Challenges in understanding and responding to crisis in urban contexts
March 2008

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Introduction

It has been widely accepted that the world theatre of conflict is changing, with not only a general decline in the number of cross border conflicts, but an increase in the number of countries emerging from full blown internal conflict to phases of *transition* or *post conflict*. In turn there appears to be an increase in the number of hybrid forms of conflict within and across state boundaries, conflict and violence perpetrated by individual or collective groups that is often not political in nature, but instead driven by economic and/or criminal gain. These are not necessarily conflicts restricted by classical territorial boundaries, or carried out by clearly defined (and identifiable) actors. As such the civilian population may no longer be stuck on the wrong side of a border, but instead exposed in ways that allow everyone to become a victim. Urban settings in particular are fast becoming less a safe haven to escape to and more a new territory of opportunity for those with power to extort. At the same time (but only in part due to conflict dynamics) there has never in the history of the known world been such large concentrations of population living in cities and towns – estimates by urban demographers observed that in 2006 roughly half of the world's population is residing in urban areas. This rapid urbanization is in turn also shaping trends in global peace and security. There are now more 'child soldiers' under the employ of urban criminal gangs worldwide than in the organized ranks of insurgent or military groups. Conflict-induced family separation produced a high number of single headed households now living in urban slums; women and children are striving to cope with this change.

The reality is we also find urban living conditions to be far more squalid, unhealthy and despairing than living conditions in conflict affected rural regions or among IDP camp settings, and access to health care where it is present is not necessarily a given. We also find (e.g. in the case of Colombia/Haiti) that conflict can continue in the urban setting in ways that parallels the rural conflict region and/or in different and less obvious or visible forms. Whether by definition we refer to a setting as post conflict (Haiti) or ongoing political/criminal conflict (Colombia) we find in fact very similar violent trends that have a significant impact on the health and wellbeing of poor urban communities. As MSF however, we find we struggle to defend and justify the need for medical humanitarian action the farther we move away from what is generally accepted as the 'battle field' as defined in our strategic plan.[1] We would argue however that there are un-met medical humanitarian needs in urban contexts that fit easily within the limits of our Health and Operations Policy ambitions.

Many organizations are coming to the realization that as the scale of 'classic' internal and cross border conflict declines; the suffering of populations as direct or indirect victims of violence does not. There is now a growing international awareness that urbanization is becoming untenable,

[1] MSF OCA Strategic Plan 2007-2010: Our aim is to respond, first and foremost, to the medical needs and suffering of people in situations of violence, abuse and deliberate neglect: we seek to save lives and alleviate suffering by addressing major morbidity and mortality in the populations we assist through the provision of direct medical aid. Continue to prioritize operations that respond to the medical needs of people in areas of active and chronic conflict, where an increase in man-made suffering and mortality is at its most intense. […] As a result, we will

- Focus on responding to the medical needs of populations affected by pervasive violence and abuse where normal mechanisms of protection fail.
- Seek to have independent and relevant humanitarian and medical interventions in systems, where severe repression creates medical need and reduces human life to mere survival, without dignity or choice.
- Act in response to natural disasters and major outbreaks of diseases, where these have a significant impact on human survival and where response capacity of other actors is inadequate.

representing in some contexts a crisis that far outweighs the impact of ongoing conflict in remaining regions of a given country. That ICRC devoted a good part of its 30th annual conference (Nov 2007) to questioning the movement's framework for action in violent urban settings is indicative of new debate among humanitarian actors coming to grips with these changing dynamics. Urban settings no longer seem to be the province of development organizations and planners alone, and perhaps even represent the *failures* of development in what are often increasingly unstable environments.

