1914-1958* (Oxford: Oxford University Press, 2006).

Histories of humanitarian relief in the immediate post- Second World War period have closed the gap between two tracks of scholarship: 'war studies on the one hand and Cold War histories on the other'.[14] The Balzan Foundation-funded project, 'Reconstruction in the immediate aftermath of war: a comparative study of Europe, 1945-1950', worked to illuminate the emergency humanitarian experience in the period 1944 to 1949. Hosted by the Department of History at Birkbeck College the project considered themes of restoration of post-war economies and societies, including the place of displaced peoples, the role of the United Nations Relief and Rehabilitation Administration (UNRRA), other international non-governmental organisations (INGOS), and the nature of state power.[15] As historian Jessica Reinisch advises, the *medical* humanitarian histories are easily lost within the broader narratives of humanitarianism and a gap still exists relating to the 1950s period, between scholarship on the immediate post-war reconstruction in Europe, and the postcolonial 'development decade' of the 1960s.[16] This thesis will consider medical humanitarianism from 1948, through the 1950s and 1960s, to 1976. This thesis considers the medical history of refugee camps throughout a period that saw significant shifts in development practices and theory. By the mid-1970s, revisionist development theory was increasingly challenging universal models and practices of development and proposing alternative concepts centred around citizens and community. [17]

Scholarship by Nancy Gallagher has discussed in-depth the humanitarian/refugee camp history in the camps in Gaza, illuminating how the American Friends Service Committee (AFSC) reconciled the practical realities of protracted exile with the desire to provide more than charitable relief: to assist in the reconciliation and repatriation processes.[18] The experience in Gaza has been subject to further scholarship, including work that expands across the territories such as historian Elise Young's thesis on midwifery.[19] This thesis re-situates medical

[14] Jessica Reinisch, 'Introduction: Relief in the Aftermath of War', *Journal of Contemporary History* 43 (3), (July 2008), pp. 371-404.

[15] 'Reconstruction in the immediate aftermath of war' <https:www.balzan.bbk.ac.uk> [Accessed 27 April 2023]. Jessica Reinisch and Flora Tsilaga, 'Relief and Rehabilitation in the Immediate Aftermath of War: Second Balzan Workshop, Birkbeck College, 16 June 2006', *History Workshop Journa,* 63 (1) (Spring 2007), pp. 371-4. Waqar Zaidi, 'Planning, Production and Reconstruction in Postwar Europe: Fourth Balzan Workshop', *History Workshop Journal* 65 (1), (Spring 2008), pp. 279-284. Geoff Eley, 'Writing the History of the Aftermath: Europe after 1945', *History Workshop Journal* 65 (1), (Spring 2008), pp. 195-212.

[16] Reinisch, 'Introduction: Relief in the Aftermath of War', pp. 371-404.

[17] Jan Nederveen Pieterse, 'My Paradigm or Yours? Alternative Development, Post-Development, Reflexive Development', *Development and Change* 29 (2) (1998), pp. 195-408.

[18] Gallagher, *Quakers in the Israeli–Palestinian Conflict.*

[19] Elise G. Young, 'Between Daya and Doctor: A History of the Impact of Modern Nation-State Building on Health East and West of the Jordan River', (PhD Thesis, University of Massachusetts Amherst, 1997).

humanitarian action within the Palestinian refugee camps with a focus on Jordan, and the Sahrawi refugee camps in Algeria. These two refugee camp contexts have been the subject of less academic scrutiny from the perspective of medical humanitarian action despite their large refugee populations. By September 1949, Jordan would become host to over 50% of the estimated Palestinian refugee population.[20] This thesis asks, what are the details of the historical medical experience of refugees in these two different contexts? The scholarly literature presents some tantalising specific details of the medical humanitarian experience in the historiography of Palestinian and Sahrawi refugee camps. For example, in the case of the Western Sahara, historian Pablo San Martín claimed that despite the acknowledged presence of a Médecins Sans Frontières (MSF) team working alongside a medical team from Cuba who arrived in 1976 there was 'no organized and systematic aid from any international or transnational organization until 1977, when the World Food Programme and, later on, the United Nations High Commissioner for Refugees (UNHCR) took responsibility for the refugees'.[21] This thesis considers the validity of this claim.

A deep dive into the historical archives uncovers a rich medical humanitarian experience that lends itself to comparison. Scholars such as anthropologist Randa Farah have drawn comparisons between Palestinian and Sahrawi refugee camps and their roles related to national liberation movements.[22] Whereas there are clear lines for comparison, writing a comparative history demands caution. For example, this thesis finds that the Sahrawi refugees were creative agents of change, but it would be insulting to simply suggest that, by comparison to the Sahrawi the Palestinian refugees were not creative in their response. I agree with theorist Ariella Aïsha Azoulay, there are too many potential histories unwritten in the archives to allow for definitive comparisons.[23]

Furthermore, I acknowledge that how refugee crises are conceptualised—how history presents the reasons and responsibilities for the catastrophe of Palestinian forced displacement, for the Nakba, and how the determinant factors of the Sahrawi crisis are represented—these

[20] IRIS, EM/RC2/8, World Health Organization, Regional Office for the Eastern Mediterranean (1949), 'Palestine Refugees – Health Needs', 1 September 1949, report by Dr. J.D. Cottrell, Chief Medical Officer and WHO Representative UNRPR <https://iris.who.int/handle/10665/124391> [accessed 10 October 2023].

[21] Pablo San Martín, *Western Sahara, the Refugee Nation* (Cardiff: University of Wales Press, 2010), p.110.

[22] Randa Farah, 'Refugee Camps in the Palestinian and Sahrawi National Liberation Movements: A Comparative Perspective', *Journal of Palestine Studies* 38 (2) (2009), pp. 76-93.

[23] Ariella Aïsha Azoulay, *A Potential History: Unlearning Imperialism* (London: Verso, 2019).

representations of the past can have almost unfathomable consequences. Unreconciled perspectives of Palestinian and Sahrawi history and continued misunderstandings and conflicting readings of real, lived experience can contribute to seemingly intractable conflicts, conflicts wherein millions of people remain refugees.[24]

Locating the Palestinian and Sahrawi refugee camps within the arcs of humanitarian history and the history of development

Scholars of modern humanitarianism, Michael Barnett, Silvia Salvatici, and Keith David Watenpaugh, present the arc of modern humanitarian history as a long adventure intersecting with histories of modernisation and development. This grand arc sees an international system of humanitarianism coalesce in the interwar period with the emergence of development thinking in the post-war decades, as master-narrative histories of humanitarian relief intertwined with both local human action and the geopolitics of the Cold War. For Barnett, the 'age of neo-humanitarianism' between 1945 and 1989 was one shaped by the destructive forces of the Cold War and decolonization, the productive forces of development, and the compassionate forces of sovereignty.[25] For Barnett, in these post-war decades, humanitarian relief (the work of providing goods and services to keep people alive, i.e., food rations, water, shelter, sanitation, emergency medical assistance) became transformative rather than functional: humanitarian actors and institutions began putting development principles at the heart of their imagining (and their action), to transform decolonizing traditional societies into modern societies.[26] Both Barnett and Salvatici situate this transformative spirit and action in the humanitarian adventures and rehabilitative action of UNRRA,[27] with Barnett further arguing that 'the new alchemists' active in this neo-humanitarian era began to look beyond the immediate relief needs and instead began 'to consider what people and societies needed to insulate them from the causes of suffering'.[28] In

[24] Figures published by UNRWA as of 31 December 2020 accounts for 6,388,887 registered persons. This figure includes 5,703,546 UNRWA registered refugees plus other registered persons who include non-refugee wives, non-refugee husbands, non-refugee children, Frontier villages, Jerusalem poor, Gaza poor, and compromise cases. UNRWA [Online] UNRWA in Figures 2020-2021, Sept 6, 2021 <https://www.unrwa.org/sites/default/files/content/resources/unrwa_in_figures_2021_eng.pdf<Accessed 29 June 2022].

[25] Michael Barnett, *Empire of Humanity, A History of Humanitarianism* (Ithaca: Cornell University Press, 2011).

[26] Barnett, *Empire of Humanity*, p.108.

[27] Silvia Salvatici, *A History of humanitarianism, 1755-1989: In the name of others* (Manchester: Manchester University Press, 2019), pp. 116-140.

[28] Barnett, *Empire of Humanity*, p.122.

counterargument, Watenpaugh proposed that the key transformative moment occurred earlier, with humanitarianism response to the Armenian genocide:

> That humanitarianism addressed more than just a response to their bodily suffering; it embodied a bureaucratically organized and expert knowledge-driven effort to repair their human being, reconnect them to their communities, and restore them to humanity.[29]

Tracing the arc back to the First World War and interwar periods, Watenpaugh originates modern humanitarianism in Western Europe and North America as a specific ideology of 'organized compassion' that was public, professional, internationally backed and globally integrated.[30] Distinct from practices of early humanitarianism formed by missionary ideals, abolitionist aims, responses on the battlefield in Europe, and the civilising mission of the colonial nations, Watenpaugh argues that 'modern humanitarianism was envisioned by its participants and protagonists as a permanent, transnational, institutional, neutral, and secular regime for understanding and addressing the root causes of human suffering.'[31] In addition to illuminating the early cases of transformative action by organizations such as the Near East Foundation,[32] scholars have analyzed the work of the American Red Cross in Jerusalem between 1918 and 1920, showing a humanitarian project that stretched beyond immediate relief to rehabilitation and construction.[33]

Did medical humanitarians active in the Palestinian and Sahrawi refugee camps take-up the mantle of a modern humanitarianism that bloomed in the eastern Mediterranean in the interwar period? Is there evidence of medical humanitarianism in the form of something beyond emergency repair? There are two shifts from 'emergency relief to development' that need to be considered here. First, there is a shift over a period of time wherein the nature of the humanitarian agencies changes, as outlined above. Second, there is a related, yet more localised

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[29] Keith David Watenpaugh, *Bread from Stones: The Middle East and the Making of Modern Humanitarianism* (Oakland, CA: University of California Press, 2016), p. 15. See also Davide Rodogno, 'Beyond Relief: A Sketch of the Near East Relief's Humanitarian Operations, 1918-1929', *Monde(s*), No.6 (November 2014), pp. 45-64.

[30] Watenpaugh, *Bread from Stones*, pp. 4-8.

[31] Watenpaugh, *Bread from Stones*, p. 5. Watenpaugh is relating to observations made at the turn of the century by Frank T. Carlton, 'Humanitarianism, Past and Present', *International Journal of Ethics* 17 (1) (1906), p. 54.

[32] Watenpaugh, *Bread from Stones*, pp. 91-124.

[33] Davide Rodogno, 'International Relief Operations in Palestine in the Aftermath of the First World War: The Discrepancy between International Humanitarian Organisations' Visions, Ambitions, and Actions', *Journal of Migration History* 6 (2020) pp. 16-39.

shift wherein organisation(s) steer the agenda increasingly to development, rather than emergency during their involvement with a specific context. This shift can be in direct response to the humanitarian crisis itself, and how, over time from the point of crisis, the medical needs shift from emergency needs to more developmental (social, economic, political). Generally speaking, in the post-war period at the beginning of a crisis of mass influx, there has been a pattern of high mortality rate during the acute phase of an emergency, fuelled by epidemics, the exacerbation of endemic infectious disease, and acute malnutrition[34], as well as traumatic injuries caused by conflict. But over time, the medical needs would increase in complexity as people continue their life-cycles in camps.

In the first years of the Palestinian refugee camps, a secularized humanitarianism attempted to take root and framed the imagining of refugee health, a humanitarianism which Barnett describes as being driven by actors committed to science, development economics, technical responses, knowledge, and training as crucial for the stimulation of country's development.[35] However, the result in the Palestinian camps appeared to be one characterized more by endurance on the part of the refugees than transformation on the part of the humanitarians and the agents of development working alongside them. In the Sahrawi refugee camps, the spirit of transformation was found more closely in the activity of the refugees themselves.

All refugee camp histories are intertwined with national histories and different stories of care and control.[36] Authors have proposed that states should not be considered humanitarian actors, as they cannot adhere to the fundamentals of humanitarian action of impartiality, neutrality, and independence.[37] A state hosting a refugee camp might be legally obligated to ensure the human rights of refugees are upheld, but as scholar of migration Oliver Bakewell concurs, how far these rights to relief are met, in the form of shelter, food, water, *medical support,* education, sanitation, will vary between states and historical contexts.[38] However, this thesis accepts the premise that a

[34] Caroline Sa'Da and Micaela Serafini, 'Humanitarian and medical challenges of assisting new refugees in Lebanon and Iraq', *Forced Migration Review* 44 (September 2013), pp. 70-73.

[35] Barnett, *Empire of Humanity*, p. 130.

[36] Liisa H. Malkki, 'Refugees and Exile: "From Refugee Studies" to the National Order of Things', *Annual Review of Anthropology* 24 (1995), p. 498.

[37] Grant Broussard, Leonard S. Rubenstein, Courtland Robinson, Wasim Maziak, Sappho Z. Gilbert, Matthew DeCamp, 'Challenges to ethical obligations and humanitarian principles in conflict settings: a systematic review', *Journal of International Humanitarian Action* 4 (15) (2019).

[38] Oliver Bakewell, 'Encampment and Self-Settlement', in *The Oxford Handbook of Refugee & Forced Migration Studies,* eds Elena Fiddian-Qasmiyah, Gil Loescher, Katy Long, Nando Sigona (Oxford: Oxford University Press, 2016), p.129.

state providing relief to a refugee camp and state-less or exiled citizens (acknowledging that Palestinians were granted citizenship of Jordan in 1954) for whatever reason or motivation (fully appreciating that a state can masquerade as humanitarian for its own gain whilst perpetuating suffering[39]) is in most cases taking action or supporting action to benefit non-citizens, and as such can be considered within the bounds of humanitarian action. Scholars have also proposed that the value of humanitarian work undertaken by an NGO can be undermined by its collaboration with states.[40] However, in both the refugee camp contexts discussed in this thesis, host states and state allies connected to the refugee camps through the processes of decolonisation do provide grist to the humanitarian mill in ways which supported the enactment or development of medical humanitarian action.

The framing of humanitarian secularization as a master narrative is of unavoidable relevance to this history. As historian Johannes Paulmann argues, the longevity and renewal of religious organisations involved in humanitarianism can be obscured by the modernization narrative proposed since the 1960s.[41] Faith-based medical humanitarian action is also uncovered in this thesis, and I find that the contributions by (Christian) faith-based religious organizations have at times been both overstated in terms of action in the field and understated in terms of their influence as advocates for humanitarian action in both Palestinian and Sahrawi refugee camps. The Palestinian and Sahrawi refugee camps are both 'sacred spaces of humanitarianism', by virtue of their substantiality and physicality as sites of humanitarian action: humanitarian actors and institutions are drawn to the camps to enact their values and beliefs within this 'meaningful and inviolable sphere of ethical action'.[42] The ethical pillars of humanitarian action, neutrality,

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[39] Eyal Weizman, *The Least of All Possible Evils: A Short History of Humanitarian Violence* (London: Verso, 2017).

[40] Asad L. Asad, Tamara Kay, 'Theorizing the relationship between NGOs and the state in medical humanitarian development projects', *Social Science & Medicine* 120 (2014), pp. 325-333. See also William F. Fisher, 'Doing Good? The Politics and Antipolitics of NGO Practices', *Annual Review of Anthropology* 26 (1997), pp. 439-464.

[41] Johannes Paulmann, 'Conjunctures in the History of International Humanitarian Aid during the Twentieth Century', *Humanity* (Summer 2013), p.219.

[42] Andrea Paras and Janice Gross Stein, 'Bridging the Sacred and the Profane in Humanitarian Life' in *Sacred Aid: Faith and Humanitarianism,* eds. Michael N. Barnett and Janice G. Stein (Oxford: Oxford University Press, 2012), p. 213. The concept of "espace humanitaire" was first proposed by former MSF President Rony Brauman, who described it in 1990 as: "A space of freedom in which we are free to evaluate needs, free to monitor the distribution and use of relief goods and have a dialogue with the people": Inter-Agency Standing Committee 70th Working Group Meeting, 'Background Document: Preserving Humanitarian Space, Protection and Security', 11-13 March 2008 <https://www.refworld.org/pdfid/48da506c2.pdf> [Accessed 8 July 2023]; Johanna Grombach Wager, 'An IHL/ICRC perspective on 'humanitarian space', *Humanitarian Practice Network*, Issue 32 (Article 11), January 10, 2006 <https://odihpn.org/publication/an-ihlicrc-perspective-on-%C2%91humanitarian-space%C2%92/> [Accessed 8 July 2023].

impartiality, independence, and universality hold-up the sacred spaces of humanitarianism in the refugee camps, but other actors and institutions are seen to entangle themselves with these spaces. State actors, both close and distant and also Western pharmaceutical companies were welcomed into this sacred space, specifically in the form of donations of measles vaccines to the Palestinian refugee camps between 1965 and 1975.

History in dialogue with social science scholarship: refugee camps as hostile places, sites as medical technology and the production of refugees as 'bare life'

The Second World War displaced around 30 million people in Europe, with 11 million seeking relief and refuge outside their own country.[43] In the arc of humanitarian history, the refugee camp takes centre stage in the post-war world. The UNHCR defines a refugee camp as any purpose-built, planned, and managed location or spontaneous settlement where refugees are accommodated and receive assistance and services from government and humanitarian agencies. Furthermore, refugee camps are defined by the limitations that the camps and their operators place on the rights and freedoms of the people that occupy them: their ability to move freely, to choose where to live, to work or open a business, to cultivate land, or access protection and services.[44] This thesis is principally concerned with refugee camps as sites of medical humanitarian action, but I recognise that the narrative and reality of refugee camps extends beyond the physical boundaries of the camps: that borders and boundaries to camps and humanitarian assistance are porous and humanitarian response to refugee camps will frequently also impact and interact with refugees living outside camps and non-refugee populations.[45] In the Palestinian refugee crisis particularly, due to the highly fragmented living situations of the refugees and the extremely malleable definitions of who should be recognised as a refugee, the humanitarian response was predominantly aimed at all Palestinian people displaced, not just those encamped, and on occasion relief would be directed to and received by non-refugee populations. Nevertheless, refugee camps exist in the 'borderlands' of the world, as humanitarian practitioner and thinker Antonio Donini suggests, somewhere on the fringes of global governance and capitalist development: spaces of stateless peoples subject to exceptional laws.[46]

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[43] Liisa H. Malkki, 'Refugees and Exile: "From Refugee Studies" to the National Order of Things', *Annual Review of Anthropology* 24 (1995), p.497.

[44] UNHCR, 'UNHCR Policy on Alternatives to Camps' Date of entry into force: 22 July 2014, p.12, <https://www.unhcr.org/media/32550> [Accessed 16 May 2023].

[45] Bakewell, 'Encampment and Self-Settlement', pp. 127-138.

[46] Antonio Donini, 'The far side: the meta functions of humanitarianism in a globalised world', *Disasters,* 34 (S2) (2010), p. S224.

Yet, they remain tethered to global systems and agendas, and this thesis is concerned with these connections.

A broad swathe of anthropological scholarship has characterised refugee camps as hostile places. In post-war Europe, standardised techniques for managing mass displacements of people emerged saw the refugee camp embodying a new technology of power.[47] Anthropologist Liisa Mallki summarises:

> The refugee camp was a vital device of power: The spatial concentration and ordering of people that it enabled, as well as the administrative and bureaucratic processes it facilitated within its boundaries, had far-reaching consequences. The segregation of nationalities; the orderly organization of repatriation or third-country resettlement; medical and hygienic programs and quarantining; "perpetual screening" … ; and schooling and rehabilitation were some of the operations that the spatial concentration and ordering of people enabled or facilitated.[48]

For Malkki, refugee camps epitomise a dichotomy of care and control.[49] In the same vein, anthropologist Michel Agier depicts a system of humanitarian government that operates with two hands, a hand that heals and a hand that controls; for Agier, power is displayed in the 'petty detail of humanitarian action on the ground'[50], the screening and selection of beneficiaries on the ground. Rooted by four phases of crises, the first phase being the mid-1970s, Agier argues humanitarian government is an increasingly global mechanism of exceptional power, embodied by a grand network of humanitarian organisations.[51] As spaces of exceptional power, for Agier and others (including social anthropologist Barbara Harrell-Bond, and Professor of International Law Guglielmo Verdirame[52]) the camp became a space of exception, set -apart from 'the common world' where in fact these are 'not zones of 'non-right', but rather zones of exceptional rights and power, where everything seems possible for those in control'.[53]

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[47] Malkki, 'Refugees and Exile', pp. 497-498.

[48] Malkki, 'Refugees and Exile', p. 498.

[49] Malkki, 'Refugees and Exile', p. 498.

[50] Michel Agier, *Managing the Undesirables* (Cambridge: Polity, 2011), pp.80-203. This text is based largely on ethnographic field studies, predominantly in Africa between 2000 and 2007.

[51] Agier, *Managing the Undesirables,* p.208.

[52] Guglielmo Verdirame and Barbara Harrell-Bond eds. *Rights in Exile: Janus-faced Humanitarianism* (New York: Berghahn Books, 2005).

[53] Agier*, Managing the Undesirables,* p. 82.

The notion that refugees represent 'the Other', 'the world's 'remnants', dark, diseased and invisible' as opposed to the 'clean, healthy, and visible world,'[54] is implicit and explicit in refugee camp narratives. And here, refugee camps become the embodiment of medical technology for control and care of these Others.[55] Professor of architecture, Eyal Weizman argues:

> These camps are planned according to medical principles, a combination of makeshift hospitals for the mass treatment of large populations, and military camps for disciplined control. Hygiene, sanitation, the management and containment of plague, the circulation of services, infrastructure and the provision of water, electricity, medicine and nutrition, along with the disposal of sewage and waste, all become the organizational principles of a new spatial regime of multiple separations and regimentation of time and space, intersecting quasi-military with quasi-medical principles.[56]

Scholars frequently apply philosopher Giorgio Agamben's theory of biopolitical suppression to refugee contexts, arguing the camps produce and perpetuate the existence and treatment of refugees as 'bare life'—as life that can be killed with impunity.[57] For example, for sociologist Sari Hanafi, over the course of decades of encamped life the Palestinian refugees have been stripped of political existence and identity, reduced to bare life as individuals in need of shelter and food;[58] refugees are de-politicised and disempowered, and reduced to bodies and lives of victimhood. Anthropologist Alice Wilson suggests that the Sahrawi refugees could be classed as bare life due to the continued denial of their rights to self-determination.[59] Since the 1960s, both the UN and the International Court of Justice have affirmed the Sahrawi's right to self-determination,[60] yet they are not permitted to take up this right. Instead, Wilson argues, they are '… allowed to remain alive, in exile or under annexation, Sahrawis can nevertheless be

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[54] Agier, *Managing the Undesirables*, p. 4. See also Ryszard Kapuściński, *The Other* (London: Verso, 2008).

[55] Sharon Abramowitz and Catherine Panter-Brick, *Medical Humanitarianism, Ethnographies of Practice* (Philadelphia: University of Pennsylvania Press, 2015), p 140.

[56] Weizman, *The Least of All Possible Evils, p. 59.*

[57] Giorgio Agamben, *Homo Sacer, Sovereign Power and Bare Life* (Stanford: Stanford University Press, 1998).

[58] Sari Hanafi, 'Palestinian Refugee Camps' in *The Power of Inclusive Exclusion: Anatomy of Israeli Rule in the Occupied Palestinian Territories,* eds. Adi Ophir, Michal Givoni, and Sari Hanafi (New York: Zone Books, 2009).

[59] Alice Wilson, *Sovereignty in Exile: A Saharan Liberation Movement Governs* (Philadelphia: University of Pennsylvania Press, 2016), p. 11.

[60] Between 1966 and 1974, the UN adopted several resolutions emphasising the rights to self-determination of the Western Saharan people, and the General Assembly consistently reaffirmed the inalienable rights of the people of the ex-Spanish Sahara to self-determination, in accordance with General Assembly resolution 1514 (XV): UN Digital, A/RES/3458(XXX)[B], 'Question of Spanish Sahara', General Assembly – Thirtieth Session, 2435th plenary meeting, 10 December 1975 < https://digitallibrary.un.org/record/640036?ln=en>, [Accessed 1 November 2023].

understood as bare life in the sense that their rights have been shown to be repeatedly violable, with impunity'.[61] Wilson caveats this, stating that a site that produces bare life can at the same time accommodate practices of citizenship and state power.[62] Other scholars dispute that refugee camps are sites that produce bare life, emphasising that camps are sites of vibrant life, where 'nothing is taken for granted and everything is contested'.[63] Scholars, including Hanafi[64] and Harrell-Bond[65] have characterised refugee camps as sites of depoliticization and disempowerment, others argue that camps are sites of identity formation and re-historicization,[67] or sites that form refugees as hyper-politicized nationalists or groups of political opposition.[68]

As a form of medical technology, refugee camps are sites that turn people into populations.[69] Refugees are pathologized by the camps' mechanisms of biopower, refugees' bodies and their vital needs are objectified, categorised and counted, managed by systems of food rations and medicalised through programmes such as infant feeding campaigns.[70] Anthropologist and sociologist Didier Fassin counts the following as tools of biopower and biopolitics: 'demography, epidemiology, psychology, family planning, public health, policing the self'—and argues that all of these functions use refugee camp contexts to increase knowledge and develop interventions for population management or improvement.[71]

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[61] Wilson, *Sovereignty in Exile*, p.11.

[62] Wilson, *Sovereignty in Exile,* p. 11.

[63] Simon Turner, 'What is a Refugee Camp? Explorations of the Limits and Effects of the Camp', *Journal of Refugee Studies* 29 (2) (2015), pp. 139-148.

[64] Hanafi, 'Palestinian Refugee Camps' in *The Power of Inclusive Exclusion.*

[65]. Barbara E. Harrell-Bond, *Imposing Aid: Emergency Assistance to Refugees* (Oxford: Oxford University Press, 1985).

[67] Liisa Malkki, 'National Geographic: The Rooting of Peoples and the Territorialization of National Identity Among Scholars and Refugees', *Cultural Anthropology*7 (1) (Feb. 1992), pp. 24-44. Liisa Malkki, *Purity and Exile: Violence, Memory, and National Cosmology Among Hutu Refugees in Tanzania* (Chicago: University of Chicago Press, 1995).

[68] Wilson, *Sovereignty in Exile.*

[69] Didier Fassin, 'Another Politics of Life is Possible,' *Theory, Culture & Society* 26 (5) (2009), p. 47.

[70] Julie Peteet, *Landscape of Hope and Despair, Palestinian Refugee Camps* (Philadelphia: University of Pennsylvania Press, 2005), p. 70.

[71] Fassin, 'Another Politics of Life is Possible,' p. 46. The discussion of value is central to Dider Fassin's thesis, and the attempt to link matters of life with the meaning of politics: that Foucauldian theory should be developed to encompass questions of biolegitimacy (*the power of life* rather than the Foucauldian ((bio-) power over life)) and bio-inequalities (biopolitics not merely as the politics of population but relating to the inequalities of life) as central tenants in 'the construction of the meaning and values of life instead of the exercise of forces and strategies to control it': Fassin, 'Another Politics', p. 52. Using two examples, Fassin links the *biological experienc*e of the irradiated body of victims of the Chernobyl disaster to their *political experience of citizenship* through the granting of specific political status, and therefore compensation and aid

This thesis considers refugee camp history in dialogue with scholarship from the social sciences, not least because the history of medical humanitarianism is still an emerging field. However, the roots of medical historical scholarship are strong, and there is an opportunity to re-frame the history of refugee camp in terms of the history of medicine and healthcare.

Refugee camps and the development of Western preventative medicine

The theory and practice of medical humanitarianism tends to stand for *emergency* medicine, the services and programmes, resources and materials given to people at times of medical crisis following conflict or disasters. Disasters that severely impact on human life include events caused by humans such as industrial explosions; or severe events considered 'acts of God' including earthquakes, tsunami; or crises that combine severe human and environmental damage, such as famine.[72] As the moment of crisis passes and emergencies morph into situations ripe for the application of development in all its guises—economic, political, social, agricultural, technological—the issues of public health begin to play a more dominant role in the planning and delivery of humanitarian relief.[73] With a focus on the initial crisis years of two refugee camp contexts, this thesis considers the nature and form of medical humanitarian action as foundations, and goes on to consider aspects of medical history over twenty years past the initial crisis in the case of the Palestinian camps.

The histories of medicine, medical care, health, and healthcare are not easily differentiated in the written record of humanitarian action. Therefore, all aspects are represented within this thesis. From a medical point of view, this thesis is concerned with both science and practice (medical knowledge and its applications), i.e., preventative medicine and vaccination campaigns (and the research and development processes associated with them); emergency medical care and primary care services (personnel and the programmes), and the infrastructure and medical technology that delivers them (dispensaries, clinics, hospitals, ambulances, syringes, milk formula, pneumatic-powered jet injectors). Furthermore, refugee wellbeing—both mental and physical—

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due to their victimhood. In a similar way he links the illegal Kenyan migrant in France suffering from AIDS, granted residence permit and medical aid on humanitarian grounds. See also Adriana Petryna's work on biological citizenship: Adriana Petryna *Life Exposed: Biological Citizenship after Chernobyl* (Princeton, NJ: Princeton University, 2002) and John Harris, *The Value of Life: An Introduction to Medical Ethics* (London: Routledge, 1985).

[72] Jlateh Vincent Jappah, and Danielle Taana Smith 'State Sponsored Famine: Conceptualizing Politically Induced Famine as a Crime against Humanity,' *Journal of International and Global Studies* 4 (1), Article 2, (2012), pp. 17-31.

[73] Marcos Cueto, Davide Rodogno, and Nicole Bourbonnais, 'The meaning(s) of global public health history', *História, Ciências, Saúde-Manguinhos (HCSM)* 27 (Supplement 1), (2020), pp. 7-10.

is considered integral to good health, not simply the absence of disease, illness, or injury.[74] It should also be noted that food rationing, as an integral part of refugee relief closely linked to refugee healthcare, is not discussed in detail. This is because food aid is considered a discrete humanitarian category of assistance, sitting alongside medical response.[75]

From the post-war period into the mid-1970s profound changes took place in Western medical practice: a 'great expansion in the therapeutic armoury, new medical technologies, rising patient demand, financial pressures, and the rise of specialist medicine'.[76] As sites outside the mainstream of societies organised by nation states, refugee camps exist on the fringes of the colonial and decolonising peripheral states, yet links are still clear and present between the camps and the 'central' Western medical enterprise. As historian Robin Wolfe Scheffler describes it, the mid-century experience in North America was one of a 'biomedical settlement', implying a 'tacit promise that in lieu of providing health care to its citizens directly, the government could foster public welfare through biological investigations of disease'.[77] At this time, a bio-medical boom took place in the name of this goal: the mass production of penicillin started in the USA, with stocks made available to the British public in 1946. In the laboratory, advancements included work conducted by American pharmaceutical company Merck and Co. (who will play a significant role in this thesis) funding a research project into Streptomycin (an antibiotic to treat bacterial infections including tuberculosis) in the mid-1940s;[78] to monoclonal discovery in the mid-1970s[79]; and the war on cancer hinged on identifying a viral cause for cancer in American laboratories after the Second World War.[80] But it was in the realm of preventive medicine that

[74] Harrison, 'A Global Perspective', p.668.

[75] Davide Rodogno, 'The Near East Relief and the American Board Commissions for foreign missions. Humanitarian partnership and divorce in the Near East (1918-1929)', *British Journal of Middle Eastern Studies* (2023), pp 1-20.

[76] Anne Hardy and E. M. Tansey, 'Medical enterprise and global response, 1945-2000' in *The Western Medicine Tradition: 1800-2000,* ed. W.F. Bynum (New York, Cambridge: Cambridge University Press, 2006), p. 438.

[77] Robin Wolfe Scheffler, *A Contagious Cause: The American Hunt for Cancer Viruses and the Rise of Molecular Medicine* (Chicago, IL, 2019; online edn., Chicago Scholarship Online, 23 Jan. 2020), [Accessed 15 May 2023].

[78] J.H. Jr. Comroe, 'Pay Dirt: the story of Streptomycin. Part I. From Waksman to Waksman', *American Review of Respiratory Disease* 117 (4) (1978), pp. 773-781.

[79] Lara V. Marks, *The Lock and Key of Medicine: Monoclonal Antibodies and the Transformation of Healthcare* (New Haven: Yale University Press, 2015).

[80] Scheffler, *A Contagious Cause*.

there were specific connections between the rapidly expanding pharmaceutical industry powered by research and development (R&D), and the Palestinian refugee camps.

From the 1940s therapeutic boom into the 1960s, the crucial bonds of trust between scientist/doctor and recipients/patients that held the development of modern medicine together—'the social contract of utilitarian medicine'—began to show signs of fracturing.[81] Historian Cathy Gere adeptly argues that societal and individual trust placed in utilitarian medical experimentation 'for the good of the many' was rocked by tragedies and misadventure during this period. Coupled with this fracturing, the 1970s bought a wave of instability to the Western economic-medical enterprise, with oil-crisis induced inflation escalating the costs of research and development (R&D).[82] Nevertheless, the West was becoming increasingly healthy, not least with the retreat of infectious diseases (Poliomyelitis, Tuberculosis, Smallpox) due to successful eradication campaigns. In this context, what sort of 'settlement' (if any) existed between refugees with the Western medical enterprise in this post-war period? International bodies established in the post-war period, principally the WHO founded on 7 April 1948, sought to solidify and extend the reach of Western medicine globally but recent historiography of global public health continues to challenge the constraints of the centre-periphery model 'tracing cross-national connections and entanglements, giving due attention to developments in colonial and postcolonial spaces, exploring the construction of asymmetric hierarchical networks, and examining how people, ideas, and practices have changed in processes of transnational circulation'.[83] I acknowledge a normative centre-periphery exchange framing the subsequent discussion of how pharmaceutical philanthropic donations and vaccine trials connected the Palestinian refugee camps and the refugees themselves to a Western endeavour of disease prevention.

Historical scholarship has discussed the flight and encamped experiences of refugees, but in order to present a detailed medical experience in the context of globalising humanitarianism and emerging development agendas, and medical advancement, four inter-related questions are central to this thesis.

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[81] Cathy Gere, *Pain, Pleasure, and the Greater Good: From the Panopticon to the Skinner Box and Beyond*, (Chicago: University of Chicago Press, 2017).

[82] Hardy and Tansey, 'Medical enterprise and global response', p. 407.

[83] Cueto et al., 'The meaning(s) of global public health', 2020.

- What was the nature and form of medical humanitarian response in the Palestinian and Sahrawi refugee camps, particularly in the initial months of the refugee crisis?

- How did the Palestinian and Sahrawi refugees experience, or interact with, humanitarian healthcare?

- Did medical humanitarianism constitute transformative change?

- What comparisons can be drawn between the two refugee camp contexts and the different forms of medical humanitarianism in the mid-1940s and the mid-1970s?

This thesis responds to these core questions by presenting a history of medical humanitarian beginnings in two refugee camp contexts, by putting forward an analysis of the foundations that were laid by humanitarian actors and institutions responding to refugee crisis and refugee encampment in 1948-1953 in the Middle East and in 1975-1976 in the Western Sahara. It does this in full recognition of the emerging development/Development agendas of the time (meaning, 'development' in terms of regional economic development strategies that were exported to the 'developing world' and 'Development', the phenomenon of global international Development strategies with a capital D: the structuring of world economies and societies tethered to the West) and considers how medical humanitarianism is moulded by states and the geopolitics of the time, but also by the refugees themselves. It considers a specific case of interaction between the development of Western preventive medicine and the Palestinian refugee camps, namely a measles vaccination programme.

There is a relative imbalance between the analysis of the Palestinian refugee camps and that of the Sahrawi refugee camps, with the discussion weighted towards the former. This imbalance is, in part because of a decision to include a full chapter discussing the measles vaccination campaign in the Palestinian refugee camps between 1965 and 1975. This chapter has three functions; first, it enables detailed analysis of a case of specific medical humanitarian programme in refugee camps (where detailed examples are few in the historical scholarly literature) and evidences a humanitarian commitment to preventative medicine coupled with vital philanthropy from pharmaceutical companies; second, it extends analysis of the Palestinian refugee camps over nearly three decades and third, it provides a bridge to the final chapter discussing the Sahrawi refugee camps from 1975, thereby enabling a full discussion of the changing context of globalising humanitarianism across a 'full arc' from 1948 to 1976. However, the inclusion of the

Sahrawi case, despite its focus on just the beginnings of the refugee crisis, enables a comparison of *the foundations* of two exceptional cases, that nevertheless share important conceptual space as protracted refugee camps. The comparison demonstrates that, despite being separated by thirty years, the nature and form of the medical humanitarianism in the two camp contexts share characteristics, yet the Palestinian refugee camps and the Sahrawi refugee camps experience of medical care was far from identikit. The globalising development-humanitarianism nexus interacted with the two refugee camps in very different ways and with different results; this thesis enables a discussion of this, not least because the Sahrawi refugee camps themselves have received less attention in the scholarly literature in the English language. Further research could stretch the analysis of this thesis beyond 1976 to uncover further specific details of medical humanitarian action that took place once the Sahrawi camps were more established. However, the proliferation of information generated by the Western humanitarian system lends itself to historical analysis of how this system has changed between the more immediate post-war period, and the mid-1970s, and in turn, how refugees interacted with the system and created their own futures.

Methodology

Methodologically, this thesis is anchored in archival research. The decision to write about Palestinian and Sahrawi refugee camps followed the trails left in the archives of the British state, UN agencies and Save the Children Fund (SCF). Data pertaining to other refugee camp contexts, in Thailand for example, (particularly information relating specifically to medical activity) was very sparse or absent in the archives. Precarious situations of emergency and mass displacement tend to lead to rapid decision-making, lost documents, and strained practices of record-keeping, which places certain limitations on the work of historians and limitations will be many. The empirical work of this thesis began in the British state archives and led to archives of international and non-governmental organisations in Birmingham, New York City and Geneva. This thesis is scaffolded by evidence which, on the one hand relates to the physical, bodily experience of disease and health; and on the other hand, pertains to the humanitarian response and action (donations, services, personnel deployments, infrastructural developments). Scrutinising the evidence relating to Palestinian and Sahrawi refugee camps enables a representation of life in two refugee camps at different junctures of humanitarian history, that otherwise has not been fully presented.

The archives of the United Nations Information System on the Question of Palestine (UNISPAL) are also integral to this thesis. At the time of writing, access to the UNRWA

archives in Amman was restricted, forcing attention online. The UNISPAL archives enabled a deeper scrutiny of the point of emergency in the Palestinian camps, and the crucial years prior to the formation of UNRWA. Annual, interim, and advisory reports archived with UNISPAL enabled a thorough investigation of the relationship between the UN Economic Survey Mission for the Middle East (henceforth, ESM), development approaches, refugee relief and the health of Palestinian refugees. Research at the UN archives in New York City focused on fonds of the UN Mediator for Palestine, Count Folke Bernadotte (1948-1949) and his successor Ralph J. Bunche, including examination of documents relating to the UN Disaster Relief Project (UNDRU), UNICEF[84], and the ESM. Fonds of the UN Conciliation Commission on Palestine (1948) included evidence relating to the work of the Red Cross movement. Sources here (and in archives in UK, and Geneva) included public documents (general assembly resolutions, published reports, newspaper clippings), internal communications (memorandum, cables, telegrams, reports, photos, proformas and instructions, letters, progress reports, maps), and personal documents (letters, handwritten notes, draft reports and memos, photos). Critical reading of formal sources (particularly official reports) was undertaken alongside the scrutiny of the contrasting minutia of formal cables, informal notes, private letters, and draft memorandums. These sources provided more immediate responses to situations, more emotional comments that are less guarded than formal reports constructed for broader audiences, partner organisations and/or funders. These types of sources enable a reading of humanitarian programmes between the lines of the formal reports.

The archives of the International Federation of the Red Cross (IFRC) were crucial for deeper appreciation of the role of the League, working in concert with the UN in the years preceding the development of UNRWA.[85] Here, a key final report from 1950[86] was consulted in conjunction with the League Reports to the UN on this early, unique mission to the Middle East. The IFRC archives also contained valuable documents pertaining to the Sahrawi refugee crisis. For this reason, more time and attention were allocated to the League archives at the expense of the ICRC archives and library. My attention was further steered from the ICRC because of the

[84] At the time of my archival research trips in October 2019, the UNICEF archives (New York City, USA) were closed for high-level review of the UNICEF core records heritage.

[85] On 26-30 November 2018, I was very kindly hosted at the IFRC archives by archivist Grant Mitchell. These were the final days running up to their move from temporary premises above IKEA in Vernier, Geneva, to new premises in the city. As part of this major relocation, the system of box labelling was transitioning to a new system. I use the new system of labelling, which was the system available to me at the time of my visit.

[86] IFRC, Vernier, R510504929 (Box 3) (Box 3), 'League of the Red Cross Societies, Relief Operation in [sic] behalf of the Palestine Refugees, 1949-1950', Geneva, 1950.

Committee's responsibility for activity within the territories of Palestine instead of the adjoining states.[87]

To deepen understanding of the Palestinian experience beyond the initial few years of crisis, it was necessary to scrutinise the archives of the WHO in Geneva. Study of the WHO Third Generation files (1955-1983) enabled study of the three decades following the establishment of UNRWA. In addition to published material and internal communications, I was able to consult two binders of 133 photographs (Palestine Refugees) that were, at the time of consultation un-digitised and not yet catalogued. Key files in the WHO archive related to the development of a measles vaccination campaign in Palestinian refugee camps, 1965-1975, which enabled the writing of Chapter Three and provided a chronological bridge to Chapter Four, which opens in 1975 in the Western Sahara. Alongside archival work, the third chapter draws from medical journals published between 1959 and 1969 and the peer-reviewed articles relating to measles vaccination trials in the United States and the 'developing world'.

The archives of UNHCR drew attention to important contextual information relating to the Spanish Saharan conflict. Within Western Sahara fonds (1976-1981) it was possible to consult public documents (UN General Assembly, Security Council and Economic and Social Council Commission on Human Rights resolutions) alongside published reports (for example a mission report from 14-20 December 1975) to gain deeper appreciation of the status and eligibility of the refugees, and the vulnerability of their health status. The UNHCR archives included limited evidence relating to the medical and health experience of alternative refugee camp contexts (Namibia, Angola, Thailand, North Vietnam), sources which could open-up avenues for future research.

Research was also undertaken at the archives of the World Council of Churches (WCC), at the Ecumenical Centre in Geneva and the SCF held at the University of Birmingham's Cadbury Research Library Special Collections. At the latter, a special collection introduced me to a SCF nurse, Mary Katherine Hawkins, who worked in Lebanon and Jordan in the post-war period. The British state archives, where this archival journey began, provided insight into the British government response to the Sahrawi refugee crisis, which opened-up a line of enquiry into the

[87] An important source on the ICRC's medical activity within the Palestinian territories between 1 January 1949 and 30 April 1950 (Covered by four separate reports): ACICR-BG.59/1/GC/E: Comité International de la Croix – Rouge, 'Rapport général d'activité du Commissariat du Comite International de la Croix-Rouge pour l'aide aux réfugiés en Palestine', Beirut, 1950.

role of states as humanitarian forces, a key issue for Chapter Four. The archives in Kew also provided access to reports from NGOs that might have otherwise been overlooked due to their presence in smaller, less accessible archives.

Whereas this thesis could never be a full reconstruction of the medical experience of refugees, it is a faithful account of the nature and form of medical humanitarianism in two refugee camps in the post-war period. It respectfully acknowledges and gives expression to, the experience of the refugees and the humanitarian actors and institutions that responded at times of mass displacement and refugee camp life. English language sources are the backbone of this thesis because English is the only language I read to a level of competency. Limited French sources are included within the thesis, of which translations were provided by two associates acknowledged above. My language limitations necessitated a focus on Western humanitarianism, and specifically British, American, and Swiss-born humanitarianism. Contributions of other nation states (Algeria, Cuba, Iran) are glimpsed through their connections with organisations such as the WHO, UNRWA, and the League. An ability to read and speak Arabic, French, or the languages of the Sahrawi people, could enable the writing of a more nuanced subaltern history focused on cultural sources. And I acknowledge that oral history is missing, which would illuminate the experiences of refugees.[88] I also acknowledge that a reliance on English language reinforces the Western centric perspective of humanitarianism, further obfuscating the role of Islamic and other non-Western/Northern humanitarian operations.[89]

Archival research risks the construction of an institutional history at the expense of refugee history. The histories of refugees as individuals, groups, and communities can be obliterated in institutional archives which emphasize the perspectives of non-refugee actors. As above, these actors prioritise the promotion and the protection of their own action, the action of the organisations they represent: the value, the complications, and implications of this action. The refugees are beneficiaries, subjects to be reported on (but not in their own voices), and these recipients are often grouped together for ease of reporting, for quantitative and qualitative impact. However, refugees are not a delimited group or identikit individuals, but rather people displaced by diverse historical and political causes in vastly unique situations facing unique

[88] For a practical guide to decolonising the humanitarian sector see: Health in Humanitarian Crises Centre (HIHCC), *Decolonising our Work at the Health in Humanitarian Crises Centre: Implementation Guidance,* Undated. Document shared with me electronically by the HIHCC in April 2023.

[89] Michael Barnett and Janice Stein, *Sacred Aid: Faith and Humanitarianism* (Oxford: Oxford University Press, 2012).

challenges.[90] In the same way that it is problematic to group all people living under an arbitrary poverty line as a homogenous mass of 'the poor'[91], it is misleading to consider all refugees living within a refugee camp as a homogenous group experiencing deprivation or access in the same way. Individual refugees and groups of refugees will have differing levels of access to services, and varying degrees of health care opportunities; class, wealth, gender, age, status, geography, physical and mental health will contribute to determining the life (and death) experiences of an individual and groups of refugees. As Edward Said wrote: 'there are many different kinds of Palestinian experience, which cannot be assembled into one. ... It is almost impossible to imagine a single narrative'.[92]

This thesis includes stories of refugee resistance when they are found. Specific examples of refugee individual experience are included, but it is important to acknowledge that these representations can reduce the subject to their suffering and victimhood.[93] For example, a reference is included to a Palestinian boy who drowned in a latrine. I reference a Sahrawi girl's memories of a napalm bombing and her later loss of limb. However, I include these stories, not to perpetuate the refugee as victim narrative but because refugee lived-experience and death experiences are often marginalised in the historical narrative.

This thesis will proceed according to the following roadmap.

A roadmap

Chapter One investigates the medical humanitarian response at the point of emergency as thousands of people were forcibly displaced following the end of the British Mandate in Palestine and the Arab-Israeli War in (1948-1949), and a complex map of Palestinian refugee camps were established. Histories of the conflict and of the mass displacement of the Palestinians are many, yet few authors investigate the specific medical and health experience of the refugees, or the medical humanitarian response. Yet, in the first two years of the refugee crisis, the foundations were laid for decades of encamped life for the Palestinians. What was the

[90] Malkki, 'Refugees and Exile', p. 496.

[91] Irvine Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal. Mortality, 1800-*1950 (Oxford: Clarendon Press, 1992), p. 46.

[92] Edward Said with Jean Mohr, *After the Last Sky: Palestinian Lives* (London: Faber & Faber, 1986), p. 6, cited in Gatrell, *The Making of the Modern Refugee*, pp. 144-145.

[93] Liisa H. Malkki, 'Speechless Emissaries: Refugees, Humanitarianism, and Dehistoricization', *Cultural Anthropology* 11(3) (August 1996), pp. 377-404.

reality of medical humanitarian action at this important moment when the refugee crisis was acute, and before UNRWA was established as the agency responsible for the refugees? One of the key findings relates to how the League had an important role within these new waters of international relief, and how an unprecedented partnership took place involving the League and the UN. This chapter investigates if this partnership was successful in generating a health and medical response that was in some way restorative or transformative.

Chapter Two. The Economic Survey Mission for the Middle East (ESM), established in August 1949, laid the anchor in the Palestinian refugee camps for an ongoing relationship between the refugees and the ideology of development. The ESM gave UNRWA, the new agency tasked with refugee management, a mandate to care for the refugees with a strategy designed along economic lines. This chapter considers how ideologies of development interacted with ideologies of medical humanitarianism and considers the implications for the Palestinian refugees. There is an overlap in the time periods under study in Chapter One (1948-1950) and Chapter Two (1949-1953). As feminist theorist Cynthia Enloe has argued, vigilance is required in any post-war period, vigilance in understanding how powerful actors use the post-war period to fashion lessons and shape future conflicts.[94] And to ensure vigilance, this second chapter allows for full discussion of the ESM through the lens of refugee health and medical humanitarianism. The ESM imagined Palestinian health along technocratic lines, ushering agricultural modernism and global development into the medical humanitarian landscape of the Palestinian refugee camps in the first three years of their existence, but did this underscore a new phase of transformational humanitarianism?

Chapter Three focuses the lens on a specific application of Western modern medicine in refugee camps. Through close examination of a measles vaccination campaign run by UNRWA and the WHO in Palestinian refugee camps between 1965 and 1975, this chapter argues that the refugees both contributed to and resisted the R&D of modern measles vaccines. Throughout history and into the twenty-first century, controversy clings to vaccination,[95] and through examination of pharmaceutical donations to the Palestinian refugee camps—and the research trials that accompanied them—this chapter considers how episodes of pharmaceutical philanthropy related to norms of medical ethics. Here, the chapter addresses an important case of overt refugee

[94] Cynthia Enloe, *The Morning After: Sexual Politics at the End of the Cold War* (Berkley: University of California Press, 1993), p. 177.

[95] Paul Greenough, Stuart Blume, and Christine Holmberg, eds, *The Politics of Vaccination, A Global History*, (Manchester: University of Manchester, 2017), p.1.

resistance, and the use of technology new to humanitarian fields: the Ped-O-Jet pneumatic inoculation gun.

Chapter Four turns to the Sahrawi refugee crisis in 1975-1976, when thousands of refugees were displaced to territory near Tindouf, Algeria and considers the beginnings of what would become another protracted refugee camp context across the border from a contested state. This chapter argues that despite the tethers to the 'great network of humanitarianism' which burgeoned in the mid-1970s,[96] the Sahrawi refugees remained in a state of unmet crisis one year after the point of initial emergency. However, through their experiences of medical humanitarianism, the Sahrawi refugees were linked to important humanitarian movements, including the nascent MSF and medical action sponsored by allied states. But ultimately, the Sahrawi case is exceptional: it was the Sahrawi themselves, not the agents of 'observational humanitarianism' that constructed foundational systems of medical care.

In summary: Ideology, Movement, Practice

Antonio Donini summarises the three realities of humanitarianism as an ideology, a movement, and a profession.[97] The original funding proposal for this thesis was based on the question, how did the professionalisation of humanitarianism impact health in refugee camps? This project subsequently evolved to explore how medical humanitarianism interacted with ideologies of development; how the humanitarian movement was characterised in two protracted camp contexts at the foundational years of their establishment; and how practices (as opposed to profession) of humanitarianism engaged with the 'great network of humanitarianism', including how pharmaceutical philanthropy was bought into the realm and how refugees themselves shaped medical humanitarian responses.

Liisa Malkki describes how refugees are frequently assigned to 'a floating world' above political structures and beyond official histories:

> People who are refugees can also find themselves quite quickly rising to a floating world either beyond or above politics, or beyond and above history—a world in which they are simply "victims". ... it is this floating world without the gravities of

[96] Agier, *Managing the Undesirables*, p.200.

[97] Donini, 'The far side', 2010.

> history and politics that can ultimately become a deeply dehumanizing environment for refugees, even as it shelters.[98]

The Palestinian and Sahrawi refugees, despite living in 'floating worlds' wherein they are in many ways incapsulated in the camps, the refugee camps and the refugees are linked to globalising development agendas, intrinsically connected to the advances of modern Western medicine, and full of life interplaying with the evolving humanitarian movement.[99]

[98] Malkki, 'Refugees and Exile', p.518.

1. Beginnings: Emergency Medical Humanitarianism in Palestinian Refugee Camps, 1948-1950

The history of Palestinian refugee health, and the medical humanitarian response to the refugee crisis involves complex movements of people, countless spontaneous settlements of refugees, and the creation of refugee camps across more than six countries and territories. The purpose of this chapter is to consider the nature and form of medical humanitarianism in the first two years of the crisis, and to better understand the foundations of what would become decades of encamped life. In the Palestinian refugee camps, the UN and associated organisations driving medical and health activity within programmes of relief, took an approach of 'adequacy-only' and delivered medical relief to a minimum. Between May 1948 (when the state of Israel was established) and April 1950 (when UNRWA took responsibility for the refugees) the Palestinian refugee situation morphed almost immediately, from a situation of emergency to a 'humanitarian condition'[1] of what I call permitted endurance—a condition into which the refugees would become stuck for decades. Vulnerable lives were quickly identified as the priorities within this humanitarian landscape, with the early response including a medicalised infant feeding programme led by UNICEF. Mothers and children were central to the early response and resources were prioritised towards new lives. But the programme was pitted with challenges, some of which have not been documented in the historical scholarly literature. Furthermore, G. Daniel Cohen has argued that Protestant Christian organisations played a leading role during the first two years of the humanitarian response.[2] And while these faith-based organisations and individuals were important actors, a landmark partnership involving the League of Red Cross Societies (the League)[3] and the UN, largely overlooked in the literature, was crucial in the medical humanitarian landscape before the establishment of UNRWA.

The first relief organisation set up by Count Folke Bernadotte, the UN Mediator for Palestine was the United Nations Disaster Relief Unit (UNDRU), a unit intended to manage the relief

[1] Ilana Feldman, *Life Lived in Relief: Humanitarian Predicaments and Palestinian Refugee* Politics (Oakland: University of California, 2018), pp. 15-16.

[2] G. Daniel Cohen, 'Elusive Neutrality: Christian Humanitarianism and the Question of Palestine, 1948-1967', *Humanity: An International Journal of Human Rights, Humanitarianism, and Development,* 5 (2) (Summer 2014), pp. 183-210.

