Humanitarian presence. Locating the global choices of Doctors Without Borders

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Humanitarian Presence
Locating the Global Choices of Doctors Without Borders

L'humanitaire au présent
Localiser les choix globaux de Médecins Sans Frontières

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Acronyms and Abbreviations

A&E: Accident and Emergency Department

AME: *Aide médicale d'Etat*, State Medical Aid

ANT: Actor-Network Theory

ARV: Antiretrovirals

BABELS: Border Analysis and Border Ethnographies in Liminal Situations

CDC: Centres for Disease Control and Protection

CMR: Crude Mortality Rate

CO: Clinical Officer

CPR: Cardiopulmonary resuscitation

CRASH: *Centre de réflexion sur l'action et les savoirs humanitaires*

Demie: *Dispositif d'évaluation des mineurs isolés étrangers*, Unaccompanied foreign minors evaluation apparatus

DG: *Directeur général*, General director

DirOps: Director of Operations

DNDi: Drugs for Neglected Diseases Initiative

DRC: Democratic Republic of Congo

ECHO: European Civil Protection and Humanitarian Aid Operations, formerly the European Community Humanitarian Aid Office

EHESS: *Ecole des hautes études en sciences sociales*, School for Advanced Studies in the Social Sciences

EIS: Epidemiological Intelligence Service

EMT: Emergency Medical Technician

ExCom: Executive Committee

FinCo: Financial Coordinator

FOOT: Field Oriented Operational Training

HoM: Head of Mission

HRCo: Human Resources Coordinator

ICU: Intensive Care Unit

IPD: Inpatient Department

IDP: Internally displaced person

KNH: Kenyatta National Hospital

LogCo: Logistics Coordinator

LSHTM: London School of Hygiene and Tropical Medicine

MAP: *mise-à-plat,* "flattening"

MCI: Mass Casualty Incident

MCP: Mass Casualty Plan

MDM: Médecins du Monde, Doctors of the World

MDR-TB: multi-drug resistant tuberculosis

MedCo: Medical Coordinator

MLKH: Mama Lucy Kibaki Hospital

MoH: Ministry of Health

MSF: *Médecins Sans Frontières*, Doctors Without Borders

MTL: Medical Team Leader

NGO: nongovernmental organization

OCP: Operational Centre Amsterdam

OCB: Operational Centre Brussels

OCBA: Operational Centre Barcelona-Athens

OCG: Operational Centre Geneva

OCP: Operational Centre Paris

OCHA: United Nations Office for the Coordination of Humanitarian Affairs

OPD: Outpatient Department

OULIPO: *Ouvroir de littérature potentielle*, Workshop for Potential Literature

OUSCIPO: *Ouvroir de sciences sociales potentielles*, Workshop for Potential Social Science

PASS: *Permanence d'accès aux soins en santé*, Health service access points

PSP: *Populations en situations précaires*, Populations in Precarious Situations

RMS: Retrospective Mortality Survey

RP: *Responsable programme*, Program Manager

SATS: South African Triage Scale

SGBV: Sexual and Gender-Based Violence

START+: Sydney Triage to Admission Risk Tool, extended version

UNHCR: United Nations High Commissioner for Refugees

U5MR: Under 5 Mortality Rate

WASH: Water, Sanitation, Hygiene

WHO: World Health Organization

XDR-TB: Extensively drug resistant tuberculosis

"*Or if the hypothesis were offered us of a world in which Messrs. Fourier's and Bellamy's and Morris's utopias should all be outdone, and millions kept permanently happy on the one simple condition that a certain lost soul on the far-off edge of things should lead a life of lonely torture, what except a sceptical and independent sort of emotion can it be which would make us immediately feel, even though an impulse arose within us to clutch at the happiness so offered, how hideous a thing would be its enjoyment when deliberately accepted as the fruit of such a bargain?"*

William James, "The Moral Philosopher and the Moral Life" (1992, p. 598)

Introduction

Locating Humanitarian Aid in the Present

1. Research Question: How does MSF select those it aims to assist around the world?

In this dissertation, we follow a French medical humanitarian NGO,[1] Doctors Without Borders (*Médecins Sans Frontières*, or MSF) to those locations where the people and populations they aim to assist are selected. This account of humanitarian aid as it takes place is meant to provide insight into three elements regularly mobilized in humanitarian mission statements: the *target populations*, the *global scope*, and the *moral mission* of medical humanitarian NGOs. These elements are visible in MSF's "mission statement":

> "Médecins Sans Frontières *provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict.*[2]"

This is the mission of this organization "without borders": "assistance to populations in distress" through medical practice. To hold together these elements of humanitarian narratives – global scope, moral mission, target populations - we ask: *how does MSF choose those it aims to assist around the world?*

We respond to this question according to an approach that can be summed up in a phrase that is simple in its formulation and radical in its implications: *analysis of international aid must*

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[1] A recent definition of medical humanitarianism: "*the field of biomedical, public health, and epidemiological initiatives undertaken to save lives and alleviate suffering in conditions of crises born of conflict, neglect, or disaster"* (Abramowitz & Panter-Brick, 2014, p. 1).

[2] https://www.msf.org/who-we-are (last accessed: 11 March 2019)

account for how humanitarians hold together the ambiguities, and even the contradictions, of this claimed mission in the ambivalent effects humanitarian aid in practice. That is, we cannot distinguish between what humanitarian practice does from the ends it claims for itself. This approach is pragmatist, in the sense that we do not take these claimed ends - humanitarian mission statements or other project-oriented objectives - to be *representations* of humanitarian aid, but the very *tools* of humanitarian practice. The reader, if they are committed to empirical social science, will almost certainly agree with the formulation of such an approach in methodological terms: studying a practice means taking seriously the way practitioners present and justify their practice. They will add, rightly, that the social scientist cannot be naive. We must not take such mission statements *too* seriously. They are socially constructed justifications. They serve to distinguish NGOs in a crowded symbolic field. They are ideological in nature and dissimulate the objective interests of the organization and its members. They are of interest only insofar as social scientists can *add* something *other*, something *more* to them, in order to demonstrate that *things are not what they seem*.

If we reject such *Suspicious Social Science* (SSS) in this dissertation and take MSF's Mission Statement seriously, it is not because we have a naive faith in the inherent and unambiguous righteousness of the humanitarian enterprise. This dissertation is not a laudatory apology of the "assistance" MSF provides to "populations in distress". Our claim - that what humanitarians say they do cannot be distinguished from what they do - depends on learning how to listen to humanitarians, for some of the most critical positions on humanitarian aid come from humanitarian practitioners. As Laëtitia Atlani-Duault has observed about the members of the International Development Organization, "it would be simplistic to believe that, because they are actors, they do not develop a sometimes violent critique of their practice" (2009, p. 34, my translation from French). MSF practitioners have experienced first-hand the limits to aid, the always ambivalent goods that it produces, the possibility that aid be hijacked by state powers, and the risk that humanitarian aid might feed into an economy of suffering.[1] Humanitarian practitioners do not claim that aid is an absolute good, characterized by 'warm fuzzies', self-congratulatory praise, or complaisance. However, while the assistance provided is made up of partial, competing, and sometimes mutually exclusive goods, humanitarians do claim that aid is *important*. Taking the importance of assistance seriously means that we cannot reduce their practice to the goods that they

[1] Many humanitarians are deeply disappointed by their experiences in the field, as Ludovic Joxe's 2019 PhD dissertation in sociology on professional dissatisfaction in MSF has demonstrated (Joxe, 2019).

fail to achieve, and neither can we look the other way when they fail (which they do, as we shall see).

This brings us to the *analytical* component of our pragmatist approach. We claim that a precise account of the practical reflexivity of humanitarian aid *as it takes place* can be a source of theoretical stimulation for the social sciences.[1] Our refusal of SSS - which turns humanitarian assistance into something other than what it claims as its mission - means, in effect, that we take humanitarian actors, in moments of reflexivity, to be the most qualified theorists, the most qualified sociologists and anthropologists of their trade. Their reflexivity is limited, like the reflexivity of professional social scientists. This is precisely the point: "their" reflexivity is not of a different nature than "our" reflexivity. It is, however, embedded in a different set of practices. The objective of this dissertation is not to *add* something to this reflexivity, but to *translate* the practical reflexivity of humanitarians into a social scientific account of humanitarian aid. This translation will not necessarily be of direct usefulness to humanitarians. It would have to be reworked, translated back, for it to have applied utility. We seek, instead, to *inverse the direction of the contribution*: we do not claim to have the last word on what humanitarian action is - we leave that to humanitarians – for translation is difficult, and there are indeed "untranslatables". This does not mean that there are things that we cannot translate. As the Philosopher Barbara Cassin has suggested, "the untranslatable is rather what one keeps on (not) translating" (Cassin *et al* 2014, p. xvii). This is why we - social scientists - must learn to accept not having the last word: the translation I propose can be contested by humanitarians.[2]

Triage is the perfect object to make such a move. Triage is central to medical humanitarian practice and poses a serious problem for their mission statements. It affords certain forms of life-saving interventions - and not others - and is understood by humanitarians to be a morally ambiguous practice. It is heavily equipped with reflexively designed instruments that carry in their form assumptions about the capacities of their users. Triage is precisely the kind of object that will allow us to work out an indigenous theory of humanitarian aid in practice, without falling back onto Suspicious Social Science or a naive apology of humanitarian aid as an unambiguous good or the vehicle of a coherent ideology.

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[1] This approach - *humanitarian aid as it takes place* - is decidedly pragmatist, in the sense of a *radical empiricism* developed by the American philosopher William James. See especially his *Essays in Radical Empiricism* (2012) – with the subtitle *A Pluralistic Universe* - and also Antoine Hennion (2015) for a stimulating proposal on how to conduct pragmatist inquiries *from* the social sciences that are able to engage with plural worlds and indeterminism.

[2] Luc Boltanski has called sociologists to renounce our claims to "intelligence", i.e., our capacity to establish the definitive version of events in the name of science (Boltanski, 1990, p. 43).

In sum, the first and most important move we make to answer our research question is to take humanitarians seriously in the ends they claim for their practice, without losing sight of actual effects (because humanitarians evaluate their activities according to their impact). This will allow us to work out a pragmatist response to our research question - *how does MSF choose its beneficiaries around the world?* - and to qualify those three elements of humanitarian narratives - *global scope, moral mission, target populations*.

The second move we make, this time to translate their practice into social science, is to focus on the spatial reflexivity of humanitarians. This relates to our research question: we examine the selection of beneficiaries *around the world*. This peculiar global space has astounding effects on the choice of MSF beneficiaries. Unlike states, MSF does not attempt to *cover* a territory, to provide exhaustive health care to all its *citizens*. Instead, MSF is a global organization, with headquarter entities, research centres, field sites, and medical platforms in locations around the world. It is from these locations that they chose to make timely *interventions* to come to the assistance of *beneficiaries* and to call to account state actors. The analysis we provide is to show how such humanitarian locations affect the selection of humanitarian beneficiaries.

How does space impact choice? To answer this question, we must attribute to *space* the capacity to have ethical effects. To work through the ways that space can have ethical effects, we will be building on materialist and post-Actor-Network Theory (ANT) conceptualizations of space and territory. Space is not an empty, homogenous container that gets filled up with material (Lefebvre 1974); it is a material-semiotic achievement (Thrift 2006). Space and time are not transcendental categories of understanding; they are ways of describing the *consistency* that heterogeneous assemblages acquire in practice. Like post-structuralists such as Foucault, we are concerned with the ways heterogeneous ensembles acquire a kind of unity or identity, however temporary, emergent, or shifting (Foucault, 2004a, 2004b). The point is to analyse MSF as an assemblage, a heterogeneous ensemble of languages in their diversity, of human subjects and technologies, of bodies (both human and nonhuman) and utterances (Deleuze & Guattari 2013; Dodier & Stavrianakis 2018). The *consistency* we ascribe to these assemblages is spatial, and the point of analysis is to demonstrate the ethical effects of MSF's *spatial consistency*.

What characteristics should we attribute to this *spatial consistency*?[1] In what might be called "classic" Actor-Network Theory, the *network* served to describe certain spatial characteristics of such assemblages and indicated the capacity of these assemblages to have certain effects. This fascinating spatial form *makes connections over the boundaries* of a world artificially, arbitrarily, imperiously sliced up into supposedly homogeneous zones, like Africa after the Berlin Conference. These border-hopping capacities provided fertile ground for reworking many of the common-sense divisions of the social sciences. Throughout the 1980s and early 1990s, ANT effectively reconceptualized the relations between sign and thing (Latour 1995), human and non-human, science and politics (Callon 1986), modern and nonmodern, nature and culture (Latour 2012), macro and micro (Callon & Latour 1981), object and subject, technology and usage (Akrich 2013). These were heady times. The world could no longer convincingly be described solely in terms of *homogenous regions* surrounded by stable *borders*. Instead, it was precisely that which could straddle borders, making translation possible while also maintaining consistency through connections, that retained the attention of these authors. The consistency of these *networks* did not depend on internal coherence for final totalization. Always in the process of becoming, of extension, these Leviathans were progressively built up through on/off *connections*. It was precisely these connections that had to be maintained; with the closure of a single station, entire metro lines can be lost to the transport network. This is the simple power of the network: through the combination of dissimilar elements over vast regions, it demonstrated everything that escaped analyses in terms of a world composed of disconnected, coherent, homogenous regions.

In the mid-1990s, however, this conception of the spatial consistency of heterogeneous assemblages solely in terms of *regions* and *networks* was brought into question (Law 1993; Law & Mol 1994). There were technologies that seemed to maintain their consistency despite the loss of essential components; unlike the network, *consistency* did not depend on maintaining connections. These assemblages were *fluid*, they could lose parts, gain others, and still function, though what it meant to function could change (de Laet & Mol 2000). And there were ensembles that could maintain their effects despite their absence, that is, like *fire*, their consistency depended on the absence of consumed fuel (Law & Singleton 2005). In what came to be known as "post-ANT" (Law & Hassard 1999), the consistency of those assemblages was understood as existing

[1] We will come back to a clearer presentation of our concept of space. For now, the reader should retain four of its components. First, as stated, space is a *material achievement*. Second, we rely on certain mathematical, or topological understandings of space for description. Third, space will also be seen to be the product of *practices of place* - mobility, bordering, scaling, circulation, setting up… Fourth, space is achieved through *attachment*, in all the complex acceptations of the word.

according to a number of *topologies*: the regional and the network topologies, already mentioned, but also, fluid and fire topologies (Law & Mol 2001; Serres 1980).

The point of this discussion is not merely to provide a simplistic summary of ANT history. Instead, I would draw the reader's attention to work in recent years, building on ANT and post-ANT, that seeks to describe the consistency of material-semiotic assemblages in terms of *space*. This includes work on *territory* (Kärrholm, 2005, 2007; Latour, 2017), but also *national economies* (Callon 1998; Mitchell 2002), an array of *platforms* (Cambrosio & Keating 2000, 2003; Langley & Leyshon 2016), the practices of *placing* (Meyer & Molyneux-Hodgson 2016), *field stations* and *spaces of concern* (Geissler & Kelly 2016; Kelly 2017), and *technological zones* (Barry 2006, 2013). In this body of literature, what stands out are the ways the spatial consistency of these heterogeneous assemblages has a variety of *effects*, in ecology, in urban planning, in economics, in finance, in medicine, in biology, in global health, in law, in international relations. This is the point: the spatial consistency of these assemblages is a lively thing. Space is an actant. In this thesis I ask about the *ethical effects* of MSF's spatial consistency: *what ethical effects does the global consistency of humanitarian assemblages have on the selection of people to assist?*

This begs the question: *how, exactly, does space have ethical effects?* To answer, we must say, first, that this is not a relativistic ethics. The point is not to say simply that morality is variable, that what is good, right, fair, just, or virtuous depends on *where* you are. Instead, this approach is a way of picking up the torch laid down by the anthropologist Annemarie Mol (2008), as she calls for ethics to move away from the principled analysis of choice, and towards the empirical description of *situations of choice*. That is, we are less interested in discussions with philosophers mired down in abstract, principial considerations associated with different schools of moral philosophy, and more interested in how *choice*, as an empirical case, comes to be formulated in a particular way, in a particular place, at a particular time, and the ways that these particularities objectively affect ethical practice. We will examine specific cases from inside MSF, where *choice* emerged as the relevant mode of investing a situation, and we will examine the concrete options with which practitioners were confronted. To identify more precisely the mechanism by which space has ethical effects, we will hold that the material ordering of humanitarian locations directs, heightens, or blunts *attention* (Hennion & Teil, 2004) and, thereby, brings to life certain *options* (Hennion 2015) while rendering others impracticable or undesirable. This is an additional conceptual move we make: we take the *ordering of attention* as a primary ethical effect of spatial configurations. Let us specify.

When we say that we will describe how humanitarian locations participate in the ordering of humanitarian *attention*, it means that we will describe some of the ways the locations of humanitarianism participate in creating moments of "*suspension"*, of "*pause on what is happening*". This *pause* symmetrically reinforces the presence of the object of attention (Hennion & Teil 2004). In our case, dealing with the selection of beneficiaries, it is beneficiaries whose presence is reinforced in specific ways: they become vulnerable and fragile, in need of medical care. Symmetrically, this ordering of attention has the effect of endowing humanitarians with certain needs: the need to know, to help, to confirm that intervention was impactful.

Taken in this way, *attention*, and its ordering, are thoroughly *ethical*. Indeed, Joan Tronto has placed attentiveness at the centre of her political philosophy of care (1993), leaning on Hannah Arendt's formulation of the moral value of attention: "*Attention consists in suspending thought, leaving it available, empty and ready to be entered by its object… thought must be empty, waiting, seeking nothing, but ready to receive in its naked truth the object that is about to penetrate it"* (1993, p. 128). It is precisely this *attention*, this cognitive availability, this openness to the situation, that makes us capable of moral action.[1] It is this attention that renders us capable of seizing what is *important* in experience, and "*our action is moral if we have thereby safeguarded the importance of experience so far as it depends on that concrete instance in the world's history*" (Whitehead, 1938, p. 15).[2]

In addition, analysing the ways space orders attention allows us to insist on the *ambiguities* of ethical practice. That is, we do not assume that this spatial ordering of attention, which makes a place where *beneficiaries* can become needy, vulnerable, and fragile, and that positions humanitarians as needing to know, help, and evaluate their action, is unambiguously good. *Ethical practice is not about finding the course of action that would assure an unambiguous good*. Instead,

[1] In recent years, work that is very close to our own in post-ANT, has indicated the ways that attention to the fragility and mutability of these variable attempts material ordering might be approached, following Annemarie Mol (2008; Mol *et al* 2015) and Maria Puig de la Bellacasa (2010, 2012), in terms of "care of things". On this, see in particular, (Denis & Pontille 2015).

[2] It has been suggested to me by Morgan Meyer that this approach to *attention* is not dissimilar to Foucault's *problematization*. Reading an interview between Rabinow and Foucault in *Dits et écrits* vol. IV, 1994, p. 591-598, on *problematization*, Foucault details his position. His politics of problematization does not consist in identifying the one right policy that would cancel out the variable experiences of madness, sexuality, or crime. Rather, problematization is concerned with elaborating the problems these domains of experience pose for politics. The point is to show that the collective that emerges from these experiences, the "we" that they support, is sometimes the result of such problematization. In addition, it is problematization that allows Foucault to elaborate a "history of thought", insofar as a number of political solutions are possible with regard to the same assemblage of problems. His analysis consists of finding a way to formulate these variable responses in such a way as to show the continuity of their underlying problems. I will detail in Chapter 2 why I am uncomfortable with such a political project.

we look at how efforts are made to keep sometimes-dissonant goods present in the effects of action. Ethical practice is about *tinkering*, that is, "*negotiation about how different goods might coexist in a given, specific, local practice*" (Mol, Moser & Pols, 2015, p. 13). As such, the "*good is not something to pass judgment on, in general terms and from the outside, but something to* do*, in practice, as care goes on*" (Mol, Moser & Pols, 2015, p. 13, emphasis in original). This produces a surprising effect for those moments of ethical "failure". An ethics of attention does not assume that there will be, or can be, a "happy ending", in which all the tensions and ambiguities and ambivalences between competing and irreconcilable goods have been resolved. In the face of ethical failure, an ethics of care demands that we try again, that we renew attention. In such an ethics, *good care*, is about "*persistent tinkering in a world full of complex ambivalence and shifting tensions*" (Mol, Moser & Pols, p. 14).

To summarize, we aim to underscore the specific forms of attention and the associated ethical ambiguities enacted in and through the global configurations of a humanitarian organisation. We can now reformulate our research question one last time, before moving on to Methods, Analytical Resources and Major Contributions, and an Outline of the argument.

How does the spatial consistency of medical humanitarian assemblages participate in the ordering of attention during the selection of people to assist?

2. Methods

The advantage of our pragmatist approach and our subsequent conceptual moves - space as an actant that orders attention - and the reformulation of our research question they afford is that they allow us to employ ethnographic methods to describe specific material-semiotic processes that produce space and have ethical effects in a humanitarian NGO. Indeed, they require ethnographic methods. Insofar as our ethical position entails close consideration of the ambiguities of practice, our analysis cannot be based on external critique. Nor can we base our analysis on categories and codes elaborated in a laboratory, at a distance. We must get as close as possible to concrete situations where the difficult decisions of excluding patients from care are made if we are to learn from humanitarian reflexivity. Our research question demands close description of the practices and processes of excluding patients from health care, prioritizing certain public health interventions over others, triaging patients as they arrive in an emergency room, deciding to close humanitarian projects. In addition, the kind of spatial consistency we are interested in describing is not only the formal space of distributed coordinates on a plane. Instead, we are interested in the kinds of space

produced in the topologies of humanitarian assemblages as they affect humanitarian aid in practice. This means close consideration of the ethical ambiguities mentioned above, as they intersect with specific practices that produce space (circulation, scaling, bordering… more on this in a moment). In short, we need to observe humanitarian aid as it is taking place.

To this end, I have focused on the operations of the French branch of the nongovernmental organization (NGO) Doctors Without Borders, or *Médecins Sans Frontières-Operational Centre Paris* (MSF-OCP).[1] In this section, we will look at how the object of study emerged in collaboration with members of MSF, and then we will present the types of materials mobilized and the strategies developed for collecting them. We will then discuss how these materials were analysed and the particularities of writing a monograph on such an NGO. Finally, we will comment on what it means to write a doctoral dissertation not *on* MSF, but *with* MSF.

a. Defining an Object: Triage and its Instrumentation

A particularity of this dissertation is that the original research question was formulated by members of MSF's social science think tank, the *Centre de réflexion sur l'action et les savoirs humanitaires* (CRASH). During my MA in General Sociology - when I began working with MSF - I was a member of a student organization called the *Ouvroir des sciences sociales potentielles* (Ouscipo).[2] Ouscipo's mission is to bring social scientists and members of the civil society together. They do this by contacting civil society organizations, asking them to formulate problems or issues that they face and which they would like a historian, sociologist, or anthropologist to study. These suggestions are entered into a database that can be made available to students and researchers at the School for Advanced Studies in the Social Sciences (EHESS) in search of a research topic. Through the database of research subjects, the Ouscipo imposes constraints on researchers; social scientists must accept the theme and object put forward by civil society organizations in exchange for negotiated access to the field. This is reminiscent of the Oulipo, a

[1] There are four other operational centres, all in Western Europe (Brussels, Amsterdam, Geneva, Barcelona). OCP and Operational Centre Brussels (OCB) are the two largest and oldest operational centres, in terms of operational volume and finances. OCP is the oldest section and has sought to maintain its role as the leader of what is referred to inside MSF as the "Movement". Disagreements over operational policy and governance have sometimes led to tensions. Though I discuss MSF-OCP's relations with other MSF sections - especially in Chapter 4 - (nearly) all the case studies found in this text come from the French section.

[2] We might translate roughly as the "workshop for potential social sciences". The reference is to a French literary movement from the 1960s called the *Ouvroir de littérature potentielle* (Oulipo), the workshop for potential literature. Notable texts from this movement include Raymond Queneau's *Exercises de Style* or George Perec's *La Vie. Mode d'emploi*.

French literary movement that sought to stimulate creativity by imposing constraints on their writing (lipograms, palindromes, the retelling of the same short story in 99 different styles...).

The members of the Crash suggested four themes.[1] In April 2015, I chose "Qui aider? Impartialité et politiques de 'triage'". Or, "Who to help? Impartiality and the politics of "triage"." The problem with triage was formulated in these terms: "Given the invocation of impartiality as a 'founding principle', how does MSF make and justify, in practice, the choice of populations and patients to aid in priority?" It continued by suggesting triage was a problem of "knowledge" and of "objectivity". Like the *littérateurs* of the Oulipo, I took this externally imposed constraint as a "social science-making machine", that might renew the structure and forms of social science writing. This is one way that I effectively take up the project presented above, wherein the social sciences are not a source of external analysis of humanitarian aid. Rather, humanitarian aid is taken as a potential source of theoretical and empirical stimulation for the social sciences.

What is particularly interesting about accepting such a formal constraint imposed by those often called "informants" in social science research is that this dissertation takes to task a practice that is experienced by members of MSF as being problematic to a degree that they asked a social scientist to conduct a five-year study on the subject and to write a 300-page dissertation.[2] The theme, as defined by the CRASH, tells us the following. First, that triage is formulated as a problem means that it is a site of reflexivity. By reflexivity we mean that, when it comes to triage, we expect members of MSF to conduct local inquiries into the state of affairs, the qualities of the persons in presence, and the proper political principles and ethical stance to adopt. Second, the way the problem of triage is formulated tells us that it is a problem of choice. This too is important. There are many occasions when resources are distributed, justly or unjustly, without a single choice being made. Our interest in this dissertation is focused on the reflexivity of the members of MSF as resource distribution is ordered by choice.

As such, the collection of materials during our investigation needed to be organized in such a way as to be able to deal simultaneously with reflexivity and choice. To do so, this inquiry consisted in drawing together materials that pertained as directly as possible to the elaboration and the usage of instruments that support the allocation of resources by organizing it into questions of

[1] The options foregone: "Pratiques et impacts de l'évaluation et des outils de gestion dans l'action humanitaire", "Attitudes humanitaires face aux violences extrêmes", "Appréhension du risque et pratiques de sécurité dans les organisations humanitaires".

[2] Not to mention my MA dissertation, the three reports I wrote for MSF based on my research, and the numerous presentations I made to teams in the field.

choice. That is, the *instrumentation of triage*. This allows us to analyse together the specific forms of reflexivity that animate the members of MSF, and the situations where resource allocation is a choice.

b. Collecting Materials: Descriptions of Form and Usage

To analyse the instrumentation of triage, this dissertation draws on different materials. These include archival sources, internal reports, and videos. I also produced materials specific to this research project. The first method for producing materials was *observation*. I observed training sessions, MSF-organized "Scientific Days", as well as the French *association*'s General Assembly. Most observations focused on humanitarian operations in the field and project evaluation practices in headquarters. I also conducted and recorded in-depth interviews with MSF practitioners, which I then transcribed. In total, I conducted 31 weeks of observation inside MSF, during which I filled 29 observation notebooks and conducted 62 interviews.[1] Fieldwork was completed between September 2015 - during an MA in General Sociology on patient recruitment practices in an MSF speciality hospital in Amman, Jordan - and October 2019.[2]

Observation focused on the *instrumentation of triage*. These include protocols, lists, charters, performance indicators, and evaluation methodologies.

The first object of description was instrument *form*. That is, through close attention to the material and linguistic components of these instruments, I sought to describe the ways that the instruments had been designed with certain schemas for action in mind. These included the evaluation of needs, the definition of operational priorities, the differentiation of levels of

[1] See the Annexes for a list of notebooks, and a short description of their contents, plus a list of interviews, with date, location, and position of the person interviewed.

[2] I spent eight weeks (October-November 2015, Avril 2016) in a hospital specialized in reconstructive surgery in Amman, Jordan, receiving severely injured patients from countries in the throes of armed conflict around the Middle East (Iraq, Syria, Gaza, Yemen). This material was mobilized to write my masters thesis. Though not discussed here, the research question was similar - focusing on patient selection and a regional network for patient recruitment - and the material collected figures as a backdrop and supports the analysis I develop in the dissertation. I spent eight weeks (March-April 2017, December 2017-January 2018) observing a mobile clinic, providing primary health for migrants sleeping in the streets of Paris, and collecting data to open a long-term project. I spent seven weeks (April-May 2018) in Nairobi, Kenya, on a project that included an emergency call centre and an ambulance service, a multi-drug resistant tuberculosis (MDR-TB) clinic, and somatic and psychological care and legal support for victims of Sexual and Gender-Based Violence (SGBV). These medical activities were destined for the inhabitants of one of the most violent slums in the world (according to MSF internal reports). I spent six weeks (October-November 2017) in MSF-OCP's headquarters in Paris, where I observed the annual season of project evaluation. In addition, I spent ten days (May 2017) in a training session for MSF "Coordinators" (Field-Oriented Operational Training, or FOOT), organized by the *Centre de réflexion sur les actions et savoir humanitaires* (CRASH). I spent two days at MSF-France's June 2017 General Assembly, where part of the elected board was renewed. I spent a day at the May 2017 "Scientific Day" for Epicentre - the epidemiological research wing of MSF. I also attended a tour of the *Musée des douanes* exhibition in Bourdeaux on MSF-Logistics, guided by the President of MSF-Logistics, in February 2018.

emergency, and, finally, decisions regarding whom to help. The goal then was to describe the capacities attributed to different actors in the schematic functioning of the instrument. For instance, when a standardized questionnaire, developed for widespread use across MSF, states at the top where it should be completed, by whom, and specific phrases that should be used to reassure beneficiaries and to provide them with the ability to make an informed choice regarding their desire to participate in the survey, we learn a great deal about the attributes ascribed to field workers filling out the questionnaire, the beneficiaries as respondents, as well as the capacities that MSF attributes to itself as an organization. It is of note that instruments of triage often entailed taking measurements and inscribing, objectively, the characteristics of persons and the situation, in such a way as to inform decision-making; the production of knowledge through distributed and regulated forms of cognition are an essential part of triage practice. As such, this thesis also spends a great deal of time describing the writing practices associated with triage, and the specific cognitive tasks that inscription technologies shoulder for humanitarians - memory, decision-making, projection into the future, coordination, and calculation. Above all, we were interested in the ways this type of tool could order resource allocation as a *choice*.

In addition to interest in the formal qualities of these *instruments*, observation also focused on the concrete practices of selecting patients and targeting populations through these instruments, that is, *usage*. While initial attention to these instruments focused on what their designers hoped to accomplish through them, observation was also directed to the ways triage practice might exceed, bypass, or even hijack instruments to ends that could be in contradiction with the formal goals of the instrument. This means that careful attention was paid to styles of investing instruments of triage, and the continuities and discontinuities in the effects of instruments on triage across styles.

c. Analytical Moves: The Spatial Consistency of Instruments and their Ethical Effects

We submitted the materials collected to three analytical operations. First, they were analysed in terms of their spatial consistency and the ethical effects of this spatial consistency on triage. This is accomplished through close attention to specific processes entailed in the form or usage of triage instruments that enact space, give it specific characteristics, capacities, and behaviours. The processes of spatialization described in this dissertation include mobility, bordering, appropriation, association, presence, exploration, distribution, scaling, levelling, platforming, mapping, and networking. These processes enact different *locations*. The four chapters of this dissertation each focuses on a different humanitarian location: *humanitarian space*, *the field, a medical platform*, and *headquarters*.

The second analytical move was to describe the ways that in these locations, as ordered by instruments of triage, certain considerations or problems were continually or repeatedly designated as important by the designers or users of the instruments. For instance, in discussions on *humanitarian space*, questions of sovereignty and the possibility of providing care given the risks of contributing to a larger economy of violence, are continually indicated as important issues that directly affect MSF's capacity to make fair resource allocation decisions. From this designation of what is *important*, we followed the emergence of choices: MSF considers it important to be in direct contact with their beneficiaries, in order to gauge for themselves the kinds and levels of need, but also to ensure that aid is not diverted by warring parties. In those situations where it is not possible to talk directly with beneficiaries - members of MSF might say "there is no humanitarian space" - MSF is sometimes faced with a choice: to accept less than ideal ordering of space - and *co-presence with beneficiaries* is a spatial concern, as we shall see in Chapters 1 and 2 - or to cease activities. The point will not be to show that because *situations of choice* are the result of specific activities of ordering, they are somehow unreal or naturalized social constructions. This is not a *Suspicious Social Science*. Instead, the point is to provide analysis of the ways that MSF gains spatial consistency affects the kinds of choices with which they are faced. These are *genuine choices* that force MSF to determine the kind of assistance they provide, and, thereby, what kind of organization they strive to be (cf. Chapter 3 on *genuine choices*).

The third analytical gesture was to focus on those situations where choices, and their associated options, emerged, and to analyse normatively charged debates inside MSF over the proper course of action. This entailed analysis of the kinds of arguments that members of MSF could mobilize during such disputes. These arguments were not separated out from the situations in which they were pronounced. The goal was not to work out a list of acceptable forms of justifications and critique. Nor was it to account for the kinds of socialization necessary for members of MSF to formulate such arguments. Nor was it to reveal the micropolitical strategies of individual actors in their quest for resources and power inside the organization as they mobilized different arguments and modes of critique.

Instead, we sought to analyse the ways in which such arguments, justifications, demonstrations, and critiques re-ordered the choices with which MSF practitioners were faced. For instance, in the summer of 2017, members of the CRASH began to criticize the use of standardized mortality thresholds for the definition of emergency situations, especially insofar as these thresholds, being based on data from the 1980s, were outdated. This had the effect of initiating the development of a new tool: a map interface which was also a database containing the most up to

date mortality data, making it possible to pass a cursor over a region or a city and *see* mortality spatialized. This new cognitive prosthetic has the capacity to reorder strategic planning operations, especially insofar it made novel kinds of comparison between field sites and between mortality rates possible. A criticism made in terms of "old data" has the power to transform the kinds of choices MSF faced when deciding where to intervene based on mortality rates. Today, there is a (contested) movement inside MSF-OCP to abandon the use of strict mortality thresholds to define emergencies and to make resource-allocation decisions. In other words, analysis of ethical reflexivity aimed to take into consideration not only the arguments mobilized, but also the unpredictable ways these discussions transformed the *genuine choices* to be made, and thereby transformed *MSF*.

d. Totalizing MSF: Inquiries into Inquiries on MSF

The mode of analysis discussed in the previous section can be divided into three parts: we are interested in describing humanitarian locations, in describing how these locations participate in ordering attention and situations of choice, and in describing how discussions surrounding these situations of choice then affect the kind of organization MSF becomes. In a phrase, I claim to qualify *MSF-as-a-whole* through this dissertation. And yet the four humanitarian locations we have mentioned - humanitarian space, the field, medical platforms, and headquarters - do not begin to cover the possible spaces where MSF's humanitarian action takes place.[1] How is it then that I can claim to talk about *all* of MSF, or at least *MSF-as-a-whole*? I will not manage to make a complete list of the kinds of choices with which humanitarian practitioners are faced. Nor will I suggest that we unify MSF behind a single value or a coherent set of beliefs and practices - something like Atlani-Duault's "institutional ideology", which seeks to qualify the "political coherence of those constructions made of practices and discourses on social suffering" (2009, p. 37 my translation), which, for MSF, might resemble Redfield's *secular value of life* (2013). Nor will MSF be made into an ideal-type, that turns medical humanitarianism into a regime of global health to be contrasted with global health security - this is what Andrew Lakoff and Stephen Collier do (2010), also building on Redfield's *secular value of life*. I do not claim that my inquiries, on their own,

[1] There have been numerous discussions on the distinction between *place* and *space* in geography. Against the positivist propositions of geography as an objective spatial science, humanist geographies build on existentialism and phenomenology to analyse the *sense of place* of lived-in space. The work of Edward Relph (2008) is a case in point. Critical of work on *sense of place*, Marxist geographers have claimed that these support a conception of space as an *absolute*, understood to support the abstract spaces of capitalism (Lefebvre 1974). With Soja (1989), *place* is a form of *space*, that emerges through practices of power and naming. On these discussions, see Phil Hubbard's useful introduction in Atkinson *et al,* 2005).

allow me to produce an exhaustive or representative description of MSF. And yet, this is a monograph of MSF, and I do claim to be able to say something about *MSF-as-a-whole*.

The issue is of some import, given that in the last decade, at least three ethnographic monographs have been written on MSF (Rambaud 2013; Redfield 2013; Fox 2014). In the last two decades, numerous others have taken MSF as a case for wider discussions on the field of humanitarian action (Siméant & Dauvin 2002, Fassin 2012, Krause 2015, Abramowitz & Panter-Brick 2018). Interestingly, such texts disagree on some very basic issues when it comes to characterizing "MSF". Let us take two of the book-length monographs of MSF as an example, Peter Redfield's *Life in Crisis* and Renée Fox's *Doctors Without Borders* (Redfield 2013; Fox 2014). Both are based on years of ethnographic inquiry, undertaken by respected and mature social scientists. They are published a year apart, and differences cannot be attributed to historical changes in an organization created in 1971. And yet they disagree on such simple questions as to whether MSF avoids working with local NGOs or seeks to work with local NGOs; whether they avoid public health approaches, or whether their history is defined by a progressive attachment to professional public health. Our strategy for totalizing MSF is not to come to a definitive conclusion about these disagreements, to have the last word, to say that MSF definitely does or definitely does not do public health.

To my mind, the problem with such strategies relates back to questions raised by postmodern anthropologists in the 1980s during the "crisis of totalization" (Dodier & Baszanger 1997). For instance, Renato Rosaldo claims in his contribution to Marcus & Clifford's *Writing Culture* that the totality of the object of study is primarily an effect of the ethnographer's authority (Rosaldo 1986). In his reading of two anthropological classics - Evans-Pritchard's *The Nuer* and Le Roy Ladurie's *Montaillou* - ethnographic totalization takes place at two moments: when the fieldworker puts their informants to The Question as would an inquisitor, and when the ethnographer's authoritative writing style bludgeons the reader into acceptance. The starting hypothesis of this dissertation is that MSF exists outside of the fieldwork I conducted and despite the text you now read. Yet Rosaldo levels a serious critique against anthropological inquiry and writing, and we must be very careful when attributing totality to our objects.

To deal with these dangers, we develop a pragmatist strategy for totalizing MSF: we describe the inquiries led by members of MSF that seek to totalize MSF. This means that criteria for retaining the four humanitarian locations mentioned above - humanitarian space, the field, a medical platform, headquarters - was not that they could offer a *representative* view of MSF-as-a-whole through extrapolation, or that they could be *added* up through simple arithmetic to arrive at

the sum total of the organization. Rather, these locations were retained because MSF practitioners give a great deal of thought to the problems each of these locations pose for MSF-as-a-whole. As mentioned previously, we take reflexivity to entail conducting local *inquiries* into states of affairs, the qualities of people and things, as well as the appropriate political and ethical stance to adopt. In each of these locations, *inquiries* are conducted into the characteristics of "MSF-as-a-whole", especially insofar as members of MSF are not always sure of what "MSF" should be or do. Humanitarian practitioners lead inquiries in order to be able to attribute to MSF certain characteristics or to claim that MSF ought to develop certain characteristics: MSF has or ought to have a kind of politics, an epistemic infrastructure, a mode of engaging with human life, and organization-wide strategic orientations. It is through *an inquiry into these inquiries* that we will be describing MSF's politics as nongovernmental (Chapter 1); we will describe the epistemic infrastructure of field epidemiology that cancels out the distinction between the local and the global field of humanitarian action even as it orders the point of con-tact with beneficiaries (Chapter 2). We will describe the ethical implications, affecting MSF-as-a-whole, of approaching human life as always potentially on the brink of irreversible morbidities and death (Chapter 3). We will describe a series of strategic orientations defined through practices of calculating the value of humanitarian projects, which tells us about the values of MSF (Chapter 4). These are some of the ways that the globality of MSF is achieved in practice, in moments of reflexivity, by members of the NGO. In other words, the totality of the object of study - MSF - does not emerge from my own multi-sited ethnography, as is the case for Marcus' "world-system" (1995). I hope the reader accepts that if I manage to write convincingly – and I will try to do so – this does not me that "MSF" is the effect of an authoritative writing style, as Rosaldo would have it. The analytical strategy we adopt to get at "all of MSF" is to conduct an inquiry into the inquiries led by MSF practitioners on the qualities and capacities of the organization of which they are a part.

The inquiry I have conducted is only one among many relevant inquiries into the global consistency of MSF. It is important, however, that we place this dissertation in that long list of investigations, if we are to understand something of its performative effects.

e. On the Ethics of Doing Research *with* MSF

This dissertation - as a response to a request made by members of MSF to study triage - is itself an *instrument* of inquiry into triage that I have made available to the organization throughout this thesis, through reports I have written, presentations I have made, and intermediary versions of various chapters. We also specifically mentioned that inquires, and the controversies they spark, can have the curious effect of modifying the characteristics of the entities and collectives initially

engaged in the debate. This was our third analytical gesture, to look at the ways controversies over triage decisions modify the kinds of choices that could emerge. This is one reason this is not a dissertation *on MSF*, but a dissertation *with MSF*. The peculiar ethical conundrums that this position entails have imbued certain sections of this dissertation with a moralizing flavour, that will not be to the taste of every reader. Please allow me, at the very least, the opportunity to explain this choice.

I have claimed that this inquiry carries with it potential normative effects in MSF. Being aware of this does not mean that I am entirely lucid when it comes to these affects or to my own normative engagements. For instance, if this dissertation is read by members of MSF, they will most likely be members of the CRASH, mentioned above. According to the CRASH's website, their "raison d'être" is to "animate debate and critical reflection on [MSF's] field practices and public positioning in order to improve the association's action."[1] Given that their objective is to "improve the action" of MSF, they produce books, studies, and public statements, situated somewhere between scientific knowledge, public engagement, and humanitarian expertise. Inside MSF, the CRASH seeks to occupy a position of reflexivity and critique. Some have claimed that the CRASH's unique position and their capacity to formulate criticism has afforded them great authority, at the expense of other groups and other, less outspoken, modes of reflexivity (Rambaud 2009). We can take this to indicate the possibility that this study on triage in MSF-OCP, in collaboration with the CRASH, has led me to take part in debates, that exceed my awareness of them, and have micropolitical effects inside the organization.

The lack of lucidity about the effects of inquiry and about my own normative engagements is perhaps a good reason to place political and ethical reflexivity outside of scientific practice - necessary to science, perhaps, but not science. Yet, if we claim that we should make no attempt at right action because it is impossible to get a complete idea of our normative engagements, we risk falling into the trap of moral nihilism. As such, the impossibility of providing a complete account of my own normative engagements and of grasping the potential normative effects of this dissertation does not place them outside of the realm of science – because science always already entails normative engagements - nor does it exempt me from responsibility for them.

[1] http://www.msf-crash.org/qui-sommes-nous/ Translated from French by the author. Site last visited: September 2016.

But what can be the basis of ethical science when I am unable to get to the bottom of my normative engagements? Pursuing this question means potentially getting caught in a reflexivity loop, and this is precisely one form that the critique of the poststructuralist conception of the subject has taken. With a subject that is always in the process of becoming, always partially unknown to itself, always partially unaware of the norms that regulate its relations to the Other, we lose the very foundation of personal and social responsibility. In a word, an ungrounded subject seems to make ethical action impossible. Judith Butler has provided what is, to my mind, a convincing rebuttal of this critique in her 2001 article entitled "Giving an Account of Oneself".[1] She claims that, given that 1/ it is precisely by virtue of its relation to the Other that the subject is constituted and that 2/ it is precisely by virtue of its relations to the Other that the subject is always at least partially unknown to itself, therefore, 3/ ethical responsibility is based on the willingness to risk one's subjective consistency in relation to the Other. This, too, is a kind of *attention*: a moment of suspension wherein I allow the object of attention – MSF – to penetrate thought, temporarily reinforcing the presence of the object, of the Other, perhaps at my own expense.

This is where I accept responsibility. By accepting the constraints posed by MSF in order to transform their reflexive practice into a social science writing machine, I am also risking myself. This is how I avoid getting caught both in the inertia or nihilism of unending reflexivity and the agnosticism of an unsustainable claim to exteriority.

*

Having discussed the strategies adopted to define a research question, to collect materials, to analyse those materials, to totalize the object of study, and to think through the performative effects of this dissertation, it is now time to consider the bodies of literature to which I can claim to make contributions.

3. Resources, Contributions, and a Point of Contention

In this section, we discuss analytical **resources** available to us in our attempt to locate global humanitarian aid - in the anthropology of the spaces of global circulation, the anthropology of global assemblages, and of the politics of resource distribution in global health. We will also mention the **contributions** we can make to these fields: an account of the topology of humanitarian locations, of the epistemic infrastructure that supports humanitarian technologies of intervention,

[1] I must thank Brice Laurent for this important reference.

and through a description of the ways humanitarians locations and epistemic infrastructure script for a certain kind of *beneficiary*. We then move on to a point of contention we develop regarding the usage of Michel Foucault in the anthropology of biomedical humanitarianism: namely, that this field inherits his tendency to unify, and thereby reduce, apparatuses to a single problem.

a. MSF's Global Humanitarian Presence: Topology, Assemblages, Health

A major **analytical objective** of this dissertation is to describe the global spaces of humanitarian aid. This will allow us to describe one current global – what we call *humanitarian presence* – and make contributions to a recently developed field in anthropology. This body of work seeks modes of description and analysis that do not place the "global" in opposition to the "local". This is done in a variety of ways: through the description of centres and periphery, flow and rupture, circulation and distribution, assemblages that territorialize and deterritorialize, and the topologies of relating across difference. Here, we discuss three sites of debate in anthropology on *the global* - global capitalism, global assemblages, and global health - in view to define what contributions this dissertation can make to these fields and to propose three possible sites from which we can qualify MSF's global humanitarian presence.

The first group of studies has taken *capitalism* and *development* as their object of analysis. Their roots can be traced back to the "total history" of Fernand Braudel (Braudel, 1992), the core and the periphery of dependency theory (Vernengo, 2006 for a useful introduction), and Immanuel Wallerstein's reworking of Marxist economics to constitute his world-systems analysis (2011). These early historical and economic theories were reworked in the 1990s to deal with the globalization of cultural production and scientific practice (Marcus, 1995; Appadurai, 1996). Capitalism, economic development, and the dynamics of culture and media continue to be a theme in the sociology and anthropology of global spaces. James Ferguson (2006) has shown how the spaces of global capitalism cannot be analysed in terms of James Scott's "grid" of the state (1998). Describing the work of extractive industries in Africa, Ferguson has also shown how the sites of extractive industries are *enclaves*, between which capital does not flow, but "hops" (2005). Anna Tsing's has made a similar move regarding the spaces of capitalist production and circulation, showing that the capitalist order cannot be problematized as producing a unified and homogenous whole (Tsing 2015). Rather, it maintains complex relations with an "outside", through global supply chains. These flows are not without "friction" (Tsing 2011) but allow for goods produced in predatory economic regimes to be integrated into the global flow of capital. We will contribute to this body of literature by describing the global spatial forms that a humanitarian organization

enacts around the world. We term these spaces ***humanitarian locations***, and we will describe them in terms of their topology.

Another influential line of analysis of the global has been formulated in terms of *global assemblages*. This relates back to the work of Aihwa Ong, Stephen Collier, and Andrew Lakoff (Ong & Collier 2008; Collier & Lakoff 2008). They have conceptualized how certain *global forms* – potentially valid everywhere, potentially bearing on how human life is lived *qua* biological life – territorialize in assemblages and create sites where anthropological problems - that is, the problems of "Man", of life, labour, and language, as described in Rabinow & Dreyfus' influential rereading of Foucault (Rabinow & Dreyfus 1983; Rabinow 2008) - can be posed. In these actualizations of the global in assemblages, "living" - in an ethical and biological sense of the word – is rendered problematic. Biomedicine constantly reworks what biological life could be, and with these changes, the *telos* of a "good life" becomes a slippery thing (Collier & Lakoff 2008; MacIntyre 2013). More recently, Andrew Lakoff has worked with Frédéric Keck in a similar vein on what they have called *sentinels*. The varied topologies of sentinels, with borders, interfaces, and reservoirs, are shown to rework the way individual and collective life is entangled with power relations, effectively demonstrating the limits of biopolitical governmentality for analysing public health interventions (Lakoff & Keck 2013; Keck 2008, 2014). In contribution to this body of literature, we seek to describe the ways specific assemblages oriented towards the production of knowledge on impending or ongoing emergencies bring into question Foucauldian conceptions of governmentality. We term these assemblages ***humanitarian technologies of intervention***, and we discuss three sorts - a mobile clinic as a technology of exploration (Chapter 2), field epidemiology as epistemic infrastructure (Chapter 2), and the early warning systems of emergency triage protocols (Chapter 3).

In rich dialogue with Stephen Collier and Andrew Lakoff is the research of a number of authors that have sought to analyse the modes of access to public health resources given the anthropological problems of living, as they relate to the continual renewal of what it means to live biological life, and the ways this relates to an ambiguous *telos* that might support a "good life". Adriana Petryna's research is a case in point. Specifically, her work describes the ways bodies, populations, and citizenship were redefined at the end of socialism and in the wake of the Chernobyl accident in Ukraine. Where rights were once based on the ability to situate citizens in predefined categories, science has become insufficient to the production of unambiguous knowledge of suffering as a category granting access to public resources. Through ethnographic description of new "at-risk" populations, Petryna proposes the concept of *biological citizenship* to

work through new modes of access to public resources (2002). More recently, in her 2009 book *When Experiments Travel*, Petryna proposes a political and ethical reading of the work of Contract Research Organizations (CRO) that undertake randomized control trials for pharmaceutical companies in the USA, Poland, and Brazil. Through ethnographic description, she underscores the ambiguities associated with making access to medicines depend on the experimental value of human subjects. In a similar vein, Vinh Kim Nguyen has analysed the organization of access to antiretrovirals in the years before they were made widely available in West Africa. His book, *Republic of Therapy* (2010), demonstrates how the practices of triage of Western donors and health structures participated in subjectivating recipients of treatment in very specific ways. The processes of triage incited potential recipients to recount their experiences in rituals of veridiction, in order to perform reliability and deservedness. This subjectivation is part of what Nguyen terms *therapeutic citizenship.* Referencing both Petryna and Nguyen, a 2014 article by Fanny Chabrol, based on her PhD dissertation (2017), analyses the multiple modes of access to antiretrovirals for people living with HIV in Botswana intersect. In the early 2000s, access to ARVs in Botswana became, simultaneously, a question of the pharmaceuticalization of public health (Biehl 2007), but also of the ethics of clinical trials, of national citizenship and of the performance of a reliable "development state". Global health, pharmaceuticals, biomedical science, and national public health intersect to effect novel forms of subjectivation supporting specific modes of access to health care. This line of thought - from Collier and Lakoff to Rabinow and Dreyfus, from Petryna to Nguyen and Chabrol - will provide inspiration to this dissertation. However, insofar as "the figure of the beneficiary contrasts with the figure of the citizen" – as Monika Krause has suggested[1] - our analysis does not conceptualize the target of humanitarian intervention as *biological* or *therapeutic citizens*, but as ***humanitarian beneficiaries***. In a move similar to that of Krause, who works out how the *beneficiaries* of state interventions figure in three New Public Management instruments, we describe how MSF's *humanitarian beneficiaries* figure in the form and usage of MSF's triage instruments.

As such, this dissertation will make contributions to current discussions in three fields of anthropological research on the global: the topologies of the global circulation analysed in terms

[1] "Citizens are thought to benefit from policies with broad goals; beneficiaries are shown to benefit from specific interventions. Citizens are owed service; beneficiaries are selected for intervention if it suits specific funding priorities." (Krause, 2010, p. 534). Where Krause's article focuses on the ways results-based management in the public sector increasingly scripts for beneficiaries instead of citizens, we focus, of course, on *humanitarian beneficiaries*. In Chapter 4, we will be discussing the point developed in this article and in Krause's book *The Good Project* (2014) that, contrary to citizens, who are "the origin of politics and the end of policies", beneficiaries are "a means to an organization's success and are transformed to be shown as results" (2010, p. 534).

of *humanitarian locations*; the territorialisation of global assemblages termed *humanitarian technologies of intervention*, as they demonstrate the limits of Foucauldian governmentality; and global modes of determining access to health resources, which we discuss through the ways the *humanitarian beneficiary* figures in MSF's triage instruments. Through our description of MSF's aid in practice, as well as the problems associated with these three concepts, we provide an account of MSF's *humanitarian presence*, in its physical extension and global consistency, its nongovernmental politics and its ethics of attention, and in the health care it practices.

b. Point of Contention: the anthropology of humanitarianism has a Foucault problem

As the reader may have gathered, this dissertation spends some time discussing the work of Michel Foucault. This is in part because Foucault is a resource. Alongside Deleuze & Guattari, Foucault's work marks an early interest in those objects, which he calls *dispositifs*, that do not fit nicely into homogenous zones, those composite ensembles of linguistic and non-linguistic elements (Dodier & Stavrianakis 2018). However, we will also claim that certain usages of Foucault in the anthropology of biomedical humanitarianism and global health are problematic. We will be engaging in earnest discussions with a number of influential authors from this field, all of whom take inspiration from Foucault, and who see continuity between the biopolitical governmentality of the modern state (Foucault, 2004a, 2004b), and the global health apparatus currently in place, especially in its humanitarian form. They hold that humanitarian global health is an iteration of biopolitical governmentality, with its disciplining interventions and forms of subjectivation. This is visible in the work of Didier Fassin (2012), Mariella Pandolfi (2000, 2003, 2008), Peter Redfield (2013), and Myriam Ticktin (2011). Redfield coined the oft-cited expression "minimum biopolitics", which supports the critique of a humanitarian reduction of "qualified life" to "bare life" in their "beneficiaries" (Agamben 1998). Fassin and Ticktin argue that "humanitarian reason" produces forms of governmentality that reduce the humanity of their beneficiaries, while forming humanitarian subjectivities based on the moral sentiments' ethical philosophy. These approaches to humanitarian action focus on the "tragic choices" of humanitarian action, in which dissonance between the goods potentially produced by humanitarians lead to a kind of "sacrificial logic", a "politics of life", based on hierarchies of life that establish which lives can be saved and which lives do the saving.

This body of literature has been productive. Yet, I will argue that they inherit at least two weaknesses from Foucault. The first is a tendency to attribute totality to *dispositifs* according to a series of interrelated strategies. We see this with *governmentality*. Through description of an

incredible variety of institutions and instruments, from the role of the king in the Hebrew tradition, to urban planning in Nantes in the 18th century, to the reorganization of medicine in the 19th century, Foucault sees one strategy: *governmentality*. This brings us to a second, and related, weakness, recognized by several committed experts of Foucault: his under-conceptualization of *territory*, and its reduction to a spatial strategy of control. Following Stuart Elden (2007), *territory*, despite featuring the title of *Security, Territory, Population*, serves primarily as a foil for more in-depth discussions of other forms of governmentality. As Foucault himself stated in the fourth lesson, a more appropriate title would have been "Security, Population, Government". Elden shows that despite this attempt to play down the importance of "territory", it keeps turning up, and at each turn, it is "repeatedly marginalised, eclipsed, and underplayed." William Walters makes a similar point in a 2010 article, speculating that the relative absence of the problems of territory and borders in Foucault's work might reflect the fact that "frontiers and border security was not a political issue in the 1970s in the way that it is today in many western states." Both Elden and Walters then suggest *ad hoc* modifications in the Foucauldian conceptual "toolbox" that would make it possible to integrate *territory*. However, the urban scholar Mattias Kärrholm brings up a more serious problem with the Foucauldian conceptualization of territory that both Walters and Elden fail to address: taking territory as the spatial strategy of sovereignty - in contrast to the problematics of circulation in the security regime - Foucault reduces territory to the power over life, and thereby fails to account for the variety of attachments that territory affords (Kärrholm 2007).

On its own, this critique of Foucault would have no place in a dissertation on MSF and humanitarian aid. Except of course that he is a shared reference to all anthropological studies in the field, and that - I will claim - they inherit these weaknesses from his work. An example in the literature on humanitarian action of this reduction of a *dispositif* to a single strategy, and of territory to spatial strategies of control, might be helpful. It is particularly visible in Mariella Pandolfi's concept of *mobile sovereignty* (2000, 2003, 2008). A reference for much of the work in the anthropology of humanitarianism, *mobile sovereignty* allowed Pandolfi to analyse the ways the militaro-humanitarian complex sapped local structures of power of their legitimacy in the late 1990s in the Balkans. She found other examples in western interventions in Somalia and Iraq in the 1990s. Mobile institutions carried with them globally recognized modes of justification and modes of governmentality, and established territory behind the barbed wire of their compounds. The concept has gained much traction in the anthropology of humanitarian action, and authors repeatedly demonstrate humanitarian strategies for establishing spatialized control in local power dynamics (Agier & Lecadet 2014; Abramowitz, 2015). It is of course understandable that

anthropologists feel the need to repeatedly demonstrate how humanitarians enact forms of spatial control in their areas of intervention, not least of all because it is empirically verifiable: humanitarians do indeed exercise spatialized control. Moreover, the idea that "*sovereignty has been unhinged from the state and is now running amok in war theatres around the globe*" (Hyde 2010, p. 170) sustains an important political point in the dynamics of this postcolonial world. However, it limits the spatial strategies that humanitarian territories afford to a kind of control that it steals from the state, and, in doing so, misses something essential about medical humanitarianism. It misses something about the kinds of relationships humanitarians can establish with their *beneficiaries* from humanitarian space.

In this thesis, I will argue that humanitarian locations afford spatial strategies and tactics that are not primarily about governing bodies. These locations order economies of attention that open strategies of *health care* that cannot be understood using the conceptual toolbox of biopolitics. I will show that the spatial configurations MSF enacts are meant to support a specific kind of relationship to populations. Humanitarians do not engage with populations as citizens, economic or experimental subjects, but as *beneficiaries requiring care*. Given that the locations of humanitarianism are configured specifically for these *beneficiaries*, we can learn quite a bit about them through the way these spaces are ordered, and the role beneficiaries are attributed. I will show that the role attributed to *beneficiaries* in these spaces cannot be reduced to those roles associated with biopolitics. In sum, our claim is that we must attribute an analytical specificity to the practice of *humanitarian aid* that distinguishes it from other forms of intervention. This is not to suggest that *control* is absent from the practices of care, that care is unconditionally good, or that beneficiaries necessarily, or even actually, benefit from humanitarian action. The proof of good care is in the pudding of practice: as the etymology of the word *beneficiary* reminds us, the "good" (bene) has to be "done" (facere), and nothing guarantees success.

As already mentioned, the *critique* that we seek to develop in this dissertation consists in underscoring the ambiguity of humanitarian action. There are numerous theoretical and empirical resources in the literature on care ethics that underscore the ambiguity of care in practice, which we discussed above (Tronto, 1993; Mol, 2007; Mol, Moser & Pols, 2010; Murphy, 2015; Hennion & Vidal-Naquet 2015). With these ambiguities in mind, I will hold that humanitarian spatial assemblages order attention in such a manner as to continually renew efforts to ensure that the targets of their interventions become *beneficiaries*. Our argument is that *humanitarians must make a place where their beneficiaries can become vulnerable*, that is, a place where beneficiaries can accept the position of person in need of help without this position being in contradiction with the

conception they have of themselves. There are clear cases when these attempts fail, and efforts must once again be redoubled.

These are the resources that I will oppose to the biopolitical steamroller and to those authors who see territory exclusively in terms of strategies of control or government.

4. Outline of the argument

We will respond to our research question – how are beneficiaries selected around the world? - in four chapters. One *humanitarian location* will be analysed in each chapter: *humanitarian space*, *the field*, *medical platforms*, and *headquarters*.

In **Chapter 1**, we will explore the kind of politics that MSF organizes from *humanitarian space*. To do so, we will describe a common humanitarian technology of intervention, *mobile clinics*, based on observation and interviews in Paris, as well as analysis of MSF videos presenting mobile clinics around the world. This will allow us to discuss the political and ethical effects of MSF's *mobility* and *territorialisation*, as they relate to the kinds of connections MSF practitioners maintain with sovereign actors and beneficiaries in a complex institutional ecology. Through a discussion of its conceptualization, and a description of its everyday material enactment, I will demonstrate that *humanitarian space* is meant to allow MSF to engage in a rather specific brand of politics. My qualification of the politics of *Doctors Without Borders* is based on the reworking of two oft-discussed boundaries in the social sciences. First, between *ethics and politics*. Second, between *governmental and nongovernmental politics.* I will contend that MSF maintains this second boundary, establishing themselves squarely on the side of *nongovernmental politics*, and that they displace the boundary between ethics and politics. This is *humanitarian politics* as organized from their *territory without government*, that is, humanitarian space.

In **Chapter 2**, we ask if the fact that MSF's politics are nongovernmental means that the field of humanitarian action is an "other place", that is, a Foucauldian *heterotopia*. The peculiar positionality of *the field of humanitarian aid* - somehow outside of government but influencing government - might give the impression that it is ordered in a way that is different from the *rest* of society. Indeed, "going into the field" is often experienced and described, by humanitarians and social scientists alike, as a journey into otherness; opposed to home, office, headquarters, and laboratory, the field is an "other place". We will show that we cannot reduce this otherness to its opposition to a single, unified order. Instead, we must sustain prolonged interest in the multiple modes of ordering and practices of place that enact the field of humanitarian aid, while paying close attention to the place of the *beneficiary* in this location. To make this demonstration, we

describe the practices of knowledge production that open the field at the start of humanitarian interventions. These practices are what MSF practitioners call *explo/action*. Our description is based on observation of data collection practices on MSF's project in Paris, interviews with fieldworkers and epidemiologists, textual analysis of methodology guides for collecting data edited by MSF, as well as a report of debates inside MSF on the emergency thresholds for mortality rates. In addition, we will provide a short history, based on analysis of scientific literature in the field of epidemiology, of MSF's role in developing the use of field epidemiology to inform humanitarian projects.

By the time we arrive in **Chapter 3**, we will be ready to face, head-on, the problem of triage. Once again, our approach consists in taking what MSF practitioners do seriously, believing them when they present the ends attributed to their activities, and building on their reflexive practice to rework common-sense social science. The results provide a radically different account of the ethics of emergency triage than those currently available in anthropology and sociology. The main point of this chapter will be that *triage* practice, as it takes place, cannot be fruitfully described as a "tragic choice" made in the name of the sacrifice of the few for the renewal of a political order. Instead, triage is a practice that creates the option of saving lives in situations when it is particularly difficult to answer the two questions of ethics: *what is it that is going here?* and *what is it that we should do?* To make this point, we will examine an MSF project in the slums to the east of Nairobi. This project is composed of a Call Centre, an ambulance service, and a "trauma room". MSF receives calls, dispatches ambulances, and then seeks to get these patients accepted into public facilities. The trauma room makes it possible to stabilize patients before transfer. This set-up will be analysed in terms of a *platform for emergency*. This mode of ordering emergencies in Nairobi has two essential components: *patient triage* and *patient transfer*; a moment when MSF defines their responsibility towards patients, and a moment when MSF transfers this responsibility to national health services. This discussion will also help us to qualify one way a humanitarian assemblage enacts human bodies as always potentially on the brink of rapid and irreversible deterioration, that is, as *fragile lives*.

In this **final chapter**, we discuss *project closure,* and we contribute to the literature that discusses how such decisions are made. Despite widespread disagreements about the proper justification and procedures for "exit", anthropologists and philosophers seem to share the assumption that humanitarian organizations are capable of *strategically oriented decision-making based on a kind of value rationality*. We do not question these assumptions, but nor would we take such capacities for granted. Instead, we seek to provide an account of the specific spatial and

temporal consistency that supports the development of such capacities in MSF. Our first surprise is that decisions to close a project can only be made in *headquarters*, even when it consists in recognizing a *fait accompli.* As such, we take as our starting hypothesis that there is something about headquarters that provides MSF with what is necessary for project closure. To account for this, this chapter is based on an ethnography of project evaluation and planning meetings in headquarters, focusing on moments when closure was discussed or decided. We show how the spatial ordering of MSF 'headquarters entities', at a distance from the field and the beneficiary, participates in making MSF capable of *strategy*. Following Michel de Certeau, we will show that strategy is based on the circumscription of a place of one's own for MSF, a place from which it becomes possible to look out on the world as if it was a flat surface, to read a system of relations and to calculate moves that produce *outcomes of worth*. We then attend a series of meetings to discuss how *outcomes of worth*, or *project values*, are calculated – by being projected into a flat surface and recombined - and how they then come to reinvest the world as *ways forward*. Of course, there are different ways of calculating the values of a project and there can be disagreements about which value, or which calculation, should be retained. As such, we end this chapter by focusing on organizational decision-making. We suggest that decision-making entails reducing the number of possible *ways forward* to only one. Our goal will be to describe a number of ways that *closure* becomes the only viable way forward.

In this dissertation, we organize the problems of deciding where to intervene and whom to help according to three terms: *humanitarian locations, humanitarian beneficiaries, humanitarian technologies of intervention*. The four locations we discuss – *humanitarian space, the field, medical platforms,* and *headquarters* - will be described as the material production of a set of *humanitarian technologies of intervention* (a mobile clinic, an epistemic infrastructure, a medical speciality, project evaluation, and strategic planning, among others). *Humanitarian locations* and *technologies of intervention* order attention in different ways, and the characteristics and capacities attributed to *humanitarian beneficiaries* vary with them. The characteristics of beneficiaries also constrain the production of space and planning of interventions. These three terms, and their associated problems, designate what we call MSF's ***humanitarian presence***, that is, the specific forms of their global physical extension, as well as the politics of their interventions into space of governing bodies and the ethics of their interventions into the bodies of the governed. We will come back to this concept in the conclusion, to show what it will have allowed us to accomplish and the kind of critique that it supports.

Chapitre Un
Territoire sans gouvernement :
Ethique et politique de l'espace humanitaire mobile

Dans ce premier chapitre, nous allons explorer l'action politique que MSF cherche à accomplir depuis son *espace humanitaire*. Pour ce faire, nous prenons pour objet une technologie d'intervention très commune : les cliniques mobiles. Nos analyses sont basées sur l'observation et des entretiens, ainsi que l'analyse de vidéos présentant des cliniques mobiles autour du monde. Ces matériaux nous permettront de discuter des effets politiques et éthiques de la mobilité et de la territorialisation de MSF, alors qu'ils s'installent et établissent des relations avec des acteurs souverains et des bénéficiaires dans une écologie institutionnelle complexe. En discutant de sa conceptualisation et en décrivant sa production matérielle, nous démontrerons que l'espace humanitaire soutient un engagement politique particulier. Pour qualifier cette politique, nous devons retravailler deux frontières souvent discutées en sciences sociales : celles qui coupent entre éthique et politique, d'un côté, et de l'autre, entre gouvernemental et non-gouvernemental. Nous soutenons dans ce chapitre que MSF maintient cette seconde frontière pour s'établir du côté de la politique non-gouvernementale, en même temps qu'elle déplace la frontière entre éthique et politique pour mener de front une politique qui se soucie de l'éthique de ses relations avec des bénéficiaires. C'est bien cela la *politique humanitaire*. Nous procéderons en trois temps.

1. L'espace humanitaire comme concept relationnel. Nous commençons en discutant un concept clé pour comprendre l'éthique et la politique de l'espace que fabrique MSF : l'espace humanitaire. Conceptualisé et popularisé par Rony Brauman, ex-président de MSF, nous verrons que l'espace humanitaire a servi à théoriser la politique et l'éthique des espaces que MSF crée par son action. Passant par la discussion de quelques textes clés, nous décomposerons l'espace humanitaires en concepts constitutifs afin d'identifier les problèmes qu'il permet de gérer. Il apparaît tout d'abord que l'espace humanitaire est un concept relationnel. Il sert à gérer des problèmes d'écologie institutionnelles, de souveraineté, et d'éthique, alors que MSF sonde les limites de leur action avec ceux et celles qu'ils cherchent à secourir, avec des acteurs souverains, et avec d'autres institutions. De deux, nous verrons qu'en tant que concept relationnel, une des capacités de l'espace humanitaire et de faire prendre conscience de la limite qui sépare l'aide aux « victimes » et l'appui aux « bourreaux ». Pour MSF, cette frontière ne peut être définie *a priori*, et pour rester du côté de leurs bénéficiaires, ils doivent accepter de travailler avec des acteurs peu recommandables. Nous devons donc imaginer la fabrique de l'espace humanitaire comme une tactique qui permet à MSF de s'insinuer jusqu'à dans l'espace étatique pour tenter d'apporter des modifications partielles et de catalyser des points bascules, au lieu d'amener des changements radicaux au niveau des politiques globales. Nous finirons cette section en discutant de la politique de MSF à Paris, pour conclure qu'ils s'engagent dans ce que nous appellerons,

avec le philosophe Michel Feher, *la politique non-gouvernementale*. Nous décrivons donc l'espace humanitaire comme un *territoire sans gouvernement*.

2. La politique de la fabrique matérielle de l'espace humanitaire. Ici nous décrirons les spatialités matérielles de la clinique mobile à Porte de la Chapelle. Ceci est un pas de côté par rapport à l'espace humanitaire en tant que concept légal, éthique, et politique. Pour rendre compte de sa fabrique matérielle, nous explorerons les topologies des productions territoriales de la clinique mobile. Cela nous mènera ensuite à une prise en compte de la mobilité de la clinique mobile, spécifiquement par une abstraction que nous appelons *la séquence de mobilité*. Nous finirons cette partie en décrivant les tactiques politiques de la mobilité et de la territorialisation de la clinique mobile. Nous montrerons comment les rythmes de la mobilité associés à la clinique mobile permettent : la possibilité du témoignage ; la déterritorialisation et la reterritorialisation rapide ; de jouer sur les tensions entre visibilité et présence ; et une adaptation progressive à une niche écologique. Ces tactiques permettent à MSF de se déplacer dans un espace densément peuplé, pour rester proche de leurs bénéficiaires, tout en évitant des conflits avec des acteurs étatiques et institutionnelles. Ces tactiques de la mobilité s'intègrent dans la stratégie de politique non-gouvernementale de MSF en Europe.

3. Triage aux frontières : sur la duplicité de l'opposition inclusion/exclusion. Dans cette dernière section, je décrirais un dispositif de triage développé et déployé à la mobile clinique à Porte de la Chapelle, dans ses liens potentiels avec la fabrique de frontières et d'autres productions spatiales. Nous verrons comment l'outil en question – une liste – participe à la performance de l'espace humanitaire en tant que territoire « bordé », avec un intérieur et un extérieur, un accès contrôlé, et une régulation des comportements. Parmi les compétences de cette liste est la régulation du *flux des patients* à travers les différents espaces de la clinique. Pour y arriver, la liste soutient un nombre important de responsabilités cognitives et éthiques pour le personnel de MSF. Nous verrons aussi qu'il produit un espace et un temps qui sont *ouverts*, où l'attention du personnel de MSF peut être dirigée vers celles et ceux que MSF souhaite secourir. Enfin, par la description ethnographique des pratiques de refus de soin, nous verrons comment la variété des pratiques de prise de décision dépassent largement l'opposition binaire entre exclusion et inclusion, pour souligner la diversité des formes que le *care* peut investir dans l'espace humanitaire.

En somme, ce chapitre traite des problèmes éthiques dont l'aménagement de l'espace humanitaire permet de gérer, ainsi que les politiques que cet aménagement soutient. Il traite des tactiques politiques qu'afforde la fabrique matérielle et les formes de production territoriale de l'espace humanitaire. Il traite des pratiques de triage, la mise en frontières, et l'opposition inclusion/exclusion. Nous conclurons avec une histoire alternative du lien avec éthique et politique. Nous soutiendrons que l'histoire des *sentiments moraux* n'est pas celle d'une invasion de la politique par la morale, pour établir des formes de solidarité basée sur une vulnérabilité

constitutive de l'expérience humaine. Suivant le travail de la philosophe politique Joan Tronto, il s'agira de montrer que l'histoire des sentiments moraux est celle de l'invention de la politique et de l'éthique en tant que domaines indépendants – condition nécessaire à une « invasion ». A la fin du chapitre, nous aurions décrit comment l'espace humanitaire soutient dans sa production même l'éthique de la politique non-gouvernementale. En effet, la politique humanitaire est beaucoup plus radicale que la simple irruption de l'éthique dans la politique ; il s'agit d'un appel à déplacer la frontière qui les sépare pour développer une solution au problème que cette frontière résout en faisant comme s'il n'existait pas : la fragilité de la vie humaine.

Chapter One

Territory Without Government. The Political Ethics of Mobile Humanitarian Space

Question: What are the politics of humanitarian space?

In the 18th arrondissement of the city of Paris, on Boulevard Ney at *Porte de la Chapelle*, exhaust fumes make breathing a chore. This is where the city of Paris charged a large French non-profit organization (NPO), *Emmaüs Solidarité*, with setting up and administering its "humanitarian centre" in October 2016, in response to the "European migrant crisis". Having lived in Paris for several years, I was familiar with the neighbourhood. It had changed considerably when my fieldwork started in March 2017. Hundreds of people had set themselves up under the underpasses of the intertwining ring road, highway, railroad and tramlines. Some had tents; others did not. Parisians stopped and stared. The city had connected a stainless-steel sink unit to a fire hydrant, and six faucets spit out potable water. Portable toilets had also been made available, but not showers. Occasionally, station wagons would stop along the side of the road and hastily distribute hot meals, hoping to get away before police patrol cars fine them for illegal parking. At other times

- usually early in the morning, but opening hours were changed often and without notice - long lines would extend out from the entrance of the "humanitarian centre". Those sleeping around the centre would try to get inside where there were beds, hot showers, doctors, and hopes of obtaining legal status. However, there were only 500 beds inside. The centre limited people's stay to 10 days, but there was still not enough space for everyone. So, thousands of migrants are sleeping in the streets of Paris, hundreds of them at Porte de la Chapelle. Sometimes all those people, sleeping among the boulders on the central median disappear overnight: the prefecture had decided to relocate them to gymnasiums outside the city. New people come and soon it is as before.

In this chapter, I deal with *the politics of space* at Porte de la Chapelle. I describe how this space is produced, I define a number of problems this space must deal with, I explore some of the spatial tactics of the beings that inhabit it. More fundamentally, I ask what kind of space this is. Is this the space of humanitarianism? Is it state space? It is hard to tell the difference here, and it could be something else entirely. We're in an international tourist destination, next to a "humanitarian centre" run by the city of Paris, working in coordination with the ministry of the Interior, delegating activities to an NPO, that are contested by a very politicized civil society. This space has another surprising characteristic: we may be at the very centre of the French state, in its capital, hundreds of kilometres from a materialized border, yet that boundary between legal and illegal presence is palpable. Here is one of the sites where the so-called "European migrant crisis" is taking place.

The work of humanitarian organizations is central to the ordering of this space. The "humanitarian centre" is run by *Emmaüs Solidarité* and the French Red Cross, with the help of small, local NPO, called Utopia56. Several smaller organizations and citizen collectives offer food and clothes. *Médecins sans frontiers* (MSF) sets up a *mobile clinic* on the pavement a few afternoons a week. These are the organizations that are active in the management of migrants at Porte de la Chapelle. It is *their* space, as it intersects with other spaces, that I will be analysing in the present chapter. This space is designated as "humanitarian", and yet, if this is the space of humanitarianism, it is criss-crossed by, and it criss-crosses, many other kinds of spaces.

A recent and evocative analysis of the space of humanitarians in the "European migrant crisis" has been put forward by Polly Pallister-Wilkins. She has suggested that what is happening at *Porte de la Chapelle* should be approached as a *"humanitarian borderscape"*, that is, part of a decentred national border, where the "complementary logics of care and control", and the "inclusion of non-state actors into borderwork" are discernible (Pallister-Wilkins 2018: 116). There is indeed all of this. *Emmaüs Solidarité* and MSF, as we shall soon see, participate in getting some migrants past the barrier of legal presence. In other words, there are non-state actors charged with

providing care and who take part in borderwork. Here, care and control complement each other. This could be spun in a positive light: a humanitarian ethics of care improving the lot of those who fall under the control of a state bogged down in political realism or bureaucratic formalism. Pallister-Wilkins problematizes the intervention of humanitarian actors into "borderscapes" a bit differently. In her words, humanitarian NGOs:

> *both challenge the international order of territorialised and sovereign states and at the same time consolidate it by everyday practices of reterritorialisation through processes of triage or ordering that enact hierarchies of humanitarian victimhood, or what Fassin calls of 'politics of life' (2012). These processes of categorising humanitarian victims that enact processes of inclusion and exclusion can be understood as a form of bordering (Pallister-Wilkins 2018: 120).*

In sum, the politics of space at Porte de la Chapelle would put humanitarian action in a position of reinforcing the government of deterritorialised, mobile, migrant bodies by forcing them to reterritorialise, through the inclusion and exclusion practices of triage, necessary to the provision of care. These practices perform "hierarchies of victimhood", and, in their push to get the most "vulnerable" onto the legal side of presence, they enact national borders.

Pallister-Wilkins' point is to foreground the ways in which humanitarians participate in the production of a shared space – a borderscape – where hybrid logics complement each other, resulting in *humanitarian government*. She identifies a few problems associated with this kind of space. Specifically, she holds that the introduction of humanitarian actors into this borderscape leads to framing problems encountered by migrants in purely "humanitarian" terms, which limits possible responses and evades the "issues". These "issues" can only be solved "politically". Thus, if the practices taking place in the "humanitarian borderscape" can be described as governmental, their politics is that of depoliticization. To her mind, the "issue" is with European migration policy and its ties to an economic and political order. Because of their lack of reflexivity concerning the role they play in the control of migrant bodies and populations, humanitarians – Pallister-Wilkins is describing the work of MSF in Europe – become the implementers of "humanitarian government".

Pallister-Wilkins builds here on the work of Didier Fassin (2007, 2010, 2012). To clarify two of the points she makes with regard to her humanitarian borderscape – that humanitarian triage plays a role in "bordering"; that this bordering is part of a humanitarian government of bodies – it is useful to look directly at his work. As Didier Fassin states, humanitarianism is "the continuation of politics by other means" (2010: 269). Starting out with Michel Foucault's "government of men", and defining "government" as the "the more or less institutionalized practices by which human beings act on the behaviour and destinies of other humans" (2010: 269), Fassin puts "humanitarian

government" alongside "economic" and "political government". The genealogy of this humanitarian government follows the introduction of moral sentiments – by which people feel concern for one another - into the "political sphere" at the end of the 18th century. This concern forms the basis of a specific kind of solidarity. Unlike political and economic solidarity, humanitarian government, couched in moral sentiments, is concerned with all those categories constituted in terms of "vulnerability". The problem with "vulnerability" is that it fails to account for the human condition in its breadth, understood in terms of sameness and difference, referencing Hannah Arendt. This is a powerful criticism of humanitarianism: humanitarian government tends to transform difference into need differentials. This reduction is violent and dangerous.

These contradictions between the government through concern and solidarity and the reduction of difference are particularly visible in practices of triage and bordering, presented in terms of "inclusion and exclusion". Insofar as humanitarians have difficulty accepting the sacrifice of human well-being for some greater good, they refuse many forms of political action that would depend on the suffering of a few to ensure the well-being of the many.[1] Yet there is no humanitarian action without the "tragic choices" of triage.[2] Triage, deciding to help some and let others suffer or perish, necessarily entails a hierarchizing of life, or, to be more precise, of lives. It involves the decision that some people's suffering requires a response and other people's suffering does not. When this hierarchizing is the basis for action, humanitarians are in effect participating in a kind of sacrificial politics, abandoning some to their fate while coming to the aid of others, justifying this selection according to the differential worth of human lives (Fassin, 2007, 2012). Fassin and Pallister-Wilkins' contention is that the borderwork accomplished through the 'politics of life' MSF enacts as it triages is founded on restricted categories of humanity, i.e., humans as universally vulnerable beings. As such, it does not consider the full human experience of those it supports and is so blind to such important aspects of human existence that it risks harming those it hopes to help. When these hierarchizing practices take place in the "humanitarian borderscape", with MSF using medical need to push migrants onto the other side of borders, humanitarians actively participate in the borderwork of states. That is, as humanitarians claim to take care of the most basic needs of migrants, they are in fact part of an international order that territorializes mobile bodies to better govern them. This approach is similar to the work of Miriam Ticktin (2006, 2011). Ticktin's work

[1] The moral difficulty of political sacrifice, of designating a scapegoat, has been addressed in fiction by Ursula K. Le Guin, in her short story entitled "The Ones Who Walk Away from Omelas". Le Guin has stated that the idea for the piece came from William James' "The Moral Philosopher and the Moral Life". The quotation that Le Guin takes from James is this thesis' epigraph.

[2] I will be dealing more directly with the "tragic choices" approach to triage in Chapter 3.

deals with humanitarian politics in light of the "humanitarian clause" in French migration law, which allows gravely ill foreign nationals, without access to adequate services in their own countries, to legally access French national territory and health services. She wonders about the government of life that this serves. Ticktin argues that, through a sick and ironic twist, the "humanitarian clause" reduces the humanity of those who use it. The illness comes to stand in for the person, their sick bodies justify their being in France. Once again, humans are reduced to bodily needs, failing to account for the irreducible specificity of each and every individual.

This chapter should be read as a complication. It is a "yes, but…", a "and this too…". I will be building on the suggestion the MSF engages in "bordering" and "humanitarian government" through triage practices and the constitution of a space for humanitarianism in the European borderscape. I find Pallister-Wilkins' spatial approach to humanitarian politics stimulating, but I have serious doubts about her conceptualization of space. I am equally astonished by Fassin's reduction of humanitarian action to Foucauldian governmentality with a twist, and I have doubts concerning his analysis of the incursion of ethics into politics. The shared critique of Fassin, Ticktin, and Pallister-Wilkins – pointing to the potential of humanitarianism as a reduction of difference to vulnerability through governmentality – constitutes a grave ethical and political danger to humanitarian action.[1] Nevertheless, something else is happening at Porte de la Chapelle. Therefore, I will be giving humanitarians the benefit of the doubt. They are perhaps more reflexive than these authors would give them credit for. They know they are doing politics. They are aware of at least some of the possible adverse and perverse effects of their activities. Yet they stubbornly persevere, despite the practical difficulties and ethical dangers they face, in the provision of care to people in situations of vulnerability. What is it they are doing that is so important that it is worth this moral risk?

I will be exploring these issues through a description of the activities of a *mobile clinic* that MSF set up in Paris in December 2016, next to the "humanitarian centre" mentioned above, in response to the "European migrant crisis". I will describe how the mobile clinic, as *a political technology of intervention*, enacts humanitarian space. Specifically, I will be interested in the territorial, ecological, and ethical intelligence *humanitarian space* affords MSF practitioners, in their relations with those they wish to serve, with actors claiming sovereignty, and with other NGOs and NPOs.

[1] Not only to humanitarian action, but to all practices of care and aid.

The chapter is divided into three sections.

1. A Brief Presentation of Humanitarian Space as a Relational Concept

To begin, we will discuss a key concept for understanding the politics and ethics of the space enacted by MSF, what is termed *humanitarian space*. Conceptualized and popularized by one of MSF's presidents – Rony Brauman – we will be discussing how humanitarians and MSF practitioners have theorized the politics and ethics of the space they enact. To do so, we will be discussing a few key texts in the literature on the concept of *humanitarian space*. This will allow us to decompose humanitarian space into a number of constitutive concepts and to identify some recurring problems it is meant to deal with. We will see that it is a relational concept. It is meant to deal precisely with problems of ecology, sovereignty, and ethics, helping humanitarians define boundaries and possibilities of working together, in their relations with those they hope to serve, as well as with state, military, and local authorities, and with other institutions. Second, we will see that as a relational concept, one of the key competencies of humanitarian space as a concept is to enact an awareness of that limit separating aid to "victims" and support for the "perpetrators". We will see that members of MSF have held that this limit is impossible to define *a priori*. Furthermore, they must work with unsavoury political characters if they are to stay close to their "beneficiaries". This means that the enactment of humanitarian space can be seen as a kind of tactic, where humanitarian actors partly insinuate themselves into the space of the state, and attempt to make partial changes to policy and to catalyse tipping points, rather than attempting to make radical and precipitous changes in global migration politics. We will end this section with a discussion of the political goals MSF set for itself in Paris and come to the conclusion that they are engaged in what we will call, following Michel Feher, *nongovernmental politics*. In the following sections, we will describe humanitarian space as *territory without government*.

2. The Politics of Materially Enacting Humanitarian Space

In the second section, we will describe the material spatialities of the *mobile clinic* at Porte de la Chapelle. First, in a move away from humanitarian space as a legal, ethical, and political concept, towards its material enactment, we will explore the *topologies of the territorial production* of the mobile clinic. We will then discuss the mobility of the mobile clinic, describing the territorial productions of the clinic as it moves through a *sequence of mobility*. Finally, we will describe the *political tactics of mobility* and of territorialisation in the humanitarian space enacted by the mobile clinic. I will show how the rhythms of mobility associated with the mobile clinic allow: presence and the possibility of witnessing; quick deterritorialisation and reterritorialization; play on the tensions between visibility and presence; and progressive adaptation to their ecological niche.

These tactics allow MSF to move into an already densely inhabited space, in order to remain close to their "beneficiaries", while avoiding conflict with state and institutional actors. I will also show that these spatial tactics are part of MSF's nongovernmental political strategy in Europe.

3. Triage at the Border: Confusing the Inclusion/Exclusion Binary

In the last section, I will describe a triage device developed and deployed at the *mobile clinic* and its potential ties to "bordering" and other spatial productions. I will show how the device in question – a list – participates in the enactment of humanitarian space as a bounded territory, with an outside and an inside, controlled access, and regularities of behaviour. Among its competencies is the regulation of *patient flow* through the multiple spaces of the mobile clinic. To achieve this, the list shoulders a series of cognitive and ethical responsibilities for MSF staff. This will be seen to *open* a space where, and time when, the attention of MSF employees can be *constrained* and directed towards those they hope to serve. Finally, through close ethnographic description of patient rejection practices, I will show how the variety of decision-making processes and the options available largely exceeds the inclusion-exclusion binary, underlining the diversity of forms care can take in *humanitarian space*.

In sum, this chapter is about the ethical problems "humanitarian space", as a concept, is equipped to deal with and the kind of politics it serves. It is about the political tactics afforded to humanitarians by the material enactment and forms of territorial production of humanitarian space. It is about the triage practices, and the inclusion-exclusion binary. We will conclude this chapter with an alternate history of the relation between ethics and politics. We will claim that the history of moral sentiments is not one where ethics invades politics, to constitute forms of solidarity based on a universal vulnerability. Building on the work of the political philosopher Joan Tronto, we will show that the history of moral sentiments philosophy is one where politics and ethics are invented as two separate domains. At the end of the chapter, I will have described the ethics of nongovernmental politics, as they are enacted through humanitarian space and triage in the European borderscape at the mobile clinic at Porte de la Chapelle. The point will be to show that humanitarian politics is much more radical than the simple incursion of ethics into politics; it is the call to displace the boundary between them and to rework a solution to a problem this boundary solves by pretending it does not exist: the fragility of human life.