Evidence from Latin America further challenges the stereotype that poverty is the main cause of violence and shows that inequality and exclusion (neglect, unequal access to employment, education, health and physical infrastructure) intersect with poverty to *precipitate* violence. At the same time, in context of severe inequality, living conditions of the urban poor heighten the potential for conflict, crime and violence, and also the competition between those who occupy the little urban dwelling space available. As we see in Latin America it is not only countries in active conflict or recent post conflict that could fit criteria for MSF intervention according to its Strategic Plan.[2] Some of the most violent countries are in fact those with arguably no *recent* history of conflict (Brazil, Guatemala) or others (Mexico, Colombia) where the known armed conflict is not the *only* trend of violence apparent.

We are aware that people living in some urban settings are traumatized, often homeless, unprotected, lack basic services, fall under the extortion and control of gangs or more recognized armed groups, crime blossoms as does abuse, alcohol/drug dependency, violence among youth etc. etc. The functioning of health services, security forces, judicial systems, housing, and social services is oftentimes undermined, or even completely corrupted. But despite this, among MSF we still tend to shy away from evaluating the medical (humanitarian?) needs of urban populations outside the conflict zone - largely assuming that populations *should* be able to benefit from the protection and social (health) services of the local authorities. MSF frequently assumes that there are fewer boundaries that prevent access to care in urban centers, and in our desire to be impartial we identify more immediately with those people still caught up in conflict being waged elsewhere. These are assumptions that now need to be critically questioned, as does the idea that MSF will do more long term harm than short term good in an urban setting that demands order, social and structural change. How then does violence in urban settings manifest itself and result in unmet medical needs? What are the obstacles to care facing people living in these environments? What are the challenges to accessing these communities and providing medical assistance? And what do *current* experiences where MSF works in urban settings tell us about these realities, the needs of these communities, our choices and our ability to have an effective role?

One thing should also be clear. One urban setting does not necessarily mirror another, be it between countries, cities or even slums within the same city. There will be no quick fix for transitioning our experience into one 'global approach' to urban contexts, anymore than we could do the same between wars in different cultures and continents. MSF OCA does however already work in several urban contexts, (and has a history similar to most of the movement in engaging at times with various priorities such as Watsan in urban settings). This paper reviews (through questionnaire with field, workshops, debate topics, discussion etc.) five countries where MSF OCA now works in urban settings – Nigeria, Colombia, Haiti, Somalia, Papua New Guinea. This is not intended to be an exhaustive review by any means, but a start, in a limited fashion, to explore some current experience relevant to this debate.

[2] Ibidem.

General definitions of Violence, the challenges

It is only *so* useful to try to categorize a 'typology' of violence among a given location/population. However it is perhaps useful to review within our five urban settings the nature of the violence and draw from this element's that appear to be specific to this setting. Before that, a brief overview of categories of violence.

Category	Definition	Manifestation
Political	The commission of violent acts motivated by a desire, conscious or unconscious to obtain or maintain political power	Guerilla conflict, paramilitary conflict, armed conflict between political parties
Institutional	The commission of violent acts motivated by a desire, conscious of unconscious, to exercise institutional power at individual or collective level over groups and individuals	Violence perpetrated by State political institutions such as the army and police, as well as line ministries such as health and education, social cleansing by civil vigilante groups; lynching of suspected criminals by community members
Economic	The commission of violent acts motivated by a desire, conscious of unconscious, for economic gain or to obtain or maintain economic power	Street crime, carjacking, robbery/theft; drug trafficking; kidnapping; assaults including killing and rape made during economic crimes
Social	The commission of violent acts motivated by a desire, conscious of unconscious, for social gain or to obtain or maintain social power	Interpersonal violence such as spouse and child abuse; sexual assault of women and children; arguments that get out of control

Source – adapted from Moser and McIlwaine (2004) [3]

When trying to define violence, - understood as use of physical force, causing harm to others in order to impose one's wishes (and categorized as social, gender-based, economic, institutional, political, according to its motivation) – there are two-fold limitations: on one hand it is difficult to categorically distinguish forms of violence that in reality tend to overlap and interrelate into a continuum. On the other hand, focusing on physical violence gives less weight to nonphysical forms of violence such as intimidation and other forms of abuse, which may still have significant consequences on health and well being[4]. Broader definitions of violence refer to psychological harm, material deprivation and symbolic disadvantage. Most definitions recognize that violence involves the *exercise of power to legitimize the use of force for specific gains*. Issues of power and powerlessness become fundamental to understand the factors that underpin violence, who controls who? What motivates this control? What does this control depend upon? Allowing for the analysis of wider political and socioeconomic power play within which individuals interact.