[3] Founded in 1919, the League was not officially named the League of Red Cross and Red Crescent Societies until 1983. The name was changed again to the International Federation of Red Cross and Red Crescent Societies (IFRC) in 1991. See: IFRC, 'Our history and archives <https://www.ifrc.org/our-history-and-archives> [accessed 12 October 2023].

effort independently from Bernadotte's office.[4] It estimated there were 500,000 refugees by October 1948, with refugee numbers increasing following local conflicts and readjustments of movement due to pressures from climate, employment opportunities, and access to food and other resources. The Israeli capture of the Naqab below Hebron, and the capture of land in North Galilee up to the Lebanese border (12 October 1948), forced a further 200,000 refugees from their homes.[5] By November 1949, nearly 700,000 refugees were scattered across the region.[6] A year into the crisis, the UN summarised the movements as follows:

> About 70,000 crossed the Jordan River to the east and are now in the Hashemite Kingdom of Jordan. About 97,000 fled into Lebanon, just north of Galilee. Some 75,000 are clustered near the south and western boundaries of Syria, and in and around Damascus and other towns. About 200,000 are crowded into the tiny coast desert area called the Gaza strip, at present held by Egypt. About 280,000 are in that part of Palestine not occupied by Israel–west of the Jordan–from Jenin in the north to Jericho and the Arab portion of Jerusalem and on beyond to Bethlehem in the south. About 4,000 crossed the desert to Baghdad in Iraq, far to the east. In addition, some 31,000 Arabs and 17,000 Jews, classed as refugees by the international relief agencies, are in Israel.[7]

The UN agencies circulated these refugee numbers as a 'biological aggregate', which is how anthropologist Julie Peteet describes the packaging of a very complexly distributed refugee population into an object of intervention that could be administered with aid.[8] Peteet argues that in the refugee camps in Gaza, where the American Friends Service Committee (AFSC) assumed responsibility for providing relief to the refugees, the AFSC, working with the International Committee of the Red Cross (ICRC) and UNRWA used biopolitical techniques to 'render refugees knowable and manageable', i.e., 'classification, enumeration, the census, the rations and medical system' all of which objectified the refugees and reduced them to 'an aggregate' which could be managed. She argues:

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[4] UNA, NYC: AG-022: S-0616-17(3), 'Memorandum on organisation for Palestine Relief Organisation', 27 October 1948.

[5] UNA, NYC: AG-022/S-0616, 'Minutes of Disaster Relief Project', 7 December 1948.

[6] UNISPAL, A/1106, 'First Interim Report of the United Nations Economic Survey Mission for the Middle East', 16 November 1949

[7] UNISPAL, A/1106, 'First Interim Report of the ESM', 16 November 1949.

[8] Julie Peteet, *Landscape of Hope and Despair, Palestinian Refugee Camps* (Philadelphia: University of Pennsylvania Press, 2005), p. 70.

> Providing aid necessitated a composite refugee requiring a specific caloric intake (determined according to sex and age), shelter, water, and clothing.[9]

Peteet's research centres on refugee camps in Lebanon, complementing Nancy Gallagher's work on the refugees in Gaza and the work of the AFSC. To build on this scholarship, I have undertaken a detailed accounting of the medical and health experiences of the refugees in camps within the Hashemite Kingdom of Jordan, research which shows how the League also reduced the refugees in ways to make them 'knowable and manageable'. In an ethnographic study of refugee camps in Lebanon, Julie Peteet also looks back to 1948 and highlights a UNICEF programme and that a WHO health survey took place.[10] The impact of these specific medical interventions is disputable, for example, the relationship between UNICEF and the UN was fractious, and there were flaws indicated in the programme of milk distribution; the WHO health survey that took place in the early years of the response was never formally circulated or implemented. Both will be discussed below.

Within the Jordanian territory, many of the earliest refugee camps were small and temporary. In December 1948, a UNICEF delegation to the North of Palestine and Transjordan reported on camps made-up of tents donated by the Arab League[11] in El Zerka (around 25km from Amman on the Amman-Irbid road) and North Shuneh (also in the Jordan Valley) that were inhabited by 3,000 and 1,500 refugees, respectively.[12] Over the course of two years, by November 1950, the number of camps grew to over 45 refugee camps and installations under the League's field of operations in Jordan, Syria, and Lebanon alone.[13] This expansion of refugee camps occurred in spite of resistance on the part of the UN Relief for Palestine Refugees (UNRPR), which expressed objections to the formation of camps in host countries. Camps were seen as obstacles to 'absorption', i.e., refugee assimilation within the host states, and were considered by many to be environments that cushioned the refugees and supported a dynamic of refugee dependency on UN relief.[14] However, refugees were not just living in tents in camps, but in town and on the outskirts of towns, in caves and underground. In Irbid, Transjordan there were 80 villages

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[9] Peteet, *Landscape of Hope and Despair*, p.70.

[10] Peteet*, Landscape of Hope and Despair*, p.57.

[11] UNA, NYC: AG-022: S-0626-0002-50, 'UNICEF Delegation for Trans-Jordan and North Palestine', undated. Sources surrounding this document date the camp visit to have taken place on 7 December 1948.

[12] UNA, NYC: AG-022: S-0626-0002-50, 'UNICEF Delegation for Trans-Jordan and North Palestine', undated.

[13] IFRC, Vernier: R510504929 (Box 3), 'League of the Red Cross Societies, Relief Operation in [sic] behalf of the Palestine Refugees, 1949-1950', Geneva, 1950.

[14] UNA, NYC: AG-022/S-0616, 'Minutes of Disaster Relief Project', 7 December 1948.

sheltering refugees; refugees were sheltering in the Convent of Sisters of Rosary in Husson; refugees were living in the town of Ajlun; approximately 40,000 refugees were in the capital, Amman; 12,000 were living in the town of Salt, and an unknown number were residing in Madaba and Ma'an towns.[15]

The UN Mediator anticipated a two-stage relief programme. First, a temporary response focused on a period of emergency relief between May and September 1948, followed by a short-term programme planned to run from September to the end of the year.[16] The UNDRU, set-up in October 1948 was charged with handling the donations made in response to the Mediator's appeals and was largely concerned with rations distribution. Sir Raphael Cilento was appointed as head of the unit. An Australian, Cilento was a noted authority on tropical medicine and gained significant experience of refugee management as United Nations Relief and Rehabilitation Administration (UNRRA) Director of the British Zone in Occupied Germany.[17] By September 1948 the relief activities had gained significant momentum and a programme of milk distribution led by UNICEF was officially launched on 16 September, indicating the first medicalised aspect of the UN programme.

Following on from the UNDRU, the UN Relief for Palestine Refugees (UNRPR) was created in November 1948 as a specialist agency temporarily mandated to provide emergency relief to the refugees.[18] The UNRPR was a working collaboration between the UN, the League, the ICRC, and the AFSC. This was the first large-scale collaboration between the UN and the League, which itself assumed the operational name of The Middle East Commission of the League of Red Cross Societies (henceforth, referred to as the League Commission). Herein, the League Commission assumed a substantive leadership position —working in concert with the United Nations rather than as a conduit—and gained opportunity to influence the nature and form of the response. Of course, the League was not the only partner involved: the ICRC took responsibility for relief within the Israeli-controlled territory, the AFSC supported the Gaza

[15] UNA, NYC: AG-022: S-0626-0002-50, 'UNICEF Delegation for Trans-Jordan and North Palestine', undated.

[16] UNISPAL A/648, *Progress Report of the United Nations Mediator on Palestine*, United Nations General Assembly Official Records: Third Session, Supplement no.11, 16 September 1948.

[17] Under the Berlin Declaration of 5 June 1945, the German state was under military, political and administrative occupation by Britain, France, USA, and the Soviet Union. Commissions were set-up within transit camps in the different zones, to decide whether refugees were entitled to seek sanctuary in other territories. See Mark Finnane, 'Raphael Cilento in Medicine and Politics: Visions and Contradictions', *Queensland Review* 20 (1) (2013), pp. 4-14.

[18] Gatrell, *The Making of the Modern Refugee,* p.130. UNISPAL, A/RES/212 (III), UN General Assembly Resolution 212 (III) 'Assistance to Palestine Refugees', 19 November 1948.

camps, and the League assumed responsibility in the neighbouring countries of Lebanon, Jordan, and Syria. This collaboration and the direct participation of the Red Cross preceded the establishment of UNRWA. This collaboration would serve as a framework for future joint activities between the Red Cross and other UN agencies, not least the UNHCR.[20] Historian Nancy Gallagher argued that UN Secretary General, Trygve Lie, feared losing control of the project to the ICRC or the League and was careful therefore not to give the Red Cross too much responsibility, engaging the AFSC on the suggestion of Eleanor Roosevelt as a further balance against a potential loss of influence.[21] This crisis was the first time that the AFSC too was funded by, and responsible for the distribution of supplies for the UN. As Gallagher points out, this pioneering action would become the norm with international voluntary non-governmental organisations' distributing emergency relief supplies provided by the UN and funded by governments.[22]

In his opening address to the 17th International Red Cross conference on 20 August 1948, Basil O'Connor, Chairman of the Board of Governors of the League (and President of the American Red Cross) spoke:

> The eyes of the world watch us with desperate hope, for out of the trial of two World Wars the Red Cross has emerged stronger, more capable than ever before. Responsibility walks hand-in-hand with capacity and power.[23]

Despite such claims of institutional strength and prestige, the ICRC had emerged from the Second World War with its reputation in question. It received notable criticism from the Soviet Union for its alleged inaction during the war and failures to denounce the Nazi death camps as well as to mitigate the harsh treatment of Soviet prisoners held by Germany.[24] Criticism of the

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[20] IFRC, Vernier: R510504929 (Box 3), UNHCR pamphlet, 'The Red Cross and the Refugees', 8 May 1963.

[21] Gallagher*, Quakers in the Israeli-Palestinian Conflict,* p. 14.

[22] Gallagher, *Quakers in the Israeli-Palestinian Conflict*, pp. 17-18.

[23] Library of Congress Online*,* 'Seventeenth International Red Cross Conference Report', pp. 27-28 <https://tile.loc.gov/storage-services/service/ll/llmlp/RC_XVIIth-RC-Conference/RC_XVIIth-RC-Conference.pdf> [Accessed 4 June 2023].

[24] Eleanor Davey, John Borton, and Matthew Foley, 'A history of the humanitarian system: Western origins and foundations', *Humanitarian Policy Group Working Paper, Overseas Development Institute* (June 2013), pp. 1-37. For further discussion and analysis of the ICRC internal debates regarding Soviet prisoners see Jean-Claude Favez, *The Red Cross and the Holocaust* (Cambridge: Cambridge University Press, 1999). For discussion of the ICRC's access to the concentration camps see also David P. Forsythe, *The Humanitarians: The International Committee of the Red Cross* (Cambridge: Cambridge University Press, 2010), pp. 45-46: Forsythe claims that the ICRC never achieved systematic and meaningful access to the Nazi camps and that no evidence had been uncovered in the ICRC archives of overt anti-Semitism.

Red Cross in the wake of the Holocaust was a powerful motivator for the League to also prove itself. Historian Dominique Junod argues that political convictions drove the ICRC's activity in the early years of response within the Israel-controlled Palestinian territories.[25] When its reputation was at stake, representatives of the ICRC and the League expressed an urgent desire to implement its humanitarian responsibilities and synchronise plans for relief in the Middle East with the general relief scheme spearheaded by the UN Mediator for Peace.[26]

Historical anthropologist, Ilana Feldman has studied the conditions of humanitarian life in Palestinian refugee camps over a seven-decade period, from 1948 to the present day, drawing principally from documentary records from the 1990s and ethnographic fieldwork between 2008-2014 in Lebanon, Jordan, and the West Bank.[27] From a twentieth century perspective, Feldman argues that:

> Over the course of many decades of displacement, Palestinians and aid providers have been caught in the movement between the "humanitarian situation"—the emergency that presents itself as pressing and mobilizes a humanitarian machinery; and the "humanitarian condition"—the less acute, but no less fundamental, experience of living and working in circumstances of long-term displacement and need.[28]

Building on Feldman's thesis, I argue that the Palestinian refugee situation morphed almost immediately, between 1948 and 1950, into a humanitarian condition of permitted endurance, a condition into which the refugees became stuck for decades. The medical humanitarian action undertaken by these early responders to the Palestinian crisis, particularly the UNDRU and then the League Commission working in concert with the UNRPR demonstrates how instead of permitting them to die, the refugees were permitted to endure through a humanitarian approach that was committed to *adequacy-only* and providing aid to a minimum.

A strand of scholarly work discusses gender discrimination in Palestinian refugee relief since the 1950s, including work by Christine M. Cervenak and Kjersti G. Berg. Cervenak's extensive analysis of the evolution of gender-based discrimination against certain groups of women and

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[25] Dominique D. Junod, *The Imperiled Red Cross and the Palestine-Eretz-Yisrael Conflict* (London: Kegan Paul International, 1996).

[26] UN, NYC: AG-022-S-0616-0001-15, Incoming Message, H. Beer, Secretary General of the Swedish Red Cross to Count Folke Bernadotte, 4 September 1948.

[27] Feldman, *Life Lived in Relief,* p. 27.

[28] *F*eldman, *Life Lived in* R*elief*, p. 15.

their children since the formation of UNRWA[29] offers a legalistic contrast to the analysis of UNRWA by historian Kjersti Berg who emphasises the agency's bias towards motherhood and gendered family roles wherein women are essentialised as mothers, leaving the men to be essentialised as productive.[30] The semantic coupling, 'womenandchildren'[31] has become firmly established in the lexicon of humanitarianism and constitutes a category for relief that dominates humanitarian projects into the twenty-first century.[32] In her review of the end of the Cold War period, Enloe emphasised how the media was gratified by a gendered humanitarian imagining: women could be presented as family members rather than independent actors, innocent victims that needed to receive protection from powerful statesmen.[33] The gendered nature of the emergency humanitarian response that predated UNRWA prioritised womenandchildren (or more specifically *mothers*andchildren) as a category for relief in the early Palestinian camps.

The medical and health conditions of the refugees

When Count Folke Bernadotte issued his appeal to the international community, just one day before his assassination, he entreated the international community to act based on a humanitarian imperative[34]—to save the lives of thousands of refugees and to not permit them to die.[35] I use the phrase 'humanitarian imperative' because it encapsulates the spirit with which the UN Mediator pleaded to the international community, emphasising the need to take immediate action in response to a crisis; that this action was of vital importance and should be made on

[29] Christine M. Cervenak, 'Promoting Inequality: Gender-Based Discrimination in UNRWA's Approach to Palestine Refugee Status', *Human Rights Quarterly*, 16 (2) (May 1994), pp. 300-374.

[30] Kjersti G. Berg, 'Gendering Refugees: The United Nations Relief and Works Agency (UNRWA) and the Politics of Relief' in *Interpreting Welfare and Relief in the Middle East*, eds. Nefissa Naguib and Inger Marie Okkenhaug (Leiden: Koninklijke Brill NV, 2008).

[31] Enloe described white 'womenandchildren' protected by legitimate state action during the Gulf War in 1990, and womenandchildren escaping war in Bosnia and Somalia. Cynthia Enloe, *The Morning After: Sexual Politics at the End of the Cold War* (Berkley: University of California Press, 1993), pp. 165-166.

[32] Erica Burman, 'Beyond 'Women vs. Children' or 'WomenandChildren': Engendering Childhood and Reformulating Motherhood', *The International Journal of Children's Rights* 16 (2008), pp. 177-194.

[33] Cynthia Enloe, *The Morning After*, pp. 165-166.

[34] 'The humanitarian imperative' would not be formalised into humanitarian rhetoric until several decades later, in 1994, in response to the Rwandan genocide and subsequent crisis of confidence and delivery of the system and principles of humanitarianism. The 'Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGOs) in Disaster Relief' opened with the statement: 'The humanitarian imperative comes first', formally articulating and codifying a fundamental humanitarian principle, the right of all citizens in all countries to receive and to offer humanitarian assistance. *IFRC Online,* 'Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGOs) in Disaster Relief' <https://www.ifrc.org/sites/default/files/2021-07/code-of-conduct-movement-ngos-english.pdf> [accessed 5 June 2023].

[35] UNISPAL, A/648, 'Progress Report of the United Nations Mediator on Palestine', 16 September 1948.

humanitarian grounds. Bernadotte defined the crisis in terms of vulnerability. Vulnerable groups were defined as infants, young children, nursing mothers, pregnant women, the aged, and the sick. The health of all refugees (and the vulnerable in particular) was under great stress, and they were experiencing exacerbated discomfort due to poor shelter and water supplies; there was a prevalence of eye diseases and a 'generalized existence of typhoid … some endemic enteritis and dysentery'; unfavourable environmental conditions threatened epidemics of major insect-borne diseases.[36]

An important contextual observation for this chapter is how the historical record, particularly that embodied in humanitarian reports, obfuscates the full Palestinian refugee health experience and how it interacts with medical humanitarian action; history is represented in conflicting narratives of refugee suffering, and stories of humanitarian success. It is important to include at least some of these stories of suffering, not to reduce the refugees, but to appreciate what the humanitarians were responding to (or how they represented this suffering). Defining refugees as vulnerable was core to the institution's approach and their continued striving for legitimacy.

One month on from Bernadotte's appeal, the medical emergency appeared to be worsening. Following Bernadotte's assassination, Ralph Bunche became Acting Mediator for Palestine and continued to report a generalized presence of disease, specific and localised knowledge of medical emergencies, and a lingering threat of disease.[37] Historian Margot Tudor outlines how Bunche (who became head of the UN Trusteeship Division in 1946 prior to his position in the Middle East) was an advocate for the tutelage of postcolonial populations 'not yet ready for self-governance and independence'.[38] That knowledge of medical challenges was lacking opened the way for a familiar approach of technocratic problem-solving. He reported some diseases were on the increase: 'malaria (common always at this period) and typhoid (always present but much increased lately) and actual cases of death by starvation are being reported, especially in the Nablus area.'[39]

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[36] UNISPAL, A/648, 'Progress Report of the United Nations Mediator on Palestine', 16 September 1948.

[37] UNISPAL, A/689, 'Progress Report of the Acting Mediator for Palestine submitted to the Secretary-General for transmission to the members of the United Nations', 18 October 1948.

[38] Margot l. Tudor, 'Blue Helmet Bureaucrats: UN Peacekeeping Missions and the Formation of the Post-Colonial International Order, 1956-1971', (PhD thesis, University of Manchester, 2020), pp. 16-17. Susan Pedersen, 'Dining at the White House', *London Review of Books* 45 (13) (29 June 2023).

[39] UNA, NYC: AG-022: S-0616-17(4), Draft Speech by Ralph Bunche to Committee III, 20 October 1948.

Two months later, by December 1948, the crisis rumbled on, and the leaders of the relief programme acknowledged that the medical situation remained 'uncontrolled and chaotic'[40], with camps highly liable to epidemics. From a visit to Ghor-Esh-Shuna camp in Transjordan (a small but fast-growing camp of 1,170 people, rising to 5,000), Cilento reported 'a constant threat here of epidemic diseases of grave importance.' A number of children were observed to have signs of starvation and oedema, small numbers of women ('two or three') appeared to have 'appearances ... almost indistinguishable from Beri-Beri' (a deficiency of thiamine or vitamin B1), another woman was reported dying on the ground with pneumonia. Malaria was rife, 'half the camp' were suffering from bacillary dysentery and amoebic dysentery was also quite common.[41]

In December 1948, R.M. Courvoisier, UNICEF representative for Trans-Jordan and North Palestine, also depicted a landscape of suffering and misery at the North Shuneh camp in Irbid. In this camp, the population was 1,500 refugees, 780 of which were considered 'people of concern'[42] to UNICEF:

> The misery of this camp is great. The children are almost all naked and suffering from malaria and dysentery. Most of them are attacked by the oedema. The situation of the camp is grave and the refugees are on the point of resistance. Many of the aged people cannot stand on their feet because they have been attacked by malaria. Death is increasing at an average of one dead every day. ... During the night they hyena and the jackals attack the rare poultries which the refugees still possess.[43]

These accounts of refugee suffering are perhaps not surprising. Such humanitarian crises, driven by conflict and involving mass influxes of refugees in the post-war period are expected to have had a disease profile defined by high mortality rates during the acute phase of emergencies due to conditions exacerbating endemic infectious diseases and acute malnutrition.[44] However, in the Palestinian case it must be noted that by December 1948, and the continued reports of emergency, the refugee crisis was deeply rooted. It was seven months since the declaration of the state of Israel, and three months since Bernadotte's appeal to the international community. The 'emergency' in emergency humanitarian action had become a 'plastic' word: a word which had a clear meaning in ordinary usage (in this case, a serious, dangerous situation demanding

[40] UNA, NYC: AG-022: S-0616, 'Minutes of Disaster Relief Project', 7 December 1948.

[41] UNA, NYC: AG-022: S-0616, 'Minutes of Disaster Relief Project', 7 December 1948.

[42] UNA, NYC: AG-022: S-0626-0002-50, 'UNICEF Delegation for Trans-Jordan and North Palestine', undated.

[43] UNA, NYC: AG-022: S-0626-0002-50, 'UNICEF Delegation for Trans-Jordan and North Palestine', undated.

[44] Caroline Abu Sa'Da and Micaela Serafini, 'Humanitarian and medical challenges of assisting new refugees in Lebanon and Iraq', *Forced Migration Review* 44 (Sept 2013), pp. 70-73.

immediate attention) but because of its wide use the true meaning of the word was lost. 'Emergency', in the humanitarian discourse, became a word 'so widely adopted in technocratic parlance that it no longer means anything – except what the individual speaker wishes it to mean'.[45]

Permitted endurance: Delivering refugee medical relief to a minimum

On a geopolitical level, the international community's immediate response to Bernadotte's appeal was tepid, and by 13 September 1948, whilst twenty-five of the twenty-nine nations had responded to Bernadotte's appeal, only seventeen gave unconditional affirmative responses.[46] And in its impotence to solve 'the Palestine problem' through political negotiations, the UN and the International Refugee Organization focused on material assistance at the expense of political rights and the reconciliation of questions regarding refugee legal status, disempowering the refugees' and curtailing their future return.[47] This de-politicization of the refugees essentialised them as victims, and further shifted attention to the contributions of the humanitarian responders, as opposed to the losses of the Palestinian refugees. This was the structural response to the Palestinian crisis: a tepid response, victimisation, and a focus on humanitarian materiality rather than refugee losses. In this way, the international community effectively permitted the Palestinians, not to die, but to endure.

As humans, we endure unpleasant and difficult experiences. We can suffer and survive damage to our mental, physical, and spiritual selves. We can run a marathon with a painful physical injury, survive childbirth without pain relief, or battle through Depression without seeking treatment. In modern life, endurance equates to forbearance. In a refugee camp, the limits of suffering are heightened, suffering is normalized, and the exceptional becomes acceptable. This line of thinking is influenced by the philosophy of Judith Butler and the notion that some lives are more grieveable than others.[48] The 'permitted endurance' of the Palestinian refugees became state of life wherein they were managed and looked-after according to a bearable level of suffering, a tolerable level of mental, physical, and emotional discomfort that was normalized by

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[45] Uwe Poerksen, *Plastic Words: The Tyranny of a Modular Language* (Pennsylvania: Penn State University Press,1995). Gilbert Rist, *The History of Development, from Western Origins to Global Faith* (London: Zed Books, London, 2002), p. 11.

[46] Channing B. Richardson, 'The United Nations Relief for Palestine Refugees', *International Organization* 4 (1) (Feb. 1950), p. 45.

[47] Peter Gatrell*, The Making of the Modern Refugee,* p. 130. G.D. Cohen, *In War's Wake: Europe's Displaced Persons in the Postwar Order (*Oxford: Oxford University Press, 2011), p. 146.

[48] Judith Butler, *Frames of War: When is Life Grievable?* (London: Verso, 2010).

humanitarian actors.[49] However, what is described here is a state wherein in the first two years of the refugee crisis, a state of 'permitted endurance' manifested in the medical humanitarian action in the Palestinian refugee camps, not only in the geopolitical response of the international community but through the nature and form of the medical humanitarian response. Goods and services were supplied according to a principle of 'adequacy-only', to meet needs to a minimum, only, and not to a level higher than that considered 'normal' for communities in the Middle East.

Field staff were expected to manage this state of permitted endurance, and were faulted if they tried to go beyond it. In his capacity of Director of UNDRU, Raphael Cilento professed that rations and basic services should be delivered strictly to meet only the basic level of refugee need, bemoaning the 'emotional inefficiency' of the UN field-workers delivering the aid. He demanded they be more mindful of the 'normal' life chances of Palestinian children and not to be quick to allocate resources mindlessly, like 'farm labourers':

> Then again, it is regrettable to allow oneself to be stampeded by emotion as obviously some of our officers are. Do they realize when they see infant deaths that 251 out of every 1000 Arabs born die before they reach the age of five in any circumstances, and that half of these die before they reach the age of one year? Have they realized that only a beginner at this sort of thing rushes in like a farm labourer with his harvest check and spends the whole lot at once to find himself faced with the disastrous lot of responsibilities and no supplies forthcoming with some months or some weeks at least, immediately afterwards? This is neither ability nor efficiency – it is plain emotional inefficiency and simply cannot be tolerated.[50]

Cilento's comments to Bunche, a highly influential political and practical ally of the UNDRU support how the approach of adequacy-only was grounded in a belief that acceptable standards of life should be judged against the norms of life in Middle Eastern countries or for 'normal Arab' or 'local' life. His calls for dispassionate, rational delivery were accompanied by his own racism: Cilento argued that European supervision was necessary for delivering rations in refugee camps, professing that European supervision could enable 150 people to be fed, whereas 'Arab' supervision fed only 100.[51] Resources were undeniably scarce: 'To summarise, there are three-quarters of a million people. There is a provision in the budget for only a half-million, and there

[49] Ilana Feldman uses the term 'humanitarian endurance' in her discussion of aid workers' persistence in seemingly intractable situations. In this work, Feldman reflects on aid workers presence in the Palestinian camps after sixty-five years of displacement. Ilana Feldman, 'Looking for Humanitarian Purpose: Endurance and the Value of Lives in a Palestinian Refugee Camp', *Public Culture* 27 (3) (2015), pp. 42-67.

[50] UNA, NYC: AG-022:S-0616-17(6), 'My dear Al', Letter from Cilento to Bunche, 25 October 1948.

[51] UNA, NYC: AG-022-S0616-17(6), 'UNRPR: Minutes of meeting held at offices of the Disaster Relief Project', 7 December 1948.

is a transportation system that will not carry that provision.'[52] Cilento's attitude speaks to a contradiction at the heart of the UNDRU and its response to the refugee crisis. As the unit's leader, Cilento was responsible for guiding the response and representing it to the UN and the broader international community, and whereas the unit stood for rational and objective management of scare resources, Cilento's decisions and actions were ingrained with his bias, prejudices, and emotions. Mark Finnane's biographical account of Raphael Cilento evidences the UNDRU leader's colonial racist ideologies. As a leading figure in the development of tropical medicine, Cilento's work in the 1920s was characteristically eugenicist and concerned with the colonising question of the day: 'could the white man settle in the tropics?'[53] Mark Finnane asserts that Cilento 'clung to' ideas of white settler visions 'well past their waning' into the 1970s.

At other points of the Palestinian crisis, Cilento was quick to blame colleagues for decisions which seemed to challenge this authority. In correspondence to Henri Vigier (Personal Deputy of the Acting Mediator and Principal Secretary), Cilento expressed great dis-satisfaction that a policy agreement made between himself and the late Mediator, Bernadotte—that an aeroplane would always be at his disposal for an emergency operation—was obstructed by persons on the ground. During an attempt to provide emergency food supplies in response to reports of starvation in the Jericho-Ramallah-Nablus-Jenin region, air transportation was cancelled, in Cilento's opinion, without authority by persons on the ground. He therefore blamed any loss of life on those persons, whilst also expressing derision for a proposed solution of two airlifts of milk flown to the Jericho and Jenin areas. Cilento considered this an ineffective solution that would be of benefit 'to only a few women and children':

> I will add, therefore, as my deliberate, considered opinion, that any preventable deaths in the area mentioned above pending the arrival of the major supplies by a slower form of transport, are the responsibility of any persons who prevent the provision of those interim emergency supplies which were estimated by me to be adequate to meet immediate needs.[54]

On retirement from the UN, Cilento penned a manuscript, 'Escape from UN-reality', that would never be published, about the failings of the UN and the administrative 'organized inertia of

[52] UNA, NYC: AG-022-S0616-17(6), 'UNRPR: Minutes', 7 December 1948.

[53] Mark Finnane, 'Raphael Cilento in Medicine and Politics: Visions and Contradictions', *Queensland Review* 20 (1) (2013), pp. 4-14.

[54] UNA, NYC: AG 022/S-0616-17(3), 'Emergency airlift for people dying in Ramallah-Nablus areas', Cilento to Henri Vigier, Personal Deputy to the Acting Mediator and Principal Secretary of the Mission, Haifa, 11 October 1948.

1948 and 1949'.[55] That the organisation was inert is up for debate, but it was certainly an organisation that he himself was central to on the ground in Palestine, and an organisation on which he left an indelible mark.

Most of the refugees in the Irbid area were believed to have travelled from Syria or Ramallah in Palestine and settled in the camp, but also in 80 villages in the area, in the town of Ajlun and at the Convent of Sisters of Rosary in Husson.[56] The UNICEF delegation visited this region and the North Shuneh camp in December 1948, when the camp was newly-settled, but growing daily as people travelled down from the hills. The priority action of the UNICEF delegation was to provide rations to the refugees. Courvoisier also reported a lack of basic medicines and sanitary control, and he also blamed this on an absence of competent staff.[57]

Over the course of the following 18 months of emergency, several humanitarian observers reinforced the notion that relief was managed to the refugees on an 'adequacy-only' basis. Six months on from Cilento's reports, published reports by Wilfred de St. Aubin (League representative loaned from the American Red Cross to the staff of Bernadotte) reiterated that the approach of the humanitarian system, the UN, governments, the Red Cross, and voluntary agencies, had been to 'maintain life on a minimum basis,' and claiming that in prioritising food and shelter, medical care had received little attention. As the crisis continued with an ever-present danger of epidemics (typhus, malaria, and dysentery), this prominent advisor claimed that more medical and nursing personnel and clinics were needed.[58] That a refugee camp should be in a state of inadequacy is not surprising, but the historical reading of this situation is important. Dr Elfan Rees, a principal advisor on refugee affairs to the World Council of Churches (WCC) conducted situation reports in Egypt, Lebanon, Syria, the West Bank, Jordan, and Iraq in October and November 1949. Rees played a prominent role as a representative of faith-based refugee action and headed the WCC refugee division of the Department of Reconstruction and Inter-Church Aid between 1947 and 1949, before he was transferred to the Commission of the Churches on International Affairs, where he continued to hold responsibility for refugee

[55] Kinnane is quoting from a manuscript to be found in Cilento's private papers: Sir Raphael Cilento Papers, UQFL 18/107 (Fryer Library, University of Queensland).

[56] UNA, NYC: AG-022, S-0626-0002-05, 'UNICEF Delegation', undated.

[57] UNA, NYC: AG-022: S-0626-0002-50, 'UNICEF Delegation for Trans-Jordan and North Palestine', undated.

[58] Wilfred de St. Aubin, 'Peace and Refugees in the Middle East', *Middle East Journal* 3 (3) (July 1949), pp. 249-259.

affairs.[59] G. Daniel Cohen describes Rees' perspective of the refugee camps as "optimistic",[60] but I would describe it as minimalizing. On the one hand, Rees' reports the situation in the camps to be dire ("wholly unsatisfactory and dehumanizing"), but on the other hand the conditions were an improvement on camps he observed in post-war Europe, and were, in his opinion, far superior to Bedouin camps.[61]

Despite the humanitarian story outlined so far, refugees were not simply passive recipients of aid in this history. Following mass displacement in 1948, refugees in Jordan were reported to have set-up groups and systems to distribute emergency relief, support family reunifications, and process property claims. But historian A. Plascov, for example, writing in the 1980s, argued that the refugees lacked solidarity and cohesion among the various committees, and that in the climate of restrictions imposed by the host states they also lacked the necessary support from UN agencies to develop refugee-led initiatives.[62] The responsibility for setting up medical systems or infrastructure may not have been assigned to or taken up by the refugees in the early months of the crisis, but there was evidence of responsibility being assigned to female refugees as mothers.

*Mothers*andchildren and the UNICEF milk distribution campaign

Within the framework of permitted endurance, there was still a degree of prioritisation in the first two years of the humanitarian response to the Palestinian crisis (1948-1950) and what appeared to be what I call, a 'new life bias': a prioritisation of the infants and children blessed with unmapped future opportunities and contributions to make to societies and economies, young lives with less complicity in political conflicts and less autonomy to make their own decisions. Therefore, a secondary humanitarian bias was afforded to women as mothers, as those responsible for raising these new lives. My use of the term new life bias is influenced by bioethicist Nancy Jecker's work on 'midlife bias', i.e., the privileging of autonomy as a personal

[59] Harold C Fey ed., *A History of the Ecumenical Movement*, Volume.2: 1948-1968 (Eugene: Wipf and Stock, 2009).

[60] Cohen, 'Elusive Neutrality', p. 195.

[61] Cohen, 'Elusive Neutrality', p. 195. Cohen is quoting: 'Report of Elfan Rees to the Department of Inter-church Aid and Service to Refugees of the World Council of Churches, Middle East Mission, October-November 1949', WCC Archives: Box 425.1.047.

[62] A. Plascov, *Refugees in Jordan 1948-1957* (London: Frank Cass, 1981), pp.16-26 cited in Terry Rempel, 'UNRWA and the Palestine Refugees: A Genealogy of "Participatory" Development', *Refugee Survey Quarterly* 28 (2-3), 2009, p. 416.

value during midlife, and how this bias links with policy and practice.[63] The new life bias in the Palestinian camps is demonstrated in the rhetoric of the UN leaders of the relief programmes, but there was a disconnect between their aims and proposed values, and the practical implementation of them.

In September 1948, at the time of Bernadotte's appeal, the large proportion of the refugee population, around 84 per cent, were classed as vulnerable by the Mediator's office. The vulnerable were children, pregnant women, mothers, the elderly, and the infirm. Children made up the largest proportion of this group (12 per cent were infants from 0-2 years of age; 18 per cent 3-5 years of age; 36 per cent children 6-18 years of age). The vulnerable adults were 'slightly more' than 10 per cent pregnant or nursing mothers, and 8 per cent aged, sick or infirm people.[64] These data are based on a small survey of a specific refugee population and therefore did not take into consideration the population demographics of many groups, but nevertheless they provide an indication of the population of specific interest to the UN, and how it was presenting the emergency to the international community and general publics. One month later, in October 1948, Bunche reiterated that women and children constituted the largest group of the population.[65]

The UN press department announced a milk campaign to be delivered to the refugees by UNICEF, then a nascent international agency founded on 11 December 1946. This was heralded on 18 September 1948 as the first programme of aid to be sent to the refugees,[66] somewhat overshadowing the great number of first responders, many of whom were referenced by the Mediator in his early reports.[67] This 'special' programme was to be conducted within the framework of the general relief programme and was intended to begin with a sixty-day period of emergency aid to refugees; the programme including 900 tons of supplies to be distributed for 'the neediest refugee children', in addition to the 100 tons of milk, sugar, margarine and meat already purchased and delivered to Beirut.[68] Dr D. Descoeudres, Chief of the UNICEF mission,

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[63] Nancy S. Jecker, *Ending Midlife Bias: New Values for Old Age* (Oxford: Oxford University Press, 2020).

[64] UNISPAL, A/648, 'Progress Report of the United Nations Mediator on Palestine', 16 September 1948.

[65] UNISPAL, A/689, 'Progress Report of the Acting Mediator for Palestine submitted to the Secretary-General for transmission to the members of the United Nations', 18 October 1948.

[66] UNISPAL, PAL/299, 'Special UNICEF Program Begins Operating in Palestine', UN Department of Public Information Press Release, 18 September 1948.

[67] UNISPAL, A/648, 'Progress Report of the United Nations Mediator on Palestine', 16 September 1948.

[68] UNISPAL, PAL/299, 'Special UNICEF Program Begins Operating in Palestine', UN Department of Public Information Press Release, 18 September 1948.

based in Beirut defined UNICEF 'categories of interest' as pregnant women, nursing mothers, and children aged 0 to 16.[69] Accordingly, the UNICEF campaign targeted infants aged 0-1, who would receive whole milk powder, and skimmed milk powder was targeted at children aged 1-15, if stocks were available.[70] Therefore, seventy-six per cent of the population would be targets for the UNICEF food 49ampaignn, once the older age group of children are removed from the calculation.[71] Although the elderly, sick, and infirm were also considered vulnerable groups, the Mediator's appeal was not principally geared towards these categories: children and mothers remained front and centre.

Only two years into its existence, UNICEF was beginning to expand its operations beyond the emergency scope of its work, bringing more developmental projects into its portfolio including projects in Latin American nations.[72] UNICEF's involvement in the Palestinian crisis signified a branching-out from work in European territories, but here the agency was still working within the bounds of emergency focused on milk delivery, which had been a focus of food aid programmes for children since the nineteenth century.[73] Furthermore, the UNICEF activity in the camps makes a tentative link between the refugees and the emerging human rights agenda. As the UNICEF supplies were finding their way to the Palestinian camps, the Universal Declaration of Human Rights was in its final stages of codification. The UN Third Committee sat for over 81 meetings between 30 September and 7 December to consider the draft wording of the UDHR[74] and was ratified at the 183rd meeting of the UN on 10 December 1948. Article 25.2 directly resonates with the UNICEF programme and the UN support for it, stating: 'Motherhood and childhood are entitled to special care and assistance ... All children, whether born in or out of wedlock, shall enjoy the same protection.' The very establishment of the UN, and the human rights frameworks which it created 'signalled the beginning of a period of unprecedented international concern for the protection of human rights.'[75] But it would take

[69] UNA, NYC: AG-022:S-0626-0002-53, Descoeudres Memo, 2 October 1948.

[70] UNA, NYC: AG-022, S-0626-0002053, J.W.MacCabe Memo, 'MILK: Instructions regarding the use and distribution of powdered milk', 1 November 1948.

[71] Please note that there should be an adjustment for population to this statistic because the two categories do not match: Bernadotte groups children within a 6-18 age bracket, and the UNICEF category of interest is children 0-16.

[72] Jennifer M. Morris, *The Origins of UNICEF, 1946-1953* (London: Lexington Books, 2015), p. 114.

[73] Morris, *Origins of UNICEF*, p.49.

[74] *DAG HAMMARSKJÖLD LIBRARY,* 'Universal Declaration of Human Rights (1948), Drafting History', <https://research.un.org/en/undhr/ga/thirdcommittee> [accessed 4 June 2023].

[75] Andre Chapman, *Human Rights: A Very Short Introduction*, (Oxford: Oxford University Press, 2007), p.46.

another 50 years until a crisis of legitimacy would force humanitarian organisations (and the UNHCR) to emphasise the importance of human rights as an ethical framework for their operations.[76] However, the UNICEF campaign demonstrated a connectivity between the Palestinian refugee children and the globalising rights agenda.

For historian Jennifer Morris, post-war Western ideals and gender norms of the family 'reinforced the notion of the dependence of women and children, supported the assumption that mothers were the best hope for children to survive and thrive, thereby relegating them to a role inextricably tied to their biological reproductive function and little else'.[77] These norms, expressed through government policy in the USA, were highly influential to the post-war humanitarian organisations that led the provision of aid to women and children; and through the expression of these ideals, funding from the US government could be secured.[78]

In the Palestinian refugee camps, the UNICEF activity and humanitarian actors effectively transferred responsibility from the humanitarian agency to mothers as intermediaries between donor (UNICEF) and recipients (their babies). The mothers were expected to use aid appropriately to secure the health, extend life expectancy, and develop the potential of the child so that they could become productive, economically contributing members of society. The assumed accountability of mothers reinforced paternalistic attitudes amongst humanitarian workers and provided them grounds for criticising the refugees, and female refugees in particular. Women in the Middle East had long been accused of ignorance by British Mandate officials and blamed for infant mortality, as well as for trachoma, a main cause of child blindness.[79] For League Commission officials, the causes of poor health were often attributed to

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[76] Kristin Bergtora Sandvik, 'Rights-Based Humanitarianism as Emancipation or Stratification? Rumors and Procedures of Verification in Urban Refugee Management in Kampala, Uganda' in *Worlds of Human Rights: The Ambiguities of Rights Claiming in Africa*, eds. Bill Derman, Anne Hellum and Kristin Bergtora Sandvik (Leiden: Brill, 2013). See also Karen Kenny, 'When Needs are Rights: An Overview of UN Efforts to Integrate Human Rights in Humanitarian Action', Occasional Paper No.38, The Thomas J. Watson Jr. Institute for International Studies (Providence: February 2000), *Humanitarian Library* <https://www.humanitarianlibrary.org/sites/default/files/2014/10/7.%2520IHRN%2520H%26W%2520When%2520Needs%2520OP38.pdf> [Accessed 4 June 2023]. Mark Frohardt, Diane Paul and Larry Minear, 'Protecting Human Rights: The Challenge to International Organizations', Occasional Paper No.35, Thomas J. Watson Institute for International Studies, Providence (Providence: 1999) *Columbia International Affairs Online* < https://ciaotest.cc.columbia.edu/wps/wibu/0015210/f_0015210_12840.pdf> [Accessed 4 June 2023].

[77] Morris, *The Origins of UNICEF*, pp. 2-3.

[78] Morris, *The Origins of UNICEF,* pp. 2-3.

[79] Liat Kozma and Yoni Furas, 'Palestinian Doctors Under the British Mandate: The Formation of a Profession', *International Journal of Middle East Studies,* 52 (2020) pp. 87-108.

actions or inaction of the refugees themselves.[80] For example, in May 1949 cases of conjunctivitis and scabies were attributed to 'low standards' of personal hygiene and a lack of cleanliness in Bour esh Shemali and Ein Helweh camps. In the Ein Helweh case, the refugees were additionally accused of malicious action: 'In most places where latrines were covered with balloon fabric, the refugees cut and took it away, and in several places even the wooden frames were removed. These latrines have been a failure in consequence. In future, only hessian will be used.'[81] 'Balloon fabric' was likely silk or nylon and therefore a high value material within the camps, the refugees' removal of it speaks more to the people's need for resources rather than their lack of concern for cleanliness.[82] Even though the League Commission acknowledged that 'all camps were completely void of anything approaching adequate sanitation',[83] the language of the League Commission reveals how the humanitarian leadership shifted responsibility for poorly planned or inadequately delivered camps onto the destitute refugees themselves.

With another example, in November 1949, the problems with infantile gastro-enteritis were attributed to the feeding behaviours of refugee mothers and as such were closely supervised by humanitarian doctors; the League Commission reported:

> It was found that the only way to fight this disease was by teaching mothers how to feed their babies properly… When the babies recovered and began to gain weight the mothers were allowed to feed their babies at home.[84]

Baby-weight gains indicated to Western doctors that babies were becoming healthy. These measurements were signs of victory over adversity by the humanitarians (and the mothers they were instructing). Baby weighing scales were key pieces of medical technology used in refugee camps to determine child health and monitor behaviours of mothers via a proxy. Here, in the first few years of Palestinian encampment we see the humanitarian use of weighing scales as a

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[80] For a global history perspective on health and hygiene see Mark Harrison, 'A Global Perspective: Reframing the History of Health, Medicine, and Disease', *Bulletin of the History of Medicine* 89 (4) (Winter 2015), pp. 639-689.

[81] IFRC, Vernier: 01003373 (Box 2), 'Report to the United Nations Relief to Palestine Refugees in the part of the League of Red Cross Societies in the Palestine Refugee Relief Programme for the month of May', May 1949. (Henceforth abbreviated to League Commission report to UNRPR, date.)

[82] For discussion of material resourcefulness see Benjamin Thomas White, 'Dragoslava's spindle: people and things at El Shatt refugee camp', *Singular Things* <https://singularthings.wordpress.com/2023/05/25/dragoslavas-spindle-people-and-things-at-el-shatt-refugee-camp/>[Accessed 28 July 2023].

[83] IFRC, Vernier: R510504929 (Box 3), 'League of the Red Cross Societies, Relief Operation in [sic] behalf of the Palestine Refugees, 1949-1950', Geneva, 1950, p.80.

[84] IFRC, Vernier: R510504929 (Box 3), 'League Relief Operation [Report], 1949-1950', p. 78.

form of surveillance, widening the medical lens to be concerned less with individual pathologies and more towards the health of all babies within a population – as was the case in France and Britain in the 19th century.[85]

Julie Peteet suggests that supplementary feeding campaigns in the Palestinian camps were a biopolitical control mechanism,[86] and UNICEF's bureaucracy and strict rules of engagement indicate an attempt to tightly control the behaviours of mothers. However, the rules of the UNICEF milk distribution also show how the agency attempted to control the delivery of the aid and the work of the fieldworkers distributing the supplies to the refugees. Clear instructions were provided for careful rationing, preparation, and distribution of milk to the groups eligible for care. Whole milk was targeted at infants 0-1 years old, with stocks of skimmed milk to be made available to children up to 16 if they became available.[87] John W. MacCabe, Field Liaison and Supply Officer for Transjordan (working for the UNDRP), wrote to the leaders of the milk centres at the beginning of November, and made attempts to temper the controlling tone of the agency:

> I am enclosing copies of "the rules" for distributing supplies received through UNICEF. You will appreciate these are intended to guide you, and not to bind you, but we must observe the conditions of distribution UNICEF has laid down as far as we can.[88]

The prioritisation of mothersandchildren as recipients of aid and responsible parties for ensuring the success of this aid, obfuscates the identity of men as responsible fathers,[89] and further marginalises the health needs of male refugees. The numbers relating to vulnerability outlined by Bernadotte essentially classify 15 per cent of the refugee population as non-vulnerable, i.e., all healthy men over 18 years of age, and all healthy non-pregnant or non-nursing women over 18 years of age.[90] It follows that men are statistically the smallest population demographic within a refugee camp at the beginning of a crisis, with a large proportion fighting, dead, otherwise left-

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[85] Laurence Weaver, 'In the Balance: Weighing Babies and the Birth of the Infant Welfare Clinic', *Bulletin of the History of Medicine* 84 (2010), pp. 30-57.

[86] Peteet, *Landscape of Hope and Despair*, pp. 84-85.

[87] UNA, NYC: AG-022:S-0626-0002-53: Memo by MacCabe, "UNICEF" Supplies: Milk, 1 November 1948.

[88] UNA, NYC: AG-022:S-0626-0002-53, Letter from MacCabe to milk centre leaders, "UNICEF" Milk and Other Supply "Schemes", 1 November 1948.

[89] Wenona Giles and Jennifer Hyndman, *Sites of Violence. Gender and Conflict Zones* (Berkley: University of California Press, 2004), p. 203.

[90] UNISPAL, A/648, 'Progress Report of the United Nations Mediator on Palestine', 16 September 1948.

behind to salvage or protect assets, or imprisoned. Philosopher David Benatar argues that the historic discrimination against men and boys requires greater acknowledgement and consideration.[91] The prioritisation of mothersandchildren as vulnerable objects steered attention away from biologically-male lives. But it also diverted attention from the collective health of the refugees as community. This absence of consideration left a fallow field for the humanitarian imagining of Palestinian refugee health.

There is significant evidence to suggest, however, a disconnect between the theory and the practice of humanitarian delivery in the case of the milk campaign. In practice, the UNICEF campaign demonstrates how there were executive attempts to control the overarching strategic delivery of the aid in a way that was at odds with the approach of the UN, and there is evidence to suggest failures of delivery. First, the UNICEF programme appears to be far from a-political, and an incident relating to its dispatch illustrates how executive power could threaten to de-stabilise a humanitarian project. It was necessary for Bunche to intervene against the political demands and apparent partisanship of the Executive Chairman of the Board of UNICEF, Ludwik Rajchman who held the position between 1946 and 1950. On 4 September 1948, Bunche sent a cable to the Secretary General of the UN stating that Rajchman had threatened to stop the shipment of milk already dispatched for the refugees unless the host governments Egypt, Transjordan, Syria, and Lebanon formally accepted responsibility for the refugees. Bunche strongly contested that this demand flew in the face of Bernadotte's appeal to the international community and UN responsibility under the 29 November Resolution. Rajchman also threatened that unless his request was met, supplies would instead be made available to the provisional government of Israel and he insisted on a separate parallel operation without integration with Bunche's mission.[92] Rajchman, a Polish specialist in public health had considerable experience as a medical humanitarian being head of the health section at the League of Nations and experienced in operations for UNRRA.[93] Considered by some a 'communist sympathiser', Rajchman had a reputation of being high-handed and demanding, traits which may have undermined this ability, despite his desires, to influence the medical strategy of UNICEF as

[91] David Benatar, *The Second Sexism: Discrimination Against Men and Boys* (London: Wiley-Blackwell, 2012).

[92] UNA, NYC: AG-022: S-0616-0001-15, Outgoing Cable: Bunche to UN Secretary General, 4 September 1948.

[93] Morris, *Origins of UNICEF*, p. 39.

this time.[94] But certainly this is evidence to suggest that the nascent agency was not fully committed to towing the UN- institutional line.

Second, archival evidence suggests there was a disconnect between the headlines heralding the success of 'Relief Shipped to Palestine!' and the supplies received in the camps. In theory, the UNICEF milk campaign was a manifestation of humanitarian 'minimalist biopolitics'.[95] In practice, by December 1948 the UNICEF milk allocations were reported by UN field-workers teams to be inadequate or absent. A three-month delay to supplies reaching the camps is plausible (and perhaps normal) considering the logistical challenges of shipping goods to remote camps (milk supplies were powdered so no cold chain was required). The tensions that existed at a leadership level may also have held-up supplies. However, J. W. MacCabe, reported a lack of UNICEF supply to camps in Jordan, claiming two centres in Irbed, Amman, and a centre in Madaba town had not received UNICEF milk supplies. The Zerqa milk centre was run by Miss Winifred Annie Coate, an English woman associated with the Christian Missionary Service.[96] The Zerqa milk centre also reported to have received only a small allocation of UNICEF milk, which she distributed to refugees in tents and in town. The Church Mission Society Hospital in Salt was reported to have received 'a very small initial allocation of milk powder and other supplies from UNICEF, but the amount was quite adequate for the numbers who came to register'. And no milk centres had been able to be established in the camps at Shunat Ninrin and Khor esh Shuna, 'although the needs are very great'.[97]

There was evidently no love lost between MacCabe and UNICEF officials. MacCabe's gripes were numerous, from confusion around UN field roles and responsibilities overlapping with UNICEF to problems of logistics and storage, indicating that a fractious relationship and battles over control and responsibility could colour the veracity of his claims. However, MacCabe's specific concerns over the failures of UNICEF to supply adequate milk supplies deserve inclusion here.[98] MacCabe would follow Cilento to join the ranks of humanitarians who

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[94] Morris, *Origins of UNICEF*, p. 39.

[95] Peter Redfield, 'Doctors, Borders, and Life in Crisis', *Cultural Anthropology*, 20 (3) (Aug. 2005), pp. 328-361.

[96] Cohen, 'Elusive Neutrality', p.194.

[97] UNA, NYC: AG-022:S-0626-0002-54, 'Milk centres', Letter from MacCabe to Courvoisier, 8 December 1948.

[98] UNA, NYC: AG-002:S-0626-0002-50, S-0626-0002-51, S-0626-0002-53, S-0626-0002-54: Letters and Mac Cabe Correspondence and Memos.

expressed a desire to leave a post as soon as possible. Here we should acknowledge the WHO medical report, referred to by Julie Peteet[199] which is linked to another professional who resigned his post. This report was never formally published or shared between UN organisations, reinforcing that early UN units were working with limited understanding of the medical situation of the refugees. Dr Mooser operated as Chief Medical Officer for the WHO in the field until early October 1948, when he resigned his post. Officially, the report was not published due to 'pressure of events'; a manufactured excuse wherein Cilento thanked Director General of the WHO, George Brock Chisholm for placing Mooser at their disposal, but stated rather vaguely that because 'certain recommendations' had been made in advance of the report, the report should not be published until the unit could make 'appropriate suggestions for further cooperation by the World Health Organization'.[99]

Questioning the dominance of faith-based humanitarian organisations in the early humanitarian response, 1948-1950.

Cohen argues that 'pioneering Christian initiatives filled a critical void in humanitarian assistance'[100] in the early years of the response to the Palestinian refugee crisis. Faith-based organisations were undeniably among the first responders, and evidence of missionary activity supports Cohen's claim that Protestant humanitarians played an important role in the early response. But, in the two years running up to the formation of UNRWA in April 1950, it was the participation of the Red Cross movement, and specifically the League working in collaboration with the UN that was crucial to the development of medical humanitarian action in the camps in the neighbouring host states in particular. This partnership between the UN and the League has been overlooked in the literature.

In the institutional echelons of the newly established WCC, debates on the Palestinian refugee crisis contributed to the formulation and contribution of Christian humanist thought and activism at this time. Christian humanitarian action continued to take a form of advocacy and witnessing in the case of the Palestinian camps. Practical contributions from Christian humanitarians in the field were undeniably important, but there is not substantial evidence to suggest widespread medical contributions by faith-based humanitarian actors during these crucial early years of the Palestinian refugee crisis. Cohen draws our attention to an appeal from Christian representatives in Palestine issued on 21 July 1948, writing that this appeal was

[99] UNA, NYC: AG-022, S-0616-17(6), Cilento to Chisholm, 3 October 1948.

[100] Cohen, 'Elusive Neutrality', p. 194.

answered almost immediately by the Federal Council of Churches; but Cohen does not propose details of what this appeal related to, from a medical perspective, other than a shipment of clothing and a 'quantity of vitamins'.[101] Cohen also references Channing B. Richardson, an American Quaker active in the field, but the details of Richardson's action and related 'missionary and educational groups' are not detailed beyond their bringing food to the fleeing refugees.[102]

Field researcher Georgiana G. Stevens reported that early agencies involved on the ground prior to UNRWA's operation included the Lutheran World Federation (who distributed blankets) and that schools, hospitals and supplementary feeding services were run by the Pontifical Mission, the Church World Service, [un-named] 'numerous local Arab welfare societies', and the Church Missionary Society.[103] It is undeniable that the presence and work of individual Christian missionaries was foundational; their immediate response to the refugee crisis not only provided emergency relief but also provided a blueprint for further non-governmental action and infrastructure. El Zerka refugee camp in Jordan provides a perfect example: a camp twenty miles to the north of Amman came to be operated by the British Red Cross (BRC), then Save the Children Fund (SCF) representatives, and then UNRWA. The camp was established on the site of a milk distribution centre set-up by Miss Coat. One of the nurses who came to work in the camp was Mary Katherine Hawkins. Hawkins was a former military nurse who worked with the BRC, and subsequently with the SCF. Hawkins reported that in addition to the milk centre, Coate had established a soup kitchen and a basic eye clinic for refugees. Coate herself became an important colleague for Hawkins during the time they both worked in Zerka camp,[105] providing a perfect example of gendered humanitarian relief and the working links between Christian women; Hawkins' obituary published in The Guardian closes with the words, 'Her Christian faith was unwavering'.[106] Hawkins' presence in Jordan is also evidence of the early response by the Red Cross movement in Jordan. On arrival in Amman in early 1948 two other BRC nurses went to Salt to form a team taking over the Mission hospital lent to the BRC, referred to as

[101] Cohen, 'Elusive Neutrality', p. 188.

