

Health and Human Rights 4

Violations of human rights: health practitioners as witnesses

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For humanitarian health-care practitioners bearing witness to violations of human dignity has become synonymous with denunciations, human rights advocacy, or lobbying for political change. A strict reliance on legal interpretations of humanitarianism and human rights is inadequate for fully understanding the problems inherent in political change. With examples from the HIV/AIDS epidemic in the USA, the Rwandan genocide, and physician-led political activism in Nepal, we describe three cases in which health practitioners bearing witness to humanitarian and human-rights issues have had imperfect outcomes. However these acts of bearing witness have been central to the promotion of humanitarianism and human rights, to the pursuit of justice that they have inevitably and implicitly endorsed, and thus to the politics that have or might yet address these issues. Despite the imperfections, bearing witness, having first-hand knowledge of humanitarian and human-rights principles and their limitations, and systematically collecting evidence of abuse, can be instrumental in tackling the forces that constrain the realisation of human health and dignity.

Introduction

The humanitarian community's longstanding principles of neutrality and impartiality have been challenged by a host of developments since the 1990s—including an often open disregard for international law by war criminals, direct targeting of civilians and aid workers, the use of foreign aid to fuel conflicts, and the emergence of pandemics and epidemics with unprecedented rates of transmission.¹ Organisations with interests in humanitarianism and human rights historically sought to reduce human suffering and save lives, and took a studiously apolitical stance. Lately, however, non-governmental organisations have been challenged by both their constituents and their benefactors to support or condemn government interventions and at times, have acquiesced in, and therefore implicitly accepted, military intervention.

Such a position would have been quite inconceivable a couple of decades ago. With case examples from the HIV/AIDS epidemic in the USA, genocide in Rwanda, and the role of health professionals witnessing human rights abuses in Nepal, we discuss the shift in humanitarian and human rights ideology, specifically the movement away from neutrality towards an activist approach. We also discuss the responsibility of medical practitioners to document and bear witness to violations of human rights, and to intervene to alleviate suffering if possible. We also assess the roles of individual organisations, bearing in mind that any organisation is the sum of its participants, and that its emerging philosophies represent the beliefs of the individuals involved with these groups, or the voice of a dominant few that might or might not have great experience and knowledge.

Historical institutional perspectives

Many people understand that the inherent monopoly on the power of the state needs a method of monitoring governments to prevent them lapsing into tyranny.

Effective monitoring mechanisms must, by their very nature, be independent of the state. Modern non-governmental organisations tend to follow one of two main models in their relations with the governments that they monitor and their role as witnesses to human rights' abuses.

First, is what we will call the state-reportage model, in which groups such as the International Committee of the Red Cross and Red Crescent Societies (ICRC), use their influence within the corridors of power and mainly report directly to government officials. This strategy places the onus on the government officials to react to the reports and ensures that ICRC can continue their humanitarian efforts within the country. However, government officials can choose to ignore these reports and then the option for ICRC is to make the reports public. This action also threatens their perceived neutrality, and yet is possible because of their independent status, their access to vulnerable populations and can damage their relations with the government. Examples of such indifference to ICRC reports include those about abuses at the US military prison at Guantanamo Bay, Cuba and the prison Abu Ghraib in Iraq that were provided repeatedly to US officials, without any remedial action being taken by the US government.²

By contrast with the state-reportage model, what we will call the wide-dissemination model, in which organisations, such as Amnesty International and Human Rights Watch, believe that accountability extends beyond the closed doors of governments and seek to disseminate information widely about countries' human-rights behaviours to a worldwide audience. This strategy is based on the belief that the power of the state can be limited by providing accurate information to its citizens and the worldwide community. Authoritarian regimes, in addition to several democracies, have been systematically embarrassed in the mass media as a result of evidence brought to light by these organisations. The

result of these tactics is often an antagonistic relationship between these organisations and the states they monitor, and these groups often need to sacrifice a degree of mobility for absolute autonomy, and therefore often rely on a network of confidential informants and unpaid volunteers.

Médecins Sans Frontières works in a hybrid of both models; it delivers aid and bears witness. Originally this organisation was committed equally to direct humanitarian assistance and to bearing witness when human rights or humanitarian principles are violated. In practice, Médecins Sans Frontières encounters both the difficulties experienced by state-reportage groups such as ICRC and organisations that use the wide-dissemination approach. They seek to meet humanitarian needs and to live in such dilemmas rather than always to solve them. Bearing witness is central to the humanitarian cause in that it shows the reality of human suffering at the hands of states violating the rules of war or because of state policies (eg, intellectual property issues affecting drug access, and health worker shortages) that contribute to suffering.