The WHO definition of violence indicates: "the intentional use of physical force *or power*, threatened or actual, against oneself, another person, or against a group or a community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation".[5] This definition draws attention to the fact that violence may not always be just a physical act, but also a process that can be embedded into wider social structures. Violence can also include implicit forms such as: exploitation, exclusion, inequality and injustice.[6] In MSF we too often tend to think of these issues as something far removed from the medical needs resulting from direct acts of physical violence that we prioritize within OCA operations, and strive to address through our intervention strategies. There is more that could

[3] Moser, C., Urban Violence and Insecurity: an introductory roadmap, Environment and Urbanization, 2004;16;3

[4] Moser, C., *Reducing urban violence in developing countries*, The Brookings Institution, November 2006

[5] WHO, 2002, World report on Violence & Health

[6] "*Violence can be built into the structure of society.. showing up as unequal power and consequently as unequal life chances".* Galtung, (1969), *Violence, peace and peace research*, Journal of peace research, Vol. 6, N. 3

and should be done, and as we see in most MSF programs, the bulk of our work will not necessarily be addressing these acute consequences of violence, but often the secondary impacts.

What is the 'urban violence' we witness and respond too?

Most programs could likely identify elements of all the above-mentioned categories of violence in the conflicts where we work, however among the 5 *urban* programs reviewed the violence could be predominantly categorized as *economic* and *social*. There are also elements of political (particularly Mogadishu) and institutional (Colombia/PNG) violence, but these tend to be overshadowed compared to the impact of crime (organized or otherwise) and social and domestic violence as society fabric falls apart.[7]

Living in urban centers is not always safer than living in rural areas. Different forms of violence persist and overlap in urban contexts, and they do have an impact on people's health. Urban contexts are not immune to political conflict tactics: cleansing of youth of recruitment age, active recruitment (children), rape, terror campaigns (inc. signature killings), abduction, control of organized crime for income generation, illicit trade (involving and/or abusing urban community) all bring consequences to people's health in different ways.
In addition to being the theatre of violent events, cities also are the recipient of people forcibly displaced from the countryside, often traumatized and victims of violence, looking for refuge and safety. Besides needing medical care, these populations also put an additional strain on urban resources and available services. Somalia, Colombia and Haiti clearly demonstrate these connections, and to some extent influence why and how we have chosen our urban programs (e.g. we chose to work in urban contexts in Colombia to address the needs of those displaced by the conflict, although the programs address people and issues that go beyond that).

Criminal (economic) or social violence is often less visible to witness *directly*. Although in the case of Haiti we have had periods where we negotiated openly with armed gangs, the only thing that identifies them as belligerents is the weapon they carry. We have a very superficial perspective of the power and influence and impact they wield in their territory. In Colombia these groups are if anything more organized (organized crime is decades old) and even less visible, until a drive by shooting takes place. Our perspective is that the health consequences of such control are less severe when we don't see stoned youths brandishing guns threateningly. However, the reality as described by people living under the control of organized crime (and others) is just as severe in terms of fear, anxiety and mental health repercussions. This phenomenon of the invisibility of power/control is not uniquely urban perhaps, but is a significant challenge in this setting and it bears significant consequences for MSF in terms of program design, understanding of medical impact, security management and negotiating access.[8]

We cannot make the sweeping statement that social violence is more prevalent in urban vs. rural settings, but we certainly witness many factors in the urban settings appear to be linked in fomenting this. PTSD and mental health disorders can be associated with past violent/crisis

[7] This issue bears the question about medical consequences of violence and intervention criteria. In terms of physical trauma, the number of victims of domestic violence may be higher than victims of state repression or conflict violence. Which is more relevant for MSF: numbers of victims or typology of violence?