[102] Cohen, 'Elusive Neutrality', p. 194. Richardson, 'The United Nations Relief for Palestine Refugees', 1950.

[103] Georgiana G. Stevens, 'Arab Refugees: 1948-1952', *Middle East Journal* 6 (3) (Summer 1952), pp. 281-298.

[105] Cadbury Research Library, University of Birmingham: Save the Children Fund Special Collection (Mary Katherine Hawkins (MKH) papers): SCF/A1243/1.1.3: Jordan 1 (1948-1950), MKH draft memoir.

[106] CRL, Birmingham: SCF/A1243/1.2.9 (Associated Papers–Lebanon, 1977): Newspaper cutting from The Guardian, 'Mary Katherine Hawkins Obituary', 24 January 2014.

British Red Cross Hospital No.1.[107] Hawkins, another BRC nurse, and a VAD nurse[108] then went to Zerqa to set-up a medical clinic for the 7,000 refugees understood to be in that area, 2,500 of which were living in a tented camp whilst the others sheltered in 'the town in houses, sheds and garages'.[109] The exact date of Hawkins arrival in Zerka is unclear, but sources suggest Hawkins moved on to work in Irbid in April 1948.

To Hawkins, a nurse experienced in the battlefield, the camp at Zerka appeared improvised and unmanaged:

> [no]'Camp Commandant, no organization, no refuse collection, no sanitation squad and what rubbish bins there were had been turned over by scavenging dogs. The latrines were full and overflowing and never cleaned. The pit at the back was uncovered and the day before we arrived a 4 year old boy had fallen into it and drowned."[110]

But despite a situation characterised by tragic disorder, Hawkins had notable resources available to her, such as access to local staff including Farid Akl, a Palestinian doctor employed by the Red Cross on a part-time basis[111]and midwife Mrs Hishi, a Greek Orthodox refugee from Haifa who had trained in a British hospital.[112] In addition to offering clinics, eye dressings, and follow-up injections, the team had financial and logistical capacity to send patients to hospital, including patients with advanced tuberculosis.[113] Hawkins and her colleagues also provided psychosocial support, attending and listening to patients in a style akin to Florence Nightingale:

> In the winter many people had chest infections and in those days long-acting Penicillin was not available so it was necessary to give 3 or 4 hour injections of crystalline Penicillin with at least one injection at night especially for the babies with pneumonia. Vivien and I used to visit the camp at night armed with a hurricane lamp and the necessary medical equipment.[114]

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[107] CRL, Birmingham: SCF/A1243/1.1.3 – Jordan 1 (1948-1950); SCF/SC/MKH/1/3 (1 of 5), MKH draft memoir, Jordan 1., p. 2.

[108] Voluntary Aid Detachments (VAD) were people who volunteered for the British Red Cross (BRC) during the First and Second World Wars in the UK and overseas.

[109] CRL, Birmingham: SCF/SC/MKH/1/3 (1 of 5), MKH draft memoir, Jordan 1., p. 2.

[110] CRL, Birmingham: SCF/SC/MKH/1/3 (1 of 5), MKH draft memoir, Jordan 1., p. 4.

[111] CRL, Birmingham: SCF/SC/MKH/1/3 (1 of 5), MKH draft memoir, Jordan 1., p. 3.

[112] CRL, Birmingham: SCF/SC/MKH/1/3 (1 of 5), MKH draft memoir, Jordan 1., p. 5.

[113] CRL, Birmingham: SCF/SC/MKH/1/3 (1 of 5), MKH draft memoir, Jordan 1., p. 4.

[114] CRL, Birmingham: SCF/SC/MKH/1/3 (1 of 5), MKH draft memoir, Jordan 1., p. 7.

In post-war Western nations, nursing was increasingly mechanised and less patient-centred, with nurses needing to monitor technology as much as people and defer to medical specialists.[115] In contrast, humanitarian contexts such as refugee camps offered a space in the late 1940s to provide patient-centred care armed with only the forms of therapeutic rescue (drugs, vaccines, medicines) available to them. For example, seven strains of antibiotics were discovered between Streptomycin in 1944 and Nystatin in 1950.[116] While this was a time of therapeutic revolution in the West, a full range of drugs would take time to trickle down to refugee camps. Hawkins testifies to the availability of crystalline Penicillin in the camps,[117] but a full range of antibiotic treatment would not have been available.

The presence of Hawkins and the other BRC nurses poses a challenge to Cohen's thesis, that Protestant humanitarianism dominated the field before the United Nations began its relief contribution through UNRWA. The Red Cross movement was present and active in numerous ways prior to the formation of the League Commission and its collaboration with the UN. For example, the ICRC assumed responsibility for the Red Cross laboratories in the zones of conflict in the Palestinian territory and took responsibility for a number of hospitals.[118] Here, we must pause to frame our understanding of a post-war hospital's function and characteristics. The nature of hospital care in the West evolved through the interwar periods and there was a great expansion of hospital facilities. Hospitals before 1940 operated largely as refuges for the chronically sick and the old. It was not until the Second World War, and after, that Western hospitals began to be home to new specialized medical treatments and provision – from modern blood transfusion, improved radiology and anaesthesia, antibiotics, surgical trauma techniques, plastic surgery and burns techniques. And the hospitals themselves became symbols of modernity and social egalitarian success.[119]

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[115] Anne Hardy and E. M. Tansey, 'Medical enterprise and global response, 1945-2000' in *The Western Medicine Tradition: 1800-2000* ed. W.F. Bynum (New York, Cambridge: Cambridge University Press, 2006), p. 447.

[116] James Le Fanu, *The Rise and Fall of Modern Medicine* (London: Abacus, 2011), p. 23.

[117] CRL, Birmingham: SCF/SC/MKH/1/3 (1 of 5), MKH draft memoir, Jordan 1.

[118] UNA, NYC: AG-060: S0453-0003-07: Letter Azcarate to Bunche, 8 April 1948, Letter Azcaratre to UN, 12 March 1948.

[119] Hardy and Tansey, 'Medical enterprise and global response', p. 439.

Additionally, the Red Cross rolled out extensive inoculation campaigns as early as July 1948 according to Wilfred de St. Aubin, a self-confessed 'wandering' humanitarian.[120] St. Aubin and Mary Katherine Hawkins provide information about the refugee health challenges, and the specific actions that the agencies undertook to respond to them, for example vaccination campaigns. But their letters and memoirs say a lot more about the humanity and spirit of the people who were active in the field. Their contributions were more than simply the delivery of goods or services or information, theirs was a human endeavour in which they stretched their personal, spiritual, and professional capabilities. St. Aubin's letters to colleagues at the League depict a life of humanitarian adventure, difficult journeys during conflict, navigating bombings and missed chartered planes.[121] The humanitarian adventure of Mary Katherine Hawkins is also depicted in the archive: photos and stories show a woman who appreciated the environment she was working in, the landscape, its history, the mud, and the dust. In her draft memoirs Hawkins outlines her personal adventures including tourist trips to Zerqa and Baghdad, and horse-riding trips from Irbid with one of the other doctors.[122] Hawkins' textual representation of the humanitarian adventure is reminiscent to that of IFRC delegate André Rochat's mission to Yemen, described by historian Valérie Goran in her retrospect of the photographic archives of the IFRC as a 'pioneering spirit of an unusual, exotic adventure'.[123] This tactile history sits in contrast with the references of medications, pills, and vaccines that embody the Western efforts to guard against epidemics and the spread of disease.

In summary, Christian individuals and Christian organisations undeniably made crucial contributions in the first two years of the crisis. However, it was the Red Cross movement that stands out in the humanitarian response in the neighbouring territories of Jordan, Lebanon, and Syria in the first few years of the Palestinian refugee crisis. And whereas Cohen acknowledges the role of the AFSC and the ICRC as important secular contributors, the Middle East Commission of the League of Red Cross Societies (the League Commission) was a crucial responder and collaborator with the UN in the months before the establishment of UNRWA.

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[120] St. Aubin often signed off his letters to Henry W. Dunning, Executive Secretary at the League, 'Your wandering representative': IFRC, Vernier: 999508 11/1/1: Saint Aubin (2/3), Letter Aubin to Dunning, 31 August 1948.

[121] IFRC, Vernier: 999508 11/1/1: Saint Aubin (2/3), Letters Aubin to Dunning, 11 July 1948, 19 July 1948, 31 August 1948.

[122] CRL, Birmingham, SCF/A1243/1.1.3: Jordan 1 (1948-1950), MKH draft memoir.

[123] Valérie Goran, 'Looking back over 150 years of humanitarian action: the photographic archives of the IFRC', *International Review of the Red Cross* 94 (888), p. 1367.

The League Commission, November 1948 to April 1950

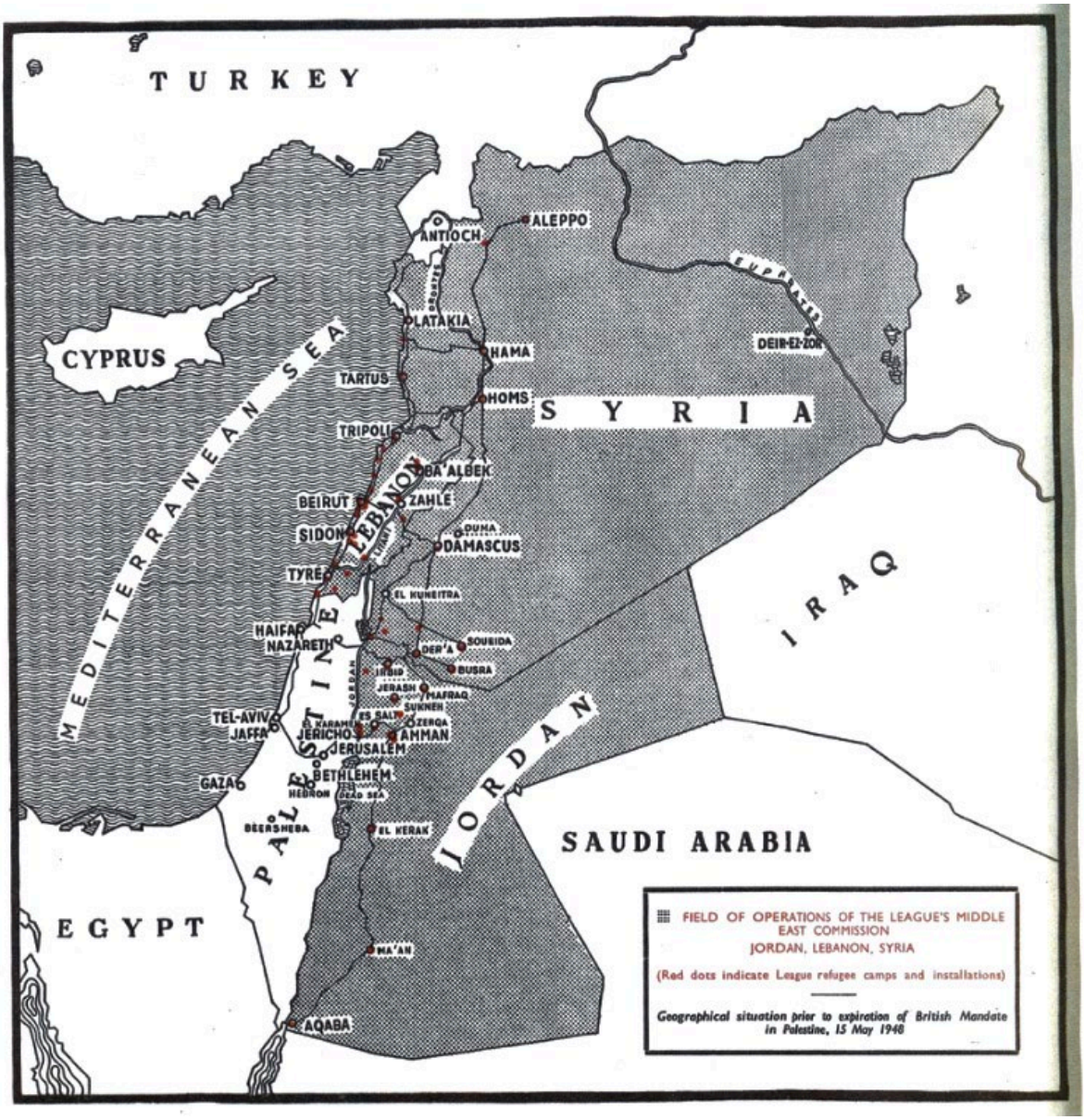

Image 1: Field of operations of the League's Middle East Commission; IFRC-V, R510504929 (Box 3) *League Commission Final Report, 1950.*

Julie Peteet introduces the work of the League Commission as a straightforward distribution mechanic whereby relief was distributed outward from the UN to the three agencies coordinated by the UNRPR (ICRC, AFSC, the League) and then to the refugees.[124] However, the role of the Red Cross, and the League Commission specifically, was much more significant than a straightforward distributor of supplies. This was the first time that the League assumed a substantive operational leadership role in an international humanitarian context, as opposed to acting as a coordinating body for national Red Cross societies or as a logistical arm for

[124] Peteet, *Landscape of Hope and Despair*, p.57.

distributing aid—and the organisation did this in direct concert with the United Nations.[125] The League was guaranteed autonomy and independence to act, and took its place in the collaboration for 16 month operating across Jordan, Syria, and Lebanon as shown in the League Commission map reproduced as Image 1 above.[126] The four-party collaboration, led by the UN and signed into agreement on 19 November 1948, was a landmark opportunity for the League to demonstrate its international humanitarian capability. The League had gained experience in missions in Europe, including in response to famine and typhus in Poland after the First World War,[127] but through the Palestinian project the League Commission wrote a history of success for its provision of relief to the Palestinian refugees up until the handing of the reigns to UNRWA in May 1950.

The League Commission inherited a medical programme from the UNDRU which prioritised preventative care and relied upon ongoing improvisation.[128] In documents relating to the handover from UNDRU to the League, Cilento advised that continued action was required—'irrespective of any former work done'—for the insecticide Dichlorodiphenyltrichloroethane (DDT) dusting and camp sanitation against insect-borne diseases such as typhus, bacillary dysentery, and malaria. [129] The UNDRU leadership did have a vision for a more established network of primary and secondary medical facilities, which it shared with the League Commission: a vision for the continuation of care for refugees as individuals and communities situated in specific places including 'approximately 10 field hospitals and 32 dispensaries'.[130] The medical programme of the League Commission followed the lead of the UNDRU and maintained an approach of improvisation until the summer of 1949 when it stepped into a phase of 'consolidation and expansion'.[131] As it moved into its phase of planned expansion, the League Commission did review the food rations in September 1949, but the daily calorific value of 1,500

[125] IFRC, Vernier: R510504929 (Box 3), UNHCR pamphlet, 'The Red Cross and the Refugees', 8 May 1963.

[126] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950.* NB: The overall programme was also known as the Palestine Refugee Relief Programme in the Near East (PRRP), nomenclature that also appears in the archival sources.

[127] Christopher Blackburn, 'The Rebirth of Poland: American Humanitarianism after the Great War', *Studia Historyczne* 4 (228) (2014), pp. 531. *IFRC*, 'About the IFRC: Our history and archives', < https://www.ifrc.org/who-we-are/about-ifrc/our-history-and-archives> [Accessed 15 July 2024].

[128] UNA, NYC: AG-022/S-0616-17(6), 'Immediate needs for Refugees' Memo from Cilento to Dodge, Acting Liaison Officer, UNRPR, 8 December 1948.

[129] UNA, NYC: AG-022/S-0616-17(6), Memo from Cilento to Dodge, 8 December 1948.

[130] UNA, NYC, AG-022/S-0616-17(6), Memo from Cilento to Dodge, 8 December 1948.

[131] IFRC, Vernier: 01003373(2), 'Report to UNRPR on the part of The League of Red Cross Societies in The Palestine Refugees Relief Programme, for the months of August, September and October 1949'.

increased only to 1,650.[132] Medical officers believed that both the old and new level of calories were insufficient in both quantity and quality, especially in their lack of animal protein, fat, and vitamins C and A.[133] Once again, insufficiency was deemed to be adequate. Practically, this was necessary because resources were stretched: key personnel in the League Commission continued to debate the issue of revising registration processes to arrive at a more realistic number of eligible refugees, therefore downwardly revising the number of rations to enable an increase in calories per capita.[134]

During the tenure of the League Commission, the physical sites of medical action were consolidated into both fixed structures (permanent and semi-permanent) and mobile structures. Through negotiation and collaboration with host states and local societies, the medical programme consolidated access to hospitals and mobile clinics across the three countries of its operation (Jordan, Syria, Lebanon). A decentralised system of infrastructure enabled refugees to access facilities within camps and opened access for refugees living in villages or situations outside of the camps. Hospitals became the principal sites of medical emergency care. In Jordan, by the end of 1949, these facilities included a hospital in Salt (taken over from the Church Missionary Society by the League and the BRC in February 1949) and an Iraqi government-operated hospital loaned to the BRC in Irbid. The reopening of the Maternity Hospital in Amman by the Jordan Red Crescent Society was reported in July 1949.[135] However, despite the roll calls of available facilities, the total numbers of beds available across the three regions overseen by the League continued to be inadequate, an inadequacy that was attributed to a scarcity of beds available to the whole populations and a lack of funds available to the League to equip and staff their own hospitals for refugees. By the close of the League Commission's operations, there were 60 beds in Salt and 40 beds in Amman.[136] By 1st May 1950 there were reported to be 43 clinics in operation across the three territories; 30 static clinics in camps or hospitals and 13 mobile clinics: in Jordan there were six static and two mobile clinics.[137] A new

[132] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, August, September and October 1949' p.4.

[133] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, August, September and October 1949' ', p. 4.

[134] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, August, September and October 1949'.

[135] IFRC, Vernier: 01003373(2), 'Report to UNRPR on the part of The League of Red Cross Societies in The Palestine Refugees Relief Programme, for the month of July 1949'.

[136] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, pp. 70-71.

[137] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, p. 69.

dental service was inaugurated in November 1949, with one dentist allocated to each of the three territories and supplied with equipment sand drugs.[138]

By the spring of 1950 when the medical programme was handed over to UNRWA, the Commission claimed to have negotiated access to a system of free medical services and facilities for around 270,000 refugees, or nearly 90% of all refugees living in the territories under their responsibility.[139] The League Commission claimed further successes, for example, in the summer of 1949 one of the main problems facing the organisation was the hospitalisation and segregation requirements of infectious open cases of Tuberculosis.[140] Provisions were initially deemed to be insufficient to handle this, but in the following three months Scandinavian teams from the International Tuberculosis Campaign undertook a vaccination campaign of all refugees within the age range 1-18 years.[141] From the League's perspective the medical programme was the saving grace for the refugees through the harsh winter:

> They are fortunate only in having sufficient medical care at hand to enable them to avoid the epidemics which are always to be feared under such living conditions.[142]

The number of medical personnel gradually increased from 80 medical staff reported in May 1949 (doctors, nurses, nurses' aides, orderlies, midwives, pharmacists, sanitation inspectors, sanitary sub-inspectors drawn from a wide range of Red Cross and Red Crescent national organisations and local personnel)[143] to 132 by October 1949[144] and 211 by April 1950[145]. The League Commission brought together a global network of Red Cross humanitarians, bringing

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[138] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, p.70 and IFRC-V, 01003373(2), 'Report to UNRPR on the part of The League of Red Cross Societies in The Palestine Refugees Relief Programme, for the month of November 1949'.

[139] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, p. 69.

[140] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, July 1949'.

[141] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, August, September and October 1949'.

[142] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, December 1949', p.1.

[143] IFRC. Vernier: 01003373(2), 'League Report to UNRPR, May 1949'.

[144] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, October 1949'.

[145] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, April 1950': The League's medical service was broken down as 42 doctors, 64 nurses, 34 nursing aids, 25 medical orderlies, 13 midwives, 4 dentists, 6 pharmacists, 4 laboratory assistants, 1 senior sanitary inspector, 9 sanitary sub-inspectors, 5 clerks and quartermasters. The closer collaboration with the sanitary team is shown in this breakdown, increasing the number of medical staff.

into close working collaboration members from European Red Cross societies[146] with personnel from America and national societies of Jordan, Syrian, Lebanon, Iraq, and the Palestine Women Red Crescent Society. It was essential to the League to maintain a 'strong non-partisanship character' and for this, 'international staff' (i.e., a mix of personnel from different societies to avoid one nationality being predominant) were maintained in Transjordan and other areas hosting Palestine refugees.[147] In terms of funds, a relatively small proportion of the League Commission's budget was drawn from the national societies, around $1,000,000 from an overall programme that was estimated to cost $15,000,000. Larger amounts of funds came from the United Nations, the British government, carry-over budget from the UNDRP and supplies from UNICEF.[148] The range of international personnel represented by the League Commission speaks to the globalising network of humanitarian workers, and for the Commission the leading actor of the humanitarian story was the relief worker:

> It is a continuation of the story reflected in previous reports of the uphill struggle of a group of relief workers striving together to bring succour and the bare necessities of life to their fellow human beings.[149]

Humanitarian victory was seen in the 'striving and overcoming', by the humanitarian worker. And the morale of their 'fellow human beings', i.e., the refugees, was another crucial barometer for measuring success. With rhetoric echoing wartime and post-war consensus building, the League used levels of morale to report the general wellbeing of the refugees. For historian Daniel Ussishkin in his study of modern imperial Britain, the concept of morale was used by the military in both World Wars to instil moral discipline and good character among officers.[150] He proposes that morale then shifted to become a universal quality, and a tool for developing cohesive social relations central to the 'post-war politics of consensus'.[151] In a similar process of building consensus of success, reporting on the Palestinian camps, the League Commission adopted a style reminiscent of a weather report, providing the UNRPR with a regular report of refugee

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[146] Red Cross personnel contributed to the programme from the national societies of America, Austria, Belgium, Britain, Denmark, France, Greece, Italy, Norway, Sweden, Switzerland, and the former Yugoslavia. The largest number of personnel were drawn from the BRC.

[147] IFRC, Vernier: 999511, Cable from Dunning to van Ketwich, 5 January 1949.

[148] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, pp. 98-101 Appendix 15, p. 149.

[149] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, November 1949'.

[150] Daniel Ussishkin, *Morale: A Modern British History* (New York; online edn., Oxford Academic, 19 Oct. 2017), p.133.

[151] Ussishkin, *Morale,* p.133.

morale using terms such as 'in the camps in Transjordan [morale] continues to be on a relatively high level, while outside camps it is reported to be satisfactory'.[152] As the League reported that refugee morale had improved, the refugees were said to have shown better spirits, endurance, and cooperation. This approach allowed the League to represent refugee wellbeing in simple terms and gave the administrators a tool for framing and reporting any issues of resistance or complaint on the part of the refugees. For example, in the May 1949 report to UNRPR, the Commission concluded:

> There is nothing new to report about the morale of the refugees. The slow, steady decline continued as before. It did not show itself in any outstanding way but only in the form of an increasing tendancy [sic] to complain.[153]

The archives of the IFRC, the WHO and the UNHCR reveal only a few details of refugee resistance, despite the reports routinely accounting for the state of refugee morale. One example, in April 1950 involved a local refugee committee in Irbid, Transjordan reporting they had 'obtained medical reports that flour was unfit for human consumption', and the League took an interest in this protracted complaint about poor quality foodstuffs.[154] There was also an 'amusing incident' wherein refugees refused to accept Swiss cheese due to the holes within the cheese.[155] This may well have been diverting to the writer of the League Commission report, but it was apparently less amusing to the people receiving the apparently insubstantial food. Overall, the League reported resilience in the refugees' mental health:

> It was a striking fact that mental diseases were rarely encountered among the refugees. Although morale was at a low ebb, on the whole the refugees appeared to be mentally well balanced and to have been able to adapt themselves to the hardships of their situation in a remarkable way.[156]

With this resilience, the refugees continued to endure. And the League continued to reassure its funders that financial contributions were being used wisely—and the refugees were not suffering beyond levels which were to the expected. The League emphasised to the UN that it sought funds only to meet 'the absolute and indispensable minimum for the survival of the refugees

[152] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, January 1950', p. 4.

[153] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, May 1949', p. 19.

[154] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, April 1950' p. 9.

[155] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, p. 57.

[156] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report*, 1950, p. 79.

entrusted to our mutual care',[157] i.e., funds for the minimum requirements for food, shelter (tents and blankets), fuel, and clothing. Medical care was considered sufficient for the refugee needs, and at the close of 1949, refugee health issues were not a cause for concern. The refugees were described as 'fortunate only in having sufficient medical care at hand to enable them to avoid the epidemics which are always to be feared under such conditions' and despite the weather and the rise in respiratory disease, 'the physical conditions of the refugees remained relatively good'.[158]

This belief was reiterated by League Commissioner van Ketwich Verschuur, in November 1949:

> Although the medical programme has provided a bare minimum only, we feel that the general health conditions of the refugee population and the prospects for future medical aid and supplies as outlined by your Medical Officer at our meeting are such that we have no reason to make any further specific demands at this moment, in the hope that no special occurrences as epidemics etc. necessitate us to appeal to you for additional funds and/or supplies.[159]

Furthermore, the Commission's terms of reference required the field operations to provide assistance on 'the basis of minimum essential need, without distinction as to race, colour, creed or political belief' whilst ensuring that those in the greatest need were prioritised over those lesser in need.[160] In a utilitarian attempt to meet the needs of the many, the League took donations to specific groups from outside agencies into account and adjusted its supply decisions accordingly.[161] Evidently, the story told to the international medical community was one of stretched resources in the camps, but ultimately a job well done. In March 1950 the British Medical Journal published an account by L.J. Bussell, D.M. of the medical service provided in Jordan. Bussell outlined a host of challenges to the refugee's health including meagre food rations, limited amounts of clothing, malaria, eye disease, dysentery, haemorrhagic petechiae, septic skin conditions and impetigo, gingivitis (a form of gum disease), 'not infrequent' hysteria and neurosis, diabetes mellitus and peptic ulcer, 'troublesome' measles and whooping cough,

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[157] IFRC, Vernier: 999511(2), 'MINIMUM REQUIREMENTS RELIEF SUPPLIES' Commissioner, H.P.J. van Ketwich Verschuur to Field Director in UNRPR in Beirut, Mr (James) Keen, 10 November 1949.

[158] IFRC, Vernier: 01003373(2), 'Report to UNRPR from the League, December 1949', pp. 1-4.

[159] IFRC, Vernier: 999511(2), 'MINIMUM REQUIREMENTS RELIEF SUPPLIES' Commissioner, H.P.J. van Ketwich Verschuur to Field Director in UNRPR in Beirut, Mr (James) Keen, 10 November 1949.

[160] IFRC, Vernier: Box 999511, Henry W. Dunning, Executive Secretary, LORCS to van Ketwich, 13 January 1949.

[161] IFRC, Vernier: Box 999511, Henry W. Dunning, Executive Secretary, LORCS to HPJ van Ketwich Verschuur, League Commissioner for the Near East, 13 January 1949.

sporadic typhoid fever, frequent tuberculosis in all its forms except miliary and meningitic.[162] Bussell further commented that mass inoculation against diphtheria, typhoid, and smallpox had been attempted, but had reached only a small proportion of the refugees in Jordan.).[163] Yet: 'To sum up, the immediate necessities of relief have been met, and, considering the magnitude of the operation, met well.'[164] And, with the familiar coda of 'adequacy-only', Bussell commented that the 'feeding and medical services have proved adequate to meet the emergency' and 'the health of the refugees is probably not lower than that of the local population'.[165]

Overall, the refugees were treated for the worst of their inflictions: eye diseases, gastro-enteritis etc., and although it was acknowledged that life for the refugees was unbearable: bear it they must. As the League Commission wound-up its operations ready for UNRWA to take responsibility for the refugees, the UNRPR summarised the situation as follows:

> The general physical condition is good and, making allowances for their hard living conditions and low dietary [sic], it can be said to compare favourably with that of the indigenous population of the countries where they are situated.[166]

In the Spring of 1949 Stanton Griffis, former United States Ambassador to Egypt and Director of UNRPR claimed the partial success of the relief mission:

> We have of course failed to give the great mass of refugees complete shelter, warmth or clothing during the winter, but we have kept them from hunger and so far have saved them reasonably health [sic] and fortunately without serious epidemics.'[167]

The crowning acknowledgement by the League was that it had been able to step-in and manage the operations of the relief aid and oversee a system successful in the securing of resources, where the UN could not have achieved this on its own.[168]

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[162] L.J. Bussell, 'Arab Refugees: Medical Relief Work in Jordan', *British Medical Journal*, (May 6, 1950), pp. 1070-1072.

[163] Bussell, 'Arab Refugees', pp. 1070-1072.

[164] Bussell, 'Arab Refugees', pp. 1070-1072.

[165] Bussell, 'Arab Refugees', p. 1070.

[166] IFRC, Vernier: 01003373(2), 'Report to UNRPR from the League, April 1950'.

[167] Feldman, *Life Lived in Relief*, pp. 6-7. Feldman references this source as IFRC, A0403-2 19740, 1948, LRCS, 'Relief to Palestine Refugees,' n.d.

[168] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, pp. 14-15.

> After the initial difficulties were overcome, there was always an adequate supply of the most essential drugs and dressings available in the General Medical Store in Beirut169, there was a system of 43 clinics established by 1st May 1950, capable of caring for 5,000 refugees per month for a medical programme that cost a mere 16 cents per refugee.[170]

The League Commission submitted a final report that reinforced the viewpoint that crisis had been averted, and serious epidemics had been avoided. The report claimed that in the refugee camps under the League's responsibility 'no disease reached epidemic proportions with the exception of a small outbreak of typhoid and paratyphoid fever of short duration which occurred in a village in the south of Lebanon'[171] Furthermore, there had been only one acute outbreak of measles in January 1950, complicated by fatal forms of broncho-pneumonia.[172] The League Commission reported that whooping cough had not spread throughout the camps and thanks to the vaccination campaign of the Scandinavian International Tuberculosis Campaign, tuberculosis was not widespread among the refugees; it reported few fatal cases of typhoid and very few cases of syphilis; there were no cases of starvation 'or even semi-starvation.'[173] The League did acknowledge the precariousness of the refugees' situation, noting for example that acute conjunctivitis afflicted the refugees more frequently than any other disease, and that infantile gastro-enteritis was a frequent disease in all camps. Despite dousing by DDT (the League Commission claimed that as of 1 May 1950, '25 camps and 120 towns and villages had been completely sprayed, which meant that every square metre of surface had been covered with two grammes of pure technical grade DDT'[174]), relapse of scabies and skin diseases were frequently observed.[175]

Speaking for refugees and the imagining of refugee health through data

Data of infectious disease in the camps were central to the League Commission's reports to the UN, its funder and collaborating partner. Epidemiological data drawn from the refugee contexts assume a particular significance: in the absence of other communication channels through which refugees could speak to, and record/document their own experience, medical data were used to

[169] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, p. 73.

[170] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, pp. 69-72.

[171] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, p. 74.

[172] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, p. 75.

[173] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950,* pp. 74-83.

[174] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, p. 82.

[175] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950,* pp. 78-79.

speak for the refugees and represent the overall state of collective refugee life. The League used epidemiological data to demonstrate the success of the humanitarian response—data banks of knowledge which could be used retrospectively to signal the effectiveness of the League's efforts. These data began to represent refugee health and wellbeing in a way that effectively silenced the full human experience of the refugees.

In the same way that medical facilities were quantified, as seen above, data pertaining to cases of diseases sat alongside the reports of refugee morale, and were accompanied by data on vaccinations against smallpox, typhoid, and diphtheria. Scholarship on later humanitarian contexts, particularly in the 1980s, discusses how humanitarians use medical data to speak for refugees. Joël Glasman's history of the quantification of humanitarianism draws from several contemporary case studies, such as how NGOs relied upon the measurement of the mid-upper arm circumference (MUAC) using a piece of paper to identify childhood malnutrition. Glasman's example of the MUAC is an example of how the medical humanitarian system can reduce complex individual human experiences to quantitative data: in this example the child's health was reduced to the number of mm in the MUAC.[176] For Glasman, and for Eyal Weizman in his discussion of MSF's use of data in the 1980s,[177] humanitarian organisations have used medical data as a central pillar of communication, where epidemiology becomes a tool for strategic decision-making and a tool for witnessing.[178] Through monthly epidemiological reports and by representing refugee lives as numbers on a page, the League Commission was able to reinforce two narratives: first, that the refugee population was 'healthy' and second, that the League was a humanitarian victor over disease. Despite pathologizing relatively small numbers of individuals—because the data in fact suggested only low levels of disease[179]—the effect was a de-historicized lived-experience of the majority. The data-led reports were a device that enabled the humanitarians to formally present and document the lived experience of a complex group of peoples in terms that were concise and manageable.

From the perspective of the humanitarian organisations leading the response, medical data demonstrating success were highly prized but also defended on the global stage as signs of

[176] Joël Glasman, *Humanitarianism and the Quantification of Human Needs: Minimal Humanity* (Abingdon: Routledge, 2020).

[177] Eyal Weizman, *The Least of All Possible Evils: A Short History of Humanitarian Violence* (London: Verso, 2011), p.45.

[178] Weizman, *The Least of all Possible Evils*, p.45. Givoni, 'Humanitarian Governance and Ethical Cultivation'.

[179] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950.*

humanitarian success. During the Third Session of the World Health Assembly, delegate to the Lebanon, Dr. J. Makari claimed that refugees had caused a serious public health problem for Lebanon, causing two hundred cases of smallpox and an outbreak of typhus fever.[180] Commissioner van Ketwich Verschuur maintained this claim was false and objected to the release of these figures to the public. The Chief Medical Officer of the newly established UNRWA, Jerome S. Peterson, also contested the claims and issued a protest to the Ministry of Public Health in Lebanon.[181]

As introduced above, all the League Commission's medical services and sites were celebrated quantitatively: the numbers of clinics and hospitals set-up under the Commission's auspices; the rate of use of these resources and numbers of hospitalisations; numbers of medical personnel working in the field; delousing and the number of refugees dusted; dental treatments delivered. The data also tracked specific respiratory diseases (pneumonia and trachoma, for example) and focused on the ailments of those groups most central to its concerns (syphilis specifically in pregnant women, for example).[182] Masked by seemingly neutral quantitative data were complex struggles, such as those faced by the Quakers (AFSC) as they took responsibility for refugee response in Gaza and attempted to reconcile that their spiritual motivations for peace-building with the political realities that constrained the refugees.[183]

In addition to the obfuscating effect of data, there is evidence that Palestinian refugee wellbeing was further obfuscated by the emerging social welfare approach. During the League Commission's phase of consolidation and expansion in the summer of 1949, there were broader efforts 'to ameliorate the unhappy living conditions of the refugees'[184] which included a greater focus on social welfare and education. During this later phase of its operation, the medical programme continued to develop as more supplies and equipment became available, but the League's reporting provides few details as to what this programme consisted of.[185] But one specific development of the medical programme involved a new co-operation between it, and a

[180] IFRC, Vernier: 999511(2), 'League's Medical programme in the Lebanon' Memo from van Ketwich to de Rouge, 19 June 1950.

[181] IFRC, Vernier: 999511(2), Letter from Peterson to Dr George Miller, Assistant Director Division of the Organisation of Public Health Services, WHO, 25 May 1950; Letter from Peterson to van Ketwich, 25 May 1950.

[182] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*.

[183] Nancy Gallagher, 'Relief Versus Repatriation' in *Quakers in the Israeli-Palestinian Conflict*, pp. 1-16.

[184] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950*, p. 55.

[185] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, August, September and October 1949'.

Social Welfare Department.[186] The League Commission acknowledged that the refugees' overarching desire was to return home and that it was in this return that the refugees envisioned happy, healthy futures. Yet, the social welfare activities were part of an alternative vision of a humanitarian system wherein refugee health developed as the refugees calmly and passively embraced a protracted settlement in place of any return home. The refugees were kept alive, they were inoculated against the diseases that threatened to become epidemic in the camp environment, and they received minimal medical care for their ills. And then, in the later phase of consolidation and expansion, social welfare activities started to be provided for the refugees (activities included soap-making workshops, shoe repairing, and sewing centres) to keep their minds from apathy and their muscles from atrophy.[187]

Chapter One Conclusion

The nature and form of medical humanitarian action in the Palestinian refugee camps in Jordan in the first two years of the refugee crisis was complex. Although Christian faith-based action played a significant part in the humanitarian action in the first two years, including in the action of Christian individuals such as missionary Miss Coate and nurse Mary Katherine Hawkins, the form of medical humanitarian action in Palestinian camps including and specifically in Jordan before the establishment of UNRWA was moulded by the significant contribution from the League of Red Cross Societies in the form of the League Commission. This role of the League has been overlooked in the scholarly literature, but is illuminated here. Furthermore, a new life bias led to the dominance of programmes targeted at mothersandchildren but these activities, namely the UNICEF milk distribution campaign, were in practice challenged by issues of supply.

The nature of the medical humanitarian action in the early years of response in the Palestinian refugee crisis was characterised by the spirit of adequacy-only, and the delivery of minimum levels of relief. Whilst scholars have argued that post-war humanitarian action began to take on traits of 'alchemical humanitarianism'[188], which transformed the life conditions of those suffering, the Palestinian refugee situation morphed almost immediately from a state of

[186] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, December 1949'.

[187] IFRC, Vernier: R510504929 (Box 3) *League Commission Final Report, 1950.*

[188] Michael Barnett, *Empire of Humanity, A History of Humanitarianism* (Ithaca: Cornell University Press, 2011). pp. 39-41.

emergency wherein new lives were prioritised (at least in theory), to a humanitarian condition of permitted endurance. This was not a transformative process wherein attempts were made to transform the life conditions of the refugees.

In the Palestinian refugee camps, we see a historical precedent to the ubiquitous minimum standards rhetoric and practice that permeates humanitarian planning and relief programmes into the twenty-first century. Whereas twenty-first century agendas of minimum standards involve the quantification of the minimum activities and resources that humanitarians must provide to be professional and accountable (largely working in emergency/disaster settings), what we see in the Palestinian camps were attempts by leading humanitarian institutions to demonstrate humanitarian success whilst delivering adequacy-only. And as such we see a flawed concept taking root. Professor Anthony Redmond, experienced international medical humanitarian physician and founder of the emergency response charity UK-Med, sums-up concerns relating to contemporary minimum standards:

> These concerns around the concept of minimum standards reflect the thread of concerns that runs through a wholesale adoption of a professional approach to humanitarian action. The concern that *minimum* may come to mean *only*; that with professionalism comes exclusivity; a purely technical approach may exclude those who simply wish to bear witness, which may become even harder if professional accountability means control over their activities to a degree that bearing witness is no longer possible.[189]

The League Commission did contribute a great deal to ensure a more comprehensive healthcare programme for the refugees was in place by April 1950 when the baton was handed to UNRWA. But the needs and complexities of refugee health were effectively minimized through strategies and tactics of delivering adequacy-only and aid to meet refugee needs to a minimum. And, through the processes of humanitarian reporting the nuances of refugee health and wellbeing were effectively silenced. The centrality of data relating to infectious disease effectively silenced general health and wellbeing of refugees. And as the League Commission moved into its phase of consolidation in the summer of 1949, the merging of healthcare into social welfare projects further obfuscated the refugee's medical and health needs. At the time of the League's handover

[189] Italicised emphasis my own. Anthony Redmond, 'Professionalisation of the Humanitarian Response', in *The Routledge Companion to Humanitarian Action*, eds. Roger Mac Ginty and Jenny H. Peterson (London: Routledge, 2015), pp. 403-416.

to UNRWA in April 1950, refugee general health remained largely unexamined: the League hoped that 'simple investigations into general health can be carried out in the future'.[190]

In a statement from the January 1950 League Commission report to UNRPR, as the Commission began to wind down their activities in the camps ready to hand responsibility to UNRWA:

> 'If the attempt is made without further delay this body of unhappy people, degenerating through already eighteen months of enforced idleness, may still be transformed into a positive force and make its contribution in a constructive scheme in whose ability to solve their problems they have been brought to believe.'[191]

In many ways, before the establishment of UNRWA, a fallow field was left for the imagining of refugee health—including how refugee lives could be improved for better health, happiness and contribution to society. Concurrent with the medical humanitarianism described in this chapter, the forces of economic development and global international Development were extending tendrils from the West into the 'developing world'. Any transformation of refugee health would become increasingly connected to the aims and objectives of technocratic Western experts, an experience that was bought into sharp relief by the United Nations Economic Survey Mission for the Middle East .

[190] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, December 1949'.

[191] IFRC, Vernier: 01003373(2), 'League Report to UNRPR, January 1950'.

2. Camouflage: Humanitarianism and Development in Palestinian Refugee Camps, 1949-1953.

Over five years, 1949 to 1953, medical humanitarianism in Palestinian refugee camps experienced a significant transition from programmes of minimal, emergency projects that emphasised vulnerability and new lives, through a formative experience driven by the United Nations Economic Survey Mission for the Middle East (UNESMME, henceforth referred to as the ESM or the survey mission) to the establishment of a new agency, the United Nations Relief and Works Agency (UNRWA). The ESM provided the UN and the international community with a mechanism for envisioning, planning, and delivering better futures for Palestinian refugees. And in terms of refugee health specifically, this was a future in which refugee health and wellbeing would stem from their transformation into productive workers. Following the ESM, UNRWA was mandated to transform the 'Palestine Problem' with strategies that reduced relief for refugees and introduced development projects to stimulate economies. In the first three years of the agency's operations, from April 1950, development and humanitarianism became closely enmeshed in the Palestinian refugee camps, although not without ruptures. Alternative imaginings of refugee health were consequently marginalised.

These were crucial years (1949-1953) in the history of both development and humanitarianism. The zeitgeist of agricultural and technological, regional economic development rooted in mid-century North America was extending its tendrils into the 'underdeveloped' world. This was also the incubation period for the globalising phenomenon of international Development, underpinned by US President Harry S. Truman's 'Point Four' speech delivered in 1952. The ESM drew personnel, expertise, and assumptions from precedents in the US, and represents an early instance of the global export after 1945 of an American model of economic development.[1] The survey mission informed medical humanitarian responses, but any importance it ascribed to medical care in its interim report was largely absent in the final report. The model of development advanced by the ESM, and the limited prominence of medical care within it, was carried over into the new organisation set up in 1950 to support Palestinian refugees, UNRWA. This was not surprising: the director of the ESM and the first two directors of UNRWA were

[1] See also: Elizabeth Borgwardt, *A New Deal for the World, America's Vision for Human Rights* (Cambridge, MA: Harvard University Press, 2005).

drawn from the same cadre of US development specialists who had made their professional careers in US itself in the 1930s and 1940s.

The overarching strategy of the survey mission was to develop the economies of the Middle East region, whilst taking a holistic approach to meeting the humanitarian needs of the refugees hosted in crucial Middle East states. The ESM mandated that refugee wellbeing would spring from self-sufficiency from relief, that refugees would be re-invigorated through work and their contributions to the economies that hosted them. Whereas the ESM was not explicitly interested in undertaking a survey of medical and health needs and goals, human health became intrinsically bound to productivity and economic health. By considering the ESM through the lens of humanitarian medical and health needs and action, this chapter provides a new reading of the medical humanitarian processes at play in the Palestinian refugee camps. And as such, the ESM indicated a shift in responsibility for raising the life conditions of the Palestinian refugees, off the shoulders of the international community—and their moral imperative to act, as advocated by Bernadotte—into the hands of the refugees themselves. This vision of a healthy future was intended to provide an alternative to the refugees' own envisioning of return as the only possible positive future.

Accordingly, the humanitarian focus quickly shifted away from *mothers*andchildren and new lives, to working (male) lives. Even though, in less than two years UNRWA had all but abandoned the key aims of the survey mission, the ESM had a profound effect on the nature of healthcare for Palestinian refugees in the early 1950s and beyond. Somewhere between an economic/development imagining and the failures of this vision, any transformative system to care and empower the refugees was camouflaged by development aims, and the state of refugee health sat somewhere between permitted endurance and development. There were attempts to develop and professionalise aspects of healthcare (for example, midwifery training for Palestinian women) but this action was criticised. There were attempts to manage infectious disease and emergency tactics of care and control persisted – and development agendas continued to wait in the wings. As a result, the foundations were established for decades of 'undercare' of Palestinian refugees,[2] a dual condition wherein Ilana Feldman describes processes of being cared for and treated by physicians within a humanitarian system, whilst also receiving care that is systematically inadequate, and viewed by the refugees as purposely harmful. Undercare becomes

[2] Ilana Feldman, 'Humanitarian Care and the Ends of Life: The Politics of Aging and Dying in a Palestinian Refugee Camp', *Cultural Anthropology* 32 (1) (2017), pp. 52-53.

manifest in a lack of medicine, limited services, failures to meet the health needs of older refugees, and this poor-quality care is acknowledged by both recipients and the service providers.[3]

The United Nations Economic Survey Mission (ESM), 1949-1950: precedents, personnel, and impact

Established on 23 August 1949, the ESM was a subsidiary body of the United Nations Conciliation Commission for Palestine (UNCCP), a key mediating body in the Arab-Israeli conflict.[4] The mandate of the survey mission was to examine the economic situation in Middle Eastern countries affected by hostilities and mass displacement, and to make recommendations to the UNCCP for an integrated programme of economic development. The ESM was arguably the result of UN failure to enforce General Assembly Resolution 194 (III) which called for the refugees' repatriation,[5] but it became an important institutional bridge between the processes of mediation for peace, and Western aspirations for economic and social development of the Middle East. The refugees were bound-up with the survey mission's intention to enable governments to 'overcome economic dislocations created by hostilities', 'to facilitate the repatriation, resettlement and economic and social rehabilitation of the refugees and the payment of compensation' and 'to promote economic conditions conducive to the maintenance of peace and stability in the area.'[6] Paul Porter, Conciliation Commission representative for the USA summed up the centrality of the development agenda, stressing that 'the economic aspects of the Palestine problem were of paramount importance and that many issues of that problem could be more easily solved within the framework of a general Middle East Development program.'[7]

[3] Feldman, 'Humanitarian Care and the Ends of Life', pp.52-53.

[4] 'United Nations Conciliation Commission for Palestine', *UN Economic and Social Commission for Western Asia* <https://archive.unescwa.org/united-nations-conciliation-commission-palestine> [accessed 30 July 2023].

[5] UNISPAL: A/RES/194 (III), 'Palestine–Progress Report of the United Nations Mediator', 11 December 1948. Maya Rosenfeld, 'From Emergency Relief Assistance to Human Development and Back: UNRWA and the Palestinian Refugees, 1950-2009', *Refugee Survey Quarterly* 27 (2/3) (2009), pp. 286-317.

[6] UNISPAL: A/AC.25/SR.90, United Nations Conciliation Commission for Palestine: Summary Record of the Ninetieth Meeting, 23 August 1949.

[7] UNISPAL: A/AC.25/SR/LM/34, United Nations Conciliation Commission for Palestine: Summary Record of a Meeting Between the Conciliation Commission and the Delegations of the Arab States, 24 August 1949.

On 20 January 1950, shortly after the publication of the ESM's final report,[8] President Harry Truman delivered his 'Four Points' inauguration speech advocating for international collaboration with the UN, support for the Marshall Plan and European reconstruction, and the creation of NATO as a joint defence force against Soviet threat. But it was the fourth point, introducing the dualism of underdeveloped/developed, which would come to dominate the postcolonial world:

> Fourth, we must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas.[9]

Despite ushering in 'the development age' largely by accident (the famous plea to extend the technical assistance already afforded to Latin America to other poor countries of the world, was said to have been added as a public relations gimmick instigated by speechwriters[10]) President Truman's vision of international development was of economic effort enabling freedom and happiness for mankind across nations of the world. And crucially, the UN and its specialized agencies were named by Truman as the vehicles to deliver, whenever practical, this development agenda.[11] Truman's speech is heralded as the departure point for the paradigm of international development, and it gave Presidential rhetorical backing to projects such as the ESM. But this was not a new phenomenon, this speech marked a coming of age for development principles and practices.

There were significant precedents to the work of the ESM in the Palestinian refugee camps, which have not been widely discussed in the historical literature. These precedents demonstrate that the ESM was far from operating in a vacuum. First, in line with the premise of the two-state resolution, Count Bernadotte was a vocal advocate for economic unity as a pillar for peace in the Middle East, believing that the common ground of economic unity could form a foundation on which to build a two-member union between the parties to which he mediated. Economic unity and development projects were put forward as objectives and shared principles: economic

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[8] UNISPAL: A/AC.25/6, 'United Nations Conciliation Commission for Palestine (UNCCP), Final Report of the United Nations Economic Survey Mission for the Middle East: An Approach to Economic Development in the Middle East, Part I: The Final Report and Appendices', 28 December 1949.

[9] Harry S. Truman Library, 'Inaugural Address', 20 January 1949, <https://www.trumanlibrary.gov/library/public-papers/19/inaugural-address>, [Accessed 20 June 2023].

[10] Gilbert Rist, *The History of Development: From Western Origins to Global* Faith (London: Zed Boks, 2002), p. 70.

[11] Harry S. Truman Library, 'Inaugural Address', 20 January 1949.

success was something worth mutually defending. On 27 June 1948, Bernadotte wrote to Assam Pasha, Secretary General of the Arab League:

> Despite the present conflict, there is a common denominator in Palestine, which, happily, is acceptable to and affirmed by both sides. This is the recognition of the necessity for peaceful relations between Arabs and Jews in Palestine and of the principle of economic unity … That the purposes and functions of the Union should be to promote economic interests, to operate and maintain common services, including customs and excise, to undertake development projects, and to co-ordinate foreign policy and measures for common defence.[12]

Second, the British state planted development seeds at the beginning of the refugee crisis, for example affording a one million pounds sterling interest-free loan to the Hashemite Kingdom of Jordan, to be spent specifically on development projects for the benefit of all citizens of the country and the refugees it was hosting.[13] This loan was itself a precedent for the Jordan Development Bank, founded in September 1951. The Bank would be a joint venture between the Jordanian government and private banks designed to provide refugees with loans for industrial and commercial projects.[14]

But the most important antecedents to the ESM lay in the USA, and its major development projects responding to the Great Depression of the 1930s and the needs of the war economy in the 1940s. The United States government had emphasised its early, substantial contributions to the Palestinian refugees, including those channelled through the American Red Cross and the Near East Foundation (NEF).[15] The involvement of the NEF is significant; the Foundation acted as an intermediary between donors including oil companies and at least one engineering company. In August 1948, the NEF facilitated a donation of $100,000 from the Arabian American Oil Company and the Trans-Arabian Pipeline Company to the relief programmes for Palestine refugees. A further $100,000 gift from International Bechtel Incorporated (a key constructor of the Trans-Arabian Pipeline and the Hoover Dam completed in 1936 on the border of Nevada and Arizona during the Great Depression) was put at the disposal of the

[12] UNA-NYC: S:0622-0001(4), Letter from Bernadotte to Assam Pasha, 27 June 1948.

[13] UNISPAL: A/1106, 'First Interim Report of the United Nations Economic Survey Mission for the Middle East', 16 November 1949.

[14] Alexander H Joffe and Asaf Romirowsky, 'A Tale of Two Galloways: Notes on the Early History of UNRWA and Zionist Historiography', *Middle Eastern Studies* 46 (5) (September 2010), pp. 655-675.

[15] UNA-NYC: S-0616-001-16, Letter from Freeman Matthews (US Ambassador to Sweden) to Bernadotte, 27 August 1948.

NEF.[16] These donations signify the interest held by oil and engineering industries for peace and stability in the region and represent gestures of goodwill from parties which would benefit hugely from development opportunities opening-up in the Middle East. The ESM was a vehicle that connected the Palestinian refugee camps and the refugees themselves with processes of trans-national development and the exploitation of natural resources. The refugees (as individuals and as a collective encamped) their health and wellbeing, their very presence and participation in any transformation of their crisis remained floating somewhere out of the frame.[17]

The Tennessee Valley Authority (TVA) project epitomised the rapid industrialisation and technological boom in the West between 1830 and 1914, wherein it was envisioned that all aspects of human life could benefit from the application of science, that nature and people could be controlled by progress.[18] Histories of American agricultural technology transplanted into 'the Third World' are not limited to histories of the TVA, for example economist Stephen A Marglin has revealed how seed manipulation and hybrid corn from the American Corn Belt spread to Mexico and beyond from the 1950s.[19] Historian Arif Dirlik summarises these kinds of developmentalism as 'an ideological orientation characterized by the fetishization of development, or the attribution to development of the power of natural (or even, divine) forces which humans can resist or question only at the risk of being condemned to stagnation and poverty.'[20] But the TVA was centrally important because it provided both a blueprint and the personnel to implement it, to be exported to the Palestinian refugee camps via the ESM. Scholars such as Cyrus Schayegh argue that the history of development is more complex than the metropole-colony relationship. Schayegh uses cases from the late Ottoman Empire and early post-Ottoman Middle East to illustrate the varying dimensions of developmentalism as a global,

[16] UNA-NYC: AG-022: S-0616-0001-16, Cable from H. Freeman Matthews, US Ambassador to Sweden to Bernadotte, quoting Secretary of State George Marshall, 27 August 1948.

[17] Malkki, 'Refugees and Exile', p.518.

[18] Scott, *Seeing Like a State, How Certain Schemes to Improve the Human Condition Have Failed* (New Haven: Yale University Press, 1998), p. 89. For a specifically medically perspective, see also: Helen Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: The University of Chicago Press, 2011).

[19] Marglin, Stephen A., 'Farmers, Seedsmen, and Scientists: Systems of Agriculture and Systems of Knowledge', in *Decolonizing Knowledge: From Development to Dialogue,* eds. Frédérique Apffel-Marglin and Stephen A. Marglin (Oxford, 1996; online edn., Oxford Academic, 3 Oct. 2011).

[20] Arif Dirlik, 'Developmentalism: A Critique', *International Journal of Postcolonial Studies,* 16 (1), (2014), pp. 30-48.

not simply colonial, issue.[21] And other scholars argue that histories of development centred on spaces where metropolitan agents and colonial subjects met and negotiated.[22] However, the historical linkages between the TVA and the ESM, and the ESM and UNRWA have a significant impact upon the Palestinian refugee camps, and it is hard to escape the neo-colonial frame when analysing refugee health experiences.