1. A Brief Presentation of Humanitarian Space as a Relational Concept

In this section, I provide a brief presentation of *humanitarian space* in three parts, followed by a fourth subsection on MSF's presence in France. If I dedicate an entire section to this concept, and use it discuss the politics of the space enacted by humanitarians at Porte de la Chapelle by MSF, it is because it is a concept closely associated with MSF through its history, and because it has been repeatedly conceptualized by MSF presidents and organic intellectuals. In each subsection, I outline a problem humanitarian space is meant to deal with as a concept. These problems point to the relations between humanitarians and other actors, and as such, "humanitarian space" can be described as a "relational concept". Following Natasha Myers, a concept is relational insofar as "it hinges on an intra-active conception of agency or agencement.[1]" Humanitarian space posits at least three relevant types of relations in the constitution of a humanitarian agency: relations to "beneficiaries", relations to sovereign actors, and relations to institutions in humanitarian ecology. Each of these relations entails a different set of problems. The first set has to do with the ethical issues of care towards "beneficiaries". The second with problems of politics and sovereignty with state and military actors. The third to ecological problems of institutions. We will see that the ability of MSF to act in a humanitarian manner depends on its relationship to these other actors. There is "humanitarian space" when each of these relations takes on specific characteristics. In the last subsection of this introduction to humanitarian space, I will relate several issues - European funding, operational objectives, and public discussions with Parisian civil society - tied to the politics of MSF's humanitarian space in Paris. This is meant to help us get a grasp on MSF's political strategy in the "European migrant crisis" and, more generally, on humanitarian politics.

a. The Problem of Ethics in Relation to Beneficiaries

Humanitarian space is a concept with a rich history in the study of humanitarian action. Rony Brauman popularized the phrase in the early 1990s, after having been president of MSF for a decade, to talk about the space where humanitarian action is possible. For this humanitarian practitioner, humanitarian space is *operational* space (Collinson & Elhawary 2012). This version of humanitarian space came to be particularly influential for humanitarians in the coming years,

[1] In *Rendering Life Molecular*, Myers opposing "relational concepts" to "lonely concepts", which attempt to pull their problems and components "out of time and out of relation", making them "abstracted, on their own; unresponsive and unaffected." (2015, p. 233).

often referenced and discussed, its association with MSF clearly identified. This is why it is of note to us in our discussion of the space enacted by humanitarians.

In an interview with Philippe Petit, published in 1995 under the title *Humanitaire: le dilemme*, Brauman talks about how he came to think about *humanitarian space* after reading Paul Ricoeur's preface to an Amnesty International report, where he develops his idea of an "ethic of solicitude" (Amnesty International *et al* 1989).[1] Ricoeur discusses the case of a doctor who provides healthcare to victims of torture. She dresses their wounds, calms them, and then sends them back into the torture chamber. Following Ricoeur, Brauman explains that the medical services provided here have been dissociated from an "ethic of solicitude". The doctor is no better than the torturer's assistant. Brauman assimilates this situation with a dilemma that humanitarians confront: providing medical relief to populations in situations of distress, but also participating in an economy and an ecology of armed conflict, or of a neoliberal government of bodies, that makes their continued suffering possible. This seems to be precisely the situation that Pallister-Wilkins is speaking to above: humanitarians claim to provide aid to migrants, but actually participate in their government. *However, following Brauman, the space of humanitarianism is where it is possible to provide care without also adding fuel to the fire of suffering.* He then gives three conditions necessary to the enactment of such a space.

> *"I'm talking about a **symbolic space**, outside of which humanitarian action finds itself detached from the ethical foundation we were talking about and which is constituted inside the following reference points (*repères*): first, the **freedom to dialogue**, the possibility of speaking freely with the people whom we work to serve, without suffering the systematic presence of anyone. This is an elementary question of dignity, and yet it cannot be taken for granted. Second, **freedom of movement and of need assessment**, as far as practical conditions allow, of course. This is an important condition to avoid becoming a propaganda tool, or a prize in some war lord's trophy case. And finally, the **freedom to check the delivery of assistance**. This is just to avoid that they be taken to feed combatants or politicians" (Brauman 1995, p. 43,* my translation*).*

At stake, for Brauman, is the "manipulation, or even in some cases, the dehumanization of humanitarian action." And the freedoms he calls for are "always freedoms that need to be "conquered" and defended (1995, p. 44, my translation)". The concept of humanitarian space for Brauman has to do with setting up a "symbolic space" where an "ethics of solicitude" is possible, and avoiding the political manipulation that would turn humanitarians into the enablers of those who would increase the suffering of persons and populations. It also means remaining aware of the fact that humanitarians would not exist if there were no "populations in distress" and if "authorities"

[1] Ricoeur develops his ethics of solicitude in *Soi-même comme un autre* (1990).

do not accord them certain liberties. These, then, are some of the problems of humanitarian space for Brauman: manipulation of aid and an ethics of solicitude attentive to effects. It also figures the torturer, the victim, and the ethical doctor as conceptual characters (Deleuze & Guattari 1991).[1]

I see here some of the issues Pallister-Wilkins brings up regarding humanitarians' role in the government of migrant bodies, where triage and territorialisation make control possible and thus participates in unjust state migration policy. Yet where Pallister-Wilkins points to their entanglement and sees a compromise of humanitarian idealism, Brauman sees this relationship in practical terms, as a problem to which one must remain always attentive. As Brauman said during this interview with Philippe Petit, enacting this space, where it is possible to engage in the proper relationship to those MSF wishes to serve, depends on "conquering" and "defending" certain freedoms; this relationship to their "beneficiaries" is something for which MSF is willing to fight. It is their territory. Here, then, are some of the borders of humanitarian space. This point allows us to segue into the problem of sovereignty.

b. The Problem of Sovereignty in International Relations

Brauman's concern for avoiding manipulation and assuring a certain distance from issues of power and politics resonated with a wide variety of actors at this time, in and outside of humanitarianism. This coincides with the start of a so-fcalled "interventionist era" in international relations, when the end of Cold War tensions increased Western military intervention, often in the name of democratic and humanitarian ideals. This new interventionism was consecrated with the Balkans conflict and the set-up and support for the Kurdish Autonomous Zone in Iraq in the early 1990s. Here then were two cases where NATO states had led armed action inside the sovereign territory of other states, which they justified in the name of humanitarian ideals and human rights. At the same time, these military interventions advanced economic and military agendas in games of power politics. Issues of "humanitarian space" thus became a question for international relations scholars working in international law, and, later, political scientists.

In these domains, however, "humanitarian space" is no longer *operational space*, as it was for Brauman, where the right kind of relationship with "beneficiaries" is possible. It is a space of

[1] See also Céline Spector (2016), for an analysis of the role conceptual characters play in embodying injustice and actively arguing against the reasonable justice of thinkers from Plato to Sade. Conceptual characters are a bridge between ordinary life and philosophical life. Insofar as philosophy is the art of creating concepts, and concepts need characters such as *the friend, the enemy, the rival* to participate in their elaboration through agonistic exchange, they are essential to the philosophical mode. She also shows that such figures have largely disappeared in the 20th and 21st centuries, and suggests that this disappearance has turned *injustice* into the blind spot of contemporary theories of justice.

intervention. In an early and influential paper entitled "Sovereignty Under Siege: From Intervention to Humanitarian Space" (1995), Thomas Weiss and Jarat Chopra show how the debates in the 1970s concerning the advantages and disadvantages of codifying objective criteria for the definition "humanitarian intervention" in international law had been largely forgotten in the 1980s, only to be revived in the aftermath of the First Gulf War. Not surprisingly, a number of "developing countries" were more sensitive to issues of "non-interference" and the "inviolability of national sovereignty" and less to these "fine-tuned legal debates". For Weiss and Chopra, legal issues of codification had been set aside, and the issue of a basic right to humanitarian intervention had been brought into question at the forefront of public and political debate. National sovereignty, then, is another problem to which humanitarian space is linked. At stake is the proper position of humanitarian action with regard to state action.

Weiss and Chopra show how humanitarian space had entered the tool kit of international relations, alongside armed conflict, economic sanctions, diplomacy, and other forms of soft power. Thus, "humanitarian" intervention always included the possibility of ulterior motives. This aligns quite nicely with the position of the so-called realist school of international relations, which maintains - in the fullest sense of the term - the strict separation of politics and ethics.[1] At issue then for international jurists was the set-up of a system where human rights could be respected, while also mitigating the possibility that they be used to forward hidden political agendas. There is then an ideal of purifying the ethical space of humanitarianism from the political realm of international relations, as a guarantee against humanitarian actors becoming pawns in inter-state rivalries. "Humanitarian space" is meant to be a "free zone", a space where human relations could be regulated by something other than "national interest". This is the point Brauman makes as well: humanitarian space is a space where an *ethic of solicitude* governs behaviour.

To summarize, another problem associated with the concept of "humanitarian space" has the following components: politics vs. ethics, sovereignty, nation-state, and intervention. The problem here is quite different from the one identified by Brauman. Humanitarian space is not only "symbolic space" where an "ethics of solicitude" should be sovereign, but also a space codified and protected in International Humanitarian Law, and which can potentially be used to encroach on the sovereign space of recently decolonized and newly constituted nation-states.

In sum, humanitarian space must be "conquered" and "defended" against state actors, who would manipulate humanitarian actors, undermining the "ethics of solicitude" that founds the

[1] More on this separation later in this chapter.

humanitarian community. However, this humanitarian conquest of space is an encroachment on national sovereignty, and the good intentions of humanitarians are suspect, given that they could hide the political agendas of powerful states using humanitarian rhetoric for "politics as usual". Many of the issues raised in these first two texts frame the debate on humanitarian space for the next decade, both in academia and among humanitarians.

c. The Problem of Negotiation in an Institutional Ecology

In the early 2000s, new issues start to feature prominently in discussions on humanitarian space. General Colin Powell, the US secretary of State under President George W. Bush, famously called the humanitarian sector a "force extender" and a "force multiplier" in Afghanistan. At the same time, the UN had developed the "cluster approach" to humanitarian action, where they held to coordinating all relief operations in areas of Western military intervention, with the US government financing the main humanitarian organizations in the field and with goals defined by the UN Security Council. Some humanitarian organizations – MSF among them – understandably felt that their action should be independent of the goals of these state actors. It was in this conjuncture that humanitarians also noticed that they were often targets of attacks, bombings, and kidnappings. In Iraq, in 2003, UN and ICRC headquarters were bombed. Humanitarians were kidnapped in Afghanistan and in the Democratic Republic of Congo. Authors began to ask if this was the result of venturing out onto the other side of the ethics/politics border. Had this incursion had the effect of turning humanitarian space into political space, exposing humanitarians to military action? Without depoliticization, without the proper remove of humanitarian space from state politics, humanitarians cannot set up a proper *operational space*, insofar as depoliticization is a precondition to security. Manipulated by the states, targeted by armed groups, humanitarians had no room to manoeuvre. A new consensus was met in the mid-2000s: humanitarian space was "shrinking" (Collinson & Elhawary 2012).

Voices critical of the idea that humanitarian space is shrinking start to be heard a few years later. Folding in older debates on sovereignty and politics, while responding to more recent concerns on security and shrinking humanitarian space, these authors conclude that humanitarian space must now be *negotiated* (Hilhorst & Jansen 2010). Sarah Collinson and Samir Elhawary summarize: humanitarian space is a "*complex political, military and legal arena*" (2012, p. 1). As such, humanitarian space is resolutely political.

Inside MSF, they develop the point of view that the only way to protect the lives of humanitarian actors is to remain useful to political actors. While MSF does not have the luxury of choosing the actors with whom they work, there is a precondition for to possible negotiation: a

shared concern for the well-being of the population (Magone, Weissman & Neuman 2011). As such, the list of actors with whom humanitarian organizations cohabitate is quite long: other international and national NGOs, as well as numerous UN agencies, "philanthrocapitalist" organizations, pharmaceutical companies, and national and local authorities. They negotiate issues regarding access, drug prices, and global and national health policies. Here, "humanitarian space" is produced through everyday practices, through *negotiations* with all these actors. They add a limit to the possibility of negotiation to which they must be ever attentive. The border they must never cross is that very fine line, difficult to see and yet very real, that separates aid to the victims and support to perpetrators. It is when the authorities show no concern for the population, when humanitarians are left with no room to manoeuvre, when they entertain no hope of changing policies, that MSF reserves the right to refuse to work in some situations or with some actors. Here then, the problem of humanitarian space is negotiating in a humanitarian ecology, of securing the necessary conditions for action, and of remaining attentive to that "ethics of solicitude".

After this presentation of some of *relational problems* "humanitarian space" – ethics of solicitude in relation to "beneficiaries", sovereignty and politics in relation to state actors, negotiation in an ecology of aid – we are better equipped to discuss the politics specific to the humanitarian space MSF would like to set up in Europe and in the streets of Paris.

d. The Nongovernmental Politics of Humanitarian Space in Paris

MSF-International decided to stop accepting EU funding because of the EU-Turkey accord on sending migrants back to Turkey. In February 2016, the European Union and Turkey signed an agreement, which allowed the European Union to send back to Turkey all those "irregular migrants", ineligible for refugee status, arriving in Greece after March 2016, that had gone through Turkey. The first "irregular migrants" were sent back to Turkey in April 2016. The agreement also stipulated that for each "irregular migrant" who was ineligible for refugee status, and sent to Turkey, an eligible Syrian would be accepted. To help with the management of these refugees, the European Union also agreed to transfer 3B€ to the Turkish authorities.

The decision to disavow European migration policy through a refusal of EU funding was not unanimous across MSF. Two of the five national Operational Centres voted against the decision,[1] and members of MSF-France have been publicly critical of this decision, though they

[1] MSF is composed of five Operational Centres, who are linked by a common charter and an attachment to democratic governance. Together, the five Operational Centres form the "Movement". Each is responsible for its own fundraising

have respected it (Brauman 2016; Neuman & Oberreit 2016). The branch of MSF I have been working with - OCP, or Operational Centre Paris - is one of the two critical MSF sections. Understanding why they were critical of this decision can help us understand the politics of MSF's humanitarian space in Paris.

In his open letter to MSF directors, Rony Brauman – today a member of the MSF-France think tank, the CRASH (Centre de réflexion sur les actions et les savoirs humanitaires) – argues against this decision in terms that are primarily *strategic*. MSF needs these funds; otherwise, they would not have accepted them in the first place. While the refusal of funds could be a tactic in the negotiation for a change in policy, Brauman holds that the conditions set by MSF before they will begin accepting funds from the EU represent a drastic and global change in European migration policy. He sees this as quixotic at best and foresees that these conditions will never be met. Furthermore, Brauman predicts that MSF will likely forget their reticence to work with the EU the next time there is a natural disaster and MSF needs funds for rapid response. Negotiating for global change in immigration policy is seen as unrealistic. This is not how politics should be done at MSF. The point is not that immigration is not a global problem, but that MSF's political strategy cannot be global.

In an interview published in the Lebanese newspaper *L'Orient Le Jour*, Michaël Neuman, Research Director at the CRASH charged with the migration dossier, comments on disagreement inside MSF on the decision to suspend EU funding. He gives us our first inkling of what MSF's strategy to change European migration policy might be.

> ***Would you propose a different European asylum policy?***
>
> ***M.N.:*** *No, but I do think that our relief operations should indicate an alternative. There were times when we engaged in acts of solidarity meant to counter the cynicism and inhospitality of European policies. That is the case with our sea rescue operations, or with the "humanitarian camp" build in the small town of Grand-Synthe in the north of France. But my ambition is not to find the message that will change the balance of power as it was defined by the British referendum* (my translation, from French).

Again, their political position is not to suggest a different migration and asylum policy. They do not harbour the ambition of modifying the global "balance of powers". They hope their activities will show an "alternative" is possible, where "gestures of hospitality" counter the "cynicism and the inhospitality of the European policies". To my mind, this suggests that *humanitarian space* enacts a kind of politics that does not perfectly align with Fassin's 'politics of

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and organizes its own operations. Some issues require movement wide consultation. The refusal of EU funding is among them.

life' or the view that the spatialization of humanitarianism participates in the government of bodies through triage. To take a term from Michel Feher, we could say that this is a *nongovernmental politics*, in which MSF moves into the space of state actors and shows them that it is possible to do things differently. Their concern is not with *who* governs, but *how* government is conducted. Building on the relational problems of humanitarian space identified in the literature, humanitarian space is an explicitly political and ethical concept. It is about negotiating oneself into the space of state actors, while remaining attentive to that limit which separates support for victims and aid to perpetrators, and then pushing those responsible for the well-being of those in need – clearly identified as European states by MSF in the "migrant crisis" – to act according to an ethics of solicitude. We will have to wait till the end of this chapter to fully grasp what this entails, but we can already glimpse the contours of the general argument we will be making: *humanitarian space allows MSF to engage in nongovernmental political ethics*.

What does this mean in practice, in Paris? To answer this question, let us look to the preparatory note written by the head of mission for MSF's activities in France, Christine. In this document, from October 2016, Christine recognizes the "global" nature of the "migration crisis", while limiting her thoughts to the borders of Europe. She then suggests that MSF's initial reaction to the crisis in Europe came from a sense that the situation in Europe was a crisis only insofar as there was *a lack of political will, a lack of anticipation, and a lack of preparation* for the arrival of migrants. This has led to a "paradoxical situation" in Europe where the "concerned population" is small, the resources available to European states are substantial, and the individual conditions of migrants are disastrous. She then gives a four-point summary what MSF-France's position should be for the Paris project:

> *1/ Develop specific and alternative activities to those that the authorities propose;*
>
> *2/ On the basis of these activities, show that the restrictive European policies have health consequences and that there are other possibilities;*
>
> *3/ push, as the case may be, authorities to invest in taking care (prise en charge) of refugee populations to assume their responsibilities by taking over these activities*
>
> *4/ in broader terms, and always on the basis of our activities and témoignages, to question the non-respect of refugee rights, human rights, the humanitarian consequences of asylum systems (*original in French, my translation)

Here again, the politics of MSF seems to start with the demonstration that there are concrete alternatives to the way things are currently being done, and then to push states to respect commitments already made. Activities are set up as *counter-examples* to what is currently being done by European states, while simultaneously pushing these authorities to "assume their responsibilities" and publicly questioning the non-respect of refugee rights, human rights, and more

generally the humanitarian consequences of the system of asylum. Furthermore, they are explicitly looking to set up operations that lead to "*a significant improvement in the quality of the life of the targeted population as well as a change in power balance with national authorities* (original in French, my translation). Humanitarian politics includes then a double goal: improving the living conditions of the target population, while also modifying the "power balance" with national authorities. This "power balance" is not about an overhaul of French or European migration policy. Following Christine, they will get nowhere "*wanting to make global changes to the asylum system or European policy*." She begins her paper recognizing that migration is a global issue, and later suggests that in operational and political terms, attempting to change the entire asylum system is doomed to fail. Instead, she holds that:

> *"It is through specific moves, based on successful, and in some way "decisive" operations, that we can get results. […] We can take the authorities at their word, confront them with their commitments (especially on issues like relocalization, reception, services), or underline, for example, how medical and social services are inadequate, due to the absence of translators or health care.* (original in French, my translation)*"*

Didier Fassin and Miriam Ticktin hold that because humanitarians reduce political situations to bodily needs, they are unable to address the political issues at stake and are doomed to participate in government. Humanitarian politics is presented as a "politics of life" that establishes the differential worth of human lives based on bodily need, defined through humanitarian space and medical techniques both idealized as apolitical. After a discussion of some of the problems of humanitarian space, and a presentation of the political strategy of MSF in the "European migration crisis", this position has started to seem strange. *Humanitarian space* is meant to deal specifically with those situations where humanitarians hesitate about the unforeseen and adverse effects of their actions on those they hope to serve. It is an explicitly political concept. A look at MSF's positioning on European migration policy suggests that there are at least some influential members of the organisation that analyse and evaluate their action in explicitly political terms, seeking to inverse power relationships and to advance concrete and alternative policy practices. They seek to accomplish this by identifying the specific limits of current practices, by taking national and local authorities "at their word", and underlining discrepancies between word and deed. They also harbour the ambition to improve the lives of specific individuals through the provision of health services, and they wonder about the effectiveness of political strategy that aims at the complete overhaul of national policy.

I would like now to see how MSF relates to other organized, non-state actors in Paris. To do so, let us look at a research conference held in MSF headquarters in Paris on January 25, 2017.[1] The conference, entitled "Paris: looking back on the Movement of Solidarity Towards Migrants (2015-2017)", was organized by the research group Border Analysis and Border Ethnographies in Liminal Situations (BABELS), led by anthropologist Michel Agier. The discussions and presentations were taken as an opportunity for civil society actors involved in issues of migrant rights from 2015 to 2017 to relate their careers as political activists. As they did, the distinction between the "political" mode of activists and the "humanitarian" mode of large NGOs working with state actors was a recurrent theme. One speaker came to the conclusion that "humanitarianism is a trap": it is "nice and it keeps you busy", but humanitarians do not deal head on with what put migrants on the street. Another participant noted that the distinction between "political" and "humanitarianism" was the source of a great deal of discussion inside the "solidarity movement" at La Chapelle in 2015. Specifically, they wondered under what circumstances activities associated with humanitarianism might be considered "political". They concluded that handing out blankets is a political act when police are confiscating blankets from people sleeping in the street in the middle of winter, as was the case in Paris. On the other hand, setting up and running a camp means doing the state's dirty work and accepting the situation as it is.

Though MSF was not (often) criticized directly, the conference was held in their Paris headquarters, and several MSF coordinators were present. A look at the questions they ask and the comments they make suggest, at the very least, that they feel concerned by the criticism of the humanitarian posture. One program coordinator, noting how critical militant organizations were of the humanitarian approach to the "migrant crisis", asked what kind of concrete alternatives had been put forward by militant groups. What had they actually done to improve the "reception apparatus" for migrants? A research director at the CRASH said that these militant groups were making unnecessary distinctions between "good aid" and "bad aid", without taking into consideration the very different histories of these politicized groups, on the one hand, and, on the other, of large humanitarian organizations. He saw "structural diversity" in the world of French non-profit organizations and wondered if it was realistic to expect everyone to have the same

[1] I would like to thank Léopoldine Manac'h for allowing me to use her observation notes for this event. As an MA student in the program Territory, Space, Society at the School for Advanced Studies in the Social Sciences (EHESS), Léopoldine took a class in ethnographic methods in which I participated as a supervisor. This meant that I accompanied two groups of 4 students in conducting fieldwork (observation, interviews) on the Parisian civil society involved in responding to the "migrant crisis". Léopoldine was also an active member of the Babels project, contributing to collective writing on migrants camps in Paris. Her precise notes - which included the names of participants, making it possible for me to identify them - are very much appreciated.

approach to politics. Finally, a second program coordinator said she was surprised by the systematic criticism of *the* humanitarian approach, noting how difficult it was for her to put *Emmaüs Solidarité* and Utopia56 - two NGOs working in the "humanitarian centre" at Porte de la Chapelle - in the same basket. Moreover, she suggested that if "you want things to change, you have to work collectively on a solid advocacy plan". She added that, just like the civil society actors present, MSF had had trouble working with the mayor's office in Paris. However, she held that this didn't mean that all public service actors are insensitive to the migrants' situation. Some are dedicated to making improvements. However limited and insufficient their attempts may be, disqualifying them is counterproductive insofar as it discourages them. It is not a good tactic for change. It is better to build on them. She ends by saying that there is "added value" in working together and asks militant groups to be "a little bit more pragmatic".

My goal here is not to compare the differential politics of MSF and Parisian activists. However, the above summary does give us some idea of how these two groups see each other. The activists present at the conference contended that humanitarian organizations were missing the point. By reducing the situation to the need for blankets, humanitarians miss what is really at "issue". They have fallen into the "trap" of "keeping busy" helping individuals, at the price of letting the root causes of the suffering intact. MSF asked their interlocutors, on the other hand, asked what these small *associations* had actually achieved, pointed to a lack of pragmatism, and said that to make a difference you need a solid, workable "advocacy plan". Public criticism had to be strategic and constructive.

In sum, the politics of humanitarian space is based on a *triple inter-vention*: they come between (i.e., intervene) individuals and their problems – especially but not only when these problems can be construed as relating to health states or events – they come between state actors and their policies – calling them out when they fail to respect their commitments and suggesting alternate modes of action, but also working together when possible – and they come between a wide array of institutional actors in search of their ecological niche. *Intervention* poses the problem of sovereignty, insofar as it includes the enactment of a space where governmentality works according to different ends, and humanitarians are ready and willing to "conquer" and "defend" the freedoms they require to work in a "humanitarian" fashion. The concept of humanitarian space is thoroughly relational: MSF's ability to act as a humanitarian organization depends on acting with, alongside, or against other organizations, individuals, populations, public actors, and, as we shall see in the rest of the chapter, materials and technologies. Importantly, though MSF sometimes

engages in specific, local practices of government, their politics is nongovernmental, in the sense developed by Michel Feher. "Neither apolitical nor governmental. To be involved in politics without aspiring to govern, be governed by the best leaders, or abolish the institutions of government: such are the constraints that delineate the condition common to all practitioners of nongovernmental politics." (2007, p. 12) While this may seem, initially, like a contradiction - what is politics without government? - this distinction between deciding *who* governs and having something to say about *how* government is conducted is essential: *it is the only way for the governed to have a place in politics*. In addition, it allows us to take seriously MSF's claim to be a nongovernmental organization (NGO). This means, in part, that their specific legitimacy has no democratic base: MSF is a private organization. Instead, their legitimacy is based on *monitoring* the effects of specific practices of government - especially the suffering they produce - and *questioning* the governing bodies claim to work for the welfare of the governed. As the reader will recall, members of MSF have stated that to be able to open humanitarian space, they require authorities that assume responsibility for the wellbeing of their population. This helps us rework one aspect of the *problem of negotiation* in an institutional ecology. We might suggest that one reason MSF has had so much trouble working in areas under the control of organizations such as Al Shabab in Somalia, or the Islamic State in Syria, is that these are not organizations that can be described as governmental. In the remainder of the chapter, we will use this base of *nongovernmental politics* to reconsider both the *problem of sovereignty*, and the *problem of ethics*.

To do so, we will now seek to further our understanding of MSF's *political tactics* through a discussion of the *spatialities of a political technology of intervention: the mobile clinic*. Spatiality is a slippery thing, and insofar as it is a material achievement, the characteristics of humanitarian space vary according to each specific set up. Keeping in mind ethics, sovereignty, and ecology, I will now describe what a *mobile clinic* can produce.

2. The Material Enactment of Humanitarian Space

In the above section, I proposed a certain reading of *humanitarian space* as a *concept* meant to deal with problems of relating. In this section, I will be describing humanitarian space as a material enactment.[1] This material enactment of humanitarian space is connected to its

[1] This is one of the primary contributions of Marxist geographer Henri Lefebvre's *The Production of Space* (1974). He suggested that space should be understood as *perceived, conceived* and *lived. Perceived* refers to *practices* in space; *conceived* to *representations* of space; and *lived*, the third term of this dialectic, in the sense of *spaces of representation*, where space is practiced and recoded. Drawing simultaneously on Marxist understandings of production, and Heideggerian criticism of the reductionism of geometrical understandings of space, Lefebvre calls

conceptualizations by humanitarians, ethicists, jurists, and political scientists. Yet it is a distinct thing, made of different stuff and done differently. It is not only a *concept;* it is a *space*. This section then is a move towards describing the specificities of the *spaces* of humanitarianism as they are enacted, and in terms of the effects this space has on the relational problems of intervention described above. For these problems are spatial and conceptual.

a. Topologies and the Territorial Production of the Mobile Clinic

As already suggested, the "humanitarian borderscape" at Porte de la Chapelle is spatially complex. On top of, or better yet, in the middle of, or perhaps alongside everything else in this borderscape… We'll see just *where* it happens as we move forward. In any case, if you are in the neighbourhood at the right time – on a weekday afternoon in March, around 1:30 – and you sit down in the right place – on a public bench under the London Plane trees not far from the Colette Besson tram stop – you will see a peculiar kind of happening. At first, it is just a Parisian sidewalk a few hundred yards down the road from the humanitarian centre: *public space* that supports the circulation of people and things. People walk briskly by. Some enter office buildings. Bikes roll by on the bike path. A tram rumbles down the rails every few minutes. You hear and see cars whizzing along the ring road and the boulevard behind you and, occasionally, one of them slows down to look for a parking spot on an alley that runs parallel. At around 1:40pm, a few migrants show up in a small group and gather under the trees. They are expecting something, or someone. A few minutes later, a box van rolls down the alley and pulls onto the sidewalk. On the back door are what appear to be opening hours: weekday afternoons from 2 o'clock to 8 o'clock, except Wednesdays. On the side panel, there is the *Médecins Sans Frontières* logo (see Figure 1).

Figure 1: The MSF logo

Once the van has stopped, a young woman gets out of the driver's side door. She is alone. She walks to the back of the van and opens the door. It seems to have been equipped for a very specific kind of activity, fitted as it is with various fixtures and cabinets. As Hélène steps through the open door, you see that the interior has been separated into two sections. The first section, a sort of vestibule, has two seats, one on the left and one on the right, and overhead compartments

for a *politics of space*. I too argue for a politics of space, and I hope to move beyond geometrical reductions of space, be they Euclidean or Cartesian. But the characteristics of the space I describe will be seen to be quite different. (Cf, Gregory *et al*, 2011, p. 590*)*.

above each one for storage. A door leads to the second section, an area with a desk, two chairs, an examination table, a sink, and a few cabinets. One of cabinets contains plastic boxes holding even smaller boxes full of tablets and tubes of ointment. It looks like a general practitioner's (GP) surgery with a small pharmacy, except for the plastic boxes and folding tables that make it hard to move around.

Hélène starts to unload some equipment onto the sidewalk. Some of it is wrapped up and you cannot tell what it is for the moment. You do recognize a generator, folding tables and chairs, and a 5-gallon water cooler. Some other people – MSF employees, you later learn – walk up and start helping Hélène set up. It is 1:55 and they are few minutes late. Hélène quips ironically: *Don't worry; it's not like I've been waiting for you to set up!* They had trouble with public transit, it could not be helped. Mahmoud gets to it. He takes the cover off a folding tent and starts pulling on its metal frame. Once spread open it forms a square and Hélène, Mahmoud, Mariam, and Kareem each grab a corner. They all walk backwards together and a tent appears, with legs two meters high. They put three benches, a table, and two chairs inside and then attach white plastic tarps to each side to form walls. A zipper down one side serves as a door. Hélène puts the generator along one side of the tent, next to a table where the water tank has been placed. She puts some kerosene in the tank and pulls the starter cord a few times before it crescendos to a roar. While she does this, Nahid puts an electric kettle and two thermoses on the table inside the tent, next to some coffee and tea bags. Mahmoud has gotten a small electric space heater and a power grid out of a cardboard box. He plugs the grid into the generator and pushes the other end under the tent wall. Nahid plugs in the water kettle and starts boiling water for tea and coffee. Mahmoud takes the space heater inside the tent and plugs it in, and in a few minutes, the tent is noticeably warmer than this chilly March day. Hélène takes a thicker cable and plugs it into the side of the van. Lights go on and you realize that Dr Amandine is inside, looking over her registers.

At some point, Mariam has walked over to the group of migrants who arrived before MSF did. She is carrying a clipboard and, after asking a few questions, she writes something on what looks like some kind of form or a list: a grid with labels, words and numbers, crosses and checkmarks, yes and no. After their brief conversation with Mariam, the migrants enter the heated tent, which now has a flag on the side with an MSF logo, and sit down on the benches. Hélène, Mahmoud, Kareem, Mariam, and Nahid have donned sleeveless white vests with MSF logos on the back. Well, they are white except for the blue and black ink stains on the front pockets where pens are tucked absentmindedly. They all have clipboards. Inside the tent, Kareem is asking those seated on the benches if they want tea or coffee. Outside, Mariam is looking down at the form, her

eyes following the pen as it moves down a list. She looks up, walks into the tent and calls a name. No one answers, and she calls again. One of the migrants stands up. He pulls a file from his backpack and Mariam leads him to the vestibule at the back of the van. Dr Amandine invites him into her surgery. Nahid follows him inside; she is to translate. The door closes, and the consultation begins.

This is no longer "sidewalk", a public space enabling circulation. MSF has arrived and set up. It is now a medical clinic with a waiting room (see Figure 2).

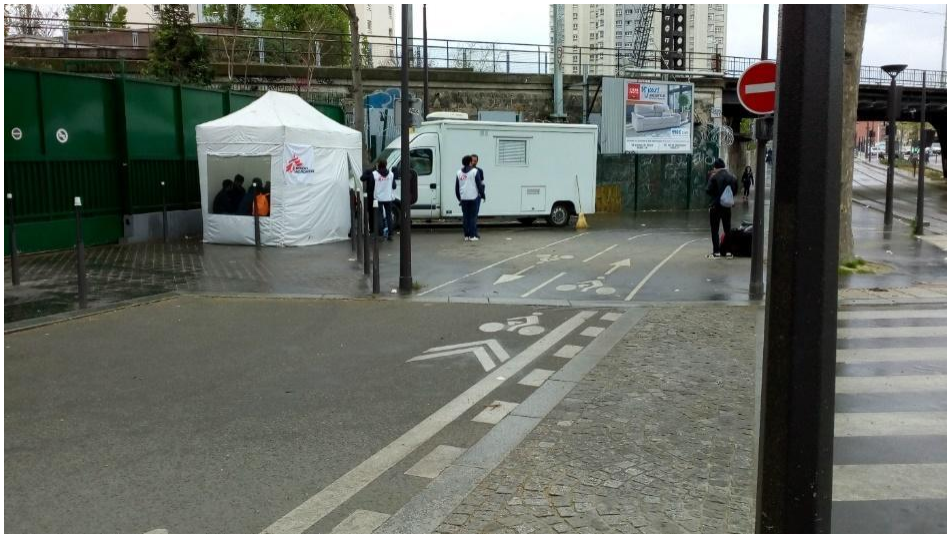


Figure 2: The Mobile Clinic at Porte de la Chapelle

Can the work cited above on humanitarian space as a concept help us understand the scene I just described? The work on the negotiation of humanitarian space (Magone, Neuman, & Weissman 2012; Hilhorst & Jensen 2010) mark a turn towards descriptions of the daily practices and concerns of humanitarians as they assist vulnerable persons and populations. They tell the stories of negotiating the production of humanitarian space with local and national authorities, with the WHO, and with pharmaceutical companies, and patent authorities. Yet, as Aurora Fredriksen has suggested, these descriptions are concerned more with the "*definitional question of* what *humanitarian space is*" and less with "*the empirically sited question of* how *humanitarian space is enacted*" (2014, p. 148, emphasis in original). Furthermore, this definitional focus has left "space" under-conceptualized, often seen as a shell, a "*static, pregiven container for humanitarian action as variously and richly defined* (2012, p. 212)." She makes an important move in enriching and complicating this conceptualization of humanitarian space by drawing on post-ANT work on topology, discussed in the General Introduction of this dissertation (Law & Mol 1994, 2001; Law & Singleton 2005; Serres 1980). This approach has allowed Fredriksen to show how different emergency shelter technologies exist according to different topologies that render different futures

possible, impossible, necessary or contingent. One of these, the "shelter kit", is analysed as a *mutable mobile*, a fluid technology (de Laet & Mol 2000). Insofar as its topology is fluid, it is open to multiple temporalities and to local differences, in a timeline of transformation rather than emergency response. These differences in topologies and temporalities have significant political implications and can be taken as a rebuttal of the critique of the presentism of humanitarianism and its inability to conceive of political solutions. "Shelter kits" – meant to last, dependent on local conditions and materials, affording improvisation and *bricolage* – situate the people humanitarians hope to serve in a longer timeline, in a biography, in connection with their environment. The transformation that this fluid technology supports is political, and is opposed to the more rigid, network technology of the "emergency tent", which breaks down after a year, is difficult to adapt to local conditions, and scripts for an inhabitant existing the short term of emergency response (Fredriksen, 2014).

Different technologies have different topologies, temporalities, and, as such, political effects; topology is a good place to start to forward our understanding of the spaces of humanitarianism. It underlines the politics of spatial enactment and moves us towards spatial complexity. It also helps with analysis of the mobile clinic at Porte de la Chapelle. The mobile clinic is a mutable mobile, a fluid technology that can be repaired with materials on hand to adapt to local conditions. It will still "work" if some pieces are missing. If you replace the tent with a tarp, if you get rid of the tea and coffee (as was done in April 2017), it is still a mobile clinic. It would probably even work without the generator, though the definition of what it means for the mobile clinic to be functional would most surely change with any one of these modifications. The medical technology here is mostly fluid as well, insofar as it is possible to follow Law & Mol in their characterization of clinical diagnostic techniques - as opposed to networked laboratory techniques - as fluid (Law & Mol 1994). The mobile clinic also depends on *networks*. It has a limited but necessary pharmacy, supported by regular and repeated supply. This is true for the hygiene kits and the scabies kits they hand out to the migrants. It depends on the road infrastructure that get the box van in which transports the mobile clinic to the site at Porte de la Chapelle.

Topologies, however, only go so far in this conceptualization of space. If the Northwest Passage – Michel Serre's metaphor for the *border* separating the human sciences from the natural sciences – is the shared reference for talking about topology (Serres, 1980), then we are interested in how you might describe the numerous European attempts at finding a way through the ice. *To put it another way, what is going on when MSF sends a mobile clinic into the "borderscape"?*

Let's come back to my description of the set-up of the mobile clinic. What happened? MSF made a space for itself, a closed space, a bounded space. It marked off borders, designated an inside and an outside. It controls entrance and exit into this space, and *inside* there are planned activities and events for which MSF feels responsible. Insofar as "territoriality" is "spatially delimitated control" within "bounded area" characterized by certain "rules" or "regular behaviours" (Kärrholm, 2005 p. 99), then the space of humanitarianism has at least some of the characteristics of *territory*. How does MSF produce a territory for itself in this borderscape?

The urban studies scholar Mattias Kärrholm provides some useful tools for the description of territorial production, stabilization, and complexity. He distinguishes between two approaches to territoriality. First, *human territoriality*, which is based on an analogy to animal territoriality and ethological or psychological description – marking, defending, or personalizing territory.[1] Second, *geopolitical geography*, which apprehends territory as "intentional strategy of power", a way to exert administrative control (Kärrholm, 2005: 99).[2] Through empirical description of the continual enactment of territory – that is, treating territory as a "spatial actant" that must continually be produced and reproduced (Kärrholm, 2007: 440) – Kärrholm moves past this dichotomy. The operative question becomes *how* territory is produced and stabilized, and less a theoretical-conceptual discussion of *what* territory is. This fits with Fredriksen's project to move away from discussing *what* humanitarian space is, and towards the "sited question" of *how* humanitarian space is produced.

Kärrholm distinguishes between four forms of "territorial production", that is, different ways space becomes an actant in "spatially delimitated control". They fit into a table, cross-referencing two types of *control* – *impersonal* and *personal* control – and two types of *production* – *intended* production and production *through use*.

Table 1: Kärrholm's forms of territorial production

Forms of Territorial Production (Kärrholm 2005, p. 100)		
	Impersonal Control	**Personal Control**
Intended production	Territorial strategy	Territorial Tactic
Production through use	Territorial Association	Territorial Appropriation

[1] Kärrholm does not give specific references for work on animal territoriality, but the work of Jacob von Uexküll on "the familiar path" (2010) seems particularly germane.

[2] Kärrholm makes no explicit reference to Carl Schmitt, but the latter's work on territory seems like an obvious exception to this division between human territoriality and geopolitical territoriality, where politics is defined in part through the friend-enemy distinction and the defense of territory against enemies. Cf. *The Nomos of the Earth in the International Law of the Jus Publicum Europaeum* (1950), New York, Telos Press, 2003. See also, Bruno Latour's discussion of Schmitt's approach to territory in *Facing Gaia* (2017).

Kärrholm holds that different forms of territorial production operate in the same place and gives the palimpsest as a metaphor of what this might look like. His specific interest in the cited articles is in the micro-territories of public squares, and how different groups and different activities can form and re-form areas of "spatially delimited control" at different times (of day, of the week, of the year), according to various rhythms and rules.

Territorial tactics involve claims made during the situation, often referring to personal relationships between persons and territory. I will be discussing the *tactics* of the mobile clinic in more detail in the last subsection. *Strategies* represent impersonal control, planned at a distance, often involving mediation, and delegation of control to things. The mobile clinic is itself a strategy, insofar as the material of the mobile clinic, once set-up, participates in the control over a bounded area. It directly affects the material set-up of the humanitarian borderscape at Porte de la Chapelle, and it offers new possibilities of action to the migrants sleeping on the street – who can receive free medical care and guidance – and to other institutions operating in the area – who can send migrants to MSF for specific needs. This control is limited to certain days and times during the week, and they tend to stay out of sight of the humanitarian centre, hundreds of yards down the road. These are the 'rhythms' of territorialisation that Kärrholm writes about for public squares. The materiality of the mobile clinic does occupy a portion of the sidewalk in the neighbourhood where hundreds of migrants *appropriate* territory under bridges, in between boulders, which are in turn part of the territorial *strategy* of the prefecture, concerned with producing public space of a certain form and governing its use. MSF governs use of space here by affording the opportunity to access health care, and by contesting, to a certain degree, the prefecture's spatial strategy of deterring migrant appropriation of space.

Territorial appropriation is production through "repetitive and consistent use" of an area by a person or group, who perceive this area as their own. For the mobile clinic, MSF appropriates a piece of the pavement on weekday afternoons. The area they appropriate is part of public space, characterized by the co-presence of strangers, circulation, and territorial complexity. *Territorial association* produces territory through the association of an area with a certain usage and those conventions and regularities associated with that usage. An example of territorial association for the mobile clinic would be the presence of migrants 20 minutes before it is set up. They wait for the van to park, for the tent to be pitched, for the coffee to be made, and they register on the list before going into the tent while they wait to see the doctor. They participate in the production of the mobile clinic as a territory by recognizing the place it occupies. This specific space is associated with the regular territorial production of the mobile clinic. This association is in part accomplished

through the materiality of the mobile clinic, and its regular material control and appropriation of this spot on the sidewalk. It is also accomplished through communication, through word of mouth. During their foot patrols, MSF employees share the opening hours of the mobile clinic at this position. They tell the members of Utopia56, another association working in the neighbourhood, that they can send those people who need medical care. The clinic is presented as providing free medical care to those migrants who have not been accepted inside the "humanitarian centre" up the road. That is, the territorial production of the mobile clinic through its association with a place and with regular activities in that place that fit into ecology of Porte de la Chapelle, filling a niche, responding to something that migrants sleeping in the street require: health care. The "spatially delimited control" materially enacted by the mobile clinic also depends on the recognition of others, strengthening the territorial association of this place with an MSF mobile clinic. This helps account for the territorial effects the mobile clinic has even in its material absence.

We are beginning to get a better idea of what the space around the humanitarian centre and mobile clinic looks like. Again, this public space has changed since the "humanitarian centre" was opened. If it continues to operate in some of its previous functions – trams and buses run, cars and pedestrians circulate, benches remain intact – it is no longer the same space. It is *associated* with the characteristic shape of the humanitarian centre, known colloquially as "the bubble" (see Figure 3), the migrants sleeping on the streets, police dismantling makeshift camps where migrants have participated in the production of territory through *appropriation*. The prefecture has also participated in the production of this territory, often in attempts to counter the *appropriation* of this space by migrants through territorial *strategies* – placing boulders in areas where they used to set up tents, physically removing migrants from the neighbourhood, or taking migrants sleeping bags in cold weather.

Figure 3: The Bubble (Source: AFP)

MSF too has a place in this "humanitarian borderscape" at Porte de la Chapelle. They enact a territory where health care is provided to those not accepted into the "humanitarian centre", to those who have appropriated territory around the centre and who participate in the association of this neighbourhood with a "borderscape" through the tactics they deploy to counter the strategies of the prefecture to dis-place them. The mobile clinic is irrefutably a technology of intervention. It

comes between people and their morbidities, and, as we shall soon see, it serves to question policies that they problematize as being inadequate to those in need. It also participates in those twin activities of "control and care" essential to the "humanitarian borderscape" of Pallister-Wilkins.

However, the mobile clinic has a spatial characteristic that is difficult to explore with the tools provided by Kärrholm and Fredriksen: as its name indicates, it is *mobile*. This mobility is essential to the forms humanitarian space takes in the palimpsest of territorial productions at Porte de la Chapelle.

b. The Mobility of the Mobile Clinic

The mobility of the mobile clinic is of interest to us for at least two reasons. **First**, because in Pallister-Wilkins' analysis of MSF in the "humanitarian borderscape", she identifies the *lack of mobility* of humanitarian care practices as being a specific cause of the humanitarian disconnect with the needs of mobile populations and of their alignment with "bordering". She characterizes as "traditional" those forms of care that are *fixed* in hospitals and clinics; medical treatment requires "*stasis*" (2018, p. 126), for patients to be monitored, treatment administered, and referrals made. This is in tension with the desires of migrants to keep moving and to continue their journeys, for whom "*mobility equates to a life with what is thought to be a secure future*" (Pallister-Wilkins, 2018: 119). She continues: "*As such, within the context of migrants in Europe, the logic of the refugee camp or the clinic as a tool of humanitarian government where and when it occurs is linked both to territorialising of care and the de- and re-territorialising nature of mobile populations*." (2018: 119) Pallister-Wilkins sees the de-territorializing and re-territorializing effects of humanitarian space through Deleuze and Guattari's *A Thousand Plateaus*. De-territorializing effects are part of an appeal to universal ethics, transcending the international state system, and re-territorializing as part of humanitarian government (2018, p. 119). Her use of Deleuze and Guattari in this context is somewhat confusing and is difficult to square with the activities of the mobile clinic. A better understanding of the mobility of the mobile clinic, as well as the processes of territorialisation and deterritorialisation, will perhaps help us get a better grasp on the politics of mobility as they relate to migration in Europe[1] and to the production of humanitarian space.

[1] As was pointed out to me by a member of MSF who proofread this text, there have been times when humanitarian actors found the mobility of fleeing populations rather bothersome. It is indeed much harder to do a vaccination campaign when your "beneficiaries" keep moving around. And it is not for nothing that MSF has done so much of their work in refugee camps. Pallister-Wilkins' critique makes more sense in this light. Even so, the mobile clinic is a common technology of intervention across the humanitarian sector.

Secondly, humanitarian space is sometimes qualified as mobile. This may seem paradoxical, considering Pallister-Wilkins' view that the territorialisation of the clinic or camp, necessary to the provision of care, is linked to the government of those who see continued mobility as a key to future security. However, Peter Redfield holds that the mobility of MSF is essential to production of humanitarian space (Redfield, 2013).[1] He argues that the technical possibility of this type of mobility – what he terms "vital mobility" – has contributed to making humanitarian response a moral imperative, much like the development of emergency services has normalized ambulances to the point where refusing to respond to a call has become a moral failure. Like the space produced by ambulances, humanitarian space is not a fixed thing. For Redfield, this space is associated not with *place*, but rather with *events* circumscribed in time: an armed conflict, a famine, an epidemic. In the humanitarian sector, what Redfield terms "vital mobility" has depended on the progressive development of "kits". This development is associated with Jacques Pinel, a pharmacist working for MSF in Southeast Asian refugee camps in the late 1970s and early 1980s. The kit changed expectations of response by turning the difficult question of procurement in resource-poor settings into a question of transportation, that is, of mobility. Following Redfield's analysis, kits are *immutable mobiles* (Latour & Woolgar 2013) that make uniform emergency response possible, but at the expense of ignoring local specificities. The kit itself has come to stand in as the response. This is what Redfield calls "kit culture". Furthermore, the temporality of this kind of response is riveted to the present. On this point, Redfield and Pallister-Wilkins agree. "Kit culture", coupled with a specific mobility sequence – response → stabilization → withdrawal – means no time can be given to the analysis of historical factors, and no energy spent on preparing the future. It is a time when biographical and social life is reduced to immediate bodily need, where mobility has left space with no territory.[2] Both of these authors are working on MSF. Yet Redfield holds that mobility makes space with no territory, and Pallister-Wilkins that MSF territorializes care against the mobility of the people MSF hopes to serve. How can we understand such radically different positions, especially when both agree that MSF is stuck in an apolitical present?

First, it is important to remember that Redfield's "vital mobility" is associated with a very precise kind of mobility: rapid response, of the kind that allows MSF to set up a field hospital anywhere in the world in less than 48 hours. This is evidenced as well in the mobility sequence he

[1] Especially the chapter "Vital Mobility".

[2] Fredriksen's work (2012, 2014), discussed above, builds on Redfield's analysis and shows that different kits enact different spaces and times, some of which are more fluid, more able to adapt to the situation, with different political effects.

proposes: response → stabilization → withdrawal. Pallister-Wilkins, on the other hand, sees mobility as the exception in humanitarian practice, where the camp is the archetypical place of intervention. In the following paragraphs, I will build on Fredriksen's argument that humanitarian space can be expected to be stabilized according to varying topologies, temporalities, and politics, according to the specific apparatuses of response. I will also be depending on Kärrholm's suggestion that territory is produced materially, but also through rhythms, rules, and regularities of use. Rather than seeing mobility and territorializing as irreducibly opposed, I will suggest they are linked in a sequence, enabling diverse spatial tactics that serve the politics of MSF. For following Deleuze and Guattari, there is constant swing, back and forth, between de-territorialisation and territorialisation (which is always re-territorialisation). In sum, and keeping in mind our conclusions regarding the three kinds of inter-vention that humanitarian space produces, I will be describing the mobile clinic as a *humanitarian technology of intervention.*

I will begin with a description of the mobility of the "mobile clinic" at MSF and the kind of space it produces. Through this description, I will propose a sequence of mobility. To do so I will be analysing videos posted by MSF on YouTube on mobile clinics. The query *MSF mobile clinic* on YouTube gives approximately 1,170 results. The first few hundred, at least, are from MSF and most mention mobile clinics. I have selected a number among them that present MSF mobile clinics in various locations in the past ten years. I have also attempted to vary locations and the situations. The variety of is striking: following earthquakes (Haiti, 2010[1]; Nepal, 2015[2]); in armed conflict situations (Ukraine, 2015[3]; Central African Republic, 2015[4]; South Sudan, 2017[5]), a typhoon in the Philippines in 2013[6][7], after a hurricane in Haiti in 2016[8]. What follows is a brief presentation of a selection among the results, chosen based on the quality of the presentation, i.e., the amount of information given. I have also included screenshots, which are meant to illustrate the diversity of possible material set-ups. My goal here is to describe the specificity of the mobile clinic as a political technology of intervention, and to try to establish a sequence of mobility.

[1] https://www.youtube.com/watch?v=3Y2rocwS850&t=2s
[2] https://www.youtube.com/watch?v=aKxHM3jtOaE
[3] https://www.youtube.com/watch?v=5wmrX2Kpww4
[4] https://www.youtube.com/watch?v=w8pgBrTIWJo
[5] https://www.youtube.com/watch?v=vClEJSsDlhs
[6] https://www.youtube.com/watch?v=SK7D5-KGZ1Q
[7] https://www.youtube.com/watch?v=4ZCiUKq71aE
[8] https://www.youtube.com/watch?v=VokT8fwFpfU

After the earthquake in Haiti in 2010, a mobile clinic, as opposed to a fixed clinic, was chosen because the situation was volatile. Fighting erupted on occasion in the camps. It also allowed them, a psychologist working for MSF says in the video, "to play on proximity. We don't stay in fixed positions; we go find people. We go where people live." Inside the repurposed school bus, visible in Figure 4, there are four consultation rooms. Two doctors, a nurse, a midwife, and a mental health officer offer primary health care services. The clinic is described by MSF personnel in the video as an "advanced consultation post" and a means of "emergency response". Main morbidities – scabies, gynaeco-urinary tract infections, sexual and domestic violence – are linked by MSF staff to crowded living conditions, hygiene and sanitation issues, instability and lack of security in the camp. They consult between 160-170 patients a day.

Figure 4: A repurposed bus for consultations in Aviation Camp

The situation in Nepal in in 2015 is somewhat different. Here, MSF accesses remote mountain villages, where there are no roads and no communication technologies. To get there from Kathmandu, the capital, they use a helicopter, the nose of which is visible in Figure 5. Then two doctors walk from village to village, depending on word of mouth to know where they should head, conducting consultations outdoors (Figure 6). Morbidities are presented as minor. They include infections, small cuts and wounds, though there is a case of tuberculosis. In these remote areas, where access to health care is intermittent, these "minor morbidities" can become serious. MSF has also set up a fixed clinic in the region, where they refer patients for surgery. Between the mobile clinic and the fixed clinic, there are 40 consultations and 10 operations per day.

Figure 5: A helicopter to reach remote regions in Nepal

Figure 6: Consulting out of doors

The mobile clinic was also the form MSF's presence took in Ukraine in 2015. The team was composed of a doctor, a nurse, and a psychologist. They focused their activities in a "buffer zone", where, according to one doctor, people stay only if they are unable to leave. Shelling and shooting are part of their daily lives, while health services are non-existent. This means MSF practitioners bring their own pharmacy with them (Figure 7) and often consult in people's homes (Figure 8). Regular exposure to violence – shelling and shootings – can provoke anxiety in the population MSF hopes to serve. Most patients are elderly, and many suffer from chronic health conditions.

Figure 7: an MSF van with a pharmacy in the back

Figure 8: consulting in people's homes

Mobile Clinics were extensively deployed in the Central African Republic in 2015, to treat "*those who remain unable to return to their communities due to the ongoing threat of violence*"[1]. MSF's priorities there were "pregnant women", "malnutrition", and "children under 5 years of age". They travel to several remote places in the region per week using 4x4 vehicles (Figure 9), where they set up large open tents where consultations are held (Figure 10). Long lines are common. They also provide treatment for survivors of sexual and gender-based violence (SGBV), malaria, and malnutrition. In 2015, MSF's mobiles clinics in the CAR undertook 57,181 patient consultations.

Figure 9: A 4x4 for access

Figure 10: A tent for consultations

[1] https://www.youtube.com/watch?v=w8pgBrTIWJo

Now to MSF's mobile clinic in the Philippines in 2013. A team of three doctors, nurses, a mental health officer, and a WASH (Water, Sanitation, Hygiene) specialist head out in two cars towards the areas hit by a typhoon. They plan to set up two mobile clinics, one in a health structure (Figure 11) and another in an evacuation centre. They see around 80 patients in an afternoon, dressing wounds (Figure 12), treating pneumonia, the common cold, and diarrhoea. They are surprised when they realize they are the first medical team to arrive on site. A doctor mentions that a simple "how are you?" can start the flow of tears. The medical consultation is a place where patients can release "mental strain" and work through "trauma" with caring professionals.

Figure 11: Heading into the health structure

Figure 12: Dressing wounds

Finally, back to Haiti again in 2016 following a hurricane. This time getting to remote villages calls for the use of donkeys (Figure 13). A WASH specialist and a nurse (Figure 14) make up the team.

Figure 13: A donkey for access

Figure 14: Dressing wounds out of doors

To help fill out our understanding of what the "mobility" of mobile clinics implies, I have identified and tabulated the verbs and prepositions used in the above-mentioned videos that denote movement, locality, and directionality, by either MSF staff or their patients. The table format allows me to abstract out from the oral presentations of the videos and in order to establish a sequence of regular movements, as well as an idea of the rhythms of spatial enactment with which they are associated. This has given the following mobility sequence, quite different from

the one suggested by Redfield, and including a moment of territorialisation: reaching people → channelling material → setting up a clinic → taking people in → tracking people.

Table 2: A New Mobility Sequence for MSF

	REACHING PEOPLE	**CHANNELLING MATERIAL**	**SETTING UP A CLINIC**	**TAKING PEOPLE IN**	**TRACKING PEOPLE**
Issues	**Transport**	**Supply chain**	**Territorialisation**	**Inclusion/ exclusion, liminality**	**Data collection, mapping**
	venir chez les gens, **venir trouver** les gens, to access, to reach people in urgent need of medical care	**acheminer** l'aide en dehors des grandes villes, carry equipment to isolated mountain villages, apporter des matériels	**installer** une clinique, on s'installe ici, installer une clinique mobile	tous les gens de la rue **viennent** consulter, nous recevons dans notre clinique, we take people in	to **follow-up** on patients, to keep track of where people are going, to go from village to village

Mobility is a process, and as such, the mobile clinic is constantly moving between these moments of mobility, which fit together modularly. The mobility of the humanitarian space enacted by the mobile clinic involves **tracking** vulnerable and mobile populations in order to **reach them** "**chez eux**". Humanitarian space includes a **movement towards** the population in need, which involves **channelling** equipment, medicines, and bandages to those sites. Once they have arrived, they **set up the clinic**, and **receive patients** in the clinic. There is movement towards patients, and patients come towards them. In some cases, MSF follows up (tracks) these patients later. This means that the mobile clinic, as a *technology of intervention*, keeps track of where people are going, and they then refigure intervention sites and methods according to people's movements in a changing ecology of need. This tracking means refiguring coordinates in this space and changing the set-up site of the mobile clinic.

I have provided an account of mobility in the enactment of humanitarian space distinct from that of both Pallister-Wilkins – who sees in the *remove* between the territorialized clinic and mobile bodies the basis of the humanitarian government of migrants – and of Redfield – who sees "space without territory" as a symptom of the mobility of a humanitarian space dependent on "kit culture". Mobility is indeed essential to the enactment of the humanitarian space of the mobile clinic. This mobility is processual. This process includes different sequences that hang together. There are multiple forms of mobility, and the mobile clinic *moves through them*, that

is, its movement is supported by them, and it evolves through them in process. *Reaching people* and *channelling material* prepare for set-up; *tracking* is essential to *reaching people*; for *people to come* to the clinic, it must have been *territorialized*; *tracking* means *reconfiguring the sites* of intervention. The important of mobility to humanitarian action reminds us that Rony Brauman claimed as a freedom essential to humanitarian space the ability to dialogue with and provide assistance to beneficiaries *directly*. Humanitarian space depends on this encounter, which must be materially ordered.

Furthermore, these multiple mobilities, disparate forms of territorial production, and plural topologies and temporalities, can be coordinated in time and in space. These are their *rhythms*. I will be discussing later in this chapter some of the work necessary for their coordination. Here, I would like to draw the reader's attention to the variability of these rhythms: tracking is done *continually* through the collection of data made into *monthly* reports, which affect *periodic* decisions taken on where to set up the mobile clinic during *daily* opening hours. Opening hours – as we shall see in more detail later in this chapter – affect the movement of patients in and through the mobile clinic. These then are some of the material and temporal characteristics of humanitarian space.

Yet our understanding of the mobility of the mobile clinic is incomplete. That the mobility of the humanitarian space enacted by the mobile clinic helps with the issue of *encounter* underlines that humanitarian space is a relational concept, meant to deal with problems of how, when, and where to relate to whom and what. We have seen here how this mobility helps to deal with some of the logistical problems of *relating* to those whom MSF wishes to serve. In the final section of this chapter, I will continue with some of the *ethical* problems of this relationship.

First, though, I will conclude this section by describing how mobility helps MSF deal with some of the relational problems MSF encounters when dealing with local authorities and with institutional actors. This will forward our discussion of the mobile clinic as a *technology of intervention*, where intervention is simultaneously between people and their morbidities, national and local authorities and their policies, and in between different institutional actors, searching for an ecological niche.

c. Presence: Tactical Mobility in the Humanitarian Borderscape

The mobile clinic is *mobile*, and this mobility has political effects. *What then are the political effects of humanitarian space that exists in rhythmic flux between the different kinds of mobility and different forms of territorial productions described in the above two subsections?*

To answer this question, I will describe a series of *spatial tactics, and their political and ethical effects*, afforded by the mobility of the mobile clinic. These tactics can be understood as having effects on how MSF relates to its "beneficiaries", local and national authorities, and other institutions, helping them deal with the relational problems of ethics, sovereignty, and ecology identified above. As such, the tactics of the mobile clinic are part of the territorial production of *humanitarian space* and help MSF as it maintains attention to that limit between aid to victims and support for perpetrators. Furthermore, I hold that, though these tactics are specific to the mobile clinic at Porte de la Chapelle, it is possible to abstract out to suggest that similar spatial tactics afforded to MSF in the production of humanitarian space by their mobility. I shall start with three spatial tactics by which MSF deals with resistance and friction from other actors. The last three spatial tactics are more directly tied to the ethics and politics that mobility affords.

I shall term the first spatial tactic ***precarious presence***. In February 2017, MSF would set up their clinic four days a week next to the humanitarian centre at Porte de la Chapelle. Once a week they would set themselves up on the *Avenue de Flandres* in the 19th arrondissement of Paris, right next to the *Dispositif d'évaluation des mineurs isolés étrangers* (Demie), or the Unaccompanied foreign minors evaluation apparatus. The purpose of the mobile clinic was to *track* unaccompanied foreign minors. Data collected was meant to inform the design of a new project.[1] It made sense then to set up the clinic in a place where they would encounter unaccompanied foreign minors. Before doing so, they had asked for the necessary authorizations from the prefecture, but to no avail. They decided to start activities without them and encountered no problems during the first month. However, the day before I started observing activities at Porte de la Chapelle, the police notified them that they would no longer be allowed to set up at their location next to the Demie. The Project Coordinator present at the time heard the police officers' superior tell them over the radio that they could "help" MSF remove themselves from the pavement if they were disinclined to do so of their own accord. They were given no explanation, but the decision was presented as final. Following this, they concentrated their activities at Porte de la Chapelle while continuing foot patrols (*maraudes*) in different neighbourhoods around the capital. They continued to send and resend requests for authorizations to set up at *Avenue de Flandres* next to

[1] A day centre for foreign minors whose status as minors has been denied by the French state, opened in December 2017 just outside of Paris in the suburb of Pantin. Present in the centre are translators, legal advisors, a psychologist, and a nurse. There are also spaces where they can relax, read, and play games. A kitchen is available to them and lunch is served. However, MSF does not provide long term shelter, even if they have a rent a limited number of rooms in a hotel for emergencies. Long term care is the responsibility of the state. Chapter 2 details these processes of data collection.

the Demie, but never received a reply. The French state refuses MSF's presence in some areas, and there are obvious limits to the control afforded by their presence when the state delivers authorizations to set up the clinic. However, because of the mobility of the clinic, because of the *limited commitment* necessary to setting up once a week next to the *Demie*, they can push their luck, tempt fate. They can spend an entire month set up while waiting for the appropriate authorizations. Their *precarious presence* does not put the entire project in jeopardy, because they are mobile and can set up elsewhere.

A second spatial tactic of mobility ***yielding presence***. Even after abandoning their presence at the *Demie*, MSF has had to move the clinic around among three different sites at Porte de la Chapelle.

Figure 15: Different positions of the mobile clinic. Paris' "humanitarian centre" was in the northwest corner. (Source: OpenStreetMap)

When they first arrived in January 2017, they set up at site 1 (see the above Figure), but at the end of February a construction company came and started excavation underneath the railroad bridge against which the clinic was set up. MSF then moved the clinic to site 2. This was less than ideal: tram rails, running along the boulevard approximately two meters the MSF tent, were a safety hazard. When excavation ended at site 1 at the end of March 2017, they relocated. Figure 2 shows the mobile clinic at that time. A few months later, they moved again. A private hairdressing school which they juxtaposed had seen a decrease in student registration since the humanitarian centre had opened in October 2016. MSF's free medical clinic had been identified as a contributing factor.[1] The prefecture intervened, asking MSF to displace their activities once again. The mobile clinic crossed the Boulevard and set up right next to the storage and coordination space used by a partner association, Utopia56, active in the humanitarian centre (the grey polygon visible in the top north west corner of the map). Utopia56 is one of MSF's partners and, for now, setting up the mobile

[1] I was told this by one of the doctors working in the clinic. I have not been able to corroborate in the press.

clinic in this adjoining space is not problematic. This *yielding presence* is made possible by the mobility of the clinic. They can move across the street when public works begin, when the tram needs space to pass, when business interests rub up against their presence.

A third spatial tactic in which mobility is involved is ***covert presence***. MSF personnel can be very sensitive to the effects of their presence. During a foot patrol out from the mobile clinic, along the fences surrounding the humanitarian centre, a Project Coordinator (PC) removed her MSF armband, explaining that she did not wish to antagonize her colleagues at *Emmaüs Solidarité*. This organization, which runs the humanitarian centre, reportedly saw MSF's activities as out-of-line. Medical services are available inside, and MSF's presence seems to question the ability of *Emmaüs Solidarité* to perform their work. So, MSF sometimes makes their presence less salient – by removing their armband their territorial claims are less boisterous – while they work alongside other organizations. Yet during the foot patrol, they remain visible to migrants, approaching them directly and presenting themselves, explaining that they provide health services down the road, participating in the territorial production of the mobile clinic through *association*. They can select to whom they make themselves known; mobile beings can run covert operations.

These first three spatial tactics have been associated with MSF's local attempts at insinuating themselves into the "humanitarian borderscape" at Porte de la Chapelle without antagonizing those who are already there. The next three spatial tactics relate more directly to *the politics and ethics associated with this technology of intervention.*

A fourth spatial tactic is ***public presence***. The mobility of the mobile clinic means MSF can go where things are happening. They can say they were there; they saw what happened with their own eyes. They can communicate publicly on what they have seen. This was the case in January 2017, when MSF issued a report denouncing police violence against migrants sleeping at Porte de la Chapelle.[1] This was the case in March 2017 when they invited a team of journalists to observe their work at Porte de la Chapelle. This presence affords them legitimacy in their public statements (Redfield 2013 and Fox 2014 on presence, the legitimacy afforded ocular witnesses, and the problematics of what is termed *témoignage* at MSF). Publicly communicating on police activities is seen as a way of increasing the publicity of these activities and of effecting a change in these activities. Here is an extract from my notes during a discussion with the Head of Mission on February 17, 2017, where she speaks about the link between presence of the mobile clinic at Porte

[1] https://www.lemonde.fr/immigration-et-diversite/article/2017/01/08/msf-denonce-les-violences-policieres-contre-les-migrants-a-paris_5059437_1654200.html

de la Chapelle, the publication of their report on police violence, and MSF's political goal of changing how local and national authorities treat migrants in France:

> *It was because of (suite à) our presence that we were able to observe police violence, taking blankets [by police from migrants sleeping in the street in winter], and to communicate on that in the press. The effect was immediate and significant. Our press release was taken up by big press agencies. "Impact was enormous." First, because it was us, MSF, who was communicating. The authorities starting to fear our presence. The modified a whole set of activities to improve conditions at La Chapelle, especially reception. They said to themselves, "MSF is here, we have to make things better.*

According to Clarisse, MSF's very presence has the effect of improving conditions for migrants. MSF is a large organization, with a good reputation. When MSF says there is police violence against migrants in Paris, the press listens. This means that authorities see them and adjust their activities. Thus, if MSF does indeed participate in the "control and care" of migrants, they can also perform a kind of control on state authorities, even in cases when we are dealing with a European state determined to maintain their sovereignty. The mobility of the mobile clinic means that MSF does not have to choose a single site but is able to follow the serial territorialisation of borders and exercise a kind of control on national authorities. This is not a global overhaul of European migration policy, but that is not their goal. What we have is a public demonstration that state actors are mistreating people who are quite visible in the urban landscape in Paris. MSF suggests, furthermore, that an alternative is possible: the treatment of migrants sleeping in the streets should not include the spraying of their blankets with tear gas in the middle of winter, as had become common practice.

A fourth spatial tactic of mobility is ***co-presence with other mobile beings***. Our abstractions on the mobility sequence of the mobile clinic would suggest that even mobile beings territorialize now and again. This leads me to suggest that migrants are not in permanent *state* of mobility. The point is a bit trite. However, it indicates an argument *ad absurdum* against the suggestion that because of the stasis necessary to the provision of care, there is disconnect between immobile clinics and mobile migrants. This would mean that migrants never stop moving, and that they are unable to change their plans to allow for medical care. Migrants stop, at least occasionally. They participate in territorial production as they *associate* certain places with the European borderscape, or with MSF's mobile clinic. They regularly pause in their mobility and *appropriate* space, as they set up tents under overpasses and next to canals. This suggests that there is a possibility of coordinating the sequences of mobility and the processes of territorial production of humanitarian actors and of migrants. This is an additional spatial tactic afforded by mobility: *co-presence with other mobile beings.* In Paris, MSF can do foot patrols next to *Gare de l'est* in the morning, telling

people they are *present* at Porte de la Chapelle in the afternoon. This is one way *co-presence* is coordinated. They can go to those places where the European borderscape materializes on the French-Italian border in the Alps, or close to Ventimiglia, or in northern France, in Calais or at Grand-Synthe. The mobile clinic can regulate its mobility, and coordinate with migrants to be in *co-presence* with mobile persons and populations. This co-presence affords public presence and the possibility of public demonstration as a political intervention. It also enacts a situation where MSF can come into direct contact with the people they hope to serve. As already discussed, Rony Brauman holds that direct contact with "beneficiaries" is essential to a humanitarian space where an ethics of solicitude is possible. That is, the co-presence that mobility makes possible supports a specific kind of politics as public demonstration, and a specific kind of ethics.

After *public presence* and *co-presence*, ***absent presence*** is another political and ethical tactic associated with mobility. The mobility of the clinic, coupled with the strategic production of territoriality through material presence and the social production of this territory through association, means that MSF can be *present* at Porte de la Chapelle, without being *present at all times* at Porte de la Chapelle. As they do foot patrols in and around Paris, as the mobile clinic moves to other sites in France, as they reduce the opening hours of the clinic when they open a day centre for minors in Pantin, they continue to be present at Porte de la Chapelle. The mobility of the mobile clinic turns it into an *absent present* at Porte de la Chapelle, able to territorialize in more than one place, to participate in the control of state activities and to stand as a public witness to these activities, *even in its absence*. When they went to Calais in the summer of 2017, the mobile clinic, *even in its absence*, continued to be *present* at Porte de la Chapelle, through the previously described effects of its presence, i.e., in the modified activities of the local authorities controlling access to the humanitarian centre. It was an *absent present*. Following John Law and Vicky Singleton, if the mobile clinic also exists in "patterns of discontinuity between presence and absence", continuing to relate to the activities of local authorities and of migrants even in its absence, then it exists according to a *topology of fire*. We have seen the fluid and network topologies mentioned to Fredriksen's work. Law and Singleton propose a fourth[1] topology: *fire topology* (Law & Singleton 2005). Law and Singleton's "fire objects" depend on *transformative otherness*. Fire is absent fuel and present flame. So, it is with the *absence presence* of the mobile clinic: the disjunction between MSF and *Emmaüs Solidarité* led to transformation of practices of control at the entrance of the "humanitarian centre". Even as there is continuity across the

[1] I say fourth, because there is also "regional topology" that I do not discuss directly in this chapter.

"humanitarian borderscape", there is *productive difference*. This too is part of a politics of MSF's humanitarian space: the transformation of the practices of other actors through its difference, through the public proposition of alternatives. French migration policy has not radically changed, but there were improvements in how migrants were treated. This is a political achievement. This is an ethical achievement.

Table 3: Some spatial tactics of mobility

Some Spatial Tactics of Mobility
Precarious presence (limited commitment)
Yielding presence (conflict avoidance)
Covert presence (invisibility and presence)
Public Presence
Co-presence (with mobile beings)
Absent presence (fire topology)

Negotiation of space for the mobile clinic is a continual affair, precisely because of the sequence of mobility and intervention. Continual tracking and daily territorialisation mean they are light on their feet. They can start activities while waiting for authorizations. They can abandon one place, when authorizations are refused, while continuing to ensure covert presence with foot patrols. They can make small adjustments, yield to the presence of other actors by moving 50 meters down the road or crossing the street. They can move out of the way for public works and avoid antagonizing local business interests. They can move when the security of staff and patients is in jeopardy because of a tramline that is too close. They can set up just out of sight of institutional actors who do not appreciate their presence, while remaining visible to the people whom they wish to aid. They can continue negotiations with other institutional actors, allowing time for relations to evolve. MSF's relations with *Emmaüs Solidarité* improved and in the summer of 2017, regular meetings were held between field-level operatives in each NGO in order to coordinate across organizations. This too is an effect of operational presence. They come to share, or at least become aware of, some of the concerns of those other institutions that occupy the humanitarian borderscape. This makes minimal cooperation possible. For example, when they encounter a migrant at the mobile clinic whose medical condition dictates that he be kept off the street, they can push for him[1] to be accepted inside. They are not systematically accepted at the centre. The Project Coordinator told me that for MSF no one should be sleeping on the street, but she had to be careful not to send too many people. This would antagonize their

[1] I say "him" because the humanitarian centre at Porte de la Chapelle was for men. Another centre for families, women and children was elsewhere in the region.

partners, who faced another set of constraints. This would close that one door they had managed to push open.

This humanitarian effect on bordering, where the bodily vulnerability of migrants is taken as a justification for the passage from illegal presence to legal presence, is precisely what Miriam Ticktin analyses as a violent reduction of humanity. The above section suggests, rather, that this is one political and ethical tactic among many, slightly modifying practices on the ground in such a way as to improve the lives of a few. The goal is not global overhaul. It is to indicate viable alternative practices that produce less suffering. These alternatives are precisely what MSF's presence is meant to render possible.

Cooren *et al* (2008) have also written convincingly on the *coproduction of presence* by MSF in the Democratic Republic of Congo, but the point they make is a bit different. We were interested in how the presence of MSF becomes a territorial tactic in the production of humanitarian space for political ends. They are interested in the discursive coproduction and problematization of an organization's presence through communication. However, the work of Cooren *et al* left us frustrated: *presence* is produced by more than discourse, and there is more to the action of MSF than communication.

*

In the first section, we saw that humanitarian space is a relational concept equipped to deal with problems of sovereignty, ecology, and ethics. We also saw that in terms of political strategy, MSF politics did not hope to achieve a radical overhaul of EU migration policy. Their strategy was to provide concrete and feasible alternatives in the field in order to improve the concrete living conditions and reception conditions for migrants and asylum seekers. Their political strategy is opportunistic, looking for openings, for tipping points, for cracks in the façade, and then pushing, precipitating, and provoking. This is a different kind of politics than the one Fassin puts forward in his suggestion that humanitarian politics is based on a violent reduction of difference. Nevertheless, it is a kind of politics and a kind of ethics. Modest politics, modest ethics, content on improving the concrete living conditions of individuals going through difficult times, through practices that produce small-scale changes. In this second section, we have seen here how the enactment of humanitarian space participated in this political strategy and ethical approach. Vacillating between mobility and territorialisation, they track mobile populations, channel aid towards them in order to reach them where they are and to take them in. We saw how, in order to achieve this, the humanitarian space of the mobile clinic is enacted according to at least three different topologies: network, fluid, and fire. We saw how mobility was a tactical tool where *presence is political and*

ethical, whether it be co-presence, absent presence, precarious presence, yielding presence, or covert presence. Humanitarian space has appeared as a materially complex thing, relating to a wide variety of actors in different modes. It is not a localized homogenous region in linear time with stable borders. Humanitarian space is mobile and plural, slipping in and out of territoriality in Paris, in Ventimiglia, in Calais. It can jump from presence so covert, so yielding that they are invisible to local authorities – becoming even an absent presence – to presence so obtrusive that they attract the attention of major international media outlets. In doing so, MSF can call out state actors when they fail to keep their promises, provide concrete and practical alternatives to these failures, while working to respond to the concrete medical needs of migrants. These are some of the material characteristics and the politics and ethics of humanitarian space in Paris.

In this section, I have been interested in the territorial production and the mobility sequence of the mobile clinic. I have described in detail the territorialisation of the clinic, and some of the tactics afforded by mobility. In the next and last section of the present chapter, I'll be looking more closely at another part of the mobility sequence – *taking people in* – in order to discuss triage, the ethical problems humanitarian space is meant to deal with in its ties to bordering.

3. Triage at the Border: Confusing the Inclusion/Exclusion Binary

The bordering analysed by Miriam Ticktin, and Polly Pallister-Wilkins was central to Didier Fassin's "humanitarian government". Fassin held that humanitarian governmentality effaces difference - essential to Hannah Arendt's anthropology – for need differentials. Pallister-Wilkins saw *triage* as the activity that made the connection between these disparate elements - control and care, bordering, humanitarian government of migrants, and violent reduction of difference - which effected a veritable depoliticization of the "issues". The proposition that triage - the rationalized choice to refuse, or postpone, care to some, in order to provide care to others based, on a bodily assessment of need - is directly implicated in forms of territorial production is highly original. In the present section, I will build on this analysis of triage in spatial terms.

However, I expect the reader will recall how our discussion of the problems of *humanitarian space* as a relational concept made *humanitarian governmentality* seem strange; humanitarian aid is thoroughly political, but this politics is nongovernmental. We saw that while humanitarian space is territory, and that these territorial productions afforded specific tactics of presence. This *presence* was as much about monitoring the effects of government policy, as it was about attracting the attention of press agencies, as it was about avoiding the antagonization of other

NGOs, as it was about maintaining co-presence with beneficiaries. Humanitarian space was specifically meant to deal simultaneously with questions of sovereignty, ecology, and ethics. If we are to take seriously the idea that *triage* produces territory, we must keep in mind this complexity.

In the present section, I will ask what kind of space the technologies of triage enact. When space is analysed in terms of topology and spatial complexity, the *inclusion/exclusion* binary associated with "bordering" and *triage*, seems simplistic. Indeed, it suggests a *regional topology* with a clearly defined border, no overlap, and the mutually exclusive *inside* and *outside*. Such spaces do exist, of course, but they cannot be assumed. Indeed, demonstrating that such a space exists would be an original result. But to see the kinds of space triage enacts, a description of the tools and practices of triage are necessary. As such, this section deals with the scriptural device that supports triage in the mobile clinic, referred to as "the list". In the first subsection, we will see how "the list" is a powerful actor that shoulders important cognitive responsibilities as it produces territory and coordinates patient flow through a series of spaces that compose the mobile clinic. In the second section, we will see how the rhythms of mobility that punctuate the mobility sequence and its vacillations between de-territorialisation and re-territorialisation enact a moment when it becomes necessary to refuse care to those whom MSF hopes to serve: closing time. In these simultaneous processes of producing territory and working out how to exclude patients, we will demonstrate that MSF's humanitarian space effectively abolishes any clear distinction between ethics and politics. That is, MSF's nongovernmental politics is thoroughly ethical.

a. The Economy of Attention in the Coordination of Patient Flow

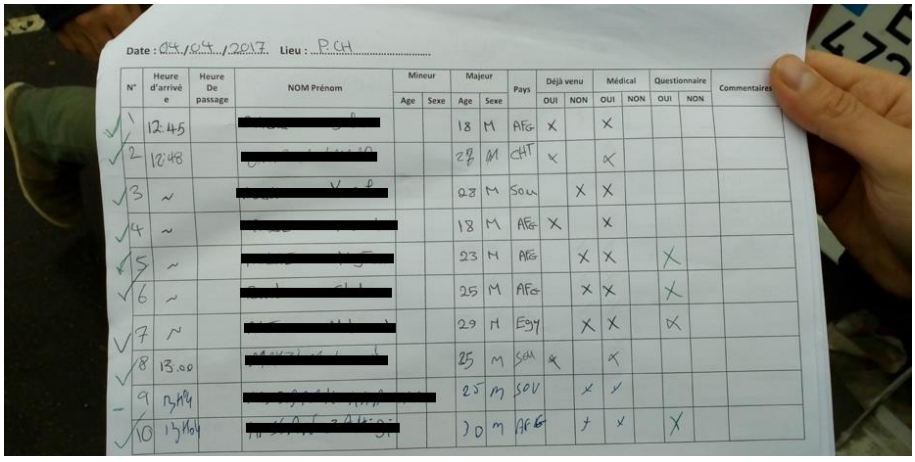
There are significant differences between mobile clinics. A short list, with no pretence of exhaustively, will include the morbidities they are equipped to deal with, the contents of the pharmacy, the specific expertise and experiences of personnel, the medical priorities MSF sets for itself, the needs of the vulnerable population, the materials used in the set-up, and the organization of patient flow in and out of the clinic. Whatever the specificities of each situation, they all require a great deal of logistical work: means of transportation (planes, helicopters, cars, vans, buses, and donkeys!) to get medical supplies (medicine, bandages, scales, stethoscopes…) and expertise in the form of personnel (doctors, clinical officers, nurses, community health workers, WASH experts, psychologists) to the patients in need. They also carry with them the materials needed to set up the clinic as *a bounded space* – the back of a box van, tents, red and white tape. Upon arrival, the materials they carry with them are deployed in such a way as to *reconfigure that space into an MSF clinic*. This is *set-up*, which I have already described in some detail. As we saw, there is *a space for patients to wait*, and, most importantly – as the common activity indicator "number of

consultations" shows – *a space for consultations*. Those whom MSF wishes to serve *flow* through these spaces. In professionalized public health management, this is termed "patient flow". At the mobile clinic at Porte de la Chapelle, a peculiar actor oversees the organization and the coordination of this *flow*: the list.

The list is just a sheet of paper with names. Yet MSF personnel repeatedly underlined the importance of the list in their activities. The day I arrived at Porte de la Chapelle, I asked the project coordinator (PC) what their main activities were and "the list" was first among them. The list is one of the things MSF does. Later, interviewing Adan, one of the translators, I presented my interests as being in the work necessary to "help migrants", specifically, how they organized themselves in such a way as to be able to provide care. Again, his reply was immediately the list. The list is an activity that organizes activities at Porte de la Chapelle. The following excerpt from my field notes at Porte de la Chapelle shows the centrality of list.

> *A second woman, a volunteer with Utopia56 I believe, has arrived. She has a migrant with her. Kareem, an MSF translator, has* ***the list*** *in his hand. He writes the name of the person the U56 volunteer brought. He is the 20th person registered today. Once this has been done, Mariam, another translator, takes* ***the list*** *and walks around the tent, repeating a name she reads off the list five times. She finally finds the person who belongs to the name and takes him to the vestibule of the box van to wait his turn for a consultation. Mariam then puts checkmark next to his name on the list. She goes back to the tent, says another name, takes another person to the vestibule. Then she puts the list under her arm and goes to speak with Iranian family that arrived earlier. She takes their papers, in French, and reads them, explains what they say in Farsi. Kareem is close by, talking with someone who I think is Syrian based on their accent, which sounds Levantine.*
>
> *Another volunteer from U56 shows up. She has two Afghans with her. Mariam registers both their names on the list. One of them is a minor. She asks: name? age? nationality? have you been here before? She then explains that they will have to wait a bit for a consultation.*

So, what is the list? The list is one of the papers the translators carry around on their clipboards. It is an A4-format printed sheet of white paper (see Figure 16 below). At the top of the


Date : 04/04/2017 Lieu : P.CH

N°	Heure d'arrivée	Heure De passage	NOM Prénom	Mineur		Majeur		Pays	Déjà venu		Médical		Questionnaire		Commentaires
				Age	Sexe	Age	Sexe		OUI	NON	OUI	NON	OUI	NON	
1	12.45		[redacted]			18	M	AFG	X		X				
2	12:48		[redacted]			28	M	CHT	X		X				
3	~		[redacted]			23	M	SOM		X	X				
4	~		[redacted]			18	M	AFG	X		X				
5	~		[redacted]			23	M	AFG		X	X		X		
6	~		[redacted]			25	M	AFG		X	X		X		
7	~		[redacted]			29	M	EGY		X	X		X		
8	13.00		[redacted]			25	M	SOM	X		X				
9	13h14		[redacted]			25	M	SOU		X	X				
10	13h14		[redacted]			30	M	AFG		X	X		X		

Figure 16: The List

page, when presented in a landscape format, two spaces are left for the date and the location of the mobile clinic. Specifically, the list is where information is collected from those who come to the clinic and inscribed. The actual table is composed of cells arranged in rows and columns. The elements to be noted in a given column are written at the top. This includes name, age, sex, nationality, the reason for their visit (medical, non-medical), whether it is the first time they have visited the mobile clinic, and whether or not they have filled out a questionnaire.[1]

The number "1" is given to the first person to register on the list each day, the number "2" to the second person to be registered, and so on and so forth. The numbers give the order of arrival of the people who come to the clinic. Once a person has seen the doctor, a check mark is inscribed next to their name in the margin. There is a space to write the time when the person has seen the doctor – *heure de passage* – but it is not used.

Once a person has been registered on the list, they have officially been received by MSF. They have been *taken into* the space MSF has set up at Porte de la Chapelle and they are now free to enter the heated tent. During the time they must wait to see the doctor, they can drink tea with their friends. In this *bounded space* carved out of the pavement at Porte de la Chapelle by the mobile clinic and the list, the *free time* of the migrants' wait is spent in discussion with friends and with translators. The translators sit with them. They serve them tea and coffee. "Green tea or black tea? How many sugars? Sorry, we don't have milk." They ask them questions and make jokes. They are attentive to what the migrants formulate in terms of *needs*. In the time the mobile clinic has been *in place*, they have put together a binder full papers translated into English, Arabic, and Farsi, detailing where hot meals are distributed, which public bathrooms have working showers – MSF has sent personnel to a number of sites and checked – where they can go if they want to take French language classes, which hospitals have a translation service. Sometimes, the translators just sit and listen, without giving advice or directing patients to other sites.

This *attention to the* migrants, to what they formulate in terms of need and the response to them, is organized. As we have seen, a bounded space is set up where migrants can sit comfortably, and a time is made when they can do so, i.e., while waiting to see a doctor. Though the tea itself seems incentive enough to come and sit. In March 2017, of the 40 some people registered daily at the mobile clinic, approximately 25 come to see the doctor. The rest come for the heated tent and the free tea. During this time that is freed up in this bounded space for the migrants, the *attention* of the translators must also be simultaneously *open* – in the sense that it is unencumbered by other

[1] Questionnaire usage will be described at length in Chapter 2.

activities – and *bounded* – in the sense that it is guided by material assemblages. Again, the list participates in both freeing up and directing the translators' attention.

The list achieves this, first, by taking on several **cognitive responsibilities** that the translators would otherwise have to shoulder themselves. One way it does this is by routinizing reception into this bounded space through registration. The "name-age-nationality-first time here?" routine, that punctuates the first encounter of a migrant with an MSF translator, is brief. The next question scripted by the list – medical/non-medical – requires a bit more involvement. But this is routine and, again, is supported by the list. It also spares them later effort in regulating the flow of patients from the *waiting space* to the *consultation space*: thanks to the list, 40 people can visit the clinic in a 7-hour period, and the translators do not need to remember who has come for tea and who has come to the see the doctor. The list divides people in the mobile clinic into two groups: those who have come for medical reasons and those who have come for conviviality. The translators have even taken to noting the motif of their visit not only in the appropriate column – smack dab in the middle of the page, a checkmark among checkmarks, visibly difficult to distinguish from other check marks that indicate if the person has already come to the clinic, if they have already filled out a questionnaire – but by putting a small circle in the left margin of the page next to their names. The circle means the person needs to see the doctor.[1] That small circle turns the person into a patient and not someone who has come for tea and a place out of the cold. The list remembers the purpose each person has attributed to his or her visit. These are some ways *the list shoulders responsibility for the translators and provides a time for their attention to be concentrated elsewhere*.