However, for Médecins Sans Frontières, bearing witness is not a priority, but becomes imperative if no other alternative is available. In the present crisis zone in Darfur, Sudan, they chose to break their silence over the systematic rape of clinic attendees by government forces. In a report in May, 2005, Médecins Sans Frontières described the number of rape victims attending their clinics in Darfur and extrapolated these findings to the general Darfur area.³ As a consequence of disseminating this information, Paul Foreman, Médecins Sans Frontières' head-of-mission for Darfur was arrested by Sudanese police and charged with crimes against the state.⁴ Médecins Sans Frontières made a difficult decision to disseminate this information, even though their delivery of care might be jeopardised, and indeed a consequence of this decision has been a reduced presence in the Darfur region. Yet, this report was the only available systematic collection of information about rape, although the use of rape as a weapon in the region was the subject of much speculation. The decision to release this information, and its consequences, were a direct response to the challenges presented by the issues of contemporary crimes against humanity including ethnic cleansing.

Each of these approaches has strengths and limitations. Human Rights Watch and Amnesty International have been criticised for supporting mainly civil and political rights without giving pragmatic aid in the form of health or economic services.⁵ The approach of ICRC, is to deliver aid while avoiding publicly criticising the states in which it operates, so they can continue to provide pragmatic aid. Intuitively, one might think that having direct access to decisionmakers would benefit the goals of the organisation; but, in reality we see time and time again organisations lauded by their host countries as long as their objectives do not interfere

with those of the host. As soon as the conformity lapses, so too does all the goodwill accumulated over time—as was seen with Médecins Sans Frontières in Sudan. Neither of these strategies can force changes in state policy for the benefit of its people.

Dominant philosophical paradigms often seem so immovable that they are like the very air we breathe, they surround us yet for the most part we are unaware of their existence, or at best simply take them for granted. Only a massive shift in the perception of an issue or discipline can compel us to see these matters in a new light, and recognise our unconscious biases. The emergence of three such threats to human rights—pandemics such as that of HIV/AIDS, genocide and crimes against humanity as seen in Rwanda and Darfur, and gross violations of human rights and intimidation of caregivers—might yet force such a necessary shift in thinking by the humanitarian and medical community. In the following section, we bear witness to the violations of human rights and humanitarian law that we have encountered as medical workers.

Chris Beyrer, New York City, USA, 1986

For people who witnessed and survived the early years of HIV/AIDS in the USA, the unconscionable reluctance of the Reagan administration to respond to the unfolding epidemic remains a source of anger, pain, and grief.⁶ In New York City, the HIV prevalence among homosexual and bisexual men was roughly 50% by the time the first HIV tests became available in 1985. Half of us.

In 1986, I was a third-year medical student at the State University of New York Downstate Medical Center in East Flatbush, Brooklyn. Our clinical training was based at Kings County Hospital, the public hospital of last resort for the people of Brooklyn, and the largest in the city. This was a difficult time to be studying medicine. Needle sticks were terrifying, the wards at Downstate were overflowing with gravely ill and dying AIDS patients, the old tuberculosis ward had reopened and was past capacity, and all we could offer was treatment for opportunistic infections—our patients' AIDS progressed, essentially unaffected by our interventions. At that time, East Flatbush was the largest Haitian community outside Haiti, and was desperately poor. The fiscal crisis of New York City had brutal effects on the public hospital system, but these effects were felt most acutely, as always, by poor and minority communities in the outer boroughs—Kings County was short of everything from soap and toilet paper, to medical supplies and support staff. Short of everything but patients.

The challenges of trying to learn medicine at a centre of the New York AIDS epidemic were shared by all my classmates, but a special poignancy was felt by the gay men among us—since we knew we had a one in two chance of becoming one of the febrile, coughing young men we admitted night after night. Our professors and

residents were generally respectful, but morning rounds would be laced with phrases like “risk factor—homosexual”. We were doctors and they were patients, and the patients were the homosexuals—not the medical staff—the presumption was that we were all straight and had nothing to fear. And then in that autumn of 1986, my lover starting having night sweats, weight loss, fevers, and a persistent cough. I surreptitiously palpated his lymph nodes—yes, greatly enlarged. He was never really well again. And for the next 5 years, as I finished medical school, internship, and residency, we lived as a discordant couple, lived with AIDS, and lost, as so many other gay men did, friend after friend.