8 These issues are explored further in the next chapters.

events, cramped living conditions, lack of privacy, easy access to alcohol and drugs, lack of work or ability to use rural skills (subsistence living) lack of organized community or family support etc. Our services in urban settings see a proportionally higher number of people seeking care due to domestic violence than in the rural settings in the same countries.[9] Sexual violence is an underlying phenomenon that we also strive to address medically.

All urban programs find particularly relevant the issue of *access to health care*, which are often obstacles that go beyond simply the cost of services, or geographical isolation. 'Urban' access problems often bring to light issues such as fear of control of information, lack of confidentiality, systematic exploitation, abuse of power, discrimination, stigmatization etc. Corruption or extortion (to the extreme of being described as institutional violence here) is also a predominant factor in violent urban settings. We have encountered repeatedly examples where intimidation, fear and of course financial gain interfere with the provision of (state) health services or our ability to work in the urban setting (e.g. the medical doctor responsible for the implementation of the HIV program in Sincelejo, Colombia who would only make a gun like gesture to his head in response to questions from MSF as to why HIV services were not provided). [10] This we could define as institutional or even 'structural violence' (i.e. intentional use of *power* rather than physical force - very controversial in MSF), something we feel less comfortable with as a 'direct' form of violence against an individual/community, but that in reality appears to demand a lot of attention within our programs, often being the core activity when our justifications remain more closely linked to addressing outcomes of physical violence.

In addition to the consequences of violence on people's health, it should not be forgotten that people living in violent urban environments, while often deprived of medical assistance, have to cope with overlapping health hazards deriving from inadequate habitat: environment pollution, lack of clean water, inadequate and contaminated food, lack of protective shelters, lack of access to sanitary home and work environments, unsafe environments in which to move around.[11] In addition, lack of basic services, inadequate building structures, overcrowding, poverty and social exclusion, all make up for people's ill health.[12]

Besides ill health, in most slum contexts the lack of health services and basic infrastructures is also a factor contributing to exacerbate the suffering of people living there. With time, this situation tends to become chronic and even 'normalized' in the perception of those who witness this, whilst in contradiction to this we believe the deprivation and scale of need could easily be described as a humanitarian crisis.

Who do we target, how and why?

The challenge of *who* and *how* to target in an impartial way those most affected by violence in an urban setting has nixed many would be programs before they were started. The singular issue of why and how to target urban IDP's in Colombia when they lived in the same abject living conditions and suffered from much the same problematic as the urban poor around them prevented three MSFH programs from reaching implementation during the height of Colombia's most violent period of rural massacres and displacement. Now all four MSF sections are working in one way or another with urban IDP's. The questions of who is an IDP? For how many months/years does this qualify? What are the direct or more indirect outcomes of displacement upon their health? Why in an urban setting in a country where most health care is concentrated

9 This might also be due to our proximity with a larger population base.

[10] This scenario can bear resemblance to some repressive regimes, where intimidation interferes with healthcare.

[11] Stephens, C., *Threats to urban health*, International Food Policy Research Institute (IFPRI), 2000

[12] WHO Kobe Center, *A billion voices: listening and responding to health needs of slum dwellers and informal settlers in New urban Settings*, 2005.

in urban settings is it necessary to duplicate or substitute? Continue (rightly so) to challenge the logic of MSF intervention in these urban settings.