The list also frees up the translator's attention by taking on **ethical responsibilities** in managing the order of consultations. To do so, it establishes the order of arrival upon which it bases the order of passage in the GP's surgery. The next person on the list is the next person who is to see the doctor. In organizing passage in the consultations in this manner, *the list accomplishes an important principle in the distribution of resources: the egalitarian "first come, first served".* This mode of organization declares irrelevant all claims to priority other than temporal priority. Priority is not a function of solvency, personal relationships with MSF staff, fame or other understandings of merit. An exception to this – medical need – will be discussed later. The list performs this ethical prioritization by scripting for a translator who simply calls out the next name and then takes the person who answers to the vestibule of the mobile clinic. Moreover, this avoids unnecessary time

[1] Unfortunately, I do not have a picture of the list with these small circles.

spent looking for patients. There are two seats in the vestibule, and two people can be taken there *ahead of time*. The list then accomplishes the cognitive faculty of *projection*. This means that *they do not need to pay attention* to the exact moment a patient comes out of a consultation to find the next person on the list. Their attention can be directed towards the migrants.

As you can see, the list is very active in the ordering of humanitarian space. The tent and tea provide a comfortable and bounded space for the migrants during the time they must wait to see the doctor. The list keeps track of who has come to the mobile clinic and for what reasons, and it orders the patient flow in and out of consultations in a fluid and just manner. It does so without requiring too much attention. The *flow* through this continually produced free space and free time, comfortable and convivial, allows translators to attend to some of what the migrants formulate in terms of needs while joking and talking with them. The list, then, can be described as a powerful tool in the performance of a space and a time where the attention of translators and doctors is directed towards migrants and their needs. The list and the bounded space it orders also serve the function of keeping some migrants out.

b. Closing Time and the Inclusion/Exclusion binary

The list is not the only element that composes this boundary. Later in 2017, they started to cordon off the mobile clinic with **red and white tape** (Figure 17). This has the effect of concentrating flow through a single *point* – the list – making control of entrance more systematic. The list, then, supported by this material ordering of space, is an instrument that formulates the question of patient reception and rejection in a manner such that responses take the form of adding a name to a list or refusing to add a name to the list. The performative power of the list, with the help of a bit of tape, formulates the patient selection problem in terms of inclusion and exclusion. And yet, as we will demonstrate, despite this clear border between an inside and an outside, excluded migrants receive care precisely *between this border*.

Figure 17: Red and white tape materializes the border

In addition to this material support for "the list" as a tool which orders the questions of triage, there are a few rules and principles that guide its use. For example, the mobile clinic is only for foreign nationals without access to healthcare in France. This excludes most passers-by. However, pedestrians do not usually stop here, and when they do, it is not for medical care. This rule is intended for those foreign nationals who can prove three months of continuous presence in France, whatever their legal status, which allows them to invoke their right to the *Aide médicale d'Etat* (AME), or State Medical Aid. For MSF, these people can go to hospitals and get care, meaning that the mobile clinic is not for them. This can be taken as a reflection of MSF's mission statement – inscribed in its charter – which is to provide care to those in need *without access* to healthcare. If they "look the part" – a recently arrived foreign national – the translators at the mobile clinic do not generally ask if they have the AME or not. Nothing scripts for this question or for the application of this rule. In practice, a few people with access to the AME come through the clinic every day. The translators often discover this as they read their papers and explain to the migrants how to jump through the administrative hoops to get papers, healthcare, and shelter. During the consultation, the translators apologize to the doctors for letting someone get through the boundary who was not supposed to, but the response is always, "well, he's already here…" Once they are *inside* the mobile clinic, having the AME does not apply a sufficient centrifugal force to propel them back *out*. Moreover, these questions are not experienced as morally entangling. On the occasions when it does lead to the refusal of healthcare, it is understood that the patient's needs are not urgent and that they can access care in any hospital with a PASS (*Permanence d'accès aux soins en santé*, Health care access point) in France.

In actuality, the refusal of care is concentrated at a specific time during the day: **closing time**. Opening hours for the clinic are posted on the back of the van. They indicate those periods of time during which the mobile clinic is *open*. Outside of these times, the mobile clinic does not take patients in. It is *closed*. Of course, when it is closed, it is also de-territorialised. All the material is boxed up, put in the back of the truck, which is taken to the other side of Paris to sit in an underground parking garage. This is another way the boundary between an *inside* and an *outside* of the mobile clinic is maintained, not in *space* - the clinic has temporarily de-territorialised - but in *time*. If the *opening time* of the mobile clinic does not pose a problem, *closing time* – that moment when MSF staff stop providing care – can be more worrisome.

Once again, the list plays an important part in organizing the daily closure of the mobile clinic. As already mentioned, the list allows MSF staff to *project* their activities into the future. They can lead two patients into the vestibule ahead of time. They can also estimate the amount of

time necessary to finish consulting for the day given the number of people registered on the list. The average time for a consultation is 15 minutes: if six people remain on the list then the doctor will need about 90 minutes to consult. They should then stop registering new patients on the list at that moment when adding a patient would keep the mobile clinic open beyond closing time.

Therefore, the list makes it possible for MSF to organize the closure of the clinic in a specific way, and participates very directly in the formulation of what is a *dilemma*: contradictory moral or practical imperatives impose themselves, none of which is unambiguously preferable. To close *on time*, the list requires that MSF staff turn people away. There are good reasons to do so, namely, respecting French labour laws and not overworking staff. Taking time to maintain the clinic and to provide rest to staff is important in ensuring quality care and self-care. There are also good reasons not to do so. During one week of observation in March 2017, the *earliest* MSF left Porte de la Chapelle was 45 minutes – approximately three consultations – after established closing time. If this is maintained over a month-long period, MSF employees at Porte de la Chapelle will work more than 15 hours over what is indicated in their contracts. MSF is a large professional organization, with tens of thousands of employees. Surely, they have caring responsibilities, not to mention legal obligations, towards their staff. And if MSF refuses sacrifice as a political principle, should self-sacrifice be allowed? In Didier Fassin's work on "politics of life", he describes the unwillingness of MSF employees to put their lives in danger to save the lives of Iraqis. He sees here an economy of life, where the political activist prepared to risk their own life in order to achieve a political goal in their own country, has been replaced by an adventurous volunteer unwilling to put their own life in danger and working to save vulnerable lives caught up in political violence. The life of the volunteer cannot be risked to save the life of the vulnerable. No self-sacrifice. However, speaking with MSF employees (and reading Redfield 2013), it becomes obvious that working conditions in the humanitarian sector are hard. Hours are long, expectations are high, and pay is relatively low. Most people recruited at MSF stay for a single 6-month mission.[1] But you try at least to respect working hours, and weekends (unless it is an emergency project).

In any case, the inclusion/exclusion question has become: *do you register a new patient on the list when you know that the time it takes for them to flow through the spaces of the clinic will keep it open beyond normal opening hours?* A great number of elements come to bear in ordering the situation in such a manner as to render this the operative question. The mobility of the clinic,

[1] That is, among those recruited on an "expatriate" contract, and not a "national" contract.

supporting its processual slipping in and out of territorialisation. The list, in the projective function that it occupies, but also in its ability to free up and direct attention. There are also French labour laws, the material bounding of the mobile clinic with its inside and its outside, not to mention its placement next to a humanitarian centre. Taken together, the situation has reformulated the abstract "tragic choice", where the options available were "inclusion" and "exclusion". We have here a practical problem of juggling between responsibilities to employees, keeping the mobile clinic in good shape, maintaining relations with state, city, and institutional actors, while also assuming their caring responsibilities towards migrants. How can all this be achieved in practice?

That moral dilemmas need to be resolved in practice does not mean that they are less cumbersome. Rather, these moral trials require a different set of *skills* than those of tramway related thought experiments. I would like now to explore a few of those moments when MSF staff grapple with the decision to *take in* or *turn away* patients. The boundary of the clinic is organized in such a way as to allow some people inside while refusing access to others. Refusal has significant moral and operational implications. MSF's mission in Paris is to come to the assistance of recently arrived foreign nationals sleeping in the streets without access to care. Do they fail in this mission when they refuse care at the end of the day? How do they deal with this apparent tension between forces acting contrary to each other – on the one hand, a force that pushes the clinic closed, i.e., the practical necessity of maintenance, rest, and the respect of French labour laws; and on the other, a force that pushes the clinic open, i.e., their mission of coming to the assistance of people in immediate need?

Perhaps we should start with the most obvious exception to the closure time rule, already mentioned: medical necessity.

> *A Sudanese man, around 40, arrives. He is having an asthma attack and does not have an inhaler. They take him, even if it is 7:45 and we are supposed to close in 15 minutes. The list is long and a few minutes ago they were saying that we would be here late today.*

An asthmatic is having an attack. He does not have in inhaler. It may be a few minutes before closing time – during the period of observation, closing time was 8pm – but there is no doubt, no discussion. They register him on the list. Then again, if they decide to take the patient, it is also because they are able to respond to his needs: MSF has inhalers in the pharmacy inside the van.

Here, again, medical need keeps the clinic open. I am in the consultation room with Dr Amandine when Octavia, the Project Coordinator (PC) and a registered nurse, arrives.

It is 7:50. Between two consultations, Octavia comes into the consultation room and takes the thermometer. A few seconds later she returns: I've got a fever of 39.2. Do we take him? Amandine: I mean, yeah.

There are four more people on the list with this addition. Amandine washes the bed with her chlorine mix. She picks up a bit of plastic casing on the ground. She washes her hands. A new patient comes in.

From the inside of the van, it looks like a migrant has arrived and Octavia is hesitating about registering him on the list. Is 39.2° serious enough to keep the team here beyond opening hours? It is serious enough. Doctor's orders.

Things can get more complicated. In the following excerpt, MSF staff has started to consider the end of registration on the list a full two and a half hours before closing time.

It is 5:30 and they start saying that there are not a lot of people on the list, they'll finish early. But in the space of five minutes, four people arrive. The first two say they have the same problem and they can go in together to get through more quickly. All they have is an irritation in the throat, a cold. Hélène, logistics manager, does not see a problem. Mahmoud, a translator, says that there might not be enough time for them today, they'll have to wait and see.

Octavia, Project Coordinator and registered nurse, comes into the tent and cuts off their discussion: we'll take them. Both of them. And in separate consultation. She adds that a consultation with two patients is "impossible", we don't do that. Hélène completes the idea: yeah, if they have any "secret pathologies", well too bad for them!

The two others are Afghans. The first has a wound on the back of his hand covered in something white. Octavia asks what it is. Mahmoud says in French that it is toothpaste, "they all do that." The patient confirms that it is toothpaste. Octavia tells him not to put toothpaste on it, "I don't know why they put toothpaste on their wounds". She takes him into the tent, her hand on his upper arm, leading him, and then sits him on a bench. She applies a clean bandage. She then explains - with a translator - that in a few days, when the bandages are dirty, it should be ok.

The second Afghan sits down, takes off his show, and shows Octavia his toe, and a black, rotten toenail. The nail looks like it broke in two. She explains that she does not have what she needs to take care of it, she doesn't have the material in the box van either. She tells him to cut his toenails more often and sends him to the emergency room at Bichat Hospital.

A few hours before closing time, four people arrive at once. If they accept all of them, it will take them well beyond closing time. The first two suggest they consult at the same time. This solution is seriously considered. When Octavia shows up, she immediately rules out the possibility of medical consultations with two patients in general, and not only in this particular case. But surprisingly, here, the choice made by Octavia is not between inclusion and exclusion, or, at least, its framing has somehow changed. When Octavia makes a decision, the choice is not that of writing a name on the list or not writing a name on the list. The choice is now between two-person and one-person consultations. She opts for two one-person consultations. A principle of medical ethics

dictated this path. You might even say that the decision was not Octavia's, Hélène's, or Mahmoud's. A principle made the decision for them. However, they did have to find the right principle, one for which they could assume foreseeable consequences. They chose a principle that did not bear directly on the justice of biomedical resource distribution. The problem this principle resolves is related to the patient's dignity and their right to privacy. It resolves the choice between options as they stood upon Aurelia's arrival at the scene: a one-person or a two-person consultation.

The point here is that, while the inclusion/exclusion binary might make logical sense when thinking about the moral dilemmas of triage, in practice unforeseen options emerge that reconfigure the ethical problem. This is the case even when a tool as powerful as the list orders the question of selection as an issue of writing their name down, or not writing the name down.

For the next two arrivals, Octavia gets into the details of their needs. The first young man shows her a wound on his hand. As a registered nurse, she can dress a wound and does so. Once again, a decision regarding writing a name on the list seems to have been avoided all while their ability to assume the consequences for the decision is maintained. Octavia is attentive to his needs, assumes responsibility for their care, then uses the specific skills acquired during her training as a nurse to care for him. She managed to foil that tension between staying open late and closing on time by abandoning regular intake procedures and providing immediate care to someone with an identified need. Once again, the inclusion/exclusion binary is inadequate to the description of the situation of triage. The list coordinates patient flow through the mobile clinic. Patient flow indicates the movement of persons seeking health care through a series of spaces - from outside the clinic, to the waiting area, from the waiting area to the vestibule, from the vestibule to the consultation room. Here, *care* - understood as attention to specific needs, a feeling of responsibility for those needs, the skills necessary to response, and further attention to ensure the requested care has been provided - was not organized by the list. The person's name has not been inscribed. The patients never make it to the consultation room.

As already seen, the inclusion/exclusion binary was ordered by the list. It formulated an abstract question into a practical choice between adding a name to the list and not adding a name to the list. It ordered *inclusion* as *patient flow*. *Inclusion as patient flow* is not what happened in the above vignette. But this does not mean the above situation is not describable in terms of *exclusion*. Something else was at stake: *attention* to the specific needs of the person in front of them, and a sincere attempt to figure out a way to help.

There are also limits to what Octavia can do. Indeed, there are limits to what Dr Amandine can do, in the absolute, but also specifically, within the mobile clinic. This becomes obvious with

the next person, who requires dressings that are beyond the technical capacities of the mobile clinic. In this facility, they are unable to debride necrotic tissue. This means that even if the person went into the consultation room, Dr Amandine would not be able to provide the necessary care. Octavia sends him to the emergency room at Bichat Hospital. Here, once again, the decision seems to be beyond the team's discretionary capacities. No one sat down to ponder two equally appealing options and made the decision to abandon one in favour of the other. They cannot help this person. They do not have the material to do so. They can direct him to those who can, however. This is a kind of care. They listen to the person's needs and direct him towards the care available elsewhere.

As you can see, even at those times when triage decisions really are framed as a binary practical dilemma – "register on the list" or "send them away" – there is clear overflow. The first two patients try to resolve the problem of closure, but medical ethics counteract their attempts: an expedient solution – two patients in one consultation – becomes irresponsible, and, at the same time, reformulates the ethical problem at hand. Both are registered on the list. What is important here is that these patients are given the possibility to speak directly to a doctor (through a translator…[1]). Then Octavia immediately delves into the medical needs of the next two patients in the tent, in front of everyone: the privacy of the consultation is no longer the relevant principle. The principles that justify sending the patient away – French labour laws – are not automatically mobilized when the time is limited. The patient flow that signalled inclusion is not at all respected here, and yet care was provided. Finally, the last patient is turned away. That closing time is approaching may have contributed to the decision, but this was not the reason given. They are unequipped to help. This incapacity to provide a solution does not cancel out all their caring responsibilities, but it does change them: they must be to direct the patient to adequate healthcare services elsewhere in Paris.

*

In this section, we saw how a powerful actant - the list - contributed to the ordering of the situation in such a way as to frame *inclusion* as *patient flow* through a series of spaces inside the mobile clinic. That is, the list clearly ordered the clinic as a space with an inside and outside, with a border made of red and white tape. It enacted a territory, a bit of space on the pavement in Paris in which MSF set itself as responsible for the regular activities it organized there. One of these activities was closing the clinic, which entailed excluding patients, turning them away, preventing them from entering the space of the clinic. And yet, when we look at those moments of exclusion,

[1] The place and role of the human mediators of humanitarian action will be discussed in more detail in Chapter 2.

we see that options other than *inclusion* and *exclusion* emerged, based on a specific form of attention called *care*. At stake is not the establishment of a "hierarchy of lives" based on categories of vulnerability, as Fassin and Ticktin suggest. Instead, what we see is that the enactment of *humanitarian space*, as a territory without government, also produces specific moral difficulties. That is, without MSF's presence, no would be confronted with the moral responsibility of getting a person with a rotting toe to somewhere with the technical capacity to provide adequate care.

Conclusions

In this chapter, I dealt with "humanitarian space" as an actant, producing a *territory*, that is, "spatially delimited control" over an area where MSF holds itself responsible for a set of regularly occurring actions, political problems, and ethical dilemmas. Through a discussion with the literature, I analysed "humanitarian space" as a relational concept, forged to deal with the ethics of relating to beneficiaries, the politics of relating to state actors, and the institutional ecology through negotiation. These were the relations that provided MSF with humanitarian agency. This helped talk about what doing politics meant for MSF in Paris: not a global overhaul a European migration policy through direct confrontation and provocation of overtly political actors. Rather, modest shifts in practice at a local level, with the overall goal of showing the efficacy of alternative modes of action. This is what we called *nongovernmental politics*. Yes, we make the radical argument that a nongovernmental organization does what it claims: nongovernmental politics. This required pragmatism, opportunism, and the willingness to work with unsavoury characters, namely, governing bodies. I also described the materials that make up this space, and how these materials continually produce and re-produce territory, rhythmically de-territorialized and re-territorialized in a sequence of mobility. This mobility was seen to allow MSF to assure a material space for itself in a crowded area, where business interests, planned public works, state sovereignty, and cold reception on the part of camp managers could be dealt with through tactics afforded by mobility. We also saw how this mobility enacted a series of ethical and political tactics, such as co-presence with those they wish to serve, public presence in order to demonstrate the feasibility of alternative modes of action, and absent presence by which they effected change through productive difference. We saw, in the last subsection, that the territory inside the mobile clinic was ordered by a powerful tool, the list, which organized inclusion into patient flow through a series of spaces where care could be provided. The list also turned the issue of triage into *inclusion through patient flow*, while leaving the terms of *exclusion* unclear. In abstract terms, it meant not allowing people who ask for care inside the space of humanitarianism, i.e., the clinic. When describing triage practice, we saw that inclusion/exclusion binary was much too limited to frame the options and problems of triage.

Triage entails liminality, which interpretive anthropology has described as the state of ambiguity and disorientation, during rites of passage, when participants no longer have their prior status and do not yet have the status the ritual is to confer on them. This leads us to two points: *triage* entails a change in status, it modifies the qualification of the participant; it also means that MSF organizes and is responsible for this border, and at the same time they feed on the border.

Fassin's argument is not addressed primarily to NGOs, but towards a humanitarian moral economy, or humanitarian reason. That is, the use of humanitarian justifications - saving lives, pity for bodily suffering - to support military conflict or public policy. The argument is evocative and points to actual problems of the contemporary world, and perhaps this might be analysed in terms of humanitarian government. It is certainly true that political scientists have demonstrated that states have increasingly delegated their governmental responsibility to ensure the welfare of their population to civil society actors, especially following the Reagan and Thatcher eras (cf. Lipsky & Smith 1993). However, to my mind these processes should not be analysed *exclusively* as a redistribution of governing power - though it is that too - but also as the inclusion of the governed in politics by affording them the capacity to make specific claims on the way government should be conducted.

Moreover, the presence of the governed in politics has had an interesting effect. It has made ethical action and affect politically legitimate once again. I say 'once again', because, as the political philosopher Joan Tronto has demonstrated, the boundaries between ethics and politics were not always what they are today. She has analysed a series of *moral boundaries* that were developed in the 18th century that were specifically related to a spatial problem, that of *distance*. As technologies of communication and mobility changed, people began to imagine much more easily that their actions could have effects on distant others, with different and strange-seeming mores. What responsibilities do we have to these distant others? According to Tronto, the moral sentiments philosophy of the Scottish Enlightenment is of little use for such questions, insofar as they require all the members of the moral community to share the same *telos*, the same conception of the good life. *Moral sentiments* did make it possible to imagine a universal human subject and, thereby, to develop attention to distant suffering (Chakrabarty 2009, ch. 5). However, in a spatially reconfigured world, where living has been made problematic, where there is no shared *telos*, this is not sufficient to the foundation of an ethics. The Kantian moral position has incredible power in such a situation. Based on universal reason, accessible to all, it examines moral questions from afar, detached, distant, without emotion, to decree universal principles that do not depend on local particularities. That is, Kantian ethics deals with the problems of otherness and distance by

imperiously declaring them irrelevant. A second consideration ensues from this new problem of distance: how does politics relate to ethics? We have here a moral community understood to englobe all of humanity, with some members living according to bizarre mores in far off climes, but in which universal reason declares Otherness irrelevant. When a political community shares a *telos*, politics and ethics interlock and overlap, with one of the essential functions of politics being is to ensure the community's *moral education*. With no shared *telos*, no shared conception of the *good life*, then any politics that seeks to educate the members of the political community ethically will appear partial and local. This *moral education* had made it possible to resolve political conflicts, by making sure members of the political community shared moral affect. Without such a shared *telos* or common *moral sentiments*, a new tool is necessary for the management of political discord: objective interests as discernible through universal reason. But this does not mean that *moral sentiments* disappear. According to Tronto, they are confined to the private sphere, to the affairs of women, condemned to the particular, the local. They lose their public and political import.

The Kantian "moral point of view" based on distant reasoning through abstract principles, the distinction between politics and ethics, the distinction between private moral sentiments and public political interest and moral reasoning, are what Tronto calls *moral boundaries* - the title of her book - and she claims that they continue to characterize such influential moral-political theories as Rawlsian justice. For Rawls, politics and ethics remain hermetic to one another, but right principles can be worked out from behind the *veil of ignorance* where particularities disappear. These right principles of justice can then inspire good political institutions. So, *first* moral principles, and *then* political institutions. This is opposed to Machiavellian politics, where maintaining a position of power comes first, and moral issues can be mobilized strategically, when useful. This can be contrasted to the humanitarian position, where the elaboration of a territory where an ethics of solicitude becomes possible is equally as important as establishing good relations with sovereign actors. Humanitarian space entails the simultaneous pursuit of ethics and politics. Neither ethics nor politics can be said to come first. *Territory without government* enacts humanitarians organizations that must simultaneously, and in equal doses, maintain the political project of calling to account governing bodies, while negotiating a place for themselves in an institutional ecology, while also ensuring that their presence does not feed into an economy of suffering, which would counter their claim to work according to an ethics of solicitude.

To conclude, we hold that the critique of humanitarian reason, in terms of the *moral sentiments* it has smuggled into politics, carries with it the normative claim that moral affect should remain in the private sphere. This is how we understand the position that humanitarianism "keeps

you busy", where "what is really important" can only be identified through the abstract reasoning of a theory of justice based on "the moral point of view". Humanitarians, by contrast, hold that *presence*, and the *attention* it affords to the abuses of government, are relevant in public politics. We claim, with humanitarians, that a position based on *presence*, *concern*, and *attention*, is not too local, not too particular. This does not entail that a theory of justice is unnecessary, only that it is insufficient to a discussion of moral experiences with political relevance.

In this chapter, we have examined the relationship humanitarian politics maintains with governmentality - "outside looking in", as it were - and shown how the enactment of humanitarian space as *territory without government* effectively displaces the boundary between ethics and politics, to make it possible to demonstrate concern for local particularities from a distance, through mobility and presence.

We now turn to a topic that, until now, has only been an underlying theme: the otherness of MSF's humanitarian aid. Indeed, it is tempting to take the field of humanitarianism, that borderscape, that ambiguous liminal zone, as an "other place". It is to this problem that we now turn.

Chapitre deux
Explo/action. L'infrastructure épistémique du terrain humanitaire

Dans le chapitre 2, nous nous demandons si le fait que l'espace et le politique humanitaires soient non-gouvernementales voudrait dire que le terrain de l'action humanitaire est un « espace autre », une *hétérotopie* foucaldienne. En effet, les humanitaires occupent une position bien particulière, en dehors du gouvernement, en même temps qu'ils modifient des pratiques de gouvernements. Cela pourrait donner l'impression que terrain de l'aide humanitaire est mis en ordre d'une façon si spécifique qu'il devrait être opposé au *reste* de l'espace social. Ceci est d'autant plus évocateur comme proposition que l'expérience d'« aller sur le terrain » a souvent été décrite, aussi bien par des humanitaires que par des anthropologues et sociologues, en tant que voyage héroïque dans l'altérité. Opposé à un chez soi, au bureau, au siège, et au laboratoire, le *terrain* ne peut être qu'un « espace autre ». Et pourtant, nous allons montrer que nous ne pouvons réduire cette altérité à l'opposition à un ordre uniforme et singulier qui engloberait ce *reste* de l'espace humanitaire. Nous devons plutôt soutenir un intérêt pour les modes multiples de mise en ordre et les pratiques de l'espace qui participent à la fabrique du terrain de l'aide humanitaire, tout en restant attentif à la place du bénéficiaire dans ce lieu. Pour faire cette démonstration, nous décrivons les pratiques de production de savoir qui accompagnent l'ouverture des interventions humanitaires. Les praticiens de MSF appellent ces pratiques *explo/action*. Nos descriptions se basent sur l'observation ethnographique de la collecte de données sur le projet de MSF à Paris, ainsi que sur des entretiens avec des épidémiologistes et des travailleurs de terrain, l'analyse textuel des guides méthodologique pour l'épidémiologie de terrain édités par MSF, et sur l'analyse des débats internes à MSF sur les seuils de l'urgence pour des taux de mortalité. Nous proposons en plus une histoire du rôle de MSF dans le développement et l'usage des méthodes de l'épidémiologie de terrain pour informer des projets humanitaires à partir d'une analyse de la littérature épidémiologique. Ces matériaux nous permettent de questionner l'altérité du *terrain* en regardant les tensions et les ambiguïtés qui accompagnent les pratiques de production de savoir et provision de soins qui doivent cependant se tenir ensemble dans les relations qui s'établissent entre les travailleurs de terrain et les bénéficiaires. Nous procéderons en deux temps.

1. Tact et tactiques sur le terrain : le face-à-face avec le bénéficiaire. Dans une première sous-partie, le terrain est décrit en tant que lieu de con-tact avec les bénéficiaires, un lieu où MSF tente des « coups » sous le regard des « autres », des bénéficiaires. Les praticiens de MSF cherchent à se positionner tactiquement afin de gérer les demandes complémentaires et conflictuelles de l'explo et de l'action. Nous discuterons de trois pratiques de positionnement : *aller vers*, *switch*, et *couverture*. Dans la deuxième sous-partie, nous examinons le terrain en tant que lieu de con-tact face-à-face entre les humanitaires et les bénéficiaires en tant qu'il est médié par un questionnaire. S'inspirant du travail de Vinciane Despret pour développer notre conception du *tact*, nous regardons comment un espace

est aménagé où les bénéficiaires peuvent exprimer leurs besoins dans une relation de confiance et se sentir reconnus tant ils reconnaissent chez les humanitaires un besoin d'aider. Nous dirons que ce travail de préparation d'un espace *pour* les bénéficiaires est précisément ce qui les rend *vulnérables.*

2. Mettre le terrain en ordre : pratiques de place et infrastructure épistémique. Dans cette deuxième partie, nous confrontons plus directement la conception du terrain en tant qu'« espace autre ». Cela nécessite que l'on retravaille la conception foucaldienne du *lieu* que l'on trouve dans son article sur l'hétérotopie avec les *modes de mise en ordre* (modes of ordering) d'Annemarie Mol. Dans la première sous-partie, nous examinerons les pratiques de place associées à l'explo/action qui transforment le terrain en bureau et le rendent connaissable comme si on l'étudiait dans un laboratoire. Nous montrerons comment le bureau et le laboratoire – les « autres » du terrain – participent à configurer le terrain. Le bureau rend possible la cartographie du terrain et la visualisation du contexte ; faire du terrain un laboratoire consistent à le quadriller, le circonscrire, le soumettre à un échantillonnage en grappe, et le confiner dans la période de rappel des enquêtes de mortalité rétrospectives. Ce sont là les modes de mise en ordre du terrain. Dans la deuxième sous-partie, nous ferons l'histoire du rôle de MSF dans le développement de la discipline scientifique de l'épidémiologie de terrain, pour montrer comment ils ont progressivement érigé un dispositif qui permettait non seulement d'intervenir dans des situations d'urgence, mais aussi de transformer les « urgences » en objet d'intervention en les rendant observable et connaissable. Regardant, enfin, des controverses actuelles à l'intérieur de MSF sur les seuils d'urgences pour les Taux de Mortalité Brut, nous verrons comment cette infrastructure épistémique globale participe à créer une réserve d'événements humanitaire : les *urgences*.

Pour revenir à la question qui guide ce chapitre, nous conclurons que ces pratiques de place, cette infrastructure épistémique, constituent des *modes de mise en ordre*, qui nous permettent de détourner l'aporie de *soit* un espace de gouvernementalité *soit* un espace autre que le concept d'hétérotopie sert à résoudre. Alors que nous avons renforcé la frontière entre gouvernemental et non-gouvernemental dans le Chapitre 1, pour montrer que MSF se situe du côté de la non-gouvernementalité, nous suggérons dans ce chapitre que la gouvernementalité n'est qu'un ordre parmi tant d'autres sur lequel nous pouvons baser des comparaisons et des contrastes. Et l'avantage du concept des *modes de mise en ordre* d'Annemarie Mol, à l'opposé de l'opposition *ordre/autre* de Foucault, et qu'il soutient la possibilité de la *co-incidence*, c'est-à-dire la possibilité que plusieurs ordres puissent occuper un même lieu. Cela ne signifie pas pourtant qu'il y a une cohabitation tranquille : entre tact et tactiques, questions et l'inscription des réponses sur des questionnaires, pratiques de *care* et production d'un savoir rendu possible par une infrastructure épistémique, le terrain est fait d'ordres multiples en tension et en flux, soutenant des objectifs et des valeurs en contradiction. C'est bien cela l'altérité du terrain.

Chapter Two

Explo/action. The Epistemic Infrastructure of the Humanitarian Field

Let us begin by looking at a blog post written by an MSF nurse working in the Democratic Republic of Congo.[1]

> *"Starting from Scratch: An Emergency Response in the Democratic Republic of Congo[2]"*
>
> ***10 Jan 2018 - Vera Schmitz, Nurse, German, Democratic Republic of the Congo***
>
> *Since May 2017, about 80,000 refugees from the Central African Republic have fled across the River Oubangui to the Democratic Republic of the Congo, according to MSF data. The conflict in their home country, which is an often forgotten crisis, does not rest. Violence between rebel groups, who also deliberately target civilians, characterises the region. […] The 80,000 refugees comprise about 80 per cent of the people who had been living in the region on the Central African side of the border, north of the districts of Gbadolite and Mobayi-Mbongo in DRC. Further east though, there are still*

[1] MSF "Field Blogs" can be visited here: https://blogs.msf.org

[2] https://blogs.msf.org/bloggers/vera/starting-scratch-emergency-response-democratic-republic-congo (Last visited 25 April 2019)

many more. There are in total 167,000 refugees from the Central African Republic in the north of DRC, according to OCHA.

I arrived in Gbadolite in August, as part of MSF's emergency unit. We found many people were living in makeshift camps, while others had found refuge with friends and relatives in host families.

Access to healthcare, safe drinking water and sanitation was difficult or absent, malnutrition was widespread in children under the age of five, and malaria was the number one cause of disease. ***That basic information had prompted MSF to send in our team.***

Support for the refugees (and the local population) barely exists, though the need is immense and obvious. ***But before we began any healthcare activities, we collected information to evaluate the situation****, to ensure that any intervention would kick off in the right place and with the right measures.*

Need to know…

Once on site, ***we recorded the situation as quickly and efficiently as possible****. We asked…*

How is people's health? How many people died last month? And how many of those were children under five? Children under five are one of the most vulnerable groups, and are usually the first to show signs of the effects of precarious living conditions.

What are the causes of illness and death? Is there a high number of cases of diarrhoea – a possible indication of precarious hygiene conditions such as lack of access to clean drinking water or latrines?

What are people eating and are there cases of (severe) malnutrition?

And finally, what are the possibilities for access to health care? The strategic and geographic distribution of health centres in the Gbadolite region is generally not bad, but drugs and consultations need to be paid for by the patient, and so are mostly unaffordable for the refugees.

We also collected information on people's access to safe drinking water and latrines. Many residents source their drinking water from the large Oubangui River, where dead bodies are sometimes found floating, victims of the ongoing conflict in the Central African Republic.

Latrines, on the other hand, are almost non-existent.

For shelter, most people have constructed simple huts in which several families often live at the same time – but whether these huts can withstand the region's heavy rains is in doubt.

Huge needs, huge plans

Information gathered, let's go?! Unfortunately, in reality it's not that easy. Here in Gbadolite, ***our assessments showed that the needs of the refugees were huge****. Which meant we needed to plan accordingly.* ***The goal? Basically, to ensure access to primary and secondary health care****, as well as various preventive measures to minimise health risks.*

It is not a small plan – but it is not impossible.

Specifically*, we decided to provide: support for two strategic hospitals in the region, especially for children, pregnant women and emergency cases; access to free primary healthcare in 13 peripheral health centres; support for four mobile clinics in places without other access to healthcare. All this with* ***a special focus on severely malnourished children****. […]*

In the first chapter, we discussed the *cycle of mobility* in which the mobile clinic evolved. We saw how the processes of territorialisation constituted a mobile humanitarian space without government and affected the way patients flowed through the clinic. The rhythms of deterritorialisation also gave the refusal of care a specific form: when the clinic closed, it was time to turn patients away. The mobility of the clinic also afforded a series of political tactics of presence that displaced the border between ethics and politics.

This chapter is about another one of the steps in this cycle of mobility - *exploration* - and the kind of place that exploration enacts - *the field*. To talk about exploration, we will take one of many terms used inside MSF to designate those inquiries that accompany and inform the start of new activities: *explo/action*. Other terms include assessment, evaluation, and exploration (or "eval" and "explo"). We prefer "explo/action" to those other terms because it indicates a series of tensions and ambiguities constitutive of the field of humanitarian aid. It is through explo/action that humanitarians *find-make* the place where humanitarian action is accomplished – *the field* - and *know-care for* the people who receive humanitarian aid - *beneficiaries*.

Question: What Is So "Other" About the Humanitarian Field?

There are other ways of problematizing "the field" than in terms of explo/action. The social theorist Monika Krause has developed a "field-theoretical approach" to humanitarian organizations, building on both the field of Pierre Bourdieu and of neo-institutionalism (DiMaggio & Powell, 1983) to describe the isomorphic effects of the "project" as a form of collective action, while remaining attentive to the work of distinction and claims to humanitarian "purity" during fundraising in the public sphere (Krause, 2014).[1] Johanna Siméant has also written extensively on "the field" of humanitarian aid, but in the terms of a methodological discussion as the destination of international social scientists (2012). These "fields" of humanitarianism – a Bourdieusian/neo-institutional *champ*, or the *terrain* of social scientists working on humanitarian action – are not the object of the present chapter. Our interest is in the field as the place where humanitarians go and where humanitarian assistance gets done.

[1] Krause develops this approach further in her work on "fielding transnationalism", with Julian Go (2016). Their project is to develop a theoretically systematic approach for dealing with phenomena that escape the scope of "methodological nationalism" through a spatial extension of Bourdieu's field analysis (Bourdieu & Wacquant 1992). This is meant to allow for analysis at multiple scales, while imagining globalized spaces that are not constructed according to a logic of diffusion while remaining attentive to both objective configurations of "players" and of subjective attribution of symbolic meaning.

We learn from the literature that the field of humanitarian aid sits in contrast to other places, maintaining distinctive relations to **headquarters, the office,** and **home**.

Political scientists Johanna Siméant and Pascal Dauvin, (2002) have discussed the status of the field of humanitarianism in an analysis of the division of decisional labour between fieldworkers and the **headquarter** employees. They hold that a logic of incrementalism - there is always something more to do - and the physical distance between the field and headquarters, mean that the field tends towards autonomy from HQ (2002, pp. 225-227). However, in their discussion of "the field/headquarters dialectic", this autonomy is said to be relative. They go so far as to say that there is a "strong trend", in the history of humanitarian organizing, towards "increasing the centralization of power in headquarters, and decreasing field autonomy" (2002, p. 356, my translation). This management of the field from headquarters cannot be taken for granted, however, because there are tensions inside organizations concerning the "ideal" form NGOs should take. In concrete terms, this has to do with the increasingly complicated "bureaucratic complex" of humanitarian NGOs, which contrasts with humanitarians' dedication to fieldwork. *The field* is the site where aid is provided; headquarters is the site of vain intellectualism and bureaucratic waste, disconnected from the evolving context of activities. The point made is that there is a "dialectic" between the field and headquarters that plays on autonomy and control, bureaucratic legitimacy and the intimate knowledge of the travails of humanitarian aid in the field.[1]

Anthropologist Erica Bornstein - who evokes "the field" in the methods section of her monograph of World Vision, a large, Protestant NGO – claims that "the field" is a peculiar place, with special moral status. This stems, she argues, from its distinction to **the office**.

> *"Similar to the moralizing and naturalizing distinctions between "the country" and "the city" (Williams 1973) or between modern Europe and the lost paradise of Africa for nineteenth-century missionaries (Comaroff and Comaroff 1991), employees of World Vision constructed the object of their aid, "the field", as a sacred place. […] Why would I want to speak with people in administrative offices? "They're not interesting, they're just accountants," he said. The conceptual interstices between the "office" and the "field" was vast. Each of the employees I spoke with in the California office who had worked in the field desired to return. The field was described to me as a truer place, closer to the poor and the needy. Those who had not been to the field dreamed of going, and those who had made trips to visit projects or children they had sponsored spoke fondly of the pilgrimage" (Bornstein, 2005, p. 39).*

[1] This suggestion is similar to the one made by Elsa Rambaud's PhD dissertation on MSF (2015), in which she reads MSF's history as a dialectical becoming, where moments of internal crisis lead to the NGO to oscillate between "emergency missions in conflict situations" and "long-term, development-style projects".

Bornstein's methodological comments on the distinction between "the office" and "the field" stop here. We would highlight the distinction made between the mundane work of "accountants" in the office, and the sacred work of aid to the needy understood to occur in the field.

Renée Fox's sociological analysis confirms that in MSF, too, the field of humanitarianism is seen as a "truer place", closer to "real needs". Through analysis of MSF field blogs – like the one quoted at length at the start of this chapter – Fox describes what it means for MSF personnel to leave **home** and "go into the field". It is a transformative experience. This means that humanitarians learn new skills, in domains of medicine rarely practised in their home countries. They also learn about the limits of care, about how their best efforts can, and do, fall short. Some bloggers mention a new-found patience in an unjust world; others talk of a recently developed "intolerance for bullshit". The field pushes aid workers to "take stock of their lives" when aid workers come "home" – that other place, after "headquarters" and "the office", from which "the field" must be distinguished – and they have trouble reintegrating. "How do you explain life in another universe?", one blogger asks. Another describes the feeling of working in a "developed world" hospital again:

> *"I have worked five shifts now in a "developed world" hospital that never runs out of gloves or clean needles or medicine and there is always a doctor when you need one. There is running water and electricity. Nobody has cholera or measles. It feels very strange. In all honesty I am not really sure what to do with myself" (quoted in Fox, 2014, p. 37).*

"The field", then, appears as an alternate moral universe. It transforms the humanitarian subject, broadens their horizons, but also jeopardizes the relations they maintain with "home". It can trigger or strengthen an attention to distant suffering, while destabilizing subjectivities.

Yet, there were other bloggers that explicitly criticized the idea that "the field" could be an alternate moral universe. Fox quotes at length one blog post that identifies the "common assumption" at the core of such feelings: "that there is a categorical difference between the life I lead "here," and the one I experience in the field" (quoted by Fox, 2014, p. 39). While this may seem like an "innocent" way of representing the "threshold" that is crossed by humanitarians when they "go into the field," the blogger holds that these "metaphors" harbour "deep-rooted prejudices" (blog quoted in Fox 2014, p. 39). The blogger continues:

> *"If we allow ourselves to see our humanitarian experience as occurring **between "two worlds,"** [...] we fall prey to the romanticization characteristic of colonialism… [...] The fantasy of MSF field experience as a "rite of passage" onto some higher plane of human understanding is replete with narcissism – even more repulsive because this so-called initiation is parasitic on the "host" of the suffering we seek to eradicate… **In short, there is absolutely nothing "otherworldly" about humanitarian experience in the field: to assume so is to posit an artificial difference in kind between "us" and "them"**" (quoted by Fox, 2014, p. 39-40, emphasis added).*

Some of these remarks are similar to arguments made by James Ferguson and Akhil Gupta on fieldwork in anthropology (1997). Fieldwork has played a critical role in defining anthropology as a discipline, and going into the field has been a basic, constitutive experience in what it means to become an anthropologist. This is the case for the field of humanitarianism. Gupta and Ferguson also develop an analysis of the spatialization of difference associated with the concept of "the field" in anthropology. The concept of "the field" is based on an idea of the world being divided up into "field sites", delimited locations in which "Otherness" inheres. This makes anthropology a "regional science", and fieldwork becomes part of a heroized journey into Otherness. This is what is criticized in the above blog post.

The problem with a facile rejection of those who imagine the field of humanitarian aid as an "other place" is that the sense of leaving "home" and venturing into an alternate moral universe is shared by many humanitarians. They experience the tense relationship to headquarters, between autonomy and increasing centralization, and they sense that activities in the field are more legitimately humanitarian than those that are accomplished in "offices". One critical trait of our approach is to extend great consideration to the perceptions and analysis of the people most concerned by the problematics posed in the field of humanitarian aid, and not least of all because the overarching goal is to describe the ways space and attention interfere with one another in the ethical ambiguities of care. In addition, we see in the above literature on the humanitarian field that it is described in terms of what it is not: not headquarters, not the office, not home. Social scientists' experience in the field is also "otherworldly". Taking "other place" both in the sense of a site of contrast to a series of locations from which perception is organized - the office, headquarters, home - and in the sense of an alternate moral universe, we ask: *what is it about the field of humanitarian aid that makes it possible to perceive it as an "other place"?*

An additional consideration organizes this chapter. *Beneficiaries* are a central character in tales of humanitarian aid, and their presence clearly distinguishes the field from the office, headquarters, and home. Though hinted at in the above discussions, beneficiaries are mostly taken for granted. Moreover, the reader will recall that a major analytical objective of the thesis is to describe and qualify this personage. Given their presence in the field, a *hypothesis* guides this chapter: *accounting for the ways the "beneficiary" features in explo/action practices can tell us a great deal about "the field" as a space, and, inversely, looking at how the field is ordered can tell us a great deal about humanitarian beneficiaries.*[1] In sum, an ensemble of three terms organize

[1] I will not be using scare quotes around the term *beneficiary.* My goal is to describe and qualify the *beneficiary,* as they are scripted for in humanitarian instruments. I have no interest in the "beneficiary". This is because, in my

this chapter: explo/action as field inquiry, the field an "other place", and beneficiaries as scripted for in the field.

In addition, these considerations will help us move forward with the thesis we defend in this dissertation. We held in Chapter 1 that humanitarian space is a kind of territory without government, and as a nongovernmental politics, it can be described both as the politics of the governed, and as displacement of the boundaries between ethics and politics. In this chapter, we wonder if the fact that humanitarian space is not governmental space, means that it is a Foucauldian "other place", a *heterotopia*.

To begin, we will first look at "the field" as it features in practices of knowledge production other than "explo/action". In discussion with work in the sociology and anthropology of science that provides incisive spatial analysis of diverse field sciences, I will hold that a discerning response to our research questions is afforded if we take the field as a threshold, a site of encounter and face-to-face contact.

Explo/action: The Field as a site of Contact

In this section, I will open a discussion with a number of social scientists whose work on the field sciences is useful in our search for conceptual tools supporting analysis of explo/action, that is, the inquiry that opens the field of humanitarian aid. Let us start with the geographer and historian David Livingston's "geography of scientific knowledge" (2010), to understand the difference between "lab" and "field" for 19th-century naturalists. We learn, first, that there are markedly different "cognitive styles" (2010, p. 41) for open-space and closed-space naturalists. For naturalists who sit at a bench in a lab, knowledge comes from the steady and immobile gaze, at a *distance*, from a place where they reside. For fieldworkers, knowledge is derived from passage over terrain, *closeness* with nature, in the field where they are visitors. The skill of the fieldworker lies in their ability to deal with the deeply *uncontrollable* character of the field, as it is *found*, and the wide variety of social types found there (hunters, poachers, campers, tourists, farmers…). Yet the field is a constructed place, if only because its boundaries must be established.

Historian and sociologist Robert E. Kohler (2002) goes further than Livingston in his description of what he calls the *practices of place* through which the field is ordered. Taking 20th-century field biology as his object, he shows that once the lab became the legitimate place of

rendering, the beneficiary is not a psycho-social type that might exist in the real world. It would be reductive to suggest that any real human can be described exclusively as a *beneficiary.* However, I am interested in the beneficiary as the place-role that is provided for, scripted for, made room for, in humanitarian operations.

biological science in the mid-19th century, tales from the field ceased highlighting the heroism of field workers and began recounting how the field was configured to produce knowledge under lab-like conditions. The point of Kohler's articles is that field biologists embrace place by turning it into an *active participant* in the production of knowledge. This entails, for example, finding "patches of simplified nature", with a limited number of species, or where a single variable changes between two sites because of local topography. Kohler concludes: "*By manipulating place, field biologists can measure exactly, perform quasi-experiments, and read the record of natural processes as if they were experiments, inferring their principles and causes*" (2002, pp. 204-205).

In other field sciences, the reference to the laboratory is managed in different ways. The sociologist Thomas F. Gieryn shows how the city of Chicago, as taken by the first Chicago School of sociology and urbanism as its empirical object and its "truth spot", was both "field" and "lab" (2006). It was *found* – taken as a "natural" site, affording the direct observation of unadulterated reality – and *made* – put into grids, objectified, quantified, using surveys and statistics, making control of the entities in presence possible. Chicago was also *here* – a singular site – and *anywhere* – representative of urban exodus and industrialization, made to speak for cities and societies in the throes of rapid urbanization. Finally, the mode of engagement in the city by the researcher was both *immersed* – the researcher was connected and committed to the city and its improvement through social work – and *detached* – they could take it as objectified, distant reality to be manipulated as an object.

Ann H. Kelly's work in medical anthropology on field entomologists engaged in medical research in East Africa shows that their field is a "semi-field", "*a boundary, a trading zone, a threshold*" (2012, p. S146). Kelly describes the "experimental hut" of entomologists conducting a malaria transmission vector study, showing how they are set up as both the natural setting for transmission – with local volunteers to sleep in the huts – and a place where entomologists can monitor the movement of mosquitos. The point is that experimental huts are "*a threshold, where insect and human behaviours meet and are transformed into elements of a malarial dynamic* (2012, p. S146)." This means that "*The experimental hut renders the malaria situation coextensive with the material processes of investigation – fostering practical-ontological co-ordination"* (2012, p. S157).

To summarize the take-away from this discussion with the literature, I will be describing the field as a site of encounter, a place where both sameness and difference are maintained between the field, on the one hand, and home, headquarters, the office, and the lab on the other. In terms of the contra-distinction to the lab, the field is found and made, a site of immersion and detachment, here and anywhere, with distance and presence in tension. The more general argument for the

chapter will be that these *practices of place*, this spatial ordering in reference to home, the office, and the lab, do not result in a stable field. Rather, the field is a site of encounter, of mediated contact: it is a place where humanitarian practitioners and potential beneficiaries come into face-to-face contact, and, together, constitute a mediated humanitarian dynamic. In this dynamic, knowledge production about beneficiaries (explo) and care for beneficiaries (action) are coextensive to each other. That is, they hang together in practices of humanitarian place. As we shall see, the conception of place that underlies this description of the field of humanitarians is quite different from that which describes the field as a mirror to "other places". I will argue that this conception is useful for getting at processes made invisible by the "other" approach.

The rest of the chapter will detail empirically what it means to say that the field is a threshold, a site of encounter. We will proceed with two sections.

1. Tactics and tact in the field: face-to-face with the beneficiary

In the **first section**, we will examine the field as the site of a mediated face-to-face contact between humanitarians and beneficiaries. In the **first subsection**, the field will be described as a place in which humanitarians make moves under the observation of their "others" - beneficiaries. That is, the field is a place where humanitarians tactically position themselves in order to deal with the competing and complementary demands of explo and action. Three practices of tactical positioning will be examined: *approach*, *switch*, and *cover*. In the **second subsection**, we will examine the field as a site of face-to-face contact between humanitarians and beneficiaries mediated through a *questionnaire*. Taking tact in a sense developed by Vinciane Despret, we will look at the ways *a place is made* for beneficiaries where they can *become vulnerable* - a recurrent descriptor for MSF beneficiaries - and express their needs in confidence.

2. Ordering the field: Practices of Place and Epistemic Infrastructure

In the **second section**, we will deal directly with the conception of the field as an "other place". This entails a reworking of Foucauldian conceptions of place developed in his article on heterotopia using Annemarie Mol's *modes of ordering.* In the **first subsection,** we will examine the practices of place associated with explo/action that turn the field into an office and make it knowable as if it were being studied in a lab. I demonstrate how the office and the lab - the field's "other places" - effectively participate in configuring the field. The office in the field makes it possible to map the field and to "visualize context"; turning the field into a lab meant it was circumscribed, put in a grid, subjected to cluster sampling, and confined in the recall period of retrospective mortality surveys. These are modes of ordering the field. In the **second subsection**, we follow the history of field epidemiology to show how MSF has effectively participated in erecting an apparatus by which "emergencies" are observed, described, known, and turned into

objects of intervention. Looking at current controversy inside MSF around the thresholds for emergency Crude Mortality Rates, we will also show how this global epistemic infrastructure participates in creating a *reserve of humanitarian events*: emergencies.

1. Tactics and Tact in the Field: Contact with the Beneficiary

The blog entry that opened this chapter is the start of our inquiry into exploring-enacting the field and finding-caring for the beneficiary. We learn, first, that assessments are about "starting from scratch", as the title of the blog post indicates; explo/action "opens" the humanitarian field. While the need in northern DRC was "immense and obvious", they did not know what these people required in any precise way. A group of Central Africans in the DRC had public existence, to which MSF had access via mass media, demographic surveys, and surveillance data. It was this public exposure that makes the Central Africans' vulnerability clear. From there, it was no leap of the imagination to suggest that they may require assistance. But of what kind? To figure it out, MSF went there.

That is, *exploring-enacting the field is an essential first step in finding-caring for the beneficiary*. Fieldwork begins with movement through space, a point on a map becoming a destination. There was doubt about what MSF was going to find, and to ensure that operations "kick off in the right place," MSF collected information. That is, explo opens the field by collecting data that allow humanitarians to understand what is going on. This understanding, meant to inform operations, is achieved by going to where these people are and by talking to them.[1] In other words, *finding-caring for the beneficiary is an essential part of exploring-enacting the field*. Explo/action dissipates doubt, "quickly and efficiently", by systematically asking questions in face-to-face encounters with potential beneficiaries, often mediated by a questionnaire. This encounter in the newly opened field allowed the formulation of a diagnostic in terms of needs. Attempts are made to identify specific groups that need additional attention: target populations. From the diagnostic of the situation that emerges, objectives and activities were defined: support two hospitals and 13 health centres, set up four mobile clinics, conduct a vaccination campaign.[2]

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[1] This is an important distinction to be made between my work and the work of Luc Boltanski on humanitarianism (1993). In his *La souffrance à distance,* he diagnoses a moral crisis associated with the spectacle of distant suffering through mass media, the politics of pity, mediated action through humanitarians, and attenuated confidence in NGOs. How ever interesting his analysis of public affect, he never seems to get to account for the possibility of acting at a distance in situations of crisis except through public discourse. Little room is made for humanitarian aid in the field.

[2] These decisions concern humanitarian activities in the location the exploration is conducted. Different processes are at work in the decision to open a field site or to close a project, and as Siméant and Dauvin have noted, "It would

The goal of this chapter is to describe and qualify this "pattern of inquiry", where humanitarian actors and beneficiaries are caught up in a collective dynamic of mutual recognition, knowledge production, and care as they open up the field through explo/action. In this section, I confront this task by examining how humanitarians come into face-to-face contact with beneficiaries. The **first analytical subsection** asks how humanitarians tactically position themselves in order to come face-to-face with beneficiaries in the field. We learn first that the tensions of finding/caring for beneficiaries mean that the ruse necessary to getting close to beneficiaries and turning their information into population-level data can only be justified by making sure the knowledge produced serves the beneficiaries. The **second analytical subsection** examines how a questionnaire mediates this face-to-face encounter. We learn that this point of mediated contact between humanitarians and beneficiaries - where the former asks the latter a series of personal questions and then write down their response - puts the constraints of data collection and care in tension that is resolved through *tactful inter-facing*: a place is made where beneficiaries can express needs and receive attention and care, a place where they can *become vulnerable*.

a. Tactical Positioning in the Field: Approach, Switch, and Cover

Approach, switch and cover, are terms used by members of MSF to talk about a series of ways of dealing with the tension between "exploration" and "action" as they arrive in the field and encounter beneficiaries. Each scripts for the beneficiary and figures the field in specific ways. **Approach** is a mode of ordering explo/action where the issue is with how to get close enough to the people potentially in need to provide them with care. Yet the provision of care means you must already know what their needs are, which means you have to have already asked them questions. However, if you want them to answer your questions, they must recognize you as someone who wants to help, which means already being able to provide them with care. For humanitarians, approach is both about recognizing the "people in need" who can become beneficiaries and being recognized as someone who "needs to help", that is, a humanitarian. **Switch** refers to that moment when humanitarians stop thinking about the people whom they meet face-to-face, and they start thinking about all the people whom they do not meet. This second constitutive movement in the field also traces a line between exploration and action, when humanitarian practitioners start thinking about the *population*. **Cover** refers to the use of aid, in the field, to dissimulate MSF's need to collect data. That is, during interaction with potential beneficiaries, where care is

be naive to believe that it is only according to exploratory mission [...] that the set-up of humanitarian missions is decided (2002, p. 209, my translation)." Those processes are the object of Chapter 4.

sometimes but not necessarily provided, care becomes a lure. The knowledge constituted in this way informs project set-up. It is an operational tool. This is one way explo and action hang together in tension.

i. Approach (*aller vers*): recognition through marauding

In the following recorded interview extract, I ask Clarisse, the activity supervisor for MSF's project in Paris – described in detail in the previous chapter – how the "data collection" was done while the project was opening. Activities in the field in Paris began in the last week of December 2016, and Clarisse started the following month.

> ***Clarisse****: So, when we started in the field, data collection also started really fast. When I arrived, it had already started. It started really quickly, it's the first thing we did, because we need to be operational in the field. And you can't work in the field without collecting data. And at the same time, you can't just do data collection, without exchanging with people, without offering them something. That doesn't work.*
>
> *So, it just takes time. It's complicated, really, what we call "approach" (aller vers). It's a way of working that isn't at all straightforward. So, we started "approaching" (aller vers) people. We figured out how to connect with people, with people in the street. And once it was launched, we were able to target the information we needed to collect data.*[1]

The difficulty Clarisse describes has to do with "being operational in the field", which you can't really do if you don't "collect data", but you can't "collect data" if you have nothing to offer in return. However, you do not know what people need, unless you have already spoken to them. Here we have the classic bootstrapping problem: you must know what is going on, where people are, what they need, before you can help. But you must be recognized as having a sincere desire to help, be recognized as a humanitarian, before people will trust you enough to tell you what they need.

Clarisse summarizes these difficulties under the heading *aller vers*. In French, this means "going towards", and has to do with the practice of going to those in need wherever they may be. It has become an important technique for social work in France, coming into existence in the 1980s, notably through the work of the *SAMU Social*, or "Social Ambulance". *Aller vers* entails taking care directly to people in need in the street. Interestingly, it was also with the *SAMU Social* that the noun *maraude* came to be used to mean the foot patrols that took social workers to the street. Before that, it was used by taxi drivers to talk about cruising, driving slowly through the streets and looking for clients. This is primary etymology that Xavier Emmanuelli - founder of SAMU Social Paris in 1993 and co-founder of MSF in 1971 - attributes to the word (Emmanuelli 2018). It also has a

[1] Translated from French.

meaning like the verb "to maraud" in English, that is, to steal or pilfer, especially from farms, by soldiers on campaign. We might then think of MSF staff marauding through Paris, looking for clients - but we will say "beneficiaries" - and pilfering any information they can get on their "needs" and their "situation".

In Clarisse's formulation, "*aller vers*" entails being able to help, establish trust, be known and recognized, connect, in order to be able to ask questions and fill out a questionnaire during *maraudes* and mobile clinics. We have here a tactical understanding of assistance, which I have translated into English with the term *approach*. This *practice of place* spatially orders the field through movement: it is someplace you go and where you encounter people you hope to assist. This is what Clarisse says:

> ***Clarisse:*** *So, at the very beginning, we need to understand* ***the situation of migrants sleeping in the street****. Understand the situation, that means, where they were coming from, how they got here, and what they wanted now that they were here. Yeah. And access, did they have access to the information they needed on the administrative side of things? Did they have access to healthcare? Did they have medical problems? And their current situation, meaning, access to food - fundamental needs - access to food and shelter. That's the start (*la base*). And this information, that we collected, and we collected a lot, really a lot. Well, when we started it was kind of complicated. People didn't know us. So, they had to trust us. Then we realized that, well, taking down information, that's fine, but put yourself in the shoes of these people. When you're disadvantaged (*démunis*), and someone approaches you, addresses you in your language - and that was a real advantage, having interpreters, that is what made it possible to make a connection. But when you finally have someone who can speak your language,* ***it isn't just about saying everything that is going wrong, but also about figuring out how you can cope with the situation (*se débrouiller*).***

Here is what MSF needed: they needed to know what the situation of migrants sleeping on the street in Paris was. They needed to know more about the people there, and they needed to know about their "fundamental needs". We are at the base of Maslow's triangle. If they want these migrants to tell them about their needs, they have to be recognized by them as someone who wants to help, nay, who *needs to help*. That is, if these migrants are in a tough spot and meet somebody who speaks their language, they might not be interested in talking indefinitely about their needs. MSF wants to know what the migrants' situation is, but the migrants have to know them and know that they can be trusted. So, the data collection tool becomes a tool for providing care.

In addition, inside MSF, it is clear that the questions asked have an effect on the expectations of those they wish to help. This is what Karla P., Director of the Field Epidemiology

department at Epicentre[1], tells me here, as she describes an assessment she did while she was in Indonesia in 2004, after the Boxing Day Tsunami.

> ***Karla**: There's a limit to what we can offer. It's true that I didn't ask, "do you need a school?" because I knew that's something we would never do. I can write down that there are thousands of people that want a school, but we won't build a school. You know? I think that we can ask questions about needs that we won't meet in the end. I think you do your eval, and in the end, you tell them, "I'm sorry, but we can do this but not this…". I think that is possible. But I mean there are things that are so far outside our field of activities, that I see no reason to ask the question. I don't know, maybe I'm wrong, but I usually try to be more practical.* ***Because every investigation creates expectations.*** *Even if you try to explain that you're just doing an evaluation, that it isn't an action plan. And you can't promise anything, if there'll be any follow up or not. You can't promise anything. But I mean, it's human to have expectations.* ***So, I won't ask questions about things that I know, at the outset, that I'm not going to be able to influence.*** *Like education, or very little, or, I don't know, getting people ballot sheets, or working out transportation to church, or rebuilding the church.*[2]

That is, the mode of *approaching* potential beneficiaries in the field can participate in reinforcing certain needs, even creating expectations. This does not mean that you only ask questions to which you can provide a direct response, but you must make it clear just what you are doing and why you are doing it. This is part of what the "field" of humanitarian action is about then. It is about finding a way to "approach" (aller vers) people in need. Well, MSF practitioners think they are in need, but they do not know what these needs might be. So, they have to ask questions, talk with them. They need to be able to have something to say to the migrants in Paris, to people who have lost their homes during a tsunami, that can help with their potential problems. The questionnaire shapes the responses of those they talk with – that is, it pushes for problems to be formulated in terms of "needs" – and the needs they hear about structure the tools for the provision of care.

Importantly, the needs that have been filled are both those of MSF and the needs that MSF figures as those of their "beneficiaries". MSF needed to understand the situation and needed to help; and those who responded to MSF's questions and accepted MSF's assistance filled this need. Data collection tools have become the instruments of care, care for both those to whom MSF hopes to provide assistance and care for MSF. This fits with what Liisa Malkki has called the "need to

[1] We will detail shortly just what Epicentre is. For now, the reader should know that Epicentre is an MSF associated epidemiological research centre. Their "field epidemiology" department conducts operationally relevant research for MSF.

[2] Translated from French.

help" in humanitarian action, focusing on how the so-called "beneficiaries" of humanitarian action fill the "need to help" of humanitarian practitioners and donors (2015).

ii. Switch: establishing priorities

We have just discussed the difficulties in getting *close* to beneficiaries; now we will discuss some of the ways *distance* is necessary to explo/action in the field. During an interview with Karla P., director of the Field Epidemiology Department at Epicentre, she details the move that takes the investigator, or clinician, away from that face-to-face interaction where care, recognition, and information are exchanged, and to a place from which it becomes possible to establish public health priorities. Though our interview is in French, she repeatedly uses an English word to talk about this move: *switch*. *Switch* refers to that moment when practitioners stop thinking about the person in front of them and start thinking about the population "as a whole", in order to define the priorities of intervention according to standardized indicators and thresholds.

During the interview, we talk about a training session Karla is responsible for organizing - *Populations en situation précaires* (PSP), or populations in precarious situations. The PSP is meant to provide trainees with "tools" for opening projects during emergencies with displaced populations, that is, conducting an initial assessment that will determine priorities for the intervention. Here, I ask when Karla first became familiar with these tools, and she tells me about her first mission with MSF, in 1994 in the Dagahaley camp for Somali refugees in northeast Kenya.

> ***Karla**: I was the only doctor in a camp with 40,000 people! And you feel really… well, it's complicated to know what to do, what your priorities are. What do you do? You can't just keep seeing patients, one after another. You have to think differently. […]*
>
> *And the [tools of epidemiology], they really help a lot. I mean, I'm making it sound like these tools were really complicated, but it's just **a switch** (*in English throughout the original*). I mean, it's stupid, you just count the number of cases, you look at whether they're going up or down, you look at the fatality for different diseases, you do an analysis of your patients and an analysis of what's going on in the population. Which group is at the most risk of catching the disease? Which group is at the most risk of dying? **And that gives you an idea of what your priorities are.***
>
> ***EF**: And this first experience with epidemiological tools, what kind of tools were they?*
>
> ***K:** No, but really, there's really nothing complicated about these tools. It's not big and impressive public health, it's not complicated epidemiology. It's really just looking at the number of cases, by age group, with spatial criteria, I mean, what neighbourhoods they live in, or their clan or ethnicity. […] And if you cross-reference all that data, you get an idea of who is most at risk of catching this or that disease, who is most at risk of dying. That gives you **an idea of where to start**. It's that simple. There's nothing magical about it (*c'est pas sorcier*), it's really just a switch you have to make in your head (*snaps fingers*), but a **switch** that is really enormous. [...] What matters, is that **switch between "one patient after another" to "it's the whole population that I'm looking at".** That's how you know where to intervene, what to do, what your priorities are. […] Yeah, you're not*

thinking just about the patient that is there, in front of you. You also think about ***the people that aren't coming to your hospital****. You think about the whole population.*

Instead of thinking exclusively about the "patient" in front of you, you also think about the "population". The tools that make this switch possible are simple things - proportions and rates - yet they shoulder the weight of an "enormous" cognitive, political, and ethical switch: from the clinical approach that looks at one patient after another, to the public health approach that looks at all "those people that don't come to your hospital". It is this switch that allows MSF teams to establish *priorities* and to know "where to start". In the terms of moral philosophy, it is the basis for an indigenous theory of justice. In terms of nongovernmental politics, it is what provides MSF with the sight that makes rational, probability-based health care intervention decisions possible.[1]

However, I would suggest that this switch does not *only* take place "in your head", like Karla says. Part of what makes this possible is the methods of field epidemiology, the PSP training session, and a booklet in MSF's guidelines series called *Rapid Health Assessment of Refugee or Displaced Population.* The third, and most recent edition, is from 2006. It is organized around the "focus" of the *Rapid Health Assessment*. This "focus" includes morbidity data, the presence of diseases with epidemic potential, nutritional status of the population, as well as a description of accessible health services. "Vital needs" must also be assessed: quantity and quality of food available, sources and accessibility of water, presence of facilities for excreta disposal, quality of shelter, availability of cooking utensils, blankets, as well as the exposure of the population to violence. We will come back shortly to these guidelines shortly.

Continuing with Karla, we discuss the questions she asked during a field assessment she led in Indonesia in 2004 after the Boxing Day Tsunami, and more generally, the kinds of questions she asks during rapid health assessments, the list of concerns is very similar to what we see in these guidelines:

> ***Karla****: I've often asked if people have blankets during investigations (*enquêtes*). Because often they don't, if displacement is recent. Shelter! I asked about shelter in Indonesia, if they have a roof over their heads to protect against rain. Yeah, I asked that, and I have asked that in other places too. Otherwise, it's about mortality, which we do often too, but that is a different kind of investigation. [...]*
>
> *Vaccination status is something I often ask about too. If people are vaccinated, that's something I nearly always ask with displaced populations. And I think I always will ask because I really want to know, if people are vaccinated for measles. Because measles epidemics are really awful. And I ask*

[1] This also maintains the problematic guiding the entire thesis: to look at how the instruments that participate in the definition of MSF's operational priorities, target populations, and health care offer, order the spaces of humanitarian action and the attention of staff, bringing about situations of choice replete with ethical ambiguities.

> *if they have access to clean water and if they have clean containers to keep the water. I mean, unless I see that everyone has running water, then I don't ask. But otherwise, I always ask that. I think I said everything else, shelter, vaccination status…*
>
> *After that, the rest is a question of context, of what people express as health needs, or needs around their health. And you might say that a petrol lamp has nothing to do with health, but for me it's important. Even for mental health.*

Some questions Karla asks are repeated in inquiry after inquiry - blankets, shelter, water, food, vaccination status, and mortality - while other questions are based on what people say during interviews - she gives the example of petrol lamps in an inquiry she led in Indonesia in 2004. From these questions, basic proportions are established, which tell the operational team if they should provide blankets and fuel, drill wells and dig latrines, do a vaccination campaign, or whether more resources are needed. That is, the number one "top priority" - the Initial Assessment - directs the teams towards the other "top priorities", as in indicated in a 2011 document edited by the Belgian branch of MSF, called *The Priorities.* After the Initial Assessment comes: 2. Measles Vaccination, 3. Water, Sanitation, Hygiene (WASH) 4. Food and nutrition, 5. Shelter, site planning, and non-food items (NFIs), 6. Health care in the emergency phase, 7. Control of communicable diseases and epidemics, 8. Public Health Surveillance, 9. Human resources and training, and 10. Coordination.

So, MSF gets close to their beneficiaries to ask them questions about their needs, demonstrates the need to help, and then makes a switch to think about the whole population. This switch puts MSF in the peculiar position where they aid they provide serves as *cover* for data collection.

iii. Cover: Taken in For Questioning

On February 13, 2017, I spoke for the first time with Christine, the Head of Mission for MSF in France. She had been involved in MSF's project in Paris for migrants since the summer of 2016. During our conversation, she related to me how they had initiated activity with *maraudes* during the month of December. On the 26th of the same month, they transitioned to a mobile clinic. We discussed the functioning of these mobile clinics extensively in chapter 1 and will not come back on them now. The mobile clinic and marauding serve the purpose of "explo/action", as Christine termed them. This is, according to the notes I took during our conversation, how she explained the purpose of the mobile clinic:

> *They quickly set up a mobile clinic in December and, "under the cover of" (*sous couvert de*) providing basic medical services, started collecting information with a questionnaire. The goal being to understand how reception services work in Paris, that is, if they actually work. They set up in front of La Chapelle's humanitarian centre, knowing that those not accepted inside had no access to medical consultations. They were hoping to gain access to those people.*

At Porte de la Chapelle, MSF is looking to gain access to certain people. More specifically, migrants who are not housed inside the centre and who cannot consult with the doctors there. These migrants are a source of information: they can tell MSF what the "situation" is. To collect that information, a questionnaire-based survey is conducted "*sous couvert de"* medical consultations.

I leave "*sous couvert*" in French – literally "under cover" – to insist on its meaning. The term implies the dissimulation of one's intentions in order to achieve a goal not publicly admissible. Medical consultations (action) are "cover" for data collection (exploration). This modality of relating "exploration" to "action" looks like the manipulation of beneficiaries. In Paris, they talk with migrants sleeping in the streets to analyse the working of the migrant reception apparatus in Paris. The provision of care is meant to "take in" patients. Here "taken in" does not mean being welcomed into a space where care is possible - as it did in Chapter 1 - but swindled and beguiled. Furthermore, it would mean that they are "taken in" the clinic so MSF staff can ply them with questions. Not for their own good, but so that MSF can understand how the system works. "Taken in", but "taken in for questioning", and not "taken in for care".

This is only part of the story, of course. Yes, the questionnaire can potentially turn a clinic into a space where one is "taken in for questioning", and it is important to remember that this is always a possibility. However, insisting too much on the "lure of care" misses the point; care really is provided at the mobile clinic. Furthermore, this turn of phrase – *sous couvert de* – was uttered in a meeting room in the NGO's Paris headquarters. The person who pronounced them was responding to the questions of a pesky sociologist who kept asking about how she worked. At the time of our conversation, Christine's work consisted (in part) in writing a project proposal. To write that proposal, she needed to know that the reception apparatus for unaccompanied minors is dysfunctional. She needed to know that there are youth who fall through the cracks, who don't get legal advice, who are without access to medical care. And she needed to know what their specific needs were. So, during our conversation when I asked her about writing a project proposal, she was most interested not in the direct provision of care, but in organizing future care. Christine needed to know what their needs were so she could set up a project intended to provide them with appropriate and adequate care.

Yet tactics of dissimulation, justified through some "greater good" of care, are sometimes brought into question by members of MSF. What follows is an excerpt from a "mise-à-plat" (pronounced and written "MAP"). MAPs are semi-annual meetings for review and planning of activities. They are held in headquarters. Present in the MAP we discuss here are the Head of Mission (HoM) – here, Christine – and a team working in an Operational Cell headed by Laurent

(RP – Responsable Programme). Sometimes there are members of the Medical Department, the Communications Department, and field epidemiologists from Epicentre.

> ***Mission France MAP, notes translated from French***
>
> *Next slide: "Mobile activities". Christine (HoM) proceeds with her presentation. Since January 2017, we have done 1,530 consultations and 288 referrals. The number of mobile clinics in Paris has been reduced. But we will continue and seek to do one or two a week.*
>
> ***Laurent (RP):*** *The mobile clinic is part of surveillance?*
>
> *It is. And we've been doing maraudes on foot too. We've counted (*recensé*) 9,000 migrants, and 1,505 questionnaires have been completed.*
>
> ***Laurent****: And should we really continue with the questionnaires? What's the use exactly? Is it for more than just making up numbers (*faire des chiffres*)? (…) We should ask if there is another way to follow the situation. We ask people lots of questions. We have seen the same problem in Uganda. Doing foot patrols is a good thing, but do we have to systematically ask people questions? How is it useful to us?*
>
> ***Christine:*** *Without the questionnaire, there would be no program.*
>
> ***Laurent****: I agree. And now that it's open, we must ask ourselves if it's necessary to keep going.*
>
> ***Another RP****: Does the questionnaire help us see the evolution of migrants' pathways?*
>
> ***Laurent:*** *That would be a good reason, yes!* ***But you always have to know why people are being questioned.***

Another day, another MAP, this time for the Uganda Mission. They again talk about a survey – the Journey Survey, completed at the Reception Centre for South Sudanese refugees arriving in northern Uganda. Once again, the ethics of surveys in the field is questioned. Else, the Assistant RP, says: "there's also the ethical question, of systematically asking people personal questions. We need a specific reason to do that." Laurent asks: "Why are we continuing with the survey? What is it for?" Else specifies his point: "Is there information you don't have, that you can get by adapting the survey? Use the survey as an operational tool, you know?".

Can MSF systematically ask people personal questions about their suffering? The answer is 'sometimes', but "*we always need to know why we're making people answer our questions*". Asking people questions must serve operations. In headquarters, the goal is not to resolve these tensions. Rather, the people present draw them out, devote themselves to their discussion, and remain vigilant about the effects questionnaires and surveys produce. Simply put, cover is an acceptable tactic only insofar as the answers to the questions asked cannot be otherwise answered, and as the survey can be construed as an "operational tool". They need to help MSF provide care, and headquarter staff make sure they do so through public discussion of their effects.

Let us conclude this section. Approach, switch, and cover are indigenous terms that I have taken to designate different ways of dealing with tensions between *explo* and *action* as humanitarians move through the field of humanitarian assistance. Each of these moves figures **the field** figures in different ways. Approach figures the field as a place you go to and range over, pilfering information. Switch figures the fields as the space of the population, of all those that do not come to your clinic. Cover figures the field as a place where care dissimulates data collection, a move that must be justified in terms of its utility to operations. **The beneficiary** figures in different ways in each: someone with whom recognition is exchanged, whose needs are to be met, and who meets needs; someone part of a larger population, whose needs may be different from the individual's; someone to be "taken in for questioning" under cover of care. Approach, switch, and cover are not *steps* of doing fieldwork, but indicate a series of *moves* that can be made to hold explo and action together, in tension. They indicate a series of ambiguities between *proximity* and *distance* that push humanitarians to find the appropriate mode of engaging with the field and with those who are present in the field, between immersion and care, and the distance of project planning.

These tensions are never resolved but remain present in the relations between humanitarians and beneficiaries during data collection. It is to these face-to-face relations that we now turn.

b. Tactful Inter-facing: the ethics of asking questions and writing down the response

Another line of anthropological research on "the field" in medical and public health field investigations in East Africa focuses on the key role played by locally recruited fieldworkers, and the specific problems they face as they engage with members of their own community. While the problematics developed by these authors are not directly applicable to our purposes, they do indicate a series of interesting questions. Specifically, in discussion with these authors, we can see some of the ways in which the tensions discussed in the previous section are managed as fieldworkers come into *contact* with beneficiaries, ask them questions and write down their answers on questionnaires. Let us take a moment to look at how these problems are discussed by anthropologists of medical fieldwork.

In the introduction to a special issue of *Developing World Bioethics* on fieldwork, the "field worker" in global health research is presented by the medical anthropologists Geissler *et al* as "those whose main role is face-to-face engagement with participants, who usually speak the participants' first language, who are from or live in the study areas, and whose work entails moving around the study areas or health facilities" (2013). According to the authors, many of the

challenges, and advantages, that field workers face comes from their position "in between" researchers and the community being studied. Employing members of the community means participating in the local economy and increasing responsiveness of the community. On the other hand, staff can exploit the trust of their peers to meet recruitment objectives, and there can also be privacy and confidentiality breaches because of everyday proximity. It is in part these complications that informed Geissler *et al's Ethical Case Studies from Africa* (2016). Meant for fieldworkers doing "global" medical research in Africa - that is, research that implies partnerships between institutions in the North and South - the goal is to reinforce ethical reflexivity and to support fieldworkers in developing their own positions on a variety of commonly-encountered ethical "dilemmas" in the field.

Global medical research is understood to pose particularly complex ethical conundrums because of the structural inequalities and violence that have historically linked the North and South, in colonial and post-colonial situations.[1] It is not always easy to talk about these inequalities, which is in part what is behind the "absent presence" of knowledge in research ethics - which Geissler has analysed elsewhere as "public secrets" (2013) and, with Robert Pool, as "rumours" (2006).[2] This is part of an emerging *anthropology of ignorance*, as is the title of an edited volume published by Kelly *et al* (2012). In their introduction, entitled "Making Ignorance an Ethnographic Object", these authors point to the ways that ignorance is not simply "the absence of knowledge", but also "a substantive historical phenomenon that in each particular case might incorporate certain knowledge, logics, ethics, emotions, and social relationships" (Kelly *et al*, 2012, p. 3). Geissler's work on "public secrets" (2013) echoes this point. Building on an ethnography of a team of public health fieldworkers in an East African country, he explores how the "known unknowns" of the material inequalities between Western and African colleagues are kept silent to maintain good professional relations; how the difficult living conditions, the hunger of respondents is intentionally kept out of reports and articles as irrelevant.

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[1] The goal of the workbook is to initiate processes of collective reflection and to begin accepting the moral discomfort that goes with situations of inequality. This is meant to move beyond ethical nihilism, minimalist regulatory ethics, simplistic activism, while helping those involved work out an ethical vocabulary, through what the authors call "deliberation". This is the process by which concerned persons meet, talk, and listen. Deliberation does not provide simple solutions, but it does enrich the ethical reflexivity of those involved.

[2] Here, Geissler and Pool analyse rumours about blood-stealing, birth control, and deliberate spreading of disease across sub-Saharan Africa in relation to medical research. According to these authors, the most common way of understanding these public concerns is to oppose them to *truth*: of course, medical researchers do not steal blood or deliberately spread disease. However, those that spread rumours are sceptical about their truth, even mocking those that believe them. This means that analysis in terms of their truth or falseness is beside the point. The authors' goal is different: to "appreciate [rumors] as modern commentaries on social relations that involve, and extend far beyond, scientific medical research." 975

This ethnographic approach to the *production of ignorance* about such inequalities makes for an interesting source of discussion with MSF's *production of knowledge* on difficult living conditions, hunger, high mortality rates, and absence of legal support. The point here is to start from the consistency of the ignorance produced – Geissler mentions that structural inequality is left unaddressed in global health research because unpleasant facts are easier to ignore in the relational labour – to work out the kinds of relational labour necessary to producing knowledge about vulnerability. Indeed, as we shall see, the strain of acknowledging and expressing vulnerability weighs even on those inquiries whose explicit goal is to document needs in order to address them (claiming at the same time that ignorance is one cause of bad care). Given that it is the expression of vulnerability is often difficult, it is of political and ethical import to pay attention to how fieldworkers engage with respondents in such a way as to make them feel comfortable expressing their needs, and the work done to get these needs documented so they can become social knowledge. How is that humanitarian fieldworkers manage to get their respondents to accept, and perhaps even feel comfortable in, the position of a vulnerable being, a beneficiary? *How do fieldworkers manage to make a space where respondents can become vulnerable?*

As we shall see, much of the strain imposed on the work of making a place for vulnerability comes from the fact that humanitarian fieldworkers not only ask personal questions, but also that they write down the answers. This work of inter-facing with respondents, of making a place for them, of eliciting responses to difficult personal questions, and finding a way to write down the answers, is what I refer to as *tact*.[1] *Tact* here refers to the capacity of fieldworkers to address their respondents with the skilful reflexivity necessary to allow them to express their needs, *to become vulnerable*, so that MSF can meet its own *need to help* (Malkki 2015).

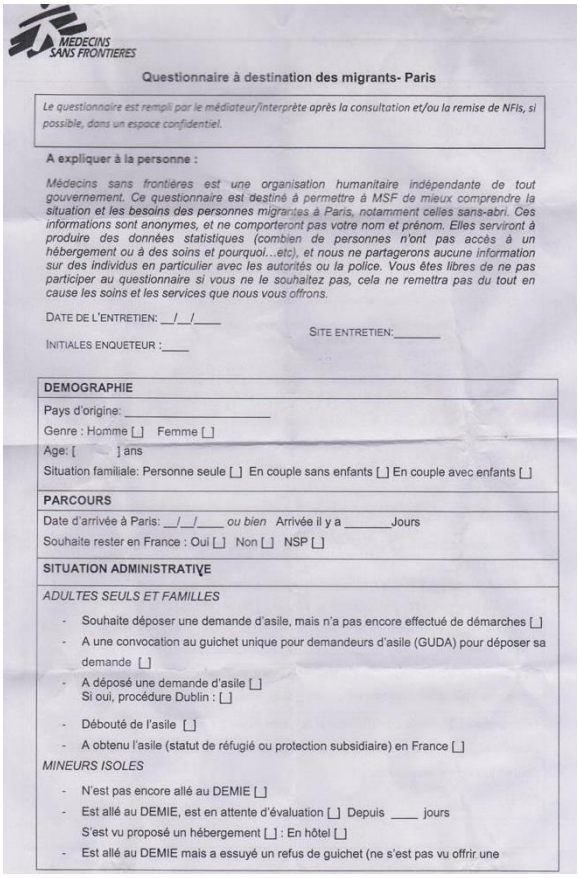
i. Inter-facing: Fieldworkers, Questionnaires, Respondents

Contrary to some epidemiological surveys, questionnaire usage in Paris has not been standardized. That is, fieldworkers have received no training meant to make questionnaire completion uniform. Of course, the idea that questions are actually asked the same way between

[1] I take inspiration from the work of Vinciane Despret, especially her comments on "ontological tact" in *Au bonheur des morts* (2017: 32-34). In her inquiry into the modes of existence of the dead, ontological tact is a methodological stance that consists in leaving "deliberately open all possible hypotheses concerning the ways one can harmonize with the intentions of the deceased" (p. 34, my translation). This echoes with the overall approach of *What Would Animals Say if We Asked the Right Questions?* (2016), that is, the capacities we attribute to animals depend in part on the kinds of tests we make them undergo. More specifically, I would refer to the discussion in the section "C for Corporeal", where Despret comments on the primatologist Shirley Strum's hesitation to urinate in front of baboons, and the biologist Farley Mowat's practice of "marking his territory" when studying wolves, in order to initiate an interaction. In Despret's understanding, it is in this moment of a tact that the baboons and wolves under study discovered a shared corporeality with their humans (2016, p. 15-20).

respondents, or that the progression of the interaction is always linear, has been brought into question (Biruk, 2012: 356-357). Even so, the questionnaire does constrain the interaction, and it is meant to do so, through instructions that figure at the top of the page, and the fact that it indicates a series of data points, or questions, to which answers must be gained. Let us look more closely at the discursive constraints posed by the questionnaire, and three styles of composing with them.

First, as is visible in Figure 18, there is a sentence at the top of the questionnaire, which addresses the person who is to be asking the questions, which states: "The questionnaire is to be filled out by the mediator/translator after the medical consultation and the distribution of [non-food items], if possible, in a confidential space". That is, it states who should fill out the questionnaire - a "mediator/translator", someone who speaks the language of the respondent. It stipulates the exact moment when the questionnaire is meant to be filled out - after the consultation - to avoid making the questionnaire a condition for access to care. This rule is not respected, because they would get a great deal less respondents. It is already difficult to get patients to stay after their consultations to provide them guidance; it would be next to impossible to get them to stay for questions. More interesting is that this sentence, written by MSF mid-level managers, copying from model questionnaires in the guidelines for *Rapid Health Assessments*, figures the moment and the place the mediator/translator fills out the questionnaire as key components of the ethics of questionnaire usage. In addition, it scripts for a translator/mediator that is responsible for the way the questionnaire is filled out, while giving explicit rules to be followed. If the translators do not wait until after the medical consultation to fill out the questionnaire, they do (generally, there are exceptions as we shall see) make it clear that they do not have to fill out the questionnaire. Translators also attempt to complete questionnaires away from the straining ears and prying eyes of other migrants. The sentence at the top of the page also suggests that a shared language is essential for proper questionnaire completion.



MEDECINS SANS FRONTIERES

Questionnaire à destination des migrants- Paris

Le questionnaire est rempli par le médiateur/interprète après la consultation et/ou la remise de NFIs, si possible, dans un espace confidentiel.

A expliquer à la personne :

Médecins sans frontières est une organisation humanitaire indépendante de tout gouvernement. Ce questionnaire est destiné à permettre à MSF de mieux comprendre la situation et les besoins des personnes migrantes à Paris, notamment celles sans-abri. Ces informations sont anonymes, et ne comporteront pas votre nom et prénom. Elles serviront à produire des données statistiques (combien de personnes n'ont pas accès à un hébergement ou à des soins et pourquoi...etc), et nous ne partagerons aucune information sur des individus en particulier avec les autorités ou la police. Vous êtes libres de ne pas participer au questionnaire si vous ne le souhaitez pas, cela ne remettra pas du tout en cause les soins et les services que nous vous offrons.

DATE DE L'ENTRETIEN: __/__/____ SITE ENTRETIEN:_____

INITIALES ENQUETEUR :____

DEMOGRAPHIE

Pays d'origine: _____

Genre : Homme [_] Femme [_]

Age: [ ] ans

Situation familiale: Personne seule [_] En couple sans enfants [_] En couple avec enfants [_]

PARCOURS

Date d'arrivée à Paris: __/__/____ *ou bien* Arrivée il y a _____Jours

Souhaite rester en France : Oui [_] Non [_] NSP [_]

SITUATION ADMINISTRATIVE

ADULTES SEULS ET FAMILLES

- Souhaite déposer une demande d'asile, mais n'a pas encore effectué de démarches [_]
- A une convocation au guichet unique pour demandeurs d'asile (GUDA) pour déposer sa demande [_]
- A déposé une demande d'asile [_]
  Si oui, procédure Dublin : [_]
- Débouté de l'asile [_]
- A obtenu l'asile (statut de réfugié ou protection subsidiaire) en France [_]

MINEURS ISOLES

- N'est pas encore allé au DEMIE [_]
- Est allé au DEMIE, est en attente d'évaluation [_] Depuis ____ jours
  S'est vu proposé un hébergement [_] : En hôtel [_]
- Est allé au DEMIE mais a essuyé un refus de guichet (ne s'est pas vu offrir une

Figure 18: The Questionnaire, front

Second, there is a paragraph at the top of the questionnaire with information that the translators are to provide to the migrants:

> *"Doctors Without Borders is a humanitarian organization independent from all government bodies. This questionnaire is meant to help MSF understand the situation and needs of migrating persons in Paris, especially those without shelter. The information gathered is anonymous and does not include your first or family name. This information will be used to produce statistical data (how many people are without access to shelter or healthcare and why… etc.), and we will not share any information on any particular individual, with the police, or other authorities. You are free to not participate in the questionnaire if you do not wish to, and this will not at all affect the healthcare or services we offer you."*

"MSF" is addressing a person who has intentions, desires, and worries, and who can make informed decisions. Among their worries is the need to access healthcare and other services that "MSF" may provide. But "MSF" does not want them to feel like answering questions is a prerequisite to care. To avoid this morally unacceptable situation, where answering personal questions is a condition for seeing a doctor, translators are supposed to tell migrants they are free to not respond. That is, making a positive effort to make explicit that access to care is not conditional to the answering of questions, is meant to give this person an informed choice, understood to make *care* possible.