Modern states have long embraced large-scale technological systems to shape the environment, and forge interactions between people and the environment for economic gain through environmental change.[23] The TVA was one of the USA's most ambitious place-based regional development programmes which intended to modernise the economy of the Tennessee Valley region through a series of large-scale infrastructure projects including the construction of around 30 electricity-generating dams, new roads, canals, and flood control systems.[24] From its inception in 1933, the project was intended to raise-up one of the nation's poorest regions, with peak activity between 1940-1958 corresponding with the pressures and demands of the Second World War.[25] A beacon of modernist development projects centred on agricultural and large-scale environmental resource development, the TVA model would be repeatedly exported from the United States to international development contexts by American administrators, economists, planners, agronomists.[26] As a 'total, multipurpose project' the TVA touched on the whole socio-economic existence of the people that lived there, including public health programmes, malarial control, education, library services and mass resettlement. [27] Historian David Ekbladh argues that the TVA became a powerful and enduring emblem, not just because of the technologies delivered to assure modernisation but because it enabled Western democracy as opposed to the principles and practice of Communist control, meaning a form of 'grass-roots democratic

[21] Cyrus Schayegh, 'Imperial and Transnational Developmentalisms: Middle Eastern Interplays, 1880s–1960s' in *The Development Century: A Global History*, eds. Stephen J. Macekura and Erez Manela (Cambridge: Cambridge University Press, 2018) pp. 61-82.

[22] Antoinette Burton and Tony Ballantyne, 'Introduction', in *Bodies in Contact: Rethinking Colonial Encounters in World History* (Durham: Duke University Press, 2005).

[23] Paul Josephson, 'Technology and the Environment', in *Companion to Global Environmental History*, eds. J. R. McNeill and Erin Stewart Mauldin (Wiley-Blackwell, 2012), pp. 340-359.

[24] Joseph Morgan Hodge, 'Writing the History of Development (Part 1: The First Wave)', *Humanity*, (Winter 2015), p. 446

[25] Patrick Kline and Enrico Moretti, 'Local Economic Development, Agglomeration Economies, and the Big Push', *Quarterly Journal of Economics* 129 (1), (February 2014), pp. 275-332.

[26] Scott, *Seeing Like a State*, p. 270.

[27] Hodge, 'Writing the History of Development', p.446.

participation by the people affected by the programs'.[28] The 'Palestine Problem' provided a perfect opportunity to test the export value of large-scale federal development projects/ agricultural modernism hegemonic in the USA between 1945 to 1975.[29]

In principle, the ESM followed the lead of the TVA, not least because it was led by the same people. Gordon R. Clapp, chair of the TVA from 1946 to 1954 was appointed chair of the ESM by Trygve Lie, Secretary-General of the United Nations. The leadership of UNRWA would also be mined from the same seam of American regional economic development: John B. Blandford Jr., Director of UNRWA between July 1951 and March 1953, held a prominent position in the US Economic Cooperation Administration in Greece as well as a general manager position for the TVA,[30] and acted as consultant to President Truman on the Marshall Plan.[31] Blandford's successor at UNRWA, Henry Labouisse, was also a principal State Department official dealing with the implementation of the Marshall Plan.[32] Margot Tudor has traced the colonial legacies of UN peacekeeping, taking the baton from scholarship on nineteenth-century imperial interventionism which adopted a 'humanitarian guise', and studies of transference of colonial practices into the development and humanitarian spheres in the 1950s and 1960s.[33] In the Palestinian camps we have a direct attempt at transference from the American regional development agenda to the Palestinian refugee camps.

The objectives and tone of the ESM, as evident in the Final Report published in December 1949, were characterised by a dispassionate concern with functionality and the centrality of regional economic development. The earlier, Interim Report of the ESM, published on 16 November 1949 acknowledged that the refugees faced a continued crisis, and recognised that without emergency interventions their basic needs would not be met and their food stocks would not last through the winter. Acknowledging the need for crisis response, the report conceded that

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[28] David Ekbladh. "'Mr. TVA': Grass-Roots Development, David Lilienthal, and the Rise and Fall of the Tennessee Valley Authority as a Symbol for U.S. Overseas Development, 1933–1973," *Diplomatic History* 26 (3) (2002), pp. 337.

[29] James C. Scott, *Seeing Like a State,* p. 270.

[30] Kjersti G. Berg, 'The Unending temporary. United Nations Relief and Works Agency and the Politics of Humanitarian Assistance to the Palestinian refugee camps' (PhD thesis, University of Bergen, 2015), p. 66.

[31] Benjamin N. Schiff, *Refugees into the Third Generation, UN Aid to Palestinians*, (New York: Syracuse University Press, 1995), p. 27.

[32] Schiff, *Refugees into the Third Generation,* p. 292.

[33] Margot l. Tudor, 'Blue Helmet Bureaucrats: UN Peacekeeping Missions and the Formation of the Post-Colonial International Order, 1956-1971', (PhD thesis, University of Manchester, 2020), pp. 26-27.

matters of economic development should be deferred for the longer term.[34] Despite this acknowledgment, there were no specific health or wellbeing recommendations aligned to the works projects that the ESM was formulating: participation in the projects themselves was to be the key to healthy futures. The relief aspects of the programme — designed principally to support those refugees who were needy and could not work — were vague in detail, but an estimated $19 million was projected for one year of 'food, clothing, tents, necessary health measures, administration and a small reserve'.[35] The report did not elaborate what constituted the 'necessary health measure' to meet the broad challenges of refugee health, and the ESM proposed a collaboration with host governments 'to study the problem of rehabilitation of refugees; including matters concerning their civil status, health, education and social services.'[36] The ESM acknowledged that relief services and supplies provided by international non-governmental organisations were necessary resources, and bundled medical and health services into the broad definition of Relief, but it also suggested that these services constituted obstacles to change if they were not reduced, and reduced quickly:

> Were all direct relief to be cut off now, many refugees would face a winter of disease and starvation. Were charity alone to be provided for another year, it would be more difficult and costly to take constructive measures later. Nevertheless, the extent of direct relief provided through United Nations funds should be stringently cut within the next two months.[37]

The cuts proposed by the ESM necessitated the assurances given to the Secretary-General by the major humanitarian organisations (ICRC, the League of Red Cross Societies, and American Friends Service Committee (AFSC)) that they would continue their cooperation with the United Nations until the end of March 1950. UNICEF, the International Refugee Organization, the WHO, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Food and Agriculture Organization of the United Nations (FAO)) and other private groups and organisations were urged to work in consultation with the Director of the newly formed UNRWA 'to furnish assistance within the framework of the programme.'[38] Humanitarian action from partner organisations provided vital injections of resources, but these contributions were

[34] UNISPAL, A/1106, 'First Interim Report of the United Nations Economic Survey Mission for the Middle East', 16 November 1949.

[35] UNISPAL, A/1106, 'First Interim Report of the UNESMME', 16 November 1949.

[36] UNISPAL, A/1106, 'First Interim Report of the UNESMME', 16 November 1949.

[37] UNISPAL, A/1106, 'First Interim Report of the UNESMME', 16 November 1949.

[38] UNISPAL: A/RES/302(IV), General Assembly Resolution 302(IV) Assistance to Palestine Refugees, 8 December 1949.

considered supplementary and secondary in importance to the role of economic development projects. The WHO would go on to sign a partnership agreement with UNRWA in September 1950, but under the UN Relief for Palestine Refugees (UNRPR) framework the WHO did play an advisory role. Dr J. D. Cottrell was appointed to coordinate public health and hygiene aspects of the refugee relief programme working with agencies including UNICEF.[39]

The interim report outlined plans to reduce relief up to 31 December 1950, but the survey mission acknowledged that the crisis was not close to resolution and stalemate between Israel and the Arab states at the end of 1949 precluded 'any early solution of the refugee problem by means of repatriation or large-scale resettlement.'[40] Despite this, the report does not concern itself with housing or encampment plans, rather the clear principle that employment would boost economies and morale:

> The amount of relief and the amount of employment in each family or village group should have a direct relationship. The formula is more work and less relief. Humanitarian considerations should temper administrative decisions, but the success of the works relief programme will inevitably be measured by the speed with which direct relief diminishes, as men and families begin to earn a living.[41]

Specific initiatives to support the health and wellbeing of the refugees might have been absent, but refugee health was of dual importance to the success of the ESM project. First, refugee good health was vital for the successful operation and completion of the projects, and second, a healthy population would be a sign and measure of UN success in the field.

Here we see the implicit shift from a focus on new lives and the mothers that nurtured them to the working male, or working father. Where the emergency relief offered by the 'early responders' in 1948-1949 had concerned itself above all with reducing infant mortality, in the ESM's 'developmental' conception refugee health was configured in terms of whether refugees (by default male refugees) were able to work. If a (male) refugee was not able-bodied, they were therefore considered more needy of relief: these refugees fell within the category of 'the hardcore', those refugees who were difficult to accommodate within projects of resettlement or

[39] IRIS, EM/RC2/8, World Health Organization, Regional Office for the Eastern Mediterranean (1949), 'Palestine Refugees – Health Needs', 1 September 1949; report by Dr. J.D. Cottrell, Chief Medical Officer and WHO Representative UNRPR <https://iris.who.int/handle/10665/124391> [accessed 10 October 2023].

[40] UNISPAL, A/1106, 'First Interim Report of the United Nations Economic Survey Mission for the Middle East', 16 November 1949.

[41] UNISPAL, A/1106, 'First Interim Report of the United Nations Economic Survey Mission for the Middle East', 16 November 1949.

work because of older age, or for other reasons of incapacity.[42] The value of refugee lives became increasingly reduced to countable bodies, apolitical units of measure within a technical response; in this way, the ESM could project the management of ration numbers and justify the reduction of rations through the costs saved. The kinds of labour envisioned by the ESM can be seen in the proposed pilot scheme of the Wadi Zerqa Project in Jordan. This project would require workers to construct roads for access, participate in the engineering and construction of a series of dams, plant trees for forestry and fruit trees on embankments, labour for terracing, take part in the construction of a central village that would provide housing for the workforce and after the development of the dam system there would be roles to fulfil in new agricultural systems including crop experiments.[43]

It was proposed that the wages paid would enable the worker to provide for three dependents, for whom no relief would be needed.[44] With the average size of a refugee family acknowledged to be almost six persons,[45] a degree of inadequacy was written into the strategy. The interim report estimated the number of able-bodied refugees to be between 14 percent and 45 percent employable males, which it rounded down to a conservative 25 percent of the refugee population, adjusting the numbers by probable percentages of duplicate registrations destitute persons, and other non-repatriable relief recipients.[46] I include these numbers here to illustrate the de-humanising effect of the processes of quantification. Numbers available for work were, in total: in Jordan and Arab Palestine (78,000), Gaza Strip (48,000), Syria (15,000) and Lebanon (22,000).[47] The ESM also attempted to stretch the able-bodied workforce to include child labour and a female workforce, stating that the category of 'Female employable under certain circumstances' added a potential further ten per cent to the employable workforce. The interim report also noted that this group included 'a certain number of older children and adults over 50, as well as some persons listed as dependents'.[48]

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[42] Gatrell, *The Making of the Modern Refugee*, p.113. Also, Baher Ibrahim, 'Uprooting, trauma, and confinement: psychiatry in refugee camps, 1945-1993' (PhD thesis, University of Glasgow, 2021).

[43] UNISPAL, A/AC.25/6, 'Final Report of the ESM', 28 December 1949.

[44] UNISPAL, A/1106, 'First Interim Report of the UNESMME', November 1949.

[45] UNISPAL, A/1106, 'First Interim Report of the UNESMME', November 1949.

[46] UNISPAL, A/1106, 'First Interim Report of the UNESMME', November 1949.

[47] UNISPAL, A/1106, 'First Interim Report of the UNESMME', November 1949.

[48] UNISPAL, A/1106, 'First Interim Report of the UNESMME', November 1949.

In early consultations between the principal interlocutors of the ESM and government representatives from the host nations, Gordon Clapp articulated his belief that the problem of the refugees was a human problem.[49] Clapp professed that the refugees had agency, but were surviving an intolerable humanitarian situation, over which the ESM held minimal power to exert.[50] Clapp appeared to be conciliatory to Israel's position stated early in the mission: that the solution to 'the refugee problem' (i.e., the very existence of the refugees, the conflicting points of view over repatriation and compensation, and the intolerable humanitarian situation of the refugees) was resettlement in neighbouring countries, principally Trans-Jordan, Syria, and Iraq as part of a broader development strategy for the whole of the Middle East.[51] Clapp believed: 'the immediate task of this Mission ... is to find a place to start and that place, it seems to us, is obviously the refugees in their present status and their present condition.'[52] He proposed that peace was reliant on their needs being recognised and met, whilst also recognising that the refugee population contained 'a reservoir of idle manpower'.[53] The processes of the survey mission solidified a dichotomous imaginary of refugees as either needy, idle, and weak or 'able-bodied' and capable of productive work. Based on this imaginary, the ESM articulated the purpose of a relief and works programme at the heart of the survey mission as four-fold:

> ...it will halt the demoralizing process of pauperization, outcome of a dole prolonged; the opportunity to work will increase the practical alternatives available to refugees, and thereby encourage a more realistic view of the kind of future they want and the kind they can achieve; a works programme properly planned will add to the productive economy of the countries where the refugees are located; the chance to earn a living will reduce the need for relief and bring its cost within the ability of the Near East countries to meet without United Nations assistance.[54]

[49] UNA-NYC, AG-022:S-0627-0002-23, 'Meeting with the Economic Survey Mission' (Minutes), 10 October 1949.

[50] UNA-NYC, AG-022:S-0627-0002-23, 'Meeting with the Economic Survey Mission (Minutes)', 10 October 1949.

[51] NYA-NYC, AG-022, S-0616-0001-15: Letter from M. Shertok Minister of Foreign Affairs to Bernadotte, 1 August 1948.

[52] UNA-NYC, AG-022:S-0627-0002-23, 'Meeting with the Economic Survey Mission (Minutes)', 10 October 1949, p.18.

[53] UNISPAL, A/1106, 'First Interim Report of the UNESMME', November 1949.

[54] UNISPAL, A/1106, 'First Interim Report of the UNESMME', November 1949.

In this way, poverty and impoverishment became an organising concept in the Palestinian refugee camps.[55] Moshe Sharett, Minister for Foreign Affairs for Israel evoked the experience of the European Displaced Persons (DP) camps to illustrate that even if relief was plentiful, people living in 'idleness' would suffer 'inevitable physical and moral deterioration':

> And there is also the pressing necessity of providing for the day-to-day needs of the people, of maintaining them and enabling them to keep body and soul together. We appreciate that the provision of relief funds is a hard problem. Supposing there is no lack of relief funds, even then we would say, the sooner you make these people work and earn their livelihood the better, so that they should not live in idleness and be a charge on public funds, and that there should be the inevitable physical and moral deterioration. We are well familiar with this problem, after our experience of the D.P camps in Europe and the camps here. It is not difficult for us to identify ourselves with you in that respect.[56]

Somewhat at odds with Clapp's characterisation of the refugees as people with agency, Sharett's characterisation echoed the description of European DPs encamped in the wake of the Second World War. At that time 'DP apathy' emerged as a term located in psycho-social theory, to describe refugees as apathetic and unable to assume roles in society-legitimised employment programmes; the term, and its usage reinforced beliefs that DPs could not contribute without some kind of rehabilitation or external 'push'.[57] To experience DP apathy was not to hold a lack of concern for one's situation, but rather to experience a suffocation of concern: a process of exhaustion caused by war, displacement, and encampment.[58] This was a mental and physical experience wherein all mental capacity was taken up with thoughts of how to survive and how to emigrate, coupled with the additional psychological rumination of imagining what was happening to the friends and family they were disconnected from.[59] Eduard Bakis' (an Estonian psychologist who lived and conducted research in DP camps between 1945 and 1947) articulation of DP apathy is relevant here because it speaks to an alternative representation of the refugee experience, one which is obfuscated in the historical record by the perspective of the

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[55] Arturo Escobar, *Encountering Development: The Making and Unmaking of the Third World* (Princeton NJ: Princeton University Press, 1995), p. 24. Eleanor M. Godway, 'Thinking About Development: The Lived Reality of Globalization', *International Journal of Technoethics* 6 (2) (2015), p. 1-13.

[56] UNA-NYC: AG-022:S-0627-0002-23, 'Meeting with the Economic Survey Mission (Minutes)', 10 October 1949, p. 16.

[57] Silvia Salvatici, ''Help the People Help Themselves', UNRRA Relief Workers and European Displaced Persons', *Journal of Refugee Studies* 25 (3) (2012), pp. 428-451. Ibrahim, 'Uprooting, trauma, and confinement'.

[58] Fred C. Bruhns, 'A Study of Refugee Attitudes' *Middle East Journal* 9 (2) (Spring 1955) pp. 130-138.

[59] Eduard Bakis, 'D.P. Apathy', in *Flight and Resettlement*, ed. H.B.M. Murphy (Paris: UNESCO, 1955).

ESM leaders and their representation of refugees as refugees as idle and deteriorating. Also, in 1950 there remained far more refugees living in DP camps in Europe than there were Palestinian refugees living in camps, but as such this was an ongoing shared reality. Bakis claimed 'DP apathy' was an expression used by the refugees themselves to describe a state of disorganization, the almost complete absence of joy and happiness.[60] Bakis described how DP apathy was caused by a raft of psychosocial challenges: living in a too rapidly changing environment (the interruptions of a life encamped, in their displacement before that, and the unstable and quickly changing wartime environment before that- what we might too easily call 'stress' now) that created an environment of a lack of continuity for mental development. He argued that small, constant, interruptions to your thoughts had a mental toll. That is, a preoccupation with things outside the present environment: imaging, guessing, attempting some 'extra-sensory perception' of what was happening, how people away from them were, when it would be time to leave.[61] To be cut off from your traditions, to be cut off from your future – coupled with a lost belief in the meaning of justice, meant experiencing a 'deep and drastic separation of words and meaning'.[62] The consciousness of having 'an injured emotional life' increased anxiety, coupled with the depressing feeling of no longer being a personality, i.e., of being reduced to a number on a roll call with no status, no duties, no social position, no uniqueness, no worth.[63] Bakis' theoretical analysis was published in 1952, and again in 1955 by UNESCO. He describes an ongoing shared reality between the European DPs and the Palestinian refugees; and describes a life condition, that the humanitarians responded to with apparent criticism rather than care.

In the Palestinian camps an important link is evident between the refugees' mental experience and physical nourishment. DP apathy experienced in the European camps was a condition wherein the exhausted refugee used what scarce calorie-power they had for working towards their goal of emigration.[64] In the Palestinian refugee camps, there was an attempt to use the management of calories to enforce work, which had a highly gendered impact. Principally, rations were reduced for women and girls and prioritised for the able-bodied men who were targeted for heavy manual labour. The ESM estimated the proportion of employable males who could undertake heavy manual labour to be 75%, an estimation based on the assumption that

[60] Bakis, 'D.P. Apathy', pp. 76-86.

[61] Bakis, 'D.P. Apathy', in H.B.M. Murphy, *Flight and Resettlement*, pp. 81.

[62] Bakis, 'D.P. Apathy', pp. 76-86.

[63] Bakis, 'D.P. Apathy', p. 87.

[64] Bakis, 'D.P. Apathy'.

sufficient calories will be provided to permit heavy labour.[65] Despite signs of an early prioritisation of *mothers*andchildren and new lives, as demonstrated by the UNICEF milk distributions campaign, the ESM's approach to rationing suggests a prioritisation of fuelling working males. This approach was not a new one, the rationing of food from the very beginning of the relief efforts would have marginalised women and girls, who were vulnerable to the loss of rations, with inadequate resources often being inequitably shared with male relatives.[66]

Democratic development was entangled with economic development for the TVA project, and in the Palestinian camps, refugee participation as employees and workers in the relief and works programmes was necessary for the enhancement of democratic societies.[67] The interim report focused on four major employment-stimulating works programmes, planned for the countries and territories hosting Palestinian refugees. First, terracing of sloping land for agricultural development. Second, afforestation of land as erosion control and fuel supplies. Third, road development for transport networks to enable the works programme. Finally, agricultural and industrial activities including irrigation and water conservation projects.[68] However, this was not to say that the refugees were invited to participate in the design of the proposed works projects, or any calculation as to how the refugees themselves could best contribute to them (if indeed they agreed this was an appropriate course of action, which evidence suggests they did not[69]). The conspicuous absence of input from the refugee population was a wasted opportunity on the part of the ESM to benefit from the broad points of view of the refugees, and their own vision of what a 'bright future' might constitute. The democratic participation which the TVA advocated for was absent in the Palestinian camps, and the ESM ignored the 'mētis' of the refugees themselves,[70] including their capacity for influencing how a healthy life might be led.

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[65] UNISPAL, A/AC.25/6, 'Final Report of the ESM', 28 December 1949.

[66] Elise G. Young*, Gender and Nation Building in the Middle East: The Political Economy of Health from Mandate Palestine to Refugee Camps in* Jordan (London: I.B. Tauris, 2012).

[67] Terry Rempel, 'UNRWA and the Palestine Refugees: A Genealogy of "Participatory" Development', *Refugee Survey Quarterly* 28 (2 & 3), p. 415.

[68] UNISPAL, A/1106, 'First Interim Report of the UNESMME', 16 November 1949.

[69] Fred C. Bruhns, 'A Study of Refugee Attitudes' *Middle East Journal* 9 (2) (Spring 1955) pp. 130-138. In a socio-psychological study of refugee 'non-cooperation' of the Palestinian refugees 1948-1950 i.e., their (non-)cooperation with the works programmes, Fred C. Bruhns, engaged by the International Refugee Organization as a Resettlement, Repatriation, and Placement Officer (supported by the Ford Foundation to research the Palestinian refugees) emphasised that "non-cooperation" was a term used to reflect a diagnosis, and as such did not carry a value judgement.

[70] Scott defines that as 'a wide array of skills and acquired intelligence in responding to a constantly changing natural and human environment': Scott, *Seeing Like a State,* pp. 313.

The final report of the ESM is a modernist treatise on economic development: a vision of agricultural modernisation leading to substantial industrial opportunity [71] — again, refugee health and wellbeing is barely mentioned.

> The better use of water and land, the control and eradication of disease and pests, an increased manufacture and flow of goods and the spread of education, require the application of what man knows or can find out about the productive capacity of men and things.[72]

The final report noted that there were already significant obstacles to the many development projects tabled in the Middle East (not least lack of capital and complex international water rights) and admitted that the pilots amounted to modest beginnings for what was projected to be a long, complex process of resource development. And ultimately, the ESM was not followed through, this was a failed project, even though the principles deeply impacted the imagining of refugee care. The story of the ESM and refugee health is, again, one of absence: the final report does not propose any specific framework or approaches relating to medical- or healthcare. Perhaps this is to be expected of this kind of strategy document, this kind of technical details was often left to other parties. However, strategy is of undeniable importance in how the realities of life are imagined. Despite the influence of North American policy and practice, both UNRWA and the ESM were out of pace with the emerging rhetoric of American public health at the time which advocated for improving the health of populations in the 'underdeveloped' world as a cornerstone of American post-war foreign policy. In October 1950, Willard L. Thorp, United States Assistant Secretary of State for Economic Affairs addressed the 78th Annual Meeting of the American Public Health Association:

> Health has become recognized as a major factor in economic and social progress throughout the world — and thus in the preservation of peace.[73]

Upgrading the status of people's physical health and wellbeing across the world was a process implicitly and explicitly tied to economic prosperity and the maintenance of post-war peace. Also writing at the time, Leonard A. Scheele, Surgeon General of the US Public Health Services emphasised the centrality of international health to American foreign policy, that this represented the basic social aims of Western societies: the preservation of human life and the development of

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[71] UNISPAL, A/AC.25/6, 'Final Report of the ESM', 28 December 1949.

[72] UNISPAL, A/AC.25/6, 'Final Report of the ESM', 28 December 1949.

[73] Willard L. Thorp, 'New International Programs in Public Health', *American Journal of Public Health* 40 (December 1950), pp. 1479-85.

economic well-being.[74] As the Surgeon General, Scheele was 'the nation's doctor'[75] and an extremely influential figurehead who recognised that the policies of the United States governments and their aspirations overseas were enabled by the multilateral agreements for participation in and support to international organisations such as the WHO, and bilateral agreements with governments.[76] However, despite the rhetoric of the time, the direct enhancement of refugee health was not a cornerstone of development strategies or tactics, and health goals were not outlined as targets to seek through the processes of economic growth.

The details of refugee health were left to the technical experts at the WHO and the other relief agencies who, in the final report of the ESM were again thanked for their contributions, but whose contributions appeared to be of secondary importance. There is a nominal mention within the report that national health agencies should be co-opted on a temporary basis by the national development boards it advocates be established as agents of government, to ensure a continuity of development of resources.[77] In a rare mention of medical issues, the final report did advocate for technical research to be prioritised across the Middle East and recommended that this should include health and medicine concerns.[78]

> It cannot be over-emphasised that even if all the above surveys are made and economically integrated, development will not achieve its true aim of eliminating human suffering and raising the living standards of the great mass of the poverty-stricken people of the Middle East, if it is not accompanied by widespread social reforms. Hence technical advice will be required … of medicine and the like. Widespread public health measures must be taken – and these will entail detailed technical surveys by high ranking experts, and prolonged research into the main endemic diseases.[79]

The ESM became a vehicle for the United Nations to use the guise of participation to shift responsibility for the health and wellbeing of the Palestinian refugees from the shoulders of the international community to the refugees themselves. The UN took tactical responsibility for

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[74] Leonard A. Scheele, 'Public Health and Foreign Policy', *The Annals of the American Academy of Political and Social Science* 278 (November 1951), pp. 62-72.

[75] Mike Stobbe, *Surgeon General's Warning: How Politics Crippled the Nation's* Doctor (Berkeley: University of California Press, 2014).

[76] Scheele, 'Public Health and Foreign Policy', pp. 62-72.

[77] The Final Report also advocated that alongside public health there should also be national development boards for housing and education. UNISPAL, A/AC.25/6, 'Final Report of the ESM', 28 December 1949.

[78] UNISPAL, A/AC.25/6, 'Final Report of the ESM', 28 December 1949.

[79] UNISPAL, A/AC.25/6, 'Final Report of the ESM', 28 December 1949, p. 65.

delivering the aims of the ESM by establishing UNRWA. But responsibility for creating a brighter future was ultimately placed in the hands of the refugees themselves: their participation and engagement with the works opportunities presented to them was crucial. This was perhaps a post-war example of what Ferguson terms the 'antipolitics machine', wherein problems of humanitarian crisis were addressed through purely technocratic mechanisms rather than political solutions.[80]

Medical humanitarianism in the early years of UNRWA, 1950-1953

The survey mission was central to UNRWA's failed attempts at refugee economic-reintegration, leading UNRWA to quickly evolve from a relief-aid centred organization to a social services-centred organization grounded in development aims, and principally focused on education.[81] Rosenfeld argues this shift happened from the 1960s onwards, continuing to a watershed moment in the early 1970s when education became the largest component in UNRWA's regular budget.[82] However, there were attempts in the more immediate post-conflict period to enforce development aims in an emergency context, which essentially obfuscated refugee health issues, a side-lining which continued into the later decades of the camps' existence.

UNRWA was authorised by General Assembly Resolution 302 (IV) on 8 December 1949 to deliver two objectives. First, to collaborate with local governments to deliver direct relief and works programmes as recommended by the ESM. Second, to consult with host governments to prepare for the time when international assistance for relief and works programmes was no longer available.[83] The works programmes were designed to reduce the need for relief, which would (because medical services were subsumed within the categories of relief more broadly) include a reduction of medical services. UNRWA's programme was envisioned to run to 30 June

[80] For Ferguson, in his study of Lesotho 1975-1984, these mechanisms—the development apparatus—held NGOs as central cogs and legitimised the technical experts. James Ferguson, *The Anti-Politics Machine: "Development", Depoliticization, and Bureaucratic Power in Lesotho* (Cambridge: Cambridge University Press, 1990). See also: William F. Fisher, 'Doing Good? The Politics and Antipolitics of NGO Practices', *Annual Review of Anthropology* 26 (1997), p. 446.

[81] Maya Rosenfeld, 'From Emergency Relief Assistance to Human Development and Back: UNRWA and the Palestinian Refugees, 1950-2009', *Refugee Survey Quarterly* 27 (2/3) (2009) pp. 286-317. See also: Nabil A. Badran, 'The Means of Survival: Education and the Palestinian Community, 1948-1967', *Journal of Palestine Studies* 9 (4) (1980), pp. 44-74. For further discussion on the dominance of education in refugee relief: George Dickerson, 'Education for the Palestine Refugees: The UNRWA/UNESCO Programme', *Journal of Palestine Studies*, 3 (3) (Spring 1974) pp. 122-130. Jalal Al Husseini, 'UNRWA and the Refugees: A Difficult but Lasting Marriage', *Journal of Palestine Studies* 40 (1) (Autumn 2010), pp. 6-26.

[82] Rosenfeld, 'From Emergency Relief Assistance to Human Development and Back', p. 303.

[83] UNISPAL, General Assembly Resolution A/RES/302(IV) 8 December 1949 302 (IV) Assistance to Palestine Refugees.

1951, with direct relief to be terminated not later than 31st December 1950, unless the 5th session of the UN General Assembly determined otherwise.[84] The subsuming of health within the development agenda had implications for the health, wellbeing, and status of the Palestinian refugees: it laid the foundations for a lasting system of undercare.

Looking back from her research undertaken in camps in 2011 and 2012, Feldman comments that (despite criticisms of the development of a system of undercare) the services provided by UNRWA in its first decades of operation were 'extensive' in their coverage of five areas of delivery: rations, clothing, housing, education, and health care.[85] UNRWA advisor, Lex Takkenberg credits the creation of a cost-effective system of primary healthcare to the partnership between the WHO and UNRWA signed into agreement on 28 September 1950.[86]Also presenting UNRWA's health system in a positive light, political scientist Benjamin Schiff judged UNRWA's health services to be largely a success:

> [that] except for some government complaints that the health services were not good enough, the health program operated without controversy and with the support of host states, voluntary agencies, and WHO and UNICEF. Statistics from annual reports show the health program to have steadily expanded, with corresponding reductions in infectious diseases.[87]

From its establishment, UNRWA operated under the constraints of significant budget insecurity, and without a long-term remit the agency could not transparently plan or effectively set-up systems for longer term development plans.[88] Chronic underfunding filtered down to the health services which worsened as refugee populations increased. By September 1949, the WHO reported that the health services were attempting to care for 'double the number of refugees with half the amount of money originally recommended'.[89] From the establishment of UNRWA as it took up the mantle of refugee support, the reality of refugee health responses was left somewhere between a biopolitical support system designed to maintain 'bare life' and a system of development that faltered as it tried to materialise.

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[84] UNISPAL, General Assembly Resolution A/RES/302(IV), 8 December 1949.

[85] Feldman, 'Humanitarian Care and the Ends of Life' p. 47.

[86] Lex Takkenberg, 'UNRWA and the Palestinian Refugees After Sixty Years: Some Reflections', *Refugee Survey Quarterly* 28 (2-3) pp. 253-259.

[87] Schiff, *Refugees into the Third Generation*, p. 27.

[88] Kjersti G. Berg, 'Unending Temporary'.

[89] IRIS, EM/RC2/8, 'Palestine Refugees–Health Needs', p.3.

Some of the works programmes that did begin operation created specific health hazards for the refugees, because of the environments the projects were taking place in, and the health risks associated with the work. These health hazards included risks of bodily injury and disease risks exacerbated by the works programmes, such as malaria and schistosomiasis.[90] High numbers of suspected clinical cases of malaria were identified in the UNRWA clinics in East Jordan which were attributed to 'a wave of relapses occurring among labourers who were engaged last year in Works Projects areas which were not protected'.[91] In these cases, the projects which were intended to improve refugees' lives and wellbeing and ensure a reduction in the need for humanitarian relief, created additional refugee health issues that UNRWA and its medical programme would be called upon by the refugees to support.

There were attempts to execute economic development projects beyond the landmark works projects,[92] but it was acknowledged that the works approach offered no enduring benefit for the refugees, nor financial relief for the Agency, and the works projects of the ESM were all but abandoned by the end of June 1951.[93] The objectives of the ESM had not been realised; sufficient funds had not been available, not least due to increased costs of the relief programme caused by rising commodity prices following the Korean War and world shortages of flour coupled with poor harvest prospects.[94] UNRWA claimed that failures of the relief programme had led to refugee reluctance to cooperate with the Agency's works programmes; refugees also feared that by engaging with the works programmes they would renounce their right to return

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[90] World Council of Churches Archives, the Ecumenical Centre, Geneva: Box: 425.02.09.025 (03), 'Report by Jerome S Peterson, MD. Chief Medical Officer and WHO Representative UNRWAPRNE', Presented at the Third Session of Regional Conference for the Eastern Mediterranean of the World Health Organization [15th] September 1950.

91 World Council of Churches Archives, the Ecumenical Centre, Geneva: Box: 425.02.09.025 (03), 'Medical report for April 1951', Undated. [Content of the document suggests the report was written after 16 April, when the author of the report, Chief Medical Officer Jerome S. Peterson returned to the Middle East from a period of home leave.]

[92] Edward H. Buehrig, *The UN and the Palestinian Refugees: A Study on Nonterritorial Administration* (Indiana: Bloomington, 1971), pp.113-126.

[93] UNISPAL, (A/1905), 'Assistance to Palestine Refugees, Report of the Director of the United Nations Relief and Works Agency for Palestine Refugees in the Near East'; General Assembly Official Records: Sixth Session Supplement No.16., 28 September 1951. This first annual report covers the period 1 May 1950 to 30 June 1951. See also discussion in Buehrig, *The UN and the Palestinian Refugees,* p.114 and UNISPAL, (A/2171), 'Annual Report of the Director of the United Nations Relief and Works Agency for Palestine Refugees'; General Assembly Official Records: Seventh Session Supplement No.13., 30 June 1952. This report covers the period 1 July 1951-30 June 1952.

[94] UNISPAL, (A/1905), 'Assistance to Palestine Refugees, Report of the Director of the UNRWA', Sixth Session, 28 September 1951.

and receive compensation for their losses.[95] Political Scientist Edward H. Buehrig attributed the failings of UNRWA to fulfil the policies of the ESM to 'the unresponsiveness to an economic approach of a principle exclusively political in origin'.[96]

The ESM provided a vision for longer term refugee health, but in the context of the failure to turn the survey mission's plans into reality, any future health programmes were without a strategic compass. In the absence of a clear mission, the health system was left in a 'holding pattern' of minimal servicing, sporadic technical specialist assistance and neo-colonial attempts at knowledge collection and training. UNRWA attempted to steady the ship in the first six months by standardizing and centralising the work of the four autonomous bodies already active in the field: UNRPR, ICRC, the League of Red Cross Societies (the League), and AFSC. UNRWA also took over the work of UNICEF in the supply of milk, cod liver oil, sugar and dietary commodities to children, adolescents and pregnant or nursing mothers.[97]

For the management of refugee health, a partnership agreement was signed between UNRWA and the WHO on 28 September 1950, assigning leadership of UNRWA's medical programme to the WHO. The WHO ('the organization') was obligated to plan a medical programme and health services for Palestinian refugees and to carry out aspects of the plan that could be executed according to funds available. In turn, UNRWA ('the agency') agreed to administer the general programme as well as assume administrative direction for the WHO programme through the role of the Director of UNRWA. The Chief Medical Officer in September 1950, Jerome S. Peterson summarised the philosophy of UNRWA/WHO's relief programme as 'essentially a maintenance one'.[98] Peterson also quoted Dr Hermann Biggs, New York State Commissioner of Health who, in the early 1900s, battled against disease and the establishment that resisted his approaches to public health and epidemiological linkages between poverty and disease.[99]

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[95] UNISPAL, (A/1905), 'Assistance to Palestine Refugees, Report of the Director of the UNRWA', Sixth Session, 28 September 1951.

[96] Buehrig, *The UN and the Palestinian Refugees,* p. 113.

[97] UNISPAL, A/1451/Rev.1, 'Interim Report of the Director of the United Nations Relief and Works Agency for Palestine Refugees in the Near East'; General Assembly Officials Records: Fifth Session Supplement No.9., 6 October 1950. [The first interim report covers 1 May 1950-15 September 1950.]

[98] World Council of Churches Archives, the Ecumenical Centre, Geneva: Box: 425.02.09.025 (03), 'Report by Jerome S Peterson, MD. Chief Medical Officer and WHO Representative UNRWAPRNE', Presented at the Third Session of Regional Conference for the Eastern Mediterranean of the World Health Organization [15th] September 1950, p. 2.

[99] Laurie Garrett, *Betrayal of Trust: The Collapse of Global Health* (Oxford: Oxford University Press, 2001). C.C. Thomas, 'Book Notice: The Life of Hermann M. Biggs, M.D., D.Sc., LL.D., Physician and Statesman of the Public Health', *JAMA* 93 (15), p. 1171.

Confirming his own commitment to preventative medicine, but also to cost-saving, Peterson reported:

> In few other situations is the following slogan more applicable: "Public health is purchasable. Within biologic limitations any community can determine its own death rate." It soon became obvious that with the limited funds available prime emphasis must be placed on the prevention of epidemic and devastating diseases. This was accomplished through immunizations, sanitation and insecticide campaigns. Clinical services, both OPD and hospital, aimed more at the care of the acute curable diseases than the chronic incurables. Reparative dentistry, elective surgery, physical rehabilitation programs, though desirable, could only be undertaken as the more essential problems were met.[100]

Here we see a continuation of a commitment to minimal standards and the lack of financial support to develop more transformative or democratic health programmes. Working within an environment of protracted uncertainty would have no doubt played into this approach: why imagine anything different from the refugees if there was only a vague vision of their future?

Like the Middle East Commission of the League of Red Cross Societies (the League Commission) in the earlier months of the response, and with the same effects, UNRWA and its associated agencies came to focus their monthly reports around quantitative data. The tentative and time-limited existence of UNRWA's mandate required a progress reporting system to justify UNRWA's continued existence to the UN General Assembly, and to demonstrate its continued value to the international community. The online repository of the United Nations Information System on the Question of Palestine (UNISPAL) contains UNRWA annual reports submitted to the General Assembly between 1950 to 1953. And the WCC archives house UNRWA Medical reports from October 1950 and April 1951. Through the channels of official reporting, the medical system was presented as established and working. The progress reporting reduced the programme to quantifiable signifiers of success: how many medical officers, how many staff, how many clinics, how many visits. For example, for the period between 1 May 1950 and 15 September 1950 the medical programme was reported to include one WHO Chief Medical Officer, 30 international staff, 66 doctors, 81 clinics, 1,400 beds available, a system capable of supporting 600,000 visits.[101] Limited epidemiological investigations carried out in the field to this

[100] World Council of Churches Archives, the Ecumenical Centre, Geneva: Box: 425.02.09.025 (03), 'Report by Jerome S. Peterson, MD. Chief Medical Officer and WHO Representative UNRWAPRNE', Presented at the Third Session of Regional Conference for the Eastern Mediterranean of the World Health Organization [15th] September 1950, p. 2.

[101] UNISPAL, A/1451/Rev.1, 'Interim Report of the Director of the UNRPR: Fifth Session', 6 October 1950.

point, and the absence of refugee perspectives on the medical programme undermines any claims to success by the humanitarians reporting those claims. Just because personnel and services were enumerated, does not mean they were successful.

Another issue that deserves comment is UNRWA's reporting of the so-called 'treaty diseases'. Following the Spanish-American war and the Treaty of Paris in 1898, the Americas developed a regional system of disease surveillance and control, centred on the 1924 Pan-American Sanitary Code which required the immediate notification of plague, cholera, yellow fever, smallpox, typhus, and other contagions.[102] These were the colonial quarantine diseases that were of concern to the global community during the preceding century.[103] In the twentieth century, ten International Sanitary Conventions had created a state-backed system of 'functional disease surveillance and the sharing of epidemiological information among countries'.[104] In 1951, the WHO adopted the International Sanitary Regulations, a tool for multinational regulation and surveillance. UNRWA was established at this juncture for global health governance and the global surveillance and management of communicable disease, and the agency participated in these systems. That included surveillance of the so-called 'treaty diseases', on which the agency reported annually to the General Assembly.

The first UNRWA annual report celebrated that 'of the five classical treaty diseases' cholera, plague, and yellow fever did not occur among the refugee or the indigenous populations, that smallpox was controlled and although typhus had increased to a small degree, minor outbreaks had been limited to near Irbed[105] in East Jordan.'[106] The fact that UNRWA leaders were seeking validation through reporting the avoidance of tropical diseases which were not even prevalent in the Middle East region (i.e., yellow fever) speaks to its heightened need to score points for as many wins as possible – even wins that it was not remotely responsible for. The following year, the report stated with satisfaction that 'out of the six classical treaty diseases—cholera, plague, yellow fever, small pox, typhus fever and relapsing fever (louse-borne)—only two cases of

[102] Obijiofor Aginam, 'International law and communicable diseases', *Bulletin of the World Health Organization* 80 (12) (2002) p. 947.

[103] David P. Fidler, The globalization of public health: the first 100 years of international health diplomacy, *Bulletin of the World Health Organization* 79 (9) (2001), pp. 842-49.

[104] Aginam, 'International law and communicable diseases', pp.946-951.

[105] The use of Irbed and Irbid are used interchangeably in the sources.

[106] UNISPAL, (A/1905), 'Assistance to Palestine Refugees, Report of the Director of the UNRWA: Sixth Session', 28 September 1951.

endemic typhus have been reported.'[107] Finally, in June 1953, it reported that, of the treaty diseases, 'only one case of epidemic typhus was recorded.'[108] This is a continuation of a practice demonstrated in the early years of the response wherein agencies including the League celebrated the control of contagious disease.

UNRWA's approach to the medical response continued to be explicitly minimal, and the agency continued to operate under real financial constraint. The agency was formally mandated to carry out relief (with medical response included in this basket) on a 'diminishing scale',[109] UNRWA professed that the need for aid would be reduced as the works projects took refugees out of a state of dependence. In UNRWA's first interim report, the Director reported 860,000 refugees as eligible for relief/rations: 'the minimum feasible to distribute unless the Agency was to leave itself open to grave criticism on humanitarian grounds.'[110] The UNRWA system also remained married to delivering a standard of curative medicine that was comparable to the 'normal', i.e., 'not much above the level provided by the host countries for their indigent nationals.'[111] However, the value of healthcare seemed to be further diminishing in the first few years of UNRWA operations, to the extent that members of the UNRWA leadership were explicit in their comments that healthcare services constituted one of the many crutches that refugees could lean on, and that refugees would suffer 'psychological debilitation' in the process of depending on this relief: relief—and healthcare services as part of humanitarian relief—was considered to be a harm. In the 1952 annual report, UNRWA officials asserted that camp life can have a 'deteriorating influence' on refugees and that services within camps 'tend to create and reinforce a professional refugee mentality.'[112] Under the health banner, amenities including clinics, maternity and infant welfare centres, supplementary feeding clinics, milk distribution points are listed alongside non-health services such as schools, recreational areas, and libraries as example

[107] A discrepancy between the sources is noted: one source referring to five treaty diseases and another referencing six. UNISPAL, (A/2171), 'Annual Report of the Director of the United Nations Relief and Works Agency for Palestine Refugees'; General Assembly Official Records: Seventh Session Supplement No.13., 30 June 1952. [This report covers the period 1 July 1951-30 June 1952.]

[108] UNISPAL, (A/2470), 'Annual Report of the Director of the United Nations Relief and Works Agency for Palestine Refugees in the Near East'; General Assembly Official Records: Eighth Session, Supplement No. 12., 30 June 1953. [This report covers the period 1 July 1952 to 30 June 1953.]

[109] UNISPAL, A/1451/Rev.1, 'Interim Report of the Director of the UNRWA: Fifth Session', 6 October 1950.

[110] UNISPAL, A/1451/Rev.1, 'Interim Report of the Director of the UNRWA: Fifth Session, 6 October 1950.

[111] UNISPAL: A/1905, 'Report of the Director of the UNRWA', Sixth Session, 28 September 1951.

[112] UNISPAL: (A/2171), 'Annual Report of the Director of the UNRWA', Seventh Session, 30 June 1952.

of services which could contribute to an entrenched reliance of relief.[113] The inclusion of infant and maternal health services within this list of services further evidences the shift that took place in the early years of UNRWA's refugee assistance from a prioritisation on new lives to a focus on working lives as the most important subjects of concern.

The underlining philosophy that the refugees were highly susceptible to a mentality of dependence and weakness went together with a commitment to training and development, and the UNRWA/WHO medical programme acted as a centripetal force for international technical experts. Specialist programmes delivered in the refugee camps included malaria prevention campaigns, trachoma treatment, anti-venereal disease campaigns, and programmes in maternal and child health. For trachoma, an internationally recognised ophthalmologist, Professor G. Bietti surveyed trachoma among the refugees in the autumn of 1950, and a control programme was initiated and carried out by a Dr Ferraris, employing a 'regimen of an ophthalmic antibiotic (aureomycine, terramycine ointment locally, together with sulphonamides by the mouth).'[114] At the time it was proposed that if sufficient drugs could be obtained, the programme could stretch from the few thousand patients then under treatment, to the treatment of all refugees with trachoma: 'great possibilities for an outstanding mass control programme.'[115] UNICEF assisted with the procurement of drugs, and by September 1950 a very different relationship was evident between UNRWA/WHO officials and WHO, in comparison to the fractious relationships demonstrated during the emergency milk distribution campaign. Peterson praised the contributions of UNICEF, emphasising their contributions to the medical programme above and beyond their 'much greater procurement of food stuffs, textiles, mil and cod liver oil';

> The understanding and cooperation of UNICEF from the Middle East Mission, the Paris European Headquarters and the New York World Headquarters have been essential to the success of this program.[116]

By September 1950, UNICEF was credited with significant funding: 'at least half of the medical and supply procurement came through UNICEF'.[117]

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[113] UNISPAL: (A/2171), 'Annual Report of the Director of the UNRWA', Seventh Session, 30 June 1952.

[114] UNISPAL: A/1905, 'Report of the Director of the UNRWA', Sixth Session, 28 September 1951.

[115] UNISPAL: A/1905, 'Report of the Director of the UNRWA', Sixth Session, 28 September 1951.

[116] WCC, Geneva: 425.02.09.025(03), 'Report by Jermone S. Peterson', Sept 1950, p. 23.

[117] WCC, Geneva: 425.02.09.025(03), 'Report by Jermone S. Peterson', Sept 1950, p. 23.

Further technical expertise was drafted for training programmes in the refugee camps. UNRWA began to instruct local healthcare personnel and by 1951 when the first annual report was delivered, it was acknowledged that the WHO was leading more instructional campaigns via its provision of loans to the agency of experts in various fields including venereal diseases, health education, nursing and public health administration, which experts: 'planned and set up campaigns and courses in instruction in their respective fields among Palestinian refugees and the locally recruited medical staff of UNRWAPRNE.'[118] A training scheme was designed to provide employment and opportunity for Palestine refugees, including a para-medical training programme begun in July 1951,[119] and intensified the following year.[120]

The Westernised system adopted by UNRWA minimised the potential for alternative narratives and imaginings of refugee health and wellbeing to emerge. This included an obfuscation of female imaginings of alternatives to the dominant economic development argument for effecting change and peaceful solutions in Palestine. For example, UNRWA claimed to raise the standards of midwifery,[121] but through the processes of professionalisation, many indigenous healers and dayat (midwives) lost their livelihoods.[122] Elise G. Young's research into women and health in camps in Jordan 1948-1994 generates arguments that are in stark contrast to Benjamin Schiff's claim that the UNRWA approach to refugee healthcare was lacking in controversy. Young argues that Palestinian women connected politics to health in their fights to maintain rights to reproductive practices, both as dayat, and as pregnant women, or mothers,[123] and that for refugee women, health was formulated in homecoming.[124] Young's research reflects on ways that 'women utilise health care as a paradigm for healing the planet from the politics of war.' She continues:

> There are traditions and current practices among Palestinian women (and among Latina women) emphasizing continuity, integration, and wholeness in relation to biology, the earth, community, and politics that inform definitions of health and health care systems. Perhaps a closer study of such paradigms and awareness of their

[118] UNISPAL: (A/1905), 'Report of the Director of the UNRWA', Sixth Session, 28 September 1951.

[119] UNISPAL: (A/2171), 'Annual Report of the Director of the UNRWA', Seventh Session, 30 June 1952.

[120] UNISPAL: (A/2470), 'Annual Report of the Director of the UNRWA', Eighth Session, 30 June 1953.

[121] UNISPAL, (A/1905), 'Assistance to Palestine Refugees, Report of the Director of the UNRWA', Sixth Session, 28 September 1951.

[122] Elise G. Young, *Gender and Nation Building in the Middle East: The Political Economy of Health from Mandate Palestine to Refugee Camps in Jordan* (London: I. B. Tauris, 2012).

[123] Young, *Gender and Nation Building*, pp. 107-108.

[124] Young, *Gender and Nation Building*, p. 147.

> historical place could be a path toward recognizing 'our inherent completeness, integration, and connectedness' so vital to world peace.[125]

The narrative of development failed to manifest a secure framework for healthy futures for the Palestinian refugees, indeed setting the refugees up to fail at a system they did not want to be part of.

In addition to a failure to include female imagining of refugee health, faith-based imaginings of refugee health were also marginalised in the humanitarian system. Reflecting on the ESM and the foundations it laid for UNRWA and the first years of the agency's operations, the ESM was in contrast with the earlier experience of the United Nations Relief and Rehabilitation Administration (UNRRA), which put trust in faith-based organisations such as the American Jewish Joint Distributions Committee (The Joint) for 'the restoration of mental health, morale, and the dignity of the individual achieved by recreational, spiritual, and vocational training programs'.[126] UNRRA was a secular institution but effectively endorsed 'an idea of 'rehabilitation' in which religion took on a crucial role because it not only alleviated spiritual suffering but also contributed to the re-acquisition of behaviour that was considered healthy and morally correct'.[127] There were no such overt endorsements in the reports of the ESM, despite the Christian beliefs of the survey mission's leading architect, Gordon Clapp who believed that faith in technological advancement could be combined with a Christian ethic of faith for the execution of purposeful work. In Clapp's own words:

> Too much of our administrative theory and more of our management practice in and out of the public service puts the Christian ethic beyond the pale of 'practical' affairs. Too many experts see human beings as units of energy to be manipulated by devious means or enticed by extrinsic favors and rewards. Successful administration carefully prepares the site quietly, without ceremony puts the key foundation stone in place—a faith in the feasibility of the enterprise and a faith in one's associates—and builds upon it an organization held together in a framework with ample tolerances for individual difference, growth, and dignity. In this structure, discipline is exerted by the pressure of faith in a purpose—the assignment to be filled, the dam to be built, the birth of a region's economic vitality.[128]

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[125] Young, *Gender and Nation Building*, p. 3.

[126] Silvia Salvatici, *A History of Humanitarianism, 1755-1989: In the Name of Others* (Manchester: Manchester University Press, 2019), p.130, citing George Woodbridge, UNRRA: The History of the United Nations Relief and Rehabilitation Administration (Vol. 2) (New York: Columbia University Press, 1950) p.77.

[127] Salvatici, *A History of Humanitarianism,* p.130.

[128] Harry L. Case, 'Gordon R. Clapp: The Role of Faith, Purposes and People in Administration', *Public Administration Review* 24 (2) (June 1964), pp. 86-91.

As refugee responsibility transferred to UNRWA, faith-based imaginings of refugee health did not gain traction in the practice of medical humanitarian action beyond the presence and action of the AFSC in Gaza. Here, the Quakers' attempts to forge peace through their relief activities may have been thwarted by the weight of the political context, but their contributions to education were significant and have been extensively documented by the historical scholarship of Nancy Gallagher.[129] Whereas faith-based imaginings may not have translated into action, representatives of the WCC undertook important fundraising activity[130] and its representatives acted as advocates for the Palestinian refugees, and as such acted as humanitarian witnesses to the Palestinian refugees' crisis. Rooted in a long lineage of predecessor institutions, the WCC was founded at its First Assembly in Amsterdam, 22 August to 4 September 1948, and in this configuration was a fledging institution as the Palestinian refugee crisis unravelled in the Middle East. Within the council, in the early years of UNRWA's operations, representatives assumed an advocacy role for the Palestinians, within the international community. And whilst there is evidence that Christian humanitarian actors believed in a spiritual solution to the refugee crisis, there were clear signals of agreement and support to the technical/economic development approach of the UN.

Earlier rhetoric of members of the WCC included specific concerns for the 'Arab Christians' affected by the crisis. In a letter to WCC General Secretary Willem A. Visser't Hooft (1948-1966), Elfan Rees expressed the view 'that U.N. action absolves the Refugee Division from any responsibility for contributing to a Disaster Relief project as such. I feel that we can concentrate what little we have on meeting the spiritual needs of the Arab Christians'. Despite this narrative, the WCC held two conferences on the Palestine Crisis, in May 1951 and in May 1956, bringing together church leaders from the USA, UK, and across Europe. The first conference emphasised that a large number of voluntary agencies (26) were active in the crisis, including 15 with a specifically Christian focus.[131] As a result of the first Palestine conference, financial support to the Middle East increased (a $15,000 additional contribution was agreed) but importantly, channels of communication were opened for representatives of the Church to advocate for the Palestinians to state powers in the USA and in Israel. In the USA, the National Council of

[129] Nancy Gallagher, 'Relief Versus Repatriation' in *Quakers in the Israeli–Palestinian Conflict: The Dilemmas of NGO Humanitarian Activism* (Cairo, 2007; online edn., Cairo Scholarship Online, 14 Sept. 2011) <https://doi-org.ezproxy.lib.gla.ac.uk/10.5743/cairo/9789774161056.001.0001> [accessed 18 October 2018], pp. 99-118.

[130] WCC, Geneva: 42.5.045: Rees to Hooft, 'Palestine Refugees', 13 December 1948.

[131] WCC, Geneva: 425.02.09.025 (03), 'Interim Report on the Conference on the Palestine Refugee Problem, Beirut', May 1-8, 1951.