The challenge of targeting people in urban settings is not limited to IDP's vs. urban poor. With a program focused on HIV care or the reduction of maternal mortality, how can we limit or filter our assistance so it reaches those that really have no other means to access other services where user fees may be levied (but they could potentially afford). Among urban slums settings, who is the most marginalized, affected by violence or extreme in condition? With whom do we become associated within one slum vs. another, and do we have to target several locations regardless of impartiality ambitions or scale of need to safeguard security and access? When there is one ethnic group that may be more marginalized/desperate than another (such as was assumed with the Benin refugee population in the slums of Lagos, Nigeria) is it possible to target assistance primarily at them? Or will this in fact heighten *their* insecurity?

In our urban programs we also find the blurring between victims and perpetrators, civilians and combatants can appear to be even more difficult to decipher than in open conflicts. The proximity (being a neighbor) of "genuine civilians" to gangs, weapon carriers, resource providers, those trafficked by organized criminals (children, women) within the community make them even more vulnerable to becoming direct targets of violence. Some people are left with little other choice but to become part time informers, hide weapons for the gangs, cook food, carry information, and/or form family links to urban 'combatants' or criminals. An environment that doesn't allow for subsistence farming, or much chance at any other trade can leave little choice but to turn to crime, extortion, prostitution, or dependency on others the protection of those in power/control for livelihood. Many of the perpetrators of violence in Haitian or Colombian slums were once the victims of the armed conflict, many will now continue to be victims of the new urban conflicts. Perpetrators such as demobilized paramilitaries in Colombia are among those with the greatest need for mental health care (but will be rarely seen as civilians).

A common component identified in context analysis prior the opening of the projects seem to be the necessity to understand patterns of *social exclusion and discrimination* of the populations living in these urban environments. For Nigeria and Colombia the identified target population belongs to general vulnerable categories of people living with HIV/AIDS and the internally displaced. In Haiti[13], Mogadishu and Lae (PNG), the vulnerability of the target population is identified by its gender and tends to coincide with women and children, as being often more vulnerable to violence.[14] It should be noted that young men, often very vulnerable and prone to recruitment by gangs and armed groups, appear to be overlooked in most projects. Two reasons could be identified for this: concerns for security implications of treating potential fighters (made explicit in Mogadishu, certainly an issue in Colombia and Haiti) as well as a tendency to use traditional analytical tools to assess vulnerabilities. The overall vulnerability of all these groups is compounded with the lack of access to *free* health care, in contradiction to the level of abject poverty most live under.

We can summarize, that we identify with and target in our urban programs the following:

- Internally displaced persons (Colombia only)
- Those systematically excluded from health care (which could include a health care system that does not recognize and allow financial dispensation to victims of a crisis)
- Those denied health care due to the nature of their illness, and lack of services to deal with this (HIV, TB, mental health disorders)

[13] In Haiti other MSF sections do address specifically men with trauma resulting from violence, influencing OCA's choice in targeting. However MSFF and B have reported the complications of treating known gang members wanted by security forces, who demand access to MSF medical facilities to prevent them becoming safe havens for criminals.
[14] Both in terms of abuse as well as in terms of difficulties in accessing care due to violence and insecurity.

- Women and children in the general urban poor population seen to be at risk and abused by the violent environment they live in.
- Anyone where the health system is basically in collapse (e.g. Mogadishu, Rio Sucio Colombia, Iraq?)

What programs have developed? Are there any specific innovations in this setting?

The medical models of operation in our urban settings do not appear to be very different from other settings. Most are interventions based out of fixed clinic or hospital locations, with in some cases a mobile component of outreach (ANC clinics into slums for example, or health promotion activities). For most it is conditional that MSF has a MoU or partnership agreement with the MoH. Although *"MSF cannot and should never substitute the MOH" (PAP),* in Haiti we do exactly that, in the absence of good alternatives.