This paragraph also foresees a degree of anxiety in migrants regarding possible interaction with state actors, police, and other "authorities". To reassure them, MSF guarantees anonymity. The "person" will be dissociated from information on their "situation" and their "needs" through statistical analysis. This is one way that positive effort is made to keep some things unknown. It also shows how the *switch* from the 'person in front of you' to all the 'people who don't come to the clinic' also allows, surprisingly, the respect of the person in front of you in their desire for anonymity. The ethical effect is to maintain the anonymity of respondents, while providing MSF with aggregate data meant to allow them to "understand" the situation and needs of migrant persons sleeping in the streets of Paris.

This preamble to interactions with migrants who fill out the questionnaire specifically addresses two moral issues: giving migrants the possibility of making informed decisions regarding whether or not they are willing to fill out the questionnaire; making sure migrants understand that filling out the questionnaire is not a condition for care.

Third, the questionnaire consists of a series of uniform data points that should be obtained from all respondents. However, questions are not written out, which means they cannot be read. Moreover, the absence of standardization means different ways of filling out the questionnaire are

flagrant, and no attempts are made to dissimulate them. The same translator can fill out the questionnaire different ways depending on the situation.

There is at least one commonality: questions asked allow both "data collection" and "guidance" (*orientation* in French). "Guidance" means providing information on where to get access to health care, food, and shelter. "Data collection" means responding to the questions on the questionnaire. Here, I present a few ways of managing these twin activities based on observations in the field. After discussing tactical positioning in the previous section, I would now draw the reader's attention to the *tact* required in dealing with these constraints at the site of *con-tact* with beneficiaries.

One style is to make very little time and space for the questionnaire during the face-to-face encounter:

> *Kameel, an Arabic translator, comes out of the van, out of a consultation. He picks up the three-ring binder "Information for migrants" and goes into the tent, following the guy he was with for the consultation. In the tent, he opens the binder to the page "Law Clinics", and marks down addresses and opening hours in a little notebook, with the telephone numbers. I'm a little bit far away, I can't hear everything they are saying. Kameel tears the paper from his notebook and gives it to the guy. (…) He then does a questionnaire with him. He explains what the questionnaire is for in Arabic[1]: "to know what is going on here." At the top of the page, he writes date, site (P.C. for Porte de la Chapelle). Nationality: Algerian. He keeps going, very quickly, scanning the questionnaire more than reading, he jumps over the section on minors, which doesn't apply. Accommodation: he puts a checkmark in the "no" box and writes nothing else. He does the questionnaire start to finish in 30 seconds. Kameel has stopped writing, listening now, still has the "Information" binder open on his knees. He absent-mindedly plays with the papers, puts them in order, as they talk.*

After giving "guidance" based on the individual's needs, the questionnaire is filled out "just to know what is going on here". After having spent time with the Algerian man in the medical consultation, the translator already knows many of the answers on the questionnaire. Then their conversation continues. The questionnaire is an afterthought, a formality. What is important here is "guidance". The binder – another tool that MSF has created, going so far as to visit all public bathrooms in Paris to check if the showers are in working order and if they are open to migrants – enacts this more effectively than the questionnaire. Kameel knows what this man needs – legal aid – because he had a conversation with him, not a questionnaire-scripted interaction. A moment of attention created a place for the beneficiary where he could express needs. At the same time, we

[1] I speak Arabic at a A2-B1 level on the European scale, and can understand basic phrases, such as this one, and sometimes more complex ideas, depending on context and theme.

might wonder to what extent Kameel's conversation was inflected by the regular use of questionnaires and the contents of the classer filled with information useful for "guidance", that was compiled using responses from the questionnaire: a moment for the provision of care was made by the regular work of soliciting beneficiaries to express their needs.

Here is **a second style** of questionnaire completion, where the questionnaire is used almost like a semi-structured interview guide:

> *Mariam begins the questionnaire for two minors, in Farsi. She writes down the date, then their initials. For the first blank spaces, in the "demography" section, she already knows the answers and does not ask questions about age, nationality, gender. She starts with the one who has bandages on his hand. [...] She skips the part "accommodation" and completes the part "access to care." It is sometimes clear, even if I do not understand Farsi, that she isn't following the order of the questions on the questionnaire, step-by-step. After several speaking turns, without her writing down anything, she writes a few sentences in the "Comments" section at the end of the questionnaire about "accommodation". From where I am, I cannot see what she is writing well. Under "access to care", she writes down "Red Cross". Mariam asks me to spell "Richard Lenoir", a metro station in Paris, which is a site where some migrants find accommodation. Altogether, the questionnaire takes 5 minutes.*
>
> *She starts with the second minor. She has moved, and now I can see what she is writing. She writes down "P.Ch." for Porte de la Chapelle under "site", then date and initials. After marking down the age, nationality, and gender, which she knows without asking, she passes on the main questions on the top of each sub-part of the questionnaire. Accommodation? No. Went to the Demie? Yes, he was deemed to be an adult. This is a box that she ticks on the form. In the comments section: "he left his country 3 years ago, he has been in Iran, then Turkey and France. He has recently applied for placement with the ASE (*Aide sociale à l'enfance, a public agency responsible for protection children's rights*) and he is now sleeping in the street. "Access to care" – a check in the "no" box. "Most urgent needs?" There is a list. She puts "1" next to "accommodation", "2" next to "health".*

In this extract, we see Mariam filling the questionnaire with two Afghan minors. Here the questionnaire seems to act more like semi-structured interview guide. Mariam fills out the questionnaire, but she does not follow the order of questions or systematically write everything down. The interaction is not "question-response", but a dialogue whose purpose is simultaneously to connect with the person, to listen to what they have to say about their situation and their needs, while also filling out a questionnaire where there are predefined categories of needs. Contrary to that other style of filling out the questionnaire, we do not see Mariam immediately respond to what these youths designate as their needs. This is done later, after the questionnaires have already been filled out. So, this translator separates the two activities of "data collection" and "guidance". She makes a place where these two young people can express their needs, by asking open-ended questions to her respondents, and being attentive to their paragraph-length responses. From these,

Mariam gleans what information she needs for the questionnaire. Once this is done, she provides them with guidance on where to get help: that is, it is the place made for expressing needs that makes it possible to tell the beneficiaries where they can go to get appropriate help. This is a very different style for filling out questionnaires.

I would like to discuss **one last style** of filling out questionnaires, where concern for guiding the person disappears and data collection takes up all the space. When the translator is not able to enter into a caring relationship, when they are not recognized as being there to help – here because of a language barrier – the type of relationship established with the respondent is quite different from what was seen above.

> *(My notes here move between French, English, and Arabic.) Haidar begins the questionnaire in English. Date, place (P.C.), initials of translator. [...] Haidar turns towards the youth, explains that he will ask questions. He gives some examples, reading the questions off the survey. It's no problem! The youth answers but does not seem thrilled. Gaze lowered. His answers are sharp, laconic. How long have you been here in Paris? 3 months. He came here because he heard there was a camp. Do you want to stay in France? I* will *stay in France. Do you have a rendezvous? I try every day, just to do papers, but I can't. Haidar has trouble with English. No, you don't understand! Are you a statutory refugee? The youth does not understand the question. Do you have a 1-year card or a 10-year residency card? (The 1-year card is for "subsidiary protection" and the 10-year card for "refugee status".) The young man answers: 10 years, I'm going to ask for 10 years. Haidar: ah ok, but you had an interview at the OFPRA (French refugee administration)? No, not yet, I already said that! You're in the street? Yeah. But you know the 115 - "*cent quinze*", he says in French - the phone number for emergency housing? Yeah.*
>
> *The youth says in English: "I am going to do a depression." Haidar: it's complicated, I am "arabophone". The guy answers: "I understand French, mais je ne parle pas. I can't speak it" Haidar switches to French: so, you've been in the streets for three months? Yes. When did you leave? Journey: Eritrea, Sudan, Libya, Italy, France. It lasted five months in all. Haidar says: Thank you. You're welcome, now I need medicine!*

Because of the language barrier, the translator is unable to provide the necessary attention to the person in front of him. Little room is made for the person to express their needs. Even if, despite initial mix-ups, he does manage to fill out the questionnaire, we can wonder about the quality of the information gathered. In addition, the translator does not provide any reassurance or help to the young man. He seems to fail at guidance, and therefore, at data collection. What is particularly surprising here is that it is precisely when the questionnaire is used in the way we intuitively expect - a mechanical back and forth between formal questions and the written response - that is least able to deal with multiple situational constraints. That is, if the questionnaire mediates the inter-face between humanitarian fieldworkers and beneficiaries, it seems to do this best when it does not function as a questionnaire.

ii. The Trouble with Writing Things Down

The above scenes help understand some of the constraints of "data collection" and "guidance" and different styles of dealing with them at the interface. But it was difficult to see the plurality of issues translators deal with as they fill out the questionnaires with migrants. I mean, quite literally, the problems with filling out questionnaires, that is, with writing down answers. The following extracts from an interview I conducted with Mariam, a Farsi translator from Iran, provides a somewhat different point of view on the ethics and pragmatics of questionnaire usage. I would invite the reader to pay close attention to two issues in this section. First, how the site where the questionnaire is filled out affects the relationship made possible with the respondent. Second, the ethical effects of different inscription devices for noting down what respondents say - *the questionnaire*, *a personal notebook*, *a digital tablet*. The interview has been translated from French.

First, the spaces of questionnaire completion.

> **Mariam**: *It's easier to fill out the questionnaire at the mobile clinic than when we do* maraudes*. Because in the mobile clinic,* ***we have a space****. Even if we're in the street, we have a space. And people come to us with a request.* ***But during*** **maraudes*****, we are going to people.*** *There is no mobile clinic, there is just us, translators, mediators, doing the* maraudes*, with a manager, and sometimes a doctor. But the doctor doesn't do consultations. We only channel people, give them guidance. That's why, for me, it's simpler to do the survey within the mobile clinic than during* maraudes*.*

We will not insist too much on this point. Suffice it to say that asking questions and getting answers is much easier when people come to you for help in a space that is your own, than it is when you go out marauding, pilfering for information, when you have to find a way of approaching them, and getting recognized as someone who wants to help.

Interestingly, the **inscription technique** these translators opt for depends, in part, on where they are inter-facing.

> **Mariam**: *That's why I suggested that we do not use tablets, for example, in front of the FTDA, where really, it's very, very difficult. I don't know if you know the FTDA?* France Terre d'Asile*?*
>
> ***EF****: I went there once on a* maraude *with you.*
>
> ***M****: Yes, so, you know. There is a big queue, people sleep there all night, sometimes two nights, a week, in the queue, just to go inside, and sometimes they don't get in. And it's cold outside, and there's always a police car there. And then you go up to them with* ***a tablet*** *and start asking questions? With nothing to offer in return! On the* maraudes*, there is no doctor with us, nothing at all. So, it was not that easy to talk to them with the* ***tablet****. That's why I suggested, that we do not do a survey in the queue in front of the FTDA, because it's difficult, or, if we do the survey, we do it with* ***a notebook or the paper questionnaire****. [...]*
>
> *In the FTDA queue, when I start talking, I, personally, say that I work with Doctors Without Borders. If you need any information to know where to go to eat, where you can go to take a shower, all*

> *the needs of this population, I say, look, here, I have all this information! Well, this is my method - I give all the information about where you can eat, translate administrative papers.*
>
> *Afterwards, when it's over, I say, can I ask some questions for our work? So that we know that, look, we did [...] a questionnaire with your friend, he tells us that, here "we need to know where to go to take a shower." That's why we translated, that's why we prepared this binder, with all the documents we can give you, to guide you. That's why it's less complicated when they ask, "why is it useful for you to ask me questions?"*

What we see then is that the inscription device is a key element at the interface. We also learn that location is an important part of the interface. We see that the proposition of aid is used tactically to make it clear why respondents should answer questions: MSF is able to help them because others like them have answered the questions. Even still, the tablet poses a problem when they go to the FTDA. Physical proximity to the administration and to the police means the tablet gets assimilated with technologies of governmentality. This is still the case, but less so, for the paper questionnaire, and less again with the personal notebook. This is the reason Mariam started using a personal notebook to write down responses during conversations with respondents - is that what they should be called here? - and then copying them later onto the questionnaire or into the tablet. Even if Mariam explains that "MSF is independent, and doesn't work with the state, or with the police, or any of that", "there is always fear of police, fear of the administrative stuff", which means that they sometimes intentionally give "wrong answers". Mariam finds this out when she then translates the medical consultation. This means, surprising, that "information is more correct when there is no paper". Mariam continues: "Because of course, when you're filling out a questionnaire, it's a bit weird. "

> ***Mariam**: They came to you for a medical problem, they want to see the doctor. Then you start asking them questions. Why? For them, it's like you're a journalist or a cop. It's a little weird. [...] And I do not know if this has happened to you or not, but when you say "can I record this?", like for this interview, really, it can be difficult to explain, right? It's the same thing. We have to explain why we want to write everything down, that it's anonymous, etc. So, imagine for this population, I'm talking about the Afghans. In Afghanistan, 43.1% of men are literate, meaning the rest cannot read or write.[1] And it's even lower for women. So, it's a bit difficult, a questionnaire! "She's asking questions, has a notebook, tablet, and everything." [...] And you know what? They're right! Based on what they've seen, what they've gone through. So, I think that's why it's a bit difficult. It was a*

[1] "Afghanistan has one of the lowest literacy rates in the world, currently estimated at about 31% of the adult population (over 15 years of age). Female literacy levels are on average 17%, with high variation, indicating a strong geographical and gender divide. The highest female literacy rate, for instance is 34.7%, found in the capital, Kabul, while rate as low as 1.6% is found in two southern provinces of the country. Male literacy rates average about 45%, again with high variation. The highest male literacy rates are in Kabul, at 68%, while the lowest is found in Helmand, at 41%." Source: Unesco. http://www.unesco.org/new/en/kabul/education/youth-and-adult-education/enhancement-of-literacy-in-afghanistan-iii/ (Consulted 2019 October 24)

little complicated. That's why I start with the notebook, even if I'm asking questions off the survey. But I'm just writing in a notebook, in front of him. And I don't write in French, like on the questionnaire. I write in Farsi. So, that also makes it easier. [...] *And after, when the conversation is over, I write down the answers. That's why, for me, the tablet was not very useful. [...]*

But some colleagues disagree with that, that we just talk with people and then fill out the questionnaire later. But for me, it was different, because I said, during a conversation, I do not ask for their name, there is nothing, there is no personal information. [...] But they say it's not fair to do questionnaires without telling them that we're actually doing a questionnaire. And actually, that's not my point of view. When I was speaking to people, sometimes it was not just for the survey. Not at all. It was just in order to understand their situation and to be able to give them guidance.

So, filling out a questionnaire is about convincing people of your good intentions, while also making clear the usefulness of the questions you ask. It means carefully calibrating the encounter to provide guidance to the person in question, while also establishing a line of communication based on trust so that the person will answer your questions. It also means navigating difficult moral terrain, perhaps even hiding the fact that personal information exchanged during an informal conversation may end up as part of aggregate statistical data. It means recognizing that the provision of care based on an understanding of a population's situation, calls for, perhaps even depends on, concealing the notes taken on their conversation. But then again, there are disagreements about this. This team of translators continually ask themselves what the best way is to fill out questionnaires while helping the people with whom they interact. There are discussions and disagreements. This is hard work, requiring skill and moral wherewithal. Different translators develop different methods of approach, different ways of insinuating themselves into the space of migrants, of getting recognized in their need to help, in order to collect data while also remaining attentive to the situation of the person in front of them, and helping them access fundamental services (healthcare, food, hygiene, legal aid).

*

There are a few points I would like to insist on before moving to the next section. The first relates to the questionnaire. We saw how the questionnaire gives the encounter between humanitarian field workers and beneficiaries a certain form: when and where it should take place, certain ethical pitfalls they can expect, concerning privacy and the risk that answering questions becomes a condition for access to medical resources. It is also clear that the questionnaire limits what is possible to express in this relation, and practices of inscription can be understood as a reduction of people's biographical life to a series of "needs". However, what might be a surprise is the degree to which the process of questionnaire completion is not only a formal exercise of reading

off questions and mechanically filling out a form. Questionnaire completion takes place at the boundary between "data collection" and "guidance" (explo/action). While "writing things down" is ethically troubling, it is less the formality of the exercise and more the possible relations of government that it exacts that worries those involved. Because of this, respondents sometimes developed tactics to protect themselves from such attempts at governing intrusions by being intentionally disingenuous, and field workers develop tactics to convince them of their need to help, which, for some, meant being disingenuous about how they would transforming a conversation into information for the questionnaire.

This brings us to our second point, concerning the kind of fieldworker and the kind of beneficiary, that the questionnaire works, sometimes unsuccessfully, to enact. Insofar as the questionnaire simultaneously organizes *data collection* and *guidance* - explo and action - it performs a situation where humanitarians must be recognizable in their "need to help" and beneficiaries must be recognizable as being "in need". If any one of these conditions is not met, then the interaction is a failure: neither data collection nor guidance can be achieved. This is the case if the fieldworker does not sufficiently perform sincere concern. It is also the case if the beneficiary cannot become vulnerable. This leads us to our primary conclusion for this section: *the mediated inter-face of the questionnaire is meant to make a place where beneficiaries can become vulnerable*. That is, vulnerability is necessary for humanitarians to provide aid. They require beneficiaries to perform this vulnerability. And when we say that explo/action makes a place where *beneficiaries* can become vulnerable, that place is *the field*.

But sometimes this does not work. Sometimes, respondents do not see the usefulness of the questionnaire. Sometimes, field workers do not pay attention to the specific needs of the person in front of them. Sometimes both data collection and guidance fail, and all that is left is the violent attempt to force people into accepting a position they do not want to occupy: that of being reduced to a set of fundamental needs.

2. Ordering the Field: Practices of Place and Epistemic Infrastructure

In the introduction to this chapter, we discussed the field as it had been taken as an "other place" to the office, headquarters, and home. A hypothesis guiding our work was that describing the ways the beneficiary figures in the practices of explo/action would tell us a great deal about the field as a place (and vice versa), while advancing the analytical objective of grasping just what is "other" about the field. This was the point of the first section of this chapter, which described the

work of tactical positioning in the field necessary to collecting data and providing care, as well as the tact associated with asking beneficiaries questions and writing down their responses on a questionnaire. This has furthered our understanding of what it is about the field that makes it perceptible as an "other place", by bringing attention to some of the ways the field is configured as a mediated interface, as a tactical field of tactful encounter between humanitarians and beneficiaries engaged in the equivocal practices of knowledge production and care. The field is a place where respondents can become vulnerable. Yet an essential question remains if we are to work through the otherness of the field as a place: in what ways does the field relate to its "other places" (the office and the lab)?[1]

One way of coming to grips with aid workers' and social scientists' experience of going to an "other place" in the field would be to suggest that sites of humanitarian intervention are what Michel Foucault called *heterotopia* (1986). Heterotopias are in space-time, but they work differently from all other sites in society, even if they are in connection to these other sites. This is, first, because they suspend and inverse the order of society, and, second, because more than one order can be at work at the same time in heterotopias. In contrast to the rest of society, they do not constitute coherent wholes. Instead, they slice out moments of time where processes of change march according to a variety of rhythms and directions.

Taking the humanitarian field as a heterotopia means that it inverts and suspends the ordinary mode of functioning associated with a neoliberal world order, the interventionism of great states, and the militarism of armed groups. In this place, being vulnerable provides access to resources[2] and ceases to imply inherited inequalities and structural discrimination. In the heterotopic archipelago of field sites around the world, the urgency of care would reign supreme. This proposition would account for the sense of going into an alternate moral universe, and the difficulties associated with sharing these otherworldly experiences with people who have not been into the field. It might avoid essentializing humanitarian beneficiaries by locating alterity in the spatial order. The fact that the usual order is suspended and inverted could explain humanitarians' new-found intolerance for "bullshit" and their heightened sensitivity to suffering. The heterotopic humanitarian field would evolve according to a different temporal order; it would be *heterochronic*. Either like the ship - an example provided by Foucault - "the field" of humanitarianism would be

[1] Analysis of the complex skein of relations connecting the field to headquarters require more than a few pages. We will be addressing these issues extensively in Chapter 4.

[2] This is a fundamental tenet of humanitarian intervention, made clear in the Charters of any number of NGOs, as discussed in the general introduction to this dissertation.

continually pushed to change and move and adapt in an unstable, open world: without borders, outside of state territory, chasing emergencies through war zones. Or like the garden - another example from Foucault - it would find itself suspended in time, immobile, a reserve for rare species: the grid of the refugee camp maintaining stateless people in their exceptional situation for decades. An "other" humanitarian field would also allow for novel political imaginations. Like the theatre or the cinema, it would seem to buttress both a conservative structure - feeding on and supporting structural violence through a politics of "small mercies" - and a near-revolutionary *imaginaire* through a radical politics of care for the vulnerable in a violent world and a refusal the human sacrifices necessary to the renewal of a neoliberal order. The field of humanitarian aid does seem to do all these things. Yet there are several problems with heterotopia as an analytical tool. Before getting into a pointed discussion with Foucault, we would do well to continue our description of how the field is ordered. This will afford a more empirical, and fruitful, discussion.

In what follows, we will see just how the office and the lab feature in the field. Both are clearly distinguished from the field, but also reconfigure the field through *practices of place* (Kohler, 2002). To understand how this is possible, we will discuss MSF's role in the history of a scientific discipline - field epidemiology - in terms of the development of an *epistemic infrastructure* (Murphy, 2017; Star & Ruhleder, 1996) for explo/action. We will finish by showing how this infrastructure effectively cancels out the difference between the local and the global, between "other place" and the "rest", while maintaining the possibility of difference. This will lead us to move past and through Foucault's heterotopia - based on a totalizing conception of order - to Annemarie Mol's proposition concerning plural *modes of ordering* (2002) as we develop our own conception of humanitarian location. That is, the next two subsections on *practices of place* and *epistemic infrastructure* are about *modes of ordering* the field.

a. The Practices of Place of Explo/action: The Office and the Lab in the Field

To get past the aporia of *either* the field as an "other place" *or* the field as the same place, we return to Kohler's claim that the field is marked by *practices of place.* Kohler shows how, by way of contrast to the oft-touted placelessness of labs, field biologists must embrace particularities of the place where they are conducting their investigation, and use those particularities to their advantage in order for the field to become knowable in ways similar to the lab. In this section, we will examine the practices of place associated with explo/action that turn the field into an office and make it knowable as if it were being studied in a lab. That is, we will be exploring those zones where the field overlaps with the office and the lab.

i. The Office in the Field: Making Rapid Health Assessments Count

We have made mention of Erica Bornstein's comments on the distinction between the field and the office in her work on World Vision. It is also a theme is Crystal Biruk's research on the fieldwork conducted by global health researchers collecting AIDS data in rural Malawi. "*During everyday data collection, the field and office became signifiers taken up and absorbed into subjectivities, social relations, and practices*" (2012, p. 350). She underscores how the rural villages were unknown to Lilongwe urbanites who went there to conduct fieldwork. Travel to these places is presented in contrast to the "number-crunching" in the office. For Bornstein, it was in the office that "accounting" is done; for Biruk, it is in the office that "information" gathered in the field becomes "data". It is essential then that the office be held apart from the field, as a place where cognitive resources can be accumulated in order to make *calculation* possible. But what happens when the "information" gathered in the field is supposed to be directly useful to an ongoing humanitarian intervention, also in the field? What forms of calculation are accomplished in the field, in order to turn "information" into "data" useful for operations? Here we are again with the problem of *explo/action*.

As the reader will recall, during Karla and I's interview, we discussed a rapid health assessment she led as an Epicentre field epidemiologist in Indonesia. In December 2004, her mission consisted in evaluating the needs of the population of an island called Simeulue, in the aftermath of the tsunami. Simeulue is an island 100 km long and 30 km wide. It is covered in steep hills and forests. Its coast is rocky and surrounded by coral reefs. According to census data from 2000, it hosted a population of approximately 57,000 people. The epicentre for the tsunami was between the island and mainland Sumatra. The assessment Karla led started with a pre-investigation: she went into one village, spoke with the leaders and a few women. They talked about access to food, clean water, and health needs. Based on what they said, Karla prepared a questionnaire. Working with a team of three Indonesians that had been hired through the national institute for health, they then went to seven camps around the island, where they entered every fourth tent, and filled out the questionnaire. The entire investigation took a few days. To see what the data collected is good for, let us see what happens to it after the questionnaires are completed and the surveys done. Just before the interview extract that follows, Karla explains that the teams of field epidemiologists that she leads are always integrated into operational teams from MSF.

> ***EF**: And the information gathered is immediately used by operational teams?*
>
> ***Karla**: That's the idea. That's what field epidemiology is for. What we do is supposed to help with decisions, right away, at the time. Later we can do other kinds of surveys, with different objectives, more* témoignage*, more long-term strategy. In that case, the investigation can be a lot more*

rigorous. What we've been talking about is the rapid assessment of needs. These kinds of investigations go fast, and the point is to inform the field directly.

***EF**: And once you've done your assessment, how do you process the data? I guess you do that back in the office, not in the field, right?*

***Karla**: No, it's the same office, I mean, **the office is in the field!** So, you go back to your base, and you enter the data you collected into your database and you click, I mean, we're not doing really complicated analysis. It's just the percentage of people who've answered X or Y. You calculate your Confidence Interval and that's it. So, yeah, it's the kind of thing you can do right away. You do data entry, and especially during emergencies, you try to go fast. In Indonesia, we would do it the same day, in the evening, we tried to enter everything and do our analysis.*

*And then we talk with the logisticians and the rest of the team in the field. Is vaccination coverage good? What are the percentages? That way, they know if they do a vaccination campaign or not. In Indonesia, we asked the logisticians to buy petrol lamps and to bring them over. Blankets too, and then we would do distribution. Then we went to the next village because there were lots of little camps all along the coast, we had to keep moving. So, in that kind of situation, it's really informal. You know, it's really just pivot tables (*tableaux croisés*), that you talk about in the evening with the team, and that's enough to start working. For the final report, you've got time to write something later that's nice and clean, that looks good.*

This is what field epidemiology is for: helping operational teams make decisions. This is achievable because "the office is in the field". In the evening, they go back to "base" and do data entry. From this work, they can establish basic proportions. This is done as quickly as possible in emergency situations, so the operational team knows if they should do a measles vaccination campaign or distribute blankets. Of course, the final report takes more time, and is done later.

Talking with Clarisse - the activity supervisor for the mobile clinic and the *maraudes* in Paris - we learn once again, that "*being **in the field and in the office at the same time** allows you to implement your activities directly"*. Using Excel sheets, she does data entry every two or three days. This data is used to write their monthly activity report - an MSF wide practice - which then allows them to "to correlate data", and to compare with previous months. Over time, Clarisse says that this has allowed them to "visualize national context" and to "map the city of Paris". This is what follows:

***EF**: A map?*

***C**: A map, saying where migrants were, of what nationality, and why they were in one location and not another. So, yeah, we realized that Gare de l'est has been the Afghans' spot for the last 10 years. When I go there, I take two Farsi translators and only one Arabic translator. La Chapelle, that's where the Eritreans and the Sudanese go, because there's a Sudanese restaurant there. It was the* maraudes *that made it possible to see that kind of thing. To know how many migrants there are, their movement too, because they are very mobile. So, for example, with Macron's policy changes at the end of 2017, we saw real changes on the ground, I mean, all the migrants left Paris and went to sleep under the bridges just outside of Paris, to the north. [...]*

> *I can tell you that in Paris, right now, there are about 1,300 migrants sleeping in the street. We couldn't say that before, […] because it changes all the time. But it's no secret, to get that kind of information, you must be out in the field, you have to walk around, you have to be there. That's what we did. You have to go under bridges and underpasses and walk through the thickets and woods along the highway. We went to migrant shelters in the Seine-Saint-Denis, in Montreuil, and we went into really unexpected places, in squats in Aubervilliers where you find 80 people, and 15 of them are minors. Behind bricked up windows! To see that, you have to go there.*

The data collected is entered into an Excel sheet. At the end of the month, an activity report is written, that, when compared to previous reports, allows them to "visualize national context", see waves of migrations, note when the proportion of different nationalities, ages, or gender changes over time. This allows them to adjust their activities and the staff present. In addition, they were able to map the presence of migrants across Paris, and see the effects of changes in French migration policy on migrants living there. At the same time, their extended presence there meant they had created connections with migrants, who introduced them to new arrivals, making new relationships easier. In the end, Clarisse announces proudly, they can say that there are 1,300 migrants sleeping in the street in Paris. This is only achieved by being present in the field, under bridges, in squats.

The office makes it possible to do data entry, and to directly inform operational decisions in the field. It also depends on the field, on fieldworkers "going there", to get the data. And at the same time, the data tends to reconfigure the field, allowing teams to visualize context, to map the effects of public policy, and to establish population size and structure. The office is in the field and of the field.

ii. Turning the Field into a Lab: Calculating Crude Mortality

In this section, we will be discussing a slightly different type of field investigation: not the Rapid Health Assessment, but the Retrospective Mortality Survey (RMS), used to establish two key, and interrelated indicators: the Crude Mortality Rate (CMR), and excess mortality. We will see how the space of the field is reconfigured in order to make certain of its features more salient, features which then become variables in the equation for calculating the CMR. That is, I will describe the practices of place that order the field like a lab, making it possible to maintain a chain of circulating reference (Latour, 1995).

I would like here to refer to a booklet that humanitarians sometimes use when they conduct explo/action, published in MSF's Guidelines series and entitled *Rapid Health Assessment of Refugee or Displaced Populations*. We have mentioned these *Guidelines* once before, and we will talk about where they come from in the next section. In Chapter 1 of the *Rapid Health Assessment* guidelines, it states: "*The objective during the acute phase of an emergency is to reduce as rapidly*

as possible excess mortality.[1]" *Excess mortality* is the operative concept. When you compare the CMR in the population from before the crisis – called baseline mortality – and from during the crisis, there is a difference between the two. This difference can be attributed to the crisis and is referred to as *excess mortality*. Forced displacement is often associated with high levels of excess mortality, attributable to a short list of "causes". For example - according to the guidelines - 68% of all deaths among the displaced population in Angola in 2002 were due to diarrheal diseases, measles, acute respiratory infections, malaria and malnutrition. *Rapid Health Assessments* establish key indicators like vaccination prevalence, or the proportion of the population with access to clean water, which help keep mortality low preventively. *Mortality surveys* are used to work out the past and current magnitude of the crisis and play a key role in the mobilization of resources, inside and outside of the NGO.

According to Karla, there is little difference between the Rapid Health Assessment and the Retrospective Mortality Survey, other than more rigorous sampling methods. And yet, the primary sampling methods used to establish the Crude Mortality Rate (CMR) demand very specific practices of place. Indeed, instead of working out the *proportion* of the population that is vaccinated, that has access to food of sufficient quality and quantity, that has access to clean water, etc., mortality surveys aim to establish a *rate*. In mathematical parlance, proportions are "dimensionless": proportions assume that the population stays the same from the beginning to the end of the period of concern. The population is "closed". Rates, on the other hand, introduce time, or, ideally, *person-time*. That is, the Crude Mortality Rate measures the **number of deaths per 10,000 person-days** (or the number of deaths per 10,000 people per day).[2] This is done with the following equation:

---

[1] This idea is repeated in Chapter 4 of the guidelines: "The main objective of humanitarian assistance in emergencies is the rapid reduction of excess mortality. With an effective humanitarian response, mortality is expected to normalize after a few weeks of months."

[2] There are a number of other widely-used mortality indicators in the global health sector. Usually, the CMR and the Under 5 Mortality Rate (U5MR) – the number of deaths per 10,000 children under 60 months of age, per day – are calculated together. Under 5 mortality is recognized to be higher than the CMR, the "normal" rate being 1/10,000/day, the double – 2/10,000/day – being taken as the emergency threshold. Proportional mortality is also an important indicator, measuring the proportion (percentage) of death attributable to specific causes. For instance, saying something like "20% of all deaths can be attributed to measles" includes a figure of proportional mortality. Proportional mortality can be useful in the planning of targeted interventions, but establishing the specific cause of death during retrospective mortality surveys is difficult. Basic causes – violence, respiratory tract infections, diarrhoea – can be established with some degree of certitude. More often, proportional mortality is measured using prospective surveillance methods, either in the population or in health structures. Another common mortality indicator used in the global health sector is the "maternal mortality ratio", or the number of maternal deaths per 100,000 live births. One of the UN's Millennium Development Goals was to reduce the global maternal mortality ratio by three quarters between 1990 and 2015. This goal was not met, even if the ratio did drop considerably (Cf, Wendland, 2016).

$$\frac{D}{N} \times \frac{10.000}{SP}$$

D = number of death during the study period
N = total population + half of the total number of death
SP = study period expressed in days

Equation 1: Crude Mortality Rate

The CMR is calculated by putting the number of **"**death events" in the numerator, the "total population" plus half the "death events" in the denominator, and multiplying by 10,000, divided by the number of days in the "recall period", and by stipulating the 95% confidence interval (CI). As such, evaluating the CMR entails establishing the total population, and the number of death events, and defining a recall period. Being able to put these values - **total population, death events, recall period** - in the equation requires ordering the field through several very specific practices of place.

Different methods for estimating **total population** are presented in chapter 3 of the *Rapid Health Assessment* guide. The ideal method for evaluating the size of the population is a census, but exhaustive counting is only possible on small sites. Population size can also be assessed during registration upon arrival in the camp or during vaccination campaigns. But many people do not register or get vaccinated. It is also possible to take the average number of persons per household, calculated from a random sampling of households and obtain an approximate population size. But you do not always know how many households there are.

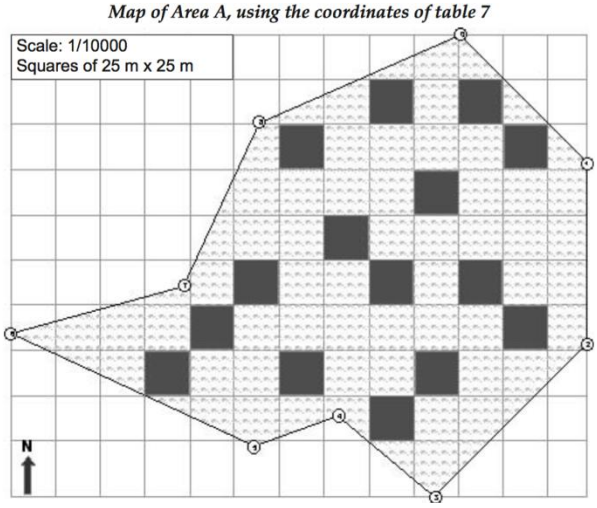


Figure 19: method for calculating population density and population size in refugee camp. Source: Rapid Health Assessment..., 2006, p. 64

The most common method in large camps is said to be "area sampling". The total surface area is surveyed, population density is estimated from sample sites, and the total population is calculated. The 2006 guide details the area sampling method. Figure 19 is an illustration. It entails, first, drawing a map of the contours of the camp. This is done by walking or driving around the site, measuring the distance between different landmarks, whose locations are established using a GPS device. This is used to draw a map. A **grid** is drawn on the map, and the number of squares is used to calculate the area. The next step is to calculate population density. To do so, a computer program generates random points on the map. This is used for sampling. Each

randomly sampled point is associated with the 25mx25m square in which it falls. Fifteen inhabited squares are required for a sufficiently high confidence interval. The probabilities behind this are not explained in the guide. The number of people having slept the previous night in the square are counted. For a household that straddles the edge of the square, at least half of its structure must be inside the square for it to be counted as inside the sample area. From the data collected, the average number of persons per square is estimated, which is multiplied by the number of squares. This provides a sufficiently accurate estimate of "total population", while also providing data on population density, useful for site planning.

We fear that this account of estimating the total population has not instilled in the reader the importance of this figure. In the humanitarian sector, field epidemiologists' obsession with the "denominator" is a common source of humour. This obsession stems from the fact that even slight errors in the estimation of the total population can introduce enormous errors in the calculation. Furthermore, humanitarians often deal with populations that are on the move, in places where the population can double or triple in a matter of weeks. As Jean-Hervé Bradol – ex-president of MSF-France – has noted, there are times when you think the CMR is going up because the number of death events you observe in your health structure has increased, and then you realized that there was a wave of new arrivals and your population increased significantly (Bradol 2014).

Once you have managed to get a figure of the **total population** – however fragile and temporary – you need the number of **death events** to calculate the mortality rate. There are two basic methods for estimating the number of death events: a sample survey or counting graves. While counting graves is presented as less than precise, it can provide valuable information when more robust methods are impracticable. Interviews with graveyard staff, or hiring someone to watch the graveyard, are presented as a good and cheap way of getting an idea of sudden changes in mortality in the camp. Such methods do not allow the calculation of the CMR. To do so, sample surveys are necessary. A number of sampling methods are presented, but the most common is said to be "cluster sampling" (see Figure 20).[1] Thirty clusters of thirty households are randomly selected

[1] Cluster and area sampling techniques were developed in the United States' agricultural administration in the 1920s. Emmanuel Didier has compared the use of different sampling techniques used by this administration at that time and demonstrated how they pose problems similar to those of political philosophers working on how a small group could speak for the whole in representative democracy. He shows how the concept of *representativeness of the sample* appears in this Agricultural Administration through area sampling techniques, and the cultural importance of small groups in the United States, with area sampling (Didier, 2002). However, despite the parallels between democratic representation and the problem of induction in epistemology (Callon 1986), we can hardly call "area sampling" a *technology of democracy* (Laurent 2011).

from across the camp - that is, the space inside the zone circumscribed for the study - for a total of 4,000 to 5,000 households.

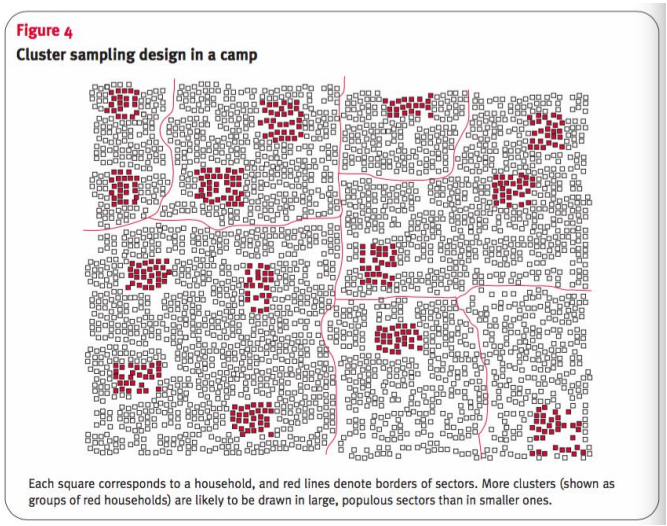


Figure 20: Cluster sampling design in a camp. Source: Francesco Checchi, Les Roberts, 2005, Interpreting and Using Mortality Data in Humanitarian Emergencies. A primer for non-epidemiologists, Humanitarian Practice Network, Network Paper, 2005, p. 15.

The exact size of the sample needed depends on the length of the **recall period**, that is, the period over which the mortality rate is measured. To define the recall period, a balance must be found between choosing a period that is not too long – to avoid memory issues among respondents – but long enough to allow enough precision, i.e., a sufficient number of "death events". In situations with very high mortality rates – the Somali IDPs in 1992, or Rwandan refugees in Goma, DRC in 1994, the famine in southern Sudan in 1998... – the recall period is only a few weeks long, and mortality rates can be 10 or even 20 times the pre-crisis rate. Once the sample and the recall period have been defined, the questionnaire is designed to establish the number of *death events* per household over the *recall period*. The fieldworkers are trained to make sure that sampling protocols are respected, that data is collected precisely and systematically, that questions are posed in a similar manner.

At stake with these sampling methods and protocols, with the training of fieldworkers, is the precision around the final figure. All the above is done in the name of the *confidence interval (CI)*:

> ***Karla**: what really makes a difference in sample size is the precision that you want around your estimate. What kind of **confidence interval** do you want around your estimate? It also depends on the prevalence or expected mortality. That's what really makes a difference, Confidence Interval, Recall period, and prevalence. Otherwise, you can do exactly the same investigation for the whole country, or for the province you are in, or for a tiny little district, and do the same sample size in each case. What changes is the Confidence Interval.*
>
> ***EF**: And why would you want a bigger or smaller Confidence Interval?*
>
> ***Karla:** It depends on **what you want to do with the results**. It also depends on the kind of results you're expecting, and what you are hoping to demonstrate.*
>
> *Let's say that I want to show that mortality has doubled, compared to the way things were before the crisis, before the conflict. That would be really serious! When two times as many people are dying than usual, for us, it's a sign of the seriousness of the situation.*

> *But imagine that I know that the mortality rate was 0.5 deaths for 10,000 in a day, for a given population before the crisis. So, it doubled, and it's around 1/10,000 by day. I need a really tight Confidence Interval! If I want to show that the mortality rate is over 0.5/10,000 by day, then the precision I get around my estimate has to be narrower than 0.5, otherwise our estimate overlaps with what the mortality rate was before the crisis. So, at the very least, I need my precision to be 0.4, if I don't want there to be any overlap. That's the strict minimum, and I'm taking a lot of risks with that.*
>
> *And now let's say I'm going to do a mortality survey, and I think the situation is really a total catastrophe. Maybe it's going to be 1.5! You know, there are signs that things are bad: a lot of burials, living conditions, and you've been in camps before, so you have an idea of whether things are bad.*
>
> *If I think mortality is three or even four times what it was before, I don't need as much precision around my estimate. For example, if I think we're at 2 or 3 deaths for 10,000 people per day, then I can have a Confidence interval of 0.5, 0.6, even 0.8.*
>
> *So that's what makes a difference.* ***If that's what I want to show,*** *if it's the reason I'm doing the survey, well, I'm going to need a big sample.*

In this section, I showed how the field could be spatially ordered to give it some of the characteristics of the lab. To my mind, these characteristics had less to do with "placelessness", "control" or "authority" of science - which Kohler and Gieryn associated with the lab in their articles discussed above (Kohler 2002; Gieryn 2006) - and more to do with maintaining the chain of reference, like one would maintain the cold chain in vaccine transportation (Latour, 1991). This is what Bruno Latour means when he says, "*For the world to become knowable, it must become a laboratory*" (1999, p. 43). The field, as the place of population displacement, is reconfigured to make it amenable to an equation for calculating the Crude Mortality Rate. The camp/population is literally circumscribed in space (limits of the camp), bounded in time (recall period), and put in a system of coordinates (the grid of sampling). The incessant movement of people and things in space is slowed down, flattened out, placed in a space-time with clear boundaries. The Retrospective Mortality Survey enacts the camp as a Cartesian plane, where households are randomly distributed inside boundaries, and a grid, and push the displaced to recount their stories of exodus and death in rituals of veridiction, all organized around the inscription practices of the questionnaire.

The point is that these practices of place and of maintaining the reference chain - like the cold chain - are oriented towards *intervention*. The goal is not to get the most accurate rate in and for itself, but to get a figure that supports specific activities. Just as "cover" was justified only insofar as the questions systematically posed to beneficiaries supported operations, the narrowness needed for the Confidence Interval depends on the requirements of the task at hand: humanitarian aid in the field.

*

In this subsection, we have examined the ways in which the field is constituted through practices of place. Not only was a place made for the office and the lab in the field, but the office and the lab effectively reconfigured the field. The *office in the field* made it possible for the answers written down on questionnaires to be entered immediately into Excel sheets, transformed into data, and made to inform humanitarian intervention. At the same time, the office in the field made it possible to map the field. That is, fieldworkers capitalize on their presence in the field by collating the collected data, visualizing "national context", and mapping the city of Paris as a field of humanitarian intervention. *The office finds/enacts the field.*

We also saw the ways in which a simple equation for calculating the Crude Mortality Rate transformed the space of population displacement. For the refugee camp to become knowable, it was circumscribed, put in a grid, subjected to cluster sampling, and confined in a recall period. These practices of place made certain features of the camp salient and made it possible to follow the trail of reference as "excess mortality" was calculated.

I would insist here on the cognitive and political effects of putting things in grids, be they Excel sheets or sampling grids. The grid has been a recurrent theme in philosophy and anthropology for decades, from the role Foucault gives to *quadrillage* in *Discipline and Punish* (1975), to Jack Goody's criticism of the effects of Claude Levi-Strauss' use of tables in his structuralist theory of myths in *The Domestication of the Savage Mind* (1977, pp. 74-110). In discussion with Goody, Carruthers and Espeland (1991) have also given precision to the claim made by Weber, Sombart, and Schumpeter that double-entry bookkeeping played an essential role in the rise of capitalism. James Scott has examined the effect of putting forests in grids in state-building in *Seeing Like a State* (1998), and Bruno Latour described how a grid was placed on a section of forest in Brazil in order to get reference to circulate from the field to a scientific journal (1995). This intense discussion of grids, when put alongside the work of data entry and area sampling in the field, demonstrates the extent to which these practices of place participate in the cognitive, political, and ethical ordering of the humanitarian field.

It would, however, be a mistake to claim that putting the field in a grid, striating the space of the field, "closes" it in some way. To understand why, we examine in the final section of this chapter one final mode of ordering the field - infrastructure - and the confusion the field maintains between the local and the global.

b. The Epistemic Infrastructure of Explo/action

This section is about the assemblage of methods and institutions that made it possible to explore/enact the humanitarian field and find/care for the beneficiary in particular ways. An

important part of this assemblage is the scientific discipline of *field epidemiology*. Even if it is only now becoming a theme in this section, field epidemiology has been present throughout this chapter. We saw how the cognitive prosthetics of epidemiology made a *switch* possible from the clinical approach of "one patient after another" to the public health approach of "the population as a whole". Through questionnaire completion in the field, we became familiar with the survey method, crucial in descriptive epidemiology. We saw the calculation of vaccine coverage rates in the office, and the work necessary to transform the field into the kind of place where Crude Mortality Rates might be calculated. We might think of field epidemiology as a kind of glue that holds all these practices together, making the field knowable in certain ways, and unassumingly rendering certain lifesaving interventions possible. *How does field epidemiology manage this?*

The primary argument of this section and this chapter - similar to the one made the historian Michelle Murphy on the use of demographic survey methods in Bangladesh throughout the 20th century by a global health research apparatus (2017) – is that the history of MSF is not only one in which a French NGO comes to intervene in emergencies around the world. Rather, MSF has effectively participated in erecting an apparatus by which these emergencies are observed, described, known, and turned into objects of intervention. This is what Murphy calls *epistemic infrastructure* (Murphy, 2017, p. 64).[1]

To make this argument, we will first look at the history of field epidemiology in global health research, and the role MSF played in developing the discipline. Second, we will look at ongoing reflection inside MSF on one element of this epistemic infrastructure - thresholds for emergency mortality rates - to see how it effectively orders the field of humanitarian aid. Specifically, we will see that this infrastructure makes different field sites commensurable to one another. These thresholds for emergency based on an ensemble of comparable sites constitutes a reserve of humanitarian events: *emergencies*. At the same time, as this infrastructure supports the work of comparison between field sites it reinforces the opposition between the field and "other places". This will allow us to make a proposition for reworking Foucault's conception of *place*

[1] Murphy's work describes the set-up of an institution that conducted repeated surveys in impoverished Bangladesh over nearly half a century. Her critique of this infrastructure is that it prefers short term, low budget interventions that maintain the "population" as an object of intervention, rather than empowering a politicized public capable collective action. She develops her critique of *population* further in "Against Population, Towards Alterlife", her contribution to Donna Haraway and Adele Clarke's edited work, *Making kin, not population* (2018). Contrary to what Murphy describes in Bangladesh, MSF's *epistemic infrastructure*, also based on sample surveys, is not built upon a single "truth spot" (Gieryn, 2018). Instead, as we shall see, it is the methods of field epidemiology that participate in constituting the field in a humanitarian dynamic.

based on a unified understanding of order (heterotopia) building on Annemarie Mol's work on *modes of ordering* (2002). This will conclude the chapter.

i. Field Epidemiology: The Epistemic Infrastructure of Explo/Action

According to one manual, field epidemiology refers to "*investigations that are initiated in response especially to urgent public health problems. A primary goal of field epidemiology is to inform, as quickly as possible, the processes of selecting and implementing interventions to lessen or prevent illness or death when such problems arise*" (Goodman & Buehler, 2008, p. 3). The *field* of epidemiology came into existence the mid-20th century in counter-reference to other technologies of counting in public health.[1] The *observational* and *descriptive* methods of field epidemiology evolved in reference to, and against, developing *experimental* and *analytical* methods. As is stated in our starting definition, the objective of "field epidemiology" is not to separate out a causal web that would explain a phenomenon, but to inform interventions in order to improve health outcomes in case of urgent public health problems.

One important method of inquiry in field epidemiology is the *survey study*. The sample survey, where sample selection was based on an understanding of probability theory, was developed in the late 1920s and 1930s in the United States, largely in the agricultural administration. Given the importance of agriculture in the economy, it was at the forefront of innovation in statistics methods, though similar methods were being developed simultaneously by unemployment specialists working in urban areas (Didier 2009). These sampling methods came to the US Public Health administration in the 1940s, through the work of Theodore Woolsey - a biostatistician who contributed to the writing of the National Health Survey Act in 1956, and played a key role in the foundation of the National Centre for Health Statistics, eventually becoming its Director in 1967 (Woolsey 1947, 1949; Duncan & Shelton 1992)[2] - and of Alexander Langmuir – a medical doctor and epidemiologist, professor at John Hopkins (Langmuir 1949). In 1951,

[1] The point is not that epidemiologists never did anything that might be described retrospectively in terms of *field work*, but that the *field* was not conceptualized as specific kind of epidemiological location entailing a specific set of problems and methods before this time. This is similar to *the field* in natural history, which came into existence only with the advent of the laboratory in the mid-19th century as the legitimate space of biology (Livingston, 2010). And it is similar to the way *the field* of anthropology was born with the Malinowskian revolution in the early 20th century in counter-reference to "armchair anthropology" (Ferguson & Gupta, 1997).

[2] https://www.nytimes.com/1992/12/04/obituaries/theodore-d-woolsey-health-statistician-79.html (Last visited: 30 September 2019)

Alexander Langmuir was put in charge of the newly founded Epidemiological Intelligence Service (EIS), part of the US Centres for Disease Control (CDC).

Founded in 1947 to eradicate malaria from US Army bases in the southern states,[1] the CDC quickly surpassed this initial mission to become a global actor (Langmuir 1980). This global extension is intimately linked to the Epidemic Intelligence Service (EIS) (Foster & Ganqarosa 1996). During the Korean War, medically trained young men did their military service there, as part of the Commissioned Corps of the United States Public Health Service. They were "Epidemic Intelligence Service Officers". Known colloquially as "disease detectives", EIS Officers became known for going into *the field*, all around the world, and investigating outbreaks in the population, often on foot. This is one of the reasons the worn-out leather shoe is a recurrent theme for the EIS, visible on its logo (Figure 21). This double theme of *the globe* - the sphere of spaceship earth seen as a whole from "above" - and *the worn-out shoe* - which figures the "disease detective" as someone who ranges over the globe on foot, in search of "patient zero" in epidemics who do not recognize political or cultural borders - is a powerful trope for these adventurous officers working in service of humanity. They also played a key role in post-war international public health, and, later, in the emergence of global health, becoming in the 1990s and 2000s a "cultural hero" in Hollywood films like *Outbreak* (1995), *Contagion* (2011), and *World War Z* (2013) (Lynteris 2016). This globalization of epidemiology was possible, in large part, because of the transportability of the sample survey in the field.

Figure 21: The EIS's logo, where two recurrent themes are visible: the globe and a worn-out shoe.

The EIS' global mission was consecrated in 1958, when a team of "disease detectives" was sent to Bangladesh to investigate a smallpox outbreak. In the years that followed, the EIS and the CDC came to be major actors in the global fight against smallpox. The survey methods they had picked up and developed for outbreak investigation and control had important effects on the smallpox eradication strategy. In 1980, this globally-concerted effort eradicated smallpox, a disease estimated to have killed 300 million people in the 20th century alone (Henderson 2011), and the

[1] This is why the CDCs headquarters are in Atlanta, Georgia. The eradication of malaria from the United States became possible with the widespread use of DDT. Of course, the environmental effects of the widespread use of DDT were criticized by Rachel Carson in *Silent Spring* (1962). She also indicated, correctly, that the use of DDT in the fight against malaria through vector control might eventually prove counterproductive, given that mosquitoes could develop resistance to the pesticide (Carson, 1962, p. 267).

only infectious disease that has ever been effectively eradicated.[1] The methods of field epidemiology were, in large part, credited with this achievement.

The EIS also sent its Officers to armed conflict situations. A case in point is the 1969 Biafra conflict in Nigeria, an important place in MSF's history.[2] There, "using a grid approach", EIS Officer Karl Western was able to provide the only "independent estimate of the Biafran population", and "using arm circumference and edema rates", he identified "pockets of severe malnutrition" in the general population (Foster & Ganqarosa 1996, p. S68). These were impressive results, and field epidemiology as a method of response to disasters, conflicts, and epidemics, at a global scale, gained traction throughout the 1970s.

Scientific publications in this discipline increased significantly in the late 1970s and throughout the 1980s.[3] The CDC's influential revue, *Morbidity and Mortality Weekly Report* (MMWR), published extensively on public health issues for refugee populations in Thailand, Somalia, Pakistan, Sudan, Malawi and Ethiopia, as well as famine situations in Mauritania, Mozambique, Niger and Burkina Faso (Noji & Toole 1997, p. 372). One major effect of these reports was to normalize the use of epidemiological reports in the definition of program priorities.

At the end of the 1980s and in the early 1990s, Epicentre, an epidemiological research laboratory in Paris, became a major contributor to the development, dissemination, and use of the methods of field epidemiology in humanitarian response and intervention (Figure 22 for their logo). Created in 1986, in Paris, by MSF, Epicentre's legal status is that of a non-profit association under French law (*loi de 1901*). Its charter stipulates that its board should be composed of ten members, six of which must be members of MSF. The board, with MSF members in a majority, approves Epicentre's strategy and budget allocations. That is, Epicentre is what is referred to as an MSF "satellite". The creation of Epicentre was part of a wave of extensive professionalization that took place in MSF throughout the 1980s. This professional epidemiological research service was created

[1] In humans at least. The last documented case of Rinderpest, affecting bovines, is from 2001. In addition, the late 1970s did witness the emergence of two new infectious diseases - Ebola and HIV - as well as a new understanding of the ability of microbes to develop resistance to antimicrobials - especially antibiotics - that quickly brought into question those heroic tales of humanity's triumph over disease through medicine.

[2] This is where a number of doctors working with the Red Cross, confronted with what they were convinced was a genocide, became frustrated with the organization's official policy of public discretion. This is understood to have led to the alliance between these doctors and journalists working for *Tonus*, a professional medical journal, who went on to found MSF in December 1971. To this day, the opposition between the ICRC's public discretion and MSF's public outspokenness is a simple line of demarcation between two styles of humanitarianism.

[3] "*There was a marked increase in the number of published papers relating to the health problems of refugees during the late 1970s and early 1980s. This coincided with the exodus of millions of refugees from Indo-China and Afghanistan into neighbouring countries, such as Thailand and Pakistan. Articles began to appear describing public health assessment and surveillance methods and accurately documenting the major health problems of refugees in south-east Asia*" (Noji & Toole 1997, p. 371).

in order to provide support to MSF's field operations, and, once again, "shed the lingering impression that [MSF] was a collection of newcomers rather than a serious medical organization" (Baron, 2009, p. 41 my translation). Interestingly, the doctors and epidemiologists who set up Epicentre in 1986 had been trained in the CDC's Epidemic Intelligence Service in Atlanta, Georgia.

In the first decades of the EIS's existence (1950s-1970s), most investigations were undertaken by epidemiologists from the United States, upon the request of the World Health Organization or national governments. In time, there were increasing demands for training from institutions around the world. The CDC set up the first international training session in field epidemiology in 1980, in partnership with the World Health Organization and the Thai Ministry of Health (Foster & Ganqarosa 1996). At the same time, the EIS began accepting international candidates in their domestic program. In the late 1980s and early 1990s, a few French doctors and veterinarians were sent to Atlanta for training.[1]

Figure 22: Epicentre logo, featuring a dotted Mercator projection world map, without poles

Three MSF doctors were also sent (Buton & Pierru 2010). Alain Moren, sent in 1985, had been the Medical Director of MSF. Impressed by the work of EIS Officers he encountered during a scurvy epidemic in a Somali refugee camp, he registered for a Master of Public Health at Johns Hopkins University in Baltimore. From there, he went to Atlanta to complete his training. Upon returning to Paris, he was instrumental in the creation of Epicentre. Both Jean-Claude Desenclos (EIS 1988) and Denis Coulombier (EIS 1991) worked as doctors with MSF and Epicentre, before going to Atlanta for training, and Desenclos went on to author MSF's *Clinical Guidelines*, whose subsequent editions are widely used across the humanitarian sector.[2]

MSF's recently-developed expertise in the methods of epidemiology in the field led, in 1992, to an important publication in their *Guidelines* series: *Rapid Health Assessment of Displaced and Refugee Populations*, co-authored by Alain Moren, founder of Epicentre, trained in field epidemiology by the EIS. These guidelines, and their subsequent re-editions, formalized methods

[1] Upon their return to France, many of these doctors were instrumental in the creation of the *Réseau national de santé publique* (RNSP), a novel French public health agency, whose surveillance work built on the methods of field epidemiology, in opposition to the clinical research methods of the INSERM. The RNSP became the *Institut de Veille Sanitaire* in 1998, with which Epicentre maintains professional relations. (Buton & Pierru 2010)

[2] Desenclos, 1988, *Clinical Guidelines. Treatment and Diagnostic Manual*, Médecins Sans Frontières, Paris.

for the assessment of a mobile population's health needs in situations of massive and forced population displacement. In addition, Epicentre epidemiologists published in major scientific journals on issues of public health in disaster and conflict situations.[1] This work *"played a key role in establishing epidemiology as a routine field tool and in developing a more professional approach to the practice of public health in emergency settings"* (Noji & Toole 1997, p. 373). In other words, Epicentre had effectively *"introduc[ed] the techniques of descriptive epidemiology into the work in the field"* (Baron 2009).

Today, Epicentre is composed of an Administrative Department, a Research Department, and a Field Epidemiology and Training Department. The Research Department is concerned with more fundamental research, conducting analytical studies, while attempting to make their work relevant to MSF operations. In addition, labs have been opened in Niger and Uganda, and they work closely with John Hopkins University in Baltimore, and with the London School of Hygiene and Tropical Medicine.

The Field Epidemiology department does field surveys, project monitoring, and training. Their annual budget has been around 16 million euros for the last few years, with 80% of funding coming from MSF's public fundraising efforts. The rest comes from contract research done for public health agencies and for humanitarian NGOs. According to the Epicentre website, there are a total of 205 active projects led by Epicentre, 59 of which are in Field Epidemiology, 25 in Program Support, and 96 in Research.[2] The Field Epidemiology department works hand in hand with operational teams inside MSF and has become involved in training MSF personnel in the basic methods of field epidemiology. This is notably the case during an introductory, 10-day course called *Populations in Precarious Situations* (PSP), held multiple times a year, in major cities in Europe and Africa, which covers public health indicators, established alert thresholds, sample survey methods, as well as priorities for intervention in camp settings. MSF's recognition in the humanitarian sector as one of the most competent and efficient NGOs comes in part from this ability to elaborate operational strategies using the methods of field epidemiology, which also serve to communicate convincingly on their operations and on the contexts in which they intervene.

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[1] *"In the late 1980s and early 1990s, the major sources of articles [on public health response to disaster] were CDC, MSF and the Paris-based Epicentre. [...] MSF was particularly active in publishing timely reports on cholera, dysentery, meningitis, leishmaniasis, scurvy and pellagra outbreaks in various emergency settings (Moren et al, 1988)."* (Noji & Toole 1997, p. 372-373). Michael J. Toole, author of the quoted article and early participant in the development of field epidemiology techniques in the humanitarian sector, is also the co-founder of MSF-Australia.

[2] Of course, this adds up to 180, not 205. My understanding is that some projects are counted in more than one of the types, leading to doubles, and some projects are not labelled, meaning they do not show up with filters. (https://epicentre.msf.org/en/epicentre/key-figures)

*

In short, MSF was not content to intervene in distant locales understood to be in states of crisis. The organization has participated in the elaboration of an *epistemic infrastructure* that made it possible to explore/enact the field and find/care for the beneficiary in certain ways, rendering certain kinds of life-saving interventions possible.

Following the sociologists Susan Leigh Star and Karen Ruhleder's classic article on infrastructure (1996), we understand infrastructure in a relational sense. That is, it is not taken as a kind of substrate that sinks into the background, becoming invisible and "just there": if an electrical grid is *context* for much of the public, it is *topic* for the engineers and repair crews responsible for maintenance. Instead, infrastructure is understood to emerge in practice, between work and technology, activities and structures. Infrastructure emerges according to the following dimensions: it is "sunk" into other structures and social arrangements; it is transparent to use, and does not need to be continually reinvented; it reaches beyond a single site or event; it's taken for granted characteristics have to be learned, and this learning is a mark of membership in a community; it links to conventions and standards, which contribute to its transparency; it is built on an installed base, and must deal with the inertia of existing infrastructure; and, finally, it becomes visible to its wider public of users primarily when it breaks down (Star & Ruhleder 1996, 113).

Let us now explore some of these characteristics through a discussion of a part of MSF's epistemic infrastructure: *emergency thresholds for mortality*. Insofar as infrastructure, as a *mode of ordering*, is understood to extend beyond a single site or event, I will argue that it helps us think through the ways the field relates to "other places".

ii. Baselines and Thresholds: Making the Field Commensurable to *The Field*

Let us return for a moment to that simple equation for calculating the Crude Mortality Rate. Imagine a population of 5,500, with 48 death events over the last four weeks, or 28 days. The CMR is calculated by first establishing the denominator of the above equation, by adding half the number of deaths to the population (5,500 + 48/2), or 5,524. The numerator is the number of death events (48). This is multiplied by 10,000/28, where 28 is the length of the recall period expressed in days.

48/5524 x 10,000/28 = 3.1 deaths/10,000 persons/day

The CMR is 3.1 deaths/10,000 person-days. Something impressive happens once the CMR has been calculated: "*Comparison over time, or with other settings is now possible*.[1]" That is, the

[1] *Rapid Health Assessment…*, p. 31.

field site takes on a temporal aspect – the CMR can evolve – and the field site becomes commensurable to other field sites. This is possible, in part, because of the standardization of field epidemiology methods and indicators, like the CMR. This is MSF's epistemic infrastructure. Comparison is not possible if the only figure available is the number of deaths. Death is an ordinary event, the end of every life. It is not the amount of death that makes sites comparable, but the amount of "excess mortality". This commensurability also has an interesting effect on field sites: they teeter on the brink between singularity - with each field site being irreducible to any other - and generality - each field site is one among many field sites, that is, it is *one* field site.[1]

To establish "excess mortality", the CMR is compared with "reference values". There are two types of "reference values": **baseline** mortality rates, and mortality **thresholds**.

Baseline mortality rates come from demographic data on the target population from before the crisis. Comparison with baseline mortality is the preferred method for interpreting mortality rates, and a CMR that is double the baseline mortality is widely considered to be an *emergency*. However, in situations of crisis, there is often a serious lack of reliable demographic data. It is one of the four primary difficulties Rony Brauman - ex-president of MSF-France - has associated with interpreting mortality data (2010, p. 85-86)[2], and some epidemiologists have suggested that baseline data is lacking in precisely those places and at precisely those times when threats to life are most severe, that is, moments of mass population displacement (Mathers & Boerma 2010). At the same time, the first CMR calculated for a given population comes to stand in as a baseline for future, prospective calculation of the CMR. As Jean-Hervé Bradol – ex-president of MSF-France – has stated (2014), more than the CMR at a given moment, humanitarians are interested in the way the CMR evolves. Malaria is seasonal and related increases in mortality rates can be predicted. On the other hand, if you calculate mortality over a long period, seasonal differences disappear and the CMR is artificially high for some periods and artificially low for others. Conversely, if the catastrophe is of the kind that lasts, then consistently high mortality rates can contribute to the

[1] On common nouns implying generality, see the logic of Charles S. Peirce: "The statue of a soldier on some village monument, in his overcoat and with his musket, is for each of a hundred families the image of its uncle, its sacrifice to the Union. That statue, then, though it is itself single, represents any one man of whom a certain predicate may be true. It is *objectively* general. The word "soldier", whether spoken or written, is general in the same way." Quoted by DiLeo (1997).

[2] The other three are: difficulties in establishing the total population, i.e., the denominator needed to calculate the CMR; the representativity of the sample, which makes extrapolation next to impossible; the reliance on survey methods means there are considerable problems with selection, data collection and entry bias. "Survivor bias" is an example, referring to the fact that the survey is meant to count the number of deaths per household, but cannot count the number of death events in those households that have no surviving members. This is once again an example of the "switch" from the person "in front of you" to the people who you do not meet, the people you do not see.

sensation that the situation has reached a kind of normal. There are other times when mortality rates stabilize after a spike because the vulnerable population – usually young children and the elderly – has already died. According to Bradol, this means that further intervention would have little effect (2014).

One way is to get around this lack of local, baseline data at the start of interventions is to rely on internationally defined **thresholds** for emergencies. Thresholds work by taking an assumed baseline, and then establishing a ratio of this baseline rate that defines an emergency. Different international organizations define different thresholds (cf. Figure 23). Following the CDC, work in academia and – until recently – MSF, the normal CMR in non-crisis situations, in Sub-Saharan Africa is taken to be 0.5/10,000 person-days. Double this normal rate – 1/10,000 person-days – is an emergency. The SPHERE Project, which sets standards in the humanitarian sector, has established regional thresholds based on baseline mortality rates specific to different areas of the globe. The double of each of these regionally specific baseline rates is taken as an emergency. According to Checchi and Roberts, while these regionally specific thresholds might be useful for planning operations, they pose serious ethical questions for humanitarians. Their formulation is one way the problem of the singularity-generality of the field and field site can be set out.

Table 2: Mortality thresholds commonly used to define emergency situations[9]

Agencies	Assumed baseline	Emergency thresholds
Centers for Disease Control, Médecins Sans Frontières Epicentre, Academia	Fixed at: CMR: 0.5 per 10,000 per day U5MR: 1 per 10,000 per day	Emergency if: CMR: ≥ 1 per 10,000 per day or U5MR: ≥ 2 per 10,000 per day
UNHCR	Fixed at: CMR: 0.5 per 10,000 per day U5MR: 1 per 10,000 per day	CMR › 1 per 10,000 per day: 'very serious' CMR › 2 per 10,000 per day: 'out of control' CMR › 5 per 10,000 per day: 'major catastrophe' (double for U5MR thresholds)
Sphere Project Note: if baseline is not known, Sphere goal is CMR ‹1 per 10,000 per day	Context-specific CMR (U5MR): Sub-Saharan Africa: 0.44 (1.14) Latin America: 0.16 (0.19) South Asia: 0.25 (0.59) Eastern Europe, Former Soviet Union: 0.30 (0.20)	Emergency if CMR (U5MR): Sub-Saharan Africa: 0.9 (2.3) Latin America: 0.3 (0.4) South Asia: 0.5 (1.2) Eastern Europe, former Soviet Union: 0.6 (0.4)

Figure 23: Mortality thresholds by agency. Source: Checchi & Roberts, 2005, p. 7

> *"Adopting different baselines (for example 0.25 per 10,000 per day in Eastern European countries and 1.1 per 10,000 per day in Darfur) is clearly useful to distinguish mild alterations in mortality from true crises that require an urgent intervention. On the other hand, their strict application would mean that threshold mortality in Darfur must be five to six times higher than in Europe before emergency relief is organised, further exacerbating the already serious aid differential between African and other populations in crisis"* (2005, p. 7).

However, posing 0.5 deaths/10,000 person-days as a generalized threshold for emergencies in all field sites poses another set of problems. Indeed, these thresholds have been brought into question from inside MSF, by Fabrice Weissman[1], in an article published in June 2018. Weissman

[1] Weissman is a Research Director with training in political science, in the CRASH, or *Centre de réflexion sur l'action et les savoirs humanitaires*.

starts by showing that baseline figures and mortality thresholds have a concrete effect on the allocation of resources and the conduct of operations inside MSF.

> *"Using the emergency threshold of 1 death/10,000/day, MSF epidemiologists estimated that during the first semester of 2015, the overall situation of displaced people and residents living in Maiduguri in Northeast Nigeria wasn't catastrophic - despite the fact that more than one million villagers had recently sought refuge in town to escape the abuses of Boko Haram and the Nigerian army. A retrospective mortality survey conducted on Maiduguri suburbs estimated that the CMR of the resident population was at 0.19/10,000/day, while that of the displaced population was at 0.41/10,000/day. Since both values were "below the emergency threshold level of 1/10,000/day defined for the developing countries in Sub-Saharan Africa", the results were interpreted as reassuring,* ***and were used by MSF headquarters to justify reducing activity starting that December"*** (Weissman, 2018, n. pag.).

This decision was contested by the teams in the field, who considered the situation to be critical based on their observations. Weissman then argues one could consider the situation was an emergency since the *displaced* population's CMR (0.41/10,000/day) was twice that of the *resident* population's (0.19/10,000/day). However, the main point of this case study is twofold. First, Weissman suggests that the choice of *reference value* to qualify emergencies is "*highly political, since it determines the level from which we judge the number of deaths to be "excessive" enough to justify exceptional measures*." The second, and main argument, it that it is necessary to rework the assumed baseline of 0.5/10,000 person-days, which was set by the CDCs in 1985. Global mortality patterns have changed considerably in the last 35 years, meaning that "*The 1/10,000/day emergency threshold currently corresponds to four times the average mortality rate in Sub-Saharan Africa and five times the world average."* Weissman finishes his piece by recognizing that the aid sector might need an easy to remember threshold as a global standard. He puts forward the rate of 0.5/10,000/day as the new global standard for emergency, insisting that *local* standards should always be preferred.

These criticisms of mortality thresholds have been taken to heart inside MSF. Throughout 2018 and early 2019, discussions between members of CRASH and Epicentre have led to the development of a new tool for interpreting mortality surveys. As of May 2019, a beta version exists, and plans have been made to pitch the tool to operations, but it has yet to be used (to my knowledge). Developed by a team led by Mathieu G., Deputy Director of Epicentre, the tool features a map as an interface - something like OpenStreetMap or Google Maps - meant to make localized calculations of "excess mortality" easier. As previously mentioned, one of the major problems with the interpretation of mortality rates, and their use as an operational tool, has to do

with finding relevant and accurate baseline mortality rates for comparison. The map interface developed by Epicentre is meant to compensate, by making available data readily accessible.

The starting point is recognizing the limits of different data sources. Institutional data sources are not granular enough to allow "zoom" on a map. That is, when data are available, they are national, or at best regional, whereas the retrospective mortality surveys conducted by NGOs like MSF are always done in particular contexts, during particular public health emergencies, in a particular population. Furthermore, different surveys describe population structure using different age ranges, making it more difficult still to calculate the mortality that is due to context as opposed to old age.[1] And sometimes measuring mortality is not the primary objective of the survey. All this means comparison - which is what makes it possible to establish the gravity of the situation - is not always easy or even possible.

The idea then was to create a *dashboard* that would make all this data easily accessible, centralized in a single, virtual space. This was done with a map, with different filters available on the left side of the screen. I attended the meeting where this tool was presented to members of the CRASH by members of Epicentre. Here, Serge, the IT specialist working on the map, explains how it works.

> *So, the idea is to get all this data on one single screen. We chose a "map" interface, with different filters - different mortality rates - that you can apply from a lateral bar on the left. Here we see Asia, with orange bubbles scattered around. In Central Asia, one bubble has "41" written on it. Serge clicks the bubble and we zoom on the Pakistan-Afghanistan-Turkmenistan region, and different orange bubbles appear in more localized areas, with a figure corresponding to the number of investigations conducted close by. The more you click on the bubbles, the more you zoom in the location where the investigation was conducted.*
>
> *At the same time, different countries light up in blue, corresponding to the places where they have been able to get global data from organizations like the DHS, WPP and GDP.*
>
> *On the left, just above the filters, the mortality rates chosen - U5MR, CMR - appear as a bar, either in blue (regional, institutional data), or in orange (local investigations), with the confidence interval directly visible. When the mouse hovers over these bars, the zone on the map to which they refer lights up.*
>
> *Serge continues: currently, we have brought together mortality surveys conducted by MSF-France, MSF-Swiss, and Epicentre, plus 50-something surveys done by Action Against Hunger. We've got 200 surveys in total. We're thinking of giving a few institutions permission to input data directly, but that's something we must budget for. We were thinking of the LSHTM and John Hopkins, since*

[1] The example from the meeting is to say that mortality rates in Biarritz and Darfur might be similar because of different population structures, with high mortality in Biarritz being "normal" since the population is elderly, whereas high mortality in Darfur is problematic because the population is very young.

we work with them. We also need to ask other sections of MSF if they have data we can use, like the UK Manson Unit.

Mathieu G. (Deputy Director, Epicentre): but we also have to talk with Operations to see what they think, if they're ok with the kind of mental gymnastics that this would require: you compare the results of one very local survey (enquête) with data for a region, or with another survey, maybe even a few different surveys that were done in an area not too far away, or in the area where your population is coming from.

And in our server, we'll have all the data, entire reports and data sets, not just the rate calculated at the end. So, you'll be able to look at methods, the way population structure was cut up, and the objective of the survey. It'll be your job to find the data that it makes the most sense to compare the results of your survey with. We're really not making our lives any easier, I have to say.

But the work we've been doing, the point was to improve the interpretation of our surveys, and not to recreate thresholds. We're not looking for something that is predictive, that will say when the situation is an emergency.

M. (anthropologist, CRASH): but are we going to keep "double the baseline" as an emergency?

Gabriel B. (Director, Epicentre): if that's what you want!

Deputy Director, Epicentre: we could work out a more flexible version, and say that we need to be vigilant when we're at 0.5/10,000/day, and that 1/10,000/day is very serious. [...]

*Jean-Hervé Bradol (MD, ex-president MSF-France, Director of Studies CRASH): we can say that "double" is practical, it's a reminder [*un pense-bête*], to know when we need to act. We can justify that, even if it's arbitrary.*

This map interface, supported by a database of institutional data and local investigations led by humanitarian NGOs and academic institutions engaged in global health studies, orders a peculiar kind of place. No longer is the field bounded, put in a grid, and made to stand still long enough for certain features to be rendered salient. We have here a very peculiar kind of virtual space where reference jumps and hops between places, regions, and countries and is then compared with thresholds and standards. This assemblage contains a reserve of potential humanitarian events - *emergencies and crises*. This dashboard - as it is called in English even as they speak in French - affords a very specific mental "gymnastics", as Marc says: a single, localized study is compared to a series of similar, equally singular figures, calculated for different purposes by various institutions that describe population structures in different ways. Movement through this space, as rapid as the eye and the internet connection, is supported by the map as an interface. This works by "zooming" in and out of areas of the globe - it is hard to contest that this is a *global space*[1] - with some rates

[1] I would like to highlight here, once again, that our conception of the global does not stand on an opposition to the local. Following points made by Bruno Latour, to which we will return in Chapter 4, we see here how the production of the global always happens locally. As Latour states, this changes our "topology of the world". The "macro" is no bigger than the "micro"; rather, it is one more "micro". The difference is in the number and the stability of its connections to other sites (Latour 2005, especially the chapter entitled "Localizing the Global", pp. 173-190).

linking to regions or countries, and others to places sometimes as small as a village. Each study appears as an orange "bubble" or a swath of blue on the map, and is simultaneously listed in the sidebar, facilitating both *comparison and grounding* in a specific location. Singular situations are made to stand still in time and space and are then related to a series of other singular situations, and it is in this movement that the seriousness of suffering and the urgency of action become clear *at a distance*.

This is possible because of *approach*, *switch*, and *cover*; because of the tact of fieldworkers as they engage face-to-face with beneficiaries, making a place for them to be vulnerable; because the office in the field makes it possible to "map" of and "visualize" context; because a lab puts the field in a grid and circumscribes it in time. These are the modes of ordering the field of humanitarian aid.

Conclusions

Taking SusanLeigh Star and Karen Ruhleder's conception of infrastructure to think through the case of thresholds for emergency mortality rates is heuristic for coming to grips with 1/ the ways the different "fields" we have encountered in this chapter hang together and 2/ with the question of the "otherness" of the field.

In the last section, we saw the tensions between the need for customizing the infrastructure to local situations and the usefulness of setting up standards applicable "anywhere". Interestingly, Star and Ruhleder state that "infrastructure occurs", "when the tension between local and global is resolved", when "local practices are afforded by a larger-scale technology" (1996, p. 114). It is precisely this characteristic of infrastructure that makes it possible to suggest that the field is both local and global, a particular site and a general *humanitarian location*, identical to and different from itself. It is office, lab, field, and even home.

This allows us to rework Foucault's *heterotopic* theory of place. As Nigel Thrift has suggested, Foucault was "blind" to space's "aliveness" (Thrift, 2007, p. 55), and heterotopia is insufficient to the task of describing differentiation, movement, and co-incidence (that is, how different contents inhabit the same space). According to race theorist and geographer Arun Saldanha (2008), this blindness stems from the fact that the counterpart to heterotopia is the "rest" of society taken as a totality, and that heterotopias serve primarily to analyse the function of difference in this totality.[1] Saldanha also asks how one might know when a given place is a

[1] A classic example - published before Foucault's work on heterotopia became known to the wider academic public - would be Edward Said's usage of Foucauldian discourse analysis in *Orientalism* (1978), in which the Orient in the

heterotopia. In Foucault's writing, he seems to hold clear criteria for distinguishing between that which is "other" and that which is the "rest". Yet, given the long list of places that have been analysed as heterotopias[1], we might wonder if there are any places that are not "other place", where a number of orders cohabitate and overlap, each in partial connection and partial contradiction to all the others spaces. Even the home and the office should be understood as aggregates, composites, with multiple temporalities, logical orders, modes of ordering truth and subjectivities, and carrying in them the potential for radical political upheaval. If such were the case, then we might wonder if there are any places there are not heterotopias. This means there is no counterpart, and Foucauldian totality breaks down. There is nothing "other" about *heterotopia*; all that is left is *topia.*

After this discussion, it seems that taking "the field" as an "other place" only adds to the confusion. The field, whose spatial order is multiple and incoherent, existing according to alternate ethics and in distinction to bureaucracy and home (Bornstein 2005; Fox 2014; Siméant & Dauvin 2002), is also part of Foucauldian biopolitical and clinical space. Through the humanitarian field, disciplining, biopolitical interventions, supported by the clinical gaze and surveillance, extend around the globe. Many have made this argument about global health interventions, from Redfield's "minimal biopolitics (2013), Fanny Chabrol's "*prendre soin de sa population*" (2017) or to Nguyen's analysis of subjectivation through the organization of access to antiretrovirals through triage in West Africa (2010). The problem is that if we try to analyse the field as an "other place", the question becomes whether the field of humanitarian aid is "other" or an extension of biopolitical governmentality. This is a false dilemma, not least because it attributes an unmerited totality to biopolitics. This is what Frédéric Keck has argued, suggesting that while the lens of biopolitics does indicate a series of techniques for organizing connections between life, human multiplicity, and power, biopolitics does not exhaust how they can hang together, even as a form of governmentality (Keck, 2008; 2014). This also gives some precision to the argument made in

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Western canon becomes an imaginary place the "Other" inhabits, saying more about the Occident than it does about any real place in the Middle East and North Africa. But this critique can also be levelled against the postmodern geographer and urban scholar most responsible for disseminating the Foucauldian concept, Edward Soja (1989), especially in its reworked version as "thirdspace"(Soja & Chouinard 1999).

[1] "There is a plethora of cases in the literature: Main St in Disneyland (Philips, 2002), Las Vegas architecture (Chaplin, 2000), El Paso's Border Control Museum (Barrera, 2003), a Buddhist monument in Kathmandu (Owens, 2002), ethnographic exhibits (Kahn, 1995), 19th century women's colleges (Tamboukou, 2000), Vancouver's public library (Lees, 1997), factories (Ahlback, 2001), alternative theatre (Cheng, 2001), Istanbul's Four Seasons Hotel (Kezer, 2004), Greek-American fiction (Kalogeras, 1998), cyberporn (Jacobs, 2004), coops (North, 1999), Kafka's oeuvre (Bogumil, 2001), Johannesburg's `security parks' (Hook and Vrdoljak, 2002). Global capitalism (Wilke, 2003), media technology (Jones, 2004), landscapes (Guarassi, 2001), and postmodernity (Relph, 1991) are said to be in themselves heterotopic because they bring disparate elements together. One wonders where there is still space left for mainstream society" Saldanha, 2008, p. 2083.

Chapter 1, that *humanitarian politics* is nongovernmental and displaces the boundary between ethics and politics. Of course, humanitarians do engage in practices that can be assimilated to governmentality. However, as the reader will have noticed, we have also spent a great deal of time detailing the multiple and sometimes contradictory tactics made available through humanitarian assemblages oriented towards exploring an uncertain world and the provision of care. This is very different from a *dispositif* unified around a monolithic discourse and the strategies it affords. Explo/action does not boil down to knowledge/power; but neither is knowledge/power excluded from explo/action.

To get past the dead-end of an either/or, we have followed Annemarie Mol's suggestions for dealing with difference and order. Mol deals specifically with how the body figures in medicine, but her theses are inspired by her work on space and topology (that we encountered and discussed in the Introduction, in our presentation of post-ANT, and in Chapter 1 *apropos* of mobile territory). Recognizing Foucault's tendency to totalize, she summarizes the *Birth of the Clinic* - with Foucault at his most structuralist - as follows*:* "Thus, it is medicine that allows society to mimic organisms. And its own knowledge hangs together, too. It forms an *episteme*: a logically coherent *body of knowledge"* (2002: 60, emphasis in original).[1] This conception of the body - a unitary, organic system, with function-specific organs, pathological and normal states - is the model for many organicist conceptions of society. Mol's contribution is to rework how the body is enacted in practice by paying attention to "differences in medicine" (Berg & Mol 1998), and to suggest that a renewed organicist conception of society could follow. Not a unitary, coherent body/society, that is *known*, but a multitude that hangs together in the plural practices of ontological co-ordination. Not one *order* that relates to knowledge-power, but *modes of ordering* an enacted body/society. Not a single discourse, order, or *episteme*, but sets of patterns, in the plural, that are attempts at ordering, not orders. These attempts at ordering are performances, embodiments, enactments, that interact, inhabit the same space, change, face extinction. And yet they hang together, dynamically, in partial connection.[2]

[1] It is no coincidence the Mol takes the *Birth of the Clinic* to attack Foucault's structuralist tendencies: published in 1963 at a time when structuralism was taking over Paris, the book is, in the terms of Dreyfus and Rabinow, a "methodological overaction" (1983, p. 12) to his foray into hermeneutics in *Madness and Civilization*, which he explicitly calls for doing away with "commentary" and for "structural analysis" of medical perception. Dreyfus and Rabinow go so far as to call *The Birth of the Clinic* "an extreme swing towards structuralism" even if his was not a search for "*atemporal* structures" (p. 15, emphasis in original). This structuralist bent continues in his 1966 *The Order of Things*, and, as I have claimed in this chapter, his 1967 article on heterotopia (made public in 1986).

[2] A second important reference on *modes of ordering* is John Law's *Organising Modernity* (1993).

We began this chapter by asking what was so "other" about the field of humanitarian aid. What we have discovered is that the field is not an "other place" to a single given order but is crisscrossed by multiple modes of ordering in tension. We explored *modes of ordering* the field through explo and action, and in hindsight, we claim that these *modes of ordering* concern not only *practices of place* and *epistemic infrastructure*, but also *tactical positioning* and *tactful inter-facing*. That is, explo/action orders an open field where beneficiaries are simultaneously an adversary, a target of aid, and someone from whom humanitarians seek recognition and to whom they are responsible. It is the tension between these modes of ordering, as they constrain and strain space, that produces the field as *one* humanitarian location (among many). The epistemic infrastructure that supports these practices of explo/action also meant that our conception of place does not stand on the opposition between locality and globality: the field as a place is in part the result of the resolution between the local and the global. The field, *opened* by explo/action, is held together in the tension between knowing/enacting *one* field and finding/caring for *one* beneficiary. The field of humanitarian aid is not the "other" for some structure, an outside that produces an inside - what Deleuze & Guattari have called the Foucauldian "*Dehors-intérieur*" (2013b, p. 114) - or a diffusion of any one mode of governmentality. The field as a place is the result of multiple modes of ordering difference, in an open-ended attempt to hold them together through tactical positioning, tactful interfacing, the practices of place and the epistemic infrastructure that put the office and the lab in the field. The otherness of the field stems from its position as a point of contact and, as such, a reservoir of humanitarian events.

We now turn to these events - *emergencies* - and to one way of ordering them - *triage*.

Chapitre trois
Une plateforme pour mettre l'urgence en ordre.
Triage et transfert au service des accidents et des urgences

Dans le chapitre 3, nous sommes enfin prêts pour aborder le problème du triage. Notre approche consistera, de nouveau, à prendre au sérieux ce que font les praticiens et à bâtir notre analyse à partir de leur réflexivité. L'argument principal du chapitre sert dépasser les analyses qui font du triage un « choix tragique », le sacrifice d'un bouc émissaire pour le renouvellement d'un ordre social. Pour nous, triage sera une pratique qui crée la possibilité de sauver certaines vies à des moments où il est particulièrement ardu de répondre aux deux questions de l'éthique : *qu'est-ce qui se passe ici ?* et *que devons-nous faire ?* Pour faire ce point nous examinerons un projet de MSF dans les bidonvilles à l'est de Nairobi, composé d'un centre d'appel, d'un service d'ambulance, et d'une salle de traumatologie. MSF reçoit des appels, expédie des ambulances, stabilise les patients, puis tente de les transférer vers des structures de soins publiques. Nous appréhenderons cette installation en tant que *plateforme pour les urgences*, regardant le moment où MSF accepte la responsabilité pour des patients et ensuite tente de transférer cette responsabilité, c'est-à-dire, le triage et le transfert.

1. Ethique de plateforme. Pour commencer, nous chercherons des ressources analytiques, sachant que celles-ci doivent rendre compte de deux spécificités des projets de MSF: la préoccupation humanitaire pour les problèmes de la *substitution* – il s'agit de ne pas faire ce que d'autres font – et de l'*intervention* – il s'agit de réorganiser l'accueil en urgences dans les hôpitaux publics à Nairobi. Ainsi, nous décrirons ce projet en tant que *plateforme*, nous référant au travail de Cambrosio & Keating (2000, 2003) : le triage et le transfert se passent depuis un espace qui est à la fois un réseau technique et un projet politique. Ensuite, nous chercherons comment analyser l'éthique d'une telle plateforme. Nous discuterons, donc, avec Cambrosio *et al* (2006) et Daston (1992) d'une économie morale de la plateforme basée sur une objectivité « régulatoire », mais aussi avec la sociologie de l'accueil en urgence (Hughes 1976 ; Nurock & Henckes 2009; Hillman 2014 ; Dodier & Camus 1997a, 1997b), ainsi que la bioéthique (Iserson & Moskop 2007a, 2007b) et l'anthropologie du triage (Lachenal *et al* 2014) et du triage humanitaire(Redfield, 2013 ; de Waal 2010). Notre critique principale des approches socio-anthropologiques consistera à pointer la manière dont celles-ci transforment l'éthique en *une opération mentale*, un raisonnement aboutissant à l'arbitrage entre principes ou écoles de philosophie morale. Ce n'est pas cela que font les praticiens en situation de triage. Notre approche exige de regarder un protocole de triage – le START+ protocol – tel qu'il est utilisé par MSF. Nous verrons que le triage répond à deux questions difficiles lors des situations d'urgences : *qu'est-ce qui se passe ici ?* et *que devons-nous faire ?* Il donne vie à des options jusqu'à là inimaginable – sauver des vies – en orientant l'attention des praticiens et en mettant en ordre l'urgence.