Churches of Christ (NCCC) formed a committee to focus on increasing relief and inter-church aid, and to handle relations with government officials in Israel. Members of the committee also attended a conference with officials of the US State Department and presented testimony before the Committee on Foreign Affairs of the House of Representatives. Members of the council also met with Arab delegates to the UN, and made attempts to simulate public opinion on behalf of Arab refugees, conducting public relations activity targeted at mainstream media in Israel and the USA in addition to Christian publications.[132] In the early 1950s, church representatives' advocacy for the Palestinian refugees co-mingled with Cold War concerns. Shortly after the first Beirut conference, Walter W. Van Kirk, executive officer of the NCCC (and delegate to the Beirut conference) stood before the US House Committee on Foreign Affairs to give a perspective relating to the Mutual Security Program for the upcoming year. The Mutual Security Act, first signed into law by President Truman in 1951 was Cold War legislation which effectively replaced the Marshall Plan and provided funds to American allies for foreign military, economic and technical aid for countries in a bid to strengthen the West against Soviet communist encroachment.[133] As the United States fought in the Cold War, refugee relief continued to be entangled, and refugee camps provided both a context for concern and for action. Van Kirk's comments (given, he professed, not as an official representative of the Council, but his comments were in line with the council's agreement at the conference to advocate on behalf of the refugees) reflected the belief that a more ethereal response, based on friendship and human spiritual bonds, to the refugee challenge and humanitarian response to it was possible, and indeed preferred by people within the Church community – a strategy of friendship in place of military installations. In his statement to the House Committee, Van Kirk acknowledged a shocking hostility and ill will in the Middle East towards the United States, suggesting that 'many of the Arabs look toward Moscow for leadership' based on a belief that they have been abandoned by the Western nations. Demonstrating an agreement with the prevailing narrative, he stated that it was of the 'upmost importance that adequate provision be made in the mutual security legislation now under consideration for economic aid and technical assistance to the Middle East' – but he also acknowledged that economic aid and technical assistance would not be enough. What the crisis required, he professed, was an 'exercise of the spirit of forgiveness and reconciliation' and the United States should display 'a larger measure of human concern

[132] WCC, Geneva: 425.02.09.025 (03): 'Follow Up of the Beirut Conference by Members of the U.S.A. Delegation', Undated.

[133] United States House of Representatives [Online], 'The Mutual Security Act of 1951', https://history.house.gov/Historical-Highlights/1951-2000/The-Mutual-Security-Act-of-1951/> [Accessed 1 November 2023].

expressed in political understanding and goodwill,' and 'mutual security is derived in larger measure from the spirit of friendship and goodwill between and among the peoples concerned than from military establishments.' Van Kirk effectively placed friendship as a Christian value, at the heart of security.[134]

In addition to the shifting of responsibility for good health onto the shoulders of the refugees, the leadership of UNRWA took pains to turn the General Assembly's attention to the host governments, to clarify that there should be a transition of responsibility from UNRWA and its associates to the host governments. By 1953, whilst recognising the agency's achievements in maintaining health standards and avoiding major epidemics, UNRWA acknowledged that the strategy of relief and works was not working, and the agency represented 'an incongruous alien organisation'. The report states:

> 18. If relief is to continue, the question arises whether an agency designed to solve the refugee problem within a specified number of years is the appropriate organ to administer a programme which is beginning to assume a semi-permanent character. There is something incongruous in the presence of an alien organization, however well-intentioned, furnishing the basic necessities for a large proportion of the population of a country, particularly when – as in the commendable case of Jordan – the refugees have been made full citizens of the State.[135]

The United Nations never intended relief to be a permanent arrangement, 'the three-year plan itself anticipated the withdrawal of the agency from an active role into one of financial and technical assistance to governments.'[136] By June 1953, UNRWA claimed twelve months of 'active, fruitful and close collaboration' with the various medical departments of the host governments.[137] The responsibility for imagining and delivering on refugee health which passed to quickly to the refugees themselves, was by 1953 looking for another home.

Chapter Two Conclusion

In the Palestinian refugee camps, refugee health was quickly subsumed within a Western technocratic imagining of regional economic development. Attempts to care for refugee health and wellbeing under the humanitarian banner following the ESM could not be termed a-political,

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[134] WCC, Geneva: 425.02.09.025 (03), Statement Before the House Committee on Foreign Affairs, by Walter W. Van Kirk, 26 June 1951.

[135] UNISPAL: (A/2470), 'Annual Report of the Director of the UNRWA', Eighth Session, 30 June 1953.

[136] UNISPAL: (A/2470), 'Annual Report of the Director of the UNRWA', Eighth Session, 30 June 1953.

[137] UNISPAL: (A/2470), 'Annual Report of the Director of the UNRWA', Eighth Session, 30 June 1953.

neutral, compassionate action because of its framing by Western development strategies. The institutions which problematised and planned for a humanitarian response to the refugee crisis and therefore the health and wellbeing needs within it—predominantly the ESM and UNRWA—were forged by international patterns and systems of economic development and power. Palestinian refugee health and wellbeing became a technocratic imagining. The focus of humanitarian health quickly changed from new lives to working lives, shifting from emergency support for *mothers*andchildren to trust in the emerging and solidifying paradigms of development and working, able-bodied (male) lives. In the experience of the European Displacement Camps, which was largely a concurrent history with that of the Palestinians, scholars have shown that a shift occurred in humanitarian action from emergency to development. In a similar way, the ESM proposed that the living conditions and the life experiences of the refugees would be raised by the forces of economic development, and through their contributions to development projects the refugees could fight the 'psychological debilitating' effects of camp life and reliance on aid: the refugees could be raised out of crippling idleness—they could be well.

Notwithstanding the fact that the Works strategy of the ESM and UNRWA largely failed, and the vision of the ESM was largely abandoned, the very attempts at the expense of an alternative solidified the foundations for decades of insufficient support to Palestinian refugees. The Palestinian refugee camps were exploited as a context for Western technical modernism and visions of development, but in terms of healthcare the foundations were laid for a protracted situation that lacked imagination and failed to deliver for the refugees.

Scholars have suggested that UNRWA's early refugee response was largely benign, others have outlined its failings, especially for women.[138] UNRWA's precarious financial position again forced the leading humanitarian organisation operational in the field to focus on epidemiological reporting as a means for demonstrating success. And that in these attempts to demonstrate success, the reality of refugee health became even more obfuscated. Through its commitments to the tenets of development, the technical programmes UNRWA introduced further undermined any alternative imaginings of refugee health. Any alternative imagining by Christian faith-based humanitarian actors did translate into advocacy, but the impact on practical medical action remains to be seen.

[138] Young, *Gender and Nation Building*.

By 1953, the responsibility for refugee health had shifted from the international community to the shoulders of the refugees themselves, and then to the shoulders of UNRWA and its partners, including the WHO. UNRWA continued to be mandated as the agency to manage refugee management in the camp, despite their own advocacy that responsibility for the refugees could/should be handed to the host states. The following chapter will step further into the history of the Palestinian refugee camps, into the 1960s and 1970s to look in more detail at a specific medical programme. A measles vaccination programme which ran from 1965 through 1975 reflected the continued commitment of UNRWA and the WHO to preventive medicine as the cornerstone of healthcare, but this vaccination activity also demonstrates important connections between the Palestinian refugee camps and the Western medical enterprise of research and development.

3. Partnerships: the UNRWA/WHO measles vaccination programme and pharmaceutical philanthropy, Palestinian Refugee Camps, 1965-1975

From the early years of UNRWA's operations into the mid 1960s, the Palestinian refugee camps transitioned from acute crisis to a protracted way of life, with UNRWA adopting a 'developmental' model of relief, albeit it one beset with difficulties. By 1965, the partnership between UNRWA and the World Health Organization (WHO) was well-established with preventive medicine at the heart of this programme. An extensive immunisation schedule was in place for the refugees covering DPT (Diphtheria, Pertussis and Tetanus), smallpox, poliomyelitis, BCG (Bacillus Calmette-Guérin) and TAB (Typhoid and Paratyphoid).[1] Alongside this, between 1965 and 1975 a programme of vaccinating refugee children against measles took place in the Palestinian refugee camps, and Western pharmaceutical companies stepped into the 'sacred spaces of humanitarianism'[2] in the Palestinian camps, taking a hand of responsibility for the health of Palestinian refugees. Through medical technologies—the vaccines and the instruments used to deliver them—the camps and refugees became connected to the development of modern measles vaccines as recipients, research participants, and resistors. Over this ten-year period, donations of vaccines were transferred to the WHO medical programme run in partnership with UNRWA from major pharmaceutical companies, principally Pfizer International Limited and the Merck Institute for Therapeutic Research, both in the USA.

This chapter will briefly contextualize the vaccination programme by outlining the spirit of the intervening years between 1953 and 1965, when UNRWA had become a proxy state for the refugees.[3] Then, chronologically, three phases of measles vaccine donations made to the Palestinian refugee camps from the mid-1960s demonstrate how a commitment to preventive medicine coupled with a mission to further research and development, became embedded in the refugee camps. Overt resistance to the vaccination campaign by the refugees demonstrates how performative humanitarian action and medical technology clashed with the refugees' need for

[1] WHO, Geneva, WHO.3: M1-445-2, UNRWA-J1, Letter Sharif to Cockburn, 16 September 1966.

[2] Michael Barnett and Janice Gross Stein, 'Introduction: The Secularization and Sanctification of Humanitarianism', in *Sacred Aid: Faith and Humanitarianism* eds. Michael Barnett and Janice Gross Stein (New York: Oxford University Press, 2012), p. 26.

[3] Terry Rempel, 'UNRWA and the Palestine Refugees: A Genealogy of "Participatory" Development', *Refugee Survey Quarterly* 28 (2-3) (2009), pp. 412-437.

agency. The specific use of the Ped-O-Jet jet injector in the refugee camps is at the heart of this case.

From the mid-1950s, UNRWA had achieved some specific notable successes in medical and healthcare provision. For example, the introduction of a special oral rehydration formula to treat mildly dehydrated diarrhoeic infants had produced 'spectacular' results and was adopted by WHO and UNICEF for global use.[4] But more broadly, following the failures of the economic development approach advocated by the ESM, from the mid-1950s UNRWA steered towards a core programme of essential services including primary healthcare, relief, and social services focused on education.[5] This approach involved a shift from top-down management to forms of participatory development, but essentially the strategy was a continuation of 'adequacy-only', whilst acknowledging the then lingering existence of the camps and the raising-up of a new generation within them. By the mid-1960s the 'right to development' narrative was emerging on the international stage,[6] and the UN Development Decade was underway (1960-1970). Laser-focused on the creation of self-sustaining growth of nations, with 'a minimum annual rate of growth of aggregate national income of five per cent at the end of the Decade,'[7] the international system needed to deploy international Development with a capital D: the advancement of less developed countries through international cooperation, increased balances from foreign exchange, increased flows of development resources and private investment capital. These processes would be coupled with industrialisation, diversification and development of agricultural sectors, technical assistance from foreign sources, improved use of international institutions, and the promotion of education and vocational training with UN member state and specialised agency assistance where appropriate.[8] The development of healthy populations in developing countries was crucial for the success of the UN Development Decade. Good health

[4] The formula was introduced in the camps in 1957. Lex Takkenberg, 'UNRWA and the Palestinian Refugees After Sixty Years: Some Reflections' *Refugee Survey Quarterly* 28 (2-3) (2009), pp. 253-259.

[5] Rempel, 'UNRWA and the Palestine Refugees', pp .412-437.

[6] Daniel J. Whelan, '"Under the Aegis of Man": The Right to Development and the Origins of the New International Economic Order', *Humanity: An International Journal of Human Rights, Humanitarianism, and Development* 6 (1) (Spring 2015), pp. 93-108.

[7] United Nations Digital Library, A/RES/1710 (XVI), 'General Assembly resolution 1710 (XVI), United Nations Development Decade: A programme for international economic co-operation', 19 December 1961.

[8] United Nations Digital Library, A/RES/1710 (XVI), 'General Assembly resolution 1710 (XVI), 19 December 1961.

(and specifically the elimination of hunger and disease) was essential for productive people. In the Proposals for Action report of the Secretary General, it was clearly stated:

> Successful development depends ultimately on the ability of people to realize their individual capacities, which cannot be realized as long as the present major barriers of disease and inadequate health and sanitation facilities continue to exist.[9]

Yet, into the 1970s contributions to UN overseas development assistance from government donors continued to be low: at the UN General Assembly in 1970, donor governments pledged to spend 0.7% of GNI on official development assistance.[10] With UNRWA budgets correspondingly precarious, the agency increasingly prioritised education and vocational training as pillars of development.[11] At a time when the average expenditure for all relief services was increasingly under scrutiny, a focus on education was a form of 'non-political human development' that enabled UNRWA to protect and promote its legitimacy.[12] As a result, the budget for education doubled in four years amounting to an average of almost $10 per capita in 1961.[13] Contrastingly, medical budgets continued to be managed as part of relief services and remained minimal, necessitating a continued strategy of minimal standards and 'making the best' of a challenging financial situation. Sanitation was also officially placed under the banner of the medical programme in 1965, with environmental protection formally recognised as essential for the success of the preventive health programme.[14]

In this context of scarcity, philanthropic donations were essential for the continuation and development of the medical programme. And vaccines were crucial for the maintenance of preventative care activity, which was in turn essential for the maintenance of refugees as 'able-

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[9] United Nations Digital Library, E/3613, 'The United Nations Development Decade: Proposals for action, Report of the Secretary General', 1962, p. 64.

[10] Linsey McGoey, 'The Philanthropic State: Market-State Hybrids in the Philanthrocapitalist Turn', *Third World Quarterly* 35 (1) (2014), pp. 109-125.

[11] Kjersti G. Berg, 'The Unending Temporary. United Nations Relief and Works Agency and the Politics of Humanitarian Assistance to Palestinian Refugee Camps, 1950-2012' (PhD thesis, University of Bergen, 2015). Kjersti G. Berg, 'Gendering Refugees: The United Nations Relief and Works Agency (UNRWA) and the Politics of Relief', in *Interpreting Welfare and Relief in the Middle East*, eds. Nefissa Naguib and Inger Marie Okkenhaug (Leiden: Koninklijke Brill NV, 2008).

[12] Riccardo Bocco, 'UNRWA and the Palestinian Refugees: A History Within History', *Refugee Survey Quarterly* 28 (2 & 3) (2010), pp. 229-252.

[13] WHO, Geneva, WHO.3/N 77/372/2 (Jacket 1), Statement by John H. Davis, Director of UNRWA, UN Special Committee, 4 December 1961.

[14] WHO, Geneva: WHO.3, N 77/372/2 (J1) Coordination with UNRWA: Sharif to Commissioner General (Memorandum Confidential), 8 June 1965.

bodied' participants in economic life, or the future workforce of the Palestinian communities. The emerging focus on essential services was typical of participatory development models in the 1960s and 1970s, and the approach opened job opportunities for refugees as managers and service deliverers. The refugees were cheaper to employ than international humanitarian workers, and they would go on to constitute the majority of the UNRWA workforce.[15] In this model, refugees were encouraged to take part in programmes of self-reliance and independence—to continue to take responsibility for their own health and wellbeing—as well as pursue modest economic development and take on professional, more skilled or senior roles, including those in the medical sphere. However, the refugees faced a glass ceiling to leadership positions (senior staff continued to be paid higher 'international salaries'), and as such their participation in more strategic activities such as needs assessment tasks, or the design and development of programmes or services was limited.[16] In the historical literature, there are extensive critiques of Western medicine as 'an act of cultural condescension on a grand scale' as the coloniser and agents of imperialism dismissed local knowledge and failed to undertake any dialogue with local communities about the nature of disease and responses to it.[17] Following the establishment of the Palestinian Liberation Organization in 1964, UNRWA did have obligations to extend planning dialogue and collaboration to the refugees through this body, but a top-down approach continued largely unabated.[18]

As part of the vaccination schedule for the refugees, newly licenced measles vaccines developed in the mid-1950s offered greater efficiency and efficacy for immunisation in the camps. Measles is a highly contagious disease,[19] yet the prevailing view at the time in Western society was that measles was a 'normal' illness experienced in a child's development, an attitude which was rooted

[15] Bocco, 'UNRWA and the Palestinian Refugees', pp. 229-252. Rempel, 'UNRWA and the Palestine Refugees', pp. 412-437.

[16] Rempel, 'UNRWA and the Palestine Refugees', p. 423.

[17] Andrew Cunningham and Bridie Andrews, 'Introduction: Western Medicine as Contested Knowledge' in *Western Medicine as Contested Knowledge,* eds. Andrew Cunningham and Birdie Andrews (Manchester: Manchester University Press, 1997), pp. 1-23.

[18] Rempel, 'UNRWA and the Palestine Refugees', p. 424.

[19] An excellent visual graphic representation of how quickly measles is spread (compared to the COVID-19 virus) is printed within the following article: Nick Evershed and Andy Ball, 'How coronavirus spreads through a population and how we can beat it' *The Guardian,* <https://www.theguardian.com/world/datablog/ng-interactive/2021/sep/09/how-contagious-delta-variant-covid-19-r0-r-factor-value-number-explainer-see-how-coronavirus-spread-infectious-flatten-the-curve> [accessed 28 June 2023].

in the Victorian experience in the cities and the countryside.[20] However, in resource-limited refugee camps with highly populated and cramped environments and high rates of malnutrition, the danger of death or health complication presented by measles was very real.[21] According to the WHO, 'the most serious complications of measles include blindness, encephalitis (an infection that causes brain swelling), severe diarrhoea, and related dehydration, ear infections, or severe respiratory infections such as pneumonia'. Malnourished children or those with low immunity were most at risk.[22] Therefore, the development of attenuated live measles vaccines and non-attenuated killed measles vaccines were a significant prospect for the medical programme and the refugee population. An attenuated live vaccine is a pathogen of reduced virulence, yet still viable or "live". The virus is applied to a foreign host, the passage through which causes the virus to adapt and become less harmful to the vaccinated subject. A non-attenuated or 'inactivated' killed vaccine uses a killed version of the germ that causes the disease. Henceforth I will abbreviate these two types of vaccine to 'attenuated live' or 'non-attenuated killed'.

Measles vaccines were donated from Western pharmaceutical companies to the Palestinian refugee camps in three phases. First, in 1965 a donation of a quarter million doses of non-attenuated killed vaccine was made by Pfizer International Limited. This type of vaccine was de-licenced in the USA shortly after its receipt in the Palestinian camps. A second phase of donations from the Merck Institute for Therapeutic Research[23] involved a small pilot study of a combination vaccine (attenuated live measles combined with a smallpox vaccine). Third, further donations were made by Merck in 1969 of 30,000 doses of attenuated live vaccine (Rubeovax) and in the early 1970s, donations included 13,000 doses of a more attenuated live vaccine,

[20] Anne Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856-1900* (Oxford: Clarendon, 1993), p. 29. J. P. Baker, 'Immunization and the American Way: 4 Childhood Vaccines,' *American Journal of Public Health* 90 (2) (2000), pp. 199-207.

[21] Peter Aaby, J. Bukh, M. Lisse, A.J. Smits, 'Overcrowding and intensive exposure as determinants of measles mortality', *American Journal of Epidemiology* 120 (1984), pp. 49–63; Peter Aaby, H. Coovadia, 'Severe measles: a reappraisal of the role of nutrition, overcrowding, and virus dose', *Medical Hypotheses* 18 (1985), pp. 93–112.

[22] *World Health Organisation [Online],* 'Measles' < http://www.who.int/news-room/fact-sheets/detail/measles> [Accessed 5 December 2018].

[23] The Merck Institute for Therapeutic Research was established in 1933. The Institute was 'a non-profit corporation'. This term seems an oxymoron, but the Institute was a prime example of a non-profit research body intrinsically attached to a large, corporate, pharmaceutical machine. See: Unauthored, 'The Merck Institute for Therapeutic Research', *Science* 97 (2523) (7 May 1943), p. 417.

Attenuvax.[24] 'Controversy clings to immunisation programmes',[25] and the ethical context for these donations is important, not least because the donations involved research trials in the camps. Unethical activity would undermine the humanitarian claims of the UN organisations leading the medical care for the refugees, and their pharmaceutical partners acting in humanitarian space.

The prevailing ethical standards in post-war Allied countries (and the ethical context to decisions made by the UNRWA/WHO medical leaders regarding vaccines and vaccine trials) can be benchmarked with President's Address for the Royal Society of Medicine delivered by Professor Robert Alexander McCance, Chair of Experimental Medicine at Cambridge University in 1950.[26] McCance was a British physiologist, paediatrician, and nutritionist who became known for a memorandum submitted in 1946 which was used by the defence lawyers at the Nuremberg Medical Trials as evidence of Western support for human experimentation.[27] The subsequent Royal Society speech was perhaps an attempt to set the record straight.[28] McCance proposed that the definition of experimental medicine *should not* 'include the administration of established prophylactic remedies, even though some of them, particularly the attenuated viruses, may involve risk.'[29] McCance afforded greater protection to children: 'It would also, I believe, be regarded as an offence under common law to make any investigation upon a child which involved the removal of hair, skin or blood without its parents' consent.'[30] But, at the heart of his manifesto, McCance proposed that those advancing knowledge had the right to expect co-operation: that gifted and trained medical professionals held responsibility for advancing

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[24] WHO, Geneva, WHO.3, M11-445-2UNRWA-J1, Letter from G.M. Winterlings, Contribution Manager at Merck & Co., Inc to Cockburn, 19 May 1972.

[25] Paul Greenough, Stuart Blume and Christine Holmberg, eds, *The Politics of Vaccination, A Global History*, (Manchester: University of Manchester, 2017), p. 1. Please note, this thesis was completed after one of the greatest vaccination controversies in medical history, the response to the global COVID-19 pandemic. However, this chapter was drafted before the pandemic began, and as such does not refer to the pandemic as relevant context. For discussions of vaccine controversies preceding COVID-19: H. J. Larson, C. Jarrett, E. Eckersberger, D. M. D. Smith and P. Paterson, 'Understanding Vaccine Hesitancy Around Vaccines and Vaccination from a Global Perspective: A Systematic Review of Published Literature, 2007–2012', *Vaccine* 32 (19) (2014), pp. 2150–9. Stanley Williamson, *The Vaccination Controversy: The Rise, Reign and Fall of Compulsory Vaccination for Smallpox* (Liverpool: Liverpool University Press, 2007).

[26] Cathy Gere, *Pain, Pleasure, and the Greater Good: From the Panopticon to the Skinner Box and Beyond* (Chicago: University of Chicago Press, 2017), p.35.

[27] Gere*, Pain, Pleasure, and the Greater Goo*d, pp. 34-36.

[28] Gere, *Pain, Pleasure, and the Greater Good*, p. 35.

[29] R.A. McCance, "'The Practice of Experimental Medicine', President's Address, Proceedings of the Royal Society of Medicine, 12 December 1950", *Journal of Experimental Medicine and Therapeutics* 44 (3) (March 1951), p. 191.

[30] McCance, 'The Practice of Experimental Medicine', p. 193.

knowledge for the sake of curing and preventing disease (and had made personal financial sacrifice in pursuit of their tasks), and in return had 'a right to expect the fullest co-operation from their medical colleagues, from nurses and other assistants, from hospital managements, from patients and relatives and from the community at large'.[31]

It followed that attenuated live and non-attenuated killed measles vaccines were developed according to the ethical standards of the time. In 1963, both kinds of vaccine were licenced and approved for use in the USA.[32] The WHO/UNRWA measles vaccination was developed in step with American health and immunisation policies and norms of research and development, rather than that of the British state. The administrations of US Presidents John F. Kennedy and President Lyndon B. Johnson were grounded in a belief that measles and poverty were intrinsically linked, and therefore a more urgent approach was taken, with Presidential support afforded to mass immunisation programmes. In the United Kingdom the approach to measles vaccination was more cautious and insistent on mass randomized trial data. Focused on curative medicine, the British state did not initiate its own mass measles immunisation programme until 1968.[33]

The research trials undertaken in the USA to achieve this licence were first initiated in monkeys,[34] and then controlled trials took place with susceptible children including studies with 303 institutionalized children,[35] trials in state schools for the 'mentally deficient' in four American cities,[36] and trials among institutionalised home-dwelling children in Cleveland and at Harvard amongst 'normal children living at home and exposed to the usual sibling and school measles contacts' (members of the trials were often 'families enrolled in a special teaching

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[31] McCance, 'The Practice of Experimental Medicine', pp. 189-194.

[32] Jan Hendriks and Stuart Blume, 'Measles Vaccination Before the Measles-Mumps-Rubella Vaccine', *American Journal of Public Health* 103(8) (August 2013), pp. 1394. Jeffrey P. Baker, 'Immunization and the American Way: 4 Childhood Vaccines', *American Journal of Public Health* 90 (2) (2000), pp. 199-207.

[33] Hendriks and Blume, 'Measles Vaccination Before the Measles-Mumps-Rubella Vaccine', pp. 1393-1401.

[34] Editorial, 'Measles Vaccine', *The New England Journal of Medicine*, (27 August 1959), p. 466.

[35] Samuel L. Katz, John F. Enders, Ann Holloway, 'Studies on an Attenuated Measles-Virus Vaccine. II. Clinical, Virologic and Immunologic Effects of Vaccine in Institutionalized Children', *The New England Journal of Medicine* 263 (4) (1960), pp. 159-161. Samuel L. Katz, Henry Kempe, Francis L. Black, Martha L. Lepow, Saul Krugman, Robert J. Haggerty, John F. Enders, 'Studies on an Attenuated Measles-Virus Vaccine. VIII. General Summary and Evaluation of the Results of Vaccination', *The New England Journal of Medicine* 263 (4) (1960), pp. 180-184.

[36] C. Henry Kempe, Ester W. Ott, Leone St. Vincent, John C. Maisel, 'Studies on an Attenuated Measles-Virus Vaccine. III. Clinical and Antigenic Effects of Vaccine in Institutionalized Children', *The New England Journal of Medicine* 263 (4) (28 July 1960), pp. 162-165.

programme for medical students and house officers in training, the Family Health Care Program'[37]). In a trial on Staten Island, parents were documented as offering consent, and in this trial there was an 'explosive outbreak' of measles involving 46 of 73 unvaccinated (control) children; this epidemic was reported to be unusually severe, with many complications and at least four deaths.[38] In the domestic US setting, as in the international settings which vaccine trials would also be undertaken, the trials were not without risk and children's vulnerability was essential for the progression of the vaccines' research and development.

The measles vaccination campaign occurred two decades before Merck & Co. famously announced that it would provide ivermectin (Mectizan™) free of charge in the battle against onchocerciasis (river blindness) to anyone that needed it, for as long as they needed it.[39] The company's generosity was heralded by US Senator Edward M. Kennedy as 'an answered prayer for the third world … more than a medical breakthrough – it is truly a triumph of the human spirit.'[40] Merck's donation is deserving of its place in medical history: the donated antiparasitic drugs enable treatment for more than 25 million people annually for onchocerciasis.[41] Since the Mectizan Donation Programme was launched in 1987, by 2008, over 530 million treatments had been administered.[42] However, the earlier donations of measles vaccines from pharmaceutical companies to the Palestinian refugee camps—although on a far smaller scale to that of ivermectin and constituting a preventative vaccine rather than a therapeutic treatment—demonstrate interconnectivity between the pharmaceutical industry and refugees that has largely

[37] Robert J. Haggerty, Roger J. Meyer, Ellenora Lenihan, and Samuel L. Katz, 'Studies on an Attenuated Measles-Virus Vaccine: VII. Clinical, Antigenic and Prophylactic Effects of Vaccine in Home-Dwelling Children,' *The New England Journal of Medicine* 263 (28 July 1960), pp. 178-180.

[38] Paul Krugman, Joan P. Giles, and A. Milton Jacobs, 'Studies on an Attenuated Measles-Virus Vaccine—Clinical, Antigenic and Prophylactic Effects of Vaccine in Institutionalized Children', *New England Journal of Medicine* 263 (4) (28 July1960), pp. 174-177.

[39] Annual Reviews Conversations [Online], 2011, 'A Conversation with P. Roy Vagelos', <https://www.annualreviews.org/userimages/ContentEditor/1337783424709/P.RoyVagelosTranscript.pdf> [accessed 5 July 2023].

[40] The New York Times, 'Merck Offers Free Distribution of New River Blindness Drug', 22 October 1987, <https://www.nytimes.com/1987/10/22/world/merck-offers-free-distribution-of-new-river-blindness-drug.html> [accessed 18 April 2018].

[41] Kimberly Collins, 'Profitable Gifts: a history of the Merck Mectizan donation program and its implications for international health', *Perspectives in Biology and Medicine* 47 (1) (Winter 2004), pp. 100-109. Michael Useem, *The Leadership Moment: Nine True Stories of Triumph and Disaster and Their Lessons for Us All* (New York: New Rivers Press, 1998).

[42] B. Colatrella, 'The Mectizan Donation Program: 20 years of successful collaboration–a retrospective', *Annals of tropical medicine and parasitology* 102 (Supplement 1) (2008), pp. 7-11.

been overlooked.[43] And in the case of measles vaccine donations to the Palestinian refugee camps, the refugees were also connected to the project through the contribution of data as research participants. The UNRWA/WHO measles vaccination campaign was heavily influenced by the processes of vaccine research and development in the USA, whilst being professionally tempered by the ethical caution of key WHO and UNRWA professionals.

Merck's donation of ivermectin to patients with onchocerciasis (principally those in the developing world) has received considerable scholarly attention. This history of Mectizan has been dominated by executive voices from within the pharmaceutical industry, through autobiographical accounts from executives and leading virologists[44] re-enforcing the 'great men' narrative of global health history. Herein, prominent men were in the right place at the right time to rapidly accelerate development and delivery of important vaccines.[45] The literature tends to present executives such as Roy Vagelos, CEO of Merck & Co., as moral agents working within an ethical framework whilst meeting their fiduciary duty to shareholders.[46] Does the presence of donations of measles vaccines in the Palestinian refugee camps reflect similar acts of philanthropy from key individuals or benevolence of pharmaceutical corporations?

The pharmaceutical philanthropy in the Palestinian refugee camps took place more than a decade before the rise of 'Big Pharma' in the 1980s. Certainly Pfizer and Merck were large, global operations in the mid-1960s, but it was not until the administration of US President Ronald Reagan in the US that pro-business government coupled with changing public opinion freed business and pharmaceuticals to pursue great wealth.[47] This turn towards neo-liberal

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[43] I have found one minor reference to the campaign within a discussion about the development of measles vaccines: Jan Hendriks and Stuart Blume, 'Measles Vaccination Before the Measles-Mumps-Rubella Vaccine', *American Journal of Public Health* 103(8) (2013 August), pp. 1393-1401.

[44] P. Roy Vagelos and Louis Galambos, *Medicine, Science, and Merck* (Cambridge: Cambridge University Press, 2004). P. Roy Vagelos and Louis Galambos, *The Moral Corporation: Merck Experiences* (Cambridge: Cambridge University Press, 2006). Michael B.A. Oldstone, *Viruses, Plagues, and History: Past, Present and Future* (2nd edn.), (New York: Oxford University Press, 2020).

[45] William A. Muraskin, 'The power of individuals and the dependency of nations in global eradication and immunisation campaigns' in *The Politics of Vaccination, A Global History,* eds. Paul Greenough, Stuart Blume, and Christine Holmberg (Manchester: University of Manchester, 2017). William A. Muraskin*, Crusade to Immunize the World's Children: The Origins of the Bill and Melinda Gates Children's Vaccine program and the Birth of the Global Alliance for Vaccines and Immunization* (Los Angeles: Global BioBusinessBooks, 2005).

[46] Collins, 'Profitable Gifts', pp. 100-109. For discussion of how moral debates intersect with economic concerns and shareholder value, see also Peter Wehrwein, 'Pharmacophilanthropy' *Harvard Public Health Review* (1999), pp. 35-36.

[47] Marcia Angell, *The Truth About the Drug Companies; How They Deceive Us and What to Do About* It (New York: Random House, 2004).

pharmaceutical philanthropy ushered in new forms of 'philanthrocapitalism'[48] followed by corporate social responsibility in the twenty-first century.[49] The companies donating to the Palestinian refugee camps, whilst existing as large influential institutions, were incubators for capitalistic power. And, as such the individuals driving the philanthropy remain centre stage to the narrative. The story of measles vaccination in the Palestinian camps was also dominated by 'great men', principally Dr Mohammed. Sharif, Director of Health and WHO representative at UNRWA, Dr William Charles (Chas) Cockburn, Chief Medical Officer at the Virus Diseases section of the WHO and Maurice Ralph Hilleman, Director of Virus & Cell Biology Research at Merck Institute for Therapeutic Research. Yet, in contrast with the male executive decision-makers, female humanitarian actors were present in the history of Palestinian refugee camps in the 1960s and 1970s, and individuals were playing a role in bringing the humanitarian experience into popular consciousness. In 1964, three years prior to her return to the refugee camps in Jordan, Save the Children Fund nurse (introduced to us in Chapter One) Mary Katherine Hawkins appeared on the popular television show, 'This is your life'.[50] On national prime time television in the UK, Hawkins was presented as a humanitarian 'hero', and as a witness to humanitarian strife and refugee suffering, further bringing humanitarian nursing into popular culture.

The WHO Scientific Group on Measles Vaccine Studies which convened in Geneva, July 1963[51] solidified a mandate for vaccine field trials taking place in countries with different socio-economic and environmental conditions.[52] Prior to the publication of the 1963 Scientific Group report, studies of Enders' Edmonston B strain vaccine and antibody response had been conducted in Chile, India, South Africa and Iceland and Upper Volta, West Africa.[53] A mass

[48] McGoey, 'The Philanthropic State', pp. 109-125; M. Bishop and M. Green, *Philanthrocapitalism: How the Rich Can Save the World* (London: Bloomsbury Press, 2008).

[49] Micael Givel, 'Modern Neoliberal Philanthropy: motivations and impact of Pfizer Pharmaceutical's corporate social responsibility campaign', *Third World Quarterly* 34 (1) (2013), pp. 171-182.

[50] Cabury Resarch Library (CRL), Birmingham, SCF Archives: Mary Katherine Hawkins Collection, SCF/SC/MKH/5/17, 'This is Your Life' Red Book.

[51] The Group convened between 15-20 July 1963. Predominantly a group of non-developing world representatives, both Hilleman and Cockburn were members of the group.

[52] IRIS, 'Measles Vaccines: Report of a WHO Scientific Group', *World Health Organization Technical Report Series*, No. 263 (Geneva: WHO, 1963), p.37 <https://iris.who.int/handle/10665/40566> [accessed 10 October 2023].

[53] Upper Volta was a part of French West Africa until August 1960. Its name was changed to Burkina Faso in 1984.

vaccination campaign conducted in the Upper Volta region in 1962 involved approximately 730,000 children—administered by jet injection.[54] It was reported in *JAMA*:

> Vaccination began in the fall of 1962, many months before licenses for the manufacture of the measles vaccines were approved in the U.S. But the Upper Voltese were desperate. … If successful, the immunization programme will have saved an estimated 100,000 to 175,000 lives.[55]

Further research into attenuated live measles-virus vaccine strains was undertaken in Japan, Nigeria, USSR, Yugoslavia, and the USA. Further comparative studies of attenuated live measles virus vaccine, in part sponsored by a US Public Health Service Grant,[56] were conducted under WHO auspices in Canada, Czechoslovakia, Nigeria, Switzerland and Yugoslavia.[57] Researchers were emboldened by the institutional support for undergoing trials among susceptible, needy, desperate populations and further field trials took place in Tegucigalpa, the capital of Honduras, of two commercially available measles vaccines: unmodified Edmonston B and a further attenuated Schwarz strain[58] and a small-scale simultaneous trial of measles and smallpox took place.[59] The trials in West Africa and other parts of the 'developing world' have informed decades of debate in the West about population health, mortality rates and the role of preventive medicine, not least debates related to the McKeown thesis and the relation of vaccination to declines in mortality rates.[60] These extensive trials demonstrate how the Palestinian camps were another context for the medical establishment to advance its aims, whilst developing a product that it understood was necessary for those contexts.

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[54] IRIS, 'Measles Vaccines: Report of a WHO Scientific Group', p. 12.

[55] Unauthored, 'Medical News: Measles Vaccine Expected in Curtail Annual Epidemic in Upper Volta', *JAMA* 184 (2) (13 April 1963), pp. 43-62.

[56] W. Charles Cockburn, Josef Pečenka, T. Sundaresan, 'WHO-supported Comparative Studies of Attenuated Live Measles Virus Vaccines', *Bulletin of World Health Organization* 34 (1966), pp. 223-231.

[57] These studies investigated the reactions and antibody responses to Enders' Edmonston B vaccine to the Schwarz, Beckenham and Milovanović vaccine. Altogether 1,685 children took part in the study (1,217 vaccinated and 368 controls): Cockburn et al., 'WHO-supported Comparative Studies', pp. 223-231.

[58] George Miller, J. Gale, V. Villarejos, W. James, C.G. Artega, H. Casey, D.A. Henderson, B. Edmonston, 'Edmonston B and a Further Attenuated Measles Vaccine: A Placebo Controlled Double Blind Comparison', *American Journal of Public Health* 58 (8) (August 1967) pp.1333-1340.

[59] Matthew A. Budd, Robert G. Scholtens, Read F. McGehee, Jr., Pierce Gardner, 'An evaluation of measles and smallpox vaccines simultaneously administered', *American Journal of Public Health* 57 (1) (1967), pp. 80-86.

[60] Anne Hardy, *The Epidemic Streets*. Bill Bynum, 'The art of medicine: The McKeown thesis', *The Lancet* 371 (February 23, 2008).

There were of course additional benefits of combining pharmaceutical donations with the processes of research and development: the good publicity of humanitarian endeavour. Records from GlaxoSmithKline (GSK) (a peer to Merck), show how the Wellcome Foundation (a legacy company of GSK) recognised the benefits of raising good publicity connected to humanitarian donations. The following minute was recorded at a Meeting of Directors of the Wellcome Foundation Ltd., 15 January 1964. The board had been approached by the WHO for a free supply of 1.5 million doses of oral polio vaccine as a contribution to its emergency stockpile for tackling disease outbreaks. A comment was recorded by a Dr. Wrigley, that 'on the basis of past experience it was most unlikely that such a gesture would produce any commercial advantage in the form of increased business with the WHO.'[61] Clearly, increasing business income was of importance to the foundation, but other avenues to commercial benefit were identified in the form of public relations value. The donation was agreed, acknowledging that 'proper handling of the public relations by the Company, a fair measure of prestige could be gained and, subject to the Company being permitted to handle this aspect, the donation of 1.5 million doses was APPROVED.'[62]

At the same time, (and when the Pfizer vaccine was being shipped to the camps) the American legislative context for drugs research, development and human testing was rapidly evolving. The US congress began to require that drug companies prove their products were safe and effective, and demanded new rules and an environment for research and development wherein clinical trials were an appropriate method for proving both safety and effectiveness.[63] And for the first time, patient consent was written into US federal legislation: ratification of the Kefauver-Harris Drug Amendments to the Federal Food, Drug and Cosmetics Act in 1962 required the need for informed patient consent for the use of experimental substances.[64] In the UK, the Safety of Medicines Act was enacted by the Medicines Commission in 1968, providing a unified legislative framework for medical drug control.[65] However, within the legislation in the US there existed with a gaping legal loophole in the form of an exception provision wherein researchers "deem it

[61] GlaxoSmithKline, Middlesex, UK: Minutes of Meeting of Directors of the Wellcome Foundation Ltd. (No. 6058), 15 January 1964. Source shared by email by a Heritage Archivist at GlaxoSmithKline.

[62] GlaxoSmithKline, Middlesex, UK: Minutes of Meeting of Directors of the Wellcome Foundation Ltd. (No.6058), 15 January 1964.

[63] Angell, *The Truth About the Drug Companies* (New York: Random House, 2004).

[64] Gere, *Pain, Pleasure, and the Greater Good*, p. 43.

[65] Anne Hardy and E.M. Tansey, 'Medical enterprise and global response, 1945-2000' in *The Western Medicine Tradition: 1800-2000* ed. W.F. Bynum (New York: Cambridge University Press, 2006), p. 478.

not feasible or, in their professional judgement, contrary to the best interests of such human beings"[66] to gain consent. The degrees of discretion open to scientists and researchers conducting experimental medicine, as opposed to rights held by patients, continued to dominate medical practice and investigative medicine in this period and such 'degrees of discretion' should be expected in the refugee camp contexts. Third world contexts have long been considered sites of exception, treated as 'living laboratories'[67] under neo-colonial structures and systems and as such refugee camps might be expected to follow suit.

Both attenuated live and non-attenuated killed vaccines became commodities in a neo-colonial exchange between Western pharmaceutical companies and the Palestinian refugees. The vaccine products donated to the camps from the Western 'centre' to the post-colonial 'periphery' involved the exchange of a product of preventive medicine in exchange for data. Bound-up in this exchange was a demonstration of power: measles was a sign of poverty, and inoculation campaigns were signals of the power of the Western medical institutions in overcoming disease. This exchange was not without resistance from the refugees.

A donation of non-attenuated killed vaccine from Pfizer Ltd., 1965 -1966

In September 1965, Pfizer made an offer of one million doses of non-attenuated killed measles vaccine.[68] Following deliberations, the smaller quantity of 250,000 doses was shipped to the UNRWA camps: a donation valued at $250,000.[69] To put the volume of doses required to immunise the Palestine refugee camp population into context: between 1968 and 1972, Merck Sharpe and Dohme sold almost 61 million doses of its new vaccine for measles, mumps, and rubella.[70] However, this was a significant volume and sum for the UNRWA/WHO team, given the apparent absence of a budget to procure such pharmaceuticals. The supplies took over five months to be delivered after the offer was originally made to UNRWA.[71] The delay to the vaccines' delivery can partially be attributed to the bureaucracy and administrative processes of

[66] Gere is referring to the Drug Amendments of 1962, Pub. Law No. 87-781, 76 Stat. 783: Cathy Gere, *Pain, Pleasure, and the Greater Good*, p. 43.

[67] Helen Tilley*, Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011).

[68] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Memorandum: Donation of Formalin-Killed Measles Virus Vaccine, Cockburn to Dr. Prince Mohan Kaul, Assistant Director General, WHO, 16 December 1965.

[69] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, WHO Purchase Order, 8 June 1966.

[70] Louis Galambos and Jane Eliot Sewell, *Networks of Innovation, Vaccine Development at Merck, Sharp & Dohme, and Mulford, 1895-1995* (Cambridge: Cambridge University Press, 1995), p.120.

[71] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Cockburn to Sharif, 19 October 1965; Cable from Singer, WHFUSA to Sharif, 20 April 1966.

working through an intermediary to manage the donation, in this case the World Health Foundation of the United States (WHFUSA), a non-profit organisation established in 1966 to receive and process gifts for the purposes and programmes of the WHO.[72] Donations made via the WHFUSA for use outside the USA were tax deductible,[73] indicating one of the other benefits to the company making the donation.

Pfizer's non-attenuated killed vaccine (Pfizer-Vax Measles-K) was prepared by formalin inactivation of the Edmonston virus and branded as Rubeovax, was granted approval for use in the USA in 1963.[74] It was removed from the market only four years later in 1967 following significant concerns about unusual, unanticipated medical associations. On 12 August 1967, the US Public Health Service Advisory Committee on Immunization Practices published a report revising its former recommendations and removed the non-attenuated killed vaccine from the recommended immunization schedule. The Committee did advise that children who had already received non-attenuated killed vaccine should also be given attenuated live vaccine 'for full and lasting protection against natural infection', therefore normalising a more drawn-out removal of the vaccine from use.[75] The Committee on Control of Infectious Diseases of the American Academy of Paediatrics also recommended that the non-attenuated killed vaccine be deleted from the schedule and attenuated live vaccine be administered to children who also received non-attenuated killed vaccine (to be administered alongside educative information to parents for their observation of local and systematic reactions).[76] Published in JAMA on 18 December 1967, researchers at the University of Colorado Medical Center and Denver Children's Hospital recommended that the non-attenuated killed measles vaccine should no longer be administered.[77]

The decision by the leaders of the refugee vaccination programme, to proceed with use of non-attenuated killed vaccine in the camps was made whilst the vaccine was licenced in the USA and knowledge of the vaccine's efficacy and risks was still developing. The decision to proceed was

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[72] WHO, Geneva, WHO.3: M11-445-2UNRWA JKT:1, Letter from Cockburn to Sharif, 25 July 1969.

[73] WHO, Geneva, WHO.3: M11-445-2UNRWA JKT:1, Letter from Cockburn to Sharif, 25 July 1969.

[74] J.P Baker, 'Immunization and the American Way: 4 Childhood Vaccines', *American Journal of Public Health* 90 (2) (2000), pp. 199-207.

[75] S. Krugman, 'Measles Vaccines', *JAMA* 202 (12) (1967), p. 1098.

[76] S. Krugman, 'Measles Vaccines', p. 1098.

[77] Vincent A. Fulginita, Jerry J. Eller, Allan W. Downie, C. Henry Kempe, 'Altered Reactivity to Measles Virus: Atypical Measles in Children Previously Immunized with Inactivated Measles Virus Vaccines,' *JAMA* 202 (12) (1967), pp. 1075–1080.

underscored with an intention to further investigate the limitations of this type of vaccine. Cockburn believed that the medical infrastructure-base in the camps was strong enough to provide a service that could handle the immunisation of each child with three injections,[78] and notably, the decision to accept and use the donation was made in the knowledge that options to procure sufficient volumes of donated vaccines were limited.

In the mid-1960s, Cockburn was in continuous dialogue and correspondence with Maurice R. Hilleman, Director of Virus & Cell Biology Research at Merck Institute for Therapeutic Research. Hilleman's career had burgeoned as pharmaceutical virology R&D came of age in the United States through the 1930s and 1940s, when new networks of innovation in virology developed with support and funding from scientific research foundations and federal organisations such as the National Institute of Health and the Centers for Disease Control.[79] Merck's success from the 1930s had been based on therapeutic innovation and the development of new products such as vitamins, antibiotics, anti-inflammatories, and antihypertensive medicines. Hilleman became a Director at Merck in 1957 when R&D of measles vaccines was well-underway and by the end of the 1960s, vaccine products were crucial to the company's success and accounted for three-fifths of Merck Sharp & Dohme's (MSD) growth in sales.[80] Kimberly Collins refers to the Merck Medical Outreach Program, established in 1954, which donated antibiotics, anti-parasitic medications, and vaccines to developing countries and humanitarian disasters.[81] The relationship between Cockburn and Hilleman, and ongoing dialogue about vaccine availability and safety was crucial to the Palestinian vaccination campaign from the beginning. Writing to Hilleman, Cockburn acceded that 'there seems no other suitable sources [other than the Pfizer non-attenuated killed measles vaccine] for free vaccine at the present time', but as early as the Spring of 1966, he also acknowledged his intention to institute an enquiry into the implications of using non-attenuated killed vaccine in addition to a attenuated live vaccine.[82] From the mid-1960s there were other ethical checks and balances in place. The WHFUSA, for example, asked questions of the proposed use of the Pfizer donation and its

[78] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Correspondence from Cockburn to Hilleman, 5 April 1966.

[79] Galambos and Sewell, *Networks of Innovation*, p. 42.

[80] Galambos and Sewell, *Networks of Innovation*, pp. 120-121.

[81] Collins, 'Profitable Gifts', pp. 100-109.

[82] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Correspondence from Cockburn to Hilleman, 5 April 1966.

specific research purposes in Czechoslovakia, asking whether this donation a justifiable use of the gift.[83]

The use of the Pfizer vaccine in the camps was non-maleficent, and the decision to use it was caveated with a need to proceed with caution. I use the term non-maleficence—a duty to do no harm or allow harm to be caused to a patient—because medical non-maleficence is one of the cornerstones of medical ethics alongside beneficence, justice, and autonomy.[84] Concerns had been expressed amongst WHO clinicians, and due consideration was given to the safety and appropriateness of using the non-attenuated killed vaccine.[85] The advice from Cockburn at that time was to complete the vaccination of children who had already received one or two doses of the Pfizer vaccine, but that no new children should be brought into the scheme at that point.[86] The decisions relating to the refugee camps had implications for non-refugee populations too, as considerable quantities of the vaccine were passed to host governments for use in their resident populations. In these cases, the UNRWA field officers were tasked with informing the host states' technical teams of the change of policy regarding the non-attenuated killed vaccine.[87] In January 1968, the vaccine was fully withdrawn from the camps: 'because of the paradoxical reactions after killed measles vaccine it was agreed that this vaccine should no longer be used and would be discarded.'[88]

Somewhat ironically, despite all the deliberations regarding the vaccine's safety, it was an act of aggression against the refugees that undermined the availability of this resource. Stocks of the Pfizer vaccine were stored in Gaza while the medical team arranged potency tests, and these stocks were removed from refrigeration by the occupying Israeli forces during active conflict in June 1967. Once the vaccine batches were taken out of cold storage, the vaccines were effectively put out of use.[89] Regardless of this twist of fate, the Pfizer donation and the

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[83] WHO, Geneva, WHO.3/M11-445-2UNRWA JKT:1, Memo, Cockburn, 5 April 1966.

[84] Tom Beauchamp and James Childress, 'Principles of Biomedical Ethics: Marking Its Fortieth Anniversary', *The American Journal of Bioethics,* 19 (11) (2019), pp. 9-12. Matthew Shea, 'Forty Years of the Four Principles: Enduring Themes from Beauchamp and Childress', *The Journal of medicine and philosophy* 45 (4-5) (2020), pp. 387-395.

[85] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter Cockburn to Hilleman, 5 April 1966.

[86] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Cockburn to Sharif, 7 December 1966.

[87] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, J. M. Murphy, Acting Director of Health for UNRWA to Cockburn, 16 December 1966.

[88] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Cockburn 'Note for File', 26 January 1968.

[89] WHO, Geneva, M11-445-2UNRWA Jkt 1, Letter Sharif to Cockburn, 28 November 1967.

UNRWA/WHO leaders' handling of the vaccines demonstrates how in-step the professionals were with the changing scientific knowledge and legislative context of the killed vaccine.

The hunt for a more attenuated live strain: a measles and smallpox combination vaccine trial, 1966-1967

The second phase of pharmaceutical donations to the refugee camps involved a combined measles-smallpox vaccine. In their attempts to provide 'the best possible' measles vaccines in the camps, the UNRWA/WHO leadership proposed field studies of an attenuated live measles vaccine combined with a smallpox vaccine in the refugee camps in Jordan and Gaza. The medical programme's leaders' desire for efficacy justified a continued connection between the refugees and the development of modern measles vaccines: the combined measles-smallpox trial presented an opportunity to advance knowledge through controlled trials. At this time, vaccine innovation and a company's standing in the marketplace was driven by the competitive processes of clinical trials. And for the WHO, field studies were central to the process of developing knowledge and efficiency of practice through data accumulation: a crucial process in the context of limited humanitarian resources. As discussed above, clinical trials for measles vaccines predominantly took place within the United States, but a significant number of trials did occur in the so called 'developing world'.[90]

Sharif was committed to building a durable and efficient immunisation system for the camps. Sharif recognised the benefits of using a more attenuated strain of live measles vaccine, and specifically a combined vaccine. Notwithstanding the deliberations outlined above, a non-attenuated killed vaccine (such as that donated by Pfizer) was less desirable due to its requirement of three doses at monthly intervals.[91] A single-dose vaccine (further attenuated Schwarz or Beckenham strains) provided 'a higher completion rate and the durability of primary immunization' and this form of vaccine could save clinical staff members significant time due to the reduced number of doses to administer.[92] However, donations of large supplies of attenuated live vaccine for humanitarian purposes were by no means guaranteed.[93] To secure resources for free, the leaders of the medical programme were required to persistently and patiently develop good relationships within their international networks. Cockburn and Hilleman, who met at

[90] Galambos and Sewell, *Networks of Innovation*, p.120.

[91] IRIS, 'Measles Vaccines: Report of a WHO Scientific Group', p. 30.

[92] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Sharif to Cockburn, 16 September 1966.

[93] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Cockburn to Sharif, 14 October 1966

several global conferences (and in their correspondence passed on regards to each other's wives) nurtured familiarity and good personal relations which contributed to an opportunity arising in October 1966 to obtain live measles vaccine. WHO required good relationships to enable field studies to be possible, for the continued efficacy of the institution's vaccination programmes. In the mid-1960s, Cockburn proposed a combination of vaccines for comparative studies of attenuated live measles vaccines and maintained dialogue with colleagues for potential studies to take place in the USSR, Czechoslovakia, and in the Palestinian refugee camps. Cockburn was interested in trialling a number of different vaccines including a combined smallpox-measles vaccine from Merck, a collaborative vaccine from Burroughs Wellcome (Beckenham measles strain plus Lister smallpox vaccine) and a further 'USSR mixture', the combination of vaccines of which is not clear in the archival data.[94] Sharif agreed to undertake a comparative trial (suggesting a pilot study of about 200 children be followed by a large-scale inoculation programme of approximately 5,000-10,000 children[95]) but with the Wellcome/Lister combination vaccine seemingly unavailable, the partnership decided to proceed with a small pilot study of the Merck combination vaccine.[96] For this trial, a dried vaccine required reconstitution with distilled water, to be kept cold and to be delivered by a hydraulic jet gun only.[97]

Hilleman's faith in the trials for Palestinian camps was grounded in the data gathered in the 'developing world', particularly the trials involving 18,000 children in the Upper Volta. Reflecting on those particular trials of a combined live measles-smallpox vaccination, in communication with Cockburn, Hilleman summarised: 'There was no indication of interference between the vaccines either in terms of antibody response to each virus or in terms of dermal reaction to the smallpox vaccine component … There was no evidence for serious reaction or for increase in clinical reaction above that expected for either vaccine given alone.'[98] The published results of the trials indicated 'no untoward clinical reactions attending to the use of the combined vaccine

[94] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter (carbon copy) Cockburn to Hilleman, 21 October 1966. In this letter, Cockburn acknowledged he was discussing a trial with a Dr. Bolotovskij, who appears from cross-referenced articles, to be a head of trials with the Central Institute of Epidemiology, Ministry of Public Health, USSR: V.D. Solov'ev, 'The Results of Controlled Observations on the Prophylaxis of Influenza with Interferon', *Bulletin of the World Health Organization* 41 (1969), pp. 683-688.

[95] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter Cockburn to Hilleman, 'Smallpox-Measles vaccine', 21 October 1966.

[96] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Cockburn to Sharif, 7 December 1966.

[97] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Hilleman to Cockburn, 14 December1966.

[98] WHO, Geneva, WHO.3, M11-445-2UNRWA-J1, Hilleman Introduction, dated 28 July 1966; attached to letter from Hilleman to Cockburn, 14 December 1966.

and the serologic responses to all components were judged to be adequate'.[99] A combined vaccine was judged to be safe and effective.