The presence of the MOH in urban settings can more or less be assumed (exception Mogadishu), therefore creating referral possibilities to specialized structures and the necessity for MSF to work in partnership with the MOH. This presence can nevertheless also represent a challenge where certain groups or categories of patients are not granted access to free health care to begin with and where corruption is rampant rendering referral possibilities limited. The additional challenge for MSF is represented here by the need to work "within" the system without being complicit "with" the system.[15]

Local partnerships or at least fairly elaborate networking with local authorities and other organizations (church, NGO, civil society groups etc.) is more commonplace in urban settings, and provide an opportunity to avoid a total substitution role. Our programs do seem however in fact to largely either substitute or duplicate the work of the MoH, despite their presence (exception Mogadishu). We aim to target those that cannot/will not access public health services where present, are in fact denied access to services or where the services simply do not exist.

Where certain specific services do not exist (very common in the case of mental health in general, or for example HIV care in the case of Lagos, post rape treatment in PnG) we describe our role as 'gap filling' (not substitution), the provision of medical attention being the priority, but in all cases reviewed here, with a secondary ambition (or innovation) of using our presence to demonstrate a 'model of care' or at least to be, dare we say it, catalyst for change. It is a mixed review of how successful we are in this secondary role. A good example in Colombia could be the MSFB rehabilitation program in Cali which was handed over to the MoH, whilst a frustrating example in the same country may be our attempts at bringing about real change in mental health care under the MoH in any of the urban settings where we work.

There are some other specific innovations that have emerged, e.g. the use of legal councilors and/or social workers to get through the minefields of patient access issues, to provide orientation and secure referral for secondary level care. Rape 'crisis centers' with hotline numbers (means of communication generally not being an issue in urban centers).

Strong partnerships with civil society activist groups to further common lobby objectives (Lagos being a very strong example) Links to legal departments, social security services and other agencies or centers that offer protection (legal or physical) for victims of violent acts, or those under direct threat.

[15] Not to mention double standards in quality of care between public and private sector.

Strong links to social security services have developed to refer/support cases of suspected or known child abuse, and other forms domestic violence. Inevitably we have faced and addressed quite some cases of domestic violence, which would seem to be an important and valuable experience for MSF to explore further, particularly in terms of Mental health where activities are present or planned in *all* urban settings reviewed.

Lastly in all the urban settings without exception, we have a low opportunity cost. The medical output is generally very high compared to investment required. Reaching patients and even following up with the same patients over time allows for growth and innovation in our medical approach.

What are the challenges to programming?

As mentioned beforehand, managing the scale and volume (extremely high demand because of population density in urban settings) of potential beneficiaries and being able to identify and appropriately target those most affected within a wider population base seems to be a significant challenge.

The security concerns linked to the proximity (read exposure) with the target population and the higher unpredictability and complexity of violence presents real challenges in a) understanding these dynamics, b) interpreting the risks they represent to those we assist and ourselves, and c) how to limit these risks whilst securing reasonable access for our target population.

Violence tends to be more difficult to predict than in other violent settings – the blurring of the lines between civilians and armed actors adds increasing complexity as well as the lack of clear frontlines and invisibility of the 'conflict'. In addition, the multiplicity of armed actors (in all their forms) can make negotiating access and obtaining security guarantees difficult (although this is not a uniquely urban problem of course)

Identifying and separating issues that we feel as MSF impact the wellbeing of a population in *any* resource poor urban setting (such as poor sanitary conditions, insufficient health care, higher demand on social services, illegal housing, lack of planning, roads etc.) from issues that can be linked (more directly) to physical violence and abusive use of power is a real challenge. How to target our assistance to meet *these* needs, and at the same time avoid 'project creep' into areas where we also see real needs but will become too removed from our chosen 'humanitarian' role generates endless debate. In addition, being able to measure the impact of certain of such projects might require different analytical and qualitative tools, not usually used in more traditional interventions.

It has been argued that, given their specificity, such projects are at times in need of human resources with different profiles with specific skills and specialties that we do not usually employ in emergency settings (e.g. toxicologists for projects that address drug abuse). It is suggested that the nature of some urban projects also has implications for the length of stay of expatriates, and it is considered that in order to have a significant impact a longer-term presence is needed.