2. Une enquête sur le protocole SATS. Nous portons maintenant notre attention sur un deuxième protocole de triage en place à Nairobi : le *South African Triage Scale* (SATS). Il s'agira de rendre

compte de comment il devient possible, éthiquement, pour le personnel médical de MSF à Nairobi de disqualifier moralement certains patients qui se présentent dans leurs services en tant qu'« hystériques », « exagérateurs », ou « menteurs ». L'hypothèse est qu'en regardant ce que le protocole exclu en le disqualifiant, nous comprendrons mieux ce à quoi il rend attentif. La deuxième sous-partie nous plongera dans l'histoire du développement du protocole, pour conclure qu'il s'agissait, pour ses développeurs sud-africains, de créer un outil pratique, fiable, et équitable, qui répondait aux défauts du système de santé national. Dans la dernière section, nous regarderons en détail la manière dont ces besoins différentiels sont établis par le protocole de triage par l'attribution d'un *score* et d'une *couleur*. Nous verrons comment le protocole performe des corps qui sont toujours déjà fragiles, sur le point d'une détérioration rapide et irréversible. Enfin, nous verrons que cette fragilité fait que le *score* attribué est rapidement périmé. La description ethnographique nous indiquera que le triage n'est pas une opération faite une fois pour toute, mais une forme de vigilance, d'attention continue, et ce même pour les patients qui « exagèrent » ou « mentent ».

3. Le transfert de patients et l'intervention depuis la plateforme pour l'urgence. Une fois que MSF a accepté la responsabilité pour les patients dont les besoins sont « urgents », elle cherche à transférer cette responsabilité vers des structures de soins publiques. Il s'avère que les structures kenyanes ne sont pas toujours disposées à accepter cette responsabilité. Il s'agira de comprendre comment fonctionne le transfert et ce qui le rend difficile. Le premier point est que la place de MSF sur la plateforme pour l'urgence est difficile à saisir pour leurs partenaires kenyans : entre les soins primaires et secondaires, elle dispatch des patients selon leur niveau de besoin, parfois en sautant des niveaux. MSF peine d'autant plus à stabiliser des parcours de transfert que le système public connaît des grèves récurrentes depuis plusieurs années, et que le niveau de soin que peut proposer réellement une structure ne correspond pas nécessairement à son niveau officiel. Etant donné que l'objectif principal de MSF est d'augmenter l'accès aux soins hospitaliers pour la population des bidonvilles, les problèmes du transfert de patients tendent à remettre en cause son mandat humanitaire et certains à MSF se demandent si le projet est un échec, ou si le projet relève plutôt du développement que de l'humanitaire.

À la fin du chapitre, nous aurons décrit les urgences humanitaires en tant qu'elles sont mises en ordre depuis une plateforme médicale, par la mise en ordre de l'attention vers la fragilité de la vie humaine, tout en intervenant dans un système de santé national, dans une tentative – partiellement ratée – de transférer cette plateforme vers le ministère de la santé kenyan. L'approche se distingue donc d'une approche du triage comme opération mentale, en ce sens qu'il se saisit du problème par une description fine du triage en pratique. Les problèmes ne sont plus celles des écoles de philosophie morale et du bouc émissaire, mais de l'attention, la responsabilité, et des options vitales.

Chapter Three

A Platform for Ordering Emergency. Triage and Patient Referrals in an Accident & Emergency Department

Question: How does humanitarian triage order emergency?

The following is an excerpt from an interview conducted with Lucy, an Emergency Medical Technician (EMT), working on an MSF project in the Eastlands of Nairobi. The project includes a Call Centre, an Ambulance service, and a trauma room. The project's primary objective is to increase access to hospital care for slum inhabitants. Here, Lucy tells me of a time when she was the first responder on site when a five-story building collapsed.

> ***EF**: Could you give me **an example of an MCI [Mass Casualty Incident] where you were the first team on site and you had to deal with the situation**, and how you did that? I don't know if there have been any MCIs that you've been on recently?*
>
> ***Lucy**: There are many. There is which even I was the one who called. Yes, it was a building that just collapsed, hum. I [live] in the catchment area,[1] yes, when you are on your way to Mama Lucy, I stay just around. So that evening, there was a building that collapsed. And I heard the building that collapsed, it was just about 500 meters from where I stay. And it was in the evening.*
>
> *So, first of all, **I had to know what has just happened**. So, I got closer, and I asked a few people who are around. Of course, they are so worried, they are anxious, they are screaming. And I asked them just one question: did we have occupants in this building? Yes. **That was enough information to know that it's an emergency.** So, I called the Call Centre, and they sent an ambulance. At that time, **I was not on duty, but somehow, I found myself on duty, because you are able**, from the time the ambulance came.*

[1] The "catchment area" is the geographical zone for which MSF's ambulance service provides emergency response. In human geography, a *catchment area* refers to the zone from which an institution attracts the population that uses its services. In natural geography, a *catchment area* is the zone from which water flows towards a lake or a reservoir.

What normally happens in such a case, most of the time, ***there is no order****. So, you will arrive,* ***the first ambulance who arrives, it's just chaos****. You get to the scene, and people are trying to get patients into your ambulance. Because they are thinking that these patients need to be taken care of immediately. So, they just try to get patients into the ambulance. So, it's upon you to try and* ***sort out the mess. To triage, to maybe set up what is supposed to become of the situation and maybe to try to work it out systematically.***

So, for that time, when they arrived, I was there. Because I had to change into my ***uniform****, and get something for* ***identification*** *better. "****I am a medic, and I'm here to assist.****" So, at that time, when they came, I had to assist them to do* ***Vital Signs****, and to* ***assess*** *the patients, to know which patients will be taken first to hospitals. And which ones not to take to the hospital. But, now, fortunately, we've been there about one hour, or one and half hours,* ***everything had normalized, and now we had like a triage area set up by MSF. So, it was MSF in charge now.***

EF*: At the site?*

Lucy*: At the site, yes.* ***So, MSF was doing all the triage, then they give to other ambulances to refer.*** *Fortunately, in Kenya, when we have an MCI, we don't have any* ***problems in referring****. Because whenever Kenyatta [National Hospital] is called and there is an MCI they just receive all patients. They are just coming. And they don't ask them to go, and stay for cards, to do this and that.* ***So, everything moves very fast. So that's what was happening at that time.*** *Yes. Many patients, like when MSF set up a place, we had our equipment ready. Nobody slept in their house that day. All of them, at that time, we had Christine, as the [Project Coordinator]. So, she was on the ground with all other staff.*

So, you are assisting to triage the patients. ***If a patient is Black, they have already died, you give to the police to take to the morgue. If a patient needs to be referred, systematically, there were so many ambulances from other agencies, not only from MSF. So, they were just receiving the patients and taking them to hospital.***

It's an incident that took almost three days. *Yes. Because it, I think, it was a five-story building. Yeah, so before they get to the last, to the ground floor, yeah. You have to be on the scene, throughout. Yeah. But now in the same, in that case, you know about the Red Cross, they normally set up a tent, like now, for information, counselling. Then material starts streaming in, to assist the people who have been affected. Like linens, food, water. Yeah, they normally take care of that. Whenever, whenever there is an emergency. So basically, that's one that I can really remember,* ***we have had two incidents of buildings collapsing in the same area****. Yes.*

EF*: In Mathare? Which part of Mathare?*

Lucy*: In Huruma. Yes, in Huruma, we have had in Huruma. Which I can remember. I stay in Huruma, maybe that's why I can remember them so well. Yeah. But apart from building collapsing, we also have like RTAs [Road Traffic Accidents].* ***When you arrive on the scene, and there's an RTA, you have to take charge. If you are the first one on the scene, you triage.*** *Then after triaging, you will have to call the Call Centre for back up and maybe if there is need to activate other agencies to come and respond, to come and assist. So, we also had, once we had* ***a bus which just overturned on the highway, and we had so many casualties.*** *So, we went on the scene, but we were not the first ones, so we were not doing triage, but just to get on the scene, get a view of what has happened, maybe get from the people who are there, and they are just like,* ***"this is the patient who needs to be taken care of"****. Yes.*

When you arrive on the scene after a five-story building collapses, or when a bus full of people has overturned on the highway, it is "chaos". People are confused, in shock. If you are the first person on site to have the skills to know what to do, then "*somehow, [you] find [your]self* ***on duty***". Your duty is to try to figure out "*what is going to become of the situation*". Some of the people around the accident site try to push patients into the ambulance and you must tell them no. Other members of staff said there are times when a crowd gathers and insists that a specific patient obtain immediate attention. This can make their job dangerous. By way of contrast, the EMT's job is to work out what is going to come of the chaos "*systematically*". They bring "order" where there was a "mess". They can do this because their uniforms make them identifiable as medics. Their uniform says, "*I am a medic, I am here to assist*." To establish "order", to "sort out the mess", to figure out what is going to become of the situation, they do *triage* and they *transfer* patients to other responsible institutions. Through triage, they can do this systematically. They tell the ambulance teams who to take to which destination. They tell patients in mild need to seek care in Primary Health Care (PHC) facilities. They tell the police to take the bodies away. They "*take charge*". In the following days, the Red Cross and public outpour of support bring tents, water bottles, linens, and psychological counselling. But in the 180 minutes following the incident, the responding organization – here, MSF – figures out what is happening and begins a process of ordering.

In this chapter, we will describe the *platform* that makes the ordering described by Lucy possible. This is the third humanitarian location we encounter. We saw, first, how humanitarian space was set up as an incursion of the governed into the territory of governing bodies, and how this nongovernmental space was thoroughly ethical in its politics. We must retain this lesson for the present chapter: MSF's activities in Nairobi question *how* government is conducted, to the point of developing alternatives, but they do not question *that* there is government or *who* governs. In Chapter 2, we saw how the field, and fieldworker/beneficiary relations, were ordered through explo/action, which subsumed Foucauldian knowledge/power dynamics, and introduced the possibility of care at the inter-face. This, too, is a lesson to be retained for what is to come in this chapter. Relations between field workers and beneficiaries will be ordered through the complex relations of knowledge production and the ambiguities of humanitarian care. In **this chapter**, we describe *a humanitarian platform for emergencies*. Following Cambrosio and Keating, we take a platform to be a kind of *assemblage* that entails a *project* (2000). Throughout this chapter, we focus on the twin activities of *triage* and *patient referrals* as they are ordered from, and for, the platform. We will concentrate on the *ethical effects* of the ordering accomplished by the platform. Once

again, we respond to this dissertation research question by describing the ethical effects of a spatial configuration through the ordering of attention.

This chapter's outline includes three sections: 1. Platform Ethics, 2. An Inquiry into the SATS Protocol, and 3. Patient Referrals and Intervention from the Emergency Platform. We summarize here the argument of each section before moving ahead.

3. Platform Ethics

To begin, we will be looking for analytical resources. We will start with the sociological literature on patient admissions in emergency departments and see that MSF's A&E department presents two specificities that make the translation of such approaches difficult. These specificities have to do with MSF's status as a *humanitarian* organisation and their concern for *substitution* and *intervention*. To render these two specificities, we will propose describing MSF's A&E set-up in Nairobi as a *platform for emergency*. In what remains of this section, we will look for a way to re-integrate the sociological concern for the *values* of triage into our analysis, absent or underrepresented in the literature on platforms. First, we will discuss the dominant approach to the ethics of triage in anthropology and bioethics, which I call the "tragic choices" approach. My critique of this approach is that it turns ethics into a mental operation of reasoning through competing principles, rights, or schools of moral philosophy - Tronto's "moral point of view". Second, I will make a proposition meant to allow for a reintegration of *platforms* and *ethics*. To do so, we will look at the START+ triage protocol used by MSF in MCIs in Kenya as described by Lucy in the interview extract above. We will see that the "tragic choices" approach misses essential characteristics of *triage* as part of the *platform for emergencies*. Namely, triage allows practitioners to answer two difficult questions during situations of emergency: *what is it that is going on here?* and *what is that we should do?* After this, I put forward an alternative mode of ethical analysis, attentive specifically to how triage participates in ordering attention and bringing to life options in situations of choice during emergencies.

4. An inquiry into the SATS protocol

In the **second section**, I will build on my proposal to study *triage ethics through the ordering of attention on the platform* to analyse the triage protocol in place in MSF's A&E service in Nairobi: the *South African Triage Scale* (SATS). In **2.1**, we will first look at those situations where there are expressed needs to which the platform orders *inattention*: patients who express needs that cannot be rendered in the language of the platform elicit a moral disqualification from MSF staff as "hysterics", "exaggerators", or "liars". This will help us get our first inkling of how

the platform for emergency orders *attention*. In **2.2**, we will explore the history of the protocol to better understand how it came to order ethics in such a peculiar way. Through a discussion of the scientific literature presenting and critiquing the SATS protocol, we will see how the higher-order justifications for triage implied the design of reliable and practical tool that took into the consideration the shortcomings of the South African health system, while also allocating resources according to the relative needs of South African patients. Finally, in **2.3**, we will explore how those relative needs are established in more detail, through a discussion of how the triage protocol works. We will see what it means to enact bodies that are always already *fragile*, on the brink of rapid deterioration, and what this does to the question of *reference* in the epistemology of the triage device. Specifically, the *fragility* of bodies makes the triage score *unstable*, always already out of date. This means that triage is not a one-off operation, but a constant vigilance with regard to patients, even those who seem "hysteric". This is the kind of *attention* that the SATS protocol orders.

5. Patient Referrals and Intervention from the Emergency Platform

In the final section, I will be discussing the ways MSF's platform for emergency supports the coordination and the ordering medical interventions across institutions. To do so, we will be looking at *patient referrals* from the platform to health facilities in the Kenyan public health system. In **3.1**, we will provide an account of the platform as a site from which refers patients are referred "up and down", according to the "*level* of care" the patient requires. Referred "down" to Primary Care and referred up to hospital-level care (Secondary or Tertiary). The position of MSF's platform on this *scale* – somewhere between Primary and Secondary care, responsible for dispatching emergency patients to adequate definitive care whatever the *level* – has caused misunderstandings and made it difficult to refer to the Tertiary Care facility. In **3.2**, we will then discuss difficulties in *referrals from the platform* as they relate to problems of unstable reference in referral sites. Due to a series of strikes in the Kenyan health system in recent years, and the disparity between the *levels of care* Kenyan facilities are meant to provide on paper, and the quality and quantity of care they are able to provide in practice, it has been difficult to stabilize reference and establish routine referral pathways. Finally, in **3.3** we will show how these problems of scale and unstable reference to referrals sites link to questions of the *humanitarian remit.* Some inside MSF have held that the overarching goal of increasing access to hospital-level care through the emergency platform is a *development*, not a *humanitarian* objective. Others prefer to focus on what actual improvements have been made over the long term: these consist in effectively transferring

bits and pieces of the *platform for emergency* to specific sites in the Kenyan health system, supporting Kenya's recent recognition of emergency medicine as a speciality.

At the end of this chapter, I will have described *humanitarian emergencies* as a medical platform that orders attention to the fragility of human life, while intervening into the national health system in a largely, but not totally, failed attempt to transfer this platform into their hands. My ethical approach in terms of *attention* will allow me to grasp ethical ambivalence of prehospital triage, while describing what, exactly, MSF hopes to *transfer* to the Kenyan health system. They hope to transfer a *platform for emergency* that orders *attention* to fragility and gives priority to greater fragility. This will allow me to render the specificity and ambiguity of the MSF's humanitarian intervention in Nairobi.

1. Platform Ethics

In this section, we will be looking for analytical resources to deal with the problem of bringing order to the chaos of emergency. We start with work in sociology on patient admission, which, as we will see, are unable to account for two specificities that MSF's A&E project presents (*substitution, intervention*). To render these specificities, I will put forward the concept of a *platform for emergency*, and exploring work in anthropology and bioethics on the ethics of triage, I will put forward a proposal to analyse the ethics of the emergency platform by describing the kinds of attention it orders and the options this attention brings to life.

a. The sociology of emergency admissions and the specificities of MSF's A&E

The sociology of medicine has shown interest in patient admissions at Emergency and casualty departments from the 1970's to the present, in the United Kingdom, the United States, and France. Considering that Emergency Medicine was recognized by the American Medical Association in 1978, we can say that the sociological gaze has rendered emergency medicine into the language of the social from the moment this speciality came into existence. Some of these authors have been interested in how common-sense knowledge affects patient admission. David Hughes' pioneering article (1976) effectively demonstrates that the border between "common-sense" and "expert knowledge" in medical services is less clear than might be thought. He shows that common-sense social categories - concerning class origins, age, or the consumption of psychoactive substances - regularly influence decision-making in a "casualty department" in the UK. Others have asked what value presenting patients represent to medical staff. In doing so, Nurok & Henckes (2009), follow in the footsteps of work on the "value" or "worth" of patients (Sudnow

1967; Glaser & Strauss 1968).[1] In an attempt to reconcile this patient "value" approach with more structural explanations of medical decision-making (Freidson 1988), they compare the US and French A&E departments, and show the different kinds of values – social value, technical value, competence value, medical and surgical value, heroic value – exist in a "fluctuating economy" that inform the mobilisation of emergency medical teams. In line with more recent conceptions of the performance of identity (Butler, 1990), Hillman's work (2013) demonstrates how patients arriving in an emergency department in the UK must "perform" the legitimacy of their demand for health care. This takes place during the "negotiation" of triage, where self-presentation and identity work must confirm the patient's individual responsibility in their health state, which leads to staff placing them in in "positive or negative" categories. Together, this body of work seeks to qualify what the "good patient" in the Accident & Emergency department.

Despite the productivity of sociological analysis, a humanitarian A&E department presents several specificities that escape the above-mentioned approaches. Insofar as these specificities relate directly to how a humanitarian organisation claims to bring *order to emergencies*, we will miss something essential that MSF's A&E project accomplishes if we do not take them into account. In the following paragraphs, I will succinctly describe MSF's Accident & Emergency set-up and the present these two specificities. These specificities related directly to its being a *humanitarian* project for medical emergencies: a concern for what is called *substitution* and the form of its *intervention* into the Kenyan health system. These two specificities will then be seen to relate to *triage* and to *patient referrals.*

MSF's project in Nairobi is composed of a Call Centre, an ambulance service, a triage protocol, and a trauma room. This platform for responding to emergencies supports different patient pathways: patients can walk into the A&E service or an ambulance can go pick them up. *Triage* and *patient referral* are central to both. "Triage" entails the rapid assessment of presenting patients' health states in view to attribute an order of priority in care. The result of triage affects the medical acts that staff accomplish. "Referrals" entail the rapid transportation of emergency patients to sites of definitive care, at higher levels of care (Secondary, Tertiary) in the national health care system. Both are essential to prehospital emergency medical care. In MSF's set-up in Nairobi, both present ethical and practical specificities with regard to the A&E departments studied

[1] We will return to a discussion on value and worth in Chapter 4.

in the United States, in the United Kingdom, and in France by the above-mentioned sociologists (Hughes, 1976; Nurok & Henckes, 2009; Hillman, 2013).

The **first specificity** is related to what MSF practitioners call *substitution,* and the effects this has on *prehospital triage*. Unlike most emergency departments, MSF's A&E only provides health care to patients in *urgent need*. In France and the United States, it has been shown that people with inadequate health coverage use emergency services for routine care (Belorgey, 2013; Nurok & Henckes, 2009). If patients are willing and able to wait, they will receive care. MSF, by contrast, specifically refuses to provide "routine" primary health care and "routine" care for chronic diseases. The reason for this has to do with results of an epidemiological field study conducted by MSF in 2013, which indicated that MSF's "target population" - the inhabitants of the slum - did not "need" routine care. The public health system was adequate in this respect, and if MSF opened a clinic providing the same kind of care, they would run the risk of *substitution*.

Substitution is a common problematic for MSF. By *substitution,* they refer to those interventions which would take over activities that rightfully belong to public authorities. In their project for foreign minors in France, this means they only provide nurse consultations – not consultations with a doctor – and they only offer short-term emergency shelter solutions for minors sleeping in the street. For MSF, long-term solutions for accommodation, and medical care are the responsibility of the French state. Nurse consultations enable MSF to direct foreign minors to the correct public health services with a specific medical demand written on the referral form filled out by a nurse. The provision of short-term shelter allows them to deal with accommodation emergencies for minors, while gathering information on their situation, which enables them to make credible public statements on the inadequacy of the French state regarding French law.

This concern for *substitution* has a direct effect on triage practices in Nairobi. To avoid *substitution,* they do not provide Primary Health Care in an Accident & Emergency department, as this would run the risk of taking patients away from public Primary Care facilities. If this were the case, such facilities might see a drop in the number of presenting patients, which could potentially influence budget allocations. Cooren *et al* (2008) have shown how MSF's role as a *substitute* for health services in the DRC meant the revenues of these structures dropped and making it harder for them to assume responsibility for care when MSF left.[1] In other words, providing Primary Health Care could potentially have adverse effects on the Kenyan health system. A&E departments

[1] On the problematics of *substitution* on MSF's "migration" projects, see also (Neuman, 2019).

in the US, UK, and France provide primary care and do not turn these patients away. Triage practice in MSF's A&E platform in Nairobi entails *refusing routine care* to patients in need, in order to identify patients who require *urgent care*. Once triaged, these patients are referred to the Kenyan health system.

As such, an important analytical point to be made in this chapter will relate to the instruments available to MSF staff as they detect "emergencies" and turn away "routine" cases, and the ethical effects of refusing care to some. Such instruments are *prehospital triage protocols*. I will be presenting two such protocols. The first is the START+ protocol, used during the Mass Casualty Incidents (MCIs) described by Lucy in the above interview extract. The second is the SATS protocol, used by MSF staff for walk-in patients in their trauma room and by EMTs and nurses when they arrive on site for ambulance response. The primary difference between the two protocols relates to the case profiles they are capable of dealing with: the START+ protocol is primarily for trauma – the most common form of emergency during MCIs – and the SATS protocol is capable of performing accurate triage for patients with both trauma and medical emergencies. Both attribute a colour code based on the urgency of need. "Green" cases refer to patients who require "routine care". They are directed to Kenyan Primary Health Care facilities. MSF's only takes Yellow, Orange[1], and Red cases. Black cases, the "expectant", are already dead or beyond the ability of medical staff to save. MSF turns them over to the Kenyan police, who transport them to the morgue.

A **second distinguishing characteristic** relates to how this A&E department connects to other hospital departments: MSF's A&E department is not attached to a hospital, either physically or through a formal agreement. There are, of course, significant differences between how individual emergency departments connect to other specialized hospital departments around the world. Michael Nurok's 2001 article is interesting in its comparison of US and French systems in this regard. He analyses controversies following the death of Princess Diana in 1997, which arose after US emergency physicians claimed Diana would have survived the car crash if it had taken place in the United States. They claim that the US *"scoop and run"* emergency response model is superior to the French "*stay and play*" model. The US model is based on light, rapid, protocolized response done by nurses and EMTs, where the priority is getting the patient to a hospital-based A&E department as quickly as possible. The medical team in the A&E, better equipped to stabilize and

[1] The START+ protocol does not have an Orange colour code.

diagnose patients than the ambulance, then decides the department to which they will send the patient for definitive care. French ambulance teams, by contrast, are led by a physician, whose priority is to stabilize patients on-site before taking them directly to the hospital department where definitive care can be provided. These are two different models for A&E platforms in their relations to sites of definitive care.

It is difficult to place MSF's A&E set-up in this comparison: teams are composed of EMTs and nurses, who provide heavily protocolized care, and transport can be directed either to sites of definitive care or to A&E departments, depending on the case profile and difficulties in referrals. An important contrast, however, is that MSF does not have a formal agreement with those places it refers patients. It is not directly attached to any hospital and must send its patients to the national health system for definitive care. This is outside of MSF's institutional boundaries and represents an *intervention* into the territory of another institution. By *intervention*, I mean that through referrals, MSF comes between these hospitals and their patients, effectively reworking and redefining the kinds of relationships that are possible between them. MSF meets resistance from the staff in the Kenyan health system as they refer patients to them (for reasons that we will explore in the third section of this chapter). The point is that this is not the case in the Emergency departments described in the literature discussed above. A&E departments in Europe and North American are an essential contact point between the population the hospital serves and specialized hospital departments. Patients present in the A&E and, according to their needs, they can be sent directly to appropriate definitive care in the same structure. While there is of course negotiation between departments for high or low "value" patients inside a single health structure - as has been demonstrated by Dodier & Camus (1997b) - systematically referring patients from a humanitarian A&E to public health facilities for definitive care, with whom no formal agreement has been established, poses a different set of questions.

In another article from Nicolas Dodier & Agnès Camus (1997a), we find an attempt to link the pragmatics of patient admissions to historical, hospital-based "forms of response to suffering"[1]. This could be a resource for describing the ways MSF A&E department is connected to the question of *intervention* by contrasting how MSF responds to suffering and how the Kenyan health system responds to suffering. Dodier & Camus have convincingly shown that the spatiality of patient recruitment (local, national, transnational), the kinds of suffering for which the hospital provides care (wide variety of forms of suffering, biomedical problems, suffering interesting for research

[1] "Formes de prise en charge du malheur", my translation.

purposes), and the forms of exchange expected (care provided free of charge, socialized exchange through social security, suffering that is interesting for medical research) can help qualify historical forms of response to suffering in French hospitals. They suggest three different forms: *hospitality* extended to the suffering based on geographical proximity to hospital and common religion; *collective management* of medicalized suffering based on belonging to a national collective and the social solidarity of salaried work; dynamics of *medical innovation* based on the suffering being of interest to teams of medical researchers who recruit across the world.

Building on Dodier & Camus' approach, we could suggest that MSF's admission of patients in proximity to their A&E service is based on specific biomedical criteria assessed during triage that establish the *urgency* of care. Services are unconditional and free. The conception of the *human* embedded in such a model is based on cosmopolitan ethics (Ignatieff, 2006), or the moral sentiments of the Scottish Enlightenment that made a universal "human" conceptually possible for Europeans[1]. I could then show how the Kenyan health system recruits locally, based on ethnicity, nationality, or participation in the national economy. We might find that suffering is medicalized and collectively managed. But there are several important elements in MSF's A&E set-up that would escape such analysis. If we were to use Dodier & Camus' approach to historical forms of *response to suffering* and contrast MSF's and a contemporary Kenyan form, we would still not be able to qualify MSF's presence in Nairobi as a form of *intervention* into the Kenyan health system. We would have two *forms* sitting side by side. But MSF's services are both *inside* the national health system – insofar as they refer systematically to public health services, provide material support Mama Lucy Kibaki Hospital, conduct public health inquiries in Kenyan public hospitals and train staff there – and *outside* the national health system – they are a French NGO, with private funding and staffing from across the globe. Over 80% of staff are Kenyan, with a few Kenyan managers, even if most managers are from elsewhere (Japan, Nigeria, France, Belgium, Sudan, and Burundi). Yet the Kenyan health facilities where they refer patients reserve the right to refuse admission of new patients – even when MSF insists on the patient's immediate need for care – and to ask patients (referred to as 'clients' in the Kenyan health system) to pay for the health care they require. Furthermore, MSF's project-level objective is to *increase access to hospital-level care in the slums around Nairobi*. In the long term, they aim to transfer their platform for emergency – the ambulance service and Call Centre – to the Ministry of Health. Dodier and Camus' approach does

[1] We would reference once again Chakrabarty's analysis of moral sentiments and the universal "human", a prerequisite for humanitarian aid, cf., Chakrabarty (2009), especially Chapter 5, "Domestic Cruelty and the Birth of the Subject".

not allow us to qualify this particularity of humanitarian A&E service: MSF's presence in Nairobi is not only a form of response to suffering; it is also a project with the explicit objective of modifying the medical practices of the Kenyan public health system and to increase *access* for the slum population. It is an *intervention*.

We will need other resources for our analysis of the kind of *ordering emergencies* that MSF accomplishes in Nairobi. In the next section, I will suggest describing MSF's A&E set-up as a *platform*. This is meant to allow us to analyse the specifically humanitarian aspects of MSF's activities: the concern for *substitution* and their presence as a form of *intervention*.

b. A humanitarian platform for emergency intervention

In this section, we will describe MSF's project in Nairobi as being set on a *platform for emergency*. This meant to help render the previously mentioned specificities related to *substitution* and *intervention.*

As Lucy told us in the introduction, in situations of chaos, EMTs' systematic response to situations of chaos was to bring order through *triage* and *patient referrals*. To hold triage and patient referrals together in their humanitarian specificity, I will be talking about how a *platform for emergency* orders emergency responses. Importantly, this platform does not "belong" to MSF. MSF participates in the development of a common platform for emergency medicine in Nairobi county, but it is not MSF's platform. However, this platform is "under construction". This is because emergency medicine has only recently been recognized in Kenya as a medical speciality by Kenya Medical Practitioners and Dentists Board as well as the Clinical Officers Council. This integration of the speciality has not yet led to professionals trained in the field to be recognized as medical professionals (Wachira 2017). Lack of recognition of "emergency physicians" and "emergency medical technicians" means that there are no national standards or regulation on emergency medicine training and no nationally recognized certification. Each institution establishes its own curriculum and reference standards for their students (Emergency Medicine Kenya Foundation, 2016). An article from 2011 by Benjamin Wachira, presented as the "first and only emergency medicine specialist in the country (Kilonzo 2017)", and Ian Martin established that most doctors working in emergency departments in Kenya have no formal training in emergency medicine (Wachira & Martin 2011).

This "gap" in emergency medical services has become a topic in the national press. In an incident on October 5, 2015, a patient who had been struck by a car spent 18 hours being driven from hospital to hospital across Nairobi, before ending up at the national reference hospital,

Kenyatta National (KNH). KNH initially refused to admit the patient, because of lack of space in their Intensive Care Unit. He was finally admitted 18 hours after the event, but it was too late and the patient died a few days later. The incident inspired a popular Kenyan film *18 hours*, that follows the ambulance crew in their search for a place to take their patient. Following the film's release in 2017, a series of articles were written in many popular Kenyan newspapers. This has also been a theme of protest during recent strikes in the medical sector. In January 2017, medical personnel began using the #MyBadDoctorExperience handle to voice their complaints. Many of these were directly related to the lack of "proper" Emergency Medical Services in the country.

In this context, several initiatives have been taken to develop emergency medicine as a speciality, as well as Emergency Medical Services, generally at the county rather than the national level. Aga Khan University Hospital in Nairobi began offering the first post-graduate diploma in Kenya in January 2016, and in October 2017, the Kijabe College of Health Sciences began offering a post-graduate certificate in emergency medicine for Clinical Officers (Kilonzo 2017). The Emergency Medicine Kenya Foundation holds monthly "Emergency Care Talks" in Nairobi which count for medical staff's Continuing Medical Education. The foundation also began holding an annual conference on emergency medicine in June 2018. The second annual conference was scheduled for August 2019.[1]

MSF's is an attempt to graft onto this burgeoning platform and participate in its development in Nairobi. Let us look at the South African Triage Scale as an example. Triage protocols are an essential part of the emergency medicine platform. Kenyatta National Hospital (KNH) in Nairobi, the Level 6 national reference hospital, uses the South African Triage Scale (SATS). They receive patients from all over the country and from the larger East Africa region. It is also one of the hospitals where MSF has the most difficulty referring patients from their trauma centre in the Eastlands slums of Nairobi, as we shall see in the last section of this chapter. MSF became interested in using the SATS protocol in their own services to integrate their activities in the Nairobi emergency medicine platform using a shared triage protocol. The idea was that if they used a shared tool to describe the health states of their patients, then communication and coordination would be easier. The use of a standardised tool could participate in the coordination of an emergency response by improving referrals.

Before adopting the protocol in their own service, MSF offered to help another Nairobi hospital where they refer patients, Mama Lucy Kibaki Hospital (MLKH), set up the SATS protocol

[1] https://www.emergencymedicinekenya.org/ (Consulted 8 April 2019)

there. This entailed paying the salaries of Emergency Medical Technicians – who are not recognized as medical professionals in Kenya, as already mentioned – for MLKH's A&E service, who they then trained to use the SATS protocol. After the protocol was in place for six months, the executive medical officer for MSF's activities in Nairobi – a Kenyan national – conducted a retrospective, cross-sectional, multinomial logistic regression analysis on the link between the triage colour code and patient disposition in the SATS protocol as it was used in MLKH, as part of an MSc in Public Health at the University of Liverpool. Here, "patient disposition" is understood as "*the event that ends a patient's engagement with the treating facility either through discharge, referral, admission, death or leaving without being attended to*" (Mbaka, 2017, p. vii). This study confirmed that the rates of "over-triage" and "under-triage" – that is, the percentage of patients that are triaged to a category more serious than their actual condition (over-triage) and the percentage of patients triaged to a category less serious than their actual condition (under-triage) – were within the norms determined by the American College of Surgeons Committee on Triage (ACS-COT). According to the ACS-COT report, "over-triage" can be at 50% of cases, but "under-triage" cannot exceed 10% of cases. In other words, a valid triage protocol can *overestimate the urgency of need* in one case in two but can only *underestimate the urgency of need* for one case in ten. In those situations where the triage tool does not respect these norms, it must be adapted. This is an important point for our understanding of the ethical ordering of triage practice: it is much more serious to underestimate need than to overestimate need. After confirming that the SATS protocol functioned according to standards set in the United States, MSF put in place the SATS protocol in their A&E services in Mathare in December 2016, in part in preparation for the foreseen period of instability and violence following the August 8, 2017 presidential elections in Kenya.

This example should be enough to show how MSF participates in ordering a *platform for emergencies* in Nairobi, that does not belong to MSF. My conceptualisation of this *platform for emergency* is based, in part, on the work of Alberto Cambrosio and Peter Keating (2000, 2003). Following their work, *platform* refers to a heterogeneous ensemble of technologies, regulations, protocols, and materials that constitute, in a dynamic process, a basis for collective action. A platform is both an *instrument* and a *project*. The order it produces "*results from consistency between the various parts, be it consistency of purpose or consistently measuring distances between, for example, the components of an optical or electronic device*" (2000, p. 347). ***Consistency of purpose*** and ***consistency of measures***: this is what the adoption of the SATS protocol was understood to do by MSF.

This platform "*is less a thing than a way of arranging things in both a material and discursive sense*" (2000, p. 346). In some respects, platforms are like networks. They cut across social and institutional boundaries. They are flexible and afford different ends. They support distributed, rather than centrally planned, forms of organisation. To show the specificity of platforms, Cambrosio and Keating make distinctions between *platforms* and *infrastructure* (Star & Ruhleder 1996) and between *platforms* and *experimental systems* (Rheinberger, 1997). *Infrastructure* is meant to show *historical continuity*. It is learned as a requisite to membership in a community. Generally invisible, infrastructure is the object of attention only in moments of breakdown, and for those charged with its maintenance. *Platforms*, by way of contrast, support *timely projects* – here the project is to improve Emergency Medical Services in Kenya.[1] *Experimental systems*, fundamental to the practice of science, are "machines for producing difference", notably, the difference between science and technology. Platforms grow out of experimental systems; especially out of the distinctions they make. But platforms are not about *producing difference*, but about *regulating difference*. This is precisely what the SATS protocol does as it scores patients according to urgency of need based on a statistically validated algorithm for decision making.

My use of the platform concept serves a different purpose than that of Cambrosio and Keating. For them, *biomedical platforms* support analysis of the changing relationship between the "normal" and the "pathological" in medical practice after World War II. These new relations are inscribed in the architecture of hospitals, and specifically in the place the laboratory came to occupy, becoming an obligatory point of passage through which speciality activities in medical laboratories – haematology, parasitology, virology, biochemistry… - are connected to transversal activities. This material reconfiguration has considerable effects on the role of the "clinic" and the "laboratory" in the diagnosis of different kinds of cancer.

I am interested in how the *platform for emergencies* that MSF participates in developing, serves as both an instrument and a project for ordering medical activities with specific patients, in situations of collective emergency, and in the wider Kenyan health structure. I will be interested, specifically, in the scientific basis of medical technologies that support the protocolisation of triage in MSF's A&E department. I will be interested in how MSF's platform for emergency supports interventions into the Kenyan health system. And I will be interested in those moments when MSF

[1] Mathieu Hubert (2015) suggests that platforms can productively be described as infrastructure. He follows Leigh Star and Ruhleder's approach to show how four configurations were "platformed" (my suggestion to translate their "mise en plateforme") and made transparent, i.e., into infrastructure.

fails as it attempts to intervene into the Kenyan health system during the referral of patients to Kenyan public health facilities. We will see some of the ways this platform allows for *consistency in purpose* and *consistency in measures* through a material and discursive "arrangement of things" that crosses institutional boundaries. It serves as a basis for collective action that exists in the form of a project, supporting specific objectives that can be questioned and criticized. It supports the consistent, regulated distinctions established through *protocolized prehospital triage*. As a physical platform for distributing responsibility and capacities across organisational sites, the emergency platform supports *patient referrals*.

However, there is an important element in emergency patient admissions that is absent from the concept of *platform* as proposed by Cambrosio and Keating: *the ethical ordering of platforms*. As we saw in our discussion with sociologists working on admissions in emergency departments, "values" (Nurok & Henckes, 2009) and the "moral order" of personal responsibility (Hillman, 2013) were ever-present. We must find a way to maintain attention to the moral question in triage, insofar as it seems to be *the* subject in the sociology of medicine, and, as we shall see, in work in bioethics and anthropology dealing with triage. We might put forward Cambrosio *et al*'s "*regulatory objectivity*" to catch something of the flavour of the protocolary ethics of triage. In such a case, following protocols becomes in itself a form of objectivity, one that is "*based on the systematic recourse to the collective production of evidence*" (Cambrosio *et al*, 2006). As Lorraine Daston has shown, *objectivity* came to the philosophy of science by way of moral sentiments philosophy and in scientific practice, objectivity maintains this moral flavour (Daston 1992). In other words, objectivity is what Daston calls a *moral economy* (1995).

However, we will come to see that the objectivity produced through routine respect of procedures - *regulatory objectivity* - is insufficient to the task of analysing the ethics of emergency triage. Before I make my own proposal for an ethics of triage from an emergency platform, we will continue our search for resources in bioethics and anthropology.

c. Triage as the Rationalization of Tragic Choice

In the next two subsections, I will be looking for a way to integrate the sociological concern for the "worth" of patients into our platformed conception of emergency ordering. What is the ethical order produced by the platform for emergency is Nairobi? To begin, we will look at how triage as a *rationalized form of choice* has been analysed in bioethics and in anthropology. I will call this dominant mode of analysis the "tragic choices" approach. I will argue that these authors

reduce the ethics of *triage in practice* to a mental operation that consists in choosing between competing rights or competing schools of moral philosophy.

Following John Moskop and Kenneth Iserson – bioethicists and medical doctors both - triage concerns *rationalized micro-allocation in situations of rarity* (2007a, 2007b). It espouses the values of *human life* - a relative value, for the goal of minimizing mortality can be achieved through the sacrifice of individual lives - *health, the efficient use of resources, and equity* (2007a). However, triage also stands against some of the basic principles of contemporary medical ethics. A healthcare decision is taken without consulting the patient, in a time when *informed choice* and *autonomy* are foundational. The *fiduciary relationship* between medical professionals and patients - where the former is held to act in the best interest of the latter - can be broken as well (2007a). The sociologists discussed above did not discuss medical ethics; we can only assume that they take them to be irrelevant or secondary. Yet in one of the most cited articles in bioethics on triage, we see that triage breaks with medical ethics' most basic principles.

Iserson and Moskop (2007b) also detail a series of philosophical traditions that have been mobilized to justify such a break. *Utilitarian* principles have sometimes been used to justify prioritizing organ transplant candidates according to their social function. The authors then wonder to what extent the "social consequences" of triage can be foreseen, and, if they can, where sacrifice should stop - can a healthy person be cut up to save the lives of 5 people who need organ transplants? Rawls' *maximin* principle has also been put forward, where the goal of triage is to minimize the worst outcome possible. The authors note that, following who is identified as the "worst off group", and what are the "worst possible outcomes", actual triage practices can vary enormously. Finally, Iserson and Moskop identify *egalitarian principles* as an ethical resource for the justification of triage practices. This approach explicitly rejects utilitarian principles and aims to assure equal chances of access to resources for all, for the value each person attributes to their life must be considered as equal. Often, these kinds of triage mechanisms work on a "first come, first served" basis or on a lottery system (2007b).

In any case, Iserson and Moskop hold that there is no one best solution. What the actual ethical order produced through triage and an ambulance service looks like is a question that must always be answered afresh, based on the specific protocols in place, the organizational culture of the care provider, and the ecology of care available. An important issue for us, as we show how triage orders situations of emergency, will be to describe the ethical order of triage as it is accomplished in Nairobi.

In the social sciences, there is a widespread conception that the difficulties of triage should be thematized in terms of "tragic choices" and their rationalisation. This has been the case from at least the late 1970s. A widely read and quoted book, Philip Bobbitt and Guido Calabresi's *Tragic Choices. The Conflicts Society Confronts in the Allocation of Tragically Scarce Resources* (1978), seems to be an important starting point for this current of thought. Following these authors, a "painful" choice becomes "tragic" when any assertion of a right involves a further wrong, any allocation decision implies the denial of essential resources to someone else. This makes these choices intolerable, even when they are necessary to the greater good. And yet "we" must choose. As such, whatever the allocation protocol retained, it is better for the rationale behind triage to be explicit. For choice is the price of progress, and if "we" lack the wherewithal to face down these "tragic choices", to make our sacrifices explicit, the result will be decadence and injustice. This argument – whereby "tragic choices" are rational and just when they are shown to benefit the "many" at the expense of only a "few" – has continued to be seen as the mental operation associated with triage, even when it is criticized.

Indeed, not all those who work on "tragic choices" are as optimistic as Bobbitt and Calabresi. In more recent work, this time in medical anthropology, Guillaume Lachenal, Vinh-Kim Nguyen, and Céline Lefève define triage as, "*in a general sense, the operation by which a doctor classes patients by order of priority*".[1] As such, triage is a banal act, part of normal practice, organized in advance for emergency services. However, triage is also part of an "order of exception", where doctors shoulder a task of great moral import: saving some lives while sacrificing others. *Sacrifice* is the operative concept here. Those who practice triage must devote themselves to a "higher order", be it a political ideal, the common good, a higher principle. Some lives can be sacrificed in order to maintain and renew this higher order. Consequently, not all lives are equal: some can be sacrificed, others cannot. Triage represents the *rationalization* of this sacrifice, in the sense of an *a posteriori* and *ad hoc* justification, but also in the sense of a reorganization of an activity in order to increase its efficiency with regard to a predetermined end. According to Lachenal *et al*, this *rationalization* gives hope in the possibility of establishing a hierarchy of lives according to "medical logic", free of "social" constraints. This is meant to accomplish triage in a way that is fair, and whose operations are recognizable and transparent. However, according to these authors, triage necessarily implies the hierarchizing of lives, and, in

[1] « A*u sens général, l'opération par laquelle un médecin classe des patients par ordre de priorité*. » My translation. (Lachenal *et al* 2014 : p. 2).

principle, cannot but be unjust. Surprisingly, these authors seem to agree with Bobbitt and Calabresi on several points concerning the operation entailed by triage, but the tone is critical rather than jubilatory.

Lachenal *et al* then offer their readers conceptual tools for the critique of triage. Of note is what they call the "epistemological critique". The sacrifice implied by triage suggests a commensurability between the individual body and the public good. Tools are developed in order to establish this relationship between the particular and the general. The individual and the collective, however, are necessarily heterogeneous to each other. The epistemological critique of triage looks for the scalar effects introduced by these tools in those places where practitioners see a collective benefit from individual triage, and then deconstructs it. Lachenal *et al* also suggest a critique of so-called "lifeboat ethics": instead of wondering who to put on the few lifeboats available on a sinking ship, they wonder why there are so few lifeboats. In other words, instead of allowing scarcity to justify triage, they denounce it.

Several authors have worked specifically on triage inside humanitarian organisations. Peter Redfield – who approaches *triage* through a cultural anthropology of science and technologies – looks at triage inside MSF as working according to a "sacrificial logic". Drawing on an article written by Jean-Hervé Bradol (2003), ex-president of MSF-France, who denounces a "sacrificial world order", Redfield begins by noting that MSF stands against the possibility of sacrifice in an "ethic of refusal": no life can be offered up for the greater political good. But at the same time, MSF must stop somewhere. Choice, he claims, is a practical necessity to action. The question then becomes "*How to select even as one "refuses" to choose? If MSF follows an ethic of action as well as refusal, then it must engage, under protest as it were, but also in a manner that appears to favor the good.*" (Redfield 2013, p. 167). Here, choice is a *prerequisite* for action: to act, one must first choose. To act, one *triages*, where triage is defined as "*a system of selection based on the facts of suffering themselves"* (Redfield 2013, p.169). A kind of "*bodily egalitarianism*", where rank or station is of no import in the allocation of healthcare. But how ever choices are made, they must be made, and any choice entails foregoing the options not taken. There is no escaping the "*sacrificial logic of choice*".

For Alex de Waal, social anthropologist and long-time humanitarian, the "humanitarians' tragedy" refers to the fact that "cruelties are intrinsic to the humanitarian predicament". This is what he calls "inescapable cruelty" (de Waal 2010). Here again "tragedy" is the result of pursuing irreconcilable goals, and of attempting to realize ideals in situations of violence and social upheaval. While there are 'escapable tragedies' – primarily due to technical failure, which,

according to de Waal, can always eventually be surpassed – there are also 'inescapable tragedies'. These are tied to "clashes between rights" and the inability to meet people's expectations. The typical example is the triage of combat surgeons: "*Treatment is denied. The humanitarian physician must look into the eyes of a man or woman in the most desperate need of his or her expertise, and withhold that help. It is an act of cruelty*." There is also the more prosaic work of humanitarians in IDP camps:

> "*He or she may also be turning people away—the children who are not quite thin enough to meet the criterion for admission. They are needy nonetheless. On returning home in the evening, he or she may encounter destitute beggars on the road, and refuse to give them any small change. The begging mother with her child has her own piece of history of distress. She is a person, in need, against whom the relief worker has no personal grudge or special reason to be indifferent or cruel. However, she is someone who does not receive help, even though the aid worker has it within his or her power to assist her. These are the instances of failing to do good at the margin, the cases of cruelty—each one escapable, but collectively inescapable*" (de Waal 2010, p. S132).

According to de Waal, this marginal analysis of our ethical shortcomings produces "cognitive dissonance": humanitarian workers do not see themselves as cruel, and yet they must refuse to help some people. There are competing rights, competing principles and the resulting dilemmas produce "inescapable cruelty".

Following Bobbitt and Calabresi, "tragic choices" cannot be avoided, but through *rationalization*, they can be tamed. Lachenal *et al* see decision-support in the allocation of medical resources as *ad hoc* rationalisations for reproducing social hierarchies through the public health statistics which place the individual and the group on a scalar continuum. They see this as epistemologically feeble, but the only alternative offered is external critique. Redfield has suggested that, despite humanitarians' denunciation of "sacrificial" politics, in practice they cannot avoid the sacrificial logic of "choice before action". De Waal holds that the competing principles and ideals that humanitarians attempt to perform in situations of social upheaval and armed conflict entail "inescapable cruelty".

All these authors underscore the tragedy and the sacrifice entailed in triage. Some seem to exalt in the possibilities offered by the rationalized sacrifice of some for the greater good; more critical authors hold that the sacrifice of the few for the many can never be justified. Redfield and de Waal are refreshingly descriptive. They attend to a *tension* in the field of humanitarianism – the impulse to help and the limits of action. However, as Redfield speaks to triage, *the options are always already there.* Both Redfield and de Waal focus on the sacrificial *logics* of tragic *choice*. Iserson and Moskop, medical doctors, are the only authors who deal with what should be done in practice, and their conclusions - as in all of the above cases - frame ethics as a kind of mental

operation, logical reasoning through which we resolve *dilemmas*, relating the pros and cons of each option to pre-established principles. That is, these authors hold that the *choices*, as a prerequisite to action, are tamed through their *rationalization*.

Framing ethics as a mental operation whereby the tension between competing rights or principles is resolved is a gross reduction of the ethics of triage. To understand why I would invite the reader to follow me into the next section as I describe a triage tool - the Simple Triage and Rapid Treatment (START+) protocol – used by MSF in Kenya during Mass Casualty Incidents (MCIs) like the one described in the introduction to this chapter.

d. Ethics on the Platform: MCIs, START+, and Care

In this section, I will be presenting the START+ protocol. My goal is to bring to light some of the difficulties in understanding how it works from the "tragic choices" perspective described in the previous section. In order to do so, I will describe how the protocol works, underlining how it offers practical options to two difficult questions posed during emergencies: *what is it that is going on here?* and *what should we do now?* These questions are taken as the questions of reflection on ethical practice. Then, building on the literature on care ethics and on pragmatic philosophy, I propose an alternative mode of ethical analysis, based on how triage participates in *ordering attention and bringing to life options in situations of choice*.

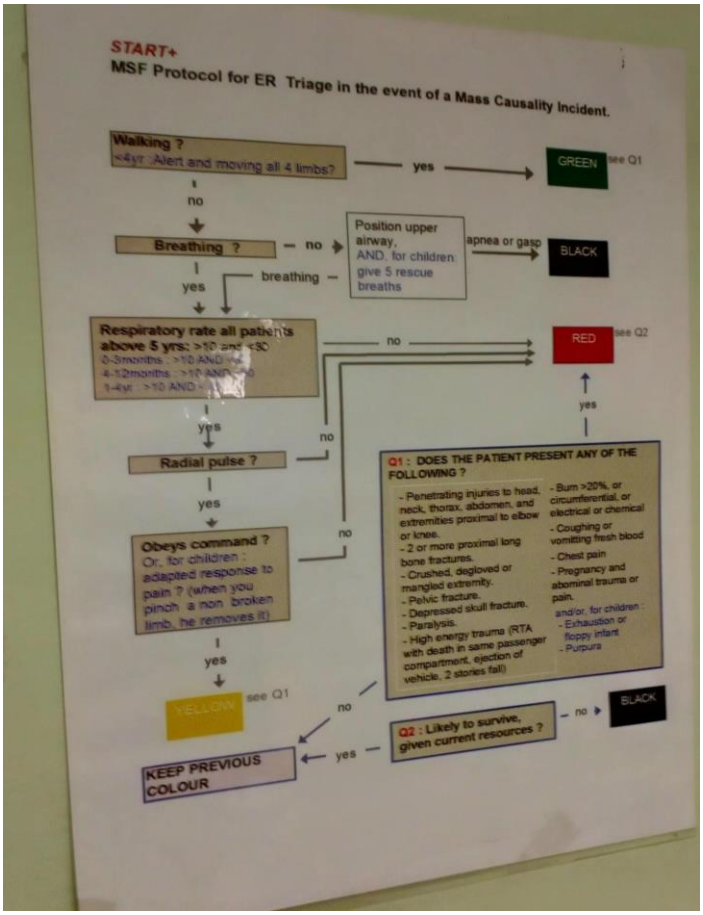

Figure 24: START+ flowchart above triage station in Mathare trauma room

The flowchart in the photo in Figure 24 is posted on wall next to the triage station in MSF's Trauma Room in Nairobi should there be a Mass Casualty Incident (MCI). The World Health Organization (WHO) defines an MCI as "*an event which generates more patients at one time than locally available resources can manage using routine procedures. It requires exceptional*

emergency arrangements and additional or extraordinary assistance" (WHO, 2007, p. 9).

Many health systems across the world have prepared "*exceptional emergency arrangements*" referred to as Mass Casualty Plans (MCPs) for any situation with a high number of casualties. MSF elaborated their MCP in the months preceding the August 2017 elections in Kenya, anticipating the possibility of rioting and police violence, as occurred during the 2007 elections. Part of their MCP is the START+ protocol. It is used in situations where MSF responds to such multi-victim situations as Road Traffic Accidents (RTAs), or the collapse of buildings, as Lucy detailed above.

The first thing the reader should note is how streamlined the START+ protocol is. This is possible in part because it is meant for situations where most patients need care for trauma-related emergencies – high impact injuries like falls and car accidents, as well as lacerations, crush wounds, and burns – and not for medical emergencies – hypo- or hyperglycaemia, heart attacks, infectious diseases, and the like. This means that there are only four triage colour codes, not five (no Orange triage code); there are few clinical discriminators and the list of "Vital Signs" to check is short. For example, contrary to the SATS protocol, used inside MSF's A&E services, the START+ protocol does not assess blood pressure, body temperature, or blood oxygen saturation.

The first step is to see if the patient is ambulant: if they can walk, they are triaged Green, that is, a *"victim with minor injuries"* (**Ambulant = Green**). The term "injury" is important. A diabetic patient that goes hypoglycaemic is in need of emergency care, but these are not the kinds of cases you deal with when a bus is overturned or when a building collapses. The "Ambulant = Green" step makes ordering the scene easier: it means that any patient who is Green can be asked to walk to another area, leaving only more serious cases in the triage area.

The next step is to check if those patients who cannot walk are able to breathe. If they cannot, and the simple repositioning of the airway does not induce *spontaneous* breathing, then the patient is triaged Black (**No walking + no breathing = Black**). These "Black" cases, who cannot walk or breath, are "Expectant", that is, they are *"unlikely to survive"* given the severity of injuries and the level of care available.

If they start breathing after repositioning the airways, then you check the respiratory rate, or the number of breaths taken in a minute. For adults who cannot walk, a respiratory rate (RR) below 10 or above 30 breaths per minute means the patient is triaged Red (**RR <10 or >30 = Red**). If the RR is between 10 and 30, you check for a pulse. If they cannot walk, can breathe, but do not

have a pulse, they are triaged Red (**No pulse = Red**). Red patients are *"Emergencies"* and must receive immediate care.

If they cannot walk, have a respiratory rate between 10 and 30, and have a pulse, you check if they can obey commands and respond to simple questions ("lift your arm, tell me your name"). This is a simple assessment of the level of consciousness. If they can, they are "Yellow". Yellow patients are "Delayed" (**No walking + RR 10-30 + pulse + conscious = Yellow**). They include patients with *potentially but not immediately life-threatening* injuries. They are not at significant risk of irreversible deterioration in the coming hours.

However, any time a **Green** or **Yellow** code is attributed, the triage officer looks at a series of discriminators that can potentially change a patient's triage code to **Red**. If they have **penetrating injuries** to the head, thorax, abdomen, or extremities proximal to elbow and knee; if they are two or more suspected **proximal "long bone" fractures** – that is, the femur or the humerus – or a pelvic fracture; if they have **crushed, mangled, or degloved** extremities; if they have a **crushed-skull fracture, high energy trauma, or more than 20% of their body covered in burns**; if they are spitting or **vomiting blood**; if they have **severe chest pain**. All these cases are triaged "**Red**". And whenever a patient is triaged "Red", then the triage officer is supposed to jump to "Q2": is the patient "likely to survive given current resources?" If the answer is "no", they are triaged Black, or expectant (**Unlikely to survive = Black**).

Juxtaposing this rapid presentation of a triage protocol to the above discussions of triage ethics is somewhat surprising. It is difficult to wax lyrical about inescapable cruelty when talking about degloved extremities. Gone is the debate between utilitarian and egalitarian sensibilities. Gone is the consideration of patient autonomy and "informed choice". Gone are the anthropologists' preoccupations about the epistemological relation between the individual and the group. The problems here are quite different. What stands out is how triage provides concrete options in practitioners' attempts to respond to two practical questions: *what is going on here*, and *what is to be done?* This clearly appears when we look at some of the slides from the MSF training session on the START+ protocol. Below is the last slide from the PowerPoint presentation. The slide immediately before this one details four cases, where the relevant details of a Patient 1 through 4's health states are described in a phrase or two. On the slide below, the original description is provided and the "*Answers*" – that is, the correct triage colour code – are given.

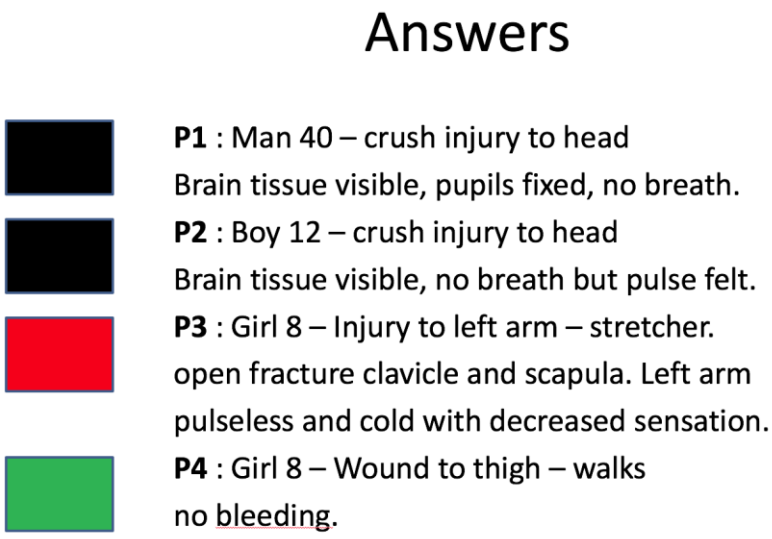

Figure 25: PowerPoint slide from START+ training session for MSF personnel

The reader may be slightly disappointed to see how much *the problem of triage* has been deflated. Please be reassured: there are no tragic choices here, but there are pressing concerns. The triage protocol orders the situation in such a way as to provide "correct answers" to such compelling questions as "should I help an 8-year girl with a wounded thigh or an 8-year old girl with an open fracture?". Triage orders the scene of the MCI. It distributes bodies in space. It states what *proper aid* looks like. This makes a certain kind of life-saving activity possible. Triage provides an *objective basis* – that is, based on the objectified reality of bodily injury defined through collective and regulated practices of gathering evidence – for the instauration of an ethical order through right conduct in situations of distress, confusion, and chaos. It does this by *qualifying* the situation in a certain way (*what is it that is going on here?*) and circumscribing the *responsibilities* of the medical personnel present (*what is it that we should do?)*. Lucy said her job was to work out systematically what was to become of the situation. Here, we see that emergency personnel work towards a future in which people survive, where irreversible morbidities are minimized, despite the building collapse, the overturned bus, or the fire.

It is possible to force the square peg of triage protocol and practice into the round hole of cognitivist "tragic choices". However, the above analysis of the START+ protocol – where triage ethically orders the situation in such a way as to define medical personnel's responsibilities and to assist in the emergence of practical options in the face of emergency – has put us on the scent of another conception of ethics.

Indeed, the cognitivist conception of ethical reflection detailed above has come under much scrutiny in recent decades from the perspective of a feminist ethics of care. Carol Gilligan started the movement (1982) when she criticized psychologist Lawrence Kohlberg's approach to moral development. She suggested that instead of framing moral tensions in terms reasoning through of "*competing rights*" - clear in the proponents of "*tragic choice*" discussed above - moral practice is a question of "*contrasting responsibilities*". Joan Tronto (1993), building on Gilligan, has presented responsibility as one of many moral qualities, constituted both by "*particular acts of caring*" and "*habits of mind*". Responsibility builds on *attention* to problems and the recognition of caring needs. It implies asking what role we play in the conditions of possibility and the potential resolution of those problems and needs. The ethical question triage implies, then, is *what are the contrasting caring responsibilities of those who design formal triage protocol and of those who engage in caring practices with the support of such protocol?*

This approach in terms of "contrasting responsibilities" allows us to retain analysis of *choice* in triage that was absent from *regulatory objectivity* and *objectivity as a moral economy*. As Tronto has stated, "*Some of the most difficult questions within the moral framework of care arise out of trying to determine what "needs" should mean and how competing needs should be evaluated and met"* (1993, p. 138). The problem of triage is still choice, but the choice is no longer between competing principles that must be reasoned out (as in the anthropological "tragic choices" approach), nor about choosing patients who perform a certain moral identity or embody certain "values" for staff (as in the sociological approaches to patient admissions). Choice is between caring responsibilities that must be resolved in practice. As such, I will be following Annemarie Mol's suggestion that our moral interest should be for those situations where choice is performed. We should ask ourselves if there are no other modes of ethically ordering the situation that might better prepare us to assume the consequences of our actions (2007).

In our discussion of the "tragic choices" approach, we saw that the *rationalisation* of choice was taken as the dominant mode of ethically ordering the situations of choice implied by triage. As previously mentioned, this *rationalisation* was taken in both the Weberian sense of the reordering of a situation to distribute resources more "efficiently" with regard to a specified end – that is, *instrumental rationality* – and in the psychoanalytical sense of an *a posteriori* and *ad hoc* justification of some accomplished action that is perceived as immoral. For some, rationalization enacts situations of choice for which responsibility can be assumed. For others, it is a defence mechanism.

We should be wary of blanket praise or blame of *rationalisation*. As Marc Berg's work on the history of medical practice in the United States has shown (1997), the rationalization of medicine has not been an unequivocal process. Despite widespread agreements, from the 1950s on, that the rationalization of medical work was necessary, the means, objectives, and ends of rationalization have been variable. In addition, Berg has convincingly demonstrated that different instruments of rationalization – he analysed three different decision-support techniques: statistical tools, protocols, and expert systems - entail different ideas of what medical work is or should be. Some take the calculating computer as a metaphor for the physician's mind, and medical decision making as a practical application for Bayesian statistics. Other rationalization tools stage medical practice as the logical and sequential execution of standardized steps. For the students of medical ethics that we are, this is an important point: *if the rationalization of medicine is shown to be a multivocal phenomenon, the ethics of rationalized medicine cannot be assumed to be homogenous, unambiguous, or stable*. Rationalization is not a singular force that orders unambiguously situations of choice, which can then be praised or criticized as an internally coherent whole. The actual tools and practices of rationalized emergency medicine must be analysed if we are to understand the ethical ordering of the situations they enact.

However, we cannot evacuate so easily what others have problematized in terms of "tragedy" and "cruelty", where doing good entails an unavoidable wrong.[1] There is indeed something peculiar about the situations of choice enacted in triage: the options are what William James calls genuine. *Genuine options are living, momentous, and unavoidable.* Choices made in triage are not between an infinite number of discrete needs or between schools of moral philosophy. They are between concrete, immediately available and practical options that present themselves as real alternatives.[2] These alternatives are James' *living options* (James, 1992: 457-459; Hennion 2015; Hennion & Vidal-Naquet 2015). Living options are not purely intellectual, or moral principles. They are the practical alternatives that call out to us as they emerge in the situation (Hennion & Vidal-Naquet 2015). James references the live wire as the germane metaphor for living options. Live wires conduct electric current and make a connection possible; a living option can

[1] Martha Nussbaum (2000) has written engagingly on the difference between what she calls the "obvious question" in situations of choice – what shall we do? – and the "tragic question" – is any of the alternatives open to us free from serious moral wrongdoing? She also holds that cost-benefit analysis is useful for answering the "obvious question", but tends to obscure the "tragic question". In this chapter, we will be looking at the "tragic question" in the final section.

[2] Antoine Hennion has developed a point similar to the one we make here in an article 2005 – all the more convincing and moving because it is hesitant – on the question of euthanasia and Alzheimer's disease (Hennion 2005).

resonate with the chooser and conduct their will. Triage practitioners have the ability, of course, to criticize the situation of scarcity that necessitates triage, as Lachenal, Nguyen and Lefève have suggested we must do. However, denunciation of the situation of scarcity is not a living option in the situation of triage itself, insofar as it does not help answer the urgent question of "what shall we do?". Denunciation of scarcity can be, and is, brought to life as an option in many other situations. Staff are aware that the availability of resources is a political decision, which they can discuss during tea breaks, meetings with their managers, or interviews with social scientists. Managers can denounce scarcity as they write their monthly situation reports. Anthropologists can denounce scarcity as they write about the ethics of triage. *Indeed, it is politically important to denounce the tragedy of scarcity but doing so is not a living option in the practice of triage.* As we shall see, *scarcity* is an issue for those who design triage protocol, whose resolution must be dealt with in practice.

In addition to being alive, the options of triage are *momentous*. Triage implies the irreversible decision to care for one person, and, at the very least, make another person wait for care. It is no exaggeration to say that triage entails questions of life and death, all the more momentous that the decisions of triage are sometimes taken in great urgency. There is not always time to conduct the tests and screenings which would allow medical personnel to establish beyond a shadow of a doubt the order of priority. It may sometimes be preferable to make a decision quickly, and with it the risk of being wrong, rather than waiting until all the evidence is in to make the "right" choice. Waiting is not a living option because triage includes momentous options in situations of deadly urgency. Furthermore, these options are *unavoidable*. In such situations, not doing anything is itself an option for which one can be held responsible. Not choosing is a choice. Engaging in *triage* means confronting situations of choice between *genuine options*.

I have now presented what I aim to achieve in my discussion of the ethical ordering of emergencies from the platform. It is not the "value" of patients, nor their ability to perform a moral identity that I will be describing. In order to gain insight into two of the specificities of MSF's A&E department in Nairobi – a concern for substitution and intervention into the Nairobi health system – I will be describing the elements that dynamically compose the platform for emergency onto which MSF projects itself. To render the ethics of the platform for emergency, *regulatory objectivity* or a simplistic understanding of *rationalisation* are insufficient. Instead, I will show how a triage protocol – part of the platform for emergency – orders *situations of choice* and *attention*. This will help show how emergency triage answers the ethical questions of *what is it that*

is going on here? and *what is it that we should do now?* by bringing to life genuine options for which medical personnel can assume responsibility.

The protocol in question is the South African Triage Scale (SATS).

2. An Inquiry into the SATS Protocol

In this **section**, we analyse the triage protocol in place in MSF's A&E service in Nairobi: the *South African Triage Scale* (SATS). To begin, we will look at those troubling situations of choice where certain forms of expressed need cannot be rendered in the language of the platform. This elicits the disqualification of certain patients as "hysterics", "exaggerators", or "liars". To understand how such a situation can be experienced as morally acceptable, we explore the issues the SATS protocol was meant to resolve according to its designers in the Universities of Cape Town and Stellenbosch. In the third subsection, we will come back to MSF's A&E and explore in more detail how the SATS protocol orders attention. We will see that the protocol enacts bodies that are always already *fragile*, on the brink of rapid deterioration. This poses a problem of *reference* in the epistemology of the triage device. That is, the fragility of these enacted bodies renders the triage score unstable. This instability of the triage score turns triage practice into constant vigilance, constant attention for signs of fragility, even in those who seem "hysteric". This is how the SATS protocol orders attention from the platform for emergency.

The SATS protocol was designed in South Africa in April 2004 by the interdisciplinary Cape Triage Group (CTG). The CTG had been convened by the Joint Emergency Medicine Division, from the Universities of Cape Town and Stellenbosch to develop a triage protocol that was suitable for "local use". According to the group, several international triage protocols existed at the time, but none was adapted to the problems of triage in South Africa. The design of a tool usable in the South African context was even more urgent given that there was no standard *prehospital triage tool* in the country, and, in some places, there was no triage tool in use at all. This made communication and coordination between medical centres more difficult, led to suboptimal allocation of resources, had adverse effects on hospital mortality rates, and made audit of triage decisions impossible. After epidemiological validation of the tool in 2006, the SATS protocol came

to be in use in a great number of countries in the Global South, from Pakistan and Afghanistan to Haiti and Panama, from Somalia and Ghana to Botswana and Kenya[1].

The SATS protocol works by guiding junior medical personnel through a series of steps. These steps are divided into two parts. First, the protocol invites them to observe a series of clinical "discriminators", and, then, to note a series of Vital Signs. As the triage officer does this, they progressively fill in a score sheet. At the end, they sum up the score. This score dictates the attribution of a colour code to the patient. Red is an "emergency", and requires *immediate* intervention; Orange is "very urgent" and requires intervention in less than 10 minutes; Yellow is "urgent" and should be treated in less than an hour; Green is "routine" and should receive treatment in less than four hours from a Primary Health Care facility. "Green" patients are not given treatment in MSF's A&E.

In the following pages, I attend to the ambivalences of prehospital emergency triage. I describe the work of ethical ordering that the triage protocol accomplishes as it is based on the *platform for emergency* that MSF has set up in Nairobi. I base my analysis on notes taken during my seven weeks of ethnographic observation on the MSF Mathare project in April and May 2018. During that time, I also conducted 18 semi-structured interviews with MSF staff on their work practices in the trauma room, in the Call Centre, in MSF's ambulances, and as they triaged. I coded these interviews and observation notes – as two separate corpuses – in view to underscore the ethical reflexivity of medical personnel as they engaged with the protocol.

a. The "Hysterics" of Triage

To begin, we will explore expressed needs to which the triage protocol is inattentive. This will contribute to our ethical intelligence of the situations of choice ordered by the platform for emergency by telling us what is *not important* during emergencies. This is a way of ethically investigating triage by wondering about those who go "*unrepresented in encounters with technologies*" of triage (Star 1990, p. 29). If we take the triage protocol as a formal tool that classifies patients, there are cases that the tool cannot prepare MSF personnel to deal with. There are demands for care that don't translate into the SATS protocol classification scheme. There are

[1] I have not been able to find reliable information on the exact number of countries where the SATS is currently in use, but epidemiological studies on the SATS protocol have been undertaken in all the above-mentioned countries. Furthermore, a SATS mobile triage application was developed in partnership with The Open Medicine Project of South Africa (TOMPSA), who reports that their application has been accessed 30,189 times by users in 63 countries. Of course, this might not reflect actual use of the protocol in medical settings, but does give an idea of its influence. http://openmedicineproject.org/photo-gallery/mobile-triage-app/ (Last accessed: 3 January 2019)

even people who subvert the protocol, hijack the protocol to their own ends. In this section, I wonder what these cases tell us about the caring responsibilities and genuine options enacted by the triage protocol. I show how triage enacts the "hysteric" patient as a threat to its ethical order. As such, it diminishes staffs' caring responsibilities for their reported needs, and supports their moral devaluation.

When arriving in MSF's trauma room in the slums of Nairobi, I was distraught as an ethnographer of care by the frequency at which MSF staff disqualified the needs of patients. These were the "liars", "fakers", "exaggerators" and "hysterics". MSF's expatriate ER doctor, from Nigeria, complained of them often and said one of his goals was to have a team in place that was able to detect "fakers" in just a few seconds. These patients didn't have any "real" need. They just wanted "*attention*", he said. Kenyan medical staff referred to them as "hysteric" patients and seemed to see them as part of their routine medical work. Hope, a Kenyan nurse, told me during an interview that she was able to pick them out when she got patient history. She would learn, for example, that the person had been quarrelling with a neighbour, or "their wife wanted to go" or was being "demanding" about getting money for rent or groceries. And then they just "*dropped down*". These cases were "*obviously staged*". The person just wants "*attention*". "*In the slums, it's something that is very common*, Hope said, and then imitated the panicked voice of a caller: *"Ah, he was just here, and he slipped off the chair!*" The head nurse, from Japan, gave a culturalist explanation, saying that in her home country people tended to downplay needs; for reasons that were unclear to her, patients from the Nairobi slums tended to "exaggerate". All agreed that this posed a serious threat to triage practice.

When a patient "exaggerates" their pain, "fakes" breathing problems, is loud and "hysterical" beyond what is appropriate, they can distort their triage score. This subverts the purpose of triage and can potentially cause a life-threatening delay for a patient in "real" need. The Nigerian ER doctor - Dr Abayo - explained that "exaggerating" is hard to detect for certain potential emergencies. This is the case for asthmatics. Even a "Moderate" asthma attack - as defined according to pre-set emergency room protocols - can change to "Severe" at any moment, if there is pollen in the air, if there is a lot of pollution that day, if the patient has to exert his or herself, if there is an increase in stress. Exaggerating asthma symptoms can mean a patient is rushed into the Trauma Room and "stabilized" by being put on oxygen. But MSF only has three beds in the Trauma Room, and they need to let the asthma patient wait while the attack subsides. This can take 15, 20, even 30 minutes. And other patients are waiting. Dr Abayo explains that this is why protocols are so useful. The asthma protocol lets him know that if a patient can formulate complete sentences,

then the attack is "Mild". He adds that it's good to get a second opinion, of course, to have a nurse with you to confirm or contradict you. In any case, the patient should be kept nearby for observation, because asthma is always potentially life-threatening. But need is not "Very Urgent" and patients who "fake" or "lie" just want "attention".

While I was able to understand Dr Abayo's point, I was not convinced. As Susan Leigh Star has said, "*stabilized networks seem to insist on annihilating our personal experience, and there is suffering*" (Star 1990, p. 48). While I did not have Star's article in mind, I was dismayed by the easy dismissal of patients who were clearly in need of care, if not emergency care. So, one day I confronted Dr Abayo. This is a summary of the notes I took in the hours following our encounter.

> *After 6 weeks in MSF's trauma centre, I confronted Dr Abayo. As a social scientist with no medical training, no experience doing triage, and whose hands shake whenever there's a serious case in the trauma room, I tell Dr Abayo that "hysteric" patients might just deserve the "attention" everyone says they desire. Just because their symptoms do not fit into the needs pre-defined by triage protocols doesn't mean that they don't require* care*. They are expressing a need in the language of medicine.*
>
> *Abayo tells me the story of a woman who realized that she wasn't going to receive emergency care and held her breath until she started to lose consciousness. Her heart rate started to drop, and she was given care. He tells me the story of a man who wanted transport to another medical centre, which MSF refused. He started stabbing his own leg so they would drive him across town. He tells me that "**these people are not emergencies**". I respond that if someone is willing to hold their breath until they lose consciousness or stab their own leg, then they are in such a state of distress that they need immediate care. He says, yes, they need a psychologist, a counsellor, but not a doctor. He repeats: "**these are not emergencies**". I disagree. I tell him that "mental health" is health, that there is such a thing as "psychological first aid".*
>
> *He says, perhaps, but they don't need immediate attention **here**. **Here** we don't look at underlying conditions or aetiology. **We just stabilize and transfer**. If they harm themselves, **we triage, stabilize, and transfer. It is a question of triage: "hysterics" try to get triaged as Orange or Red when they're Yellow or Green.***

Taking Dr Abayo seriously means accepting that the triage protocol exists for the presenting patients as well: "Hysterics*" try to get triaged as Red or Orange when they're Yellow or Green*. The triage code, then, scripts for the cunning patient who can "exaggerate", or act "hysterically", in an attempt to gain access to the trauma room. The triage protocol produces a legitimate target of intervention and tells triage agents what their responsibility to those patients looks like. In doing so, it enacts a patient who solicits attention and a feeling of responsibility greater than what is dictated by the protocol. In their attempt to subvert the protocol, these "hysteric" patients threaten the ethical order of the triage protocol: someone with urgent, life-threatening needs could be made to wait while someone without life-threatening needs takes up vital resources. This supports the moral devaluation of "hysterics". While other members of

medical staff fussed about "exaggerators" and "hysterics", Dr Abayo was particularly adamant in his moral devaluation of "fakers" and "liars". Yet most staff agree with the sentiments he expressed above: *patients who "exaggerate", who are "hysteric", are not "real" emergencies*. The responsibility of MSF staff is to "triage, stabilize, and transfer" patients with urgent and life-threatening need. That is what triage is about. People may be suffering psychologically, but this is not where the *caring responsibilities* of Accident and Emergency staff lie. Triage is about life and death and the division of labour in an institutional setting with limited resources. The protocol is a tool for rationalization, but it does not attempt to order the entire world or to establish an exhaustive and extensive list of all possible needs. Something else is at stake.

In the next few pages, we will describe what that is. To do so, we will first explore what the Cape Triage Group was trying to accomplish as they designed the SATS protocol in 2004.

b. Human Resources and Differential Needs for Speed

In this section, we look at the history of the protocol's design in order to get a better idea of the reasons for ordering ethics in such a peculiar way. I will be doing this by looking at the scientific literature produced by the team working on the SATS protocol and literature in emergency medicine critiquing the SATS protocol.

Several internationally recognized triage algorithms were in place in 2004. The Manchester Triage Group developed a tool in 1997. The Canadian Triage Assessment Scale (CTAS) had been developed in 1998 and the Australian Triage Score (ATS) in 2004. Why did the Cape Triage Group feel the need to design a new triage tool in 2004? Couldn't they just take the triage protocols used elsewhere and set them up for local use? They could not: the specificity of the South African context meant that these other protocols could not be easily imported and applied. Couldn't they just do without a formal triage protocol in South Africa? This was not an option either. To understand, I follow discussions in the scientific literature on the SATS triage protocol. The analytical style is that of semiotic de-scription (Akrich, 2013) of journal articles in the domain of emergency medicine, and the 2012 SATS Training Manual made available by the Emergency Medicine Society of South Africa (EMSSA) and edited by the Western Cape Government.

This allows me to report, **first**, on the justification provided by the Cape Triage Group for the necessity of a triage protocol. **Second**, we will see that one of the primary capacities attributed to triage scales – the ability to detect *differential needs for speed* – is done in what was a rather original way at the time of the SATS protocol design. **Thirdly**, we will see how this was a response to the specificities of the Human Resources situation in South African.

In a 2006 article signed by the developers of the SATS protocol, the authors hold that the "*need to prioritise the care of South African patients in both the pre-hospital and emergency unit (EU) is obvious*".

> *"Accurate pre-hospital triage is essential for appropriate utilisation of resources, accurate notification of receiving hospitals, quality management and audit of the ambulance service. [...] Absence of a triage system leads to prolonged waiting times, poor management of clinical risk and increased morbidity and mortality. In order to maximise the efficient use of resources and to minimise the risk to the patient, an effective triage system with high sensitivity and specificity is required" (*Gottschalk *et al* 2006, p. 53*)*.

This justification for triage follows what Iserson and Moskop (2007a, 2007b) identified as the values of triage - human life and health, and the efficient use of resources. The use of a single protocol at a national level allows for referral between hospitals where clear communication on the state of the patient is possible: "Red" means the same thing in different places. We have already seen similar effects as MSF took up the SATS protocol in Nairobi to better integrate and support the emerging *platform for emergency*. Triage is also presented as reducing both waiting times for patients and mortality and morbidity rates. In other words, it maximizes efficient use of resources, while minimising clinical risk to patients. These are the terms in which many public health interventions are evaluated today, and, as the authors state, triage allows for secondary management operations. Notably, a formalized and uniform national triage protocol allows for the audit of emergency activities. This is what an "*effective triage system*" with "*with high sensitivity and specificity*" promises. It helps managers deal with the optimal resource allocation from the perspective of public health evaluation and the ethical order specific to that domain.

However, the above presentation and justification lacks a clear presentation of the fourth value Iserson and Moskop claim for triage - *equity*. In an abstract sense, "equity" is understood, in the domain of public health and epidemiology, as the allocation of resources in accordance with the respective burden populations or individuals bear (Carneiro & Howard 2017). That is, *equity* does not require that everyone gets the same amount of resources. It demands that each receive according to their needs. Let us now move to an excerpt from the SATS Training Manual, to learn more about the specific kind of equity that the SATS protocol carries with it.

> ***"Triage**, from the French word "trier", literally means: "to sort". The aim is to bring "the greatest good to the greatest number of people" – this is achieved through prioritising limited resources to achieve the greatest possible benefit. Patients are sorted with a scientific triage scale in order of urgency - the end result is that the patient with the greatest need is helped first" (*West Cape Government 2012, p. 3).

"Equity" here has a number of characteristics. The "greatest good to the greatest number of people", especially with the quotation marks, implies a Utilitarian sensibility. That is, "limited resources" – for as health economics has taught epidemiologists, scarcity is the human condition – are allocated in view to maximise satisfaction/utility at a population level. To do so, triage places patients on a scale of urgency. Need differentials are defined in terms of the speed required in the response in order to reduce morbidity and mortality rates. What varies between people, and what justifies differential access to medical resources, are *differential needs for speed*. The SATS protocol establishes these differential needs for speed in a way that distinguishes it from other protocols existing at the time. Understanding how it works can help identify what was so specific about the South African context that it required the design of a new triage tool. It can also help explain an ethical mode of ordering triage where the moral devaluation of "hysterics" is possible.

The primary innovation of the SATS protocol, when compared to previously developed protocols, is the introduction of an "Early Warning Score" (EWS). EWSs are a scoring tool developed in the United Kingdom at the end of the 1990s. They set the normal values for a series of Vital Signs and physiological discriminators. The monitoring of these "signs" allows for rapid and uniform scoring of deviation from the statistical norm. Epidemiological studies have shown that certain patterns of deviations from these norms are associated with admission to an Intensive Care Unit and rapid deterioration resulting in irreversible morbidities and death. The EWS used on the SATS protocol aggregates variations from these norms into a "score" that serves as an index for the urgency of need. The integration of an EWS into a triage protocol brings to life specific options with regard to the caring responsibilities of staff: *differential responses for people with different scores*.

There is a three-fold justification for EWSs in the literature. *Primo,* there is a statistical association between *instability* in Vital Signs and rapid, irreversible deterioration of the patient' state, often resulting in death. The logic goes that if those vital signs can be rapidly *stabilized* – that is, if the Heart Rate, Respiration Rate, Systolic Blood Pressure, Random Blood Sugar (RBS), blood oxygen saturation (SpO2), can be quickly brought back and kept inside the normal range – then the chances of avoiding irreversible deterioration can be greatly increased. This is what Dr Abayo told me about the purpose of triage – "we triage, stabilize, and transfer". *It is these vital signs – as proxy markers for a person's health state – that must be stabilized.*

Secundo, EWSs can quickly establish differential needs for speed. For hospitalized patients, the above-mentioned vital signs can be constantly monitored. An alarm can sound in case of sudden instability, engaging a rapid, standardized response. The vital signs of patients presenting in an

Accident and Emergency service can usually be assessed, with the help of a DINAMAP monitoring machine, in less than two minutes. Emergency signs can be assessed in less than 30 seconds. In other words, the triage tool establishes differential needs for speed, and brings to life the statistically established option of preventing irreversible morbidity or death.

Tertio, individuals in unstable health states are not necessarily capable of accurately expressing the need for speed in their own words. There is, of course, the ethically ambiguous situation described above, with "hysteric" patients that "exaggerate" their need, and those cases where cunning patients "lie" to gain access to resources they do not "deserve". However, it is also important to remember that there are patients who are unable to express their needs. The list of patients regularly encountered in a hospital setting in this situation is quite long: infants, young children, patients who are unconscious or in shock, patients who have cognitive disorders, are intoxicated or unfamiliar with allopathic medicine, patients who speak a different language than staff, are psychotic or just confused. Furthermore, it is precisely those patients who are unable to express their condition that are often in the greatest need for speedy stabilization. *That is, a triage protocol that scripts for a patient capable of accurately expressing their needs would be inadequate to the task of establishing differential needs for speed and preventing irreversible morbidities or death in an A&E department.*

However, the introduction of an Early Warning System in triage protocols - referred to as the *Triage Early Warning Score*, or TEWS, in the SATS protocol – has been deemed ineffectual by proponents of the Manchester Triage system (Subbe *et al*, 2006). Subbe *et al* conducted a retrospective cohort study in a district general hospital in the United Kingdom, covering all main branches of medicine and surgery. The goal of the study was to compare the use of triage score based solely on a physiological assessment of instability with a triage score using an Early Warning System. Their contention is that an EWS improves neither specificity nor sensitivity of triage scores.[1] They hold that "only a small number of emergency department patients are likely to be identified earlier" (Subbe *et al* 2006:845), with the EWS when compared to a clinical assessment of instability in an A&E triage protocol. This means that the SATS protocol is not any more

[1] *Specificity*, in epidemiology, refers to the ability of a diagnostic tool or test to correctly identify those with a given health state. The more specific a test, the more patients with a given health state will be identified. However, a very specific test might also have a high level of "false positives", that is, patients incorrectly identified as having a given health state. Conversely, *sensitivity* refers to the ability of a diagnostic tool to identify those who do *not* have a given health state. In other words, the more sensitive a diagnostic tool, the fewer patients will be incorrectly identified as having a specific health state, but it might also be less *specific*. Evaluation of diagnostic tools takes into consideration specificity and sensitivity (as well as prevalence and incidence data for the population, and a number of other considerations, but this is not the place for such a discussion).

sensitive or specific in its ability to identify unstable patients in time to stabilize them than the Manchester Triage system, based solely on physiological assessment.

The Cape Triage Group responded with an article in 2012 in the recently founded *African Journal of Emergency Medicine*. Their article, entitled "Warning Scores in Triage – is there any point?", is based on a 2-month prospective study conducted in the Emergency Centres of two privately funded hospitals in Cape Town, South Africa (Gottschalk *et al* 2012). They prospectively assessed 1,867 patients and then correlated patient outcome with their EWS score, where outcome is used as an index for acuity. They hold that while an EWS that has not been adapted may be unsuited to Emergency Centres receiving *trauma patient*s – that is what the START+ triage protocol discussed above was good for – the adapted Triage Early Warning Score (TEWS) was able to accurately predict patient outcomes for both medical and trauma patients. In their discussion section, the authors hold that the Subbe *et al* study from 2006 was undertaken in "*mature system with different staffing and case mix to our environment*" (Gottschalk *et al* 2012:106). The interest of the Cape Triage Group was to "*design a concise triage tool which junior staff were capable of using"* (Gottschalk *et al* 2012, p.106).

It would seem then that there is something specific about the patients and about the staff in South Africa that differs from their counterparts in the United Kingdom, which justifies the use of an adapted EWS in the context of Accident and Emergency triage. Indeed, this is a point they had made in the 2006 article summarized above (Gottschalk *et al* 2006). The tools existing at the time demanded *extensive training* for practitioners, were only appropriate for *trauma patients*, or were *too detailed* for "roadside use" (2006, p. 53). This makes them ill-adapted to South African context, where the severity of pathology is high – as patients tend to wait until their situation is serious until they present, in an attempt to avoid healthcare costs – and where there are particularly high numbers of patients relative to available resources. And a similar point is brought up in the 2012 Training Manual, as you can see in the Figure 26.

This was one of the essential qualities of the SATS protocol then. It could act as a vehicle for such values as human health and life, the efficient use of resources, as well as equity. Using a

1.3 Who should be the triage provider?

Nurse-based triage has been successfully implemented worldwide in the countries of North America, Europe, the Middle East and Australasia since the development of Emergency Medicine as a speciality about 30 years ago. Table 2 shows the number of medical practitioners and nurses per unit of population in South Africa, compared to some "developed" countries. Given the significantly lower doctor: nurse ratio in South Africa compared to countries where nurse triage is widely practiced, it is apparent that the development of nurse-based triage should be a priority in our setting.