By March 1967, the pilot study of the measles-smallpox vaccine was underway in camps in Jordan,[100] with 30-50 paired blood samples offered to Merck two months later.[101] This was a small study, and as such was aligned to the WHO recommendation that accurate surveys, if properly planned, did not need to be large-scale studies.[102] The measles campaign in the Palestinian camps, with an approach that evolved with the R&D of the time, demonstrated an active commitment on the part of the WHO/UNRWA partnership to extend a Western-centric body of power and knowledge. Whereas the WHO acted in line with ethical norms, through vaccine trials it nevertheless spearheaded the extraction of bodily data from the refugee camps. The WHO representatives worked according to the objective that information collection, and the development of knowledge was the priority, to enable mass inoculation activity and expand knowledge across a spectrum of health conditions including malnutrition, the incidence and severity of encephalitis, and other serious health complications.[103] During the vaccine campaign in the camps, it was acknowledged that vaccines in sufficient quantities to meet all needs would not be available for 'a considerable time'; therefore supplies which were available should be used to obtain missing data.[104]

The measles-smallpox trial demonstrates how the Palestinian refugee camps were parallel sites of R&D, meaning the camps existed on a parallel to cities and villages across the developing and developed world where field trials were taking place. Since its founding, the WHO was committed to developing levels of immunity across the world and upgrading global healthcare. From its founding to the 1960s the organization became increasingly committed to scientific and technical approaches to disease control such as epidemiological surveillance and technical tactics (including training programmes and the development of technical manuals). This was a departure

[99] WHO, Geneva, WHO.3, M11-445-2UNRWA-J1, Hilleman Introduction, dated 28 July 1966; attached to letter from Hilleman to Cockburn, 14 December 1966. Hilleman cites a publication by H.M Meyer, D.D Hosteltle, B.C.Bernheim, N.G. Rogers, P. Lambin, A. Chassary, R. Labusquière, J.E Smadel, 'Response of Volta children to jet inoculation of combined live measles, smallpox and yellow fever vaccines', *Bulletin of World Health Organization* 30 (6) (1964), pp. 783-794.

[100] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Correspondence Sharif to Cockburn, 2 March 1967.

[101] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Correspondence Cockburn to Hilleman, 26 May 1967.

[102] IRIS, 'Measles Vaccines: Report of a WHO Scientific Group', p. 30.

[103] IRIS, 'Measles Vaccines: Report of a WHO Scientific Group' p. 30.

[104] IRIS, 'Measles Vaccines: Report of a WHO Scientific Group', p. 31.

from the legalistic and regulation focused approaches which were core to the quarantine conventions of the previous centuries.[105] Reports were given at the WHO Scientific Group on Measles by (developing) countries experiencing a 'clear and urgent need for measles vaccination', including some warning that '5% or more of children under five years of age might be expected to die from the disease'.[106]

The attempts to undertake trials of measles vaccines in the Palestinian camps are significant because of the extra-state status of the refugee camps and the refugees as exiled people. Here, the UNRWA and WHO were claiming rights to conduct medical activity in extremely vulnerable populations. Furthermore, although this vaccination activity was deemed to be a high priority, no budget line was dedicated to buying vaccine for use in the measles vaccination campaign,[107] indicating the essentiality of pharmaceutical companies' action in the humanitarian space. The refugee camps presented opportunities for both parties to benefit from further trials, and the WHO representatives did continue to consider sites of research beyond the camps, for example Cockburn and Hilleman considered at least one opportunity to participate in a long-term study of the duration of immunity with measles vaccines with the Israeli state.[108]

Scientists turned pharmaceutical philanthropists such as Hilleman were motivated by a complex combination of altruism and invested interest in the R&D of their work and refining the most successful and marketable products. They were enabled by humanitarian managers' commitment to technical solutions to disease control as well as a clear need within the refugee camps. This drive for, what I would term, 'technical medical paternalism' remained largely uncontested until the 1978 Declaration of Alma Alta. Political scientist Sung Lee sites the shift a little earlier, arguing that it was not until China entered the WHO in 1973, when low-technology healthcare delivered by 'barefoot doctors' ushered in a new era that demanded deeper consideration of traditional medical practices, that a significant de-emphasis on Western-style professional medicine began to take place on an institutional level.[109] However, in the Palestinian refugee

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[105] Pierre Dorolle, 'Old Plagues in the Jet Age. International Aspects of Present and Future Control of Communicable Disease', *British Medical Journal* 4 (1968), pp. 789-792. Socrates Litsios, *The Third Ten Years of the World Health Organization, 1968-1977* (Geneva: WHO, 2008).

[106] IRIS, 'Measles Vaccines: Report of a WHO Scientific Group', p.5.

[107] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Cockburn Report, 15 September 1972.

[108] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Cockburn to Hilleman, 3 February 1967.

[109] Sung Lee, 'WHO and the Developing World: The Contest for Ideology', in *Western Medicine as Contested Knowledge*, eds. Andrew Cunningham and Birdie Andrews (Manchester: Manchester University Press, 1997) pp. 24-45.

camps, ultimately, supplies which could have been used for a large-scale inoculation programme of Palestinian children were diverted instead to Chile and South Africa. Merck needed sufficient data to support a bid to the Division of Biological Standards of the USA for a full licence of the vaccine for general use, so it seemed necessary that Merck gather this data from fields outside the Palestinian refugee camps.[110]

Refugee resistance and further reflections on consent

The Western medical establishment, that reached out into the refugee camps, had nurtured the belief throughout the 1950s that experimental medical care was a duty and a privilege. There was public reverence to the medical establishment, demonstrated in subtle ways. For example, in the Salk vaccine trials (an inactivated poliovirus vaccine developed by American virologist and biomedical scientist, Jonas Salk) undertaken in the mid-1950s, the parental consent form phrasing was "I hereby request" as opposed to more passive phrasing, "I consent".[111] There was evidence of vaccine-reverence in the Palestinian refugee camps in the earlier years of their establishment: Save the Children Fund nurse Mary Katherine Hawkins noted 'a near universal demand for injections' amongst refugees in Jordan c.1948-1950. Recalling refugee demands for injections in the Irbid camp, Hawkins describes the hot and hectic clinics: 'Inside the children were screaming because they did not want an injection and the adults were shouting because they were afraid they were not going to have one'.[112] Here, injections symbolised a panacea to the refugees, a sign of solutions and cure, a belief Hawkins believed was encouraged and exploited by less credible doctors:

> [unscrupulous private doctors] who made a lot of money from perpetuating the idea that an injection was much more effective than tablets or liquid medicine. Some had a routine for each patient; an injection into each arm of calcium, camphor and sometimes sterile water as well. People would go around the town looking for the doctor who gave the largest injection.[113]

The trials of measles vaccines, whether conducted among 'mentally deficient' children in Massachusetts, needy children in northern Togo, or among Palestinian refugee children, were all trials bound-up in, and indicative of a social contract of utilitarian medicine present in practices of medicine and medical tests for decades. This contract wherein choices faced by scientists and

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[110] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Correspondence Cockburn to Sharif, 1 May 1976.

[111] Gere, *Pain, Pleasure, and the Greater Good*, p.40.

[112] Mary Katherine Hawkins, *Nursing Times*, 24 March 1951.

[113] CRL, Birmingham, SCF/A1243/1.1.3 – Jordan 1 (1948-1950), MKH memoir.

medical professionals relating to the advancement of modern medicine were made to achieve results for the greater good and harm to research subjects was weighed against the utilitarian benefits to society. The Second World War had helped to cultivate an ethos of sacrifice, including the notion of human contribution to the common good through the participation in medical experimentation. Historian Cathy Gere argues that by the mid-1960s the social contract of utilitarian medicine was fracturing in the West.[114] The public euphoria generated by the conquering of polio by Salk's vaccine was promptly shattered in 1955 when 200,000 cases of polio were traced to vaccines contaminated with virulent live polio strains, manufactured by the Cutter Laboratories in Berkeley California: 200 people were paralysed and ten people died.[115] Six years later, the thalidomide tragedy deeply damaged public confidence in the whole medical research enterprise. Thalidomide, a sedative developed by the German pharmaceutical company Chemie Grunenthal was licenced in forty-six countries, yet between eight and ten thousand children of mothers prescribed the drug were born with extreme birth defects.[116] In the USA, unlicenced Thalidomide was distributed by doctors as samples without adequate information about its experimental nature. These episodes had a dramatic effect on public confidence, and consumer spending as Gere notes:

> 'American consumers stopped buying pharmaceuticals, and the price of shares in the sector began to plummet, losing anywhere from 10 to 60 per cent of their value. Even sales of aspirin dropped.'[117]

In the Palestinian refugee camps, how the refugees felt about the vaccination campaigns and their role in the research and development of measles vaccines is largely absent from the archival records. Any explicit or implicit 'contract' between the refugees as patients and the medical humanitarians providing vaccines or other medical products and services was not formally ratified by the refugee population. The core recipients of the measles vaccine were Palestinian refugee children in camps in Jordan and Gaza aged six months to three years (plus some non-refugee children in the territories, particularly in Syria).[118] At the beginning of the period under investigation, in November 1965, Sharif requested vaccine supplies to cover 55,000 children.[119]

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[114] Gere, *Pain, Pleasure, and the Greater Good*.

[115] Jonathan R. Carapetis, 'The Cutter Incident: How America's First Polio Vaccine Led to the Growing Vaccine Crisis', *BMJ* 332 (7543) (2006), p.733.

[116] Gere, *Pain, Pleasure, and the Greater Good*, p. 41.

[117] Gere, *Pain, Pleasure, and the Greater Good*, p. 221.

[118] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter Sharif to Cockburn, 11 November 1965.

[119] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter Sharif to Cockburn, 11 November 1965.

This was a public health programme designed to benefit both individuals and the collective, it was intended to protect the young from disease and develop herd immunity among the camps to prevent the spread of measles, which if sparked into an epidemic, was extremely difficult (if not impossible) to contain. However, it is not documented whether the refugees were consulted about the programme's design or its execution, and no review of any processes for gaining consent was apparent. It appeared that UNRWA officials were selective about which mothers were chosen to provide children to participate in the combined measles-smallpox vaccine trial. First, in a letter dated 16 December 1966, Dr. J. M. Murphy, acting director of Health, UNRWA acknowledged that the combined measles-smallpox vaccine trial would take several months to complete, not only due to the need for new subjects to come of age for vaccination, but also to choose the mothers.[120] However, no other records were found of parental consent being sought.

The use of the Ped-O-Jet—a multi-dose jet injector originally developed in the field of military medicine but then adopted for use in humanitarian contexts—was followed by an incident of overt resistance by the refugees. In the spring of 1967, the measles-smallpox vaccination study was suspended on a temporary basis in the refugee camps in Jordan when the refugees objected to the use of this medical technology in their community. Sharif reported to the WHO:

> Although we obtained blood samples and vaccinated five infants and gave several hundred cholera vaccinations to school children, we had, nevertheless, in the state of emotional lability of the population in Jordan, to suspend temporarily any new procedure such as this one in deference to the situation.[121]

Sharif attributed this interruption to a passing phase of emotional reluctance, and the vaccination campaign was planned to restart in a few weeks. The choice of the words 'emotional lability' by the clinician (lability in a clinical sense refers to rapid and exaggerated changes in mood and the occurrence of strong emotions and reactions) suggests that Sharif did not consider the refugees to be acting rationally. Sharif wrote:

> A combination of circumstances, not primarily related to the use of the jet gun, chanced to occur at the time the study was initiated. The introduction of the jet gun, combined with the taking of some blood samples, happened to alight upon an

[120] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Murphy, 16 December 1966.

[121] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Sharif to Cockburn, 7 April 1967.

> emotionally charged atmosphere, not apparent at the time but ripe for exploitation by any manner of absurd rumour.[122]

Sharif may have believed it was unfortunate timing, that the use of the jet gun coincided with other circumstances that were creating an atmosphere of mistrust. Refugees are recognised to be one of many groups that at different times and in diverse places have resisted state-led vaccination campaigns.[123] Immunisation programmes have been tied to campaigns of nation-building, as well as challenges to the national status quo; Jaime Benchimol's discussion of yellow fever vaccine campaigns as a tool for building the nation state in Brazil between 1822 and 1980,[124] can be contrasted with Niels Brimnes' history on the opposition to immunisation in India which threatened to destroy, rather than strengthen, the national body.[125] In relation to Japan, Timothy M. Yang has demonstrated how the Japanese pharmaceutical industry of the early twentieth century was integrated with national development and imperial expansion.[126] Histories of smallpox vaccination have considered the controversies of compulsory inoculation campaigns in Britain[127] and in the People's Republic of China. China inoculated almost six hundred million people in the 1950s against smallpox, an exercise of control and power that had an extensive impact nationally, but also represents an under-told contribution from China to a global story of scientific advancement.[128] Resistance to vaccination in the Palestinian camps was about refugee agency versus humanitarian performance.

The jet gun, Ped-O-Jet device was a very efficient piece of medical kit that enabled rapid inoculation of large numbers of children (up to a 1,000 an hour) using hydraulic injection

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[122] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Sharif to Cockburn, 7 April 1967.

[123] Paul Greenough, Stuart Blume and Christine Holmberg, eds, *The Politics of Vaccination, A Global History*, (Manchester: University of Manchester, 2017). Laura A. Jana and June E. Osborn, 'The History of Vaccine Challenges: Conquering Diseases, Plagued by Controversy', in *Vaccinophobia and Vaccine Controversies of the 21st Century*, ed. Archana Chatterjee (New York: Springer New York, 2013).

[124] Jaime Benchimol, 'Yellow Fever Vaccine in Brazil: Fighting a Tropical Scourge, Modernising the Nation' in *The Politics of Vaccination,* pp. 174-208.

[125] Niels Brimnes, 'Fallacy, Sacrilege, Betrayal and Conspiracy: the Cultural Construction of Opposition to Immunisation in India' in *The Politics of Vaccination,* pp. 51-76.

[126] Timothy M. Yang, *A Medicated Empire: The Pharmaceutical Industry and Modern Japan,* (Ithaca, NY: Cornell University Press, 2021). Ann Jannetta for discussion of nineteenth century Japan relationships with the West: Ann B Jannetta, *The Vaccinators: Smallpox, Medical Knowledge, and the "Opening of Japan"* (Stanford, CA: Stanford University Press, 2007).

[127] Williamson*, The Vaccination Controversy.*

[128] Mary Augusta Brazelton, *Mass Vaccination: Citizen's Bodies and State Power in Modern China* (Ithaca, NY: Cornell University Press, 2019).

powered by a foot pump, in place of a needle.[129] The alternative procedure for measles vaccine administration was far less efficient and required the use of sterile plastic one-use disposable syringe (to avoid the difficulty of sterilising syringes). The Ped-O-Jet was clearly reminiscent of a weapon, which was highly problematic: mass inoculation required people to be gathered in a large group, with children lined-up in preparation to be shot in the arm with a device that looked like a gun.

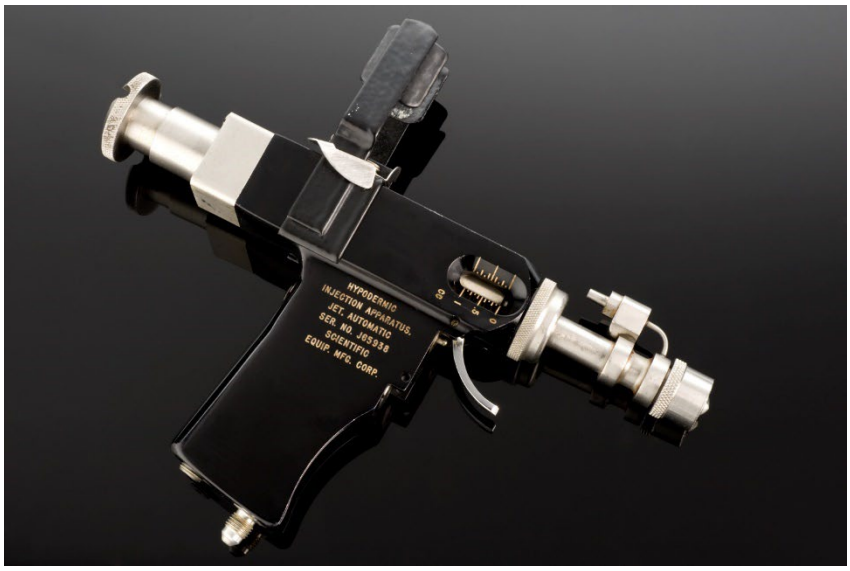

Image 2: Image taken from the Science Museum collection: "Multidose Jet Injection Apparatus, known as "PED-O-JET", hydraulically powered with carrying case, by Scientific Science Museum Group Collection. This device was manufactured by Scientific Equipment Manufacturing Corporation.[130]

In refugee camps, medical humanitarian action is not just exercised, it is performed.[131] The objects and devices of medical material culture used by medical humanitarians are props for performed knowledge, authority, skill, compassion, and power. In the camps, these characteristics are exercised and performed with the help of items such as stethoscopes,

[129] *Science Museum Group*, 'Ped-O-Jet mass inoculation gun' <https://collection.sciencemuseumgroup.org.uk/objects/co8061806/ped-o-jet-mass-inoculation-gun-standard-lamp>[accessed 12 October 2023]. Leading Article, 'Vaccination by jet', *British Medical Journal,* (31 December 1966), p. 1610.

[130] *Science Museum Group,* Object No.1990-274 Pt2. Science Museum, *Brought to Life* <https://collection.sciencemuseumgroup.org.uk/objects/co8061806/ped-o-jet-mass-inoculation-gun-inoculation-gun> [accessed 7 October 2019]. According to the Science Museum Group, the Scientific Equipment Manufacturing Corporation was active between 1970 and 1975 in New York, suggesting that a different company manufactured the equipment used in the Palestine camps.

[131] Alfred Gell, *Art and Agency, An Anthropological Theory* (Oxford: Clarendon Press, 1998).

weighing scales, feeding tubes, physiotherapy equipment, operating tables and their lights, and the Ped-O-Jet pneumatic inoculation gun (Image 2). To widen the scope of audience for these performances, the devices used by medical personnel are photographed and distributed to further cement the meaning and value of their performance. As discussed above, the Ped-O-Jet was used in Palestinian refugee camps in the late 1960s, and there were discussions at the time to also use the device to deliver a WHO yellow fever vaccination campaign in Ethiopia, another 'developing world' setting.[132] Comments published in the British Medical Journal in 1966 seem somewhat presumptive, that the jet injectors 'do not look like conventional needles and syringes and are therefore less frightening, particularly to children'.[133]

Image 3: "This 1968 image depicts a young West African, Cameroonian boy in the process of receiving his vaccinations, during the African Smallpox Eradication and Measles Control Program. The public health technicians were administering the requisite vaccines using a Ped-O-Jet® pneumatic jet injector, applied to either [sic] of the boy's upper arms."[134]

The Ped-O-Jet was a piece of medical technology that symbolised status and medical power. The symbolic power of the Ped-O-Jet can be compared with the stethoscope, one of the most important objects in the history of medicine in the nineteenth century.[135] Jonathan Sterne writes:

[132] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter Cockburn to Sharif, 1 May 1967.

[133] Leading Articles, 'Vaccination by Jet', *British Medical Journal* (31 December 1966), p. 1610.

[134] Centers for Disease Control and Prevention (CDC), USA, Public Health Image Library (PHIL) [Online]: Photo ID No.:14452, Content provider CDC/ J.D. Millar, M.D.

[135] Jonathan Sterne, 'Medicine's Acoustic Culture: Mediate Auscultation, the Stethoscope and the Autopsy of the Living', in *The Auditory Culture Reader*, eds. Michael Bull and Les Back (Oxford: Berg, 2003), p. 191.

> Like other technological innovations, the stethoscope is an artefact of a technique: it was designed to operate within the parameters of a set of social relationships, and it helped to cement and formalize those relations: the doctor-patient relationship, the structure of clinical research and pedagogy, and the industrialization, rationalization and standardization medicine (along with the improvement of physicians' social status). It was developed as a technical response to a social and investigative problem in a clinical setting.[136]

The stethoscope provides a symbol of 'doctorliness', of medical legitimacy and the knowledge, skills, and status of the medic who carries it. Tom Rice argues that the stethoscope, when used in a clinical situation (or the pretence of a clinical situation, such as an advertisement or a television show) 'allows for a particularly neat enactment of key 'dispositions' of what might be described as a doctor 'habitus'.[137] Despite the distancing between doctor and patient that a stethoscope creates (a physical distance defined by the length of the device, and the gap in awareness: one can hear, the other cannot), the stethoscope has historically played an integral role in cementing the relationship between a doctor and a patient. The device enables medical information to be shared from patient to doctor; information which is then translated back as advanced knowledge from doctor to patient. By comparison, the Ped-O-Jet demands little data from the patient, it simply delivers expert knowledge in the form of a vaccine, from healthcare worker to patient. Furthermore, this rather exceptional item (a piece of medical equipment not used regularly by medical professionals and not regularly encountered by patients) enabled non-professional members of medical teams to assume roles of status and power. The person administering the inoculation was enacting a role of modern medical humanitarianism: a role imbued with the qualities that are technological, efficient, effective, and correct.[138] The Ped-O-Jet provides an excellent example of how material items can cement a certain relationship between provider/recipient, but also how it can enable people to cross the lines and join the other group. Refugees made up a large proportion of staff after all.

Using the Ped-O-Jet does not require a process of diagnosis, nor the treatment of ailments. As opposed to the quiet exchange of information between doctor and patient mediated through the stethoscope, the exchange involving the Ped-O-Jet has two sides. On one hand, the exchange silences the patient. On the other hand, it involves a loud, potentially painful exchange (see Image 3 and Image 5) in which a degree of distress can be experienced by the receiver of the

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[136] Sterne, 'Medicine's Acoustic Culture', p.192.

[137] Tom Rice, 'The hallmark of a doctor': the stethoscope and the making of medical identity, *Journal of Material Culture* 15 (3) (2010), p. 287.

[138] Rice, 'The hallmark of a doctor', p. 294.

injection(s). Whereas the stethoscope was a common-place piece of equipment, relatively inexpensive and would accompany the medic for many years,[139] the Ped-O-Jet was an expensive and difficult to access piece of equipment that would not ordinarily be carried by the medic.[140] As such, being in possession of the Ped-O-Jet signified a privileged beholder, and indicated a service which the recipient should be grateful for, even if it might be painful.

The jet injector was also used during the African Smallpox Eradication and Measles Control Program (ASEMCP) (Image 3), a WHO/USA bilateral technical and financial assistance programme to eradicate smallpox which ran between 1966 and 1972 across 20 countries in West and Central Africa; the programme also immunised 28,000,000 children between the ages of one and six years of age against measles.[141] Image 3 shows that for the ASEMCP, a pneumatic, foot-pumped version of the jet injector was used. It is not explained why the child is receiving two shots simultaneously. Photographs taken during the ASEMCP demonstrate attempts to legitimise the mass inoculations and the technology used to distribute the vaccine. In Image 4, a photograph demonstrates Ghana's former Chief of State receiving a smallpox vaccination, at the International Trade Fair in Accra, Ghana, February 1967 (the period 1966-1969 was one of military rule in Ghana).

Image 4. "This historic image depicted Ghana's former Chief of State, General Ankrah, as he was receiving his smallpox vaccination using a Ped-O-Jet® pneumatic injector gun. The photograph was captured during the West African Smallpox Eradication, and Measles Control Program efforts, and while the General was at the International Trade Fair, held in Accra, Ghana, in February 1967."[142] Ghana was under military rule between 1966 and 1969.

[139] Rice, 'The hallmark of a doctor', p.296.

[140] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Cockburn to Sharif, 9 January 1967.

[141] William H. Foege, J.D. Millar, D.A. Henderson, 'Smallpox eradication in West and Central Africa', *Bulletin of the World Health Organization* 76 (3) (1998), pp. 219-232.

[142] *CDC,* Public Health Image Library (PHIL): Photo ID No. 13239, Content Provider: CDC/J.D. Millar, M.D.

Image 5. “A girl receiving a measles vaccination given in public school, Highland Park, Illinois, 1976.”[143]

The Ped-O-Jet was highly desired by the UNRWA medical humanitarians. Before the suspension of the trials, Sharif requested a second Ped-O-Jet to enable concurrent studies for Jordan and Gaza refugee camps.[144] The jet injector could speed-up the delivery of an extensive immunisation schedule which was planned to continue during the hottest months of the year, a season which would be expected to bring high incidences of gastro-enteric infections and a pressurised workload for the limited number of staff.[145] It was, however, not possible to secure a second jet due to the excessive expense (US$690 per piece of equipment) and the long delivery time, but nevertheless, it was sought-after equipment.[146] There was a development however, in the winter of 1967 when further Ped-O-Jets became available to the camps because of a ‘face-saving’ incident. Some apparent confusion arose relating to drug availability to the camps thanks to unwarranted communication from a third party that muddied the communication between Merck and UNRWA (namely the Commissioner General of UNRWA in Beirut in communication with Maurice R. Hilleman and a Dr Emmett Holt from UNRWA). In a bid to

[143] *Reddit*: r/TheWayWeWere, Photo by Thomas S England, <https://www.reddit.com/r/TheWayWeWere/duplicates/4lfroj/a_girl_receiving_a_measles_vaccination_given_in/> [accessed 7 October 2019].

[144] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Sharif to Cockburn, 16 December 1966.

[145] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Sharif to Holt, 21 February 1967.

[146] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Cockburn to Sharif, 9 January 1967.

clarify the situation and smooth over the waters, Hilleman wrote to Cockburn offering to keep the 40,200 doses of measles-smallpox frozen, ready for use by WHO in any location at any time they saw fit—and he also offered a loan of three Ped-O-Jet guns from Merck's stocks.[147] This offer emphasises the importance Merck placed on maintaining good relations with Cockburn and the WHO. However, the Ped-O-Jet story also shows how the Palestinian refugees needs were being balanced with the needs of other contexts: by 1 May 1967 one of the Merck Ped-O-Jets was under consideration for shipping to Ethiopia to support a yellow fever vaccination team in operation, instead of making its way to the Jordan and Gaza studies. The diversion of one of the jets to a different context reinforces the fact that the Palestinian camps were one of many humanitarian contexts battling for scarce resources, and that no matter how hard the leaders of the medical programme in the camps worked to negotiate access to resources, these resources were by no means guaranteed.

The backdrop to the refugees' resistance to the Ped-O-Jet was the violent disruption of 'normal life' caused by the Six-Day War, 5th – 10th June 1967. This was a complex time for UNRWA and this escalation of conflict had an immediate effect on UNRWA and the refugee camps. The hostilities between Israel and Egypt, Syria and Jordan and Israel's territorial advances in the Sinai Peninsula, Golan Heights, the Gaza Strip and the West Bank placed some of UNRWA's operations directly under Israeli occupation, and dramatically increased the number of Palestinian refugees. Between 300,000 and 400,000 Palestinian's fled from Gaza and the West Bank when these territories were occupied by Israel.[148] In the Western part of Jordan, about 130,000 persons left their homes and moved to the Ghour area, in the East of the River Jordan.[149] UNRWA and WHO were of course not operating alone in the camps, and many voluntary organisations continued to be active in the field, including Save the Children Fund (SCF), some of which were critical of UNRWA's response to the conflict and renewed refugee crisis. Nurse Mary Katherine Hawkins undertook her fourth deployment to Jordan in April 1967.[150] Hawkins claimed there were about 480,000 registered refugees in camps in Jordan by

[147] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Hilleman to Cockburn, 24 January 1967.

[148] *Gatrell, The Making of the Modern Refugee, p. 128.*

[149] WHO.3, E17/180/2/EMR.1(Jacket 1): Khalid Munaymanu, WHO Sanitarian 'Assignment Report: Emergency Assignment in the Refugee Camps, Jordan, 1 July – 6 August 1967'.

[150] CRL, Birmingham: SCF/SC/MKH/1/3 (4 of 5): MKH draft memoir, 'The June of 6-Day War: Jordan 4'.

May 1968,[151] and she remained critical of UNRWA, suggesting that the agency was slow to take over control of the 1967 refugees.[152]

UNRWA did continue its programme, despite the conflict and a further emergency assistance project was run by WHO in Jordan in which a WHO medical consultant and WHO sanitation expert arrived in Amman in early 1967.[153] Following the conflict, UNRWA acknowledged the refugees' vulnerability and suspended the collection of paired serum samples relating to the measles/smallpox vaccine trial.[154] Sharif wrote to Cockburn on 8 August 1967, that 'the psychological climate amongst the refugees has not been such as to encourage our staff to make approaches for these further samples.'[155] The Six-Day War certainly interrupted the vaccination programme, but it also demonstrated the resilience and commitment of UNRWA as an institution administering preventive medical care. There is little to no correspondence in the archives relating to the vaccination programme between 18 April 1967 and 8 August 1967, in the days before, during and after active conflict. Yet, when evidence of correspondence resumes, documents from August 1967, Sharif clearly expresses a wish to continue with the measles programme. By 31 January 1968, over seven months since hostilities, Sharif reaffirms a commitment to the measles-smallpox vaccine. Charles Cockburn reports to Hilleman at Merck that 'the situation in the camps is still very difficult, but that he [Dr. Sharif] hopes to be able to use larger quantities of the measles–smallpox vaccine before very long.'[156]

Sustaining the measles vaccination campaign into the 1970s

As the new decade dawned and the refugee encampment persisted, the WHO continued to run a comprehensive immunization programme.[157] Although far from guaranteed, regular donations of measles vaccines from Merck were joined by donations from other sources, including supplies

[151] CRL, Birmingham: SCF/A1243/1.1.3 - Jordan 4 (1967), SCF/SC/MKH/1/3 (4 of 5), MKH draft memoir, 'THE JUNE OF 6-DAY WAR: JORDAN 4', p. 10.

[152] CRL, Birmingham, SCF/A1243/1.1.3 - Jordan 4 (1967), 'The June or Six Day War: Jordan 4' MKH draft memoir, p .6.

[153] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Correspondence from M.G. Candau, Director General, WHO to Dr. Salih K. Burgan, Minister for Health, Hashemite Kingdom of Jordan, 25 July 1967.

[154] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter Sharif to Cockburn, 7 April 1967.

[155] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter Sharif to Cockburn, 8 August 1967.

[156] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter Cockburn to Hilleman, 31 January 1968.

[157] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter Sharif to Dr. Mahmoud Ziai, Executive Director of the World Health Federation in Iran, 23 January 1975.

of vaccines for Gaza and the West Bank from the local Public Health Department[158] plus a supply of vaccine from Glaxo for Gaza of live measles vaccine.[159] These donations kept the UNRWA/WHO programme afloat from 1969 into 1972: the attenuated measles vaccine remained a 'non-budgeted programme item', so donations were unequivocally important.[160]

The later donations from Merck demonstrate the ongoing attempts of the WHO/UNRWA leadership to 'make the best' of an imperfect situation, and provide the vaccines with the best possible efficacy. When Merck agreed in 1969 to donate 30,000 doses of Rubeovax (attenuated, live vaccine)[161] for use in the camps in Jordan,[162] the WHO leadership acknowledged that 'the time for trials was past'.[163] Cockburn wrote to Sharif on 9 July 1969 advising him that although the vaccine 'causes rather more reaction than some of the more attenuated vaccines … it has been used on a very large scale without any record of untoward sequelae'.[164] Following a series of apologies and industrial action disrupting delivery of vaccines from Merck, the company instead offered a more attenuated strain (Lyovac Attenuvax) 'found to give very good antibody levels', and a donation of 3,000 plus ten dose vials was confirmed to the WHFUSA on 11 December 1969.[165] A further donation of 13,000 doses, of Attenuvax, a more attenuated live vaccine, was made in May 1972.[166]

The UNRWA/WHO leadership demonstrated shrewd management in order to maximise the use of the vaccines available, but the leaders also continued to demonstrate non-maleficence in their decisions relating to the vaccines chosen for the camps. For example, Cockburn raised the possibility of using two vaccines then in use in the UK, one prepared from the Schwarz strain

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[158] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter from Sharif to Cockburn, 4 October 1974.

[159] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter from Sharif to Cockburn, 10 March 1969.

[160] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter Sharif to Candau, 26 June 1975. The WHO/UNRWA leadership discussed a lack of funds throughout the programme, including in early 1968: WHO.3: M11-445-2UNRWA-J1, Letter Sharif to Cockburn, 20 February 1968.

[161] Rubeovax was a measles vaccine licenced in the United States in 1963: *The College of Physicians of Philadelphia*, 'The History of Vaccines' <https://www.historyofvaccines.org/content/rubeovax-licensed>[Accessed 20 February 2020].

[162] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Hilleman to Cockburn, 30 June 1969.

[163] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from Cockburn to Hilleman, 8 May 1969.

[164] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter Cockburn to Sharif, 9 July 1969.

[165] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from C.F.E. Hertler to Singer at WHFUSA, 11 December 1969.

[166] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1, Letter from G.M. Winterlings, Contribution Manager at Merck & Co., Inc to Cockburn, 19 May 1972.

(by Glaxo in the UK and Dow in the USA) and one from the Beckenham 31 strain (in development by Burroughs Wellcome). In July 1971, Sharif decided that the Beckenham 31 strain was not suitable for their programme of routine vaccination of children under three.[167] This decision followed a confidential review on the part of the WHO of recommendations presented to the Medical Vaccination Committee of the Medical Research Council.[168] The figures suggested that the risk of convulsions after the Beckenham 31 vaccine was about twice as great as after the Schwarz vaccine, and that there were twice as many cases of encephalitis, most of which recovered completely although there were some reports of mild paralysis. The Beckenham vaccine was licenced in the UK, but it was not being purchased by the Ministry of Health for its regular vaccination programmes.[169] With their decision not to accept donations from Burroughs Wellcome of the Beckenham vaccine the WHO/UNRWA leaders demonstrated a professional, measured approach to securing the most appropriate vaccines despite the pressure of limited resources. The team were also mindful of expiration dates. The programme continued to use potency testing to assure the utility of the vaccines, and this activity was undertaken in partnership with the relevant local authorities. For example, following the occupation of the West Bank, the Ministry of Health of the State of Israel ruled that the Attenuvax vaccine supplied to the West Bank should be potency tested in Israel itself.[170]

From the summer of 1973, the WHFUSA had assumed a greater role in lobbying for and securing the supply of vaccines for the refugee camp programme. In July 1973, it was the WHFUSA, not Cockburn or Sharif, that approached and secured a further donation from Merck to supply to the refugee camps.[171] It was also through the WHFUSA international network that a donation was secured in 1975 of 15,000 doses of measles vaccine from the Razi Vaccine Institute, Tehran.[172] These two donations mark the close of the third phase of pharmaceutical involvement which ran into the mid-1970s. The UNRWA and WHO officials, now further

[167] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter from Sharif to Cockburn, 7 July 1971.

[168] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Confidential letter from Cockburn to Sharif, 28 April 1971.

[169] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Confidential letter from Cockburn to Sharif, 28 April 1971.

[170] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter Murphy to Cockburn, 5 May 1970.

[171] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Foord-Kelcey to M.G. Candau, 4 January 1973.

[172] Through its connections with the World Health Foundation, Iran. WHO, Geneva, M11-445-2UNRWA-J1: Sharif to Cockburn, 28 April 1975.

supported by WHFUSA, persevered to secure a regular supply of measles vaccines, handling several episodes when offers were withdrawn or diverted elsewhere.[173]

Following the suspension of the measles-smallpox trials and the disruption of the war in the summer of 1967, the volume of the immunisations took a couple of years to reach a higher, stable rate,[174] most probably supported by the combination of donations secured from both America and the Middle East. However, Cockburn claimed success for the measles immunisation programme during this period, noting that less than 0.2 percent of immunised children contracted the disease. Recognising the possibility that not all cases among the immunised would have been reported, and that data sets were not sufficient evidence to define levels of immunity, Cockburn did however suggest that data were in line with 'a vast body of experience in different parts of the world that about 90 – 95 per cent protection is afforded by the vaccine and that the immunity lasts for a very long time- perhaps for life'.[175]

Chapter Three Conclusion

Vaccination campaigns were present and prioritised in the Palestinian refugee camps through periods of crisis and into the state of 'unending temporary'[176], that was in its adolescence by the mid 1960s when the measles vaccination campaign gained momentum. For the leadership of the medical programme in the camps, this campaign was both a commitment to preventive medicine in the camps and a commitment to the broader research and development of vaccines and their delivery globally. In this case, the focus being the delivery of more attenuated live measles vaccines.

Political scientist Michael Barnett has argued that UNRWA and the WHO were within the flock of UN institutions which developed as signifiers of moral progress against the backdrop of the disgrace of violence of the Second World War.[177] And the measles vaccination campaign

[173] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Letter from Hilleman to Cockburn, 8 March 1971.

[174] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Report from Cockburn to Foord-Kelcey, 15 September 1972.

[175] WHO, Geneva, WHO.3: M11-445-2UNRWA-J1: Report from Cockburn to Foord-Kelcey, 15 September 1972.

[176] Berg, 'Unending temporary'.

[177] Michael N. Barnett, *Empire of Humanity: A History of Humanitarianism* (Ithaca, NY: Cornell University Press, 2011). For critique, see also David Rieff, 'The Wrong Moral Revolution: On Michael Barnett', *The*

demonstrated ethical humanitarian endeavour, with UNRWA and WHO working in concert with pharmaceutical philanthropists. The leadership of the WHO and UNRWA medical programme demonstrated a concern for the safety and efficacy of the measles vaccines and acted based on these concerns. Although the donations were intermittent, the vaccines did constitute a significant contribution to the UNRWA and WHO programme and as such hold an important place in the medical humanitarian history of refugee camps. The development of efficacious measles vaccines was an episode in which a valuable good was created for the global commons, and the Palestine refugees played a role in this story. From a certain perspective this is a story about 'great men of history', a story of individuals working hard to do their jobs well. But in addition to the leadership of the campaign, other humanitarian actors took on roles opened-up by technology, specifically the Ped-O-Jet, as deliverers of humanitarian medicine and as resistors. The case of overt resistance outlined above not only demonstrated the performative action of medical humanitarian care, but also the attempts of the refugees to push back. The refugees may have been resisting the social contracts of utilitarian medicine, or at the very least they were demonstrating a breakdown (or absence) of trust between the refugees and the medics serving them.

Vaccination campaigns epitomise care and control, but they are also crucial weapons in the armoury of development. In the camps, vaccination campaigns were signs of the UN Development Decade in action. When Sharif took on the role of Director of Health and WHO representative at UNRWA, his predecessor Dr S. Flanche handed him a commitment to the principles of the UN Development Decade (1960-1970).[178] By accepting pharmaceutical philanthropy into the refugee camps, the WHO and UNWRA gained support to deliver positive results for preventative medicine in the camps which was aligned to a broader, longer-term vision of developing the Middle East through the building of strong, healthy, productive populations. In the mid-1970s the UN was institutionalising the links between medicine and development, demonstrated in 1974 by the multi-lateral Onchocerciasis Control Program run by the WHO and the United Nations Development Programme. Also launched in the same year, the Expanded Programme on Immunization (EPI) was established by the WHO, aiming to

Nation <https://www.thenation.com/article/archive/wrong-moral-revolution-michael-barnett/> [Accessed 5 July 2023]. Michael Barnett, 'Evolution Without Progress? Humanitarianism in a World of Hurt', *International Organization* 63 (Fall 2009), pp. 621-63. Michael Barnett, 'Human rights, humanitarianism, and the practices of humanity', *International Theory* 10 (3) (2018), pp. 314-349.

[178] WHO, Geneva, WHO.3, N 77/372/2 (J1) Coordination with UNRWA: S. Flanche to M.G. Candau, Director General of WHO, 'Summary of Important Aspects and Problems related to the UNRWA Health Programme', 31 December 1963.

immunize every child globally against diphtheria, pertussis, tetanus, poliomyelitis, measles, and tuberculosis by 1990.[179]

And at this time, in the mid-1970s, forced mass displacements across the world continued to create refugee camp settlements bigger than the world had ever known, each with their own precarious health contexts. In 1975, another conflict of de-colonisation was forcing mass displacement and the creation of large refugee camps that would become some of the most protracted in history; the Sahrawi refugee camps, and the refugees' experience of medical humanitarianism in the camps provides a second context for the discussion of medical humanitarian action. Again, the globalising system of humanitarianism reached out to the refugees at a point of emergency in Algeria, across the border from one of the world's last contested states, the Western Sahara.

[179] K. Keja, C. Chan, G. Hayden, R. H. Henderson, 'Expanded programme on immunization', *World Health Strategy Quarterly* 41 (2) 1988, pp. 59-63.

4. Observation: A Year of Medical Humanitarian Emergency, Sahrawi Refugee Camps, 1975-1976.

The previous three chapters discussed medical humanitarianism in the Palestinian refugee camps from the period of emergency relief (1948-49), through a transition to a 'developmental' model of relief and the establishment of UNRWA as an acute refugee crisis became a protracted one in the 1950s. Then, they investigated a period when international humanitarian institutions increasingly opened themselves up to working with private companies, in the 1960s and into the 1970s. This chapter will discuss how medical humanitarianism in refugee camps was characterised in the mid-1970s, at the outset of what would become another protracted displacement crisis. Like the Palestinians in the 1940s, the Sahrawi refugees who fled into Algeria when Morocco and Mauretania annexed their homeland on the withdrawal of Spanish colonial rule in 1975, arrived in a state of medical need and were rapidly encamped. But unlike the Palestinian case, existing UN agencies were already in place (including the UNHCR) to take some degree of responsibility for refugee care, and the landscape of medical humanitarianism had changed with the appearance of more self-consciously political NGOs, notably Médecins Sans Frontières (MSF), committed to 'bearing witness' (témoignage). In practice, however, the UN institutions failed to grapple with the problem of Western Sahara. And whereas international NGOs (MSF, faith-based charities, and many more) were involved in the initial medical humanitarian response, it was mostly as observers. The key medical humanitarian actors in the camps at Tindouf, Algeria were neither international agencies nor NGOs but states. Not Western states like the USA or Britain, which were keen to maintain good relations with Morocco, but Global South states at the height of their postcolonial ambition: the state hosting the refugees, algeria, and also Cuba. Furthermore, compared to the early years of the Palestinian refugee crisis the Sahrawi state-in-exile played an overt role in delivering assistance to its people.

In 1975, Sahrawi refugees were setting up in camps in the Hamada region of the Algerian desert near the city of Tindouf, across the border from the decolonising Spanish Sahara. In the first year of the camps' existence, interactions between the refugees and the 'great network of humanitarianism'[1] would contextualise another protracted refugee camp situation. For Michel Agier a powerful system of humanitarian government is rooted in the mid-1970s experience of

[1] Michel Agier, *Managing the Undesirables* (Cambridge: Polity, 2011), pp. 5-9.

humanitarianism, a system of control that exists at global and multi-local levels to order and police extra-territorial spaces—refugee camps, frontier zones, asylum centres—to keep 'outcasts' apart.[2] Contributing to this malleable system, networks of humanitarian organizations support these extra-territorial spaces with a hand that controls, and a hand that heals.[3] However, the Sahrawi refugees were not lifted out of a state of medical emergency by humanitarian agents of this powerful globalising network—rather they were observed by it. With support from their political allies in the international community, the spaces of medical humanitarianism were moulded by the Sahrawi state-in-exile and the refugees themselves were agents of creative change.[4]

In the mid-1970s, a new world was being violently forged by the forces of decolonisation, complex Cold War conflicts, and the brutal emergence of new states. At the same time, international humanitarianism was crystallising into a global structure of networks incorporating diverse international and national organisations. Over the course of the 1970s, UNHCR developed into a major humanitarian actor in its own right, in place of the legal office with coordinating roles it had been, becoming active across contexts, including providing assistance to refugees of South Asian origins ordered out of Uganda by President Idi Amin in 1972.[5] In the early 1970s UNHCR became the '*de facto* implementing agency for the 1973 New Delhi Agreement' and assumed responsibility for a massive scale repatriation of refugees in South Asia, including a huge airlift operation between October 1973 and January 1974.[6] Here, UNHCR took on the title of 'Focal Point' for the coordination of all UN assistance to the refugees on the appointment of the UN Secretary-General, a role which included the handling of medical supplies and the mobilisation of personnel.

By the mid-1960s, UNHCR recognised an interdependence between refugee support and development aims, not least to secure its financial future.[7] At a meeting of the UN Third

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[2] Agier, *Managing the Undesirables*, p 5.

[3] Agier, *Managing the Undesirable*s, p. 200.

[4] For discussion of refugees as victims rather than agents of change, see Peter Gatrell, *The Making of the Modern Refugee* (Oxford: Oxford University Press, 2013).

[5] *UNHCR*, *The State of the World's Refugees 2000: Fifty Years of Humanitarian Action*, 01 January 2000, <https://www.unhcr.org/publications/state-worlds-refugees-2000-fifty-years-humanitarian-action> [Accessed 24 July 2023], p.69.

[6] *UNHCR, The State of the World's Refugees, p.60.*

[7] WHO, Geneva: WHO.3, N77/372/2 (Jacket 1): Coordination with UNRWA: Memorandum from Director, Liaison Office with United Nations to Dr. L Bernard, Assistant Director General, WHO, 'Agenda item 50. Office of the United Nations High Commissioner for Refugees', 29 November 1967.

Committee, the resolution that UNHCR would continue for a further period of five years from January 1969 was adopted, and the High Commissioner was invited to attend the meetings of the Inter-Agency Consultative Board of the United Nations Development Programme and 'participate in the preparatory work of the second Development Decade'.[8] It was proposed that the High Commissioner's programme 'should be progressively taken over by the United Nations agencies concerned with development'.[9] The UNHCR began adopting a policy of rural settlements, in Tanzania, Uganda, and Zambia for example from the 1960s onwards, wherein the Commission attempted solutions of local assimilation and re-population, sites of agricultural production that may generate self-sufficient, settled populations.[10]

With UNHCR's position solidifying, the form and nature of global humanitarianism continued to evolve and by the mid-1970s, in Fassin's words, a 'second age of humanitarianism'[11] began, centred on the emerging zeitgeist of humanitarian witnessing. In the first year of the Sahrawi refugee camps, humanitarian witnessing took on a unique form. The humanitarian response to the medical challenges during this year of emergency included the presence of representatives of MSF and a diverse range of international NGOs, including Christian faith-based organizations (which were themselves forging fundamentally different ways of framing their medical humanitarian action), which all engaged in a form of humanitarianism that I call 'observational humanitarianism'. Furthermore, state-support from allies constituted significant medical action (which I contrast with the minimal contributions from British and American states) in conjunction with the central role of the Sahrawi state-movement. The emergency medical experience of the refugee camps and the refugees in this formative year was characterised less by control, and more by the creativity of the Sahrawi population themselves.

[8] WHO, Geneva: WHO.3, N77/372/2 (Jacket 1): Coordination with UNRWA: Memorandum from Director, Liaison Office with United Nations to Dr. L Bernard, Assistant Director General, WHO, 'Agenda item 50. Office of the United Nations High Commissioner for Refugees', 29 November 1967.

[9] WHO, Geneva: WHO.3, N77/372/2 (Jacket 1): Coordination with UNRWA: Memorandum from Director, Liaison Office with United Nations to Dr. L Bernard, Assistant Director General, WHO, 'Agenda item 50. Office of the United Nations High Commissioner for Refugees', 29 November 1967.

[10] Agier, *Managing the Undesirables*, p. 54.

[11] Didier Fassin, 'Humanitarianism as a Politics of Life', *Public Culture* 19 (3) (2007), p. 516.

The beginning of the refugee crisis and an exceptional humanitarian response

The Spanish state's withdrawal from Spanish Sahara and the processes of decolonisation that accompanied it triggered conflict between Morocco, Mauritania, and the POLISARIO (abbreviated from the Spanish: Frente Popular de Liberación de Saguía el Hamra y Río de Oro, referring to the northern and southern geographical regions of the former Spanish Sahara) in conjunction with the Sahrawi state-in-exile, the Sahrawi Arab Democratic Republic (SADR). Together, the POLISARIO, a liberation movement rather than a political party, and the SADR, formed on 27 February 1975 by the POLISARIO, became a partially recognised state with 'its own constitution, camp-based ministries, police force (and prisons), army and parallel 'state' and religious systems, the latter implementing a Maliki interpretation of Islam'.[12]As the conflict between the three nations escalated, around October 1975, people began to pre-empt violence and fled, dispersing within the borders of the ex-Spanish Sahara and across the eastern borders into Algeria. In those early months of a refugee crisis, the Algerian Red Crescent (ARC) assumed relief responsibility for the refugees.[13] From late November, as the conflict escalated, more refugees began to arrive in camps in Algeria, and a further wave of people urgently fled active fighting from early December into January 1976 as military occupations increased.[14] The actual numbers of Sahrawi people displaced into camps during this crisis was a highly contested question (as it remains into the 2000s), and the League of Red Cross Societies (henceforth, the League) was at pains to carefully manage the issue of numerating the refugees, in order to protect their claim of neutrality and their relationships with the Moroccan and Mauritanian states and their associated Red Cross organisations. However, by July 1976, when the camps were well-established, the League estimated there were 45,000 refugees in camps: 60 per cent children, 20 percent women, 10 per cent 'old folks' and 10 per cent 'able men'.[15] The Algerian state and the POLISARIO claimed the numbers were much higher, at around 165,000 people.[16] Refugee

[12] Elena Fiddian-Qasmiyeh, 'The Pragmatics of Performance: Putting 'Faith' in Aid in the Sahrawi Refugee Camps', *Journal of Refugee Studies* 24 (3) (2011), p. 536.

[13] IFRC, Vernier: Box 999682: Sven Lampell memo (LORCS), 'Report on Survey of Refugee Situation in Algeria, December 10-12, 1975', 8 January 1976.

[14] IFRC, Vernier: Box: R509625967, ROP 7522: Sven Lampell Memo, 'Report on Survey of Refugee Situation in Algeria, December 10-20, 1975'.

[15] IFRC, Vernier: Box: R509625967, ROP 7522: Sven Lampell, 'Summarized Situation Report as of 1/8/76 - Relief Operation for Refugees from Western Sahara in Algeria', 29 July 1976.

[16] Elena Fiddian-Qasmiyeh claims that 'the POLISARIO/SADR and the Algerian government have consistently stated that the camp population has always been 1650,000': Elena Fiddian-Qasmiyeh, 'Protracted Sahrawi Displacement: Challenges and Opportunities Beyond Encampment', *Forced Migration Policy Briefing* 7, Refugee Studies Centre, Oxford Department of International Development, May 2011. This number has been institutionalised by agencies including UNHCR, who published it as an 'initial estimate' by the Algerian government of the total refugee population, a figure which has been used to represent the camps in their state pre-1977: see *UNHCR*, 'Sahrawi Refugees in Tindouf, Algeria: Total In-Camp Population',

camp numbers have always been notoriously difficult to quantify in an accurate or consistent manner not least because of the political weight attached to the data.[17] Nevertheless, as shown by the archival evidence, the populations of the camps faced a period of medical emergency characterised by exhaustion and disease, injury and death caused by conflict as well as napalm bombing as people fled the Western Saharan territory, as well as a devastating measles epidemic.

The response by the international humanitarian relief system began to gain traction early in 1976, when the League and the International Committee of the Red Cross (ICRC) issued a joint appeal to national societies and governments for financial and material support for relief operations to aid the Sahrawi refugees. The ICRC took responsibility for the Sahrawi people displaced inside the ex-Spanish Sahara territory, and the League worked in close collaboration with the ARC to provide for refugees in Algeria.[18] The League issued a further appeal to the national societies to support an expanded programme of assistance being prepared by the ARC.[19] However, despite these campaigns, as the year closed the UNHCR, having assumed responsibility for the raising and coordination of international funds, was acting on the understanding that the Sahrawi refugees still faced critical challenges. From many perspectives, the first year had been a year of unmet crisis and unmet needs.

In the scholarly literature, the medical and health experience of the Sahrawi refugees is seen in flashes of evidence. One standout claim, made by historian Pablo San Martín, refers to 'one sole doctor' servicing the health needs of the refugee population during the first months of the emergency.[20] In his depiction of medical inadequacy, San Martín argued that there was 'no organized and systematic aid from any international or transnational organization until 1977, when the World Food Programme (WFP) and, later on, the UNHCR provided funds to cover the needs of approximately half of the refugees for a period of one year'.[21] However, as archival

March 2018. See also UNHCR, 'UNHCR Algeria: Fact Sheet, August 2010', August 2010 <https://www.refworld.org/docid/4caede172.html> [Accessed 20 September 2023].

[17] Jeff Crisp, '''Who has counted the refugees?'' UNHCR and the Politics of Numbers', *New Issues in Refugee Research, Working Paper No. 12* (UNHCR Policy Research Unit, June 1999). Jeff Crisp, 'Who is counting the refugees? Displacement data, its limitations, and potential for misuse', *Refugee History* [Online]<https://refugeehistory.org/blog/2022/8/4/who-is-counting-refugees-displacement-data-its-limitations-and-potential-for-misuse> [Accessed 13 August 2023].

[18] IFRC, Vernier: R51048307 (Box 3): Press Release, 7 January 1976.

[19] IFRC, Vernier: R510483307 (Box 3): League Press Release, 'A New Appeal for 45,000 Saharan Refugees in Algeria', 12 March 1976.

[20] Pablo San Martín, *Western Sahara, the Refugee Nation* (Cardiff: University of Wales Press, 2010) p.110.

[21] San Martín, *Western Sahara*, p.110.

and secondary research shows, a rich diversity of medical responses took place in the first year of the refugee crisis.

In many ways, the experience of the Saharawi refugee camps, and the humanitarian response was exceptional. By 1975 the humanitarian world was firmly in what Michael Barnett describes as the period of 'neo-humanitarianism'. In this period, there was no international metric for choosing which population's needs matters most: there was no meta-scale 'humanitarian version of triage'; chance dictated which crises were chosen by funders or agencies for the deployment of resources.[22] Emerging humanitarian organisations did take the opportunity to develop themselves in the field of the Saharawi camps, including MSF medics who joined forces with charity L'appel in the camps. However, in the case of the Sahrawi, it was not chance that dictated whether the refugees received aid, but rather choices made for political expediency: it was political expediency that steered the UNHCR away from the Sahrawi crisis, and political expediency that tempered the response of some states, including the British state. Scholars have explored the Western Saharan conflict through the lens of American foreign policy in the context of the Cold War,[23] and others have teased out connections between Cuban medical internationalism and the Sahrawi refugees.[24] The response of the British state, as a leading neo-colonial power orientating its standing in the world through new Development models, provides a contrast to the more significant response of states allied to the Sahrawi people.

Scholars across historical, anthropological, and political science disciplines have presented the Sahrawi refugees as revolutionary nationalists and agents of revolutionary transformation.[25] The decolonialisation conflict of the Western Sahara made the Sahrawi refugees into state-builders and the refugee camps became a crucible for nation- and identity-building.[26] And, as Elena

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[22] Barnett, *Empire of Humanity*, p.119.

[23] Jacob Mundy, 'Neutrality or complicity? The United States and the 1975 Moroccan takeover of the Spanish Sahara', *The Journal of North African Studies* 11 (3) (2006), pp. 275-306. Stephen Zunes, 'U.S. Recognition of the Illegal Israeli and Moroccan Annexations of Occupied Territories' in *Palestine, Taiwan, and Western Sahara: Statehood, Sovereignty, and the International System*, ed. Sabella Ogbobode Abidde, (Lanham, Maryland: Lexington Books, 2023).