Some projects identified practical issues such as waste disposal, incineration, water supply and sanitation as being particularly challenging in projects urban settings due to actual structural limitations such as physical space, illegality of community settings, high and poorly population density in such contexts etc.[16] This has been explored in past urban intervention approaches which have had a tendency to focus on these issues to the cost of direct medical action.

[16] See also Mariken Gaanderse, "Challenges in Urban slums", AZG, 1998

Establishing exit criteria or deciding when to stop or close a project in an urban setting is particularly challenging. For most of the projects (with the exception of Mogadishu) the exit strategy is linked to an improvement of the health care provision by the MOH (or to a certain extent the possibility to hand-over the project to other capable actors) something that depends on external factors that are beyond the control of MSF (although not beyond our ability to at least influence).

It is worth noting that no project mentions the improvement of the overall urban situation as criteria for reducing activities. It seems that context improvement (read: reduction of violence or vulnerability) is not expected and that a longer-term approach has to be foreseen. i.e. we are working in areas with a problematic of not only economic, social and institutional violence, but all these trends are chronic in nature.

Conclusions…

MSF response to the medical consequences of violence in urban settings should – as obvious as it may seem – be based on an analysis of the consequences of violence on people's health and people's capacity to access to health care. This does not necessarily require a rigorous understanding of the local dynamics of violence in the assessment phase, but will be essential to understand and interpret into program strategy as an intervention develops. I.e. we need to focus on the health situation of the population to justify and determine an intervention and not the violence itself.

When developing an understanding of the nature and consequences of the violent environment, it is essential to interpret and understand not only the impact of physical confrontations, but also the impact of psychological and 'institutional' (for want of a better definition - the impact of abusive use of power) violence on health. Therefore analysis *should* take into account the direct as well as *indirect* consequences of living in a violent setting, (such as social exclusion, neglect, discrimination, increased domestic violence, child abuse, substance/alcohol abuse, sexual abuse resulting from criminal setting etc.). This may not be where we chose our medical role lies as MSF, but this is all too often discarded as simply the outcomes of living in poverty, and therefore beyond the scope of attention.

It is essential to clearly define our target population in order to be able to cope with the inevitably high demand on our free services in a densely populated environment. All our urban interventions face this challenge, and different approaches developed have met with some success in coping with this challenge.

In most settings we need to accept we will be either substituting or filling gaps in health services that are otherwise available, if not directly accessible to the affected population. Therefore In order to have a direct and beneficial medical role as MSF it is essential to define the scope but also limits of interaction and partnership with health authorities and civil society groups. It is not our role to become a service provider focused *only* on building a bridge between a population and their access to other available services (e.g. referral can be an important & essential program component, but not the extent of the program itself)

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The complexity of these contexts do not make them necessarily *more* challenging to manage than a non-urban setting, but there are unique conflict dynamics that have potential security implications for MSF and those we intend to assist. MSF works in proximity with the population in an environment where the lines between combatants and civilians are blurred, where frontlines are not clearly defined, where violence can be a largely an invisible phenomenon to the outsider

making it difficult to predict and avoid, and where those charged to protect/provide security (police) are often one of the perpetrators themselves.

Experience shows us that accessing and developing programs in urban settings can take a lot of time and effort to achieve. Approaches often need to be cautious and step-by-step, requiring investment of time and resources before we realize the outcomes that justify such a program. Likewise exit strategies are often frustratingly difficult to define or even develop over time, given the often-chronic nature of the problematic encountered in an urban setting. Although there is already an organizational understanding that this should not deter us from responding to needs in these settings it is important that this comes with the commitment of the necessary time and resources.

Relevant and necessary programs can be developed and justified with a significant focus on the indirect health issues, (in fact almost all our programs *have*) as long as this is not to the exclusion of the treatment of direct consequences of violence.