Country	Rate per 100,000 population/ year		
	Doctors	Nurses	Doctor: Nurse ratio
South Africa	56.3	471.2	1 : 8.0
Canada	229	897	1 : 4.0
Australia	240	830	1 : 3.4
Israel	385	613	1 : 1.6
UK	164	479	1 : 3.0

Table 2: Doctor and nurse rates per 100,000 population per annum for selected countries

Nurses are the first medical contact for the patients attending the Emergency Centre in most instances. In South African studies, adequately trained Enrolled Nursing Assistants (ENAs) have been shown to be accurate to a degree comparable with international standards of nursing triage.[2 3]

Figure 26: Ratio of doctors to nurses and explicative text. Source: West Cape Government, 2012.

statistically valid scientific triage protocol, it could establish differential needs for speed in both medical and trauma cases, with appropriate levels of specificity and sensitivity, while respecting ACS-COT recommendations on over- and under-triage. *This brought to life an option hitherto inert in situations with HR limitations: preventing irreversible morbidities and death in A&E patients with both medical and trauma profiles.* Furthermore, it can do this without relying on a patient capable of accurately expressing his or her present state. As we saw, this was too much to ask of many patients presenting in an Accident and Emergency department. Finally, we saw that, unlike other triage protocols in use at the time of its development, it could be accurately used by junior staff, without extensive training, in settings with HR limitations. This was meant to improve the overall health systems by increasing the ability to communicate on the states of patients between health facilities, allowing easier audit of emergency departments, and reducing morbidity and mortality in a national health system.

It would seem then that the designers of the SATS protocol were indeed attached to a higher-order "greater good". However, this "good" is not achieved through sacrificial logics or tragic choices. Rather, triage promises to allocate resources *according to need* and to improve coordination at the health system level. This was not accomplished solely through adherence to abstract principles, but by designing a practical and reliable tool adapted to the shortcomings of an

imperfect system, which brought to life the option of preventing irreversible health states (morbidities, mortality). These are the options and responsibilities of the tool's designers.

As we shall see in the coming section, these promises can only be kept if triage orders a specific kind of attention that enacts the *bodies* presenting in A&E services as *fragile*. This has serious effects on the living options and caring responsibilities that emerge with the SATS protocol *in situ*.

c. Fragile Bodies, Unstable Reference, and Caring Responsibilities

In this section, we will describe how the *differential needs for speed* are established by the triage protocol. We will see how the triage protocol enacts bodies that are *unstable*, always already on the brink of irreversible deterioration and death. We will then see what this does to both the *problems of reference* to bodily states in the triage protocol – that is, the epistemology of triage – and the *caring responsibilities* of staff – that is, the ethics of triage. To be more specific, I will show how the fragility of bodies makes the triage score *unstable*. This means that triage is not a one-off operation, but a constant vigilance – a kind of attention – to patients, even those who exaggerate. This is how the protocol orders *attention*.

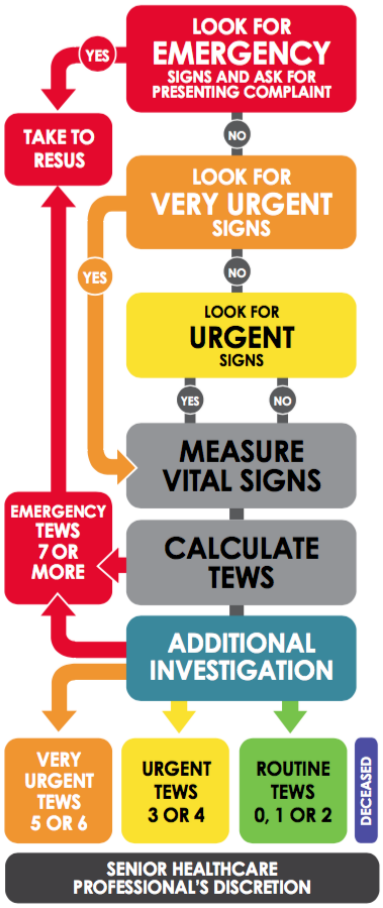

Figure 27: SATS flowchart. Source: Western Cape Government, 2012.

To see what kind of bodies we are dealing with, let's look at how the SATS protocol works. It is a stepwise system (cf. flowchart in Figure 27). It assumes, first, that there are patients that come to an Accident and Emergency (A&E) service with a complaint, and that these patients wait for medical staff to provide care to them. As the patients present, it tells the triage agent to look first for a series of clinically anomalous "signs" (never symptoms).

In MSF's A&E department in the Eastlands slums, patients come and wait to be triaged. The triage agent surveys the patients as they arrive, and those presenting with "Emergency Signs" can be taken directly into the trauma room. Their TEWS is scored inside, not at the triage desk. These "Emergency" signs include an obstructed airway, a patient not breathing, ongoing seizure, facial burn, cardiac arrest, hypoglycaemia, and trauma. These signs do not establish diagnosis or aetiology. They do not say what kind of care the patient needs. They only tell the triage agent that

there is a potential need for urgent, life-saving care. As such, the patient should be taken *immediately* to the resuscitation unit. That is, these signs engage a *Red response*, before TEWS scoring has been done. The TEWS is established inside, and this score written on the triage form, often after the patient has been stabilized.

If there are no "Emergency" signs - if the need for care is merely "Very Urgent" (Orange), "Urgent" (Yellow), or "Routine" (Green), then the patient comes to the triage agent and tells them what their complaint is. The triage agent writes the *Complaint* - not *history*, just the *complaint* - on the triage form and establishes a Triage Early Warning Score (TEWS). They do this by speaking to the patient and by measuring a series of statistically stable *Vital Signs*. As already mentioned,

ADULT TRIAGE SCORE								
	3	2	1	0	1	2	3	
Mobility				Walking	With help	Stretcher/ immobile		Mobility
RR		Less than 9		9 - 14	15 - 20	21 - 29	More than 29	RR
HR		Less than 41	41 - 50	51 - 100	101 - 110	111 - 129	More than 129	HR
SBP	Less than 71	71 - 80	81 - 100	101 - 199		More than 199		SBP
Temp.		Less than 35		35 - 38.4		38.5 or more		Temp.
AVPU				Alert	Reacts to Voice	Reacts to Pain	Unresponsive	AVPU
Trauma				No	Yes			Trauma
Over 12 years/taller than 150 cm								

Fig. 1. Triage Early Warning Score (TEWS) (RR = respiratory rate, HR = heart rate, SBP = systolic blood pressure, AVPU = Alert, Verbal, Pain, Unconscious).

Figure 28: TEWS Score chart. Source: Gottschalk et al, 2006.

these include heart rate, respiration rate, systolic blood pressure, blood oxygen saturation, and body temperature. Variation from the statistical norm is worth between 1 and 3 points in calculating the TEWS (cf., the green bar on TEWS score chart in Figure 28). In addition, there is a mobility score (walking, walking with help, immobile/stretcher - 0, 1, or 2 points), a trauma score (trauma, no trauma - 0, or 1 point) and a test for neurological problems. The SATS protocol stipulates the use of the AVPU neurological test, but MSF-wide guidelines dictate the use of the Glasgow Coma Scale (GCS) to establish levels of consciousness.[1] On the GCS, any score below 10 is "Severe" and is worth 2 points in the TEWS calculation. A score of 10-12 points is "Moderate" and is worth 1 point. A score of 13 or above is "Minor" and worth 0 points when calculating the TEWS. If the patient only opens their eyes and speaks in response to painful stimuli, and can pronounce a few words, but not complete sentences, even confused ones, they would be scored "Severe". A "Severe" GCS score would be worth 3 when calculating TEWS.

As the triage agent takes Vital Signs and history, they go down the TEWS score chart and circle the appropriate cells on the chart. Above the cell, in the green bar, is the score associated

[1] The AVPU is a simplified version of the GCS (Cf, McNarry & Goldhill, 2004).

with each Vital Sign level (Cf. Figure 28 above). They add these together, and a TEWS score of 7 or above is an "Emergency" - Red - and the patient is taken directly to Resuscitation. Between 5 and 6 is "Very Urgent" - Orange - and the patient should receive care in less than 10 minutes. Between 3 and 4 is "Urgent" - Yellow - and should receive care in less than an hour. Below 4 is routine - or Green - and they can wait 4 hours for care. MSF does not receive Green cases in the Trauma Room in the Eastlands' project.

The emergency room patient is suffering. Triage does not establish the cause of this suffering, nor does it explain this suffering. It makes a prediction. Based on statistical evidence, triage says that living bodies suffering in certain ways – ways that are discernible through certain signs that appear on the body independently of the presenting patient's will[1] – are *fragile*: they could stop being alive at *any time*. If these soon-to-be-no-longer-living bodies, or at least soon-to-be-no-longer-the-same bodies, arrive in the A&E *on time*, then the doctors, clinical officers, and nurses can stabilize them. They do not treat underlying conditions. They do not even have a laboratory to get blood work done. Junior medical staff use simple medical techniques and technologies to keep these bodies living and to avoid irreversible morbidities. Then they refer them to Kenyan hospitals.

These are the options that triage brings to life in MSF's trauma room in the slums of Nairobi, and this is the extent of their responsibility. Triage renders medical staff attentive to the *fragility* of living human bodies. Their *responsibility* in these situations is to establish priority based on the degree of urgency. The situation is ordered in such a way that the options brought to life are to help those with life-threatening need first, and to send patients with non-life-threatening issues - primary health care or chronic illness - to Kenyan Primary Health Care centres. Their skillset, developed through training and experience in emergency medicine, allows them to stabilize patients who are always already on the brink of irreversible deterioration. Once stabilized, they are referred to Kenyan public hospitals for further diagnosis, treatment, and, if necessary, hospitalization. This set-up is meant to allow MSF to fulfil its project-level objective for the Eastlands Trauma Room, which is to increase access to hospital-level medical care for the slum population.

There is, however, a *problem of reference*. These bodies are fragile; their vital signs are unstable. Sudden changes in Vital Signs might be missed if they take place before assessment or

[1] Analyzing triage in terms of Carlo Ginzburg's *indexical paradigm* (1980), with inspiration from Chateauraynaud & Torny's work on Early Warning Systems (1999) would produce very interesting results.

after assessment. As Dr Abayo told us, a Mild asthma attack can become Severe, and life-threatening, *at any time*. Such patients should remain close by for observation, because a single triage score attributed to a patient at a single point in time cannot be any more stable than the body it references. The initial situation – where patients were unreliable - has been somewhat reconfigured. No longer is it the patients who are "faking" and "liars", but the triage score that is spurious. The protocol may support the mechanically (Daston 1992) or regulatory objective (Cambrosio *et al* 2006) inscription of the patient's physical state on the triage form. But as long as this inscription is immutable (Latour 2013), it is problematic. Insofar as triage enacts bodies as *fragile*, a *stable* triage score breaks a link in the chain of reference.

It comes as no surprise then that triage is not a single operation done once and then forgotten. As we have seen, triage is a stepwise process, where the patient is continually assessed according to different criteria, signs, discriminators, markers, and clues, any of which could tilt the scales of the triage score into the Yellow, the Orange, the Red. *Not only is the body of the patient fragile, but the triage score is unstable as well*. Let us look at what this processual approach to triage – as continual assessment and reassessment – does to the caring responsibilities of MSF staff. What follows is an excerpt from the notes I took during my fieldwork in MSF's trauma centre.

> *I sit and talk with Roberts, the Trauma Room nurse, and we hear a crash, then a scream in the street. He winces, and says "car accident", and is* ***already*** *hurrying towards the door. I follow. Outside, a man is* ***already*** *helping a young woman move towards the Lavender House. Her flowery dress is covered in dirt. She is breathing heavily and whimpering, visibly in a great deal of pain. She can barely walk and is hanging on the man's shoulders.* ***They skip the triage station and go directly to the trauma room.*** *She is put on a bed, where she lays down. Roberts and Dr Abayo are* ***already*** *by her side. Abayo is putting on gloves. The Clinical Officer comes in and pulls the DINAMAP to the side of the bed, to measure blood pressure, heart rate and [blood oxygen saturation]. "Can she speak?", Abayo asks. He says aloud that she is in shock and unresponsive. They pull curtains around the bed. I am sitting at the nurse's desk in the corner of the trauma room. The curtain is open in such a way that I can see some of what the medical team is doing, but I cannot see the patient. Abayo repeats her name a few times, with his hand on her chin and jaw. He moves her head back and forth, repeats her name, seemingly looking into her eyes. They pull the curtains all the way closed. I feel like some kind of voyeur. I leave the trauma room. I'm writing at the desk in the "medical office". It's 8:45am.*
>
> *At 8:50am, I walk to the nurses' station and ask the Clinical Officer, if the patient is ok.* ***Yes, she's just in shock.***
>
> *Abayo comes out and tells me about the woman. She's in pain, enough that they give her Tramadol. It worked almost immediately. She sat up and stretched her arms above her head. So, she's ok. Then her husband came into the room, and Abayo says she became "hysteric", whimpering again, saying she couldn't sit properly.* ***He says she's just trying to get "attention" from her husband.*** *[…]*

> *The lady hit by the car is walking around in the reception area. Her husband is holding her arm. Abayo looks out the office door towards her, and then back at me. With a knowing grin. In a low whisper,* ***he tells me that she is obviously faking. If she was really in pain, she would be shouting, whimpering, something.***
>
> *I write my notes, then go into the trauma room a few minutes later. Roberts and Abayo are talking.* ***Roberts mentions the accident was not as serious as they initially thought. He adds that she was maybe a little "hysteric", but you never know.*** *Abayo says again she was faking but adds that the sound of the crash was so loud. The impact was impressive.* ***You never know****, he adds. I ask what they'll do in terms of follow-up for a case like this. Roberts says that they always tell patients they can come back if there are complications. They also have a check list for head trauma that they give the patient. He shows me one.* ***It gives a list of symptoms – nausea, loss of consciousness... - and says that if the patient has any, they should immediately come back to the trauma room.***

This is a "false alarm". A woman is hit by a car, taken to the trauma room, where they realize the patient is "hysteric", "not as serious as they thought", "but you never know". However, to get to that conclusion, A&E staff went through a series of assessments, all aimed at establishing the *need for speed*, recognizing that the patient could change states at any time. There were "emergency signs", allowing them to skip over the triage station and go directly to the Trauma Room. There, all hands are on deck: the Clinical Officer, nurses, and the ER doctor. Dr Abayo talks to the patient, looks into her eyes. The Clinical Officer sets up the DINAMAP and takes the vital signs. Here, the patient's state is being monitored, assessed, evaluated. Her situation was deemed an emergency, but what exactly needs to be stabilized? They are still looking. They end up giving her Tramadol – an opioid used for moderate levels of pain – but come to realize that she will be fine, there is no real emergency here. Just a bit of shock. She was exaggerating. *But you never know*. To be able to evaluate the patient as hysteric, they go through all the predefined emergency procedures that are stipulated by the protocol. And the staff continue evaluating her condition, even after they concluded that she is exaggerating. Abayo says she's faking it and says he can tell because she is not shouting or whimpering: he is still assessing her state. The patient's health state, her body, is still being enacted as *unstable*. This continues even after she leaves the clinic. She may have received a head injury, and if this is the case, the seriousness of the situation may not be immediately apparent. They give her an information sheet with a list of symptoms in Kiswahili. If she starts to feel nauseous or confused, or to have memory loss, then she should return immediately to the Trauma Room. *Because you never know*.

The point here is that, to deflate even more the *tragedy* of triage, we cannot imagine the decision to allocate resources in an A&E as a one-off event. Patients arrive, and they are evaluated. They wait their turn to be triaged, and as they do, their state is being evaluated. They undergo the formal operation of triage, physiological markers and vital signs. Here, we saw that if triage were

to require certain forms of intentional action would be too much to ask of some patients. It is her body, as it moves in unintentional ways, that must behave in specific ways. It is when the unintentional workings of her body contradict what she expresses with words and with body language that she is deemed "hysteric". In addition, when patients make it into the trauma room, evaluation of their state continues. This is a far cry from the *tragic choices* approach to triage that situated tragedy in a single moment where an irreversible decision was made once and for all. Not only is triage a question of practical options in moments of potential loss of life – as opposed to the mental operations of "tragic choice" – but it does not occur at a single moment. Triage orders *sustained vigilance* to the ever changing and forever fragile bodily states of their patients. The triage score is as unstable as these bodies. It is constantly being reworked and can always be brought into question, even after everyone in the trauma room agrees that the patient was "exaggerating". *Whatever the staff may think of the reality of the patient's need, their responsibility is to remain attentive and responsive to this fragility.*

*

Somewhere along the way, the "sacrificial logic" and "tragic choices" of triage have disappeared. This is not to say that triage does not include troubling moments, that can elicit the indignation of observers. Indeed, those patients designated as "hysteric" by staff indicate some of the ethical trouble associated with triage. The way staff classify patients who "exaggerate" echoes similar results in the sociology of patient admissions that show how patients must perform a morally identifiable identity as they negotiate access (Hillman 2013). However, it is important to underscore how the performance in question is that of a fragile body, not individual responsibility for one's health state. The moral devaluation and the refusal of care to patients who "exaggerate" their needs is brought alive as an option insofar as the caring responsibilities of the medical staff of this A&E service lie with those whose lives are in danger. We can also claim, with Nurock & Henckes (2009), to have integrated a structural analysis of patient admission with work on the "good patient" of A&E. However, instead of Freidson as our reference for structural analysis, we prefer Erving Goffman. In his analysis of "embarrassment and social organization", Goffman analyses *discomfiture*, which occurs when contradictory organizational principles must be maintained in an interaction ritual, as the mechanism by which these principles and, thereby, the organization are maintained. (cf. Goffman, 1967, especially p. 109-112, where Goffman clarifies his structural analysis of interaction). Here, we saw another form of moral discomfiture - the disqualification of presenting patients as "hysterical" - that "saves" an organization as it prevents death by refusing care to people who are not in *urgent* need of care. In other words, we have sought, like Goffman, to work out a (post)structuralist response to the question of his *Frame Analysis*, and

which we posed – with Martha Nussbaum – as one of the two key ethical questions: *what is it that is going on here?*[1] We also managed to integrate the concern for rational choice that preoccupied work in anthropology, but instead of analysing choice as the result of reasoning through abstract principles that led to the sacrifice of some for the greater good, we saw that choices were the result of mundane practices of ordering - an Early Warning Score - that made it possible to detect those who were on the brink of irreversible change in their bodily state. This organized triage in such a way as to enact sustained attention to the fragility of MSF's beneficiaries.

In the next section, we will look at how this platform for emergencies supports MSF's intervention in the Kenyan health system. This occurs during another essential activity that the platform for emergency supports, namely, patient referrals.

3. Patient Referrals and Intervention from the Emergency Platform

In this section, I am interested in how MSF's triage practices link up with patient referrals to order the provision of emergency medical care, spatially and ethically, in the slums of Nairobi. The overall project objective is to get patients *from* the slums *to* definitive care at the hospital level *in time* to save their lives. That is, *triage* is a crucial moment when MSF defines their own responsibility towards a patient, and then they *transfer that responsibility* to another institution. That is what they do, "triage, stabilize, and transfer*"*. As it turns out, patient referrals are difficult. Public facilities in Kenya are not always keen on accepting responsibility for the patients MSF sends to them. MSF staff claim to have the ability to decide when a patient requires hospitalisation. Kenyan public hospitals contest MSF's ability to dictate when they should accept a patient. This is not particularly surprising. These lead to difficult experiences for MSF staff. When I brought up referrals with Lucy, she told me *"that's a nightmare. Like every morning, I just have to go like, 'God, give us a smooth day'."* All the nurses and Emergency Medical Technicians I interviewed

[1] For Goffman's take on the question w*hat is it that is going on here?*, see (Goffman, 1974, p. 16). This reading of Goffman builds on Daniel Cefaï & Eduard Gardella's 2012 article "Comment analyser une situation selon le dernier Goffman?". « Goffman tente de comprendre comment s'organise l'expérience d'une situation, fondée sur la saisie des indices présents dans le contexte d'une interaction et sur l'accomplissement d'activités situées, conformément à des règles. Il ne se donne pas d'avance un système d'intérêts constitués ou d'identités sociales, qui court-circuiterait la contingence des circonstances, mais il ne postule pas non plus l'infinie plasticité de la réalité : l'expérience est organisée par des cadres, elle ne réinvente pas à chaque fois ses coordonnées. Goffman respecte une relative autonomie des acteurs, capables d'anticiper ou d'apprécier les conséquences de ce qu'ils font et de jouer des coups, dotés d'un sens stratégique et d'un sens moral, sans en faire pour autant des champions de l'action délibérée. C'est sur cette ligne de crête entre structuralisme et interactionnisme que Goffman déploie ses analyses » (Cefaï & Gardella, 2012, pp. 236-237).

had stories of losing patients because of difficulties in referring patients. Lucy told me about one patient that had been eviscerated, another with an intestinal obstruction, who died because the Kenyan hospital to whom they had attempted to refer had refused responsibility for them. These refusals are, in part, tied to a lack of resources, and to the fact that, as already mentioned, the public health system is still building up their emergency platform. And yet, MSF's overall objective in the Eastlands is to transfer responsibility for emergency patients. The question is where the limit to this objective lies. *When do difficulties in transferring responsibility for patients become the sign that their project has failed? When does intervention into the public health system cease to be humanitarian aid and become development?*

I will be analysing these issues as platform problems. In the first section, we will see that MSF's unique position on the platform - in between levels, a kind of dispatcher - has made it more difficult for them to refer patients. In section two, we will see how recent changes in the Kenyan health care system, and associated social movements, have made it difficult to set up routine referral pathways. In the third section, we will see how the entry price to the emergency platform is perhaps too high for the Kenyan health care system, which has led some in MSF to wonder if their Mathare activities is a humanitarian project or a development program.

Before we go into more detail, it will help if the reader has some idea of the geography of the *platform for emergency* in Nairobi. The figure below is a map of the Eastlands of Nairobi. The orange line is the approximate border of the Catchment Area for the ambulance service, that is, the orange line represents the extent of MSF's responsibility for emergencies. The yellow tag with a star close to the centre of the Catchment Area, and adjacent to the intersection of two main arteries is where MSF's Trauma Room is located. Also visible on the map are three public hospitals to which MSF most often refers the patients they pick up. The first is **Mama Lucy Kibaki Hospital (MLKH)**, the yellow circle to the east of the Catchment Area. This is the hospital, previously mentioned, where MSF has supported the improvement of the A&E service. These improvements include the introduction of the SATS protocol; hiring EMTs, paying their salaries, and providing them with training; training laboratory staff; and hiring radiographers. In addition, an MSF Nurse Activity Manager from Burundi worked there full time until December 2018, and an MSF doctor visited twice weekly. The Memorandum of Understanding between MSF and MLKH – which did

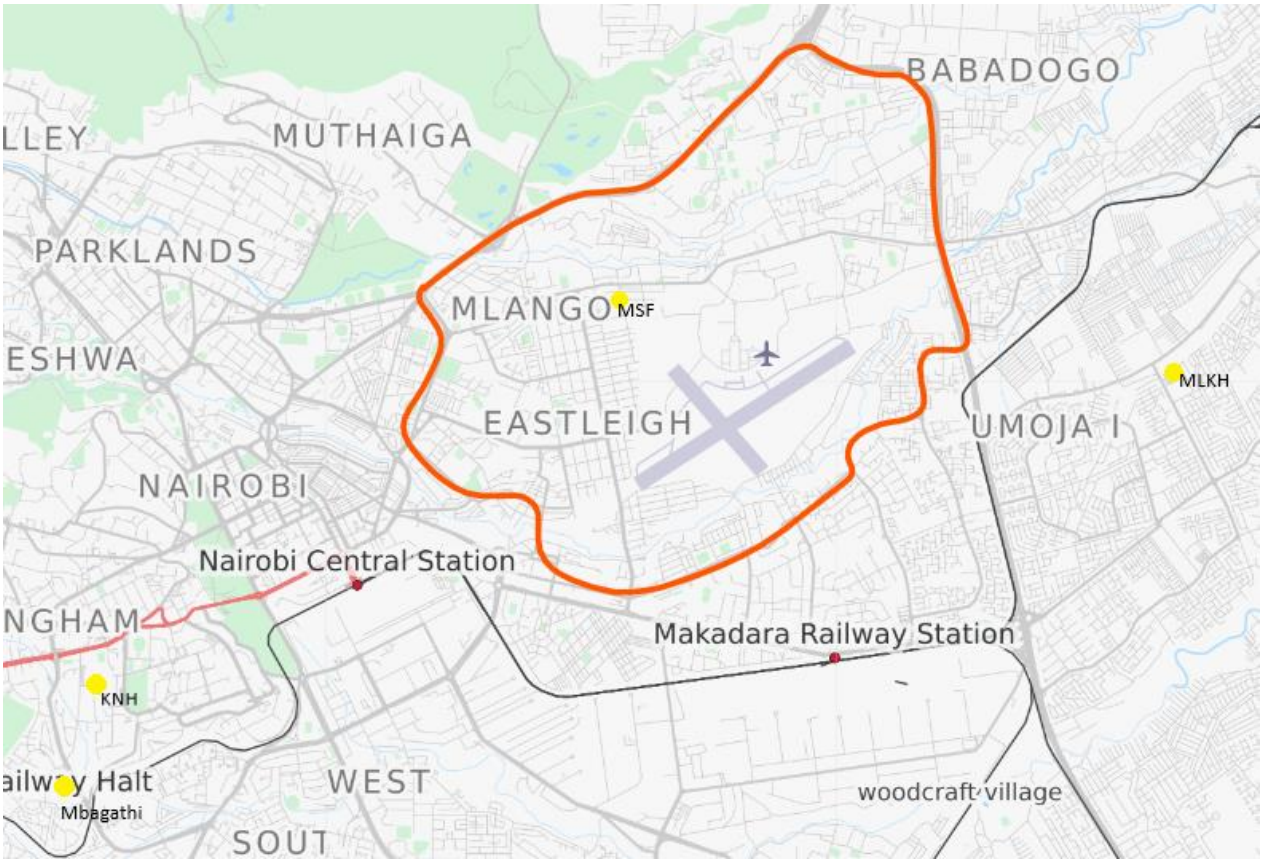

Figure 29: MSF Ambulance Service Catchment Area (inside orange line). The yellow circle at the centre of the catchment area represents the location of MSF's A&E. The yellow circle to east, Mama Lucy Kibaki Hospital (MLKH). The yellow circle to the southwest that

not cover patient referrals – ceased to be in effect in December 2018. Salaries have been defunded, and there are doubts about whether the Ministry of Health (MoH) will keep the staff at all or keep

them in the same service. To the southwest of the catchment area are two hospitals. Farthest away is the **Mbagathi District Hospital**, specialized in infectious disease. Second, **Kenyatta National Hospital (KNH).** This is the Level 6 national reference hospital, receiving patients from all 47 counties in Kenya and from the wider East Africa region. This section is about how patients are dispatched to these sites of definitive care, and to what this set up can tell us about MSF's intervention into the Kenyan public health system. This is how referrals are supposed to work.

a. The platform and levels of care: referring up and down

Medicine is organized into levels of care: Primary, Secondary, Tertiary. The position of MSF's platform on this *scale* – somewhere between Primary and Secondary care, responsible for dispatching emergency patients to adequate definitive care whatever the *level* – has caused misunderstandings.

Here is how referrals are supposed to work: MSF staff send patients to the appropriate medical facility based on their *speciality and capacities* – that is, maternity ward, an isolation unit, an ICU – and their *level of care* – Primary, Secondary, Tertiary. They "*refer up and down*", as I was told. They "refer down" when they advise patients to go to Primary health facilities – that is, level 1 care in the Kenyan classification system. They "refer up" to district hospitals – Mama Lucy Kibaki and Mbagathi Hospitals – and national reference hospitals – Kenyatta National Hospital. In the Kenyan classification system, these are levels 5 and 6, or Secondary and Tertiary in other health systems. Secondary and Tertiary are "hospital-level". Insofar as MSF's project-level objective in the Eastlands of Nairobi is to "increase access to hospital-level care", their overall goal is to "refer up".

We have hit upon one of the specificities of MSF's trauma room and their ambulance service. They "refer down" to Primary Care, and they "refer up" to Secondary and Tertiary Care. Clearly, then, they provide neither Primary, nor Secondary, nor Tertiary Care then (or, in Kenyan parlance, in Levels 1-2, 3-4, or 5-6). What level of care does MSF provide? When I asked the head nurse, she was unsure. She asked the Assistant Activity Supervisor. He did not know either. They asked the Activity Supervisor, who said "2 or 3", holding her hand flat and tilting it back and forth. Dr Abayo, hearing the conversation, agrees. They provide what they call *prehospital care*, somewhere between the Primary Care of local health centres, and the hospital-level care at the Secondary and Tertiary levels to which they hope to refer. The Medical Team Leader – responsible for all of MSF's medical activities in Nairobi – tells me that, officially, the care provided in the trauma room is level 2 and ambulance care is level 1.

This lack of clarity concerning the level of care that MSF provides has led some in MSF to suggest that MSF has an "unclear remit" in Mathare. Even more, it has been claimed it has made referrals more difficult. The following is an extract from a British ER doctor's End of Mission report. She addresses her successor in the second person "you".

> ***"Unclear remit -***
>
> *One of the main challenges with your role in Trauma Room is that* ***the role of the facility itself is poorly defined*** *and has been from the outset.*
>
> *It is difficult to know* ***what level of care the trauma room is aiming to provide****. Most patients seen are minor injuries and the rate of attendance is fairly low so having a full-time doctor presence would mean a lot of wasted resources. However, about 3 times a week there are serious emergencies like major trauma in need of high levels of care with which the [Clinical Officer] struggles. […]*
>
> *The best illustration of this is the use of the trauma room for CPR [Cardiopulmonary Resuscitation]. There have been a handful of cases during my time where patients have arrested in the community and been brought to the trauma room for CPR as two out of three of the ambulances are too small to perform CPR in.*
>
> *This leads to the problem of what next? On one occasion ROSC [Return of spontaneous circulation] was achieved.* ***This left us with a patient in need of immediate intubation and inotrope support in trauma room.*** *They were transferred back into the ambulance where they lost output after 20 minutes and were* ***declared dead on arrival at Kenyatta****. Besides replacing the ambulances to make them all capable of delivering CPR on route […]it is difficult to know what the alternative is, but bringing patients for a brief stint of CPR before transfer to hospital seems futile."*

MSF provides "prehospital care" in Mathare. This is an important part of "emergency medicine", but it is only one part of this larger speciality. The other parts of "emergency medicine" – some surgical procedures, the stabilization techniques used in an ICU, toxicology, and more – are only available in a hospital setting. In general, "prehospital care" set-ups are directly attached to hospital A&E services and constitute an essential access point to hospital-level care. MSF's set-up in Nairobi does not include a hospital, and they refer patients in need of these hospital-based parts of emergency care to the MoH system. As previously discussed, emergency medicine was only recently recognized as a medical speciality in Kenya. Yet, there is little or no training in the country, and no staffing. The public ambulance service is technically deficient and dysfunctional, and private ambulance services are too expensive for most in the slums. The long-term goal for MSF's ambulance service is its transfer to the national Ministry of Health. In the meantime, they must deal with referrals, while attempting to reinforce Nairobi hospitals capacity.

Now that we have a better understanding of the issue of defining the "level of care" MSF provides in their A&E service, we can look at a related issue: getting patients from *prehospital care* to appropriate Secondary or Tertiary care facilities. The following are from notes I took

immediately after a conversation I had with Dr Abayo, the expat Trauma Room doctor, and Shadrak, the national Assistant Activity Supervisor. While everyone agrees that "Kenyatta is overwhelmed", the problem, according to Abayo, is that "they refuse patients whose lives could be saved". As a response:

> *Shadrak talks about how Kenyatta says that MSF can't do many investigations. They have no lab, no CT scans. Nothing. So,* ***patients arrive with no reports, no investigations, and with no specific demands.*** *They want us to refer through Mama Lucy first, because they can do these tests. Like blood tests, CT scans. That way they can say, "ok, we're referring to you for this specific thing, the patient needs this." […]*
>
> *I mention that it sounds like Kenyatta refuses referrals in part because MSF is "jumping too many levels". From Level 2 to Level 6, and KNH wants them to go through a Level 5 first, that is MLKH. Yeah, exactly, Shadrak repeats the "jumping too many levels" expression. Abayo says – but this means* ***they think we are incapable of assessing a patient and saying when they would benefit from ICU, isolation, etc.***

The tool MSF uses to establish need in this A&E service is *triage*, which establishes the need for speedy intervention. It does not establish aetiology or diagnosis. Triage only says how unstable the patient is. Without no scans or tests, they refer patients to a tertiary care facility without being able to say what they are expecting. The problem is that KNH - perpetually overwhelmed - must take them at their word, without the diagnostics that would make their requests more specific.

This situation is further complicated by the fact that – as the Medical Team Leader for activities in Nairobi told me – MLKH is Level 5 "on paper", but not in practice. Mama Lucy Kibaki Hospital can get scans done - sometimes sending patients to a private lab across the street - but they do not always have a radiologist on hand that is capable of writing a report to go with them. MSF is aware of the limits at MLKH and has been supporting them in the improvement of services. MSF has improved the lab, trained lab staff, set up triage protocol, hired staff to do triage, trained staff on triage, sent an experienced nurse to help, and even hired a radiologist. They intervene extensively in this public hospital with the goal of helping them set up the capacity of their Outpatient Department (OPD) to detect emergencies upon their arrival and to respond with emergency medicine. They have made progressive improvements in the quality of emergency care provided. This is precisely the reason KNH wants MSF to send their patients to MLKH. Not only is MLKH Level 5 "on paper", but the Level 5 care that they do effectively provide is in limited supply. MLKH was built as a maternity hospital, not a general hospital. There is no Intensive Care

Unit (ICU) and Inpatient Department (IPD) capacity is limited.[1] This lack of space has a very direct effect on referrals.

The problem of referrals is in part a problem of *levels of care*: the prehospital care MSF provides is technically Primary Health Care, but triage provides them with the unique ability to detect instability. Given the recent introduction of emergency medicine in Kenya, this ability is not necessarily appreciated, and patients arriving at Tertiary Level facilities without a clear request in the referral documents are often turned away. MSF is attempting to set up as a platform for emergency medicine in Kenya, but the recent introduction of this speciality has complicated their task: how far can they go, should they go, in improving public health facilities in order for them to have the capacities to manage emergency patients? What is MSF's *remit* in Mathare?

b. Coordination from the platform: routine referral pathways

Is it that simple? MSF is jumping too many levels? Unfortunately, this is only part of the problem, and, in truth, it is a recent development. A second problem has to do with setting up **routine referral pathways and the coordination of referrals** between MSF Call Centre staff, MSF trauma room staff, and the staff of MoH facilities. In the previous section, we saw that MSF sent patients to different referral destinations based, in part, on the *level of care* provided. I also mentioned that they send patients to those sites with the *appropriate speciality* of care. Given these rather stable considerations for patient referrals, it should be possible to establish routine destinations based on case types. This is confirmed by a discussion I had the first day I spent observing activities in the Call Centre:

> *I ask if they refer to some facilities for specific conditions, health situations. Shadrak, the assistant activity supervisor, answers. What we do is we **stabilize** and then **refer**. That's what the **ambulances** do, and that's what we do in the **trauma room**. We **stabilize**, and if they need further care, we **refer**. Otherwise we **discharge**. We don't have a lab, so that limits the investigations we can do. To **Mbagathi**, we send malnourished, TB, HIV/Aids, maternity, paediatric. To **Mama Lucy**, we send malaria, minor pneumonia, paediatric, maternity, diabetes, sickle cell anaemia, mild anaemia, diarrhoea and vomiting, typhoid fever, and simple orthopaedic cases. To **Kenyatta National Hospital,** the national reference hospital, Level 6, we send severe trauma and all*

[1] Out of 112 IPD beds, only 20 are left for adult non-maternity and paediatric cases, meaning adult medical and surgical capacity is limited. MLKH has *zero* ICU beds. In 2016, MSF wanted to support the set-up of an ICU in MLKH, but there was no available room. KNH has ICU capacity of 30 beds, distributed in various units: 21 main ICU, 10 medical ICU, 6 paediatric ICU and 3 ICU bed at Accident and emergency. I was told that ICUs are always at full capacity, and that patients have to be discharged or to die for space to be found. When a bed is free, priority is given to patients coming from the wards inside KNH, and not to outside referrals.

*complications. To **Mathare North** – we send Primary Health Care, and some life-threatening chronic medical conditions, like diabetes. To **Pumwani** obstetrics, gyn, and maternity.*

MSF's responsibility is to get their patients to appropriate definitive care. When a patient needs to go into isolation, you send them to the hospital that has an isolation unit. Unfortunately, it is not this easy. The national health system has been undergoing periodic strikes for the last few years, following structural reforms in 2013 that redefined the relationship between the national Ministry of Health and county Ministries of Health. These strikes affect referrals destinations, visible in the graph in Figure 30, because the place you may want to refer is not necessarily open.

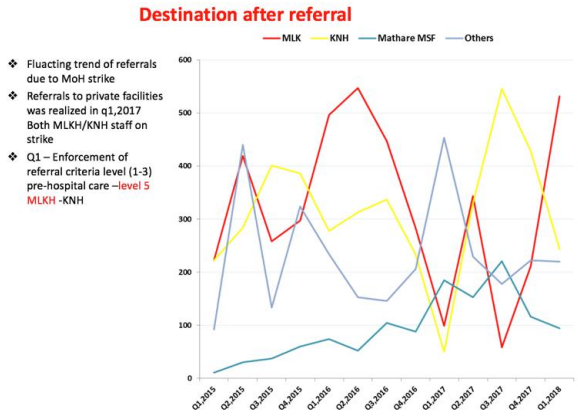

Figure 30: PowerPoint slide from the pre-MAP discussion at Mathare

The graph comes from a PowerPoint slide used to stimulate discussion and narrative building around MSF's activities in preparation for the spring 2018 MAP. During discussion among staff on this graph, the ups and downs of referrals are said to reflect the strikes as they took place in each facility. In Q4 2016 and Q1 2017, both Kenyatta National Hospital (KNH – Yellow line) and Mama Lucy Kibaki Hospital (MLKH – Red line) were on strike at the same time and, in consequence, referrals there dropped to ≈100 per quarter, when they had been >300 for KNH and >500 for MLKH. At that time, MSF received more and more patients in the Trauma Room and began referring patients to private facilities and paying for their hospitalization.

Furthermore, as of Q4 2017 - Q1 2018, Kenyatta National Hospital started enforcing *new referral criteria*. As is visible on the graph, this has led to a decrease in referrals to KNH and an increase in referrals to MLKH. The main thrust of KNH's new referral criteria is to insist that patients come from facilities at a level directly below them: that is, no "jumping levels" (even though that is precisely what emergencies demand). Primary Care facilities cannot refer to Tertiary Care facilities *directly*. Referral must first go to Secondary Care facility, where they assess the patient's needs, sending them up the chain of reference towards a Tertiary Care setting only if they are unable to handle the case. This is because – as I was told by numerous people in many different settings – Kenyatta National Hospital is "overwhelmed", so they try to lighten their load by getting district hospitals to take their fair share. This makes sense, but it also correlates to problems that MSF encounters in getting care for the patient to whom they are responsible.

Furthermore, these difficulties in establishing **routine referral pathways** can lead to "confusion" and "disagreement" between members of MSF staff. This is mentioned in the expat ER doctor's End of Mission report from January 2018.

> "***Referrals –***
>
> *There is sometimes **confusion or disagreement** with regards to which health facility a patient should be referred to within **Trauma Room and the Call Centre**. This needs careful negotiating as sometimes it is because the Call Centre have failed to appreciate the clinical picture and sometimes it is because the [Clinical Officer] or doctor has failed to appreciate the capacities of the referral centre."*

Expat doctors and national Clinical Officers are responsible for the patients they refer. Call Centre staff, responsible for the logistics of referral, have experience with the difficulties of referrals and with the actual capacities of referral sites. These different approaches to appreciating the appropriate destination has led to tensions in MSF's A&E. In the "Recommendations" section of the expat ER doctor's End of Mission report, she suggests "re-establishing referral pathways". She further suggests there be:

> *"a regular meeting cycle between MSF and the [referral] facilities to reinforce and update the referral criteria and to maintain the relationships. I feel there should also be regular surveys of the nearby health centres looking for places that we can send our patients to"*

I also heard national staff suggest MSF put in place a Memorandum of Understanding (MOU) with referral sites to clarify referral pathways and guarantee patients would be provided care under certain circumstances. This is meant to clarify relations between health facilities and allow the stabilization of referral pathways, making it easier for expat doctors to know where to send their patients.

In addition to the "level of care" problem, there are also difficulties in establishing routine pathways towards "appropriate definitive care" destinations. This is, in part, related to recurrent strikes in the national health system, which can on occasion take specific destinations out of service. The fact that expat doctors arrive with little knowledge of the effective capacity of different referral sites or the current availability of specific services, means there can sometimes be disagreement with the Call Centre staff who deal with negotiating access to referral sites over the phone.

The "jumping levels" and "unclear remit" problems, associated with issues in establishing "routine pathways", have led some to wonder if increasing access to hospital-level care in Nairobi is a "humanitarian mission" or a "development goal".

c. Getting the Ministry of Health on the Emergency Platform

MSF's activities in Mathare are about increasing access to hospital-level care through prehospital emergency medicine and an ambulance service. This relates to the fact that emergency medicine has recently been recognized in Kenya as a speciality. The idea is that MSF could participate in this movement. In this section, we relate patient referrals to the difficulties of getting the MoH on the emergency platform. These difficulties include the cost of emergency medicine - costs both in terms of the money it takes to treat emergency patients, and costs to a hospital's reputation when they cannot handle emergency patients - but also a "logic of emergency" that is contrary to current modes of attributing resources in hospital OPDs.

In an interview with Hope, a nurse, I ask for an example of a difficult referral. She talks about a patient with a head injury, whom they attempted to take to Kenyatta National Hospital. The patient was refused because they had "no machines to handle the patient". The ambulance team monitored the patient until he died.

> ***Hope**: One problem we face, and it's something most people face, is equipment. That hospital, you see at Kenyatta, from the time it was built, it has never been expanded. The population is growing. It was built a long time ago. So, the population is growing. It has never been expanded. If they need beds, they just add beds, but the space remains the same. […] They build up a very good ICU. But you hear, 'it has four beds'. You see, **it cannot accommodate everyone.** […] **There is no money. So, that is the problem we are facing. So sometimes, even if I want to help, I can't.** Because if I have to put this patient on a ventilator, you don't have the bed. So, the crew will just observe the patient until the patient dies. So sometimes their hands are tied. **And I understand.***

KNH is without a doubt a good medical facility, one of the most advanced public facilities in East Africa. However, what equipment it does have is not necessary in sufficient quantity to respond to every case that would benefit. Even if the situation is frustrating – Hope just finished telling me about a patient she lost because of this – she understands. Triage may be a simple and inexpensive technology, but the cases it identifies require additional resources.

These deficiencies are one reason MSF supports MLKH in improving their services, as already mentioned. These contributions help, but paying the salaries of a few staff does not solve the problem of limited equipment that Hope identified. Moreover, while MSF input makes sense with respect to the project objective of increasing access to hospital-level care, it also puts them in a delicate position vis-à-vis their other partners. MSF support to one MoH facility creates expectations of support in other MoH facilities.

> *I ask Shadrak - the Assistant Activity Supervisor - how long he has been here? If relations with Kenyatta were better before? He's been here four years. He explains that OCB – Operational Centre*

> *Brussels, as opposed to OCP or Operational Centre Paris, another "section" of MSF – used to be in Kibera – a slum to the West of the city – doing primary care, maternity, and HIV. They had a [Memorandum of Understanding] with Kenyatta, and* ***they would pay Kenyatta for patients they sent****. So now OCP comes along, they "dump" patients on them, and offer no support. And Kenyatta doesn't see a difference between OCP and OCB,* ***they only see MSF****. He points to the MSF logo on his vest.*
>
> *And* ***"they" know that "we" are supporting Mama Lucy****. They know that we pay salaries there, we set up triage, we hired EMTs, we support the lab. We do capacity building and training there.*
>
> *Shadrak says* ***it's like you have two wives, you only support one, but you always go to the other to eat and to wash your dirty laundry!***

MSF-OCP supports MLKH, and yet sends their most difficult – and expensive – cases to KNH. This is cause for resentment. But this does not mean that MLKH dutifully accepts all the patients MSF sends their way. The following are notes taken during a night shift I spent in the Trauma Room.

> *5:30am – As I type up some notes, [EMT] comes back from her call. As she left a couple of hours ago, she had an icepack in her hand, so I knew it was a maternity call – oxytocin needs to be kept cold, and it's the only thing they add to the ambulance that's not in the standard set-up. She's just come in and says* ***she's had a "crazy night"****. I ask what's going on.*
>
> *She says they went for a woman who had given birth at home. When they arrived, the baby had died. But the woman needed attention, so they took her, with the body, to Mama Lucy.* ***But Mama Lucy refused to take her. This is unheard of – Mama Lucy is an MSF supported hospital.*** *[…] They have a pretty good relationship with the staff, and some of the salaries are paid by MSF. I ask [EMT] what reason they gave. She says that there were no real reasons, it was an "attitude" problem.* ***They said that most of the patients MSF brings end up in the morgue. All the patients in the morgue are MSF patients.***

MSF may support activities in MLKH, but they ask too much. MLKH has had trouble in the past with its reputation, and more than one member of MSF suggested that MLKH might falsify patient mortality rates in official reports to avoid outside audits. If an outside organization begins to send you hundreds of seriously unwell patients to your facility every quarter, there is a good chance that this will adversely affect already bad hospital performance indicators.

Clearly, then, what little material support MSF brings to this Nairobi hospital is not enough to get patients from the slums to the hospitals. The previously quoted expat ER doctor's January 2018 End of Mission report was quite critical of the project in its current form. To her mind, the overall project goal of getting patients into hospitals seems insufficient when looking at the referral deadlock and the insufficiency of the care provided in the national system. She continues:

> *The emergency project is a response to a clear gap in care for the population of Mathare (and in fact many other Kenyans unable to afford healthcare). It has been* ***designed from the field up, responding to one set of barriers on the ground before appreciating and tackling the next layer****.*

> *As long as the cost of definitive care is unaffordable to the population and the **capacity is below the need**, MSF will be unable to properly meet its objective. Kenya is a relatively wealthy country and by rights, should be providing a far better level of healthcare to its population than it does. The reasons behind its failure to do so are complex but need to be considered and addressed if MSF hopes to achieve its aim **without simply operating a parallel system**.*
>
> *In my opinion many of the problems with this mission stem from the fact that the initial goal – to offer access to secondary care to the population of Mathare - is **a development goal** that needs a long timeline and close, well considered partnerships with the Ministry of Health.*
>
> *This makes it feel frustrating at the ground level as there are few places left where it feels like you have sufficient influence to make a difference. **It is frustrating helping to improve initial care in one part of the system for your patient when you know that the next part will fail them.***

How ever damning this take on the Mathare project may be, it is important to remember that it is only one possible position. When I spoke with the Medical Team Leader (MTL), responsible for all of MSF's medical activities in Nairobi – a Kenyan doctor – about the future of MSF's activities in Mathare, she related to me that "expat doctors" come in, spend a few months in Mathare with European standards for Emergency Medicine in mind, and are unable to see what the project achieves over the long term. This implies that the expat doctor's criticism of the "short term" nature of the project is tied more to her position, and less to the project set up itself. The MTL held that over the years, MSF's activities had had real and positive effects on the overall quality of care provided in Mama Lucy and in improving access to the hospital-level care for the slum population. Part of these improvements had to do with getting the "*logic of emergency medicine*" accepted by MoH staff. MSF's emergency services are based on the provision of care to those who are at risk of immediate, irreversible morbidities or death. It is an emergency care service. Staff in Kenyan A&E's are used to working according to a logic of "first come, first served". This is antithetical to emergency triage protocols.

> *Cara (MTL): Actually the speciality of Emergency Medicine was just accepted a few years ago in Kenya. It hasn't even been five years. Meaning it's not in the training curriculum, we have no staffing for it. And there aren't any resources, so the reasoning is always, 'yes, I see the Red case, but at the end of the day I have one Red case and 30 Green cases. And I have to finish my shift, so...' So yeah, the diffusion of an ideal OPD is a problem here.*

The "logic of emergency" the MTL talks during our interview is linked to the recent recognition of emergency medicine as a speciality in Kenya. There is a local initiative then, that would "improve the health system" by setting up a *platform for emergency*. The MSF project is trying to operate on this *platform for emergency*, while also contributing to it. At the same time, there is little infrastructure, experience, or resources. In an A&E, staff may realize that some patients require urgent care, but they also see that the majority does not. There are egalitarian principles that justify such an approach, especially given the HR and resource limitations. One of

the hopes for MSF's project is to engage with the MoH in setting up ambulance services. County health officials have approached MSF and asked if they would be interested in running the public ambulance service. MSF declined the offer, because that would be *substitution*. However, they did take the opportunity to organise a workshop with the County on how to set up and run an ambulance service in September 2019. That is how MSF participates in elaborating the *platform for emergency* in Nairobi. In addition, their daily negotiations for referring patients builds awareness of the "logic of emergency" medicine.

The MTL showed frustration with the difficulties they faced and expressed ambivalence when considering the future of the project. She also insisted on the fact that during the four years the project has been in place, they have made non-negligible improvements in Mama Lucy Kibaki Hopsital's OPD. However, she recognized that if there was not a change in the MoH, with a real effect on referrals, MSF would come face-to-face with a decision no one wanted to make: either they *close the project* or they *open a hospital*, in order to decide for themselves how referral to OPD, IPD, and ICU is decided. If they cannot get the Kenyan health authorities on the *platform for emergency*, and they are unwilling to set up *a parallel system*, then the only solution is to close.

Is the project a failure because of these difficulties in referrals? Are they doing 'development' and not 'humanitarianism' in Mathare? In this shell game of accepting responsibility and then forcing the hand of the Kenyan health system, we see the limits of MSF's non-governmental politics. Both the limits of its efficiency, for a governing body must accept responsibility for government in precisely that place that MSF points to a lack. But also the limit that MSF establishes between humanitarian aid and development, for the development of a medical platform in the public health sector requires a different set of practices than that of setting up an ambulance service. MSF's activities continually test limits. Laïtitia Atlani-Duault has demonstrated some of the ways that humanitarianism and development can get entangled in practices of governance in post-Soviet central Asia (2009),[1] and this is indeed a recurring question for MSF. As we shall see in the next chapter, there were intense discussions in headquarters regarding this project six months after my fieldwork ended. Specifically, the team in the field

[1] See also Atlani-Duault & Dozon (2011), where the ties between colonialism, development, and humanitarianism are clarified, and where the authors call for an *anthropology of aid*, as opposed to more sector-specific approaches. This move is important for defining the pertinent domain of literature for discussions on work in the anthropology of aid: we should not only read on humanitarianism, but also on colonial attempts at social improvements, and the heritage of development throughout the Cold War, in order to understand recent changes in the organization of the humanitarian sector, where the "lines are blurred" with development initiatives.

wanted to close, while the Director of Operations held that project was providing an important service to the population and should remain open. Is this project a failure? Is it humanitarianism?

Conclusions

In this chapter, I have shown one way a spatial configuration has ethical effects through the ordering of *attention*, and the subsequent tensions and ambiguities that arise. We started this chapter wondering about the ordering of emergencies by MSF in Nairobi. In response, I claimed we could engage with the issues specific to *humanitarian* ordering – *substitution* and *intervention* – if we looked at their activities as participating in the development of a *platform for emergency* in Nairobi. MSF actively participates in this by setting up the SATS protocol in Mama Lucy Kibaki Hospital and by harbouring the goal of *handing over* their ambulance service to the Nairobi County health authorities. That is, of *forcing the hand* of the county Ministry of Health. This platform ordered attention in MSF's A&E service in such a way that it made it possible to save lives that were always already on the brink of rapid and irreversible deterioration or death. It also supported the moral disqualification of patients' expressed needs in terms that echo a long history of medical paternalism and sexism: hysteria.[1] That being said, the particular kind of *attention* ordered from the *platform for emergency* must deal with persistent doubt – *because you never know* – remaining ever *vigilant* and even finding ways of distributed attention beyond the walls of their A&E service. There were other doubts as well, related to what the difficulties in referring patients said about the *limits of humanitarian aid* (limits to its efficiency, and the border separating humanitarian aid from development). These difficulties showed the complicated spatial configuration of the platform, fitting awkwardly on the "levels of care" mode of organising the health system. These "levels" were especially problematic because of a lack of resources and recurring strikes that destabilized referral sites and the levels of care they provided. Alignment between the platform and the "levels" was hard to establish. This led MSF personnel to question the overall objective of the project – increase access to hospital-level care in the slums – and its consistency with "humanitarianism". Is "access" a humanitarian objective or a development goal? Once again, we conclude with doubt and ambiguity. The project clearly saves lives and participates in improving A&E services in the public sector as well. Yet if referrals do not improve, MSF will have to choose between closing the project

[1] See (Grose 2018) for a recent edited volume on the actualization of "hysteria" – no longer a psychanalytical category - in contemporary medicine.

and setting up a hospital. In early 2019, the highly contested decision was taken to close MSF's ambulance service in Nairobi.

But closure is for the next chapter.

Chapitre quatre
Ce que vaut la fermeture des projets
Ou, à la recherche de MSF-dans-son-entier

Dans ce chapitre final, nous discutons des décisions de fermer des projets, et nous contribuerons à une littérature qui discute de comment de telles décisions sont prises. Malgré les désaccords de fond sur les justifications adéquate pour la fermeture de projets, les philosophes et anthropologues qui traitent de ce problème semblent d'accord pour dire que les organisations humanitaires sont capables de *la prise de décision stratégique basée sur une rationalité de valeur*. Nous ne remettons pas en cause ces présupposés, mais nous ne pouvons pas non plus les prendre pour acquis. Ainsi, nous rendrons compte dans ce chapitre de la consistance spatiale et temporelle qui soutient le développement de telles capacités chez MSF. Notre première surprise, en regardant les décisions de fermer, est que celles-ci ne sont prises qu'au siège, même lorsqu'il s'agit de reconnaître la fermeture comme fait accompli. Notre hypothèse est donc qu'il y a quelque chose de particulier qui se passe au siège, ou que le siège rend possible, et qui permet la fermeture des projets. Cette étude de la fermeture des projets se base donc sur une ethnographie des réunions d'évaluation et de planification des projets qui se passent au siège, nous concentrant sur les moments où la fermeture est discutée ou décidée. Le chapitre est divisé en trois. Dans un premier temps, nous analyserons les ressorts de la stratégie ; dans un deuxième temps, ceux de la rationalité de valeur ; et enfin, ceux de la prise de décision.

1. La vision globale et la direction : la stratégie dans une organisation polycentrique. La première étape sera de décrire l'espace produit par les liaisons entre le siège et les sites qui sont à fermer (les projets sur le terrain). Selon un Responsable programmes au siège, son travail consiste à *soutenir* le terrain en leur proposant *une vision globale* et *une direction* à suivre. Nous utilisons le terme *stratégie* pour marquer ces liens entre terrain et siège, et cette section cherchera à décrire *l'organisation* de cette attention stratégique. Pour ce faire, nous analysons des documents internes et des entretiens conduits avec le personnel de MSF. L'argument qui en ressort est que la capacité à faire de la stratégie dépend du geste cartésien qui consiste à désigner, circonscrire, et tenir une place propre, un espace à soi. Depuis cet espace à soi, il devient possible de regarder l'environnement – désormais un *extérieur* – comme s'il était immobile, pour y lire un système de relations, et pour se projeter, de projeter l'organisation, vers un avenir désirable (De Certeau 2017). Cependant, nous apprenons aussi que cet espace propre à MSF est polycentrique et qu'il évolue simultanément en des directions multiples. Dans une telle organisation, la tâche principale de la Directrice des opérations est de faire en sorte que l'organisation reste concentrée sur « la réalité », et non sur la gouvernance de l'évolution de MSF. Ainsi, nous conclurons que l'espace du siège est constitué par un double mouvement qui consiste d'abord à circonscrire un espace à soi, un intérieur, et ensuite, à rester focalisé sur ce qui se passe dans le monde qui les entoure à l'extérieur.

2. Mettre à plat les valeurs de la fermeture. Dans cette deuxième partie, nous allons regarder comment sont calculés les « résultats qui le valent » (*outcomes of worth*), si important à l'attention stratégique, et comment on statue dans les choix entre de valeurs concurrentes. Pour ce faire, nous allons examiner la décision contestée de fermer les activités médicales de MSF pour les personnes atteintes de tuberculose multi-résistante (MDR-TB) à Nairobi. Cette décision a été prise lors des réunions semi-annuelles d'évaluation et de planification des projets appelées les MAPs, ou les *mises-à-plat*. Cette analyse se base sur la déscription ethnographique d'une série de MAPs. Nous nous sommes intéressés à la manière dont sont calculées les valeurs composites, comme *l'impact* de ces activités. Nous verrons que différentes façons de calculer *l'impact* soutiennent des manières différentes d'imaginer des *manières d'aller de l'avant* (ways forward), ce que certains à MSF appellent des *visions stratégiques.* De plus, c'est pendant les MAPs qu'il devient possible de comparer l'impact potentiel d'un projet dans un endroit avec l'impact potentiel d'un projet semblable dans un autre endroit, en les rapportant aux ressources nécessaires à les réaliser. C'est-à-dire que c'est aux MAPs que l'on fait une analyse des coûts d'opportunité des projets humanitaires. Dans les situations où aucun accord n'est possible entre les membres de cet *agencement collectif de calcul*, alors on appelle au *choix*. En somme, nous analysons dans cette partie comment se constitue la capacité organisationnelle de la *rationalité de valeurs*.

3. Se décider à fermer. Il nous reste, donc, dans cette dernière partie, de proposer une lecture de la *prise de décision* stratégique et rationnelle en valeur. Nous regarderons donc trois cas de figures où la prise de décision est imbriquée avec le calcul de l'impact et une lecture stratégique. D'abord, les stratégies de sorties dans les camps de réfugiés à Yumbé, en Ouganda, où il s'agit de passer les activités vers d'autres organisations afin de créer de la valeur supplémentaire. Ensuite, les rendements décroissants de plusieurs projets qui, après plusieurs années d'activités, s'avèrent incapables de créer de la valeur. Enfin, nous regarderons la place de la valeur monétaire dans la décision de ne pas fermer le projet des urgences de MSF à Nairobi. Ces modes variables de rationaliser les valeurs et de prendre des décisions nous mènera à deux conclusions. D'abord, nous conclurons qu'on ne peut réduire la création de valeur humanitaire à une analyse marxienne où les bénéficiaires deviennent de la matière première pour la production des projets à vendre à des bailleurs institutionnels (Krause 2014). Ensuite, nous proposerons une analyse pragmatiste de la prise de décision dans une ONG humanitaire, basée sur la lecture du philosophe William James : nous ne pouvons considérer la fermeture comme le résultat d'une prise décision qu'à condition d'élargir considérablement ce que nous entendons par « décision ». Nous indiquerons, donc, cinq types différents de prise de décisions.

A la fin de ce chapitre, nous aurions rendu compte de comment la fermeture des projets peut être le résultat de la prise de décision stratégique et rationnelle en valeur.

Chapter Four

The Values of Project Closure. Searching for MSF-as-a-whole

Question: How is it that decisions to close projects are made in headquarters?

Paris. 6 October 2017. I had lunch with Laurent, Else, and Raphaël yesterday to talk about spending time doing observation in their Cell. From their Cell, Laurent and Else manage Missions in Kenya, Uganda, Malawi, Greece, and, until recently, France. We were at the start of the "MAP season" - two months of project review, budgeting, and planning between October and December - and I was interested in what it meant, exactly, to "manage missions" from headquarters. "No problem, they said. You can start tomorrow. There is a meeting to discuss the closure of the Greece Mission." I was embarrassed by this invitation, in part because I would have liked to have more than 24 hours to read up on the Greek Mission, but also because, moments before, Laurent had told Raphaël that he had had lunch with "Paul" and they agreed that it is time for Greece to close. The meeting was to "let the team down lightly".

So, here we are, the next day at 1:30 pm, in a windowless yellow meeting room on the ground floor of MSF offices in Paris, to talk about the closure of activities on the other side of the European continent. There are about fifteen people in the room: the directors of the different "support" Departments - Logistics, Finance, Medical, and Communications; Laurent and Else, of

course, Cell Manager and Deputy Cell Manager, respectively, but also the Finance, HR, and Log managers from the Cell. The team from the Coordination offices in Athens is also here, at the front of the room. I am seated next to Raphaël, Director of Research from the CRASH, at the back close to the door. The rectangular tables are arranged in a U-shape with the open end facing a white screen where the first PowerPoint slide is projected: "*MSF-OCP - Greece. To close… or not to close?*". That is the question. Apparently, nobody has told the team that a decision had already been made, and they are in the throes of existential turmoil. I also learn who "Paul" is: the Deputy Director of Operations for MSF-OCP. He opens the discussions, in English, from his seat at the front left of the room:

> *This is the framework for the discussion today: what is **the future** of the Greece mission? You might be wondering why there is a discussion on Greece if you've already decided to close the project. **No decision has been made, in fact.** Yes, the project has been identified as a **good candidate for closure**. Overall, in Greece, the impression is that the situation has stabilized; the medical question seems less acute, and there are two other sections of MSF in Greece. So yes, it is **a good candidate for closure**.*
>
> *But the Coordination team thinks it would be a mistake to close. They want a discussion. They think the project should continue. So, we said, ok, we'll postpone the decision. Maybe we will decide to close the project, but no decision has been made yet. So, this is **a discussion on the relevance of staying in Greece.***
>
> *Laurent, the Cell manager, says from his seat that they are expecting a presentation from the Coordination team.*
>
> *The Head of Mission for Greece Mission Coordination takes over from the front and centre of the room: we had **a workshop** with our team in Samos, the place we think it is pertinent to stay. Our conversation took the form of a project proposal, which we are going to share with you today. **We'll talk later about the decision to stay or not, that is not what this presentation is about. This is a project proposal.***
>
> *Just to clarify, we are not for or against staying. **There is no "mistake"**. We could go on and on, for and against staying in Greece, and we would never get anywhere. This is what we propose to do if we decide to stay.*

There is a lot to unfold here. Some of the themes relate to resource allocation: how do you identify "good candidates" for closure? Others to decision-making: when is the decision to close Greece made exactly? When it is identified as a "good candidate for closure"? When HQ managers agree it should close? A week later when the decision becomes official? Others still to organization: what role do different organizational units - Cell, Coordination, and Project - play in the decision to close? Space is also an issue: why are we in a meeting room in Paris, and not in Athens, where the Greece Mission Coordination offices are, or Samos, where the project is located? What forms of attention link Paris headquarters to activities in Greece?

We can bring these issues together in the following question: *how is it that decisions to close projects are made in headquarters?*

Answering this question is a way of exploring the consistency of *MSF-as-a-whole*. In the three preceding chapters, we have spoken of "MSF" as if it were an unproblematic, easy to identify, collective actor. We have discussed, extensively, the ways that "MSF " enacts its spaces, where space is understood to describe the consistency of heterogeneous humanitarian assemblages in movement. The first was *humanitarian space*, which "MSF" built up through the rhythms of a mobility sequence, and the discursive and spatial configurations of the list. Then *the field,* enacted through practices made possible by an epistemic infrastructure, and the use of questionnaires and the simple tools of epidemiology, during the processes of con-tact and inter-facing, between "MSF" and their beneficiaries. We have encountered "MSF" in the set-up of mobile clinics and a platform for ordering emergencies, intervening in national health care systems while avoiding substitution. While these humanitarian locations were always emergent, temporary configurations, we took for granted that "MSF" somehow encompassed or articulated them. So, how does all of it hang together? How is it exactly that the decision to close a project in Greece is made in Paris? If the "MSF" we have explored is a scattered archipelago of sites in constant flux, what makes it possible to talk about "MSF" as if it were a unified, collective actor, that maintains its consistency in time, as we have been doing and as members of MSF do? We saw in Chapter 2 that what counted as humanitarian action, according to humanitarians, is what takes place in the field with beneficiaries. Yet *decisions* to close projects are not made in the field, but in a place where there are no beneficiaries: headquarters. How is it that which was *central* to humanitarian action - the face-to-face with the beneficiary in the field - has somehow, suddenly become *peripheral*? Finally, how does the global consistency of "MSF" affect the decisions made in headquarters to close projects in the field?

Let us begin by looking at some of the ways the closure of humanitarian projects has been addressed in the literature. Central to these discussions is NGOs' status of an integrated, collective actors, capable of certain kinds of rationality. These are classic themes in the sociology of organizations. The objective of this chapter is to describe how MSF acquires the capacity for strategically orientated value rationality that supports the decisions to close projects.

Exit Strategies and Distributive Commitments

To start, it is important to note that there is a body of grey literature on humanitarian "exit strategies" that takes inspiration from military and business strategists asking similar questions. During military operations, exit strategies entail foreseeing a way out that does not jeopardize the objectives of the mission or the lives of soldiers. In business, exit strategies entail transitioning the ownership of a company, either to mitigate loss, or, ideally, to create an outcome worth more than continuing activities. The literature on humanitarian exit strategy was constituted in response to mounting criticism of what came to be called, in the late 1990s, the "cut and run" approach to exit (Lee & Özerdam 2015). This refers to hasty departure of humanitarian operations, with little concern for the effects of closure on the health of local populations, on the ongoing peace process during armed conflict, or on the local or national economy. The new common sense of the 2000s - when 'exit strategy' became a buzzword in the UN humanitarian complex - was that *departure* is not a one-off event, a unilateral decision, but a complex process whose sequencing requires coordination with a range of actors. Exit is a question of making right and transparent decisions, and then implementing those decisions in coordination.

The humanitarian scholars Hunt *et al* have published a review article on the "ethical considerations for closing humanitarian projects" (2019) that drives home the point that exit strategy is about the *how* of decisions and implementation. They discuss considerations for closure in 60 documents in academic and grey literature.[1] Ethical questions arose on two points: the *decision to close*, and the *implementation of closure*. The ethics of deciding to close relates to *inclusion* - relevant stakeholders must participate -, *transparency* - communication of indicators justifying departure at the start of the project -, and *justification* - sharing rationale for departure. Implementation entailed *responsible planning*, *collaboration*, *adaptability*, *transparency*, *minimization of harm*, *sustainability*, and *fairness*.

This approach to closure in terms of a *collective decision*, with ethical and political *considerations*, to be *implemented*, can also be found in anthropological literature. Medical anthropologist Sharon Abramowitz discusses MSF's "sudden decision" to withdraw from Liberia,

[1] "27 were academic articles, 24 were agency or interagency reports, and nine were books or book chapters. All were published between 1965 and 2018, with 57 published after 2000. Forty four documents were published by or focused on specific organizations, including Médecins Sans Frontières (10), the International Committee of the Red Cross (9), the International Federation of the Red Cross and Red Crescent Societies (4), United Nations (3), and the Inter-Agency Standing Committee (3), amongst others. Fifteen documents specified addressing all humanitarian crises, while nine focused on armed conflicts, seven on natural disasters, and six on projects related to refugees or internally displaced persons. The focus of ten documents was detailed descriptions of specific instances of project closures, while the remainder presented more general discussion or guidance related to project closure, and often included case study examples" Hunt *et al,* 2019, p. 2.

at the end of the conflict in 2003, when "humanitarian intervention" was transitioning to "state-building" and the "development" (2015). During the conflict, the Liberian state had been unable to provide health care; building on their global infrastructure, MSF provided consistent health care to a large portion of the population. Expenditures represented up to 5% of Liberia's GDI in the years they were present, and the decision to close had a huge impact on the economy and health system. Abramowitz then contrasts the *decision to intervene* with the *decision to depart*. Intervention requires that humanitarians negotiate with local populations and consider armed groups' willingness to work with them, current moral discourse in the organization, the strength of the state, donor fatigue… And the list of concerns goes on. The decision to pull out is different. It is "when these institutions leave that these many factors *do not need* to be taken into account, nor do the economic, health, and infrastructure aftermaths of their decision to depart (p. 141, emphasis in original)." In other words, MSF's decision to pull out indicates "humanitarian sovereignty: medical humanitarian organizations' freedom or right to self-determination, to make a decision without regard for the medical or public health consequences of their departure (p. 145-146)." According to Abramowitz - although the materials that would support this claim were neither included nor indicated in the article - MSF's decision to pull out was made based on the idea that, as long as they were there, the state would not assume "*health sovereignty*". It is at the moment when humanitarians have "the least rule" - they are deciding to withdrawal - that they have "the most right" - they make a unilateral decision with little consideration for the aftermath (p. 152). Not only is closure a *decision*, to be *implemented*, but it is *the* decision over which humanitarian NGOs have the most control.

This is Abramowitz's critique of MSF: by virtue of their presence in Liberia, MSF had special duties to Liberians. Inside MSF, this concern for special responsibilities by virtue of an ongoing relationship of aid is one consideration that made the organization hesitate to provide antiretrovirals to people living with HIV in the late 1990s and early 2000s: when providing lifesaving medicines to people with a chronic disease, you cannot suddenly decide that you will no longer provide that medicine. Another example comes from an interview with a member of MSF conducted by the philosopher Jennifer Rubenstein quoted in a 2008 article: if you start a food program and discover an epidemic of kala-azar,[1] then you become responsible for the epidemic (Rubenstein 2008, p. 228). Humanitarian scholars Hunt & Miao (2018) develop the notion of *moral*

[1] Also known as visceral leishmaniasis, kala-azar is a parasitic infection of the liver and spleen. 95% of cases result in death if undiagnosed and untreated. The epidemiology of VL is complex, but vector control (sandflies) is a common method to interrupt or reduce transmission. https://www.who.int/en/news-room/fact-sheets/detail/leishmaniasis (visited 16 February 2020)

entanglements to describe these special duties. These entanglements are tighter, more bounding, when the vulnerability of the population is high, and the role assumed by the NGO is great. This comforts Abramowitz's critique, based on the claim that the decision to close should not be made according to the same criteria as the decision to open. And yet, MSF practitioners condition the morality of humanitarian aid on the fact that it is a temporary intervention, *destined to close*. Otherwise, they engage in government and are guilty of substitution. The point is important because *special duties* trouble the common claim that humanitarian ethics is cosmopolitan. Jennifer Rubenstein - in an article distributed to the *cadres* of MSF during a CRASH-organized training session - explains that approaches to humanitarian "distributive commitments" in terms of the *special duties* of medical personnel to patients and humanitarians and beneficiaries have been criticized in the same terms as *national preference* (2008, pp. 228-229): helping those nearby means distributing resources according to claims other than global equity, central to humanitarian theories of justice.

Not only is project closure a question of decision-making, implementation, and coordination, but this linear process entails "distributive commitments" which require the organization to consider their ethical responsibilities rationally. Rubenstein's article - which holds that the decision to intervene and the decision to close should be made according to the same criteria - begins, like so many others related to closure and triage, with a difficult matter of fact: nearly 4B$ were spent annually in the humanitarian sector at the time the article was published (2008), and there are still not enough resources to go around. "*NGOs must therefore make wrenching decisions about how to distribute the scarce resources at their disposal* (p. 215)." Rubenstein then details ten common humanitarian "*distributive commitments*", i.e., "*general considerations that are seen as weighty by those who have them*." (p. 219).

The **first principle** of humanitarian aid is *aid according to need*. Rubenstein reformulates this "distributive commitment" according to Derek Parfit's distinction between "equality" and "priority" views (Parfit, 1997). The "equality view" holds that aid is important in absolute terms, not because recipients are worse off than others. *Aid according to need* corresponds to a "priority view": helping the worse off is more ethically significant. For Rubenstein, this goes against the *special duties* view. The **second principle** of humanitarian aid is *maximizing harm reduction. Aid according to need* is a duty to right action (deontological), where *maximizing harm reduction* is concerned with results (consequentialist). Referencing Thomas Pogge, "harm reduction" is a formulation of the intuition that aid beyond a certain point is no longer morally important (Pogge 2006). These first two principles are foundational for the rest of Rubenstein's paper. There are, however, trade-offs between "need" and "harm reduction", when aid to the "worst off" is

expensive, and NGOs sort them out in different ways. There are eight additional moral commitments in Rubenstein's article, which we relegate to a footnote for lack of space.[1] We would insist on the tension between *special duties* to populations already receiving aid, and the obligation to distribute resources according to *need* and to maximize the *reduction of harm.*

The common assumption of these discussions is that humanitarian NGOs have the ability to work out, through a kind of calculative rationality, where their "distributive commitments" lie, to make decisions according to this value rationality, and then to implement those decisions. Humanitarian scholars, a medical anthropologist, and a philosopher, assume that "closure" flows from value rationality, to decisions, then coordinated implementation. We learn quite a lot about the dilemmas of project closure from these texts. And much is left out. The approach we develop does not entail listing the "weighty considerations" that influence *reasoning* through resource allocation but describing the practical work that makes it possible to *reason through values, make decisions*, and *strategize exit.* If decisions are made according to a kind of *wertrationalität*, how do you work out, in practice, what a humanitarian project is worth? If the point is to maximize harm reduction, how do you measure and compare the harm reduced between different projects? What are the instruments of value rationality?

We do not contest that "MSF" makes decisions to close, nor that these decisions are ordered by a kind of value rationality, nor that those decisions relate to organizational strategy. We suggest only that it is precisely these incredible capacities that must be explained, and that they cannot be used to explain closure. To answer these questions, we will once again be exploring MSF's consistency in spatial terms. The closure of projects is *always* - without exception, to my knowledge - decided in *headquarters*. Even when closure is the recognition of a *fait accompli*, it can only come from HQ. As such, we ask what kind of location MSF headquarters is, and how the capacities this spatial consistency affords affects closure.

[1] Three further morally justifiable commitments: *efficiency*, or a commitment to waste reduction; priority to victims of *violent harm*, justified in various manners; a procedural commitment to *participation*, which entails trade-offs with efficiency. There are two commitments to distributing aid at a global level that are unjustifiable: *global equality*, that is, the idea that aid is to be distributed not necessarily to those countries where it will be the most effective, but to any country where it would be effective; a commitment to *diversifying and increasing the number of recipient countries*, paradoxically to perform a kind of nondiscrimination. There are two commitments that invite criticism in terms of *partiality*: the idea that humanitarians have *special duties* to those with whom they have already begun to distribute aid; a commitment to *coup de cœur*, or allowing for the passion and indignation of operational teams to motivation allocation decisions. Finally, there is a commitment that humanitarians rightly reject: *desert*, or the idea that someone is less deserving of aid if they are the cause of suffering, their own or others.

The chapter is divided into three sections. We tackle first the problem of *strategy* from a spatial perspective. Then the problem of *value-rationality* through the instruments that support the calculation. We finish by developing a pragmatist account of organizational *decision-making*.

1. Global vision and direction: strategy in a polycentric organization

The first step is to describe headquarter space and the kind of attention that connects headquarters to those sites they close (projects in the field). We start with the comments made by a Program Manager, working from HQ, who tells us that his job is to *support* the field by providing *global vision* and *direction*. We use the term *strategy* to mark these two forms of attention, and this section deals with the *organization* of strategic attention. From our description of MSF-the-organization - based on analysis of a key internal documents and interviews with MSF staff - we learn that the ability to do strategy depends, in part, on the Cartesian gesture of designating and holding a place of one's own, from which it is possible to look out on an external environment as if it were immobile, and to read a system of relations, in order to project oneself - the organization - into a desirable future (De Certeau, 2017). However, we also learn that MSF's place of their own is polycentric and evolving simultaneously in multiple directions. Moreover, we learn that the primary task of the Director of Operations is keeping the organization focused on "reality", and not on governing the organization's evolution. That is, we see that MSF headquarters are constituted in a double movement that consists, first, in the definition of a place of one's own, and second, remaining focused on what is happening in the world around them.

2. MAP-ing the values of closure

In this section, we look at how the "outcomes of worth" so important to strategic attention are calculated, and how choices between competing values are adjudicated. To do so, we examine the contested decision to close MSF-OCP's drug-resistant TB activities in Kenya, made during a semi-annual routine project evaluation and planning meeting called *MAPs*, or *mises-à-plat*. Analysis is based on the close ethnographic description of a series of MAP meetings where we focus on the collective assemblage that supports the calculation of composite values like a project's "impact". Different composite values inform irreconcilable *ways forward*, or what some in MSF call *strategic visions*. In addition, during the MAP it becomes possible to compare the potential value of a project in one location with the potential value of a project in another location, as they relate to resources necessary to achieve them. That is, an analysis of the *opportunity costs* of humanitarian projects. In those situations where no common accord can be reached between members of this collective calculative agency, regarding irreconcilable strategic visions, and the opportunity costs of humanitarian aid, there can be calls for *choice*. In sum, we seek to describe in

this section the consistency of the strategic, calculative agency that the above accounts of closure take for granted.

3. Deciding to Close

In this section, we will examine some of the ways this *strategic attention* relates to project closure, with specific analytical focus on decision-making. We look at three ways that the decision to close relates to the creation of values and strategic vision. First, *exit strategies* in the Yumbe refugee camps in northern Uganda, where MSF transitions the ownership of activities in view to create of additional value. Second, the *diminishing returns* of several projects, where with time, the impact of projects can diminish, and, as such, are closed in recognition of a *fait accompli*. Finally, we look at the *ambiguous values of money* in the decision to *not* close the ambulance service in Nairobi discussed in Chapter 3. These variable modes of discussing the value of projects as they relate to strategic decision-making leads us to two conclusions. First, we conclude that we cannot reduce the production of humanitarian values to a kind of Marxian analysis where *beneficiaries* become the raw materials for the production of projects to be sold to we clarify analysis of humanitarian project closure that assumes decisions *precede* implementation. In this section, we see that the decision can be configured in different ways and take place at different times during the processes that lead to closure. Second, we see that the closure of projects is often associated with a calculation of a project's value. However, we question Marxist analysis of the added value of humanitarian projects, wherein beneficiaries become a primary resource in the production of projects that are sold to funding bodies on a quasi-market (Krause 2014). We saw that projects do indeed seek to create value for humanitarians, and monetary value plays a central role, but MSF practitioners refer to these *values* for MSF-the-institution as the *secondary* objectives of their activities. Second, we will put forward a pragmatist analysis of decision-making in a humanitarian NGO, based on a reading of the philosopher William James: if we are to maintain the position that project closure is the result of decision-making, we will have to broaden our understanding of what it means to decide. We will conclude by indicating five different kinds of decision-making.

At the end of this chapter, we will have described the spatial consistency of MSF-the-organization, as it supports the calculation of a project's value, and informs strategic decisions to close.

1. Global vision and direction: strategic positioning from headquarters

How does headquarters connect to projects in the field? During an interview with Laurent, the Cell Manager we met in the introduction to this chapter, he tells me that his job is "project management". He then details what this entails.

> ***Laurent:*** *I manage projects. That's the role we have, to maintain a monitoring plan for the countries you are managing, to do your evaluation missions, to make project proposals, and then, as soon as the projects are validated, to monitor those projects. And keep in mind that,* ***our role, as opposed to the teams in the field****, is that, well, they do the surveillance, they're in the field, and then there's a discussion with them. So, for me, my role, it's that of a manager that manages projects, who has a more* ***global vision****, and who has to help the teams in the field, to give them a clear* ***direction****.*

This section is about the "global vision" and "direction" that Laurent is able to develop because he is *not* in the field, face-to-face with beneficiaries. This first section will allow us to detail some of the forms of distant attention that headquarters, as a humanitarian location, makes possible, as opposed to the forms of attention associated with co-presence with beneficiaries that we have discussed in previous chapters. We will argue that this attention is ordered, first, by a distinction between MSF's place of their own, and an external environment. However, MSF's place of their own is not unified: it is polycentric and decentralizing in multiple directions. A series of organizational processes aim to keep the collective focused on operations, on "reality", and not on governing the Movement.

a. MSF as a polycentric movement: the Global Institutional Footprint (GIF)

What kind of place is headquarters that it provides Laurent with "global vision" and the ability to provide direction? To begin, MSF headquarter entities are structured into what are called *Operational Centres* (whose locations are visible as yellow stars in Figure 31 below). Throughout the 1980s and 1990s, MSF "associations", or "nonprofit organizations", were created in different countries, in the legal framework specific to each. Some of these became the "Operational Centres" from which most operations are run today. These Operational Centres are named for the city in which their offices are located: Paris (OCP), Belgium (OCB), Amsterdam (OCA), Geneva (OCG), and Barcelona/Athens (OCBA). Each Operational Centre opened "Partner Sections" or "Branch Offices" in Australia, the United States, Italy, Japan, Germany, Canada… These "Sections" and "Branches" serve fundraising, recruitment, and communication purposes, funnelling resources from around the world to the OCs. The oldest and largest OC is OCP. The second oldest and largest is OCB. OCP tends to claim the position of the Movement's leader, though this is continually

contested. Together, Centres, Branches, and Sections compose what is referred to as *The Movement*.[1]

As you can see in Figure 31, MSF's OCs are geographically concentrated on the same continent, in the same time zone. They have been MSF's Operational Centres for nearly 30 years. While it is true in some sense that these centres in Western Europe are the "centre" of MSF - even if these five centres make MSF polycentric - a presentation of the OCs does not exhaust the question of where "Head Offices" are. This is because the management of operations has increasingly been "**decentralized**" to "Decentralized Cells" and "Partner Sections". OCBA has a Decentralized Cell in Nairobi, and OCP runs missions from New York, Tokyo, Dubai, and Dakar. Geographical decentralization of headquarters is linked to the NGO's capacity to gather together, **accumulate and concentrate resources**, both financial and human.[2] While capitalization was important for MSF's strategic agency, the "place of their own" necessary to accumulation does not have to be in one, single location.

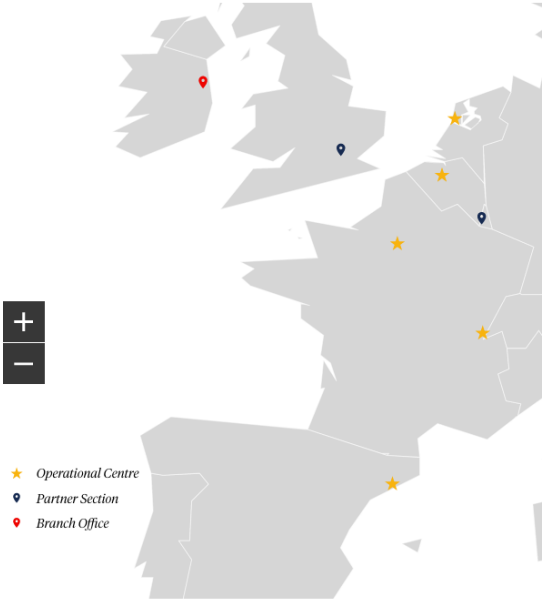

Figure 31: Map of MSF's Operational Centres. Source: https://www.msf.org/how-we-are-run. Last visited: 12 July 2019

This structuring of the organization may seem incidental. However, the Terms of Reference to report ordered by the Executive Committee[3] on MSF's "institutional development" claim that "MSF's global institutional footprint is a key constituent of **our identity**" (p. 44). The 2016 report, entitled "A Review of the MSF Global Institutional Footprint", was authored by Adrio Bacchetta and Frédérick Mousseau, and sought to "map" MSF's global institutional footprint (GIF), and to "draw broad lessons" for future development (p. 7). MSF is one of the only organizations to

[1] Renee Fox (2014, p. 43-59) shows how the structure of MSF into OCs, Sections, and Branches has led some in MSF to talk about Operational Centres as "metropoles" that are in competition for the best sites to "colonize" for potential resources (HR, fundraising). **OCP** has "colonized" France, Japan, the United States, Australia, and the United Arab Emirates. **OCB** has claimed rights to Belgium, Sweden, Norway, Hong Kong, South Africa, Italy, Brazil, Denmark, and Luxemburg. **OCA** is in possession of Holland, Canada, Germany, and the UK. **OCG** has Switzerland and Austria. **OCBA** has Spain and Greece. Different "empires" bring in more resources than others.

[2] This corresponds to Dauvin & Siméant's (2002) reading of the "internationalisation" of four French medical humanitarian NGOs, understood to have occurred to facilitate access to resources. These authors place greater emphasis on the ways legal existence in multiple countries facilitates access to institutional funding, which sometimes stipulates the nationality of the receiving organization.

[3] The General Directors of the five Operational Sections plus the General Director of the International Section.

maintain multiple Operational Centres. Oxfam, Save the Children Fund, and Care have all moved to "simplify" and "rationalize". While the authors of the report recognize the cost of this structure, they claim that it allows for greater *neutrality* and *independence*. In concrete terms, this means they can cast out an Operational Centre when they are perceived as having breached the MSF Charter.[1]

Bacchetta and Mousseau, charged with mapping MSF's Global Institutional Footprint, met with a series of difficulties. First, there was no agreement inside MSF on what a "Global Institutional Footprint" might be. The Terms of Reference state that the GIF is "*the geographical locations, and more precisely, the national states, within which MSF maintains a structured legal and/or Movement endorsed presence for the sole purpose of conducting activities in* ***support of the delivery of its Social Mission*** *[...].* ***This excludes 'missions'****.* (p. 7, emphasis added)." That is, "headquarter entities" - as they are called in the report - *support* missions and can be distinguished from them. But the authors note that the General Directors of MSF's different Sections understood the GIF in very different ways. Annexe 3 of the report provides the distinctive points of view of 22 General Directors (GD) (p. 48). Importantly, some GDs claim that while the distinction between MSF the "*institution*" and MSF's "Social Mission" - i.e., *operations* - seems clear, it is important to remember that *institutional objectives are pursued from the field and that operations depend on headquarter entities*. That is, the institution is a permanent support for the temporary projects through which MSF pursues its mission. However, the GIF that the report maps is - according to the authors - replete with **gaps -** MSF entities that were not represented - and **grey zones -** entities whose legal status is unclear, making classification difficult. Moreover, MSF's GIF is "dynamic",

[1] No example of this is provided in the report, but the Greek Operational Centre was expelled from MSF in 1999, for having sent a convoy of MSF vehicles carrying medical supplies into Kosovo. Three Operational Centers had pulled out of Pristina and Belgrade in March 1999, in reaction to a Serbian campaign of torture and rape. In April 1999, an agreement was reached between the Greek government, NATO, and the Serb government to allow Greek NGOs into the country. While MSF was highly motivated to be present in Yugoslavia, many in the organization were unsure that the agreement allowed for "independent humanitarian action". Furthermore, they were uncomfortable with what was being referred to in the press as a "humanitarian war". Despite the International Councils decision to remain outside of Kosovo, the Greek Section of MSF sent in a supply convoy (purportedly with Greek flags on their trucks, but this was later contested) in April 1999. In June, they were expelled from MSF after 5 hours of debate by the International Council. Eight years later, they were reintegrated as part of the Spanish Operational Center. Now there is an Operational Centre called OCBA, for Operational Centre Barcelona Athens. Cf., Fox, 2014, p. 73-87.

"permanently evolv[ing] with the ongoing activities of the multiple entities that constitute the movement" (p. 7).