[24] John M. Kirk and H. Michael Erisman, eds., *Cuban Medical Internationalism: Origins, Evolution, and Goals* (Basingstoke and New York: Palgrave Macmillan with the Institute for the Studies of the Americas, University of London, 2009). Julie M. Feinsilver, *Healing the Masses: Cuban Health Politics at Home and Abroad* (Berkeley and Los Angeles: University of California Press, 1993).

[25] San Martín, *Western Sahara*. Alice Wilson, *Sovereignty in Exile: A Saharan Liberation Movement Governs* (Philadelphia: University of Pennsylvania Press, 2016).

[26] Alice Wilson, 'Ambiguities of Space and Control: When Refugee Camp and Nomadic Encampment Meet', *Nomadic Peoples* 18 (1) (2014), pp. 38-60.

Fiddian-Qasmiyeh describes, over the course of three decades, the refugees developed a uniquely gendered character as a refugee community-identity presented to the world as 'ideal refugees': female, secular, democratic, worthy of international collaboration and aid.[27] Joanna Allan, through their reading of POLISARIO publications, argued that Sahrawi women 'are the signifiers of the nation and the transmitters of its culture'[28], and women were essential for building the camps in exile:

> If men were away on the frontline, women had to emerge from the *jaimas* and ensure the survival of the Saharawi people by taking over the management of the public sphere as well as fulfilling all the responsibilities of the private sphere.[29]

Anthropologist Konstantina Isidoros calls for a comprehensive feminist/gender-balanced historical framework and critical postcolonial analysis for a deeper understanding of contemporary socio-political Sahrawi transformations; as well as a deeper awareness of development-humanitarian nexus as the new external neo-colonial gaze which developed in the 1990s.[30] Women made up a relatively small proportion of the refugee population (the League estimated 20%), but coupled with their children (80% of the population were estimated to be 'womenandchildren')[31], the women become, once again, important to the development of a Sahrawi state-in-exile and refugee identity as 'ideal refugees'.

The Biafran War was the igniting spark for the formation of MSF, a new form of medical humanitarian organisation formed by and operated by humanitarian medics who acted as political agents and witnesses to suffering.[32] The Biafran war began in July 1967 when the Ibo region of eastern Nigeria proclaimed the independent republic of Biafra. The two and a half years of civil conflict that followed triggered the mass displacement of two million people. The United Nations were not mandated to respond to this intra-state conflict, and an explosion of NGOs took up the vacuum. This wave of newly created NGOs acted as the driving force for

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[27] Elena Fiddian-Qasmiyah, *The Ideal Refugees*.

[28] Joanna Allan, 'Imagining Saharawi women: the question of gender in POLISARIO discourse', *The Journal of North African Studies* 15 (2) (2010) p. 194.

[29] Allan, 'Imagining Saharawi women', p. 195.

[30] Konstantina Isidoros, 'Unveiling the Colonial Gaze: Sahrāwi Women in Nascent Nation-state Formation in the Western Sahara', *International Journal of Postcolonial Studies* 19 (4) (2017), pp. 487-506.

[31] IFRC, Vernier: Box: R509625967, ROP 7522: Sven Lampell, 'Summarized Situation Report as of 1/8/76 - Relief Operation for Refugees from Western Sahara in Algeria', 29 July 1976.

[32] Peter Redfield, *Life in Crisis: The Ethical Journey of Doctors without Borders* (Oakland: University of California Press, 2013).

fundraising and the mobilisation of international support and humanitarian aid for the Biafrans, including MSF. Whilst recognising the importance of the Biafran experience to the founding of MSF, scholars have emphasised the broader transformations of international humanitarian relief in this period, including the development of the sans frontiérism movement and the international movement for human rights developing in the 1970s.[33] Historian Eleanor Davey argues that a phase of disillusionment with the political ideology of tiers-mondisme (Third-Worldism) ran concurrent to the emergence of sans frontiérism, that tiers-mondisme, a political ideology and solidarity with third world revolutions and anti-imperialism, began to be replaced by a more radical approach to humanitarianism.[34] Influential medics pushed for a shift towards human rights advocacy and MSF which would go on to epitomise the dominant form of international humanitarian in the final quarter of the twentieth century: a mode of humanitarianism characterised by témoignage (witnessing).[35]

Founded in December 1971, MSF was very active during the early years of its operation despite its small size and fledgling organisation: medical missions took place in response to earthquake in Nicaragua in 1972 and Hurricane Fifi in Honduras in 1974, although both missions suffered from a lack of resources and experience.[36] Furthermore, in March 1975 a small team of medics were deployed to the An Loi refugee camp outside Saigon in Vietnam, and between October 1975 and March 1976, a larger team of over 50 medics travelled to Beirut in response to conflict.[37] According to anthropologist Peter Redfield, the early years of MSF were solely focused on emergency: 'Missions at this time were haphazard in organization, largely symbolic in impact, full of romantic panache, and entirely temporary in duration'.[38] MSF's first large-scale medical response during a refugee crisis, providing medical support to the Cambodian border camps in 1975, was heralded by the organization as a turning point: the weaknesses of the

[33] Silvia Salvatici, *A History of Humanitarianism, 1755-1989: In the Name of Others* (Manchester: Manchester University Press, 2019), pp. 191-192. Renée C. Fox, 'Medical Humanitarianism and Human Rights: Reflections on Doctors Without Borders and Doctors of the World', *Social Science & Med*icine 41 (12) (1995), pp. 1607-1616.

[34] Eleanor Davey, *Idealism Beyond Borders: The French Revolutionary Left and the Rise of Humanitarianism, 1954-1988* (Cambridge: Cambridge University Press, 2015).

[35] Eleanor Davey, *Idealism Beyond Borders*.

[36] Eleanor Davey, *Idealism Beyond Borders*, p.144.

[37] Eleanor Davey, *Idealism Beyond Borders,* 2015, p.144. Dan Bortolotti, *Hope in Hell: Inside the World of Doctors Without Borders* (Ontario; New York: Firefly Books, 2004).

[38] Peter Redfield, 'Doctors, Borders, and Life in Crisis', *Cultural Anthropology*, 20 (3) (Aug. 2005), pp. 328-361.

organization's logistics were laid bare, and the movement began to fracture.[39] Eleanor Davey argues that the Cambodian mission provided MSF with a formative experience, enabling it to develop its logistical capacity and professionalism as well as providing an opportunity to actively express its principle of témoignage and reflect on its political role.[40] It is acknowledged that from the 1970s and into the 1980s, refugee camps became fields for learning, of developing expertise in vaccination and epidemiology, but also a professional organised culture.[41] The presence of MSF in the Sahrawi camps speaks to another context that informed its institutional direction in the mid-1970s.

Key scholarship also depicts the Thai border camps as a melting pot for an epistemic form of humanitarianism, occurring just a few years after the Sahrawi refugee crisis began. Historian Bertrand Taithe argues how a Community of Practice developed in the Thai border camps/Cambodian refugee camps in the decade from 1979. This 'new humanitarianism' developed over a decade in an extremely complex context: this was not simply an experience of neo-colonial knowledge extraction (the camps acting as an incubator for 'the science of genocide survival' and an epidemiological testing ground e.g., for longitudinal studies of group psychology[42]), this was a community 'that imagined itself a system' and aspired to development approaches more lofty than emergency response.[43] The humanitarian network associated with the Sahrawi camps did not gain the same kind of international traction, and a more localised form of humanitarianism developed, observed by the 'great network of humanitarianism'[44]. Despite a steady flow of aid agencies into the camps to the present day, as Africa's last colony is

[39] *Médecins sans Frontières (MSF)*, '1975: Turning point', <https://www.msf.org/who-we-are>, [Accessed 4 April 2019].

[40] Eleanor Davey, *Idealism Beyond Borders*, p 164.

[41] Rony Brauman, Michaël Neuman, 'From Dadaab to Calais: what are the alternatives to the refugee camp?*'MSF-CRASH*, <https://www.msf-crash.org/en/blog/camps-refugees-idps/dadaab-calais-what-are-alternatives-refugee-camp> [Accessed 24 July 2023].

[42] Bertrand Taithe, 'The Cradle of the New Humanitarian System? International Work and European Volunteers at the Cambodian Refugee Camps, 1979-1993', *Contemporary European History* 25 (2) (2016), pp. 349-351.

[43] Taithe, 'The Cradle of the New Humanitarian System?' pp. 357-358.

[44] Agier, *Managing the Undesirables*, p. 200.

stuck in 'an exceptional state of un-decolonization'[45] — the resulting refugee camps are some of the most protracted refugee camps in history.[47]

Accounts of suffering in the Sahrawi refugee camps

The first League delegation visited the camps between 10 and 20 December 1975, led by Sven Lampell. Lampell was a Colonel experienced in conflict in the Congo, Biafra, Vietnam, and Bangladesh.[48] And his reports of the refugee conditions were bleak. The refugee population was exhausted by the hardships of flight: lack of food and clothing compounded by the cold conditions, with many refugees reported to be suffering from tuberculosis, diarrhoea, fever, bronchitis, and skin diseases reported amongst children. Some developed cases of kwashiorkor (a severe form of protein-deficiency malnutrition that usually effects infants and children through age of weaning to around five) and marasmus (severe undernutrition in all macro-nutrients) were noted. There were many cases of refugees experiencing trauma or mental shock. Exhausted mothers were struggling to nurse their babies and a number of new-born babies had died.[49] Henrik Beer, Secretary General of the League from 1960 to 1981 shared his concern in confidence with a colleague at the Canadian Red Cross:

> They are saying they have seldom seen such suffering and have seldom expressed such admiration for the morale and patience of the people concerned … and they are in a very bad state indeed – lack of food, results of a march to the desert, without clothing, without medicaments, without anything, and also temperatures at night down to sub-zero temperatures – children almost naked. Also terror stories about what happened during the march, etc. and atrocity … stories about treatment by Moroccan troops …[50]

Stories of refugee suffering were also recounted by international organisations principally concerned with guarding against human rights abuses, namely the Fédération Internationale des

[45] Isidoros, 'Unveiling the Colonial Gaze', p. 503.

[47] For discussions of the ongoing stalemate, see also Anouar Boukhars and Jacques Roussellier, *Perspectives on Western Sahara: Myths, Nationalisms, and Geopolitics* (Lanham, MD: Rowman & Littlefield, 2014); Raquel Ojeda-Garcia, Irene Fernández-Molina, Victoria Veguilla, *Global, Regional and Local Dimensions of Western Sahara's Protracted Decolonization: When a Conflict Gets Old* (New York: Palgrave Macmillan US, 2017). Erik Jensen, *Western Sahara. Anatomy of a stalemate* (London and Boulder, CO: Lynne Rienner, 2005), Yahia H. Zoubir, 'Stalemate in Western Sahara: Ending International Legality', *Middle East Policy,* 14 (4) (2007), pp. 158-177.

[48] ICRC, Vernier: 999682, Correspondence Beer to Tellier, 29 December 1975.

[49] IFRC, Vernier: Box 999682: Sven Lampell memo (LORCS), 'Report on Survey of Refugee Situation in Algeria, December 10-12, 1975', 8 January 1976.

[50] ICRC, Vernier: 999682, Confidential Note from Henrik Beer to Henri Tellier, National Commissioner of the Canadian Red Cross Society, 29 December 1975.

Droits de L'Homme (International Federation for Human Rights, FIDH), a federation of organisations established in 1922, concerned with all aspects of human rights, [51] and the Anti-Slavery Society (ASS).[52] San Martín also outlines a refugee's account of a Moroccan napalm and phosphorous bombing at the temporary camp in Guelta in 1975[53] and a Sahrawi girl's recollection of napalm bombings in Um Dreiga. This second bombing reportedly killed both girl's parents, yet she survived only to later lose her leg on a landmine whilst displaced in the desert.[54] In the Hafid Boudjema camp in Algeria, the ASS reported gross inadequacies in medical capacity to treat the survivors of the Moroccan raids (the report outlines a tragic situation wherein those suffering over 40% burns were, inevitably, dying because of their injuries).[55] The ASS report also drew the attention of the British Foreign and Commonwealth Office to the deaths of 35 women and children and the injury of 300.[56] These reports by the ASS are important examples of humanitarian witness, that contrast reports from the ICRC denying witness to any napalm bombing of the Sahrawi refugees. The ICRC asserted that no statement of witness had been made by any of its representatives, and indeed that none of its delegates had visited the Western Sahara area since December 1975.[57]

Additionally, church delegations and the Commission of Inter-Church Aid, Refugee and World Service (CICARWS) (a wing of the WCC) were witness to the refugee suffering and used examples of medical technology as representations of depletion: 'on 12 April, there were only 5 syringes and 2 or 3 litres of alcohol in the camps, and they were short on antibiotics'.[58] And finally, the League were central to reporting of Sahrawi suffering. For example, in June, the

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[51] F*IDH,* 'International Federation of Human Rights' <https://www.fidh.org/en/about-us/What-is-FIDH/>, [Accessed 30 August 2023].

[52] Between 1956 and 1990 the organisation's official name was the Anti-Slavery Society for the Protection of Human Rights: Mike Kaye, '1807-2007: Over 200 years campaigning against slavery', Anti-Slavery International (2005) <https://www.antislavery.org/wp-content/uploads/2017/01/18072007.pdf>[Accessed 31 January 2023].

[53] San Martín, *Western Sahara,* p. 2.

[54] San Martín, *Western Sahara*, pp. 108-109.

[55] British National Archives, Kew: OD 66/71, Anti-Slavery Society report, un-dated. This report was forwarded to the Ministry of Overseas Development by the United Nations Department of the Foreign & Commonwealth Office on 27 May 1976.

[56] BNA, Kew: OD 66/71: Anti-Slavery Society report, undated. Forwarded to the Ministry of Overseas Development by the United Nations Department of the Foreign & Commonwealth Office on 27 May 1976.

[57] UNHCR, Geneva: 410.ICRC.WSH.NGOS: ICRC, Spanish Sahara; Incoming Cable, 3.2.1976: From ICRC to UNHCR (Arnaout): Press release no.1258, 2 February 1976.

[58] IFRC, Vernier: Box: R509625967, Folder: ROP 7522, Translated Report, 'Appeal of the Representatives of the Church in Algeria, Following Their Visit to Sahraoui Refugee Camps', (Appendix B), 13 April 1976. This source states there were four refugee camps at Hafed Boudjemaa, hosting 28,000 people.

League reported a serious measles epidemic in the camps, an increase in diarrhoea, and many cases of malnutrition of children under the age of three. There are contradictions between League sources, and a distinct lack of clarity relating to child mortality in the camps. The contradictory numbers are possibly the result of unclear communication or inadequate notetaking, but the most reliable source of evidence seems to be Sven Lampell's situation report as opposed to debrief notes where the author is not stated, and it is not clear whether the debrief was conducted in person. In regard to refugee children, Lampell's situation report signed and dated 29 July, 1976 states:

> Like always the children are particularly exposed. As estimated 25% of the new-born die before they reached 3 months of age. An epidemic of measles took away 50% of the children under 3 years in April and May.[59]

By way of illustrating how statistics can be misreported or misunderstood, I herein include the slight (but still significant) variations on the statistics. Debriefing notes with Lampell dated 23 June reinforce the statement that 'The measles epidemic which seems to have cost the life of 50% of the children under 3 years of age is over'.[60] But debriefing notes dated slightly earlier in the month state: 'There are still a few cases of measles in the hospitals and most of the children are malnourished, particularly those under 3 years of age. Of those in the hospitals under 3 years of age, 50% may survive. The children over 3 years in the camps seem to be in good health'.[61] Nevertheless, a report from MSF also confirmed a measles epidemic in the camps.[62]

Exceptional medical humanitarianism in the Sahrawi refugee camps? UNHCR and Médecins Sans Frontières

Humanitarian action in the Sahrawi refugee camps was in some ways exceptional and set-apart from the emerging norms of humanitarian action in the mid-1970s. First, the Sahrawi camps were not a context in which the UNHCR became a 'Focal Point', and in the first year of emergency, the UNHCR assumed a restrained, observational role. The agency did provide early resources to the refugees and led a fundraising campaign as the crisis developed. But the UNHCR did not assume a role as humanitarian coordinator on an operational basis, nor did it

[59] IFRC, Vernier: Box: R509625967, ROP 7522: Sven Lampell, 'Summarized Situation Report as of 1/8/76 - Relief Operation for Refugees from Western Sahara in Algeria', 29 July 1976.

[60] IFRC, Vernier: R509625967: Unauthored, Short notes on debriefing of Mr. Lampell, 23 June 1976.

[61] IFRC, Vernier: R509625967: Unauthored, 'Short notes on Mr Lampell's debriefing', 8 June 1976.

[62] IFRC, Vernier: 999682: L'appel and Médicins Sans Frontières (MSF), 'Rapport Medical Sur Les Besoins Des Populations Sahraouies,' cover letter dated 23 June 1976.

appear to consider the application of policies of rural settlement that formed the major component of UNHCR's assistance programmes in Africa only a couple of years previously.[63] Admittedly, this was the very early days and months of the crisis, and settlement forms of assistance would not necessarily be expected at this stage.

Algeria formally requested assistance from the Secretary General of the United Nations, Kurt Waldheim in December 1975.[64] The UNHCR assumed responsibility for fundraising and when UN High Commissioner for Refugees Sadruddin Aga Khan issued the Commission's first appeal to governments in April 1976, it was the ARC that was confirmed as the operational partner.[65] At the beginning of the crisis, the UNHCR assumed a position of 'wait and see', to first observe how far assistance to the refugees from the Algerian government, the ARC, and the international Red Cross movement would satisfy the needs of the refugees, and then determine the level of assistance that it was required to deliver.[66] Throughout the first year of emergency, rather than staking an operational claim, the UNHCR held a background role, advocating that humanitarian aid could be used to de-politicize the situation, whilst helping to solve the political dispute between Morocco, Mauritania, the Sahrawi, and Algeria. The parallel between the Sahrawi and the Palestinian refugee crises was not lost on the League representative on the ground: 'It is hoped that the HCR can push for a political solution otherwise there is a risk of creating another "Palestinian" problem'.[67]

The emphasis on "Palestinian" places the root of the problem of the refugees as perceived by representatives of the League, in identity and place. In the Sahrawi dispute, one of the main points of contention was who the refugees actually were, and where they had come from. Whereas a system of control was not being established at the hands of the UNHCR, there were claims made by officials representing the Moroccan state, that the camps were subject to control at the hands of Algeria. Morocco and Mauritania clearly held decolonisation war-time agendas of their own and staked claims on the ex-Spanish Saharan territory. The representatives of Morroco

[63] U*NHCR*, Executive Committee Meetings of the General Assembly: *Report of the United Nations High Commissioner of Refugees*, (A/9612), 01 January 1975, < https://www.unhcr.org/publications/report-united-nations-high-commissioner-refugees-16> [Accessed 23 September 2023].

[64] IFRC, Vernier: R509625967, ROP 7522: Letter from the Foreign Minister of Algeria to the Sec-Gen of UN, 24 December 1976.

[65] BNA, Kew: OD 66/71: First Appeal of UNHCR, 8 April 1976

[66] ICRC, Vernier: 410.ICRC.WSH:NGOS: ICRC, Spanish Sahara. Outgoing Cable, UNHCR (Jaegar) to ICRC, 8 December 1975.

[67] IFRC, Vernier: R509625967: Unauthored, Short notes on debriefing of Mr. Lampell, 23 June 1976.

maintained the position that the refugee camps were the product of Algerian state attempts to control the people: professing that there was no forced mass migration, and the people were being sequestered in the camps, and were being prevented from returning to Western Saharan territory.[68] Speaking at the 27th session of the Executive Committee of the High Commissioner's programme, observers from Morocco and Mauritania restated a joint declaration of their heads of state that the 5,000 Sahrawi residing in the Algerian camps were being kept there against their will, and they were not subject to the UNHCR definition of refugees, and their governments requested their voluntary repatriation.[69] It is worth pointing out, that the issue of defining refugee status was far from cut and dry, despite the protestations of Morocco and Mauritania. It was broadly acknowledged in the 1960s that the UN Refugee Convention did not apply to the majority of refugees being assisted by the UNHCR.[70] The 1967 Protocol, adopted on 4 October 1967 was an attempt to clarify issues of refugee status and it expanded the 1951 Convention Relating to the Status of Refugees to apply universal protection to people fleeing conflict or persecution.

The Moroccan and Mauritanian position aside, in the absence of overarching systems of control, there was a great deal of space and opportunity for other humanitarian movements to mould the reality of humanitarianism—and specifically medical action—in the refugee camps. Agier situates the development of 'the contemporary humanitarian movement' in three phases of crisis, the first being the emergence of MSF as a part of the political activism of the 1970s: 'the 'French doctors' … bearers of the generalized critique of the First World's system of production and consumption, it's moral and political values'.[71] Alongside these emerging actors, and in the context of UNHCR's 'back-seat' role there is need for further investigation of other observers in the camps, alongside the role of states—which is not to be underestimated—particularly the role of the Sahrawi states-in-exile.

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[68] UN Digital Library: A/31/12/Add.1, 'Addendum to the report of the United Nations High Commissioner for Refugees: Report of the 27th session of the Executive Committee of the High Commissioner's Programme, Geneva, 4-12 October 1976'<https://digitallibrary.un.org/record/703861?ln=en> [Accessed 24 July 2023].

[69] UN Digital Library: A/31/12/Add.1, 'Addendum to the report of the United Nations High Commissioner for Refugees: Report of the 27th session of the Executive Committee of the High Commissioner's Programme, Geneva, 4-12 October 1976'<https://digitallibrary.un.org/record/703861?ln=en> [Accessed 24 July 2023].

[70] *UNHCR*, *The State of the World's Refugees*, p.53.

[71] Agier, *Managing the Undesirables*, p.206. Agier outlines the second phase at 'the turn from the 1980s to the 1990s … the age in which NGOs were internationalized and professionalized' and the third phase after the terror attacks of September 11th 2001', Ibid.

The Sahrawi refugee crisis took place at a formative time in MSF's history, for both individuals building the movement and for the organisation itself. The presence and influence of MSF in the Sahrawi refugee camps is largely absent in the literature. Davey suggests that the proliferation of refugee camps between 1976 and 1979, powered by a rise in the global refugee population from 2.7 million to 5.7 million, presented MSF with more work than they could accommodate.[72] Yet, despite the mounting number of crises that required attendance, the nascent organisation did have a presence in the Sahrawi refugee camps. Although its involvement in Tindouf was far-less immersive than MSF's experience in the Thai border camps, its presence might best be described as small, but not insignificant. During just one week in May 1976, a small delegation of MSF medics visited the camps with a representative from the charity L'appel (a charity originally established to support child victims of war in Vietnam).[73] The delegation included Dr Max Recamier (one of the founders of MSF, and a previous ICRC volunteer), Dr Mario Duran, and Dr Richard Rossin. Subsequently, a commitment was made to deploy an MSF team of two doctors and three nurses to the camps for two and four months, respectively. The presence of MSF in the camps is corroborated by a transcript record of the 5th Congress of MSF's General Assembly, held on 30 April 1977.[74]

The MSF delegation to the Sahrawi camps represents a side of the organisation that is often overlooked by the historiography focused on the Biafra foundation story, wherein the medics and journalists connected to the medical publication Tonus were highly influential in the organisation's founding. Incidentally, Tonus was a medical publication funded by the American pharmaceutical company, Winthrop. Here, in MSF's history is a tacit example of the continued presence of pharmaceutical subjectivities with its commitment to the value and virtues of liberal medicine, and a link between corporate pharmaceuticals and the founding of one of the most influential medical humanitarian organisations of all time.[75] The small group of doctors that first visited the Sahrawi camps and the subsequent small deployment of medics constituted an

[72] Eleanor Davey, *Idealism Beyond Borders*, p.145. Joelle Tanguy, 'The Médecins Sans Frontières Experience', in *A Framework for Survival: Health, Human Rights and Humanitarian Assistance in Conflicts and Disasters*, ed. Kevin M. Cahill (New York; London: Routledge, 1999).

[73] The mission took place between 9 and 15 May 1976. IFRC, Vernier: 999682: L'appel and Médicins Sans Frontières (MSF), 'Rapport Medical Sur Les Besoins Des Populations Sahraouies,' cover letter dated 23 June 1976.

[74] Medécins Sans Frontières, 'Ve Congres, Assemblée Générale, 30 Avril 1977'. Document made available from the MSF archives via email by the researcher Michaël Neuman, Director of Studies at CRASH/Médecins sans Frontières.

[75] Michal Givoni, 'Humanitarian Governance and Ethical Cultivation: Médicins sans Frontières and the Advent of the Expert-Witness', *Millennium Journal of International Studies* 40 (1) (2011), p. 53.

example of how MSF was, at least until after working in the Cambodian camps, what Michal Givoni describes as a 'placement agency', an organisation which simply 'matched international development agencies and other humanitarian organisations with French physicians interested in working in developing countries'.[76] For the doctors attending developing countries in needs and contexts such as the Sahrawi refugee camps, these were opportunities to 'return to purpose', to a more pure, unencumbered expression of doctoring. As Givoni argues, 'the suffix 'sans frontières' referred, at this embryonic stage, to the dismantling of professional barriers that confined physicians to a tedious, bureaucratic and commercialised labour'[77] and gave space and place for a growing number of French medical practitioners to apply their selves as enlightened experts who were not yet fully co-opted by the requirement to also be expert-witnesses. First-person witnessing became increasingly institutionalised for MSF as the decade progresses,[78] and the Sahrawi case enables deeper scrutiny of how the MSF leadership articulated witnessing at this time in the organisation's history.

The MSF/L'appel report may have expressed practical concern for the refugees, but it did not explicitly express political or ideological solidarity for the Sahrawi refugees. In fact, the report assumes a rather conciliatory tone and references the League, the ARC, and the Sahrawi Red Crescent (SRC) as organisations leading the distribution of aid and resources. The L'appel report corroborates the view that MSF's position in its early years closely resembled the principles of the Red Cross, and that the organisation maintained the language of neutrality and independence in its founding charter in 1971 and in the early years of its operation.[79] The founding charter of MSF enshrined a clear position of neutrality. Fabrice Weissman, experienced logistician and head of mission for MSF in numerous countries reflected that 'contrary to the image popularized by the media and MSF itself, the idea that silence was necessary to action was held by the majority of its founding members'.[80] The original charter of 1971 also stated that members would refrain from 'any interference in States' internal affairs' and abstain from 'passing judgement or publicly

[76] Givoni, 'Humanitarian Governance', p. 52.

[77] Givoni, 'Humanitarian Governance', p. 51.

[78] Givoni, 'Humanitarian Governance'.

[79] Katherine Davies, 'Continuity, Change and Contest, Meanings of 'Humanitarian' from the 'Religion of Humanity' to the Kosovo War', Humanitarian Policy Group (HPG) Working Paper, Overseas Development Institute (ODI): August 2012 <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7769.pdf> [Accessed 5 May 2020].

[80] Fabrice Weissman, 'Silence Heals…from the Cold War to the War on Terror, MSF Speaks Out: A Brief History' in *Humanitarian Negotiations Revealed. The MSF Experience*, eds. Claire Magone, Michael Neuman, and Fabrice Weissman (London: Hurst & Co., 2011) p. 178.

expressing an opinion – either positive or negative – regarding events, forces or leaders who accepted their assistance.'[81] It was not until 1977 that an MSF official violated the statutory confidentiality commitment in its charter, when Claude Malhuret (medic for MSF and then President for the organization in 1977), returning from the Cambodian refugee camps in Thailand, condemned on French television the crimes of the Khmer Rouge and their extermination of 'entire segments of the population in the name of some revamped communist ideology'.[82]

However, during MSF's 1976 annual meeting, Bernard Kouchner, co-founder of MSF encouraged debate about the political nature of MSF's humanitarian work in the context of the Sahrawi crisis and the organization's response to it.[83] For Kouchner, MSF's experience in the Sahrawi camps was parallel to its work in the Thai refugee camps, both proving to the organization that it could not ignore the political implications of its work.[84] For Kouchner and his supporters, these missions were inherently acts of fraternity: missions to help the dispossessed which, although MSF might not choose a side, embodied a personal political act.[85] At the time of the annual meeting, the fact that MSF missions were taking place concurrently in Algeria and Thailand provided Kouchner with evidence of MSF's commitment to missions in both the 'left' and 'right', in Algeria and in Thailand respectively. But working in these fields confirmed the need for political awareness:

> D'un côté une mission "de gauche", une autre [sic] mission "de droite". Nous savons que cela ne veut pas dire grand'chose. Nous le savons, nous autres médecins, que nous soignons des hommes et non pas des politiques. Peut-on apporter meilleure preuve de notre neutralité que celle de travailler en Algérie, dans le camps sarahouis, en territoire algérien, et en Thaïlande dans les camps de réfugiés cambodgiens?[86]

> On the one hand a mission 'on the left', another 'on the right'. We know that doesn't mean much. We, as doctors, know that we care for people [lit. 'men'], not

[81] Weissman, 'Silence Heals'.

[82] Weissman, 'Silence Heals', p. 178.

[83] Kouchner would leave MSF in 1979 following continued disagreements over the primary functions of MSF and whether witnessing was central; Malhuret, on the other hand advocated the anchoring of principles in humanitarian medicine and professionalization: Weismann, 'Silence Heals', p.179.

[84] MSF, 'Ve Congres' p. 16.

[85] MSF, 'Ve Congres', p. 14-15.

[86] MSF, 'Ve Congres', p. 16.

> policies. Could there be a better proof of our neutrality than to work in Algeria, in the Sahrawi camps on Algerian territory, and in Thailand in the Cambodian refugee camps?

In Thailand, the refugee camps established just a few years after the Sahrawi camps, sheltered people from Vietnam, Laos, Hmong tribespeople and Cambodians and exposed a complex political environment. For Kouchner, this was a political situation which created physical risks that should not be neglected in the name of neutrality, i.e., threats of bombardment and infiltration and dangerous transit routes controlled by opponents of the Thai regime.[87] By actively engaging in the camps, effectively providing care and support to those who had fled authoritarian communist/extreme leftist powers, the MSF position could not easily be considered neutral.

Kouchner argued that the Sahrawi mission (and others) was testimony to the need to recognise political considerations and acknowledge political implications for MSF's work. He argued that it was necessary to consider—but not try to 'bend' or overtly influence—the political, social, and economic forces contextual to MSF's activities. This appreciation of context and the interaction MSF must recognise was, to Kouchner, essential if MSF's work was to achieve something less superficial:

> Nous devons largement tenir compte des forces politique, sociale, économique en présence si l'on veut réussir une mission, si l'on veut que notre travail ne reste pas simplement superficiel: médicine de soins pour quelque temps et puis un départ, une fuite en laissant des besoins médicaux et même en les ayant développés.[88]

> We must take fully into account the prevailing political, social and economic forces if we want to make a success of a mission, if we want our work to be more than simply superficial: first aid for a while and then a departure, a flight, while leaving behind medical needs, or while having developed [i.e., increased, contributed to] them.

Kouchner also warned against MSF medical humanitarian behaviour constituting a form of colonialism:

[87] MSF, 'Ve Congres', pp. 20-21.

[88] MSF, 'Ve Congres', p. 16.

> Se conduire à l'identique, imposer nos moeurs, notre façon de vivre comme en France chez ces populations qui nous accueillent, constitue une forme de colonialisme.[89]
>
> Behaving identically among this populations that host us, imposing our customs or our way of life as though in France, constitutes a form of colonialism.

The need to listen and learn from the populations they were treating would help to avoid 'a spectacle of western medicine' (d'une opération théâtrale et pas d'une opération médicale), and the imposition of 'the medicalization of life' (la médicalisation de la vie), that Kouchner proposed was already characteristic of French life.[90] With the Sahrawi example, Kouchner was able to emphasise the need to do more than provide medical care, but not to go too far into imperialistic over-medicalisation that saw medics temporarily provide care and then depart leaving under-developed medical infrastructures. At this time, Kouchner may not have explicitly articulated solidarity with the Sahrawi (or indeed the inhabitants of the Thai camps); yet he expressed a commitment to human fraternity and respect for difference, and acknowledged that strict neutrality was a pipedream when it came to providing assistance to the dispossessed. That is, it would be more effective to recognise political contexts, whilst not attempting to overly influence them.

The presence of MSF representatives in the Sahrawi refugee camps and the discussion of the activity and the premature withdrawal from the camps, amounted to MSF acting as witness – which, at the time was an increasingly important obligation for elements of the organisation and certain individuals who deployed under its banner. MSF also celebrated the implementation of medical activity; Kouchner reported to the General Assembly that a written agreement had been signed by the Ministry of Health for the Sahrawi government (presumably the SADR) and MSF was allowed a permanent presence of five doctors and ten nurses across the Sahrawi refugee camps. He also praised MSF's medical activity, claiming the organisation held sole responsibility for raising funds and running a tuberculosis (TB) campaign. However, despite these activities, 'various misunderstandings' with political leaders led to the forced withdrawal of 20 MSF doctors and nurses from the camps, and the Sahrawi mission was suspended in April 1977.[91] Kouchner had hoped that the mission would be reinstated and longer-lived. However, Kouchner was upset by more than the personal inconvenience to medics who had readied themselves for a

[89] MSF, 'Ve Congres', p. 18.

[90] MSF, 'Ve Congres', p. 18; p. 35.

[91] MSF, 'Ve Congres', pp. 15-17.

two-month deployment to the desert. He offered two major points for reflection to the General Assembly: first, that it was necessary to acknowledge that operations were facing increasingly political contexts; second, that there was a need for improved preparation of MSF teams. He recognised that professionalisation and readiness for deployment would help counter the problems of 'psychological, sociological and ethnological preparation of volunteers' in the context of politically problematic environments.[92]

An active field of international NGOs, or a site for 'observational humanitarianism'?

The presence of MSF clinicians in the Sahrawi camps was significant to the intellectual development of the sans frontières movement, and it was accompanied by a diverse mesh of national and international humanitarian organisations, a web of actors and institutions connected to the camps and the Sahrawi refugees. As introduced above, San Martín referred to 'one sole doctor' servicing the health needs of the refugee population during the first months of the emergency,[93] and although he acknowledges the presence of an MSF team, and a team from Cuba who arrived in 1976, San Martín's claims deserve a more nuanced reading. Although the MSF/L'appel report reiterates the presence of a 'lone doctor', further archival research shows that the reality of medical care in the camps, even at the early stages of the crisis, was one of a diverse range of professional clinicians or non-trained volunteers assuming medical roles.

The international humanitarian community formed a mesh of allies and supporters around the refugees, but these institutions and individuals were often only tangentially connected to the camps and the refugees. The predominant characteristics of the NGOs were observation, assessment, and reporting. And despite this characterisation, there is little evidence to suggest that the NGO community created any sea-change in the production of knowledge about refugee communities: there was no creation of an epistemic community, such as that described by Bertrand Taithe in the case of the humanitarian activity which took place at the Cambodian Border Camps only a few years later.[94] More significant and lasting contributions (including contributions to the production of knowledge and community) can be found in the action of state-led initiatives.

[92] MSF, 'Ve Congres', p. 18.

[93] San Martín, *Western Sahara*, p. 110.

[94] Bertrand Taithe, 'The Cradle of the New Humanitarian System? International Work and European Volunteers at the Cambodian Border Camps, 1979-1993', *Contemporary European History*, 25(2) (2016), pp. 335-358.

This is not to ignore or discount the medical humanitarian action that was taking place in the camps by the INGOs. There were numerous people, with diverse levels of skills and professionalisms present in the camp. Towards the top of a hierarchy of personnel, appears to be a Dr. Omar (seemingly the sole doctor introduced by San Martín), an orthopaedic doctor, and, according to MSF, the only 'Spanish' doctor for the entire Sahrawi population.[95] Dr. Omar worked within the Central Hospital, originally described as a large tent, which acted as a reception point for all newly arrived refugees. Under the direction of the doctor, all newly arrived refugees were received at the hospital tent before they were directed to other encampments. This provides clear evidence of an approach which joined care with control.[96] But there were numerous other spaces wherein medical humanitarian action took place during the initial stages of the emergency. Formal spaces, which were often found at a considerable physical distance from where the refugees found themselves, included the Tindouf Hospital, which will be discussed in more detail in the section on Algerian medical humanitarian response below. Informal spaces closer to the epicentre of emergency (in desert areas en route from areas of conflict and the formal hospitals), were smaller, improvised, yet important spaces designed to protect people and resources from the challenging desert environment. These resourceful spaces included trenches dug in the ground to provide make-shift cold stores, and surgical space confined to two Land Rover Ambulances which provided some sheltered space from the sand.[97] It is not clear from the report who was responsible for these spaces. Later, in June, one Red Cross truck was reported to have been converted into an ambulance 'collecting sick children which are often hidden by their parents.'[98]

But there is another form of humanitarianism which dominated the field, a form which I call 'observational humanitarianism', a form of witnessing without action. Anthropologist Liisa H. Malkki describes 'clinical humanitarianism' as a mode by which humanitarian's expert testimony displaces the testimony of refugees:

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[95] In lieu of further information, this reference could be referring to the only doctor with Spanish nationality and/or Spanish medical training. See: IFRC, Vernier: 999682: L'appel and Médicins Sans Frontières (MSF), 'Rapport Medical Sur Les Besoins Des Populations Sahraouies,' cover letter dated 23 June 1976.

[96] Liisa H. Malkki, 'Speechless Emissaries'.

[97] IFRC, Vernier: 999682. L'appel and Médicins Sans Frontières (MSF), 'Rapport Medical Sur Les Besoins Des Populations Sahraouies', 23 June 1976. There is also evidence of schooling taking place in temporary classrooms in holes dug in the ground: IFRC, Vernier: Box: R509625967, Folder: ROP 7522, Translated Report, 'Appeal of the Representatives of the Church in Algeria, Following Their Visit to Sahraoui Refugee Camps', (Appendix B), 13 April 1976.

[98] IFRC, Vernier: R509625967: Unauthored, 'Short notes on Mr Lampell's debriefing', 8 June 1976.

> How often have we seen the media image of a (usually white) U.N. official standing in a dusty landscape, perhaps in Africa, surrounded by milling crowds of black people peering into the camera, and benevolently, efficiently, giving a rundown on their numbers, their diseases, their nutritional needs, their crops, and their birth and mortality rates?[99]

Malkki refers to a normative communication style and power structure wherein non-refugee visitors and workers speak on behalf of the refugees. To expand this conceptualization, 'observational humanitarianism' responds to its own moralizing imperative to be present, to speak of refugee suffering but it doesn't manage to be active, beyond bearing witness. This witnessing without action in the Sahrawi camps involved multiple interactions between humanitarian worker and subject/recipient, many of these interactions were at arms-length and not a two-way communication. As such, there were compassionate humanitarian acts, but they were more passive, and did not necessarily involve a physical or material contribution on the part of the humanitarian. Humanitarian action in this form gives prominence to the knowledge and voice of the humanitarian actors; providing them a channel to display their expert status. The act of observing (manifested in the writing of reports for international circulation) does have its merits, and in the case of the Sahrawi refugees the process of observation did raise awareness of the refugee situation and contributed to fundraising campaigns. So, this observational action does signify humanitarian action. Furthermore, as introduced above, if the observations take a more radical or political stance (the ASS report, for example), it is arguably also a form of witnessing.

During the first sixth months of the refugee camps settlement, the health and medical needs of the Sahrawi refugees were observed, discussed, assessed, and reported on by numerous organisations. Mr Jaeger (UNHCR Director of Assistance), a Mr Arnaout and Mr Kermina undertook the UNHCR's first evaluation mission to the camps on 15 December 1975.[100] In parallel, the established rules of relief for the League required a delegation to visit a place of crisis prior to activating any relief programme, and in December the League dispatched Colonel Sven Lampell 'to look into the matter', alongside Phillippe Grand d'Hauteville, delegate for the ICRC.[101] There are surviving records of around ten reports and debriefing notes from Lampell

[99] Malkki, 'Speechless Emissaries', p. 390.

[100] UNHCR, Geneva: Western Sahara (1976-1981), Vol.1: Fonds 13/Sub-fonds 2/Box 22/ARC-2/C1: 'The refugees from Spanish Sahara in Algeria: Report on the Jaeger/Arnaout Mission to Algeria from 14 to 20 December 1975'.

[101] ICRC, Vernier: 999682, Confidential Note from Henrik Beer to Henri Tellier, National Commissioner of the Canadian Red Cross Society, 29 December 1975.

between December 1975 and July 1977. Other observers included MSF, as introduced above, and Christian faith-based representatives which will be addressed in more detail below. These observational missions did provide a fundraising function, and both the League and the UNHCR acted as a nexus point for connecting other states to the refugee camps through financial or material donations. But the extent to which they provided actual medical assistance is perhaps overplayed.

And these leading humanitarian institutions and actors from the UNHCR and the League were not alone in their observations. In addition to observation from prominent non-governmental and international organisations, other humanitarian players visited and observed the camps. For example, with a human rights concern introduced above, Madame Denis Payot, General Secretary of the FIDH in October 1976,[102] and Dr Tim Lusty, Emergencies Officer for Oxfam visited in June 1977.[103] Individual researchers also observed the refugee camps, but sometimes from a greater physical distance: Nils Gussing, for example, was engaged by the International University Exchange Fund and he visited Algiers—but not the camps—to meet with refugee and humanitarian representatives to deliver a report at the bequest of the Swedish Development Authority (SIDA).[104] Lastly, humanitarian observers joined forces on assessment visits with research agendas that may or not may have filtered into actual material contributions. For example, a Swedish Red Cross nutritionist accompanied Lampell in October 1976, to study the acceptability of Special Enriched Food (SEF) in the refugee camps. She also undertook some comparative nutritional studies of children below six years of age, compared to research undertaken during a previous visit in the Spring.[105]

Faith-based non-governmental organisations were present as observers, advocates, fundraisers, and donors. Christian institutional presence speaks to Johannes Paulmann's critique of the dominant narratives of the development of humanitarianism during the twentieth century. Paulmann argues that by framing secularization as a master narrative, the longevity and renewal of religious organisations involved in humanitarianism can be obscured by the modernization

[102] FIDH representatives visited the camps between 26 and 31 October 1976. BNA, Kew, FCO 93/1128, FIDH Letter to PM James Callaghan, dated 23 December 1976.

[103] I chose not to include analysis of this Oxfam report, as it applies to the period after the first year of emergency.

[104] IFRC, Vernier: 999682: Nils Gussing Report for International University Exchange Fund (Educational Assistance to Saharan Refugees), May 1976.

[105] IFRC, Vernier: Box: R509625967, Folder: ROP 7522: Sven Lampell Progress Report No.4, undated. Relates to a renewed mission to Algeria between 5th and 23rd October 1976.

narrative proposed since the 1960s.[106] Religious organisations would go on to play a very important role in the formation of the Sahrawi-constructed narrative of the refugees as 'ideal refugees', as religious moderates open to dialogue across faiths, for example, welcoming in evangelical Christians as providers of aid and advocates for the refugees in the 2000s.[107] At the time of the Sahrawi crisis, dialogue was underway between key Christian humanitarian thinkers and actors within the WHO, bringing practical ideas of Christian healing into dialogue with international medical policy for global health governance.

Roman Catholic relief and development agencies were prominent in the camps, in addition to Catholic leadership playing an important role as observers, fundraisers and advocates. In the months before October 1976, financial and material donations of a medical nature came from Caritas Spain, Caritas Belgium, Caritas Germany, Caritas Switzerland, Caritas Austria, and Secours Catholique (Caritas France).[108] An allocation of these funds (and those generated from a raft of additional organisations) was proposed to equip 20 centres for the medical care of infants (baby-scales, measuring equipment, notebooks, medicine, vaccines) as requested by the Sahrawi Red Crescent.[109] Additionally, Caritas Spain donated four tonnes of medicines.[110] Another Catholic organisation present in the camps, and acting as an intermediary between the World Council of Churches (WCC) and the refugees, was Rencontre et Développement (RD), an association created by members of the Catholic Church of Algeria in the 1970s. Caritas supported other auxiliary spaces with donations that could not be fully utilised, for example 'clinomobiles' purchased in Germany were donated by Caritas Spain. These mobile clinic units were sophisticated resources that included an operation theatre, X-ray facilities, washing

[106] Johannes Paulmann, 'Conjunctures in the History of International Humanitarian Aid during the Twentieth Century', *Humanity,* (Summer 2013), p.219. See also: Michael Barnett and Janice Stein, 'Introduction: The Secularization and Sanctification of Humanitarianism', in *Sacred Aid: Faith and Humanitarianism,* eds. Michael Barnett and Janice Stein (Oxford: Oxford University Press, 2012), p.2.

[107] Elena Fiddian-Qasmiyeh, 'The Pragmatics of Performance: Putting 'Faith' in Aid in the Sahrawi Refugee Camps', *Journal of Refugee Studies* 24 (3) (September 2011), pp. 533–547.

[108] IFRC, Vernier: Box 999682, ROP: 7522 Algérie: Réfugiés Sahraouis Q-Z Press General [File 2 of 2], 1975-1982, 'Caritas Algerienne & Rencontre et Developpement – Joint Programme for Sahraoui Refugees, Statement of Account at 31 October 1976'.

[109] IFRC, Vernier, R509625967, ROP 7522, 'Short notes from Mr. Lampell's debriefing – 5th March 1976'.

[110] IFRC, Vernier: Box 999682, ROP: 7522 Algérie: Réfugiés Sahraouis Q-Z Press General [File 2 of 2], 1975-1982, 'Caritas Algerienne & Rencontre et Developpement – Joint Programme for Sahraoui Refugees, Statement of Account at 31 October 1976'.

machines, and fridges. However, they could not be used due to a lack of technicians and medical personnel to operate the units.[111]

This action from the Catholic organisations appeared to be material. Yet, a key role of Catholic leaders attending the camps was to be observers. A delegation of church leaders from Algeria attended the camps in April 1976. The delegation included the Archbishop of Algiers (Cardinal Léon-Etienne Duval); the Bishop of Laghouat (Jean-Marie Raimbaud); Jacques Blanc, the President of the Protestant Church in Algeria and Secretary General of RD; and the Bishop of Oran and President of Caritas Algeria (Henri Teissier). This delegation was about knowledge-gathering—which we shall see enabled a fundraising cross-collaboration between the Catholic Church and the ecumenical WCC—but it was also an opportunity for the churches in Algeria to give 'the witness of a fraternity measurable by the ordeal and hope of an entire people': an opportunity to demonstrate solidarity and express hope for a better future.[112] The churches' reports that were attached to their appeals for funds reported on conversations with refugees and protests of refugees: they reported that even if the immediate and 'indispensable material aid'[113] (tents, food, basic medicines) could be provided, the refugees still needed 'the witness of a fraternity measurable by the ordeal and hope of an entire people'.[114] Member of the church delegation, Jacques Blanc, noted the unmet essential need was expressed by the refugees as 'their rights and justice; dignity is man's basic possession'.[115]

The cross-faith collaboration between the Catholic Church and the WCC continued into fundraising. In solidarity with their 'Roman Catholic brethren' an appeal was launched by CICARWS, a wing of the WCC.[117] CICARWS was a major channel of aid from the 271 Protestant, Orthodox and Anglican Churches in the World Council.[118] Political Scientist Laura C. Thaut explains how ecumenical organisations had broad reach and could enable extensive

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[111] IFRC, Vernier, R509625967, ROP 7522, 'Short notes on debriefing of Mr. Lampell', 23 June 1976.

[112] IFRC, Vernier: Box: R509625967, Folder: ROP 7522, Translated Report, 'Appeal of the Representatives of the Church in Algeria, Following Their Visit to Sahraoui Refugee Camps', (Appendix B), 13 April 1976.

[113] IFRC, Vernier: Box: 'Appeal of the Representatives of the Church in Algeria' (Appendix B), 13 April 1976.

[114] IFRC, Vernier: Box: 'Appeal of the Representatives of the Church in Algeria' (Appendix B), 13 April 1976.

[115] IFRC, Vernier: Box: R509625967, Folder: ROP 7522, 'Visit to Refugee Camps, Tindouf, 12 April 1976', (Appendix C), Notes taken by Jacque Blanc.

[117] IFRC, Vernier: Box: R509625967, Folder: ROP 7522, Muriel S. Webb, 'Dear Friends ... Western Sahara – Refugees', 3 May 1976.

[118] Janet Estridge Crawford, 'Rocking the Boat: Women's Participation in the World Council of Churches 1948-1991', (PhD thesis, Victoria University of Wellington, 1995), p. 210.

fundraising opportunities, a reality which was demonstrated by the fundraising efforts of CICARWS in the case of the Sahrawi refugee camps. Scholarship by Thaut challenges assumptions that Christian faith-based agencies are uniform in their theological beliefs and style of humanitarian mission. In the light of their theological roots, Thaut delineates three classifications of Christian faith-based agencies: 'Accommodative-Humanitarian, Synthesis-Humanitarian, and Evangelistic-Humanitarian agencies'.[119] Thaut classifies ecumenical organisations within the Accommodative-Humanitarian category, a form of humanitarianism grounded in the theology of 'Christ as Culture', stating that 'the "cultural" Christian emphasizes Christ as a reformer whose life serves as the model for living the Christian life *in* the world'.[120] In this category, ecumenical organisations tend to be more difficult to distinguish from secular operations because they do not emphasize explicitly faith-based missions. The focus of these organisations tends to be on assistance rather than an incorporation of proselytizing in its operations.[121] Whereas records from the church leaders' delegation to the Sahrawi refugee camps include notes of conversations with the refugees about their expressed desires for dignity, rights and justice as basic needs,[122] the CICARWS response overall did appear to have an 'accommodative-humanitarian' focus on immediate physical needs: tents, food, simple medicine, school equipment, and stoves.[123]

However, there is a largely un-told story of Christian subjectivities and medical humanitarian action relating to the WCC from the 1960s onwards, wherein Christian healing was linked to intra-national policymaking for global health governance at the WHO. The WCC established the Christian Medical Commission (CMC) in 1968, institutionalising a commitment to Christian healing through medical practice in 'the developing world'. The CMC was grounded in a belief that certain insights concerning the nature of health were only available within the context of Christian faith.[124] The CMC was founded with both functional and theological concerns.

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[119] Laura C. Thaut, 'The Role of Faith in Christian Faith-Based Humanitarian Agencies: Constructing the Taxonomy', *Voluntas: International Journal of Voluntary and Nonprofit Organizations* 20 (4) (2009), pp. 319-350.

[120] Thaut, 'The Role of Faith in Christian Faith-Based Humanitarian Agencies', p. 333.

[121] Thaut, 'The Role of Faith in Christian Faith-Based Humanitarian Agencies', pp. 319-350.

[122] IFRC, Vernier: Box: R509625967, Folder: ROP 7522, Translated Jacques Blanc Notes 'Visit to Refugee Camps, Tindouf, 12 April 1976'.

[123] IFRC, Vernier: R509625967: Notes by Jacques Blanc, RD: Appendix C: 'Visit to Refugee Camps', Tindouf, 12 April 1976.

[124] WCC, Geneva: 4215.1.2/12: Report on the activities and concerns of the CMC, 1974-1975; CMC, *The Healing Church (The Tübingen Consultation)* (World Council of Churches: Geneva, 1965), p. 35.

Functionally, it was charged with helping churches develop a Christian understanding of health and healing; to promote innovative approaches to health care; and to encourage church-related healthcare programmes to collaborate with each other.[125] Theologically, the Commission aimed to 'seek new insights into the interconnections between healing, the Gospel and the mission of the churches'.[126] The CMC placed central importance on the Christian healing — not just the healing of the individual, but the healing of communities — as a central foundation of medical humanitarian action. Discussing the conference that launched the CMC, James McGilvray, first Director of the CMC summed this principle up as follows:

> Tübingen 1 recognised that the Christian gospel was more concerned with the sick person than with the particular sickness and that the sick person was part of an environment and a community which also stood in need of healing. [127]

If the doctors of the sans frontières movement were using the Sahrawi refugee camps as a space and place to find and express their selves as doctors, for members of the CMC, humanitarian contexts for medical care were not just places to battle against sickness, but to battle against the powers of evil.[128] The existence of the CMC and its work in the developing world pushed the WCC towards a form of 'Evangelistic humanitarianism', not due to any missionary goals but because of its explicitly religious language and terms of reference, and its focus on using medical care for spiritual transformation.[129] In the 1970s the focus of the CMC had been the functional aspects of the Commission's task, which was hoped to be followed by a more systematic engagement with the theological challenges and implications of their work.[130] This functional approach of the Commission was reflected in the type of response made to the refugees by the WCC, but the theological underpinning demands recognition. For full discussion of the search for self by the sans frontières medics and the moral subjectivities that ground the desire for witnessing[131], future research should more explicitly consider the moral subjectivities of the

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[125] Gillian Paterson, 'The CMC Story, 1968-1998: Chapter One, The Quest for Health', *Contact (A publication of the CMC-Churches' Action for Health, World Council of Churches)*, no.161/162 (June-July and August-September 1998), p. 8.

[126] Gillian Paterson, 'A *Christian* Medical Commission', *Contact*, no.161/162 (June-July and August-September 1998), p. 15.

[127] Paterson, 'The CMC Story, 1968-1998', p. 6.

[128] Dr Charles H. Germany, Acting Geneva Secretary, Division of World Mission and Evangelism (DWME), 'Closing Meditation' in *The Healing Church (The Tübingen Consultation)* (World Council of Churches: Geneva, 1965), p.45.

[129] Thaut, 'The Role of Faith in Christian Faith-Based Humanitarian Agencies'. pp. 319-350.

[130] Paterson, 'A C*hristian* Medical Commission', pp. 15-18.

[131] Givoni, 'Humanitarian Governance', p. 63.

Christian faith-based organisations, allowing for revisions of the secularisation narrative of modern medical humanitarian action.