But how exactly does the MSF-not-in-the-field connect to MSF-in-the-field? The connection transits through the *Department of Operations* of each *Operational Centre*.

The Department of Operations sits alongside a number of other departments, called Support Departments: Medical, Finance, Human Resources, and Logistics.[1] A diagrammatic understanding of the Department of Operations comes from the MSF website entitled "Work With Us" and an image entitled "From Head Office to the Field" (see Figure 32 below). The Department of Operations is organized in three levels: CELL-MSF Head Office; CAPITAL-Coordination Team; PROJECT-Field. The discussions above between Laurent, Else, and Guillaume on operations in the DRC were at the Cell level in the Department of Operations of OCP.

From the **diagram**, we learn several things. First, the Department of Operations is organized *vertically* into *levels*. Cells are *above* the Coordination team, which are *above* projects in the field. Internal to each level, a person occupying an executive position - Cell Manager, Head of Mission, Project Coordination - is *above* people occupying professional positions - Medicine, Finance, Human Resources, Logistics. Second, *lines* of two sorts make vertical connections between elements on the diagram. Internal to each level, *management lines* go down from the executive position to the professional support team. Between each level, *reporting lines* go from each profession at lower organizational units to their professional counterparts in the higher units, from the Project to Coordination to the Cell. The diagram clarifies a vertical, hierarchical relationship where lower units must account for, or *report* their activities to higher units, and higher units are meant to provide a professionalized structure that assists or *supports* work in the field. To summarize what we have learned about that special place called headquarters - that place that afforded Laurent's global vision and direction - we can say that it is the place to which the field *reports*, and the place from which the field is *supported*.

[1] These departments are distinct from those "satellites" that we have already mentioned, like Epicentre. Other MSF "satellites" include MSF-Logistics, MSF-Supply, the Drugs for Neglected Diseases Initiative (DNDi), and a production company called *Etat d'urgence Production*. We will not be discussing MSF's status as a democratically governed volunteer organization to talk about the election of the Board during the General Assembly, or how monthly board meetings affect operational policy. The role the Board has played has changed considerably over the years. In the past, its role was central. If important operational decisions can be made there - like pulling out of Iraq in 2003 (Fassin, 2007) - in recent years, its role has become that of an advisory committee, regularly discussing institutional development. The monthly meeting is open to all members of MSF - and social scientists studying the organization - and it is also a place where recent exploratory missions can be presented, where interesting or novel project types or technologies of intervention can be discussed.

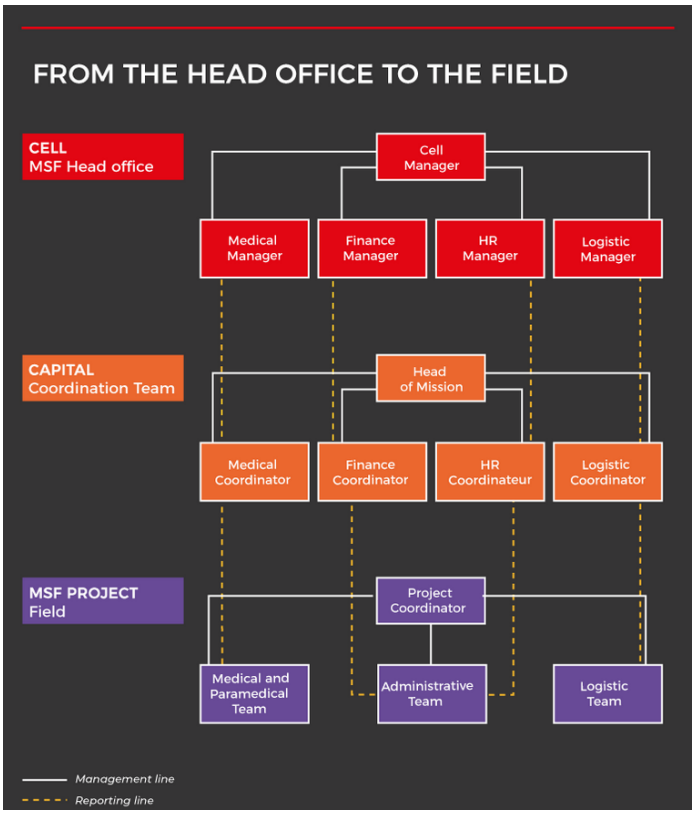

Figure 32: "From the Head Office to the Field" Source: https://www.msf.fr/en/get-involved/work-with-us/msf-from-head-office-to-the-field Last visited: 12 July 2019

It is also important to remember that there are multiple Operational Centres and Decentralized Cells, making headquarters a kind polycentric network. But it is a network connected *vertically* to the field through a series of intermediary *levels*. Moreover, institutional objectives can be pursued from the field, while the field is dependent on headquarters. So, headquarters, which is hierarchically *above* operations, is also supposed to hold up operations from below (the etymology of *support)*. And the field is supposed to "carry back" (the etymology of *report*) operations to headquarters, which is specifically that place where there are no operations - no face-to-face with beneficiaries.

b. Reforming the Department of Operations

How exactly do headquarters relate to the field? Well, through the Department of Operations, by which *support to the field* and *reporting to HQ* transit. Perhaps looking at how the Department of Operations was reformed in 20[1]6 will make things easier to grasp.

The astute reader may have noticed that the professional managers at each level in the Department of Operations have the same titles as the Support Departments already mentioned: Medical, HR, Finance, and Logistics. These Managers - as they are called at the Cell level - are under the direct supervision of the Cell Manager, a member of the Department of Operations. This is a recent organizational development, based on a 2016 reform. Before, these professional managers were under the supervision of each professionalized Support Department and were dispatched to what was called "Desks" at the time (which correspond to what are now called Cells). To discuss this reform, we will be using an internal MSF document entitled "The Conduct of Operations" - which presents what these changes mean for the way operations are run.

This internal document is presented as a "practical guide for the conduct of operations". It details the formal organizational processes that underlie the management of projects in the field

from the Headquarter level. The introduction is a justification for the reform. OCP had a heavier project load, more complex medical activities, with more human and financial resources, and a more complex and distributed organizational structure. This resulted in "malfunctions". The "decision chain" was over-centralized and confused; there was a tendency to micro-manage from Headquarters; the field was too dependent on headquarters, and thus felt "dispossessed". So far, this fits with the characteristics of MSF-the-institution: it is centralized, but polycentric with a tendency towards decentralization.

This is understood to continue with the 2016 reform, which proposed to **reaffirm the role of the Department of Operations**. This was achieved in several ways. First, through a reform of the way budgeting decisions are made. Hawa, the Finance Manager for Cell 5, explains how money flows through MSF-OCP.

> **Hawa**: So, the budget is something that is **global**. There are several **levels**. If there is not enough at the **country level** - let's say they overspend by 100,000 euros, they're really over budget - then the first person who makes a decision (*le premier décisionnaire*) is the **Head of Mission**. That means that it is up to him to find, in the budget he has for his projects, the 100,000 that's missing. Either there's something, that can be put off to later, or that they don't do at all, so they can stay in the global budget that was set for the country. If he can't, then it goes to the **next level**, to the **Cell**, where they go through the same process. So, Laurent takes all of his countries, and it is up to him to arbitrate, to make a decision. This activity is not going to happen, and this other activity will happen, etc. And then the **next level** up, is the **Direction of Operations**. That's the 250 million that we had this year.

The point of this is that, once funds have been allocated, from above, each level disposes of the funds as they see fit, once they have presented their "road map" to the level just above them. Before MSF's annual project evaluation season - in October and November - the Director of Operations asks each Cell to estimate their financial needs for the year. The Cell then communicates this request to each Coordination, who does some rapid estimates based on last year's activities while integrating big changes in context and/or strategy. The Cell sums up the amounts of each of their missions and communicates a global budget for the entire Cell to the DirOps. That is, Cell 5's budget for 2018 for all their activities in RDC, Kenya, Uganda, and Malawi, minus the France Mission because it was handed over to another cell, but with costs for closing the Greek Mission. The DirOps sums up the global budgets of all the Cells and compares it to the global budget for the Operational Centre. She then validates or rectifies the estimates sent by each Cell. The amount communicated to each Cell is referred to as the "envelope", that is, the total budget they manage for the year. The Cell then communicates an "envelope" to each Coordination/Mission. With this envelope in mind, the Coordination team prepares the project evaluation and planning meeting, in Paris, with the Cell. The Cell then validates those proposals -

or not - considering their strategic orientations and the budget. They then report to the Direction of Operations during the Budget Commission, to discuss strategic orientations and financial constraints. Because of the volatile nature of humanitarian contexts, there are often surpluses and/or deficits. These can be redistributed either at the Coordination level, between projects, or at the Cell level, between countries. Hawa called this a system of **"communicating vessels"**, where money flows from areas where there are budget surpluses to areas where there are budget deficits in each system. Here, "level" refers to the hydrostatic equilibrium reached when a fluid - funds - comes to a rest in such a system. If Coordination for Kenya, for instance, is unable to respect budget constraints, they can move funds between their projects. If the Kenya mission has surplus funds, the Cell, above them, can reallocate those funds to another Coordination, to the Uganda mission.

According to OCP's Director of Operations, whom I interviewed, the logic of this is to get decisions related to the allocation of resources as close as possible to the site where they are to be used, instead of making the decisions herself, from "on high", in a manner that is necessarily distant from the field, and made according to criteria that she herself calls "arbitrary".

The second element of the reform that reinforced the role of Operations was to give the department greater control over the support functions. This is why the professional managers now belong to Operations and no longer to the Support Departments. Further objectives of the reform include "**giv[ing] the field more autonomy**" – especially for elaborating on project ambitions – and "**reinforc[ing] organizational capacity**" by clarifying the "command chain", reinforcing the coherence of Cells, and shortening the "decision chain". One way of doing this was to move away from "*a priori* control" to "*a posteriori* reporting". So, headquarters is not supposed to *control* operations, but to *support* operations. In concrete terms, this means that while an annual **"road map"** is co-written each year by the Head of Mission in Coordination and the Program Manager in the Cell, the "Field" adapts their activities and their budget according to need and changes in context. Major changes must be "reported" to the Cell.

On the other hand, we learn from an interview conducted by the author with Isabelle Defourny, the director of OCP's Department of Operations, and elected member of MSF-France's board before that, where the reform was debated and prepared, that there is a contradiction between the two objectives stated above.[1] "*We really wanted to start delegating to the field, to make them*

[1] After working for MSF-France for over a decade - in the field from 1999 to 2004, and Headquarters from 2004 to 2010 - Isabelle applied for the position of Director of Operations in 2010. Her application was denied, and she left MSF in 2011 to create a medical humanitarian NGO called Alima, based in Dakar, Senegal. She came back to Paris in 2014, and, still working for Alima, was elected as a member of the MSF's Board. She re-applied for the position of Director of Operations, and began working at the end of 2015.

more autonomous, but at the same time, bam!, we went from 25 to 100 People in the Department of Operations, in Headquarters.[1]" There is a "*contradiction*" between "***making the field more autonomous and reinforcing headquarters***."

c. Strategic Planning to Keep MSF Focused on Reality

Isabelle insists on the fact that MSF-the-organization has tended to become an obstacle to operations, instead of providing *support*. This relates to changes inside MSF in the late 2000s. MSF had become capable of "top-level medicine", and was "very rich". While this can clearly be considered "progress", it led to a sentiment of "self-importance".

> ***Isabelle****: It had gotten to the point that we couldn't work with doctors from outside MSF and treat them like were colleagues. […] My impression was that the strength of MSF – I mean, its independence, for everything, its funding, supply, HR, Epicentre, I mean, all the super-interesting work done to construct our independence over five decades. I had the impression that we had reached, not the limits of the benefits of independence, but that we had developed an understanding of independence as a kind of isolationism. We had isolated ourselves. And it's something we talked a lot about at the time. And to my mind, the team of directors in place, at that time, wasn't doing a good job of getting in a counter-step (*animer le contre-pas). We talked a lot about *"MSF's image", about "protecting MSF". It was like MSF had suddenly become a brand to be protected! "MSF!" […] And this is the kind of thing that is necessarily done at the expense (*forcément au detriment de*) of discussions on projects, discussions about the way we deal with reality (*aborder la réalité*)."*

When independence turns to isolationism, MSF-the-institution has effects that run counter to the social mission of MSF-in-the-field. While Isabelle's predecessors were preoccupied with "reforming the governance in the International General Assembly, and setting up what we call "groups" in OCP" – that is, "big governance, with very little political effects"[2] - Isabelle claims that MSF had lost sight of reality.

She gives OCP's Strategic Plan as an example. According to Isabelle, her job as the Director of Operations is to "*to set up and explain a project portfolio that is useful and interesting*". She says that this is a way of asking the "*big question*" of "***what is our operational policy?****"* This contrasts with the role of Head of Mission - project management, as Laurent told us - with the role of the Director of Operations - project portfolio management. One of the ways she manages this project portfolio, and develops MSF-OCP's "operational policy", is through a three-year Strategic Plan. There are different ways of working out strategic plans. Her predecessor's Strategic Plan -

[1] Interview conducted on October 14, 2019, in the offices of Paris HQ. Translated from French.
[2] "de la grosse gouvernance, extrêmement peu politique"

which Isabelle claims is more concerned with the "governance" of MSF than with "reality" - encouraged specific medical activities. Obstetrics is one such activity, which MSF wanted to develop because they were losing their technical capacities in this domain. The problem is that when your strategic plan pushes specific medical activities to reinforce the institution's technical capacities, field teams write project proposals for those medical activities not because they respond to needs in the field, but because they know they will be validated. If you allocate resources according to the needs of the institution, project proposals respond to the needs of the institution and not the needs in the field. This is what she means by "decontextualized" projects. Instead, Isabelle says, once again, that her goal when working out OCP's Strategic Plan with her team, was to get MSF to "*look at the reality in the field a little more"*.

What does such a Strategic Plan look like? Isabelle says that the Strategic Plan she developed with her team for 2016-2019 is based on *contexts of intervention*. There are four such *contexts*: armed conflicts, medical catastrophes, violence, and natural disasters. We will go into some detail on two of these contexts to demonstrate Isabelle's point.

Armed conflicts and their consequences is the largest group for OCP, making up around half of all projects. Here, "consequences" refers primarily to MSF's activities with refugees fleeing conflict. As Isabelle says, "*it's simple*", "*we work in all conflict situations. So, if there's a conflict, we go, and if we don't go, then it's something we have to justify*." This context entails a number of "*big questions*", related to working in zones controlled by terrorist organizations (ISIS, al-Shabab), and in zones where, "*between the risks you take and the reality of what you can do for people, it's really not easy*". The strategic goal is to "*try to broaden our field of intervention*". This means moving away from surgery and hospitals - MSF's comfort zone - and working on mental health and chronic diseases, like diabetes or epilepsy. Because health systems deteriorate very quickly in times of armed conflict and basic medical products become difficult to obtain. The point here is not to define a specific pathology or medical activity to develop. Instead, focus is on contexts of intervention - *the reality of armed conflict* - and on the development of activities according to the specific needs of beneficiaries and the challenges faced by MSF's teams, in the field, that site of con-tact with reality.

The second context of intervention is what Isa calls **medical catastrophes**, which includes, but is not limited to epidemics. These entail high mortality or morbidity. MSF's role is "*build a medical response*" that goes beyond the patients they treat, by "*making health care accessible*". The example Isa gives is MSF's work on HIV, where at the end of the 1990s and early 2000s they were among the first to make tritherapy available in the Global South. This entailed "*decentralizing care, simplifying the care model, finding generic drugs, and, in general, making HIV care more*

accessible." They also developed similar strategies for malnutrition - through a Ready-to-Use Therapeutic Food (RUTF) called Plumpy'Nut - and malaria treatment.[1] Isa says that OCP had stopped working on this kind of project between 2008 and 2015. MSF's medical activities had stopped being "political". Currently, the "medical catastrophe" they are trying to address is cancer.

> ***Isabelle**: This is what we're trying to do in **oncology**. So, oncology, it's a real catastrophe in the South* (les pays du sud)*. It's not as common as it is here, but it is without a doubt in this domain of medicine that there are some of the biggest inequalities between the north and south. It's just mind-blowing, there's nothing in place, absolutely nothing. It reminds me of the beginning of HIV. Doctors are desperate, patients are dying, it's just horrible, it's awful.*
>
> *And so, we started in Mali and in Malawi. There are oncologists in Malawi, I mean, not a lot, there are two of them, but I mean there are some resources. So, for me, the question was, ok, we're going to provide care for 100 or 200 patients that have cancer. Great, they need care. **But how are we going to make sure that the progress we make is useful to other patients?***
>
> *And, obviously, it's not going to be with something like Plumpy'Nuts. So, what we're trying to do, is to work, for example, with the Access Campaign, and our pharmacists, so that when we find chemotherapy that is generic, cheap, good quality, etc., we can make it available in the country. If we do that in Mali, the idea is to make it available to practitioners in the region. For example, in Senegal, in Burkina, etc. And when we manage to set up a **platform of specialists**, to be able to read the slides and recognize different pathologies. So, this platform, we're thinking we could make it available to other doctors, to practitioners that are isolated. There are all sorts of things we can do, and that is how **we're coming back to a more political kind of medical practice**, that is not cut off from the world inside a hospital. Something more like when Jean-Hervé [Bradol][2] was here.*

Here, once again, the point is to push MSF to work in a kind of situation - which means being able to identify such situations - and seek novel modes of intervention, instead of falling back on habits, or technical interventions whose effects are confined to a single hospital. This is how Isabelle and her team work to keep MSF interested in "reality". These suggestions are evocative of Vololona Rabeharisoa & Michel Callon's concept of "reflexive organization", defined as an "organization that continually examines the procedures and tools that allows it to learn, that is to say, to accumulate skills and knowledge collectively produced but also to evaluate them in order to decide on future actions to take" (Rabeharisoa & Callon 1998, p. 61, my translation). Rabeharisoa & Callon go on to suggest that "this self-appraisal (*retour sur soi*) through which action is put in perspective ends up being assimilated with the action itself." (1998, p. 62). MSF

[1] Bradol & Vidal (*ed*, 2009) present a series of medical innovations undertaken by MSF in the field, on HIV, malaria, leishmaniasis, but also field epidemiology, as discussed at length in Chapter 2. During our interview, Isabelle references Jean-Hervé Bradol's presidency several times as inspiration for her approach to working out what she calls MSF's "operational policy".

[2] President of MSF-France from 2003 to 2008.

may need a place of their own to develop global vision and to give direction, but they also have to be careful not to get caught up in "protecting MSF". Autonomy can turn into a prison, even if independence is essential to being "MSF".

d. Yalta: strategic positioning in the DRC

In the next few pages, we talk about what is called a "Yalta", during which Laurent and Guillaume, another Cell Manager exchange "Missions". Laurent's "Cell" is exchanging their France Mission for DRC Mission that Guillaume's "Cell" is currently managing. MSF is present in approximately 70 countries every year. Operational Centre Paris (OCP) typically works in between 35 and 40 countries. One Cell is responsible for managing all an OC's activities in three to five countries. One Cell handles Malawi, Uganda, Kenya, and the DRC, and another has France, Libya, and Nigeria, and another still handles Yemen, Syria, Iraq, Jordan, and Palestine. MSF-OCP's world is divided up into zones of responsibility that map onto countries distributed between Cells. These countries are not necessarily contiguous, or on the same continent. During the operational review season - known as MAP season - a Cell's mission portfolio can be shaken up: they can have one mission/country close, and/or switch missions/countries with another Cell. This redistribution of missions/countries between Cells is referred to as the "Yalta". The reference is to the Yalta Conference of February 1945, where heads of state from the URSS, the UK, and the USA, met to divide up occupied zones in post-war Germany. While the elections for self-determination in Eastern Europe they agreed upon did not become reality, these negotiations served as a basis for the division of Germany into occupied zones.

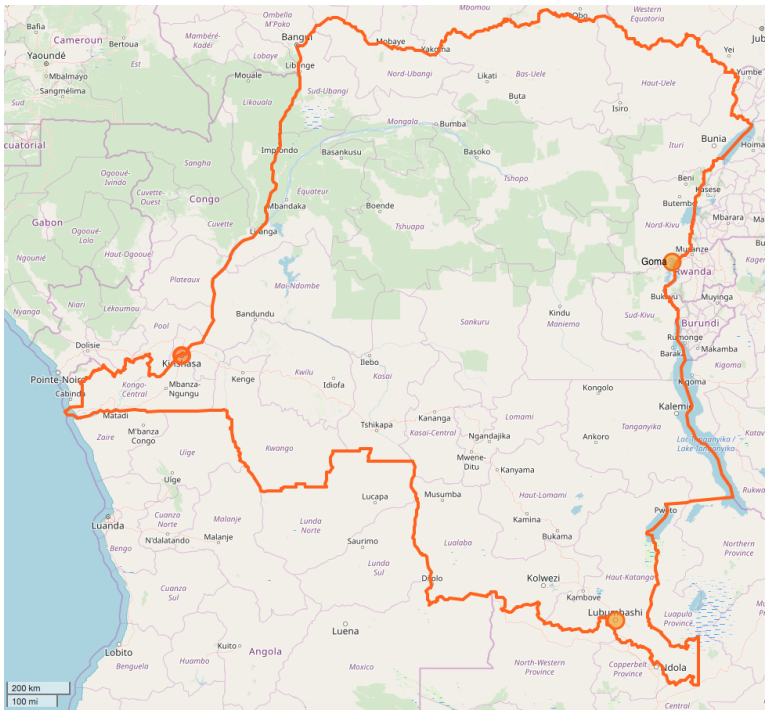

Figure 33: Map of DR of Congo, with the three cities where MSF has Coordination offices as orange dots. Kinshasa is the national capital and largest city. Lubumbashi, in the south, is the second-largest city and capital of the Haut-Katanga region. Goma, capital of North Kivu, has been the site of population displacement and armed conflict from the aftermath of the Rwandese genocide. Note scale at bottom left of map. Source: OpenStreetMap

The logic behind the redistribution of missions within MSF is complex and is not the object of this section. Suffice it to say that the portfolios of each Cell are meant to have some degree of thematic and/or regional coherence. So, while Laurent's Cell[1] was getting rid of its "migration" missions - Greece was closing and France going to the Cell that managed Libya - they were getting another central African country with emergency projects and HIV activities: the Democratic Republic of Congo (DRC). The meeting takes place in Laurent's office in Paris Headquarters. Else, the deputy Cell Manager, is also present.

> *Today, Laurent and Guillaume – the Program Managers for Cell 5 and Cell (?), respectively – are going to exchange France and Democratic Republic of Congo (DRC). It just so happens that Guillaume, a Frenchman, is getting France, and Laurent, who is Congolese, is getting the DRC. Else, the Deputy Program Manager with Laurent in Cell 5, is also here. They decide to start with the DRC, so Guillaume speaks first to "**hand over**" his mission to his counterpart.*
>
> *The first important thing is that many of the ongoing activities in the DRC are at the end of a **project cycle**, which means that it is time to rethink operational strategy. Laurent laughs, telling me that this means that he has "carte blanche", that is not tied down by what is currently being done, and that he can build up the mission's activities from scratch.*
>
> *Guillaume then talks about the **set-up** – a word they say in English, even though their discussions are in French – of the Mission, which is enormous and expensive. Usually, there is only one **Coordination office** in each country, in the capital. There used to be only one in Kinshasa, but the DRC is so big that they were taking planes all the time. So now they have three coordination offices – one in Kinshasa, the capital; one in Goma, capital of the North Kivu region; and one in Lubumbashi, capital of the Haut-Katanga region. This is better, but it's still too expensive. They are going to close one of the offices, in Lubumbashi, and turn it into a **"rear base"** (base arrière). This is supposed to save them 1.2 million euros a year.*
>
> *Else asks, does this mean we're "**closing**"? No, no, don't use that word, we're not closing. I don't know what word we should use, but not "closing". This would give the wrong impression to staff. In any case, we don't really know what we're doing in Katanga. Three different "**explos**" are ongoing, so we'll see soon enough.*
>
> *Guillaume says that some people in DRC want a project in **Kinshasa**, maybe an ambulance service like the one they have in Nairobi. There are presidential elections next year (December 2018), and an ambulance service would allow them to **"pre-position"** for the post-election violence. Else says that maybe that's a good idea, we know how to do that (*this is the Cell that manages the ambulance service in Nairobi*).*
>
> *Laurent says, maybe, but we know that Kabila is going to make a mess in **Katanga and North Kivu,** so people won't go vote. In **Goma** and in **Kinshasa**, there are going to be demonstrations. So, we really need to think about where exactly we want to **"pre-position"**. [...]*

[1] Cell's are often referred to by the name of the Cell Manager.

*Then **there's Bambu**. Bambu was an emergency project – that is, the Emergency Cell was managing it – up till last April. Guillaume says they decided to be in Bambu after they did an explo on the population displacements. But, according to Aurore - who they say is responsible for the "memory of the mission" - it's **not the most "pertinent" place** for them to be. He says that what makes the most sense is to be in two places, that way they have **a foot on the ground** (un pied à terre) on **both sides of the front line.**[1] It's just too dangerous to have to go back and forth across the line all the time. But Bambu is not the right place to be. We're doing an **explo**, and then we're going to move. But we think we're going to keep a field surgery site, that's what we agreed to with the Director of Operations.*

*Laurent: ok, so the idea is to have a hospital project and a field surgery site, because we want to **maintain the capacity to do surgery?** Yeah.*

Laurent then asks about North Kivu, you agreed on one or two projects with Ops? Guillaume says they think they're going to have three projects. The question is how it's going to work to have a bunch of small projects on the logistics side of things, and in terms of infrastructure. But the Commission went over the DRC really fast, so we didn't get a final decision. L: and what did they say? G: that everything had to be redone! Laurent and Guillaume laugh about this.

*Then they talk security along **the roads** in the area. You can get through, but you cross your fingers. There are bandits in the area, and you never know.*

*Ok, next, **Katanga**. So, as you know there's a lot of instability. We went in for a measles epidemic on an emergency project. Then there was malaria season, and after that, we realized that there was an ethnic violence on top of it all that we didn't even know about before we went in. But we weren't in **a good position** to work on the conflict.*

*L: so, the question is if we want to jump from emergency to emergency, or if we want to do something long term. G: voilà, but also to keep working on emergencies. The long-term project is to be able to work on emergencies. L: yeah, of course, we need to **find a way to be on both emergencies and long term, structural issues, when we know that, really, we could set up anywhere in the area**.*

These discussions take place in headquarters in Paris, between people looking at computer screens, sitting in an office with maps on the wall. They are literally thousands of kilometres away from the Democratic Republic of Congo, and yet Laurent and Guillaume seem somehow to be peering down a world that is uncannily immobile. All the local complications are flattened out, and the number of possible operations is greatly reduced. Their discussions relate to *positioning*: being in the right place, at the right time, for appropriate action. This entails explos, pre-positioning, opening, and closure. In short, the *global vision* and *direction* that Laurent mentions seem to relate to his ability to look out on the world as if it were a flat, immobile surface, upon which it is possible to position oneself in a system of relations, in order to achieve future outcomes of worth. This is *strategy*.

[1] There has been ongoing, low level, conflict in North and South Kivu from 2004 to the present.

The notion of *strategy*, as we use it, takes its inspiration from Michel de Certeau's work, especially in its distinction to tactics (2017). Unlike de Certeau, our goal is not to underscore the procedures, the *arts de faire*, of those without property, those without a "place of their own", who must *make do* with the social space as it is. We have talked extensively about the *tactics* of MSF throughout this dissertation, and we are not convinced by too strong or too stable a distinction with strategy. That being said, such a duality is useful in the economy of De Certeau's argument, as he makes counterclaims against two other conceptions of strategy. First, that of Bourdieu, as developed in *Outline of a Theory of Practice* (1977). Bourdieu makes clear that he is not talking about the calculative rationality with which *strategy* is generally associated. Indeed, he claims that it is precisely because people do not know why they do what they do that the *strategy* behind what they are doing is of interest to the ethnologist. This is what he calls *la docte ignorance*, or knowing ignorance. Second, that of Michel Foucault, for whom discourse affords specific strategies for dealing with singular problematics. De Certeau's interest in *tactics* - which he develops, in a sense, in response to the totalizing gesture of Foucauldian strategy - comes from the fact that they are non-discursive practices associated with *usage*, and the ways cultural artefacts can be hijacked to ends other than those of their designers or authors. Where Foucault's historiography starts from discourse in the present and then follows them back through time, demonstrating how they ossified. De Certeau is interested in all those non-discursive practices with historical importance that never became discourse with their associated strategies. That is, in the overall economy of De Certeau's argument against Bourdieusian and Foucauldian conceptions of *strategy* - to which we happily associate ourselves - the distinction between *tactics* and *strategy* is useful. This is not the case for the arguments we seek to develop.

Our goal is to understand how and why projects are closed from headquarters. Our first claim is that projects are closed from headquarters because closure entails strategic calculations, and that headquarters is the kind of place from which strategy is possible. De Certeau states that strategy is based, fundamentally, on the ability to circumscribe and hold *a place of one's own*. Strategy is the "calculation of relations of force" that becomes possible when a "subject of will and a subject of power" is isolated from an "environment" (p. XLVI, my translation). That is, it is based on the Cartesian gesture of circumscribing a place, which serves as a *base* for accumulating and *capitalizing* on that which has been acquired, and from which one can manage relations with an *exterior*. According to de Certeau, political, military, and scientific rationality are based on this model of strategy. De Certeau summarizes as follows.

> *"In sum, strategies are actions which, thanks to the establishment of a place of power (the property of a proper), elaborate theoretical places (systems and totalizing discourses) capable of articulating*

> *an ensemble of physical places in which forces are distributed. They combine these three types of places and seek to master each by means of the others. They thus privilege spatial relationships*" (de Certeau, 2002, p. 39).[1]

Our description of Yalta, where Guillaume and Laurent talk strategy, makes it clear that MSF does circumscribe a place of their own, where they can capitalize on their experience, and from which they can look out on the world as if it were an immobile surface, read it like a coherent text, and calculate relations of force in the field. This place is headquarters.

*

We can conclude that the primary problem faced in headquarters is maintaining a series of centres in which they can accumulate resources and information in order to provide strategic support to the field. The point is that while MSF-in-the-field may require MSF-the-institution, by which they are able to constitute a place of their own, against an outside, an *external reality*, it is precisely this external reality that must direct and orient MSF's strategic plan and not the needs of the institution. Otherwise, they become isolated, caught up in protecting and developing the institution, which then stops supporting MSF's social mission and becomes an obstacle. However, MSF's "place of their own" is not a single, centralized location, from which all strategic decisions are somehow handed down from on high to agents in the field. De Certeau's image of strategy does not quite hold here. He associates strategy with the vision of those that would look out from the top of the World Trade Centre and imagine a path through Manhattan, a practice which he contrasts to the tactics of walking through the city (2017, p. 139). MSF headquarters are not at the top of one tower on an island. They are at the top of multiple skyscrapers and at several intermediary levels distributed around the world. They have "satellites"[2] and offices on the ground. These locations are interconnected, like a series of communicating vessels. Everybody is supposed to do strategy, and this strategy should remain oriented towards the delivery of MSF's social mission, not protecting the institution.

2. MAP-ping project values

The goal of this section is clarifying how humanitarian values relate to strategic decision-making. We do this by looking more closely at how the "outcomes of worth" of humanitarian

[1] "*Les stratégies sont donc des actions qui, grâce au postulat d'un lieu de pouvoir (propriété d'un propre), élaborent des lieux théoriques (systèmes et discours totalisants) capable d'articuler un ensemble de lieux physiques, où les forces sont réparties. Elles combinent ces trois types de lieux. Elles privilégient donc les rapports de lieux.*" 2017, p. 63.

[2] Inside MSF, structures like Epicentre, the Access Campaign, MSF-Logistics, and MSF-Supply are referred to as "satellites".

discourse were calculated when MSF shut down TB activities in the Mathare slums. The decision to close was made during semi-annual, routine meetings called *mises-à-plat*, or a MAPs, where past activities are *evaluated* and *"ways forward"* discussed. These meetings bring together project evaluation, strategic planning, and decision making. To begin, an overview of MSF's work on TB in Nairobi will be useful. The following is a summary of TB activity history, as it was presented in an interview with Dr Absame, the Medical Team Leader in charge of TB activities on the ground.

> *MSF has been working on TB in Mathare since 2001. At first, TB activities was part of a larger HIV project, in which MSF provided treatment for opportunistic infections in HIV positive patients. In 2006, we began providing treatment for drug-resistant TB (DR-TB) in this same context. It was around this time that several large institutions began funding HIV projects in the Global South. As local actors received training and funding, we realized our activities were not sustainable, and we decided to pull out of HIV in Mathare, eventually handing over our HIV facilities and patients to a partner organization in 2011. But we kept both drug-sensitive TB (DS-TB) and DR-TB patients. At the same time, we introduced a new diagnostic machine in Kenya – the GeneXpert – that uses DNA sequencing technology to detect strains of* mycobacterium tuberculosis *that are resistant to Rifampicin, a first-line drug that quickly develops resistance. It does so quickly and at little cost. This new diagnostic tool allowed us to begin recruiting up to 10 DR-TB patients a month. Feeling overwhelmed by this rapidly expanding patient cohort, we realized we needed a new facility. We moved to the Green House in 2013. Our patient cohort continued to grow, and we eventually decided that we had to hand over our DS-TB patients to the Ministry of Health. This hand over began in 2016. The same year, MSF began to support the Ministry of Health as they set up a "centre of excellence" for DR-TB in Mathare at the Bahati Clinic. The idea was to establish a model treatment centre within the Ministry, that could then be copied in other locations across the country. It was in coordination with the Bahati clinic that MSF began piloting a new and shorter treatment regimen for TB in Kenya, called the 9-month regimen. We also introduced, at the same time, two recently developed molecules for treating DR-TB into Kenya and worked to increase their uptake inside the Ministry. MSF also began training in mentorship and counselling. We had over a decade of experience working with TB treatment in Kenya, for all sorts of patient profiles (HIV co-infections, DS-TB, MDR-TB, XDR-TB, pre-XDR-TB) and with experience in regimen design for complex cases (piloting 9-month regimen, introduction of new molecules). We chaired the national technical working group on TB, provided regular and free training to Kenyan health professional faced with TB treatment, supported the public health sector workers in treatment regimen design, trained laboratory technicians on the use, maintenance, and optimization of the GeneXpert diagnostic machine, and provided psychological counselling tools to health professionals in order to improve patient adherence.*

Dr Absame's presentation tells the story of MSF's TB interventions as a series of "realizations" and "decisions" (both words come back repeatedly during our interview). He smoothly switches back and forth between "we" and "MSF" throughout. In what follows, instead of focusing on these moments of consensus - collective "realizations" and then commitment to a new course of action - we will discuss a moment when there was deep-rooted discord concerning the appropriate way forward for the project. Because of disagreements regarding the value of the

project and appropriate "ways forward", it is impossible to tell this story with "MSF" and "we" as the only actors. Here, to understand what is happening, we must divide MSF up into its constitutive organisational units.

In the spring of 2017, Laurent, the Cell Manager, announced to the Coordination team that it was time to stop recruiting drug-resistant tuberculosis (DR-TB) patients, who were now to be referred to the Ministry of Health's Bahati Clinic, the "centre of excellence" that MSF helped set up. This was met with surprise and confusion in Kenya. The members of the Medical Coordination team in Nairobi – Samantha and Peter, in charge of planning all medical activities in the country – felt that DR-TB was the activity with the most added value. Discussions came to a head in October 2017 MAP. There was a basic disagreement between the Cell team in Headquarters, and the Coordination team in Kenya. The main protagonists from Coordo in this story are Samantha – the Medical Coordinator – and Peter – the Deputy Medical Coordinator. Put simply, in headquarters the Cell thought there were not enough patients to justify keeping the project open; in Nairobi, the Coordination felt that the TB program was their most impactful activity in Kenya, with wide-ranging and long-lasting effects for a neglected population without the resources necessary to access healthcare. They thought it should be extended.

a. The MAP: Calculating Value and Finding a Way Forward

Discussions regarding the future of TB activities in Kenya continued during the October 2017 project evaluation and planning meeting called the *mise-à-plat*, the MAP. The French noun *la mise-à-plat* could be translated as "the flattening". This is not particularly evocative in English. Yet we must keep in mind the idea of getting six months of operations into two-dimensions. The term MAP - homophone of "map", another two-dimensional tool - is also used, in both French and English. So, MAPs provide both an overview of the past, and support the plotting out of a "way forward". MAPs combine these distributed cognitive capacities: memorizing and summarizing past activities, while making projection into the future possible. In more descriptive terms, *mises-à-plat* are semi-annual, routine meetings where people from Support Departments and the Department of Operations come together to talk about a mission. To capture the idea of "flattening", we could say that all the technical intricacies and organizational entanglements of the mission are "laid out" or put "on the table". But instead of being "laid out" on a table, they are "projected" onto a screen. The Coordination team projects PowerPoint slides onto a smooth white surface that the 20 to 30 people in the room can see. These slides have titles like "Political Context", "Health Context", "Potential for Emergencies", "Homa Bay", "Diagnostic Network", "Objectives", "Challenges",

"Prevalence Data", "Monitoring Data", "Achievements", and "What is to be done?" (next to a picture of V.I. Lenin).

This rendering of a mission's past and future in two-dimensions is a day-long affair. The Head of Mission – here, Omar – opens the session by mentioning the order of presentations, then talks about the political and humanitarian situation in the country and develops long term strategic goals and opportunities. During the October 2017 MAP for Kenya, Omar reminds every one of the ongoing presidential elections in Kenya and talks about difficulties in managing staff in the Ministry of Health facilities. He then puts forward a plan to rework the Memorandum of Understanding (MOU) with them through the addition of a Service Level Agreement (SLA). After his introduction, the Medical Coordinators – Samantha and Peter – present all medical activities in detail, covering project history and objectives, set-up and logistics, presentation of indicators, and ideas for a "way forward". Often, HR and finance are saved to the end of the day, if there is time. There are usually representatives from all OCP's Support Departments, and sometimes there are members of Epicentre if there are ongoing studies in-country. Discussions can be intense, but there is also the need to just move on, given the extent of activities to be "projected" on the screen and into the future.

The MAP presented here took place in October 2017, about six months after the recruitment of DR-TB patients was stopped.

> *Peter – the Deputy Medical Coordinator in Nairobi – goes to the TB part of the project.*
>
> *He starts with recent updates on TB prevalence data presented in a graph form: prevalence in urban centres is twice that in rural settings, with much higher risks in the slums. But, overall, DR-TB prevalence is relatively low in Kenya. He then does a reminder of* ***specific objectives*** *– improve case detection and case management in the Eastlands of Nairobi – and looks at progress made by showing changes in indicators. Case detection seems to be one of the primary indicators. But Peter says that there are key gaps in analysis and diagnosis: it is very likely that many TB cases are missed during screenings in Ministry of Health facilities. This is tied to long waits for culture tests at the national lab (average: 68 days). There are also issues with drug resistance and gaps in care, specifically for HIV co-infections. He notes that the rate of HIV/TB co-infections is going up. This has to do with the closing of the Somalia-Kenya border, the decrease of Somali patients, and the higher HIV prevalence in Kenyans.*
>
> ***Peter: There was a request from the Ministry of Health, who has had challenges in scaling up the shorter MDR-TB treatment regimens we've piloted, and with diagnostics. They've asked for the continued support of MSF.***
>
> *This causes significant debate, around the decision to stop recruiting patients this year.* ***Is it MSF's role to support the Ministry of Health?*** *The discussion stops with no conclusion.*
>
> *They continue with a series of slides entitled "Activities 2018". They've improved screening in Ministry of Health decentralized facilities in the Eastlands. The discussion on their* ***proposal to extend support for screening DR-TB at a national level*** *starts up again.*

Laurent's argument against such an extension comes from the prevalence data: there are only 160 potential DR-TB patients for all of Nairobi, while 26% of deaths in the slums are due to drug-susceptible TB. Does it make sense to keep working on DR-TB here? ***What's the impact?*** ***Sam****:* ***the "added value" is at the national level****. They have introduced new drug protocols in the Ministry of Health and provided access for a neglected and vulnerable population. This is what such a small program can do, even if there were only 7 patients in the last year.*

Laurent*: it's really a pity that the TB people aren't here, to get another opinion. They are the ones who suggested we get out of TB in Homa Bay.*

Sam*: it would really be a pity to get out of TB in Kenya, there is a lot we can do. Helene (HIV specialist from Medical Department). Yeah, but 5 patients, it's not enough to be able to demonstrate anything or show anything to the Ministry of Health. Why were there so few patients? No answer.*

We move on to the ***next slide: "Paediatric TB".*** *Peter continues. The national program points to gaps in paediatric TB case detection.* ***We wanted to ask if that's something we might want to engage with in Kenya.*** *We might look at a screening protocol. Or we could explore new tech options, like AEONOSE.*

Sam*: just to complete what we've been saying on TB, these would all be very short term.*

Laurent*: OK, yeah, it's just I thought that* ***we had decided to pull out of Kenya on TB.*** *We've stopped TB cultures and closed the Green House.*

Sam*:* ***this is the first time I'm hearing this. We were not included in that decision!*** ***Omar****: and we think TB is the priority. But if you disagree, OK.* ***Laurent****: just to be clear,* ***to conclude,*** *for now, we're fine with setting up the GeneXpert network for the Ministry of Health in the Eastlands. But next year, in June or in October MAPs, we need to discuss what we will do in Mathare after that.*

DR-TB activities in Mathare are "MAP-ped". Prevalence data is provided, and "2018 Activities" are presented for everyone to see, including the number of patients screened and the number of patients on active treatment. Projected into this flat space is a great deal of information regarding the situation in the field, prevalence values, case detection rates, as well as progress on specific, predefined project performance indicators. This heterogeneous ensemble is said to refer to project activities. This is one way the *reporting* to HQ on activities in the field takes place. This is how the field is "carried back" to MSF headquarters: in the form of indicators and prevalence data. Peter says things like "urban prevalence" is higher than "rural prevalence", but overall DR-TB prevalence is "low" in Kenya. The wait for culture tests is long (68 days), and this affects case detection. A problem is identified, and the possibility that MSF supports public health authorities is proposed as a "way forward".

Laurent reassembles these values - the rates, figures, indicators projected onto the screen - into a new value: the overall **impact**, or added value, of the project. Considering the prevalence data, there are only 160 DR-TB patients in a city of over 3 million people. What kind of "impact"

would future DR-TB activities have with such a small target population? The set of values on the PowerPoint slides, projected onto the white screen, are recombined, reconfigured, and a new value is calculated. These same values projected onto the flat screen can be combined in a different way. According to Sam, the "value" of the project is not in Nairobi and cannot be calculated through the simple addition of potential future patients – which is what Laurent attempts when he states that there are only 160 potential patients in Nairobi. According to Sam, "added value" is at the national level, and is related to their influence on national treatment protocols – that is, the new "9-month regimen" Sam mentions – and to the access to care they provided to a "neglected" and "vulnerable" population. Depending on the way the values on the screen are combined the overall "impact" of the project varies.

This discussion ends with a disagreement and the deferral of a decision to the next MAP. The values projected onto the screen helped support differential calculations regarding the value of the project. When Laurent "reminds" those in presence that "we" had already "decided to pull out" of TB in Kenya, Sam claims that the team in the field was not "included in that decision", effectively dis-integrating the "we" Laurent used and "MSF" with it. For Sam, Peter, and Omar, the "way forward" they see after this MAP lies in the extension of case detection and in paediatric TB. The contradictory calculations of the value of the project do not cancel each other out. They are left as they are, with Laurent feeling that TB activities in Kenya should cease but authorizing the team to fulfil their current objectives. But during the next MAP, they will have to discuss a "way forward" after that.

*

There are two points we would like to insist on here. The first relates to the topography of the headquarters-field *agencement*. MSF headquarters do not *englobe* the field. There are *layers* in the Department of Operations, but higher levels do not *include* lower levels. The global vision that is organized from headquarters – looking out on the world as if it is a flat surface and reading relations of power in view to orient the organization towards outcomes of worth - is not made possible because headquarters is floating in the sky. Rather, it was *reporting* – when the field is "carried back" to headquarters –the continual flow of information that made it possible to "see" the field. It is during MAPs that MSF activities are projected onto a flat screen and rendered in two dimensions. This point echoes Latour's contention that:

> *"an army's command and control center is not 'bigger' and 'wider' than the local front thousands of miles away where soldiers are risking their life, but it is clear nonetheless that such a war room can command and control anything—as the name indicates—only as long as it remains connected to the theater of operation through a ceaseless transport of information. So the right topography here is not to include the front line 'into' some overarching power, but to localize both and to*

> *connect through some sort of well-fed cables what in French is called* connectique*. This is what I mean by flattening the landscape"* (Latour, 2005, p. 182).

Second, inside MSF, organizational routines assure this flow of information, this *connectique*. An important part of these routines are the project evaluation and planning meetings called MAPs. Following Jarzabkowski and Seidl (2008), we take such meetings as *strategy episodes*. Strategy episodes can destabilize or stabilize the *orientations* of the organisation. The initiation of these meetings suspends usual organisational processes, and their *termination* reinstates them, dissolving the structure of the meeting. This *suspension,* this pause, brings us back to Hannah Arendt's understanding of *attention,* quoted in the introduction: "*Attention consists in suspending thought, leaving it available, empty and ready to be entered by its object… thought must be empty, waiting, seeking nothing, but ready to receive in its naked truth the object that is about to penetrate it.*[1]*"* Here, it is not thought that is suspended and left empty, but ordinary organizational processes that are interrupted, in order to allow that which is exterior to MSF to penetrate the organization. It is during this pause that what is "carried back" from the field - values, indicators - are recombined and projected into the future.

This is how the value of a project is calculated.

b. The Values of Divergent Ways Forward: "Direct Service Delivery" and "Systems- Strengthening"

A few months after the above MAP, I sat down with Else, the Deputy Program Manager in the Cell in headquarters for a briefing on MSF's activities in Kenya before leaving to do fieldwork there. We discussed all the projects and medical activities in brief. Else's presentation of DR- TB activities revolved around the "disagreement" that had emerged during the October 2017 MAP. The Cell wants to close; Coordo wants to keep the project open. The problem, according to Else, is that "there are too few patients" and if the Medical Coordinators want to continue working on DR-TB, it is because they have a personal and medical interest in it. Laurent also mentioned the problem of low patient numbers in the extract from the MAP above. From Laurent and Else's point of view, MSF's "impact", and the future value of the TB project, is connected to the number of patients they treat.

Upon my arrival in Nairobi, Sam, the Medical Coordinator, told me that Paris was "*silently closing the project*". "*Everyone just keeps saying that the project is closing, because there's no interest. This project has lost support.*" This is an interesting idea: she does not say that there was

[1] Tronto, 1993, p. 128.

a "decision" to close, but that everybody keeps saying that the project is closing. Indeed, I was told before going to Kenya that TB activities were closing and was surprised to see upon my arrival that there were TB patients. Peter and Sam see the "value" of the project not only in the number of patients it treats, but in its ability to influence the programmatic management of TB in Kenya.

These two valuations of the project were directly tied to strategic planning – close TB activities or extend the diagnostic network and pick up paediatric TB. Interestingly, these two modes of valuation, and the strategic agency they afford, seem to sit in tension at several sites across MSF. Peter and Sam explain that they are related to different "approaches" to humanitarian action inside MSF: the "systems-strengthening approach" and the "direct service delivery approach". Through this discussion, we will come to terms with a third way that humanitarian values relate to project closure: after *exit strategies* and *diminishing returns*, we will see how *opportunity costs* are calculated.

Near the end of an interview with Peter, I ask him what he thinks the future of DR-TB in Kenya will look like for MSF. The reader will recall that the October 2017 MAP discussions on TB ended with Laurent telling the team in the field that they would have to think about what they will do next in Mathare. Peter was put in charge of preparing a proposal for the May 2018 MAP, which is to take place 5 days after my interview with him. Instead of responding directly to my question, Peter tells me about operational approaches existing in different Operational Centres: Operational Centre Paris (OCP), which runs the project in Mathare, versus Operational Centre Brussels (OCB).

> ***Peter**: So, I still think we would, we would... I still think we would have an added value... It's also quite interesting to see, I think, the preferences and operational strategy, between different sections. **OCP** is very much into **doing it yourself**. Like if you look at the Khayelitsha TB program [in South Africa, a high-burden DR-TB country], which is run by **OCB**, it's very much in line with what we proposed last year. It seems like a very **system- strengthening approach**, where you're not the one who is really directly proposing the service, but you're working with the Ministry of Health, who provides the service, to try to strengthen the system. By decentralizing care, and by working in those decentralized facilities, with roving clinical teams, to transfer their skills and knowledge to the clinicians within those facilities. And then **you are addressing system issues**, such as sample networking, are the machines working? do the peripheral facilities have the protocols?*
>
> *It's a **very systems-strengthening approach, versus a direct service delivery approach**, which I feel is an approach that is more appealing to **OCP**. And in a context like this, where you don't have a massive number of patients, with huge service delivery gaps, it doesn't make sense. We don't have huge **service delivery gaps** in Kenya, but we have **big service quality gaps**. And if you're going to fill in the gaps in terms of quality of care, then - well, arguably - a systems-strengthening approach, where you're embedding yourself in the existing system and trying to improve the quality of care, is probably a justifiable approach. I think this approach is not very appealing to OCP. In my assessment. I think it's more appealing to OCB.*

OCP values the direct provision of services to patients. OCB values "system strengthening". While these "approaches" relate to strategic styles and operational preferences, for Peter, Kenya requires a "systems-strengthening" strategy.

In my interview with Sam, when I ask how she plans to communicate the value of the project to members of the Cell in Paris during the next MAP, she makes a similar distinction between OCB and OCP regarding what she calls "vision".

> ***Sam**: It's not just a problem of communication. For me, this is very a personal opinion, that's the difference from what I've seen in OCB and in OCP. In **OCP**, where **our TB referent has always been focusing very much on clinical cases**. But, and it's not a reproach, I really think it's a question of visions. But for **OCB**, I was used to being told, 'this is really about the national policy level and so on'. [...] But, it starts from MSF as an organization, **formulating clear objectives on having policy change, yeah, policy change, impact on protocols, on service delivery systems, as a clear objective**.*
>
> *And in my opinion, that makes sense here - and that objective has been there, partly, because we were included in the introduction of new molecules. Again, it's very clinical. And headquarters has been very interested in* us *starting those molecules. There's not been a lot of interest in 'OK, how far have you managed to push the Ministry of Health to do this?'*
>
> *But that's where it starts, yeah? **So, it's not just in the reporting**. It's the objectives, that's really where it starts. Like, whether affecting the national program is, **at different levels**, seen as a priority, as an objective.*
>
> *And for me that's the key thing. I've never felt a lot of interest. Oh, they're kind of happy we've done it, you know, 'ah yeah, it's nice'. **But I've never felt like it's seen as an achievement, that you manage to work on this higher level, at the TB program level**.*

It is not a problem of communication, because, as Sam argues, these strategic visions direct the definition of project objectives, monitoring and evaluation methods put in place, and thereby the kinds of project value that can be calculated. Because the project evaluation methods used in MSF are better adapted to tracking the accomplishments of the "direct-service delivery approach", it has been difficult for the team in the field to provide a convincing, positive assessment for the future of work on TB in Kenya. Different strategic visions put value on different outputs and define different objectives. For Sam, convincing the Cell of the project's value it is not only a question of *reporting,* but a question of *what can be reported* given the objectives defined at the outset. These objectives determine surveillance and evaluation methods, and, in turn, what values get communicated to the Cell.

At the same time, from an "MSF perspective", working at a "global level" - expressions used by Sam - the number of patients remains important for project evaluation. It is understood by both Sam and Peter that, generally, large patient cohorts reduce costs-per-patient. They understand

that it can make more sense to intervene in countries where there are more patients because "impact" will be greater, i.e., more patients are treated. This is the case whatever the approach, "direct service delivery" or "system strengthening". As such, the number of potential patients is a key consideration in the justification of projects. The Coordination team understands this. During my briefing upon arrival in Kenya, Sam tells me that "*the project has lost support*", and "*from an MSF perspective, this makes sense. The large patient cohorts for DR-TB have not materialized*." There are differences in strategic approaches based on collective understanding of what MSF's overall goals are – direct service delivery through clinical interventions and systems-strengthening approach that builds that works to affect treatment protocols and service-delivery models. However, there also seems to be an "*MSF perspective*" that is somehow tied to "*large patient cohorts*". Sam continues: "*From the perspective of MSF, working at a global level, you compare the 10 patients you have in Kenya with the 150 patients you could have anywhere in Eastern Europe, and you wonder what we're doing here*." Sam was adamant about the value of the project not residing simply in the number of patients, about how important it was to step back and look at the effects their team was having on the programmatic management of TB at the national level. Yet, here she says that if you look at things from a "global level", then it is precisely the size of the cohort that tells us *if an intervention is worth it*: when comparing the number of potential "clinical cases" in Kenya and Eastern Europe, it is clear that MSF should be in Eastern Europe.

Peter, the Deputy Medical Coordinator, develops a similar argument when I ask about the Cells refusal to consider their proposal at the October 2017 MAP:

> ***Peter**: I think if you understand the history, you will understand why they say that. **One, is that DR-TB is very expensive**. So, at that time, before we shut down Green House, our cohort was about 18 patients. But then, what was our staffing? Close to 40 staff, for 18 patients. Plus, the facility to run. So, you're paying lots of salaries, very expensive drugs, for a very small cohort. Before that, like in 2013, 2014, the cohort was fairly big, about 50 patients, active on treatment. But then something happened. We had, at that time, a majority of our patients, about 60% of them, were from Somalia, they were not from Kenya. And it's because the health system in Somalia had basically collapsed. **And therefore, there was, I would say, number wise, there was a justification to continue this heavy investment. There was a big cohort. It's more efficient when there are more patients.***
>
> *And then Kenya, for security reasons, went into Somalia and strengthened security across the border. So, this cross-border movement stopped around 2014, mid-2014, early 2015, and going onward. So, the cohort just... dwindled. [...] So, when the cohort dwindled, and by the time we were having discussions last year, we had just 18 patients, and the trend is that you're not enrolling as many new patients as you are discharging from the clinic. So, your general trend is that your cohort is thinning down. I think, my understanding, is that **headquarters values TB, or DR-TB, based on numbers. So, they would consider TB a big problem if there were more numbers.** And if you look at the other countries where we are working, like Kyrgyzstan, countries in Eastern Europe, South*

Africa, these are countries that have significantly larger DR-TB problems in terms of numbers, big cohorts.

In Kenya, MSF used to have a large cohort of DR-TB patients. But the 2014 al- Shabab attack on the Westgate Mall in Nairobi, in retaliation for Kenya's military intervention in Somalia in 2011, pushed Kenyan security forces to shut down the Somali border. The number of Somali DR-TB patients in MSF's program dwindled, and in 2016 MSF had 18 patients with 40 staff with cost-per-patient at 23,374€.[1]

In this section, we saw that the value of a project could be calculated in a variety of ways and associated with stabilized strategic visions and with different MSF locations. Moreover, we saw that specific strategic visions and their consonant objectives linked to monitoring regimes and, therein, to the creation of specific values and limited possibilities for combining them: it become difficult to demonstrate the value of TB activities according to the "systems-strengthening approach", insofar as all the data collected related to the "direct-service delivery approach" (i.e., number of consultations). Both Peter and Sam linked these different strategic modes to Operational Centres in the larger MSF movement. While we heard this reading of MSF's internal environment multiple times during our investigation, we might also remind the reader of the Director of Operations Strategic Plan, discussed above. This plan included a section on supporting the development of oncology platforms in Mali and Malawi. This approach is not a recent development in MSF-OCP: she referred to the work of Jean-Hervé Bradol, president of MSF-France from 2003 to 2008, who she described as developing a kind of "political medicine". In the introduction to a book Bradol co-signed with Marc Le Pape on medical innovations led by MSF, they specifically state that the utility of these medical innovations relies on getting them adopted in national protocols (2009, p. 15).[2]

Moreover, in our interviews with Peter and Sam, they also recognized that from an "MSF perspective", deciding whether on not an MDR-TB project in Kenya was *worth it*, when compared to an intervention in Eastern Europe or South Africa, the answer was obvious to them. We would suggest then that "direct service delivery" and "systems-strengthening" are not strategies that are opposed to each. MAPs are about *calculating the values* of a project but also trying to figure out it

[1] Hennequin, April 2017, "EOM Report", MSF internal document.

[2] "Faire accepter par les pays d'intervention une nouvelle démarche thérapeutique comme protocole national, faire modifier les recommandations de politiques publiques, de politiques industrielles et commerciales, c'est aussi cela qui doit être obtenu pour que l'innovation soit généralisée : il s'agit de lier la pratique médicale à un travail politique au risque de confrontations avec des pouvoirs établis, pouvoirs politiques, économiques et médicales." p. 15.

a project is *worth it*. For a project to be worth it, ideally it should allow both "direct service delivery" and "systems-strengthening". Not one without the other. Bradol and Le Pape establish a limit not between "systems strengthening" and "direct service delivery", but between advocacy for modifications in national protocols and the humanitarian's role in restructuring national health systems in such a way as to make innovative protocols more efficient.

c. The Value of Choice: Integrating "MSF"

In this section, we present the May 2018 MAP discussions on DR-TB activities in Mathare, a little over six months after the MAP above. This MAP took place in Nairobi, in an OCBA decentralized headquarter entity, on the last day of my 7-week stay on MSF's Mathare project. The entire Cell team, as well as members of different Support Departments, had come.

Figure 34: Slide from PowerPoint Presentation at May 2018 MAP

The Coordo team's presentation on DR-TB consisted of 12 slides. The first slide is a graph representing the number of patients screened for DR-TB, with the percentage of DR-TB positive patients, from Q1 2015 to Q1 2018. The next 4 slides all have the same title: "Achievements". Here, Peter and Sam have put things like "extensive capacity building", "improved set up", "trained counsellors", "step by step training of lab staff". The next 7 slides are divided into two columns of text with "Challenges" on the left, and the corresponding "Way forward" for MSF on the right. While the team repeatedly claims their "Achievements" are significant, they do not mobilize specific, quantitative indicators that would clarify the "added value" of the project in numerical terms. Laurent repeatedly poses pointed questions on how they evaluate their activities, and the team is at a loss to respond. The disagreement over the values of the project is at its peak, with the team in the field locked into the quantitative values that support the "direct service delivery" approach. The clash reaches its apogee around the question "should we stay, or should we go?" Below, is a table of segments of the exchange that relate to requests for information that would allow the calculation of the project's value.

Table 4: Positional cording of expressions related to project value during MAP

Cell Managers, HQ	Medical Coordinators, Kenya
What is the situation in terms of targets? Do you have data for other sites? It would be good to see the number of cases screened. The objective was to improve screening and case management: do you have data on that? How do you evaluate impact? To summarize, networking doesn't work very well? How do you evaluate support for quality of care?	I don't have that data set open; can someone check? We have a lot of experience with co-infection. We don't have systematic data. Our team is the most experienced in Kenya. We need qualitative indicators. Remember how big an actor we are here for TB; we chair the technical working group. This project gives visibility and provides leverage for advocacy.

What comes back again and again is a request for data. Laurent is looking for values that he can grab hold of. The Coordo team continually reminds Laurent of the values they attribute to the DR-TB project: it provides strategic leverage in the Ministry of Health for their other activities, it responds to the lack of experience in Kenya, it supports the uptake of novel diagnostic and treatment techniques. The MAP discussions end as follows:

> ***Laurent: OK... we need to conclude these discussions.*** *There are a lot of needs. And if you want leverage in the Ministry of Health, I don't think the numbers are there. You would need more patients. And, even if it did give you leverage, is leverage a good enough reason to keep a project open?*
>
> ***Sam****: that's not the only reason we've given! There are gaps!*
>
> ***Laurent****:* ***but just to talk money****, is this the best place to work on TB? At some point we need to make a choice. You say we're not convinced, and you're right.* ***Sometimes when we say "stop", it's because there are difficult choices to make.*** *DR-TB is closing in Georgia too. We have a choice to make about where we want to work. It's just too expensive for too few patients. Sam: OK, just one thing. Our approach here is very "light". There are only 4 staff, almost no drugs. So, yes, there is a choice to make, and you're right, DR-TB prevalence is low compared to other places. But look at "return on investment", look at what you're getting. And it also provides leverage for medical advocacy.*
>
> *Else: if we are going to come to a conclusion together,* ***we need to have objectives that we can agree on, to be on the same page****. Can we say that? Just to think about. Laurent: yeah, we need to come up with something. So, we said that we would open the discussion on the HR element in SGBV on decentralization, and on DR-TB objectives. So, tomorrow, we'll have a sub-meeting on those issues, before going back to Paris.*

Laurent does not contest that there is a need in Kenya and that DR-TB activities there have an impact, but he says that there are "a lot of needs" and *a choice* must be made about where they

are going to work. It just costs too much for too few patients, when compared to other locations where MSF could pursue work on TB. They put off the final decision to the next day, but Laurent's "conclusion" is already there: a "choice". To be clear, it is only after 12 months of internal discussions that disagreements regarding the "way forward" are constituted in terms of "choice". Choice, as Else suggests, entails "getting on the same page" and coming to agreement on objectives. One of these entangled ensembles of valuations - made possible by the work of calculation conducted across several humanitarian locations - which support alternate "ways forward", must be abandoned if MSF is to maintain its consistency as an organization. The *fiche projet* for the coming year summarizes the results of this choice in its definition of DR-TB objectives for the rest of the year: "Gradual hand over of TB/DRTB activities will be completed end of the year 2018." The choice to close the project makes it possible to reintegrate "MSF". Completing the history of the project that Dr Absame started: "MSF" realized that DR-TB in Nairobi was unsustainable and decided to halt activities in 2018.

*

The analysis of MSF's operational strategy, put forward in this section, is inspired by the *strategy-as-practice* approach. Strategy-as-practice builds on Whittington (1996) to shift away from strategic planning and thinking towards the doing of strategy. This "*doing*" includes "*all the meeting, the talking, the form-filling and the number-crunching by which strategy actually gets formulated and implemented*" (Whittington 1996: 732). This approach has inspired a turn in work on strategy, both as a scholarly pursuit and a practical problem. Yet key gaps remain. In two review articles (Jarzabkowski & Spree 2009; Golsorkhi *et al* 2010), there is agreement that the strategy-as-practice approach can link micro-processes to institutionalized routines. They conclude, however, that 1/ empirical work on the constitution of macro-level entities through practice represents a gap in the literature (Jarzabkowski & Spee 2009) and 2/ that strategy research should, therefore, attempt to show how "micro-level practice" ties to the "meso and macro level praxis" of strategy (Golsorkhi *et al* 2010).

Working through the plurality of values that vie for legitimacy in an organization is a central problem for the constitution of "macro-level entities". Building on the strategy-as-practice approach, Sarah Kaplan (2008) accounts for disagreement in strategy practice through a "framing contest" model. During "framing contests", disagreement on the cognitive and political diagnostics of the situation means its "basic meaning […] is up for grabs". This compounds uncertainty and limits rationality. If Kaplan's approach has the merit of describing the effects of discord on strategy practice, the "frame" approach misses something essential in the strategy practice of non-market actors. The opponents in Kaplan's "framing contests" share the overarching goal to create

economic value for the firm. Disagreement is about how best to do so. This is not the case for an actor like MSF: what exactly is the "value" that strategic actors search to create for a humanitarian organisation? This under-theorisation of "value" in strategy research is not incidental. As Martin Kornberger (2017) has demonstrated, it is symptomatic of a larger trend: in strategy research, "value" is assumed and not analysed. He then puts forward a model for theorizing value in strategy based on valuation studies (Muniesa 2011; Doganova *et al* 2014). Following John Dewey (1939), 'valuation' shifts from 'value' as a noun to 'value' as a verb, asking how values are done. Kornberger's model provides a program for the study of valuation in strategy practice. However, its focus on *firm rivalry* limits its effectiveness to studying valuation in the strategy practice of certain kinds of actors at certain moments. While there can be competition between humanitarian NGOs for institutional funds or for symbolic positioning in the humanitarian field (Krause, 2014), during operations humanitarians strive to work in coordination (Fredriksen, 2012). If we are to understand how "contests of valuation" affect operational strategy outcomes in a medical humanitarian NGO, this model needs to be augmented.

In our search for a theoretical account for the resolution of disagreements over the value of a project, Stark's approach to valuation through dissonance is useful (Stark 2011). A situation is dissonant when there is "more than one framework for assessing it" (Hutter & Stark 2015, p. 5). Stark's work focuses on the ties between innovation and dissonance in valuation frames. He argues that, to the extent that "organizations are engaged in a search for what is valuable" (2011, p. 6), and innovation – understood as the combination of what was previously incompatible - is a source for value creation, then an organizational form that promotes dissonance and reasoned debate can consistently innovate.[1] However, the copresence of dissonant valuation frameworks does not necessarily lead to their integration in view to create "more" value. Sometimes, two valuation frameworks remain hermetic to one another, supporting "ways forward" that present themselves as alternatives or options. A choice must be made. How might we understand the choice between valuation frameworks in strategy practice?

We might adopt Boltanski and Thévenot's account of values (1991). In their orders of worth approach, specific worlds are linked to higher-order principles. A situation is more easily evaluated in the terms of a higher-order principle when its consonant world offers a hold for evaluation; it becomes easier to evaluate an entity in terms of the industrial concern for efficiency in a world where there are the productivity figures associated with the setup and conventions of a factory.

[1] Stark calls these organizational forms heterarchies, "cognitive ecologies that facilitate the work of reflexive cognition" by "recognizing that it is legitimate to articulate alternative conceptions of what is valuable".

Similarly, the values of renown are easier to test (*éprouver*) when there are Facebook likes to be counted or television audience size to measure. While these heterogeneous ensembles "form coherent and self-sufficient [worlds]" (p. 59, my translation), there are no pure situations. That is, only in utopia is there a single world against which the value of an entity can be tested (*éprouvé*). What place does choice play in Boltanski and Thévenot's model? According to these authors, the decision regarding which regime of value to adopt is a question of "free will" (p. 286). That is, this constant proximity of discrete worlds means that actors choose either to ignore the presence of entities from other worlds as the product of contingency or to claim that these other entities from other worlds are essential to the "testing" of an entity's actual worth. They must "open or close their eyes" (p. 286) to these other worlds and "choose" what is fitting.

This is an interesting point. There is no place where a single regime of worth stands alone. This constant co-presence of incompatible regimes of worth requires that choices be made. However, while we retain Boltanski and Thévenot's attention to those moments when a "choice" between values becomes necessary, we have some doubts regarding there conception of choice. Their anthropological assumption of *free choice* has attracted criticism (Juhem 1994; Rambaud 2009). This critique, however, is slightly disingenuous. Boltanski & Thévenot were not really interested in *free choice* between regimes of worth; their theoretical project entailed an attempt to get beyond the "individual choice" or "social constraint" debate. They spent much more time trying to work out how people came to an *agreement* than analysing *choice*.[1] This is what we saw in discussions between the Cell and Coordination on the future of MDR-TB in Mathare: the *choice* that was called for after a year of disagreements and discussions was meant to *get everyone on the same page, to get everyone to agree on the project's objectives*. Boltanski & Thévenot's analysis is not of an individual actor in a face-to-face with disparate value regimes, but of collectives justifying and critiquing political action and of negotiating unstable *compromises*.

But there is still a problem with the conception of choice that they develop that relates to the available *options*. We are not convinced that the available worlds and higher-order principles form "coherent and self-sufficient" wholes, always already there, serving as a common grammar for critique and justification, between which a choice can be made, that then link smoothly to the intelligible evaluation of the present entities and to specific courses of action. This is quite distant from what we saw above where similar values could be combined in different ways to arrive at figures of worth that supported starkly different paths forward. To rephrase, while some modes of

[1] The first sentence of Chapter 1: "This book deals with the relation between agreement and discord" (p. 26, 2006).

valuation might stabilize and retain validity across a variety of sites and situations, the *choice* to be made is not whether or not to refer to one "coherent and self-sufficient world" that is always already there in a latent state, rather than a second "coherent and self-sufficient world", always already there in a latent state. We have argued that, in those cases when *choice* is the appropriate mode of investing a situation, the *choice* to be made is between the concrete options that present themselves in the situation (cf. Chapter 3). The question for organisational studies is how modes of calculating value – some of which might temporarily stabilize into regimes of valuation – relate to the emergence of options in situations of choice, and what these situations of choice do to a collective actor. To give an organizational response, we must analyse *decision-making.*

In what remains of this chapter, we will be supplementing our account of the strategic calculation of a project's values with a pragmatist account decision-making.

3. Deciding to Close

We have seen that, in the literature, *closure* is a *value rational, strategic decision*. Our objective in this chapter has been to understand how a collective actor such as MSF can acquire such incredible capacities as strategic vision, value rationality, and decision-making. In section one, we argued that it was the spatial consistency of *headquarters* that provided strategic vision and direction. In section two, we saw how specific organizational processes and routines supported the calculation of a project's multiple values. This was our version of value rationality. In this section, we turn to the *decision* to close projects. An organizational decision is a *commitment to a course of action that engages a collective*. That is, organizational decisions are both a question of *will* and of *accord*.

How are strategic and value-rational decisions *to close projects made in MSF-OCP?*

a. MSF's Exit Strategy for the Yumbé Refugee Camps

We begin with MSF-OCP's medical activities in northern Uganda in the camps in which South Sudanese refugees have settled. With South Sudan on its northern border and the DRC to the west, Uganda is one of the countries in the world with the highest number of refugees. Since the conflict erupted in South Sudan in December 2013, there have been multiple waves of refugees. Following the initial forced displacement of South Sudanese populations, MSF-OCP intervened in Adjumani refugee camps in Uganda in early 2014 where more than 60,000 people had settled. In July 2015, they handed over activities to an UNHCR-funded NGO. This operational mode - setting up to hand over - is what I am calling an *exit strategy*. What kind of *decision* to close is this?

Fighting started again in July 2016 in Juba, South Sudan (see map below), and in less than six months, more than 370,000 people had crossed the border into the Yumbé region of Uganda. These individuals had fled indiscriminate and targeted killing by government forces, the abduction of political opponents, widespread rape – principally of girls and women but also of boys and men – the burning of villages, and the confiscation or killing of livestock and the loss of access to agricultural lands. Necessities, like food and medical supplies, were not easily accessible and, and when they were, inflation led to soaring prices. The newest country in the world is in crisis. Two-thousand people were arriving every day in Bidi Bidi settlement in July 2016. OCA and OCP had organized emergency response and were offering health and hygiene services. OCP set up in the camps' reception centres - that is, where refugees go to register - at Adjumani and in Zone 2 and Zone 4 Annexes of the Bidi Bidi camp. They set up an epidemiological surveillance system, an Inpatient Department (IPD), an Outpatient Department (OPD), and a maternity ward. They provided clean water and built latrines.

In the 1980s, MSF turned the refugee camp into the prototypical site of humanitarian intervention. They published guidelines on camp set up, on medical priorities following a crisis, and on setting up epidemiological surveillance systems (cf. Chapter 2). MSF has developed extensive expertise in the set-up and management of refugee camps. In Yumbe and Adjumani, in northern Uganda, at a time when other organizations were looking for funds, MSF's specific organizational and financial structure - what Isabelle called MSF's "independence" above - as well as their experience and expertise, meant they were able to get to northern Uganda before anyone else to set up basic medical services and hygiene infrastructure. Then they tried to hand these activities over to other organizations and move on.

Figure 35: The northwest border of Uganda, with main locations of South Sudanese refugee camps and the regional capital of Arua. Source: OpenStreetMaps

In July 2017, they had ongoing activities in Bidi Bidi Zone 4 Annexes: in Health Centre 3, they had OPD

services, as well as a 34-bed IPD, with antenatal care, a maternity, nutritional screening, mental health screening, and sexual and gender-based violence (SGBV) care. This was also the base for a mobile clinic they were running in the Bidi Bidi camp. According to discussions during the semi-annual project evaluation meetings held in the Paris headquarters in October 2017 - the MAP - they had been trying to hand these activities over to the NGO Doctors of the World (MDM), but the organization had been having trouble finding the funds. What follows is my notes from the Head of Mission's - "JL" - presentation of the activities in Yumbe during the October 2017 project evaluation meeting in Paris.

> *Next slide,* ***"Project Added-Value":*** *set-up of life-saving apparatus and WASH (Water, Sanitation, Hygiene) during short periods* ***while other "operators" are looking for funds****.*
>
> *Their "strategic approach" consists in ensuring access to primary and secondary care, while strengthening surveillance, and pushing to improve WASH. JL mentions that most NGO's have come through Kampala, the Ugandan capital. They talk specifically about Handicap International for mental health activities. They mention MDM as well, who have finally gotten registered in Uganda but still do not have funds. This is cause for laughter. Laurent: they'll get funding in 2019! Laughter. (*That is, after the need is gone.*) JL: they do have a small LGBTQ project, which does important work.*
>
> *There have also been recent discussions with some of the major funders, like ECHO, to help get funds for these other operators. Someone works there who used to be with MSF, an acquaintance of some people in the room. "It could help." They talk about US, Canadian, and Japanese donors. [...]*
>
> *Laurent: but it isn't clear that these organizations are going to get funds. For now, we're working with just MSF funds.*
>
> *JL: yeah, they were happy just to get funding to do an explo! I think some of them are hoping that MSF is going to "bridge" for them. The big issue is money. Everyone is there, they all showed up and want to work. But when it comes to taking over our projects, the money cycle is hard for them.*

MSF-OCP's goal in Yumbe is to get rid of its activities, but not to "cut and run" nor still to "close". MSF's financial independence - which is regularly used to distinguish MSF from all other humanitarian NGOs - makes it possible for them to get in first and open activities while everyone else is looking for funds. Once they have their funds, MSF hands over the activities. If they stay in the camp, they are working on projects which any NGO could do. Their specific financial structure or organizational expertise has no *added value*.

However, by the end of 2017, there were disagreements about MSF's continued presence in northern Uganda. Besides those activities handed over in July 2015, MSF had set up a 5-bed OPD, open 24 hours a day, which they handed over to the International Rescue Committee (IRC) in April 2017. They also handed over a number of Water, Sanitation, and Hygiene (WASH) activities to Oxfam in May 2017: hygiene promotion, water trucking, water quality surveillance,

the management of a well they had drilled, as well as latrine construction for people with special needs. There were also discussions in the Cell at the time about closing the surveillance system they had set up. They had done what they were there to do. If no one wanted to take over the surveillance system, then they would stop. Now that the camp was up and running, MSF's specific expertise and financial independence no longer had added value. This operational mode - opening activities first to hand them over - is one "strategic approach" for producing "added value". It was not their strategic intent to do what any number of humanitarian NGOs or supranational agencies could do: run a refugee camp.

In my notes from the October 2017 project evaluation and planning meeting - the MAP - the Cell team from HQ and the Coordo team from Kampala are talking about their future in Bidi Bidi.

> ***JL** shows a slide on proposed medical activities in Bidi Bidi. The idea is to **hand over the** OPD to [Doctors of the World] in June 2018. JL says they'll find a donor by then, probably.*
>
> ***Laurent**: I don't think MDM will get the funds for June. They need to have a whole package. What about OCA? They don't want this, says JL.*
>
> ***Laurent**: can we decrease activity in the OPD? People can go to another OPD, it's not far. We just keep the IPD?*
>
> ***H** (Medical Coordinator): but if you decrease OPD activity, then malaria will get worse. And then we'll have to bring OPD activity back up again. So…*
>
> ***Laurent**: ok, ok, let's say we keep the OPD for six months, and if we can't find someone to take over, we close. How's that?*
>
> ***H**: six months, starting in January?*
>
> *Everybody laughs. We're still in October. Laurent says ok, fine, six months from January.*

The point of MSF's presence in these camps is clearly to transfer responsibility for activities they initiate. This relates to what we called, with Michel Feher, MSF's *nongovernmental politics*, where MSF's goal is to demonstrate the possibility of and assume interim responsibility for government practice while refusing permanent responsibility for government and without questioning *who governs*. This is what we saw in Paris, in Nairobi, and now in Uganda. Abramowitz criticized MSF's approach, insofar as their refusal of "custodial sovereignty" meant they sometimes leave national health systems and coordinated humanitarian responses in a lurch. In the above discussion, we see MSF actively searching for someone to take over their OPD; but without a willing partner, it will close. They refuse long-term "health sovereignty" over the Bidi Bidi camp. But there are activities that MSF does maintain there. Their nongovernmental politics do not mean that everything they do is destined to be handed over in the short term. OCP wants to keep some of their activities for themselves in northern Uganda.

In the nearby Arua district, in a settlement opened to refugees in February 2017 called Imvepi, MSF was present in the reception centre, and had been supporting the mass vaccination of arriving refugees (between 200 and 400 regular daily registrations, peak days at 1,500, we do not know the proportion arriving refugees receiving vaccinations). From the same Imvepi reception centre, they were also running a sexual violence and mental health clinic, as well as mobile clinics in the surrounding settlement. They provided antenatal care, outpatient care, and mental health care. The Coordo team from Uganda wanted to maintain these activities, asking the Cell to "commit".

> ***The next slide is on the proposed medical activities for 2018.***
>
> *There will be vaccinations and a general OPD.* ***JL:*** *"Our experience is that it is hard to do SGBV separate from a general OPD, we get so many referrals for other stuff." [*the Cell had suggested getting rid of this OPD] *[…]*
>
> ***JL****: is the "general OPD '' a discussion point? Because this was really based on our experience on another SGBV project. This is a* ***commitment*** *we need to make, like mass vaccination: it's not hard, but for it to work we need to be* ***committed****. I need to know if we're going to stay if patient flow decreases in three months. Maybe we should identify a partner organization from the start?*
>
> ***Laurent****: yes, I agree. This is important. OCA could be a good choice.* ***Maybe we can let OCA start these activities?***
>
> ***JL****: I'm against that. An OPD with SGBV in a reception centre is* ***a good entry point for us****. OCA wants to do a lot, and we can hand over a lot – WASH, surveillance, vector control, mobile clinic, even vaccination.* ***But we should keep this.***
>
> ***Laurent****: so, we want to keep the reception centre?*
>
> ***JL****: yeah, it's* ***our baby****. And it's closely tied to our SGBV strategy, training staff, and developing expertise. I think we are going to stay.*
>
> ***Else****: wasn't the strategy to hand it over at some point?*
>
> ***Laurent****: if OCA is really interested in the settlement, we should give them the settlement.*
>
> ***JL: ok, fine, but not the reception centre. We have an added value. We're learning a lot, and we can train people here. It's a good place for surveillance, and no one else is interested in providing comprehensive SGBV care in the camp.***
>
> *Ok, ok,ok.*
>
> *[...]*
>
> *When these discussions are over,* ***Laurent summarizes*** *the conclusions they have reached together. Expand one activity. Close another. Pull back here. Pass over to this organization. Add a database. Bring in a psychiatrist to train staff. JL has a notebook where he takes notes as Laurent is talking.*

That is, there are clear advantages to maintaining their presence in this specific reception centre and to continuing SGBV activities, and OPD, there. It is their "baby": it is an activity that interests the team. It puts them in a good position to monitor the camp. Maintaining this activity means they can "learn", improving the institution's human resources. Providing comprehensive

SGBV care to the camp is a commitment, a "consideration" that is thought to be "weighty" by the teams in the field.

In an interview with Laurent about Yumbe, he recognizes that these *exit strategies* can be disconcerting for teams in the field.

> **Laurent**: *So, I think that the most important thing [*for the Yumbé project*], is to repeat, always, and especially for arriving staff, what the objectives we set for the projects are. And what's difficult, is when people don't understand the objectives, they are not going to understand why the decision to close was made. So, in Uganda, we know – and this is the Cell's strategy, and we're going to keep it that way, and for a long time now – every time there are countries where refugees arrive by the hundreds of thousands, there are always a lot of NGOs, funded by the UNHCR, or with funding from elsewhere.*
>
> *But what also happens, in Uganda and elsewhere, is that when there is a crisis like this, when there are a lot of people arriving, you always have a period of friction (*une période de frottement*), that lasts for three or four months, which is the time it takes for NGOs to write their proposals (*in English in original*), and to get their funding. And that is where we, MSF, where we are relevant. […] But that's not easy to accept for the teams in the field that are just passing through, that see the benefits of what we're doing, and who say to themselves that other NGOs don't have the capacities that we do. […] But doing it this way makes it possible for us to stay light on our feet, to work with a small team that can do monitoring (*in English in original*), to launch activities and then hand them over, so we can intervene where we need to when we need to. And I think that this is how the strategy in Yumbé was defined, and that's why we had some trouble with the teams, who didn't really understand why we were always handing over our activities*.

MSF's activities in Yumbe create values by providing medical services that would be otherwise unavailable, and by giving MSF the chance to acquire new skill sets. As Laurent clearly states here, this ability to read a system of relations and calculate the value of different strategic approaches depends on his *distance* from the field. While field teams are *morally entangled* in face-to-face relations, Laurent calculates the organization's added value in the humanitarian system. An important point regarding closure is the temporary nature of humanitarian interventions. When the initial situation of crisis has passed, MSF ceases activity. MSF also makes more long-term interventions, but these too are *destined to close*. This relates to what some inside MSF have called an "interim ethics", which poses the explicit goal of transferring activities to local authorities in the medium term in order to avoid aid dependency.[1] Moreover, to keep themselves ready for "emergency projects" – to maintain a state of preparedness, keeping the necessary resources and skills available for rapid response anywhere in the world – MSF must avoid over-extending itself

[1] « Une éthique de l'intérim » in French (Rambaud, 2009).

on "regular projects".[1] This orientation can lead to "misunderstandings" between HQ and the field regarding the strategic decision to close. A commitment to a course of action that engages MSF-as-a-whole in Yumbe - getting everyone on the same page - means both justifying and explaining HQ's strategic vision, while also finding a compromise with teams in the field that insist on the *added value* of one of their activities, while also indicating that this compromise is unstable and that the activities in the camp's registration centre will close in six months (six months plus two months).

This is our first case of strategic, value-rational decision-making.

b. Nothing more to do

We will assume that MSF's organizational processes - rhythms of financial valuation, project planning, and collective decision making, as well as project-cycles, field visits, etc. - influence how the collective commits itself to courses of action. Monika Krause has demonstrated that organization routines, units, and activity repertoires determine the ways that human rights NGOs allocate their resources (Krause 2019). We will take as our hypothesis that this is the case for biomedical humanitarian NGOs. What, then, are the effects of MSF's organizational processes on decisions to close projects?

During my interview with Isabelle Defourny, the Director of Operations for OCP, we discussed a series of cases of project closure. To explain why projects close, Isabelle talks about their "phases".

> **Isabelle**: *Projects, in general, they go up, up, up, they provide care for more people, we improve our quality. There is **a rising phase**, an upward phase. And then, after a while, they **stagnate**. When they start to stagnate, they can go back up again, if someone with ideas is interested in the project. Otherwise, it keeps going down and **then closes**. […] Amman is stagnating, for example, they're not far from collapse [*la chute*]. And it's often like that. Georgia and Armenia with MDR-TB, that's their story too. And then there are **choices**, yeah, choices that you make with an ensemble of projects in mind, a project portfolio.*

Projects wax and wane. They close because they "stagnate": they lose interest, nobody has any ideas. While this waxing and waning relates to seasons of *strategic planning* and *project cycles*, these rhythms do not align. The MSF "project cycle" - as it is called in "The Conduct of Operations", discussed above - is generally around three years. Project evaluation and planning cycles are annual. This three-year project cycle does not indicate how long a project stays open -

[1] Brauman, *Should I stay or should I go? Médecins Sans Frontières et les stratégies de sorties*. Les cahiers du CRASH, 2017, p. 9.

some MSF missions have remained open for multiple decades - but the time a specific *strategic orientation for creating humanitarian value* is explored. A project can follow the same strategic orientation after that if it is still creating value, or a new strategic orientation can be developed if it is not. However, if one strategic orientation has ceased to or failed to produce "added value", and if nobody has any ideas for a way forward in which it does, well, the project closes. This is "stagnation", or what we call *diminishing returns*, to insist on the decreasing *value* of such projects.

Isabelle presents the case of a project in Grozny, Chechnya, to make this point. The project, closed in 2016, was the only place where MSF did interventional cardiology. She says the project was interesting, both because it was technically complex and because they were providing a service that was unavailable in Chechnya. But they had attained their objectives and the cardiologists did not have any ideas on how to reorient the project. "*The field team wanted to stay, but they didn't have anything to propose. The Cell didn't want to stay. The Medical Department didn't want to either. So, sometimes projects close because there is no one to carry them, no one that knows the project, who is interested in the project.*"

Isabelle gives another example of an ongoing project that she thinks should close soon. This project, in Port Harcourt, Nigeria, is one of the handful of MSF projects working on sexual violence. Isabelle says the project is interesting, but it has met a dead-end. The problem is that the children to whom they provide care receive prophylactics for HIV infection and emergency contraception ('day-after' pills) when necessary, but they are not getting anywhere on the legal side of the project. They have not managed to set up anything durable that would provide additional protection. This means that they cannot do anything but send these women and children back to the families where they were being abused after giving them a few pills and basic psychological counselling. Isabelle says there will be an intense discussion with the field in the team, understandably attached to the project, but it needs to close because there is nowhere for the project to go. "*It's really a shame to close, but we're at a stage where we can't do any better*." So, projects close because they have decreasing future value, because nobody has any ideas, because ***there is nothing to do***.

This idea that projects close because there is no imaginable future with them open also relates to the idea that to be able to calculate the added value of a future project, you need to have a project proposal to evaluate.

> **Isabelle**: *Because, in the end, in a country, if you send in five different teams, you'll get five different projects. And there isn't necessarily one that is better than the others. The one that's best, it's the one you're looking at. The one that will provide the best care to the most people, or that will do something new in medicine, or that will take us, MSF, into a domain a medicine we've never worked on, or that no humanitarians have worked on. Or the project that will get a team invested and*

motivated in the long term. ***The best project is the one that will achieve something*** *(qui va réussir à faire quelque chose). You see? It's all kinds of different criteria that we try to define*.

We have been focusing throughout this dissertation on *what MSF does*, and we have claimed that this *doing* is precisely what makes MSF what it is. When humanitarian aid is approached as something that must be *done*, it is no surprise that there are times when *there is nothing more to do*. That's when they fizzle out, lose interest, and close.

This is another configuration of the strategic, value-rational decisions to close projects.

c. Value for the institution

At the end of 2018, MSF's financial situation demanded that OCP's annual operational budget drop by 12%. How did this constraint, formulated in terms of monetary values, affect the decision to close projects?

There was an "imbalance" in MSF's 2019 budget, as Thierry Allafort, the General Director of OCP, stated in a letter sent to the Director of each Department, Cell Managers, Heads of Mission, and all the way down to Project Coordinators in the field. The June 2018 budget projections were corrected in October 2018 - when the letter was sent - to the tune of a 16-20 M€ reduction in operations. This meant that operational growth was "frozen". This was despite, as the GD recognized, efforts made over previous years to reduce costs. HQ expenses in Paris had been reduced by 1.3 million over three years. Freight costs had decreased by 30% in 2017 (-2.4 million), while freight tonnage had increased by 50%. He then suggested where further efforts might be made: renegotiation of premises and land tenure contracts, rationalizing procurement strategies for medical supplies, thinking twice about construction and rehabilitation projects… The risks of fraud are given an entire paragraph, and pharmaceutical problems of "overstock" and "sleeping stock" are addressed at length.