In the 1970s there was an institutional link between the CMC and the WHO which to my knowledge has not been fully discussed in the scholarly literature, further emphasising the continued importance of the influence of the Christian narrative in the formation of global health governance. Contemporaneously with the delegation and fundraising for the Sahrawi refugees, the CMC was developing a significant relationship with the WHO. Regular meetings between Dr Halfdan Mahler, Director-General of the WHO and CMC senior staff led to the publication of a WHO/UNICEF paper entitled 'Alternative approaches to meeting basic needs of populations in developing countries', which included 'some experimental work associated with CMC'.[132] The WHO's Principles of Primary Healthcare published in 1975 state:

> (iv) Primary health care should be an integrated approach of preventive, curative and promotive services for both the community and the individual.[133]

The role of states in developing health responses for the refugees

There is no doubt that the Western Sahara posed a complex political problem, globally and locally. Henrik Beer, Secretary General of the League was at pains to assure the League's neutrality and maintain good relations with all parties, including the Moroccan leadership, the Moroccan Red Crescent and the Mauritania Red Crescent.[134] Three states in particular—Algeria, Cuba, Libya—provided a medical assistance to the Sahrawi refugees. Contrasted with this, the USA, and Great Britain (two Western states that had interests in emerging models of international development opportunities in humanitarian crises, whilst being concerned with the creation of stable states in the Cold War period) were more concerned with maintaining allegiance with Morocco and maintaining neutrality in the conflict, respectively. Both states distanced themselves from the Sahrawi refugees and the humanitarian crisis and there was a significant absence of material and financial contribution to the Sahrawi refugees from these two

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[132] Paterson, 'The CMC Story, 1968-1998', p. 13.

[133] 'The Principles of Primary Health Care (WHO, 1975), reproduced in Gillian Paterson, 'The Quest for Health', *Contact,* no. 161/162 (June-July and August- September 1998), pp. 13-14.

[134] IFRC, Box: R509625967, Folder: ROP 7522 Algérie: Réfugiés Sahraouis Ligue Délégation ICRC

UN VOLAGS Press [File 1 of 2] 1975-1982: Henrik Beer, Memo to 'Information' [Department], April 13, 1976; Henrki Beer, Memo: 'Diary from Morrocco – 4th October', October 11, 1976.

states. Greater political alignment was key to the provision of state-led medical humanitarian support, which was provided by the host state, Algeria and distant friends, Cuba.

The United States 'quietly acquiesced that the Sahara be given to Morocco'.[135] In his examination of declassified records, political scientist Jacob Mundy argues that the administration of President Gerald Ford adopted an explicitly pro-Moroccan policy, based on a history of allegiance with the Moroccan state, but with policy-decisions often influenced by misinformation supplied by US Secretary of State, Henry Kissinger.[136] Mundy reaffirmed the relevance of international lawyer Thomas Franck's earlier work published in the autumn of 1976, that the US government's role in the Moroccan takeover as 'an act of political expediency grounded in East/West political alliances', perhaps aided by alleged Soviet distance from the Sahara in return for US 'reticence' in Angola.[137] Franck suggested America had reasons to be relieved that the Soviet Union was only offering limited aid to the POLISARIO, but other Communist powers, North Korea and Libya had capacity to provide support to the Sahrawi cause.[138]

The American allegiance to Morocco was to continue into the 1980s. Barbara Harrell-Bond reported that the US continued to supply arms and give support to Morocco's claim for the following six years.[139] The grip of the Cold War cannot be ignored in the case of the USA, and the UK's response to the UNHCR appeal demonstrated the state's maintenance of a strictly neutral stance at the expense of providing aid. The Sahrawi emergency also provides evidence of the continued influence of Cold War institutions upon policy decisions. Official records reveal that the Near East and Africa Department (NEAD) of the Foreign Office consulted with the Information Research Department (IRD) (established as a secret department, set-up to act in 'British interests' and to distribute anti-Communist propaganda in the UK and abroad[140]) about

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[135] Alice Wilson, *Sovereignty in Exile*, p. 19.

[136] Jacob Mundy, 'Neutrality or complicity? The United States and the 1975 Moroccan takeover of the Spanish Sahara', *The Journal of North African Studies*, 11 (3) (2006) pp. 275-306. Mundy outlines how Kissinger shared highly partisan readings of the dispute with Ford, and 'Further, Kissinger's assertion that Algeria's interest in the Sahara was rooted in access to the Atlantic, along with the total lack of background on the manifest desire for self-determination in the Spanish Sahara, meant that Ford was making a crucial decision with a very distorted picture of the actual situation': Ibid., p.301.

[137] Mundy, 'Neutrality or complicity?', p. 291.

[138] Thomas M. Franck, 'The Stealing of the Sahara', *The American Journal of International Law* 70 (4) (Oct 1976), p. 719.

[139] Barbara Harrell-Bond, 'The Struggle for the Western Sahara: Part I: Prelude', *American Universities Field Staff Reports* 37 (1981), pp. 1-13.

[140] Lyn Smith, 'Covert British Propaganda: The Information Research Department: 1944-77', *Millennium*, 9 (1) (March 1980), pp. 67-83.

the validity of the FIDH report, deeming it a non-impartial international body (although not a communist front) that did not require an official acknowledgement.[141]

The British government made two financial contributions to the UNHCR's appeal for funds: two payments of £20,000 were made, one in November 1976[142] and the second in March 1977.[143] These two payments effectively amounted to 1.1% of the total funds requested by Sadruddin Aga Khan, to cover a programme of humanitarian assistance in the refugee camps (estimated by the UNHCR at US$ 5,725,000).[144] The British government judged the two donations totalling £40,000 as an appropriate financial contribution, weighed against the political expediency of maintaining their neutrality in the conflict in Morocco, and avoiding explicit or implicit support to the claims of the POLISARIO to Western Saharan territory. By a British state official's own admission, when compared to international donations from the Scandinavian and Dutch governments, the British contribution was comparatively small.[145] It is also important to note that the two payments were made directly to the British Red Cross (BRC) rather than to the UNHCR in response to the campaign. A letter dated 15 December 1976 from a representative of the British Ministry of overseas Development clarified that it was appropriate that the contribution be sent to the BRC to 'follow the existing precedent and partly because this may avoid direct comparison between the modest sum which we envisage and the possibly larger contributions which others may be making to UNHCR'.[146] Both donations were then distributed to the Algerian and Moroccan Red Crescent Societies: the proportion directed to the ARC was reportedly spent on locally purchased food stuffs.[147]

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[141] BNA, Kew: FCO 93/1128: Correspondence G.R. Lawes to F. Wheeler, 25 January 1977.

[142] BNA, Kew: OD 66/71: E/81, 'Official receipt', 15 November 1976.

[143] BNA, Kew: OD 66/71 no. 98. Letter from Ray Allen NEAD to Miss S. Quinn, British Red Cross, 22 March 1976. It should be noted that the British government did make further donations to the crisis after 1976, but I have focused on the donations made during the first 18 months of the crisis as these relate directly to the first two years of the crisis under discussion in this chapter.

[144] BNA, Kew: OD 66/71: UNHCR Correspondence, 25 October 1976. Exchange rates were calculated using Bank of England Spot Exchange Rates online: https://www.poundsterlinglive.com/bank-of-england-spot/historical-spot-exchange-rates/gbp/GBP-to-USD-1976 [Accessed 8 February 2018].

[145] BNA, Kew: OD 66/71, no. 53: Minute reporting $200,000 donation from Sweden; BNA, Kew: OD 66/71: no. 53: The Dutch reported to have donated Fls. 880,000 in aid (500,000 via Netherlands Red Cross and baby food and milk powder valued at Fld. 330,000); BNA, Kew: OD 66/71: no.38: Danish Red Cross Telegram reporting donation of 200,000 Kroner.

[146] BNA, Kew: OD 66/71: Correspondence from J V Kerby to G.R Lawes, NENAD at the FCO, 15 December 1976. BOX:

[147] BNA, Kew: OD 66/71: Correspondence from League (J.P. Robert Tissot, Director Relief Operations Bureau) to BRC (Mr. P.A. Adams, Director of International Aid), 15 November 1976.

Whereas the contribution of the British government may have been small and specific, the BRC was active in the Sahrawi camps in their first year, and it donated medical equipment including five ambulance conversions and seven Landrover vehicles.[148] In addition to being an intermediary between the refugee camps and the British state, the BRC acted as a channel for other organisations: supplying materials donated by charities and channelling pharmaceutical philanthropy. To the refugees, the BRC channelled donations from Cafod and War on Want, including donations of aspirin, codeine, terramycin, and chloramphenicol ophthalmic preparations[149]; the society received an offer of penicillin with one to two months' remaining before expiry[150]; and medicines donated by Glaxo Laboratories to the value of almost £8,000.[151] These small-scales examples of pharmaceutical philanthropy again places private companies in the humanitarian space, this time of the Sahrawi refugee camps. Further donations were made to the IFRC from Sandoz Ltd., a Swiss pharmaceutical company established in 1886 and famed for modern calcium therapy[152]: thirteen medicaments were made available to the Saharawi campaign through the network of relief efforts.[153]

The key states contributing to medical assistance to the refugees were closer political friends to the refugees: host state Algeria and distant friend, Cuba. Both states provided personnel, services, and contributed to medical infrastructure in the Sahrawi refugee camps. These two states, Algeria's humanitarian affiliate the ARC, and the Cuban International Medical Corps, energised the humanitarian system into action in Tindouf. Other states did contribute through medical personnel (for example Libya[154]), and goods and services were provided via multiple Red Cross societies in addition to the BRC, including the Australian, Swiss, Danish, Swedish and Finnish societies. From a medical perspective, donations appeared relatively small, but they

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[148] IFRC, Vernier: 999682, 7522: Paul A. Adams (Director of International Aid, BRC) to Jurg Vittani [Director, Relief Supplies Bureau, the League], 15 April, 1976.

[149] IFRC, Vernier: 999682, 7522: TELEX BRC to League, 30 January 1976.

[150] IFRC, Vernier: 999682, 7522: TELEX: BRC to League, 22 January 1976.

[151] IFRC, Vernier, 999682: Telex 7/12/76.

[152] SANDOZ [Online], 'Our History', <https://www.sandoz.com/about-sandoz/our-history> [Accessed 13 August 2023].

[153] IFRC, Vernier: R509625967, 7522: Memo from Jurg Vittani "Second donation of medicaments from Sandoz, Basle", 7 May 1976.

[154] IFRC, Vernier, R509625967, ROP 7522, 'Short notes on debriefing of Mr. Lampell', 23 June 1976. The League believed a Libyan medical team were active in the camps, in the Robinet area: but I have found little evidence to corroborate or expand on this observation. A Libyan presence would not be surprising in this context, given the influence of Muammar Gaddafi's revolutionary model upon the administrative structure of the Sahrawi state movement in the early period of its formation. See: Alice Wilson, *Sovereignty in Exile*, p.23.

included (respectively by national society) cash, feeding products such as Superamin, surgical and medical equipment, Semper I products (high energy food for children) and milk powder.[155]

Algeria

Close geographical proximity and political sympathies with the Sahrawi refugees led Algeria to not only host the camps, but to assume a leading role in both provision and coordination of medical assistance. In terms of preventative care, the Algerian government provided a vaccination campaign managed and run by two teams of Algerian medical students. The programme, reported by MSF/L'appel, was successful in vaccinating children against cholera, whooping cough, BCG, measles, diphtheria, polio and tetanus.[156] It is significant that the Algerian state led the way with immunisation, as this was an era in which the global forces for health (and the WHO) were experiencing the success of controlling and eradicating infectious diseases. Yet, in the Sahrawi case, the WHO is barely mentioned in the sources relating to the Sahrawi camps in the IFRC (International Federation of the Red Cross) archives and the British state archives. The Algerian Ministry of Health also gave refugees access to a hospital in the city of Tindouf.[157] This hospital space was a resource available to the Sahrawi refugees – if they could reach it. Logistically, for the most severe cases, it was reported by MSF to be very difficult to transfer injured persons to the hospital.

> Il existe une infirmerie militaire qui prend en charge les problèmes assez simples et la convalescence des blessés opérés à l'hôpital de TINDOUF.
>
> Cependant, les malades blessés dans "l'ex Sahara Espagnol " doivent subir un transfert de 10 à 15 jours avant de rejoindre l'hôpital de TINDOUF, et bien sûr seuls les cas les moins graves et les sujets les plus forts survivent, si bien que peu de blessés arrivent. Lors de grands bombardements, 292 blessés ont été admis ; actuellement, sont hospitalisés à TINDOUF 20 blessés et 15 sont convalescents à l'infirmerie militaire sahraouie.[158]

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[155] IFRC, Vernier: 999682: N. Minogue, Australian Rec Cross to League, 6 February, 1976; A. Wenger, Swiss Red Cross Relief and Social Welfare Department to League, 1 October 1976; Telex, 15 January 1976; Claes-Goran Landergren, The Swedish Red Cross to League, 7 December 1976; 'Acknowledgement of Contribution', 31 January 1983.

[156] IFRC, Vernier: 999682. L'appel and Médicins Sans Frontières (MSF), 'Rapport Medical Sur Les Besoins Des Populations Sahraouies', 23 June 1976.

[157] IFRC, Vernier: 999682: L'appel and Médicins Sans Frontières (MSF), 'Rapport Medical Sur Les Besoins Des Populations Sahraouies', 23 June 1976.

[158] IFRC, Vernier: 999682: L'appel and Médicins Sans Frontières (MSF), 'Rapport Medical Sur Les Besoins Des Populations Sahraouies', 23 June 1976.

> There is a military infirmary that takes responsibility for relatively simple problems, and the convalescence of wounded persons operated on at the hospital in TINDOUF.
>
> Meanwhile, invalids wounded in the 'former Spanish Sahara' must endure a transfer of 10 to 15 days before reaching the TINDOUF hospital, and of course only the least serious cases and the strongest individuals survive, such that only a small number of wounded arrive. During major bombardments, 292 wounded were admitted; at the moment, there are 20 wounded hospitalized at TINDOUF and 15 are convalescing at the Sahrawi military infirmary.

MSF reported that during a period of bombardment at the beginning of the mass displacement, over 200 people were admitted for medical care, yet only a small proportion were hospitalised in Tindouf. Of those wounded in former Spanish Sahara territory, only the least severe cases, or the strongest patients, survived the 10 to 15 days it took to transfer a patient from conflict zones within the ex-Spanish Saharan territory to the hospital in Tindouf.[159] Closer to the camps themselves, following an influx of refugees around mid-February 1976, the Algerian Ministry of Health and the Army Health Organisation organised a children's hospital in Tindouf with eight Algerian doctors and 30 nurses. By June, the refugee-built brick field hospital in Robinet, (25 km southwest of Tindouf) had replaced tented accommodation and was reportedly equipped by the Algerian Ministry of Health, staffed by two Algerian doctors plus nurses.[160]

According to the initial reports of the League delegation, the ARC assumed responsibility for the refugee relief as early as October 1975 which constituted the first medical humanitarian response for the refugees.[161] Working according to a government mandate, assured in accordance with the Algerian National Disaster Preparedness strategy,[162] the ARC was an essential nexus point within the mesh of humanitarian organisations, collecting and distributing donations and relief. Created only twenty years previously, in 1957, the ARC was born from a strategic attempt on behalf of the National Liberation Front (Front de libération nationale; FLN) to align the Algerian independence struggle with the rhetoric of human rights and humanitarianism that was taking

[159] IFRC, Vernier: 999682: L'appel and Médicins Sans Frontières (MSF), 'Rapport Medical Sur Les Besoins Des Populations Sahraouies', 23 June 1976.

[160] IFRC, Vernier: R509625967: Unauthored, 'Short notes on Mr Lampell's debriefing', 8 June 1976. IFRC, Vernier, R509625967, ROP 7522, 'Short notes on debriefing of Mr. Lampell', 23 June 1976.

[161] IFRC, Vernier: R509625967, ROP 7522, 'Short notes on Mr. Lampell's debriefing', 8 January 1976.

[162] IFRC, Vernier: 999682: Nils Gussing Report for International University Exchange Fund (Educational Assistance to Saharan Refugees), May 1976.

root internationally.[163] Historian Jennifer Johnson argues that the FLN attempted to internationalise the conflict, not only by developing a domestic health-service division as part of this appropriation of the new universal discourse of rights, but that it also created the ARC as part of an expansion of a medical division capable of operating beyond Algeria's borders.[164] By creating an image and reputation of being an internationally recognised symbol of humanitarianism, 'the FLN demonstrated it was conversant in a particular language [of human rights] dating back a century'.[165] By developing its international humanitarian legitimacy and plugging into the global network of the Red Cross and Red Crescent movement, the ARC was able to develop its standing as a diplomatic player in the Algerian War.[166] These strategically placed, ideological roots laid by the FLN and ARC enabled the society to become a successful humanitarian fundraiser, and an institution well-placed to be an efficient, supportive partner to the Sahrawi refugees, and the fledgling Sahrawi Red Crescent, by the mid-1970s.

The ARC was credited by the League for its rapid establishment of an administration for managing relief goods and services. The society set-up and organised five working committees by February for administration of refugees, registration of refugees, assessment of needs, the reception and distribution of relief, and matters of 'control'.[167] The ARC was not, however, without its critics. Lampell considered its bureaucracy too heavy, with too many operational details being decided in Algiers despite a decision to locate a person with full authority and responsibility in Tindouf.[168]

As introduced above, there are few traces that Sahrawi camps were subject to any Western Development policy-agenda, at least not in the first year of its crisis. And in relation to development agendas of the host nation, despite Algeria's attempts to focus the post-independent state on industrialisation, there were no signs of the camps being co-opted by regional development or state industrialisation agendas. Between 1966 and 1971, post-independence Algeria progressively nationalised oil and gas, banking, insurance, manufacturing

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[163] Jennifer Johnson*, The Battle for Algeria; Sovereignty, Health Care, and Humanitarianism* (Philadelphia: University of Pennsylvania Press, 2015) p. 197.

[164] Johnson, *The Battle for Algeria*, p. 197.

[165] Johnson, *The Battle for Algeria*, p. 198.

[166] Davey, *Idealism beyond Borders*, p. 56

[167] IFRC, Vernier: Box: R509625967, Folder: ROP 7522, Sven Lampell, 'Progress Report No.1', 6 February 1976.

[168] IFRC, Vernier: R509625967, ROP 7522, 'Short notes on Mr. Lampell's debriefing', 8 January 1976.

and followed a development policy that prioritised investment over consumption, industry over agriculture.[169] In the Sahrawi case, neither do we see the workings of development in the guise of which James Ferguson calls, an 'anti-politics machine'. Ferguson's research of the Thaba-Tseka development project in Lesotho, which ran from 1975 to 1984, discussed an exercise in expanding bureaucratic state power through the institutionalisation of development ideas.[170] Healthcare and medical humanitarian services to the Palestinian camps were bound-up with the agendas of economic development, and the Palestinian refugees were directly called upon to contribute to the economies of their host countries. But not in the initial months of crisis. And that experience appeared to be mirrored in the case of the Sahrawi camps.

Cuba

The other notable state-led medical intervention in the Sahrawi camps came from Cuba, a state whose role in the histories of medical humanitarian action has been under-discussed, particularly in the case of the Western Sahara. A brief diversion into this state-led contribution is necessary for understanding the motivations of certain states for international humanitarian contributions, which in the Sahrawi case is an important contrasting case of intervention by a state that was not necessarily dependent on the rules of the globalised Development game.

Cuba's landmark deployment of health workers to Algeria in 1963 was one of the earliest deployments of Cuban doctors and nurses.[171] This deployment not only marked the beginning of a historic military and medical relationship during and after the Algerian revolution, but the ramping up of Cuban global medical interventions into the next few decades. Following Algeria, Cuba's support for African liberation movements stretched to several nations: Congo-Brazzaville, Guinea, Sierra Leone, Equatorial Guinea, Somalia, and Angola, formalising the state's international medical aid missions. These medical actions were based on the application of human labour, hands-on application of service rather than capital intensive development policies tied to modernisation programmes.[172] Cuba deployed significant forces, both military and

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[169] John Ruedy, *Modern Algeria: The Origins and Development of a Nation* (Bloomington: Indiana University Press, 1992).

[170] James Ferguson, *The Anti-Politics Machine: "Development", Depoliticization and Bureaucratic Power in Lesotho* (London: University of Minnesota Press, 1994).

[171] Piero Gleijeses, 'Cuba's First Venture in Africa: Algeria, 1961–1965', *Journal of Latin American Studies,* 28 (1) (1996), pp. 159-195.

[172] John M. Kirk and H. Michael Erisman. eds, *Cuban Medical Internationalism: Origins, Evolution, and Goals* (Basingstoke and New York: Palgrave Macmillan with the Institute for the Study of the Americas, University of London, 2009).

medical, to the civil war in Angola, in numbers which were reported to peak at about 35,000.[173] Furthermore, continuing the experience of internationally sponsored vaccination campaigns, trilateral solidarity between Cuba, insurgents in Zaire, and allies in Moscow led to a significant vaccination campaign in which Havana and Moscow sent and administered 61,000 doses of polio vaccine to children in Zaire in 1965, representing what Kirk and Erisman argue was the first mass vaccination programme undertaken in Africa.[174]

Kirk and Erisman account for 25 Cuban development aid personnel operating in Algeria in 1977, and 50 individuals a year later, but they do not account for development aid personnel in the Western Sahara until 1986.[175] However, given the difficulties in defining what constitutes Western Saharan territory during this conflict, and the shifting spaces of refugee camps in 1975 and 1976, it is conceivable that this data is simply missing and Cuban personnel were working earlier in refugee and displaced persons camps prior to the mid-1980s. Political scientist Julie Feinsilver suggests that a Cuban medical aid programme in the 'Saharan Arab Republic (Polisario guerrillas)' began in 1977.[176] San Martín documents that Cuban medical teams attended the camps in the very early days of the crisis, as the 'only international doctors' working alongside MSF.[177] But I have yet to corroborate any details of what their medical activities entailed. The data presented by Feinsilver relate to direct medical care in the host country Algeria, and Feinsilver herself acknowledges the difficulty in gaining access to information that distinguishes between the different kinds of medical assistance provided to recipients.[178]

What were the motivations of the Cuban state for advancing medical relief on an international stage? Feinsilver proposes a semiotic approach wherein battles forged by the Cuban revolutionary state – including wars against communicable diseases – were essentially part of a

[173] Kirk and Erisman, *Cuban Medical Internationalism.*

[174] Kirk and Erisman, *Cuban Medical Internationalism,* p.71.

[175] H. Michael Erisman, *Cuba's International Relations: The Anatomy of a Nationalistic Foreign Policy* (Boulder, CO: Westview Press, 1985), pp. 78-79.

[176] Julie M. Feinsilver, *Healing the Masses, Cuban Health Politics at Home and Abroad* (Berkeley and Los Angeles: University of California Press, 1993), p160. In relation to the statistics concerning medical action taking place from 1977, Feinsilver references the following source: Dirección de Colaboración Internacional: "Cuba: 25 años de colaboración internacional," 5-6.

[177] San Martín, *Western Sahara*, p.110.

[178] Feinsilver, *Healing the Masses.*

narrative struggle against imperialism (or, the United States more specifically) and underdevelopment. She surmises:

> The health of the individual is a metaphor for and symbol of the health of the "body politic," and in which the achievement of the status of "world medical power" is synonymous with victory over the imperialists. Medical doctors are the protagonists in this war both at home and abroad.[179]

Other potential motivations range from 'a sincere concern for the betterment of people's lives'[180], to a means for establishing ties with other countries and increasing 'Cuba's symbolic capital among governments, international organizations, and intellectuals who, in the Third World, often play an important role in the formation of public opinion and public policy'.[181] The accompaniment of medical aid with military assistance, was often questioned on humanitarian grounds by parties in the west who saw Cuba as a state backed by the Soviet Union to provide military support to liberation movements in Africa.[182] Other probable motivations included the opportunity to repay debts for assistance to Cuba's own struggle; as a diplomatic opportunity for peace and legitimacy of the state; for boosting trade relations; and later (after 1977 when assistance was chargeable if the host could afford to pay) as an opportunity to earn hard currency.[183] Kirk and Erisman suggest that 'Cuban medical internationalism is not solely used to score political points abroad',[184] but rather operated on the moral tenets that were anti-imperialism, socialist principles, belief in the inalienable right to healthcare, while medical (and developmental) aid programmes served as vehicles to enact this moral landscape.[185] The feeling remains that the presence of Cuban medics provides an interesting twist to the medical history of the Sahrawi camps, and one that was a step-aside from the globalising Development agenda. But the Cuban 'feet on the ground' were limited and fleeting. A more indelible impact was created by a state-led movement much closer to home.

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[179] Feinsilver, *Healing the Masses,* p.22.

[180] Feinsilver, *Healing the Masses,* pp.182-183.

[181] Feinsilver, *Healing the Masses*, p.156.

[182] Grundy P.H., Budetti P. P., 'The distribution and supply of Cuban medical personnel in Third World countries', *American Journal of Public Health* 70 (7) (1980), pp.717–719.

[183] Feinsilver, *Healing the Masses*, pp.182-183.

[184] Helen Yaffe, 'John M. Kirk and H. Michael Erisman (eds), Cuban Medical Internationalism: Origins, Evolution, and Goals (Basingstoke and New York: Palgrave Macmillan with the Institute for the Study of the Americas, University of London, 2009)', *Journal of Latin American Studies* 43 (1) (2011), pp. 193-195.

[185] Yaffe 'John M. Kirk and H. Michael Erisman'.

The Sahrawi state-movement and the Sahrawi Red Crescent

Supported by its allies, the most significant architect of the shape and nature of medical services in the refugee camps was the Sahrawi refugee state-in-exile itself. Whereas not an independent state like Algeria or Cuba, the POLISARIO liberation movement and the SADR governing body together constitute a governing authority which anthropologist Alice Wilson refers to as a 'state-movement'.[186] And because of its state-like characteristics and state-aspirations, it belongs within this discussion of state-led humanitarian action. Alice Wilson examines the complex relationships tied-in to the state-movement's attempts at unmaking of tribes (qabīlah) and the making of state power. In its creation of institutions and its shaping of spaces and places, the state-movement influenced how healthcare was configured in the refugee camps. Not only was there an attempt by the state-movement to influence the governing character of the camps and mould Sahrawi society in exile, but in these processes the state-movement influenced the development of medical facilities and spaces for healthcare. Whether this shaping of society constituted unwanted or forced structures of control, or whether they reflected popular demands is discussed in the literature.[187] However, administrative efforts of the state-movement effected rapid change and the development of a medical service better able to care and support the refugees. This was first evidenced in the displaced persons camps in the ex-Spanish Saharan territory in the early months of the emergency.

The creation of structured state-led medical and healthcare and delivery of medical care began very early in the state-in-exile's history, during the first few months of emergency. And in these early months it is evident that the movement was planning for the longer-term as well as responding to short-term medical needs. Wilson argues that the design and physical layout of the refugee tents, neighbourhoods, and the administrative structures (including places of work) of the camps were originally meant to mix-up the refugees, rather than congregate clusters of refugees by tribe, status group, or place of residence prior to exile.[188] She argues that in the early

[186] Wilson, *Sovereignty in Exile,* p 2. The Western Sahara has been recognised by the UN as a non-self-governing territory since 1964. A twenty-first century reading of the Sahrawi Arab Democratic Republic (SADR) presents it as what Irene Fernandez-Molina and Raquel Ojeda-Garcia term 'a hybrid between a parastate and a state-in-exile' due in part to its control over a portion of Western Sahara's territory. The territorial boundaries of the emerging Western Sahara in 1975-1976 would have been very unstable, so it remains helpful to consider the state-movement as very much this, a moving, fluid entity. See: Fernández-Molina, Irene, and Raquel Ojeda-García. "Western Sahara as a Hybrid of a Parastate and a State-in-Exile: (Extra)Territoriality and the Small Print of Sovereignty in a Context of Frozen Conflict," *Nationalities Papers,* vol. 48, no. 1, (2020), pp. 83–99.

[187] San Martín*, Western Sahara*.

[188] Wilson, *Sovereignty in Exile*, p. 22.

revolutionary period (from 1975 to 1991) various physical structures, including the tents themselves, were arranged in ways to disrupt the nomadic pasturelands encampment style (known as frīg), which were manifestations of the tribal-community hierarchy of living.[189] This engineered reinforcement of social egalitarianism through the physical layout of the camps was also reinforced by the emplacement of health services (and other administrative services) at the centre of each province (wilāyah), and therefore at the 'front' of each constituent square district (dawāir).[190] Health services were therefore instrumental in enforcing the new status quo, and in their positioning these services became central resources accessible to all in spite of any remaining tribal hierarchy. Wilson describes: 'The camps situated persons within the social relations of the state-movement, effectively overwriting the segmentation that previously situated persons within the social relations of the qabīlah'[191].

Furthermore, the design of camp life extended beyond physical structures. Each refugee was asked to assume dual responsibilities within the state-movement by becoming a member of both an administrative committee and a political cell.[192] Wilson suggests that the state-movement was heavily influenced by the model of Prime Minister Muammar Gaddafi's Libya, including the adoption of Libyan style popular committees, tight political controls and repression of political opposition.[193] She references five Popular Committees that underwent reform from the mid-1980s to the mid-1990s, including the Red Crescent (responsible for distributing rations) and Healthcare.[194]

In fact, the foundations of this Sahrawi-led administrative system were laid during the very early movements of people within the Spanish Saharan territory and camps sheltering those internally displaced, and those journeying to the camps in Tindouf. This is evidenced in the reports from the League's special assistant, Sven Lampell, who reported that by February 1976 the POLISARIO had established an administrative system across the conflict-affected territory wherein each camp had a committee with representatives from various 'sides of community life'

[189] Wilson, *Sovereignty in Exile*.

[190] Wilson, *Sovereignty in Exile*, p. 63.

[191] Wilson, *Sovereignty in Exile*, p. 63.

[192] Wilson, *Sovereignty in Exile*, pp. 66-68.

[193] Wilson, *Sovereignty in Exile*, p. 23.

[194] Wilson, *Sovereignty in Exile*, p. 66.

including education, finances, security, distribution, and crucially—health.[195] The overall assessment of healthcare in the Algerian-based camps was positive as early as January 1976, compared to a bleak assessment of camps within the ex-Spanish Saharan territory. Regarding these camps for internally displaced people (many of which were en route to the camps in Tindouf), Martir El Hasch, a camp of 1,500 inhabitants, (335km WSW of Tindouf): no services; Bir Lehlu, 4,000 inhabitants (230 km SW of Tindouf): a medical student and a few paramedical assistants but no equipment or medicine; Amhairiz, 12,000 inhabitants (460km WSW Tindouf): 'in principal, nothing'.[196] However, by February (1976) the League reported that each camp had an organised dispensary combined with a tent hospital. These facilities, despite their lack of medicines and staff profile of medics lower down the professional hierarchy (one or more medical students assisted by a varying number of nurses and helpers) was a great improvement on the situation reported less than two months earlier.[197]

> I can find no other explanation to the phenomenon that the [health] situation has not worsened as feared but the natural resistance and immunity of these people combined with the fact that the unlimited space available for organising the camps has compensated for the lack of sanitary arrangements. It can possibly also be referred to the spectacular efforts that have been made with regard to the medical facilities. The situation has namely improved a lot insofar as organisation and personnel is concerned.[198]

Lampell accredited the ARC with improvements in the ex-Saharan territory. But on Algerian soil, in terms of infrastructural design, this was not led by external humanitarian actors. The Sahrawi state-movement was concerned with creating an egalitarian structure within the camps' physicality and society, and the development of a medical services and a system of clinics across the camps reflects this.

The earliest evidence of state-movement camp administration within Algerian territory was confirmed by a delegation of Christian leaders in April 1976, which suggested that barely three to

[195] IFRC, Vernier: Box: R509625967, Folder: ROP 7522, Sven Lampell, Progress Report No.1, 6 February 1976.

[196] IFRC, Vernier: R509625967, ROP 7522, 'Report on Survey of Refugee Situation in Algeria, December 10-20, 1975', 9 January 1976.

[197] IFRC, Vernier: R509625967, ROP 7522, 'Progress Report No.1', 6 February 1976. This report relates to a mission carried out 12-22 January 1976.

[198] IFRC, Vernier: R509625967, ROP 7522, 'Progress Report No.1', 6 February 1976. This report relates to a mission carried out 12-22 January 1976, p. 5.

four months into the crisis, the camp organisation was established across all 16 camps.[199] The delegation met with SADR Sahrawi National Council officials and reported that each camp had a nominated representative for each sphere of life: health, teaching, food, security, and administration. Furthermore, the same structure — for which the government was responsible — was to be found at the province/wilāyah level, and also for the groups of camps as a whole.[200] The formation of this unique camp structure is also reported by Lampell following the 3rd National Congress of the POLISARIO in August 1976.[201]

Furthermore, what is distinct about the official camp structuring is how the structure and administrative system of living was designed to mirror the communities and villages of the Western Sahara. Three separate, large-scale residential provinces/182ilayat were created and named after cities in the Western Sahara: Elayoune (also spelt Elaaium), Smara, and Dakla.[202] The provinces were made up of eight, seven, and four refugee camps, respectively. Each province administration was responsible for the camps allocated to it, and individuals were appointed as responsible for the various sectors of administration, and it was planned that these assigned individuals would continue with their assigned roles and responsibilities following their return to Western Saharan territory of the same name.[203] With what Agier calls 'toponymic transposition': 'a reproduction ... of places and institutions of the land of origin into those of the camps',[204] the state movement created a system which could be picked-up, transported, and transplanted into the territories In the Western Sahara on their return from exile. Those people appointed responsible for administration 'on different levels' were appointed to be those who would continue their responsibilities after their return to the Western Sahara and there was a degree of movement to ensure people would be 'in place', living and working in the area they would return to of the same name in the Western Sahara.[205] The map and appendix published in

[199] IFRC, Vernier: Box: R509625967, ROP 7522, Translated Report from Jacques Blanc, 'Visit to Refugee Camps, 12 April 1976'.

[200] IFRC, Vernier: Box: R509625967, ROP 7522, Translated Report from Jacques Blanc, 'Visit to Refugee Camps, 12 April 1976'. I assume that by 'government' the delegation representative is referring to the SADR given that the notes follow a meeting with, among others, Mr. Mahfoud Laroussi, Minister of the Interior and of Justice of the Democratic Arab Republic of the Sahraoui.

[201] IFRC, Vernier, R509625967, ROP 7522, 'Short notes on debriefing of Mr. Lampell', 23 June 1976.

[202] IFRC, Vernier: R509625967: Sven Lampell, Special Assistant, Progress Report No.4: Refugees in Algeria; report submitted following mission to camps 5-23 October 1976. See also, Alice Wilson, *Sovereignty in Exile*, p. 25.

[203] IFRC, Vernier: R509625967: Lampell Progress Report No.4 (visit 5-23 October 1976), undated.

[204] Agier, *Managing the Undesirables*, p.78.

[205] IFRC, Vernier: R509625967: Lampell Progress Report No.4 (visit 5-23 October 1976), undated.

Lampell's report from his October mission details the new names for the refugee camps situated on Algerian land, including Daora, Hagunia, Amgalla, and Edchera.[206]

Within the camp structure, various healthcare facilities were built by the refugees themselves, for example the hospital in Robinet and a further hospital in Bel Agra, to support a population of 8,000.[207] The pace of development from tents to more permanent, brick structures suggests that the refugees were not held back by concerns of putting down roots in permanent structures which may undermine their claims of a right to return to territory in the Western Sahara. This was in stark contrast to the experience of the Palestinian refugees.

From the beginning of the refugee crisis, the SRC was at the heart of the state-movement's structures, predominantly through the distribution of emergency rations. Set-up under the protection of the ARC, the SRC was a fledgling society which had not sought official recognition from the League.[208] The ARC offered support to the SRC, bringing SRC delegates, President Ahmed Salek and Vice-President Ali Mahmoud to visit UNHCR officials in Geneva as early as 8 December 1975.[209] The SRC acted as a partner society to the ARC on the ground, and despite aid provision flowing from Algeria and later from the international community, the distribution of aid through the SRC meant the refugees were dependent on the efforts and provision of this society as an instrument of the state-movement.[210] The state-movement offered a framework, onto which the SRC could bolt-on and develop its activities of relief distribution in parallel to the POLISARIO's administrative structure of the camps. At regular intervals (in June 1976, August 1976, and December 1976) the SRC issued its own appeals for funds and support from the international community; attached to the letters outlining the SRC appeals were long lists of specific medicines needed in the refugee camps.[211] These detailed lists signified that the SRC

[206] IFRC, Vernier: R509625967: Lampell Progress Report No.4 (visit 5-23 October 1976), undated.

[207] IFRC, Vernier, R509625967, ROP 7522, 'Short notes on debriefing of Mr. Lampell', 23 June 1976.

[208] IFRC, Vernier: 999682: 7522. Correspondence Henrik Beer to Henri Tellier, National Commissioner for the Canadian Red Cross, 29 December 1975. Also letter from Belen Landaburu Gonzalez, Spanish Red Cross to Henrik Beer, replying to this letter on 8th of the month [undated letter]: considers that the SRC did not have international status at this point due to current territorial debates and processes of decolonialisation.

[209] ICRC: 410.ICRC.WSH:NGOS: ICRC, Spanish Sahara. Outgoing Cable, UNHCR (Jaegar) to ICRC: 8 December 1975.

[210] Alice Wilson, *Sovereignty in Exile*, p. 70.

[211] IFRC, Vernier: 999682, Folder: ROP 7522 Algerie: Refugies Sahraouis A-E [File 2 of 2] and IFRC-V, R509625967, 7533 (1/2), 'Liste indicative de medicaments de première urgence', 4 December 1976.

were legitimate humanitarian leaders in the camps; the lists showed that the SRC held extensive knowledge about what the people needed.

The capacity of the Sahrawi people to govern and organise themselves in exile—and lead the development of their own medical infrastructure—was possible because the Sahrawi political leadership and its institutions were established much earlier than the mass displacement of the people across the border into Algeria. Independence movements in the Western Sahara gained momentum in the 1950s and 1960s with the Movimiento Para la Liberación del Sahara, and its strategic focus on individual action. A more unified and centrally organised resistance movement established itself in the POLISARIO, founded in 1972, which engaged in active conflict against Spanish state targets. Following Spanish withdrawal from the Western Saharan territory in November 1975, and the cession of control to Morocco and Mauritania, the POLISARIO redirected its fight to the nations it considered new invaders and the POLISARIO declared the SADR on 27 February, 1976.[212] A comparison can be made here with the Palestinian political experience. In contrast, the Palestine Liberation Organization (PLO) was founded in 1964, much later than the early refugee post-conflict crisis, and was recognised in 1974 by the UN as the 'sole and legitimate representative of the Palestinian people', much later in the development of the Palestinian refugee timeline.[213] This may partially explain why the Palestinian refugee camps did not experience the same state-in-exile development of medical infrastructure.

Chapter Four Conclusion

Between 1975 and 1976, during the first year of the Sahrawi refugee crisis, the refugees faced health and medical challenges within a landscape of globalised international humanitarianism. This landscape was moulded by well-established organisations ready to assist, to manage, to control, to heal. Furthermore, new forms of sans frontières medical humanitarianism were beginning to take prominence. With a perspective firmly on medical humanitarianism, there are two, somewhat contradictory ways of seeing the first year of the Sahrawi refugee crisis. On the one hand, this was a year of unmet emergency in which familiar patterns of undercare were laid down. On the other, this was an exceptional humanitarian and refugee experience in which a diverse range of international actors did play a material role (MSF, Caritas organizations, the leading role of Algeria and the ARC with Cuban assistance) yet the refugees themselves (and the

[212] Manuel Herz, *From Camp to City, Refugee Camps of the Western Sahara* (Zürich: Lars Müller Publishers, 2013), pp. 73-75.

[213] Feldman, *Life Lived in Relief*, p.15.

SRC organization) acted as creative agents of change and set up a system of medical infrastructure that could support the refugee community.

There is truth in both sides. Agier argues that 'despite its globalism, this world only ever exists in local forms, though none of the spaces of this apparatus falls outside the great network of humanitarianism'.[214] In the case of the Sahrawi refugee camps, they did not fall outside the great network per se, but their experience was by no means dominated by it. After one year of life encamped, the Sahrawi refugee camps continued to be sites of unmet emergency. But, in these camps, unique forms and structures of medical humanitarianism emerged, despite the failings of the international humanitarian system to raise the camps out of a state of medical emergency.

In the written historical record there are some optimistic voices—Sven Lampell, representative of the League for example—that cautiously asserted that the camps had achieved, as early as July 1976, a 'post-emergency character', meaning a stabilised situation with needs clearly identified and necessary infrastructure available.[215] Yet, evidence (particularly that relating to the role of the UNHCR, not as Focal Point, but as fundraiser) heavily supports the fact that, twelve months on from the first wave of displacement, the Sahrawi refugees were still facing a crisis of un-met emergency. The Sahrawi appeared to be permitted to endure as another refugee community. The second appeal of the UNHCR issued in October 1976 was a clear sign of a prolonged emergency. The costed programme of humanitarian assistance released by the agency reflected the needs of an ongoing crisis. The supplies requested were basic emergency supplies, not the kinds of supplies or services that signalled a shift had taken place to a more stabilised post-emergency camp, or to an environment with the beginnings of medium to longer term planning and development. The appeal requested 10,000 tons of food and an estimated total cash requirement of US$ 5,725,000 to cover the costs of a proposed system of humanitarian relief which included food, medical supplies, tents, blankets, clothing, domestic utensils, water systems, transportation, contingency costs, and programme support. The financial requirement to meet the medical needs totalled US$ 1,900,000, funds which would be spent according to a strategy which aimed to strengthen the medical infrastructure in response to widespread undernourishment and susceptibility to infectious disease, particularly among children and new-

[214] Agier, *Managing the Undesirables*, p. 200.

[215] IFRC, Vernier: Box: R509625967, Folder: ROP 7522, Sven Lampell, 'Summarized Situation Report as of 1/8/76 - Relief Operation for Refugees from Western Sahara in Algeria', 29 July 1976.

born babies.[216] The League maintained that the extensive desires put forward at that time by the SRC were unrealistic, that even the basic emergency needs of the refugees—food, vital medicine and protective materials (blankets, tents and clothing) for the winter—were not being met.[217] In October, Caritas Algeria argued that international aid was still indispensable.[218]By December 1976, other voices raised their concerns of an ongoing emergency. A renewed appeal of CICARWS demonstrated an ongoing emergency need, but it also signalled an intention to develop a strategy for an ongoing programme. Muriel Webb, Director of CICARWS stated:

> We are all agreed that the situation is going to exist for a considerable period of time. We believe that we cannot carry on indefinitely on an emergency basis and in May 1977 Jacques Blanc of R&D should come to the Geneva meetings with proposals for an ongoing programme which could be slotted into the Project System.[219]

The lip-service to 'ongoing programmes' suggests a belief that agents of 'the great networks' of humanitarianism *could* create something—some kind of 'Project'—beyond emergency relief. However, this view did not appear to be articulated widely among the humanitarian network. The Sahrawi camps seemed to be set-apart from the Western development/humanitarian structures of the 1970s, despite the ongoing machinations of the Cold War, at least in the first year of crisis.

On the cusp of the new year, the SRC issued a further appeal for aid and urgently needed medicine. The tone of their appeal was conciliatory, and the SRC expressed appreciation for international generosity to date, expressing a belief that they would be able to once again rely on human solidarity to support them. The SRC warned of a continued emergency of grave proportions due to the approach of winter coinciding with inadequate food supplies, chronic malnutrition, the presentation of secondary illnesses, and an environment favouring epidemics and pulmonary disease.[220] Yet, by the following March (1977), UNHCR reflected that despite improvements being made to the health situation in the Sahrawi camps, there were major issues

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[216] BNA, Kew: OD 66/71: UNHCR Second Appeal from Sadruddin Aga Khan, 25 October 1976.

[217] IFRC, Vernier: 999682, Correspondence from Henrik Beer to Mr. W.R. Schalz, The Norwegian Red Cross, 8 October 1976.

[218] IFRC, Vernier: 999682, ROP 7522 Algérie: Réfugiés Sahtaouis Q-Z Press General [File 2 of 2], 1975-1982: Caritas Algeria, 31 October 1976.

[219] IFRC, Vernier: 999682, CICARWS correspondence, 20 December 1976.

[220] IFRC, Vernier: R509625967, Correspondence from the Sahrawi Red Crescent, 4 December 1976.

and financial appeals continued to be unmet.[221] This lack of progress can be attributed to many factors. Those humanitarian agencies and individuals working in the field were operating under budgetary constraints, in part due to a lack of funds raised by Western states and their major donors in the international community. The presence of a more passive observational form of humanitarianism dominated throughout the year, and protracted conflict and continued wrangling of geopolitical strategies at attempted peace continued. Into 1977, the UNHCR continued to advise the Secretary General, proposing that a census could contribute towards a satisfactory solution to the ongoing dispute between Algeria, Mauritania, and Morocco by helping to address (and potentially solve) the controversy surrounding the numbers of people in the camps, and their place of origin.[222]

The Sahrawi camps were exceptional, and their experience included unique forms of local medical humanitarianism. The humanitarian networks intertwined with the Sahrawi refugees were very different to those described by Bertrand Taithe in the context of the Cambodian border camps. Taithe argues that the Cambodian camps were formative for the humanitarian sector and provided a field for a community of practice to develop at a moment in history when the sector was vastly expanding.[223] The Sahrawi refugees could have benefitted enormously from a more professionalised, globalised network, and they did experience some solidarity and support from the sans frontiérism movement in the specific form of MSF and from states both local and far. For MSF (or at least for Kouchner and his allies), the experience of the Sahrawi camps was an opportunity to argue for a more politically conscious approach for MSF, the need to provide more than just medical care, whilst avoiding the pitfalls of a spectacle of Western medicine and the crimes of neo-colonialism that could accompany it. But ultimately, potentially powerful actors, such as the UNHCR, in their acknowledgments of ongoing crisis, did not give full credit to the work of the refugees and their representatives in setting up emergency medicals structures, infrastructure, and services.

[221] IFRC, Vernier: 999682, Progress report on the UNHCR programme of humanitarian assistance in the Tindouf region, as of 23 March 1977.

[222] UNHCR, Geneva; 13/Sub-fonds 2/Box 22/ARC-2/C1, Confidential letter Sadruddin Aga Khan, High Commissioner of Refugees to Kurt Waldheim, Secretary General, UN, 22 February 1977.

[223] Taithe, 'The Cradle of the New Humanitarian System?'

The moulding of healthcare structures by the Sahrawi state-movement gives foundation to a discourse that emerges over the subsequent forty years, that the Sahrawi are 'ideal' or 'good'[224] refugees capable of 'the best run refugee camps in the world'.[225] The Sahrawi refugees have built a body of knowledge as a source of potential power for the community, for the state-in-exile, as they have continued their encampment in the twenty-first century.[226] The Sahrawi state-movement has been able to draw repetitious messages from an archive of evidence of the Sahrawi's legitimacy and deservedness for continued international financial aid.[227] Academic observations and field reports from the 1980s, for example those submitted by Barbara Harrell-Bond[228] have contributed to this archive and the re-circulation of stories about the values of the refugees and the quality of the health systems they created. Also, the presence of Christian organisations during this first year of crisis, marks the beginning of a long history of religious involvement in the camps. Faith became a foundation stone for the fundraising strategies for the Sahrawi state-movement expressed in the longer-term, to present themselves to the global community as a religiously tolerant community of ideal refugees who (by the 2000s) were open to welcoming all, from Spanish secular NGOs to American evangelical groups.[229]

International observational humanitarians came and went, but over time, the most impactful of observations, i.e., the creation of knowledge pertaining to the humanitarian crisis was stimulated by the Sahrawi state-movement itself. Observations of themselves and of external agencies' behaviours and perceptions would become part of an archive of knowledge to be drawn upon in the future. The foundations were set for the Sahrawi refugee camps to be home to ideal and worthy beneficiaries. Further research could investigate the interconnections between medical humanitarianism experienced in the Sahrawi refugee camps from the mid-1970s onwards, and

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[224] Elena Fiddian-Qasmiyeh, *The Ideal Refugees; Gender, Islam, and the Sahrawi Politics of Survival* (New York: Syracuse University Press, 2014).

[225] Chris Brazier, 'Special Edition: War and Peace in Western Sahara', *The New Internationalist,* no. 297 (1997), p.14.

[226] Elena Fiddian-Qasmiyeh, *The Ideal Refugees*, p.3 & 42. Elena Fiddian-Qasmiyeh, 'The Pragmatics of Performance: Putting 'Faith' in Aid in the Sahrawi Refugee Camps', *Journal of Refugee Studies* 24 (3) (September 2011), pp. 533-547.

[227] A photograph of the National Archive building: Herz, *From Camp to City,* p.175.

[228] Barbara Harrell-Bond, 'The Struggle for the Western Sahara: Part I: Prelude', *American Universities Field Staff Reports* 37 (1981), pp. 1-13; Barbara Harrell-Bond, 'The Struggle for the Western Sahara: Part II: Contemporary Politics', *American Universities Field Staff Reports* 38 (1981), pp. 1-14; 'The Struggle for the Western Sahara: Part III: The Sahrāwī People', *American Universities Field Staff Reports* 39 (1981), pp. 1-13.

[229] Fiddian-Qasmiyah, 'The Pragmatics of Performance', pp.533-547. See also, Elena Fiddian-Qasmiyah, *Ideal Refugees.* See also Barnett, *Empire of Humanity,* for a discussion of the development of the 'new evangelicals' developed since the 1940s, including the development of World Vision International.

any application of radical development theory and its conceptualization of alternative development paradigms which deem indigenous conceptions of knowledge as fully necessary.[230]

[230] Arif Dirlik, 'Developmentalism: A Critique', *International Journal of Postcolonial Studies* 16 (1) (2014), pp. 30-48; Rajni Kothari, *Rethinking Development: In Search of Humane Alternatives* (New York: New Horizons Press,1989); Rajni Kothari, *Transformation and Survival: In Search of Humane World Order* (New York: New Horizon Press, 1989).

Conclusion

The core objective of this research was to uncover the details of the nature and form of medical humanitarian action in specific refugee camps and to contribute to a richer understanding of medical humanitarian history and the health experiences of both refugees and humanitarians working in refugee camp contexts. The central concern of the thesis was points of emergency, the initial few years of crisis following conflict and mass displacement, and the foundations that were laid for decades of encamped life. This opened-up investigation of two refugee camps following two conflicts of de-colonisation in the post-war period. In the case of the Palestinian refugee camps, this crisis bloomed like an oil spill in the shadow of the Arab-Israeli War in 1948. For the Sahrawi, de-colonisation conflict pushed thousands of people out of place and across the border into Algeria. By considering these two refugee crises, this thesis considered the reality of life for people pushed into host countries across borders and allowed for a broad view of medical humanitarian history and the changes between the more immediate post-war period and the mid-1970s as the humanitarian international system was burgeoning. In the period bridging these two crises, this thesis further considered if the Palestinian refugee camps were connected to the emerging development agenda in the 1960s and 1970s and found that the Palestinian refugees were directly connected to the development of modern measles vaccinations. The connections between the Sahrawi refugees and the humanitarianism/development nexus do require further study beyond the initial year of the refugee crisis.

The nature and form of medical humanitarian action in the first year of crisis in both the Palestinian and Sahrawi refugee camps was characterised by undercare, but the experience of the refugees was not w*ithout* care. In the Palestinian case, the nature of the action may have morphed almost immediately from a state of crisis to a state of permitted endurance. But by challenging claims that Protestant humanitarianism dominated the humanitarian field in the Palestinian refugee camps before the establishment of UNRWA in 1950, this thesis has demonstrated the centrality of the League of Red Cross Societies working in collaboration with the United Nations in Jordan under the auspices of the Middle East Commission of the League of Red Cross

Societies League Commission. Great efforts were taken to deliver a programme of care for the refugees, even though it may have been characterised by a spirit of adequacy-only.

Palestinian refugee camps came into existence at the perfect time for the tentacles of Western agendas of development as economic and technical development models to be exported to the Middle East: there were only eighteen months between the establishment of the state of Israel in May 1948, and the publication of the interim report of the Economic Survey Mission for the Middle East (ESM) in November 1949. The work of the ESM indicated the machinations of development/Development gaining traction in the refugee camps, particularly development strategies exported from the US in a concrete attempt to exploit the environment and mould refugee life—and therefore refugee health—along economic lines. In the Palestinian camps the failings to deliver according to this developmental imagining can be contrasted with the resilience of the preventive medicine campaigns carried out by UNRWA working with WHO from the mid 1960s to mid-1970s, which also welcomed agents of the pharmaceutical world into the sacred space of humanitarianism.

In the Sahrawi refugee camps, the emergency and the early medical humanitarian response was characterised by a similar experience of permitted endurance, as the crisis stretched past the first year, suggesting that the networks of humanitarianism burgeoning in the mid-1970s had under-served the Sahrawi refugees. The observational humanitarianism revealed in the Sahrawi camps may have been more limited in its impact than the individual efforts of medical humanitarian actors working on the ground, such as the medics deployed under the emerging banner of MSF. How far the humanitarian observers were able to advocate for the Sahrawi refugees, how far they witnessed the struggles of the Sahrawi refugees cannot be concluded without further research into the public-facing and media activities of the humanitarian individuals and agencies that visited and observed in the camps. Yet, there was exceptionalism in the case of the Sahrawi refugees and the Sahrawi Red Crescent worked as agents of creative change, interacting with a diverse range of humanitarian actors that were activity and/or observing in the camps before 1977, whilst moulding the form of healthcare infrastructures. This action would go on to open the door to a new wave of humanitarian action that would ultimately sustain the camps for decades. How medical humanitarian action was approached and experienced in the Sahrawi camps post-1976 would be a compelling further study, perhaps intertwining further refugee camp contexts for comparison elsewhere across the globe.

The Palestinian and Sahrawi refugee camps have been singular in their experience yet aligned in their struggles. From today's perspective, with our knowledge that these camps will continue to exist for decades, it is difficult to answer the question, was medical humanitarian action beyond emergency repair? Did it create transformational change in the camps either in their first years, or in the subsequent few decades in the case of the Palestinian camps? In the Palestinian camps, there was a strategic attempt to transform the destiny of the refugees, but the economic scaffolding for refugee wellbeing set down by the ESM and UNRWA could never answer the refugees' own desires for health and happiness in their return to home. The Sahrawi refugees' vision for transformation had more concrete manifestation in the health and medical structures and infrastructure in the camps, even in the first year of encampment.

Throughout this period in history, humanitarians planned, reported, delivered, argued, pleaded, treated, tended, gave; and the world continued to turn, and humanity demonstrated both its potential and its failings. If humanitarian action is a minimum precursor for peace, as Count Bernadotte pleaded in September 1948, then many compassionate efforts have been made in the Palestinian and Sahrawi refugee camps to achieve a positive peace.[1] The phenomena of medical humanitarian action and the refugee camps themselves amassed new experiences, ideas, and configurations from 1948 to 1976. Yet, throughout and into the indeterminate future, the Palestinian refugees and Sahrawi refugees will live out cycles of birth and death, displaced far from home.

[1] Johan Galtung, 'Violence, Peace, and Peace Research', *Journal of Peace Research* 6 (3) (1969), pp. 167-191.

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Box 999682
ROP 7522: A: R S F-P (1/2)
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