The Director of Operations, also wrote a letter in October 2018, addressed to the Deputy Director of Operations, the Finance Director, the Operations Manager, Cell Managers, and the Field. She explained the financial situation of The Movement's operational centres: 2017 ended with a 101.6 M€ deficit, and fundraising had stagnated (+0.5% for 2018). Six months earlier, in April 2018, the ExCom had decided that operational growth should not exceed 3% for 2018 and 4% for 2019, but these new figures meant that growth prospects needed to be adjusted down. She then traced out two paths to a balanced budget by 2021. There can be a "sharp decrease" of 2019 expenses, followed by 1.5%-4% growth in operations for 2020 and 2021. Or they can freeze growth for 2019 and for the following years. In her letter, she says "OCP is in favor of the second scenario", that is freezing growth for two years. July 2018 discussions had concluded that OCP's combined

2018 and 2019 budget would be 501 M€. This was revised: the total 2018-2019 budget cannot exceed 485 M€. Since 2018 was nearly over, the entire 16 M€ would be deducted from the 2019 operational budget.

She suggests a few ways of going about this reduction. First, if the cost of maintaining "Coordination" offices could be reduced across OCP by 10%, this would equate to a total reduction of 3 M€ for 2019. The mutualization of expenses between Operational Centres in-country should be explored. Supply and stock management should be rationalized. Staff training should be reasonable and planned. Careful attention should be paid to human resources, MSF's greatest expense. An increase in institutional funding - from the EU, UN, the Gates Foundation, etc. - should also be discussed when relevant.

Talking to Else, Deputy Cell Manager of the Cell, I learned that this directive to reduce operational costs had come down to a percentage of each Cell's operational budget: **12%**. While teams in HQ were asked to rationalize HR, reduce travel and expenditures in Branch offices, the Cells passed on these budgetary restraints to Coordination offices. Coordinations attempted to reduce their own costs and began the process of postponing activities and cutting bits and pieces off ongoing projects. One Cell found more institutional funding. Another Cell, in charge of operations in Yemen, handed a hospital over to another Operational Centre. OCP had four large projects in Yemen: a hospital in the south in Aden; another in the north à Khamir; activities in Saada; and a hospital in Moka. This extensive presence means they are in a relatively good position to respond in case of emergencies. The Cell managed to hand over the Moka hospital to OCB, and pocket 3 M€. The Director of Operations told me during our interview that this was a great solution because it means the hospital stays open while they increase their capacity to respond to emergencies in Yemen by freeing up remaining staff from some of their responsibilities.

The team in Kenya had an additional difficulty: 1 M€ was missing from their budget even before the 12% reduction. This money had been authorized and earmarked by the Director of Operations for their HIV project in the western lake district, next to Homa Bay. However, the transfer of funds had been made conditional on the formal presentation of the project to the Director of Operations. The Cell took the presentation for granted and realized too late that the 1 M€ had never made it to their coffers. For the team in Kenya, this meant that, even after rationalizing all their activities, they were still 900 K€ over budget. The only solution they found was to close the Mathare Call Centre, A&E, and ambulance service.

It is important to keep in mind that the request to reduce the budget was formally communicated to the field in October 2018, and that evaluation and planning is done in October and November. They had only a few weeks to work out the kinks for the 2019 budget. Also, the

Coordination team had been working on the strategic reorientation of their Sexual and Gender-Based Violence medical activities in the Mathare. A new 'youth centre' was to be opened in an area with high levels of physical and sexual violence due to the presence of a gang that controlled a waste treatment site. They had also found a good partner: a publicly funded primary care clinic with motivated, well-trained staff, and a basic lab. There was even room for expansion in the clinic: MSF planned on using part of a maternity ward that had been closed for lack of resources, and perhaps setting it back up in the medium term. The team in the field was excited by the new project orientation: it allowed them to directly address mental health, sexual and reproductive health, while also doing basic trauma work for victims of violence. They felt this activity would allow them to achieve one of the project's secondary objectives: as one of MSF-OCP's only two projects in urban slums, they were to learn about the health issues that most affected people living in such situations and to develop adequate response strategies. Their assessments had indicated that mental health rivalled traumatology and sexual and reproductive health as the main problems for the slum population, whose demographic structure indicated they were young. The youth centre allowed them to deal with all of this at once.[1] However, with the budgetary restrictions, these new activities would have to be put aside or, at the very least, postponed. Months of negotiations with the County Ministry of Health on staffing and budgeting would have to begin again. Unless they were to close the Call Centre, Ambulance, and A&E service.

Everyone agreed that the ambulance service provided a valuable service to the community, that it was meeting its objectives, that it was doing important work. But they were 900 K€ over budget. Excited by the perspective of this new activity, feeling like they had to make a choice but without any clear criteria that would help adjudicate, they decided to close the ambulance service. This would free up close to 1 M€. This was the solution the Coordination team presented to the Cell during the 2018 MAP. The Cell accepted the proposal. They then took the proposal to the Budgetary Commission.

The Budgetary Commission takes place in the month following the autumn MAPs. After the Cell and the Coordination have come to an agreement on each Project, the finance team – between the Cell, Coordination, and Project – has a few weeks to work through the finances. The

[1] During fieldwork in Mathare in April and May 2018 - six months prior to these budget restrictions constraints - I had accompanied MSF managers (MedCo, MTL, Project Coordinator, logistics manager, activity supervisor) as they visited three potential sites for this youth centre and met with each clinic's managers. I was particularly interested in the scoring tool that the Medical Team Leader for all medical activities in the Eastlands of Nairobi had developed for site selection. What surprised me the most was that while MSF managers clearly used the scoring tool as they visited each site - using it as a kind of observation guide - it was never referenced directly during discussions regarding the site to select, perhaps because everyone was in spontaneous agreement.

Cell finance team integrates this into an overall budget proposal, meant to be close to the preliminary financial valorisation of the Cells activities from before the MAP season. This final budget proposal is sent to the Director of Operations and her team, and then presented during the Budgetary Commission. This is part of the process that Hawa detailed above: the Director of Operations gives each Cell an envelope, based on the Cell's planned activities and provisional financial valorisation, but also integrates financial constraints regarding the capacity of the organization to grow. The Cell then communicates these to the field, who works about a "road map" for the year to come that takes into consideration the budgetary limitations. These are then discussed during the MAP, and, if they are validated by the Cell, during the Budgetary Commission. A series of communicating vessels.

The Direction of Operation was uncomfortable with the closure of A&E services in Mathare. During the Budgetary Commission, they postponed the final decision and asked the Cell to do a more extensive presentation of the situation and to provide clearer justification for the closure. This presentation was done during the *Réunion des operations* - Operations Meeting - on 22 January 2019. In the meantime - since the proposition had been validated by the Cell - the team in Kenya announced to staff that they would have to start looking for work elsewhere. Else, the Deputy Cell Manager did a field visit in November 2018, and the Director of Operations visited Mathare in January 2019. Else told me that she agreed that the ambulance and A&E project was important, she saw the service they provided to the community. But they had not found another way to reduce the budget. Something had to go, and they did not know how to make the decision.

During informal conversations with members of the CRASH, they told me that the real problem was that the Director of Operations had handed down budgetary constraints - a 12% reduction of activities - without explaining how teams should go about deciding what should close and what should remain. In sum, no clear criteria had been provided for making decisions, or, at least, it was not made clear that the budget was not an acceptable justification. Budgetary constraints weigh on operations; they do not - rather, they ought not - justify *closure*.

During the "Operations Meeting " on 22 January 2019, the Cell presented the A&E project to the directors of the Department of Operations. What follows is based on the minutes from the meeting. The initial project proposal, made in 2014, had suggested a four-year project cycle. The idea was to set up a Call Centre, a Trauma Centre, an Ambulance service, and support the emergency department in Mama Lucy Kibaki Hospital (MLKH). In 2016, the project was evaluated, and this strategic orientation was validated and renewed, with the overall goal of increasing access to hospital-level care in the slums. At the end of 2018, they were at the end of the four-year project cycle. They had tried to hand over the ambulance service, but interest from

the County Ministry of Health was low - the workshop they had organized for the county in September 2019 on running an ambulance service had gotten them nowhere. If they had to make a choice between the Call Centre and the Youth Centre, then they felt it was time to move on. To do so, they made three budgetary proposals:

- They keep the Call Centre until March 2019, stop support to MLKH, and open the Youth Centre. The budget would be 573 K€, over budget by about **150 K€**.
- They keep the Call Centre, with *light* support to the MLKH emergency room, *and* do the Youth Centre. The budget would be 1.3 M€, **900 K€** over budget.
- They could keep the Call Centre, with complete support to MLKH, and do the Youth Centre. The budget would be 1.5 M€, or **1.1 M€** over budget.

When I spoke with Else, she told me the presentation was essentially a request for the 900 K€ they needed to keep the A&E service and to open the youth centre. The Director of Operations refused. She said that the youth centre seemed like an exciting idea, and agreed MSF should be working in the Nairobi Eastlands slums. The question is the *direction* their activities should take. The Youth Centre was presented as a reorientation of their Sexual and Gender-Based Violence (SGBV) activities, when they had previously agreed to hand over SGBV activities in Mathare to the Ministry. Furthermore, A&E activities were working well and filled a real medical need. The minutes of the 22 January 2019 Operations Meetings ends with this:

> "*We have an activity that works well, that we can continue and that already includes this population. We should not redirect the emergency room but continue with an activity that provides a non-negligible service, while continuing another activity that targets youth. So, it would not be the redirection of a project, but the decision to continue two activities. Except it would add 900,000 euros to the budget. It seems to me that we must not brutally cease an activity that is currently reaching both its primary and secondary objectives (learning, etc…). The proposal for new activities should be given more precision*" (translated from French by the author).

The Cell's reply is as follows : "*This choice was guided by budgetary restrictions, because it was asked of us to reduce the budget in Kenya. The team did not wish to close the emergency project this year, but add a new clinic for youth, but* ***there was the budgetary constraint and we had to make a choice***" (translated from French by the author).

This is a value-rational, strategic decision to *not* close a project.

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The cases discussed in this section can help us respond to this chapter's research question: *how is it that decisions to close are made in headquarters?* This entails working out what it means to make a decision and working through the kinds of values a project can create.

a. Let us begin with the kinds of value that humanitarian projects create. In the last section, we looked at how the value of a project was calculated, and in this section, we looked at some of the different kinds of values that humanitarian projects create. We are now ready to respond to an existing account of humanitarian value creation. This theory, developed by Monika Krause, suggests an answer to this very Marxian question. Marx was interested in the source of profit in capitalist exchange, where everything is exchanged at its real value. His answer was that profit comes from the difference between the value of labour and the price of labour, i.e., exploitation.[1] Krause, by way of contrast, asks about the source of humanitarian *added value*. Her response is to suggest that humanitarian beneficiaries are a commodity for the production of projects on a quasi-market where funding institutions and donors are the clients (2014). This is the source of value creation on humanitarian projects. In this chapter, we have seen that there are multiple modes of value creation on humanitarian projects. The monetary value of projects is important, but the primary objective is not to create monetary value for an institution to be protected. The good project is the project that "achieves something", that allows MSF to provide care no one else could, or to work in a domain no one else has, or to make the effects of intervention durable. The question is deciding when a project is *worth it*. This brings us to our second point.

b. We saw in the introduction to this chapter that existing analysis of project closure - in the scholarship of humanitarians, in anthropology, and in philosophy - assumed that decisions, made according to a kind of value rationality, were then implemented. We agreed that closure was a strategic, value-rational decision, but we were interested in describing how MSF acquired such incredible capacities. We are now prepared to rework our conception of *organizational decision-making*.

Organizational theory has had some trouble with strategic decision-making. This is tied, first, to trouble finding strategy decisions to study. It seems obvious that decisions must be made before collective action can ensue - that is, the linear *decision then implementation* model - yet it is difficult to pinpoint actual decisions, even retrospectively. This is not specific to MSF (Mintzberg & Waters 1990; Langley *et al* 1995). Taking the discussion on the closure of the Greece Mission - presented in this chapter's introduction - as an example, we might assume that some person or group decided that it would close. While it is easy to find discussions about the decision to close, I have no idea where and when such a decision may have occurred. The reader might think that this

[1] At least, this is Raymond Aron's reading of Marx (Aron, 2013, pp. 157-170).

says more about my ignorance than it does about decision-making; if we looked hard enough, we could find *a decision* happening somewhere. Allow me to disagree.

The Deputy Director of Operations said at the start of the meeting that no decision had been made. We might imagine that this opening caveat was a disingenuous ruse. I did hear Laurent say that meeting was just to let the team down lightly. This does not quite fit, however, given that the meeting involved nearly four hours of intense discussions between 15 people. The decision - well, *a* decision - was made a week later, behind closed doors. Or so I was told. But if a decision is a collective commitment to a course of action, perhaps the decision was made when Greece was identified as a "good candidate" for closure, weeks or months before the meeting in Paris. But then why have a meeting? An elegant answer is to suggest that nobody makes any decisions. Building on Weickian sensemaking, this has been the response of a few authors in the *strategy-as-practice* approach in organizational theory (Whittington 1996; Jarzabkowski 2004; Golsorkhi *et al* 2010). Decisions are a retrospective imposition of narrative order on a previously enacted world (Weick 1995, p. 185). Things happen; "decision-making" is a story we tell ourselves to make sense of it all and to make sense of ourselves. But this is not quite right either. Of course, there is such a thing as prospective decision-making. Entire journals are dedicated to developing mathematical models that might render decision-making more rational.

In recent years there have been attempts to work through the difficulties of different approaches to decision-making as they relate to strategy. John Hendry (2000) attempts to combine several classic approaches to decision-making. First, Simon's approach according to bounded rationality, where the question is *how* decisions are made, and not *if* they are made. Second, Mintzberg & Waters' approach, where focus is on organizational processes, with a tendency to occlude decision-making from analysis. Third, work from the interpretive school of Weick, already mentioned. Hendry's proposition is to analyse decision-making as *discourse*. "*At the discursive level, the representation of specific decisions operates both retrospectively, to legitimate and make sense of past actions, and prospectively, to engage consensus, mobilize resources and initiate, legitimate and direct the activities of the organization*" (2000, p. 972). This is a good starting point for us. Additionally, Laure Cabantous and Jean-Pascal Gond have attempted to come to grips with the fact that *rational* decision-making is constantly discussed and re-discussed in the literature, while everyone seems to agree that *rationality* is a problematic concept (2010). Their claim is that rational decision-making theory is performative: the bounded economic rationality that it presupposes can be, on rare occasions, crafted into being through the stubborn work of "decision analysts". We are happy to adhere to this proposition as well, but we would add Marc Berg's developments on rationality discussed in Chapter 3 (1997).

In addition, we would suggest rereading these perspectives together through the work of pragmatist philosopher William James (1992, p. 387-425). What follows is based on the chapter in James' *Psychology: The Briefer Course* entitled "Will", and it must be adapted to *organizational decision-making.* The point is not to suggest that we can take James' individualist approach to decisions and apply it directly to organizations. The goal is to *think with* James and see what happens to organizational decision-making.

James takes as his starting point that, most often, action requires no "express resolve", no *fiat*: *perception* and *ideas* are sufficient to *movement*. It is, however, possible to talk about ***deliberate action***. This implies that the mind - let us say *centres of calculation* - has before it many objects related in antagonistic or favourable ways. He gives the example of staying under the covers on a cold winter morning or getting out of bed and getting on with the day. The result is "that peculiar feeling of inward unrest known as *indecision*" (p. 398). In this state, we are said to *deliberate.* When only one object remains, we *decide*, or *"utter our voluntary fiat*" (p. 398).

This *fiat*, this decision can take many forms. James discusses five of them. First, there is the **Reasonable Type.** Here, the arguments for and against a given course of action seem to settle themselves and end by leaving a clear balance in favour of one or the other. The *reasons* decide for us, though we have the sense of being "free", that is, we do not feel constrained or coerced by these reasons. The deliberation ends when we hit upon "*a conception which lets up apply some principle of action which is a fixed and stable part of our Ego"* (p. 400). There are also two **Accidental Types**. The first accidental type is referred to as **Drift**, or *external accidents*. The image is that of a boat adrift: pulled in multiple directions by wind and water, the boat follows a single path. There is a "*certain indifferent acquiescence in a direction accidentally determined* from without" (p. 401). The second accidental type is called **Excitement** and refers to *internal accidents*. Here, the absence of an imperative principle is perplexing, and we find ourselves acting as if by "*nervous discharge*". After the build-up of energy, we throw ourselves in a direction, because in this state of excitement we come to imagine that any decision is better than no decision. James names a fourth type the **Change of Heart.** This form of *decision* comes from an inward change, when we *"pass from the easy and careless to the sober and strenuous mood"*. The consequence is the abandonment of "*trivial concerns*" and the practical acceptance of the more "*earnest alternative*" (p. 402).

Finally, the fifth type is an **Effort of the Will.** This fifth type is unlike the previous four, for which there did not seem to be a decision to make. In the reasonable type, reasons *for* or *against* accumulated and made only one path viable. In the accidental types, we passively let ourselves be carried away. With the change of heart, "we got down to business". With this last type, we must by wilful effort engage in one course of action knowing that the other is equally possible, equally

desirable, equally valuable. This is dreary resignation, heavy resolve. "*Here both alternatives are steadily held in view, and in the very act of murdering the vanquished possibility the chooser realizes how much in that instant he is making himself lose"* (p. 403)

James' tone is somewhat facetious in this discussion. The case he takes as an illustration is the *decision* to get out of bed on a cold winter morning. The point is that if we are to imagine decision-making as something other than *bounded rationality*, we must also have an anthropology that does not depend on a conception of free will that permits only one kind of decision. James' evocative transcription of the will allows us to imagine forms of decision-making that are based on something other than what Herbert Simon called "satisficing". Individuals with imperfect information and unclear preferences do make the best of it as they work to satisfy multiple criteria, of course. The point here is not to suggest that Simon's position is *wrong*, only that it is incomplete. To work through organizational decision-making, our anthropology cannot be that of an actor that is constantly reasoning through incompatible preferences in situations of imperfect information. We need a subject that can also 'get down to business', but also a subject that can get "excited" and "carried away". We need a subject with the capacity for rational decision-making, and who feels the weight of abandoning one "way forward" to be able to take another. We need a different kind of *subject*.

When we have such an *organizational subject* - engaged in organizational processes and rhythms, with the strategic vision afforded spatial consistency of headquarter entities, the collective calculative value rationality of a "MAP season", and the constraint of "getting everyone on the same page" - then we end up with a different conceptualization of organizational decision-making. We saw that most projects closed because they had reached the end of a project cycle, and without ideas for the project's future, they stagnated and closed. There was *nothing to do*, and coming to an accord was not an issue. We saw that there were projects that were not able to sustain the value they produced, to transform what they had achieved into something durable, and that such projects should also close. This required intense negotiation with teams in the field, who say day to day the services - however limited - they provided to beneficiaries. We saw that there were strategic orientations that entailed regularly opening and closing of activities in order to create value. This was not necessarily easy for teams in the field to accept, and compromises could be met, wherein certain activities were maintained. We also saw that teams could face budget constraints that forced them to close projects, without clear criteria that would make it possible to make a "reasonable" decision, that is, a decision that had clear and undeniable advantages. In such a case, a kind of excitement can take over a group and push them down a path in the belief that any decision is better

than no decision. We also saw that this tendency could be countered in ordinary organizational processes, which demanded that the closure of activities be decided according to clear criteria, explicitly excluding budgetary constraints.

Closure is indeed the result of *value rationality*, *strategic vision*, and *decision-making*, but only if we are willing to adapt our conception of decision-making to a subject with a much richer experience of what it means to "make a decision" than that of Simon's 'satisficing'.

Conclusions

There are three points to be retained regarding decisions to close. *First, closure is a function of strategic vision and direction*. This is why closure is decided only in headquarters; it must happen in a place that belongs wholly to MSF. It must take place in a location that remains after closure has happened, where there is no inter-face or con-tact with the beneficiary. A place from which they can peer out onto the world as if it were external reality, fixed on an immobile surface, which can be read and undergo the operation of calculative rationality, in order to structure a discourse on a system of relations, and to imagine moves that produce outcomes of worth. At the same time, strategy at MSF must not focus too much on maintaining or reinforcing this place of their own. This would mean their activities are no longer a response to need explo/action enacted, but to the needs of the institution. *Second, strategic closure relies on the calculation of outcomes of worth during routine project evaluation and planning meetings.* During these MAPs - which take place in headquarters - the values of a project are projected onto a screen and recombined into new figures of impact and added values. Modes of calculation can stabilize because of strategic planning, which prospectively monitors values important for demonstrating that predefined objectives have been achieved. This can sometimes make it more difficult to argue to maintain a project according to values that are not monitored, that is, according to another strategic vision. We also saw that the strategic approaches associated with *direct service delivery* and *systems strengthening* were opposed because of their incompatibility, and in some readings, became situated in different Operational Centres. As the same time, talking with the Director of Operations, the Cell Manager, and reading a text written by Jean-Hervé Bradol, and ex-president of MSF-France, we see that while there may be tensions between these strategic visions, they are to be pursued together; direct service delivery *and* then systems strengthening, never one without the other. By taking a *valuation* and *strategy-as-practice* approach, we were able to work out how concrete situations of choice emerged during organizational routines that related directed to a desirable future, able to coordinate the activities of a collective: to close… or not to close. *Third, closure is the result of decision-*

making. We must, however, to save that approach that takes closure to be a value rational strategic decision, we must include a wide range of decision types. Decisions, taken as a collective commitment to a strategy meant to produce outcomes of worth, can be the result of internal and external accidents like stagnation and excitement. Case studies of decisions must include compromise between a strategic orientation developed from headquarters and the values of the face-to-face encounter with beneficiaries in the field. Sometimes decisions are reasonable, and consideration of the pros and cons during episodes of collective deliberation leaves one option as the clear superior; the decision makes itself. The decision to close can also test the ability of the organization to establish a clear commitment, when all the options are appealing, when there is no clear criteria that would allow for the balance to sway decisively in a given direction.

To conclude, closure is indeed a value rational, strategic decision, made possible by the spatial consistency of HQ, the calculative power such a location affords, and a plurality of modes of engaging a collective commitment to an outcome that is worth it. We described how headquarters supported such capacities.

General Conclusion

A Critique of Humanitarian Aid as it Takes Place

We have sought throughout this dissertation to translate the reflexivity of humanitarian practitioners as aid takes place, into a social science account of humanitarian action. We accepted the writing constraints of a research question posed by humanitarian practitioners. We accepted the problematization of patient selection posed by MSF in terms of *choice*. We accepted the rendering of this question in terms of impartiality and the impossibility of scapegoating. We accepted them in the hope that we might turn them into a social science writing machine to renew the categories of analysis and the modes of critique available to social scientists studying the global health apparatuses of humanitarian NGOs. The machine we built may have manhandled certain elements or aspects of international aid, and it no doubt led us to jump over certain discussions in the literature too quickly. Our hope is that this experiment also produced a heretofore unthinkable perspective on our object of study. To put it another way, we hope – and claim – to have elaborated a *thesis* on the humanitarian aid that MSF provides around the world: an account of MSF's *humanitarian presence*. In this conclusion, we seek to clarify this *thesis*, what it contributes to ongoing debates in anthropology, as well as the perspectives it opens.

To indicate the originality of our thesis, we begin by providing an account of three analytical strategies for *totalizing* MSF as an object of study as they exist in the literature: unification, fragmentation, and juxtaposition. We then provide a chapter by chapter overview of our argument, paying attention to those moments when we saw *MSF-as-a-whole* taking shape and insisting on how the conception of humanitarian spaces that we have developed has allowed us to work out a novel account of humanitarian aid. Finally, we elaborate the three key concepts that compose *humanitarian presence* – *humanitarian locations*, *humanitarian beneficiaries*, and *humanitarian technologies of intervention* – to indicate what they contribute to current discussions

on the global in anthropology. We conclude by indicating the limits to my performance of this approach, as well as the kind of critique it affords.

MSF-as-a-whole: some analytical strategies

Several analytical techniques are available to us for accounting simultaneously for the obvious heterogeneity and variability of humanitarian values and activities, and the strong impression of similarity between humanitarian action in practice. While all the authors discussed below engage directly with "MSF", the whole that is integrated through analysis will be seen to acquire quite different qualities and capacities. We will present three such strategies for totalization present in the literature on MSF: ***unification***, ***fragmentation***, and ***juxtaposition***. We will see that they are unable to answer this dissertations research question.

The **first** strategy of totalizing MSF can be found in recent monographs of the NGO, where MSF, as the *unique case* under consideration, is ***unified*** behind a value or a short list of values to form a coherent ensemble. The first of these is Peter Redfield's *Life in Crisis*, where he retraces the "moral career" of an organization animated by a deceptively simple *leitmotif*: saving lives. Redfield's 2013 monograph of MSF has been a recurring reference throughout this dissertation, not least because he asks a series of fascinating questions which we have recuperated and reworked. His evocative empirical description of MSF, filled with ethnographic detail, is convincingly articulated with what he calls a *secular value of life*. In the contemporary world, moral failure is often measured in death tolls, suggesting that lives must simply be saved. This ethical outlook is based on a secular understanding of suffering: suffering makes no sense, has no meaning. It is merely a historical fact. As such, the relief of suffering is itself a source of redemption. Redfield then builds on Hannah Arendt's *politics of pity*[1] and Giorgio Agamben's reworking of biopolitics in terms of *bare life*[2] to explore MSF's pretension to sit outside of politics. Insofar as MSF holds no pretension to govern, MSF prefers immediate life-saving interventions on individual patients to public health interventions that might find political solutions to suffering.

[1] Unlike French revolutionaries, MSF refuses violent action. This led Redfield to make two claims that we have already dismissed: MSF tolerates no sacrifice, a point contested in Chapter 3; MSF refuse political engagement, a point contested in Chapter 1.

[2] That is, MSF is concerned with *bare life*, in Giorgio Agamben's terms, the simple fact of life, the cycle of biological life marked by birth and death. Though we did not have the space to discuss Agamben's reading of biopolitics in this dissertation, we wonder if it is humanitarian practitioners, or if it is Agamben who separate "bare life" from "qualified life". As Keating & Cambrosio have commented regarding the respective roles of laboratory and clinical diagnostics in hospital settings, the lab may dissociate the body from the person, but this is always a temporary operation (2003).

Redfield insists on MSF's hesitation, or even refusal, to develop public health interventions. To his mind, MSF's approach is decidedly *presentist*, and it is this presentism that allows them to circumvent sacrificial logics. Based on a reading of Mauss and Hubert's classic text on sacrifice (1899), he suggests that MSF can circumvent the sacrifice of life for the renewal of a higher-order public good by refusing an orientation towards the *future*. It is by saving lives in the *present* that individual lives are made *sacred* (i.e., sacrificed), not through the renewal of a past order, in the present, for a collective future. This is why, according to Redfield, MSF's activities cannot be understood as a fully developed form of governmentality - they engage in what he calls *minimal biopolitics* – and why MSF does not undertake in public health interventions.

The problem with analysis that unifies MSF behind even such a finely wrought concept as the *secular value of life,* is that it is easy to discount with empirical detail. Renée Fox too considers this "tension" between public health and individualized care inside MSF. "*A tension exists between the commitment to care for each patient individually, and to do what is most beneficial for him or her, and the commitment to safeguarding and furthering the well-being of a community called for in the name of public health – sometimes in disregard of, or at the expense of categories or groups of individuals.*" (2014, p. 7). In case studies from South Africa and Russia, Fox explores these tensions as MSF negotiates with state actors and with civil society organizations. In Russia, MSF worked in partnership with a Russian NGO, *Nochlezhka*, to normalize the legal status of the homeless (p. 210) and to reform the prison health system (p. 229). In South Africa, MSF worked with the Treatment Access Campaign (TAC), to fight against the stigmatization of people living with HIV/Aids and to improve access to ARVs. There are specific, documented cases of MSF working with civil society actors to make public health interventions for prisoners, the homeless, and for people living with HIV, according to an approach that has been qualified as *developmentalist*.

This *developmentalist* approach has been contrasted to the individualized medicine in emergencies, qualified as properly *humanitarian*. Fox describes an "explosive confrontation" inside MSF that took place along the lines of this distinction, which opposed two national sections of the NGO: MSF-Operational Centre Brussels, drawn more to public health interventions and development - what Sam and Peter referred to a "systems-strengthening" approach - and MSF-Operational Centre Paris, that criticized the project in Russia as "*antithetic to their paramount commitment to MSF's principle of "proximity" to patients"* (p. 235) - the "clinical", or "direct-service delivery" approach. There are other authors that detail the development/biomedical humanitarianism divide within MSF. Where Fox sees a confrontation between different sections of MSF, Elsa Rambaud's PhD dissertation in political science on MSF analyses this contrast in terms

more historical terms, detecting a dialectic inside MSF where the excesses of *development* or *emergency response* leads to a crisis within the organization that initiates the opposing cycle. These approaches have in common that they integrate MSF behind a small number of principles, or modes of organizing action, that either sit in tension, or indicate the poles of a dialectical becoming.

A **second** mode of rendering the heterogeneity of humanitarian aid is to suggest that the humanitarian sector affects a ***fragmentation***. Fragmentation is of several sorts: the fragmentation of public policy, the fragmentation of reason, the fragmentation of the humanitarian system, or the disarticulation of humanitarian projects from the goal of responding to need. In these descriptions, MSF appears as an *exceptional case* in the humanitarian world, an unadulterated form of humanitarian action, contrasted to prevailing modes of operation.

Political scientists Johanna Siméant and Pascal Dauvin - while extending the tension described above between *emergency response* and *development* to the entire humanitarian sector - have held that medical humanitarian NGOs implement "fragments" of "public policy", confusing the boundary between governmental and nongovernmental, public and private, market and state. Their 2002 book - based on hundreds of interviews conducted across the four largest French medical humanitarian NGOs, with focus on MSF and Doctors of the World (MDM) - provides powerful tools for understanding humanitarian operations. Building on the work of Michael Lipsky on street-level bureaucrats (1983) - as well as Lipsky's work with Steven Smith on the subcontracting of the welfare state's responsibilities to non-profits in the United States in the 1980s (2009) - Siméant & Dauvin explore the tensions between the *heterogeneity* of NGO actors, tied to an ever-increasing division of labour, and the strong *standardization* of humanitarian response. This standardization is linked by these authors to grant writing and the work of forcing oneself into the mould of institutional expectations in order to obtain operational funds. They describe the tactics different NGOs develop to maintain leeway in their operational strategy, while remaining financially afloat. The play between heterogeneity, standardization, and the work to maintain spaces of liberty, is what leads these authors to suggest that humanitarian organizations tend to implement "fragments" of public health policy, decided by funding agencies in Washington, Brussels, or Geneva, and in tension with their own operational objectives and financial needs.

Similarly, the sociologist and social theorist Monika Krause has analysed the effects of New Public Management techniques of the project form on humanitarian activities. The project form cuts up humanitarian activities into measurable outcomes that maintain only an incidental relation to the overall quality of response to need. It is this that Krause calls the "fragmentation of reason". *"We have rationalized parts of organizations to make them more effective and efficient, and we put*

much thought and effort into this project. In pursuing this, we have assumed that these improved parts would also add up to a better whole. It is this assumption that is proving problematic in the fragmented system of humanitarian relief, and it is in that sense that earlier ambitions of "development" have been shortchanged" (2014, p. 91). For these authors, the term fragmentation is used to indicate that the boundaries established by classic categories in the social sciences no longer hold. These boundaries separated the state and the private sector, the market and civil society actors, all bound within the borders of the nation-state. Using these categories, it is difficult to determine if MSF is a governmental *or* nongovernmental actor, private *or* public, national *or* international. From here, the suggestion is that "public policy", "reason" itself, or the "system" of humanitarian relief, are *fragmented*.

These developments target several opposing analytical positions. Krause's point is meant to deal with the perception of the humanitarian sector as accomplishing the unqualified good of meeting needs. In discussion with Boltanski & Chiapello's analysis of the project form as a political mode (1998), Krause attributes the unity of the humanitarian sector to the isomorphic effects of this mode of collective action. Projects are produced not for "beneficiaries", but for funding organizations, according to indicators of economic performance. This orientation has effectively disarticulated humanitarian activities from the goal of meeting needs: another meaning of *fragmentation*. The argument echoes the Weberian perspective on the "iron cage", where the rationality of bureaucratic forms was disarticulated from values, creating the necessary conditions for value-fragmentation, or polytheism. For Siméant & Dauvin, the argument in terms of fragmentation allows them to reject both the optimistic claims of those who hold to the birth of a "global civil society", while at the same time showing that the humanitarian sector cannot only be understood as a frontline outpost in a diffusion-like extension of neoliberal rationality (2002, p. 303).

In both these analyses, MSF stands out as an exceptional case in the humanitarian sector. Refusing to adhere to widely accepted humanitarian "minimum standards", yet widely recognized as one of the most competent NGOs, MSF is consistently described as avoiding the pitfalls inherent to the humanitarian enterprise. For Johanna Siméant & Pascal Dauvin, maintaining this "operational capacity" is understood to have been achieved through the construction of financial independence, sometimes at the expense of the democratic governance of the *association* (e.g., contrary to most French *associations*, the president of MSF is elected, but is also a salaried employee, due to the imaginative legal structuring of MSF entities). In Monika Krause's "theoretical field analysis", MSF is placed alongside the Red Cross as one of the two "pure" forms

of humanitarian action, representing the humanitarian NGO best able to avoid state, market, and religious pollution. Here, it is the entire humanitarian sector that is characterized as fragmented - or affecting a fragmentation of public policy or reason - and MSF is an exceptional case that is integrated through symbolic distinction in the humanitarian field.

The **third** mode of totalizing MSF entails the ***juxtaposition*** of MSF with other forms of global health interventions. We will examine two such analyses. The first comes from an article by Atlani-Duault *et al* published in *The Lancet* in 2016. This article looks at the history of French contributions to what would become global health. Dividing French global health history into three periods, it explores a "fundamental tension" between two "approaches": *State humanitarian verticalism* and *universal health coverage*. Both originate in the French colonial enterprise. During France's colonial period, the ideal of universal health coverage to its population in the colonies was confounded by the obligation to make the colonies profitable for the French state. In this absence of state-organized social security, two forms of response were discernible: that of Pasteurians like Eugène Jamot forcing mass vaccination campaigns on local populations in Cameroon, and that of the protestant missionary Albert Schweitzer, who raised private funds across Europe and the United States to fund his hospital in Gabon, where clinical care was provided as part of his ministry. The tensions between these modes of responding to the failure in implementing the ideal of universal health coverage provided free of charge by the state continued during and after decolonization. Vertical programs continued as before – most often vaccination campaigns – through bilateral agreements and the support of French military doctors, and, in the latter half of the period of decolonization, the French tradition of *sans frontiérisme* was established. The authors focus on MSF. From the late 1990s to the 2010s, these tensions played out once again, with what had been specific to French international medical aid became common to *global health*: the tension between privately funded vertical programs and state-funded biomedical initiatives aimed at structural factors came to characterize global public health. This was the concrete result of French agencies and organizations arguing that bilateral and multilateral development oriented towards structural reform, couples with vertical biomedical interventions, was the best form of response to the HIV/Aids epidemic. In this modelling of French – and then global – international medical aid, MSF is placed in a series, as *a case* of privately funded vertical programs that respond to state's failure in providing universal health coverage, and *juxtaposed* to development-style programs aimed at structural reform in order to reduce inequalities.

Andrew Lakoff's totalization of MSF – from his 2010 article entitled "Two Regimes of Global Health" – is also based on *juxtaposition*, but is less historical. Building on Redfield's analysis of the *secular value of life*, Lakoff takes MSF as an *exemplary case* (no longer the *unique*

case analysed by Redfield, Fox, and Rambaud, or the *exceptional case* of Krause, Siméant & Dauvin) of one regime of global health: *biomedical humanitarianism*. He juxtaposes *biomedical humanitarianism* to another regime: *global health security*. While arguments made in the terms of global health are increasingly common in a wide number of organizations, of a variety of types, and global health is increasingly institutionalized through eponymous medical and public health management diplomas and bureaucratic departments, *global health* is far from being a unified field. Different *regimes* imply starkly different understandings of the groups whose health must be protected, the most pressing threats to their health, and the appropriate justifications for health interventions that transgress national sovereignty. While stating quite clearly that the two *regimes* that he proposes do not exhaust the field of global health, Lakoff suggests that *biomedical humanitarianism* and *global health security* are heuristic for indicating a series of tensions within the domain of global health.

The *global health security* apparatus can be described in terms of its technical and normative project for intervening "at a global scale" on infectious disease. This regime focuses on outbreaks of *emergent infectious disease* that have not yet occurred, cannot be predicted, and whose consequences would be politically and economically catastrophic, with incalculable effects on the health of the population. In this regime, the threat is understood to emanate from developing countries in Asia, Africa, and South America, which, if they were to reach Europe or North America, would have catastrophic effects. Examples include SARS, weaponized smallpox, and virulent forms of influenza. Certain modes of response to the ongoing pandemic of SARS-CoV-2 might fit into this box. Next to *global health security*, Lakoff juxtaposes *biomedical humanitarianism.* In this regime – with MSF taken as an *exemplary case* – the orientation is toward infectious diseases that tend not to affect overdeveloped countries, with poor countries bearing a disproportionately large burden: HIV/Aids, tuberculosis, visceral leishmaniasis, African trypanosomiasis, malaria... Humanitarian interventions are understood as necessary because of the poor state of health systems in these countries. The target of such interventions is not a national population, but individual human lives. The technical project is to bring diagnostic and treatment capacities to these countries. The normative project is to reduce suffering. "*Whereas global health security develops prophylaxis against potential threats at home, humanitarian biomedicine invests resources to mitigate present suffering in other places*" (2010, p. 60).

"MSF" takes on different characteristics according to the research question posed and the debates in which the above authors engage, either as an organization united behind principles in tension, an exceptional case in a fragmented humanitarian sector, or an exemplary case of the

humanitarian regime in contrast with a "global health security" regime. These modes of totalizing MSF are linked to differing views on how "MSF" behaves. United by behind a secular value of life, MSF grapples with the contradictions of public health interventions. In a fragmented humanitarian system, MSF struggles to avoid the pitfalls of the project form by painstakingly constructing its financial independence, at the cost of its democratic governance. As an exemplary case of the biomedical humanitarian regime of global health, MSF transcends national borders and justifies the violation of national sovereignty in the name of individual human lives. The problem with these approaches is not that they are false, but that they are incomplete. We can always say "yes, but MSF is also…" and then give an exception and show that the exception says something essential about MSF. This is the case of any strategy of totalization. So, how might we come to grips with *MSF-as-a-whole* – how can we account for MSF's obvious heterogeneity and the clear resemblances and spatial continuity – while also keeping in mind that any account is necessarily partial and incomplete?

This dissertation has made just such a move possible. Let us now see, chapter by chapter, how we have done so.

MSF-as-a-whole: MSF's humanitarian aid in the present

This dissertation is an ethnographic monograph, and we must find a way to come to grips with our object of study: *MSF-as-a-whole*. The question is simultaneously methodological - how should an ethnographic monograph be done? - but also conceptual – what is a biomedical humanitarian NGO? As announced in our general introduction, we have provided an account of the ways MSF becomes MSF by examining the inquiries into the qualities of MSF led by members of MSF. We have investigated such inquiries as they were led from four different humanitarian locations: *humanitarian space*, *the field*, *medical platforms*, and *headquarters*. The point we made was that in those moments of reflexivity regarding the choices of where MSF intervenes and whom to help, MSF was also deciding the ways MSF behaves, and, thereby, questioning the characteristics and qualities they were to ascribe to MSF. By deciding where to intervene and whom to help, MSF was also *deciding*[1] what it would become. In a word, we saw that *MSF is always becoming itself again*.

This is one way of formulating our thesis: working through MSF's global *humanitarian presence* means dealing with the problem of how MSF becomes MSF *in the present*. This is not an

[1] Dear reader, please recall that our pragmatist account of decision-making entails a much wider range of activities than *satisficing*.

exacerbated presentism, where all that matters is what is *here and now*. It was clear that for MSF's *humanitarian presence* to pursue its global physical extension, the *past* work of organization, coordination, and setting up infrastructure was essential. Moreover, an important part of work in the *present* is precisely to project the organization into the *future*, through planning and strategizing. But all this past action and future action is only ever experienced in the present. Which past – of all possible pasts – becomes pertinent in the present is a question to be asked again and again. As Antoine Hennion, with Michel de Certeau, has demonstrated concerning the writing of history, the absent present of the past is always made *the past* from *our present* (Hennion 2020).[1] This is why we described MSF continually rebecoming itself again, in the present and only in the present.

This is our proposition for coming to grips with *MSF-as-a-whole*: members of MSF continually work out, through practices of reflexivity – they lead local inquiries into the state and status of the objects and persons in presence, as well as the appropriate ethical and political stances to adopt – what it is for MSF to be MSF. These inquiries build on the past (a past made in the present) and project MSF into the future (a future made in the present). Let us go over the argument, chapter by chapter, to demonstrate how we have managed this. We will come back at the end of this section to *the problem of the present* as an analytical strategy for getting at *MSF-as-a-whole*.

In **Chapter 1**, we were concerned with ***humanitarian space*** and the potential relations the constitution of a territory - where humanitarians felt responsible for the regular and rhythmic activities they organized there - might entertain with a form of *humanitarian government*: if humanitarians have *territory*, do they *govern*? In other words, is the relation that humanitarians maintain with their *beneficiaries*, whom they select around the world, like the relationship between a governing body and the bodies of the governed? We saw that a number of influential anthropologists of humanitarian aid concluded that it was, indeed, a particular form of governmentality, that integrated public health interventions and the invasion of the political sphere by moral affect and bodily need (Fassin 2010; Ticktin 2006, 2011; Pallister-Wilkins, 2018). We found this proposition to be stimulating - especially to the extent that it spatialized these issues in terms of *bordering* - but also surprising: it holds that humanitarianism is a form of governmentality,

[1] We will be coming back to this point in a moment, but before we continue, we must clarify one point. Hennion's argument, with de Certeau, is not that we project subjective meaning onto the past according to our socialization or current forms of subjectivation. It is also that the present – *our* present, where we find such forms of socialization and subjectivation – would not exist without this past as it is read from the present. This is what de Certeau calls the *inversion of the thinkable* ((l'inversion du pensable).

when humanitarians make the rather specific claim to be *nongovernmental*. What does it mean to say that MSF is nongovernmental?

To respond, we described the processes through which MSF's *humanitarian space* is produced (in the present). We suggested that *humanitarian space* was enacted in practices of mobility, in the materiality of this movement, and through a set of relations and modes of relating that this mobility afforded. This mobility entailed processes of territorialisation - that is, association with and appropriation of *humanitarian locations* - and deterritorialisation - that is, fading into *humanitarian space* from which several moves, constituting locations, are in a virtual or potential state. It also initiated specific kinds of relations with beneficiaries, sovereign actors, and other nongovernmental institutions and organizations. It was precisely through these processes of territorialisation and deterritorialisation, through these modes of relating, that MSF gained *humanitarian agency*, the capacity to act in a humanitarian manner (in the present). Insofar as these modes of relating did not include attempts at determining who should govern, at deposing current governing bodies, or at overturning government altogether, we claimed, with Michel Feher, that humanitarian politics are *nongovernmental*: an incursion of the governed into politics to contest the *how* of government, not the *who* of government, nor the *existence* of government.

We showed that *humanitarian space* was a space from which MSF made inter-ventions: between beneficiaries and their problems, and between governing bodies and those they are meant to govern. They are nongovernmental insofar as they position themselves between governing bodies and the bodies of the governed, specifically to demonstrate that those who are supposed to assume governmental responsibility for individuals in a state of vulnerability are unable or unwilling to do so. The point is to provide concrete alternatives to government practice. It is based on reworking the boundary between *ethics* and *politics*. We cannot analyse humanitarian politics as the incursion of *moral affect* into the political realm. *Ethics* is neither the primary concern, with politics trailing behind as a secondary consideration, nor is *politics*, as the acquisition of power and resources, what really matters, with ethics only figuring in political considerations when they have strategic value. In this nongovernmental space, always reterritorializing after deterritorializing, politics and ethics are on equal footing. The humanitarian agency provided in the specific set of relations maintained (in the present) from humanitarian space means simultaneously calling to account governing bodies, while negotiating space in a complex institutional ecology, and also making sure that the assistance they provide does not feed into a wider economy of suffering. These politics are the necessary, but insufficient conditions to a humanitarian ethics of solicitude. In brief, our response to the common claim in the anthropology of humanitarianism that global aid is an iteration of Foucauldian governmentality, was to look at how members of MSF question their role

in government – through inquiries in the present - and ascribe the quality of *nongovernmentality* to their organization.

In **Chapter 2**, we were concerned with ***the field*** of humanitarian action. We saw that in the social sciences, there was a tendency to describe the field of humanitarian action in terms of the places that it was not: headquarters, the office, and home (Siméant & Dauvin, 2002; Bornstein, 2003; Fox, 2014). This sense that the field is an *other place* is shared, and contested, by humanitarian practitioners, uncomfortable with the realization that going into the field questions their subjectivity while adding, quickly, that this change does not give them access to a higher "moral plane". Considering our argument that humanitarian aid continually enacts *territory without government*, and considering the common experience of the field's *otherness*, we wondered if the field of humanitarian aid could be analysed as a Foucauldian *heterotopia*: a site crisscrossed by multiple orders, sitting in contrast to the rest of social space, and containing simultaneously the potential to reinforce conservative structures and to initiate rapid and progressive transformation.

Describing the practices of explo/action that open the field, we demonstrated that the field of humanitarian aid was continually re-constituted through the investigative practices of a field science - *field epidemiology* - effectively adding another *other place* to our list: the laboratory. In discussion with the anthropology and history of field sciences, we saw that the field of humanitarian aid is a site of *con-tact* - insofar as the tense relations between aid and knowledge (*explo/action*) production require both tact and tactics with regard to beneficiaries - and a *mediated inter-face* - wherein humanitarians must create a place where beneficiaries can become vulnerable, which entails performing the recognizable need to help (*explo/action*). That is, the field of humanitarian aid can be specified by the kinds of connections it makes possible with the *beneficiary*. This is what the field does: it is the place where it is possible to relate to the beneficiary.

Explo/action, then, entails practices of place in support of relations to beneficiaries: approach, inter-facing, contact, mapping, and turning the field into a lab. These relations entail both care and knowledge production. Looking at MSF's epistemic infrastructure, we saw that "the field" occurred - congealed, gained consistency and agency - at precisely that moment when the distinction between the local and the global, the singular and the general, was cancelled out. The field is both distinct from, and constituted through, the reference to office and lab. Its spatial order of the field is multiple and incoherent, existing according to multiple ethics, in distinction to bureaucratic modalities of action and in reference to Foucauldian biopolitical and clinical space. The term *expo/action* is meant to indicate that MSF's becoming, in the present, does not entail going down a single and coherent path, but dealing with these multiple constraints and maintaining

these multiple goods *in the present*. In sum, adjudicating whether the field is an "other place" or whether it is part of the totalizing order of biopolitical governmentality is impossible. It is precisely the tension between these modes of ordering, as they constrain and strain space, that produces the field as *one* humanitarian location (among many). The field of humanitarian aid is not the "other" for some structure, an outside that produces an inside or the diffusion of any one mode of governmentality. The field is *topia*, not *heterotopia*.

In **Chapter 3**, we were concerned with the situations of choice that the practices of triage and patient referrals ordered from a ***platform for emergency*** in Nairobi. Taking a platform to be both a network and a project - both a *humanitarian location* and a *technology of intervention* - we were interested in both the concrete operations of triage by which MSF personnel accepted responsibility for some patients, as well as the work they did to transfer that responsibility to the Kenyan public health system.

The first point we drove home in this chapter was that the choices of triage are between the living options that present themselves to medical staff as they work through the difficult questions of *what is it that is going on here?* and *what are we to do?* We take these to be the questions of ethics. This was a response to those sociological approaches that saw emergency admissions as the result of patients performing value and moral responsibility for their health, and to those anthropological approaches that analysed triage as the rationalization of tragic choice. We deflated the philosophical problem of triage - insisting that it is not about reasoning through principles or schools of moral philosophy – but this did not mean that triage did not pose *genuine options*.Triage is about choosing to provide care to a young girl with a six-inch laceration on their thigh or an elderly man with a cracked skull. Nor is triage a question of a patient being worthy of care. This does not mean that patients are not morally evaluated, nor does it mean that the choice of patients is made lightly or easily. The options presented to medical staff, ordered through triage protocols, on a global platform for emergency medicine, were *genuine*: living, momentous, and unavoidable.

When we look at how the questions of ethics are answered through the SATS protocol, the first surprising thing we learn is that staff were at ease disqualifying presenting patients as "hysterics" and "liars". This related specifically to the responsibility MSF staff attributed to themselves in the Nairobi A&E. They sought, first and foremost, to identify emergencies in time to prevent irreversible harm. This is done by reading Vital Signs - heart rate, systolic blood pressure, blood oxygen saturation, body temperature, respiratory rate... - as Early Warning Signs. Statistical norms for these vital signs are established, and deviations are used to give a score and then a colour to the patient: green, yellow, orange, red, black. Emergencies cases *present* certain

patterns of deviation from these norms, indicating that the patient is *fragile*, in imminent danger of irreversible bodily harm. However, we also saw that this protocolary ethics on the emergency platform ordered sustained vigilance (in the present) to this fragility. Insofar as the bodies of presenting patients are apprehended as always being on the brink of unforeseeable deterioration, triage orders the repeated and continuous evaluation of the signs of this fragility, even for disqualified patients. This attention follows patients even after they have left the trauma room. They may disqualify patients for "faking" when they request *too much* given the state of their vital signs, but medical staff remain ever vigilant to potential irreversible harm. This continuous vigilance to fragility, even in patients that are morally disqualified, is the kind of attention that triage orders.

The stakes of triage from this platform for emergency relate to what happens next: the transfer of responsibility for fragile patients to the Kenyan public health system. The A&E and the ambulance service in Nairobi were meant to participate in the development of emergency medicine in Kenya, recently recognized as a medical speciality. MSF grafted itself onto this burgeoning platform and tried to contribute to its growth by supporting a local hospital. From their place on the platform, MSF identified patients in need of emergency care in the Mathare slums, and then referred them "up and down" in the public health system. They sent non-emergency patients "down" to Primary care facilities and used their three ambulances to refer emergency patients "up" to Secondary and Tertiary care facilities. These referrals proved exceedingly difficult, because the "level" from which MSF referred patients on the platform was unclear because routine referral pathways could not be established because of reforms in the health care system, because of the effects referring emergency patients to underfunded hospitals had on their finances and their mortality rates, and because staff were content working with other modes of ordering response to emergencies. Our conclusion then, was that "emergencies" are not a kind of inescapable present, an external reality so monumental in its immediacy that it makes a future course of action unavoidable. As we saw, even the present of emergencies was ambiguous (more on this in a moment). Moreover, for an *emergency* to take shape, a great deal of ordering must be achieved to render us attentive to and responsible for *fragility*.

In **Chapter 4**, we were concerned with decisions to close projects, as they are made from ***headquarters*.** Most analyses of project closure are based on the idea that organizations have the capacities necessary to make the decision to close according to a set of principles, or distributive commitments, and then to implement these decisions (Hunt & Miao 2018; Abramowitz 2015; Rubenstein 2008). This takes for granted the existence of a humanitarian agency capable of value

rationality, decision-making, and collective intentional action. We did not question that MSF has those capacities. Our goal was to examine how MSF gained those capacities as it closed projects, in order to work out how the ways *MSF-as-a-whole* hangs together – in the present - effects closure according to the calculated value of humanitarian projects.

Our hypothesis was that these capacities were somehow tied to the location where the decision to close projects are always made, namely, headquarters. Through a presentation of MSF's institutional development and the problematics of institutional reform, we saw that MSF is a polycentric organization with a tendency towards decentralization. It is a constellation of headquarter entities connected vertically to the field through five Operational Centres and their respective Departments of Operations. Getting such a vast machine as MSF to function can tend to consume attention and resources to the point that people forget about "reality", what is going on outside MSF, in the field. As such, the Director of Operations' saw her role as keeping MSF "focused on reality". She managed this through a Strategic Plan. That is, *strategy is a kind of attention to reality*. Finally, with the help of two Cell Managers, Laurent and Guillaume, as well as Michel de Certeau, we worked out how the spatial configuration of headquarters ordered strategic attention to the field. Headquarters was "a place of their own" for MSF, an inside that belonged to them properly, where they could accumulate resources and from which they could look out at the world as if it were an immobile surface and read a system of relations. As they read this system of relations, they could imagine a series of moves that resulted in *outcomes of worth*, for beneficiaries and for the institution.

We then asked how MSF work out what an *outcome of worth* looks like? This entailed getting a grip on what it means for MSF to *calculate the values* of its projects, that is, analysing MSF's value rationality. The problem of value rationality is that there are different ways of calculating value, and some of them are incompatible. To work through this, we looked at disagreements over the decision to close TB activities in Nairobi. We learned that the value of a project is calculated during project evaluation and planning meetings called MAPs. Values, facts, figures are brought together in the two-dimensional space of a projected PowerPoint slide, they are rearranged and then return to the world as composite figures of the value of the project: "impact", or "added value". These composite values are linked to strategic visions and an associated monitoring apparatus. When MSF engages in a specific kind of project, they are *committed* to its values, insofar as it becomes exceedingly difficult to calculate the values of another strategic outlook with the monitoring apparatus they set up. And not only at the project level: the *impact* of a project is also compared to the *impact* a similar project would have in other locations. These routine monitoring tools means that strategic visions can stabilize in project types, in between

Operational Centres, in Cells. At the same time, it is only after 12 months of discussions and disagreements between Coordination and Cell over the value of these activities and closure that there is a call for *choice* between strategic outlooks. Choice comes as a call *to get everyone on the same page*, a call to abandon all modes of calculating value, to abandon all ways forward except one: closure. That is, it is *in the present* of the decision regarding the values and strategic orientation to adopt that MSF becomes of a collective actor, *MSF-as-a-whole*, with the capacity for strategically oriented value rationality.

So, *MSF-as-a-whole* can be the result of a *decision* made in the present. For this proposition to be acceptable, we had to rework what it meant *to decide*. This is what we did in the final section, by looking at what it meant *to make the strategic decision to close a project according to value rationality*. Examining a series of cases where value rationality affected the decision to close or not to close – exit strategies, diminishing returns, and monetary values – we realized that we could not take decision-making to be ordered according to the bounded rationality and satisficing of Herbert Simon, nor could we just ignore it to focus on organizational processes like Mintzberg & Waters (1990), nor could we claim that decisions are a narrative retrospectively projected onto an previously enacted world (Weick 1995). In discussion with Hendry (2000), Cabantous & Gond (2010), and James (1992), we concluded that if *MSF-as-a-whole* can be the result of a decision, then we must take very seriously the fact that human subjects, when they make decisions, are sometimes reasonable, but they are also 'carried away' by their excitement or drift, they sometimes 'get down to business' and turn away from frivolities, and there are also occasions when they maintain all the options in mind and make that heroic move to follow only one path. With such a human subject, engaged in organizational processes and rhythms, with the strategic vision afforded spatial consistency of headquarter entities, and the collective calculative value rationality of a "MAP season", then *organizational decision-making* takes on different characteristics. Most projects close because they *stagnated*; they reached the end of a project cycle and nobody had any ideas for what could come next. Others closed because they had no future; they had already achieved what was possible given a strategic vision. Of course, not everyone agrees about the exact moment when a project loses value, and intense negotiation is necessary to *get everyone on the same page*. Monetary values play a role as well, but when teams must deal with such constraints, it is important that they do not see them as the criteria for closure. Otherwise, they get 'excited' and come to see any decision as a good decision, just because they have no choice but to choose. *MSF-as-a-whole* is indeed the result of strategically orientated value rational decision-making, but

only insofar as we look at what it means – in practice, in the present – to do strategy, to calculate value, and to make decisions.

This is what we have termed MSF's *humanitarian presence*. A quotation from the work of Antoine Hennion on the work of a making music *present* might help clarify what our project has been. "*Beethoven may have worked two centuries ago, the pianist practised his sonata a thousand times, and our ears had the time to become familiar with it, the trembling fingers of the performer waiting to come on stage remind him that there is only the present*" (Hennion, 2020, p. 4, my translation). This is the point. For MSF to be what it is, it most certainly requires its 50 years of history during which it painstakingly developed its financial independence, its epistemic infrastructure, its medical platforms, its technologies of intervention, and its organizational processes. We have been attentive to them. But MSF practitioners still must *do* humanitarian aid, and it is in this doing, in this performance marked by a trembling hand, that *MSF-as-a-whole* is continually made present around the world.

A cautionary comment is in order: the present is not an imperious demiurge that imposes its tyrannous order. Let us examine, once more, the present of emergency to clarify this point. What kind present is more high-handed and exacting than emergency? The past, the future, it all disappears. Suddenly, the appropriate action – response – rears up as the only possible mode of investing the situation. An emergency demands immediate response. Yet, we saw that even this most demanding of presents was best summarized by the expression 'because you never know'. The present has to happen, and this happening is both over-determined and under-determined. The present of emergency is prepared through protocols, infrastructures, and training. There are more histories, projections, connections, modes of relating, and causes that inflect the present than can possibly be imagined. The present, as it happens, is *over-determined*: there is no possible present in which all these sometimes contradictory and always ambivalent constraints can be satisfied. At the same time, the *present* (of emergency triage) is also *under-determined*. It is contingent to the point that sustained vigilance is necessary *because you never know*. Numerous alternative outcomes can satisfy the multiple and incompatible constraints at least as well.

It is in this over- and under-determined happening, in the doing of humanitarian aid, that MSF-as-a-whole enacts its *humanitarian presence*. For it is precisely in the present, that MSF's past is elaborated as that absent present of *its* history, that MSF's future is established as a political project that must be done, and, indeed, that MSF's global *humanitarian presence* achieves is form, extension, and movement. Our description of this *doing* has been partial and incomplete, but this takes away nothing from our analysis. Indeed, it confirms it. We claim that MSF-as-a-whole, as it

provides aid to the vulnerable around the world, is always a partial and incomplete achievement. This is MSF's *humanitarian presence*.

Our proposition to work through the conceptual problem of totalization is distinct from those developed by the authors discussed above. We have neither unified MSF behind a short list of values, nor have we situated MSF as an exceptional case in a fragmented humanitarian sector, nor have we juxtaposed MSF, as an exemplary case of biomedical humanitarianism, with a global health security apparatus. Instead, we have described MSF as they work to resolve both over-determination and under-determination of the present to locate MSF around the world. This is MSF's *humanitarian presence*.

We now turn to the contributions this concept can make to current discussions in anthropology on *the global*.

Humanitarian Presence: Contributions, Perspectives, and Critique

We have endeavoured to provide an account of aid as it takes place. This approach, and our performance of it, has its limits. We would have liked to analyse MSF Logistics. Founded in the 1980s, this MSF "satellite" is where humanitarian kits are developed. Though MSF does little of its procurement through this structure – there are less expensive options – MSF Logistics trains MSF logistics supervisors and managers and develops specific technologies that support humanitarian aid in the present. It is also a source of income for the organization, through the services it provides to other NGOs. This dissertation would have gained from such analysis. Nor have we considered the sources of MSF's funding, that is, the elaboration of fundraising campaigns, of public communication or of *témoignage*. Other authors, such as Siméant & Dauvin (2002), have insisted on the importance of MSF's financial independence, and it is commonly used across the humanitarian sector to distinguish MSF from other NGOs. Moreover, it is intuitively clear that funding has effects resource allocation, especially in those cases – generally between 10 and 20% of MSF projects – when MSF seeks institutional funding and writes project proposals. Nor have we analysed the fundamental research and clinical trials conducted by Epicentre, which has played a role in changing the medical activities of MSF in the field.

We worry, too, that the absence of a specific history of MSF, developed from the perspective of *humanitarian presence*, may have given the reader the impression that our approach to MSF's *humanitarian presence* is, well, too *presentist*. While we have not provided historical analysis of *MSF-as-a-whole*, we have conducted a conceptual history of *humanitarian space*. We

have also proposed a genealogy of *field epidemiology*, analysed in terms of the progressive development of MSF's *epistemic infrastructure*. This is an original historical contribution to the flourishing domain in the literature. Indeed, there are numerous existing resources on MSF history, in both recent monographs of MSF (Redfield 2013; Fox 2014) and in more general histories of the humanitarian sector (Barnett 2011; Siméant & Dauvin 2002; Lachenal & Taithe 2009; Taithe 2004, 2015; de Waal 2018).

Despite these limits, we would request that the reader also keep in mind the analytical perspectives that our dissertations opens and the novel form of critique that it affords.

This social science writing machine has allowed us to contribute to three interrelated domains of literature in anthropology on the global. Our account of ***humanitarian locations*** - territory without government, the field, a platform, and headquarters - can contribute to the analysis and critique of the globalizing spaces of the economy, culture, and ecology (Braudel 1992; Wallerstein 1974; Ferguson 2005, 2006; Appadurai 1996; Tsing 2014). Our analysis of ***humanitarian technologies of intervention*** - a mobile clinic, explo/action, triage, strategy - can provide insight into how global assemblages localize (Collier & Lakoff 2008; Ong & Collier 2008; Rabinow 2008; Lakoff & Keck 2013). Our analysis of ***humanitarian beneficiaries*** - as scripted for in humanitarian locations and technologies of intervention - contributes to a body of literature that seeks to work through emerging problems of living life *qua* biological life that effect changes in modes of access to quasi-public medical resources (Petryna 2004, 2009; Nguyen 2010; Chabrol 2014, 2017). Moreover, these *humanitarian locations, technologies of intervention*, and *beneficiaries* indicate to us some of the recurring problems that *humanitarian presence* must face.

We examined mobile clinics, the methods of field epidemiology, a platform for emergency medicine, and strategic planning as ***humanitarian technologies of intervention***. These technologies were examined in their capacity to insert MSF practitioners in between governing bodies and the bodies of the governed, and in between beneficiaries and their needs. These interventions also created one of our four humanitarian locations: *humanitarian space*, or *territory without government*. In their intervention into government, we saw a pattern repeat itself: MSF assumes interim responsibility for fragile bodies, while avoiding substitution, to make alternative propositions into concrete options for the *how* of government. Then they attempt to hand over responsibility for this fragility to other NGOs, supranational agencies, and public health structures. They effectively push for more government, better government, pointing to those sites where governing bodies do not assume their pastoral role and forget their responsibility for the well-being to each individual as well as the collective. In their intervention between beneficiaries and their

needs, they created a place where beneficiaries could recognize MSF's need to help and become vulnerable for MSF. However, MSF's also limited their responsibilities for specific kinds of vulnerability and specifically sought out those kinds of vulnerability where governing bodies were in cause. Once again, for MSF to acquire humanitarian agency, they were dependent on an outside actor to accept the role attributed to them. It was only insofar as MSF could find people willing to assume this role that they could become humanitarians and call out authorities on their lack of government. In sum, for these *technologies of intervention* to function, MSF must find a way for their activities to come between governing bodies and the bodies of the governed, beneficiaries and their problems, without participating in a larger economy of suffering. These *technologies of interventions* supported a variety of types of humanitarian presence and associated political and ethical tactics.

Getting humanitarian aid to take place in the present entailed additional ***humanitarian locations***. First, ***headquarters***, MSF's place of their own - marked by the physical absence of beneficiaries - from which they project MSF's presence around the world. The polycentric constellation of headquarter entities around the globe - with a concentration in Western Europe - is where MSF accumulate experience and resources, both human and financial, to redeploy them in operations. Headquarters is both above operations in the field - the field must report to HQ - and below operations in the field - HQ supports the field, and resources flow between these sites as in a series of communicating vessels seeking hydrostatic equilibrium. This particular positionality allows MSF staff in headquarters to look out on MSF's external reality as if it were a flat and immobile surface, read systems of relations - between governing bodies and the bodies of the governed - and imagine interventions that produce humanitarian value (providing care to beneficiaries, modifying government practice, safeguarding MSF the institution). Second, ***the field*** of humanitarian aid, the destination of humanitarian mobility and the object of exploration, is where MSF produces knowledge about, and provides care to, the beneficiary. In contrast to Headquarters, the field is specifically that place where MSF comes into con-tact with the beneficiary, inter-faces with them, and exchanges recognition (recognition of the need to help and of the need for help). The field is opened through the practices of explo/action supported by the epistemic infrastructure of field epidemiology, to which MSF has contributed since the 1980s. Through Rapid Health Assessments and Retrospective Mortality Surveys, MSF approaches beneficiaries, marauding through the field and collecting information under the cover of care, or circumscribing the field, putting it in a grid, and making it submit to randomized sampling. This information is then transformed in MSF offices in the field, allowing a switch to a bird's eye view of the population that allows them to reorganize and map the field. Then comparison with standardized thresholds

makes this *one* field site commensurable to many other fields and indicates MSF's operational priorities. Third, a ***medical platform*** from which MSF organizes their intervention into the national health systems. The *medical platforms* on which MSF works are both networks and projects, crossing and maintaining institutional boundaries, while supporting a political program with a formal set of goals. These medical platforms do not belong to MSF. The point is to graft themselves onto existing initiatives that are in an early stage and to foster their development by bringing in technologies and expertise in order to reorganize a health system, while also providing health care to beneficiaries.

We arrive now at ***humanitarian beneficiaries.*** Beneficiaries, as we have described them, are not a psycho-social type, and this is precisely the reason that we have not domesticated the term with scare-quotes: no real, existing person can be reduced to a *beneficiary*. It is perhaps this misunderstanding that has led some authors to conclude that humanitarian governmentality limits the humanity of their beneficiaries to bare life, to bodily needs. MSF makes *timely* interventions into the lives of beneficiaries to respond to very real needs. But paying attention to, feeling responsible for, and responding to someone's need is not the same as reducing a person to their needs. MSF engages with their beneficiaries as a *nongovernmental organization*, in a space where ethics and politics are on equal footing. This means, in a phrase, paying attention to individuals and groups that governments have failed, feeling a responsibility to these individuals and groups, providing a concrete medical response to their needs in order to demonstrate to governments that concrete and feasible alternatives to the *status quo* exist. Ideally, government authorities will take over what MSF has started. As MSF engages in their face-to-face, their *corps-à-corps* with beneficiaries, beneficiaries are regularly attributed certain capacities for action that either fit with, or undermine, the moral and political order that MSF seeks to enact. Beneficiaries are mobile beings, and this mobility makes aid more difficult. To make their job easier, the much-discussed and criticized tendency in the humanitarian sector has been to put beneficiaries in camps. Beneficiaries are rightfully distrustful of MSF and needed to be reassured - and sometimes deceived - as they were plied with questions. Beneficiaries can also be suspected of exaggerating their needs, in order to gain undue access to MSF resources. In light of this, MSF's responsibility is to maintain attention to beneficiaries needs. MSF must *create a place where beneficiaries can become vulnerable,* that is, *humanitarian presence* must create the conditions necessary for beneficiaries to be comfortable in the position of a person in need. This entails averting the very real and present danger that the provision of humanitarian aid feeds into the creation of additional suffering. In any case, MSF's intervention between beneficiaries and their needs is to be temporary. Again, MSF sees their role as indicating those places where government has failed in its pastoral role, to provide

concrete and feasible alternatives, but never to take over. The value of MSF's interventions depends on their closure.

What this perspective manages is to indicate a specific set of problems that *technologies of intervention, locations,* and *beneficiaries* pose to the practice of humanitarian aid. There are *zones of indiscernibility* between these concepts and the problems they pose. The kind of attention that office in the field affords is indiscernible from the strategic attention ordered from headquarters. The kinds of relations that technologies of intervention entail are indiscernible from the work of relating to beneficiaries in the field and to governing bodies from medical platforms. Humanitarian outcomes of worth, as read from headquarters, are indiscernible from the work of relating to beneficiaries and intervening in government. And yet the problems of territorialisation and deterritorialisation are not the problems of con-tact, are not the problems of strategic vision, are not the problems of transferring responsibility to governing bodies. It is the spatial, ethical, and political consistency of this ensemble of technologies, discourses, and practices, as they strategically project MSF's existence around the world and tactically insinuate MSF into existing relations between those who govern and those that are governed, that mark, what we have called *humanitarian presence*. This *humanitarian presence* indicates MSF's physical extension, its global consistency, as well as its ethics of attention and its nongovernmental politics, in addition to indicating the health care it provides in an over- and under-determined present.

This perspective allows us to develop a critique of MSF's humanitarian aid. Because the humanitarian present is both over- and under-determined, because they must deal simultaneously with multiple and contradictory constraints, and attempt to achieve multiple incompatible goods, this critique cannot be consist in claiming that humanitarians do not do what they say they do. This is why we have refused Suspicious Social Science (SSS). Of course, we use the term "SSS" humorously, but to indicate a serious argument on the practice of social science and the kind of critique we should develop. Critique cannot be based on the assumption that practitioners act in bad faith or in knowing ignorance. Critique cannot consist in claiming that humanitarians do not do what they claim. That humanitarians relate to the bodies of their beneficiaries as would a governing body, when they claim to be nongovernmental. That they sacrifice life when they claim to refuse sacrificial politics. That they take beneficiaries as a commodity in the production of monetary value, when they claim to produce value by responding to need. The problem is not that these critiques are false, but that they indicate different kinds of humanitarian failure. Our refusal of SSS style critique was not meant to allow us to write an apology of humanitarian aid. Instead,

we sought to elaborate a careful and precise critique of humanitarian interventions into the lives of their beneficiaries and into health systems around the world.

In this imperfect world, MSF's humanitarian assistance represents an imperfect attempt at pursuing multiple, incompatible outcomes of worth. Regular, repeated, and renewed effort is necessary to maintain these multiple goods in the effects of humanitarian interventions. Attending to bodily fragility entailed the risk of reducing people to needs. Territorialisation and deterritorialisation served an ethics and a politics of presence with beneficiaries, but MSF's claims to territory sometimes clashed with the claims of sovereign actors. And territorializing in camps, entailed the risk of reducing beneficiaries to bare life (Agier & Lecadet 2014). The practices of knowledge production as ordered through the epistemic infrastructure of field epidemiology made it possible for MSF to clarify the degree of urgency and the priorities for intervention. But these practices also required that MSF put their beneficiaries to The Question, demanding that they define their needs in a predefined framework. MSF practitioners sometimes dissimulated their intentions, collecting information under the cover of care, in order to make their interlocutors comfortable to better bring them in for questioning. But collecting information was also necessary to the provision of appropriate aid. To make these locally produced figures of emergency commensurable to global thresholds, we discovered that we accept high levels of mortality in some places, and not others. Yet it was precisely these thresholds that provided the impetus necessary to make funds of global institutions available. From the platform for emergency, we saw up close the complex relations between the good produced through the statistical analysis of Early Warning Signs - it allowed MSF to save lives - while it also made it possible to dismiss the expressed needs of beneficiaries as exaggerations, lies, or hysterics. In headquarters, we saw that what is of worth is unclear, difficult to calculate, and there are intractable differences in the appreciation of worth and incompatible and necessary goods to be maintained in humanitarian locations. We also saw that the values necessary to maintain and govern MSF-the-institution could sometimes get in the way of producing value for beneficiaries in the field and getting MSF to stay focused on reality was a constant concern.

It is precisely because MSF's humanitarian mission entails multiple and incompatible goods that must be maintained together in mediated practice that we cannot be content with a *global critique* of humanitarian aid, that homogenizes these plural processes of calculation, that downplays internal tension between values, worth, and attention, that reduces value ambiguity to perverse effects. Once again taking a lesson from the playbook for humanitarian political strategy, we would suggest that the constructive critique of humanitarian aid cannot demand a global overhaul of aid practices. Our critique of MSF's humanitarian enterprise points to specific

instances, cases, and assemblages, to the moral and political entanglements to which they give form, to the multiple goods that are to inhere in humanitarian locations, and to specific instances where humanitarian practitioners have failed to maintain these multiple goods.

This has been our account and our critique of MSF's *humanitarian presence*.

Annexes

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List of Interviews

	Date	Position of interviewee	City	Location	Recorded (Y/N)
1	15-09-03	Ex-Program Manager for Dubai Cell		Skype	N
2	15-09-20	Project Coordinator, Network	Amman	Restaurant	Y
3	15-09-21	Medical Team Leader, Network	Amman	Coordination offices	Y
4	15-09-21	Medical Liaison Officer, Network, Jordan	Amman	Coordination offices	Y
5	15-09-30	Patient Flow Manager, Al-Mowasah	Amman	Office, Al-Mowasah Hospital	Y
6	15-10-04	Medical Liaison Officer, Network, Jordan	Amman	Coordination offices	Y
7	15-10-05	Hospital Director, Al-Mowasah	Amman	Office, Al-Mowasah Hospital	Y
8	15-10-08	Program Manager, Dubai Cell	Amman	Meeting Room, Coordination Offices	Y
9	15-10-12	OPD Doctor	Amman	Meeting Room, Al-Mowasah Hospital	Y
10	15-10-12	Orthopedic surgeon	Amman	Meeting room, Al-Mowasah Hospital	Y
11	15-10-15	Surgical Coordinator, Jordan Mission	Amman	Office, Coordination Offices	Y
12	15-10-20	Head of Mission, Jordan	Amman	Office, Coordination Offices	Y
13	15-10-22	Ward Supervisor, Al-Mowasah	Amman	Office, Al-Mowasah Hospital	Y
14	15-10-22	Focal Point, Network	Amman	Office, Al-Mowasah Hospital	N
15	15-10-26	Medical Liaison Officer, Network, Jordan	Amman	Café in central Amman	Y
16	15-10-29	Project Coordinator, Network	Amman	Office, Coordination Offices	Y
17	15-10-31	Medical Liaison Officer, Network, Gaza	Amman	Our shared MSF apartment	Y
18	15-10-30	Medical Liaison Officer, Network, Gaza	Amman	Our shared MSF apartment	Y
19	15-11-03	Maxillo-facial surgeon, al-Mowasah	Amman	Meeting room, Al-Mowasah	Y

20	15-11-04	Medical Director, Al-Mowasah	Amman	Meeting room, Al-Mowasah	Y
21	16-03-25	Ex-Head of Mission for Amman Project	Paris	His home	Y
22	16-04-07	Ex-president, director of studies, CRASH	Paris	Office, Paris HQ	Y
23	16-04-17	Surgical Coordinator	Amman	Office, Coordination offices	Y
24	16-04-18	OPD Nurse	Amman	Office, Al-Mowasah Hospital	Y
25	16-04-18	Consultant	Amman	Meeting room, Al-Mowasah Hospital	Y
26	16-04-18	Project Medical Secretary, Al-Mowasah	Amman	Meeting room, Al-Mowasah Hospital	Y
27	16-04-19	OPD Medical secretary, Al-Mowasah	Amman	Consultation room, Al-Mowasah OPD	Y
28	16-04-21	Plastic Surgeon, Al-Mowasah	Amman	Meeting room, Al-Mowasah Hospital	Y
29	17-02-13	Head of Mission, Mission France	Paris	Meeting room, Paris HQ	N
30	17-04-11	Psychologist, France Mission	Paris	Café, Bastille	Y
31	17-04-20	Training Coordinator, Epicentre	Paris	Office, Epicentre	Y
32	17-04-20	Director, Field Epidemiology Department, Epicentre	Paris	Office, Epicentre	Y
33	17-10-20	Head of Mission, Mission Malawi	Paris	Meeting Room, Paris HQ	Y
34	17-10-20	HIV Advocacy Coordinator for East Africa	Paris	Meeting room, Paris HQ	Y
35	17-10-24	Finance Manager, Cell, OCP	Paris	Office, Paris HQ	Y
36	17-11-07	Medical Doctor, Paris Project	Paris	Field Office, Pantin	Y
37	17-11-15	Translator, Mission France	Paris	Field Office, Pantin	N
38	18-01-10	Activity Supervisor, Mission France	Paris	Field office, Pantin	Y
39	18-01-10	Translator, Mission France	Paris	Field office, Pantin	Y
40	18-03-13	HR Manager, Cell, OCP	Paris	Office, HQ	Y

41	18-03-28	HIV Expert, Medical Department, OCP	Paris	Office, HQ	Y
42	18-04-17	Head Nurse, Mathare Project	Nairobi	Meeting Room, Lavender House	Y
43	18-04-19	Data Manager, Mathare Project	Nairobi	Office, Yellow House	Y
44	18-04-30	Lab Manager, DR-TB activities, Mathare Project	Nairobi	Office, Green House	Y
45	18-05-04	Call Centre Supervisor, Mathare Project	Nairobi	Meeting Room, Lavender House	Y
46	18-05-07	Activity Manager, DR-TB	Nairobi	Field Office, Mathare	Y
47	18-05-08	Data Manager	Nairobi	Office, Yellow House	Y
48	18-05-08	SGBV Activity Supervisor, Mathare Project	Nairobi	Office, Lavender House	Y
49	18-05-09	Nurse, Mathare A&E	Nairobi	Meeting Room, Lavender House	Y
50	18-05-10	Community Team	Nairobi	Meeting Room, Green House	Y
51	18-05-11	Medical Coordinator, Mission Kenya	Nairobi	Office, Coordination Offices	Y
52	18-05-11	Head of Mission, Mission Kenya	Nairobi	Office, Coordination Offices	Y
53	18-05-15	Medical Team Leader, Mathare Project	Nairobi	Office, Yellow House	Y
54	18-05-15	SGBV Psychologist	Nairobi	Office, Lavender House	Y
55	18-05-17	Project Coordinator, Mathare Project	Nairobi	Office, Yellow House	Y
56	18-05-17	Deputy Medical Coordinator, Mission Kenya	Nairobi	Office, Coordination Offices	Y
57	18-05-21	Clinical Officer, Lavender House	Nairobi	Office, Lavender House	Y
58	18-05-21	Medical Doctor, Lavender House	Nairobi	Office, Lavender House	Y
59	18-05-21	Head Nurse, Mathare Project	Nairobi	Meeting Room, Lavender House	Y
60	18-05-22	Emergency Medical Technician, Mathare Project	Nairobi	Meeting Room, Lavender House	Y
61	19-09-27	Cell Manager	Paris	Office, Paris HQ	Y

62	19-10-14	Director of Operations, OCP	Paris	Office, Paris HQ	Y

List of Observation Notebooks

NOTEBOOK	DATES	LOCATIONS, CIRCUMSTANCES
	26 September 2015 - 6 November 2015	**JORDAN**
I M2	19 March 2015 - 18 October 2015	Paris, multiple locations in central and northern Jordan
II M2	26 September 2015 - 6 October 2015	Multiple locations in central and northern Jordan
III M2	13 October 2015 - 14 October 2015	Ramtha, Jordan
IV M2	18 October 2015 - 20 October 2015	Multiple locations in central and northern Jordan
V M2	20 October 2015 - 22 October 2015	Amman and Irbid, Jordan
VI M2	22 October 2015 - 26 October 2015	Multiple locations in central and northern Jordan
VII M2	27 October 2015 - 28 October 2015	Multiple locations in central and northern Jordan
VIII M2	1 November 2015 - 3 November 2015	Al-Mowasah Hospital, Amman, Jordan
IX M2	28 October 2015 - 6 November 2015	Multiple locations in central and northern Jordan
X M2	3 November 2015	Al-Mowasah Hospital, Amman, Jordan
	28 January 2017 - 1 December 2017	**PARIS**
Carnet I	28 January 2017 - 7 March 2017	Migrant project, Paris
Carnet II	7 March 2017 - 14 March 2017	Migrant project, Paris
Carnet III	14 March 2017 - 28 March 2017	Migrant project, Paris
Carnet IV	28 March 2017 - 20 April 2017	Migrant project, Paris. Missing Maps (x2)
Carnet V	20 April 2017 - 6 October 2017	Epicentre Scientific Day, MSF General Assembly, Greece closure meeting
Carnet VI	9 May 2017 - 10 October 2017	FOOT. Kenya MAP, Cell 5.
Carnet VII	12 October 2017 - 16 October 2017	Cell 5, Headquarters, Paris
Carnet VIII	16 October 2017 - 19 October 2017	MAP Uganda, MAP Malawi, KOBO Meeting, Paris Headquarters.
Carnet IX	2 November 2017 - 15 November 2017	Migrant project, Paris
Carnet X	6 November 2017 - 24 November 2017	Cell 5, Headquarters, Paris

Carnet XI	19 October 2017 - 27 November 2017	Malawi MAP; Cell 5 Offices; Paris Headquarters.
Carnet XII	27 October 2017	Meeting, Finance and HR Managers for Cell 5
Carnet XIII	1 December 2017	Budget Commission, Cell 5, Paris Headquarters.
		KENYA
		Note: in the A&E in Kenya, many observation notes were taken directly on my portable computer, in the medical office adjacent to the Trauma Room
K1	LOST	
K2	13 April - 19 April 2018	Mathare Project and Nairobi Coordination Offices
K3	19 April - 25 April 2018	Mathare Project - Call Centre, Ambulance, and triage in practice
K4	26 April 2018 - 2 May 2018	Mathare Project and Nairobi Coordination Offices
K5	9 May 2018 - 16 May 2018	Mathare Project
K6	18 May 2018 - 23 May 2018	Mathare Project, Kenya MAP.

ABSTRACT

This dissertation is a monograph of the nongovernmental organisation (NGO) Doctors Without Borders (MSF). It is based on an ethnographic inquiry into the operations of this medical humanitarian NGO as they take place. Observing members of MSF providing healthcare to migrants in Paris and to inhabitants of a slum in Nairobi, evaluating and planning projects in their headquarters, we see them tinker together the sometimes-incompatible goals of a seemingly simple humanitarian mission: medical assistance to the vulnerable around the world. Our pragmatist approach consists in arguing that analysis of international aid must account for how humanitarians find a way to hold together the ambiguities, and even the contradictions, of this claimed mission in the ambivalent effects humanitarian aid in practice.

To this end, we ask how MSF selects those it seeks to assist around the world. Our response entails close description of the instrumentation of triage: the problematic processes of elaborating and using tools that support the reflexive choice of beneficiaries around the globe. We then make three analytical gestures, allowing us to contribute to ongoing discussions in anthropology on global assemblages, global spaces, and global health. **First**, we show how the processes of bordering, territorializing, and scaling that triage instruments support, participate in producing *humanitarian locations*: humanitarian space, the field, medical platforms, and headquarters. **Second**, analysing the ways triage instruments script for those humanitarians claim to assist, we argue that MSF gains humanitarian agency in the ways it relates to *humanitarian beneficiaries:* the tact and tactics of care, the reciprocal recognition of beneficiaries in their need and of MSF's need to help, the acceptance of responsibility for this vulnerability coupled with an attempt to transfer responsibility to public health care systems. **Third**, accounting for these instruments in terms of *humanitarian technologies of intervention*, we demonstrate how MSF makes timely interventions into governing bodies and the bodies of the governed. Together, our description of aid as it takes place and our analysis of the problems associated with *humanitarian locations, beneficiaries,* and *technologies of intervention* constitute what we call MSF's *humanitarian presence*. This *humanitarian presence* indicates the ways MSF exists, in their global physical extension, in the health care they practice, in their nongovernmental politics and their ethics of attention. This concept supports critique by indicating, first, the multiple and incompatible goods that are to inhere in humanitarian aid, and second, those specific instances when MSF has failed to do so.

KEYWORDS

Humanitarian aid, MSF, globalization, care, decision-making, triage

RÉSUMÉ

Cette thèse constitue une monographie de l'organisation non gouvernementale Médecins Sans Frontières. Son matériel de base est une enquête ethnographique menée sur les opérations de cette ONG médicale humanitaire au moment même où elles se déroulent. En observant les membres de MSF en train de proposer des soins médicaux aux migrants dormant dans les rues à Paris ou aux habitants d'un bidonville à Nairobi, ou en train d'évaluer et de planifier leurs projets depuis le siège, nous les voyons bricoler pour faire tenir ensemble les objectifs parfois incompatibles d'une mission humanitaire en apparence simple : l'assistance médicale à des personnes vulnérables à travers le monde. Notre approche pragmatiste nous invite à prendre au sérieux dans l'analyse le fait que c'est l'aide humanitaire elle-même qui doit faire tenir ensemble en situation les ambiguïtés, les ambivalences ou même les contradictions d'une telle mission, tant dans ses projets et ses actions que dans ses effets ambivalents.

Pour ce faire, nous nous sommes demandé comment procède MSF pour sélectionner celles et ceux qu'elle cherche à aider autour du monde. Pour répondre, nous avons produit une description fine de l'instrumentation du triage : les processus d'élaboration et l'usage des outils qui soutiennent le choix réflexif des bénéficiaires autour du globe. Nous proposons pour cela trois gestes analytiques, qui nous permettent de contribuer aux discussions actuelles sur la globalité en anthropologie : assemblages globaux, espaces globaux, santé globale. **D'abord**, nous montrons comment le tracé de frontières, de territoires, d'échelles que ces instruments de triage ne cessent de produire participe à la distribution de *lieux humanitaires* : l'espace humanitaire, le terrain, les plateformes médicales, le siège de MSF. **Ensuite**, en faisant porter l'analyse sur la façon dont les instruments de triage débouchent sur une mise en « scripts » ou en scénarios de ceux que les humanitaires prétendent aider, nous montrons comment MSF acquiert la capacité d'agir spécifiquement dans ses relations avec les *bénéficiaires humanitaires* : tact et tactiques du *care*, reconnaissance réciproque des bénéficiaires dans leur besoin d'aide et des humanitaires dans leur besoin d'aider, acceptabilité d'une responsabilité envers cette vulnérabilité associée dans le même temps à la tentative de transférer cette responsabilité vers des systèmes des santé publics. **Enfin**, en rendant compte de ces instruments en termes de *technologies humanitaires d'intervention*, nous mettons en évidence la façon dont MSF opère des interventions ponctuelles tant dans les organes de gouvernement que dans les corps des gouvernés. Notre description de l'aide en train de se faire et notre analyse des problèmes associés aux *lieux, aux bénéficiaires et aux technologies d'intervention humanitaires* constituent ce que nous appelons *l'aide humanitaire au présent*. Par *aide humanitaire au présent*, nous désignons les manières d'exister de MSF, son extension physique globale, les soins de santé qu'elle accomplit, sa politique non gouvernementale et son éthique de l'attention. Sur ce concept peut se soutenir une approche critique positive de l'aide humanitaire, considérant à la fois la pluralité et l'incompatibilité des bénéfices qu'elle est censée apporter, mais aussi les cas et les instances précis où MSF a échoué à les faire tenir ensemble.

MOTS CLÉS

Aide humanitaire, MSF, mondialisation, care, prise de décision, triage