Although the personal difficulties we faced were large and real, the toughest challenges for us were those related to access to health care and to benefits, issues that still haunt same-sex couples in countless places. My partner was an actor, and had no health insurance. I was a resident doctor when he was most ill, and the training programme that insured me and the other physicians in-training had family benefits packages, but these packages did not cover same-sex couples. He could not be covered by my benefits, and I, in turn, could take no “family” leave time to care for him. Indeed, my managers insisted that I make up all the time (about 3 weeks) that I took off when he was dying, and the days of the funeral and memorial services. Our largest problem was that he did qualify for Medicaid (after we spent all of our savings on his first long hospitalisation) but to keep those benefits he had to stay registered in the state in which he became sick (New York), and not the state in which we lived during my training (Maryland). Every illness meant a long drive across three states, usually in the middle of night, to get an emergency room in New York for treatment. Our lives changed substantially for the better when HIV/AIDS was included in the Americans With Disabilities Act,⁷ and people with AIDS became eligible for disability benefits.

As a junior physician treating AIDS patients while living with my lover through the last tough stages of the disease, the roles of witness, partner, caregiver, and physician blurred. Our last challenge was an AIDS-related malignancy. When we finally got into the AIDS ward at a wonderful hospital in New York City, my partner’s physician recognised my dilemma and, for the first time in 5 years of dealing with health-care providers, addressed it openly. He pulled me aside once we were clearly out of clinical options, and said: “Let me be the doctor here. You just be his lover.”

Although physicians have some training in compassionate care, and learn quickly that a patient’s social and family supports are essential for coping with their disease—to understand, to know how unjust and dysfunctional the US health-care system can be is difficult until you experience it. More than a decade after our struggle, the University Hospital where I trained implemented domestic-partner benefits for same-sex couples. With that simple act, the huge struggles that we went through by not having those benefits were stopped with a signature. Rights such as domestic-partner benefits remain rare in of the rest of the world, and are threatened increasingly in the USA. Access to care remains such a fundamental right—and its denial is one of the most agonising insults to dignity one can experience.

James Orbinski, Kigali, Rwanda, 1994

I was Head of Mission for Médecins Sans Frontières in Kigali, Rwanda in the last weeks of the genocide in 1994. This story could have taken place in Kosovo, Bosnia, East Timor, Chechnya, Sri Lanka, Darfur, Burma, Uganda, or any number of other places where human dignity is assaulted daily by criminal acts in war.

Rwanda’s genocide was the first in which the international community had the political freedom, because of the end of the cold war, to act to prevent and stop the killing. Yet as the world watched the genocide on television, the UN Security Council equivocated on its responsibility, and states with influence in the region chose to abstain from assisting victims. The genocide was mostly done before the launch of the French military’s Operation Turquoise, which created a safe-zone covering a fifth of the country. Acts of war and revenge killings followed in Rwanda and in neighbouring Zaire in 1996 and 1997, and war engulfed the region, in what some commentators have called Africa’s World War, until 2003.⁸

One night in Kigali during the genocide, after many long hours of surgery, from the hospital balcony we watched packs of dogs roaming the streets. They were well fed with the taste of human flesh, and wild. They were fighting with each other over the remains of a corpse that lay in the street, and threatening to attack a man who had ventured outside of the hospital fence in search of firewood. Later that night, among the thousands of people we either treated or gave shelter to at the

The printed journal
includes an image merely
for illustration

hospital, a little girl aged about nine years told me through a translator how she had escaped murder at the hands of the Interahamwe killing squads. She told me: "My mother hid me in the latrine. I saw through the hole. I watched them hit her with machetes. I watched my mother's arm fall into my fathers' blood on the floor, and I cried without noise in the toilet." During that time, around Rwanda, Tutsis, and moderate Hutus were being butchered in a systematic and deliberate manner. That is genocide.

Some people, very powerful people—people who controlled the army, the economy, and the government, decided that a group of people were no longer allowed to exist. These powerful people used the apparatus of the state to achieve their aims. They were more effective and far more efficient than Pol Pot, or even the Nazis. People were killed in their homes, or after being assembled in churches, schools, and hospitals, or taken by bus or marched to mass graves where they were not shot, but had their hands and feet cut off—to bleed to death, unable to climb out of the graves. People often begged, even paid, to have their children shot, rather than for them to suffer this particular cruelty. Between 500 000 and 800 000 individuals were murdered in 14 weeks.

This period was terrible—in the truest sense of the word, it excited terror—an extreme human fear that I could literally feel in the trembling hands and quivering lips of the people I met in the city who were in hiding, or among some of the 6000 people who lived in the hallways and stairwells of the hospital that Médecins Sans Frontières reopened in Kigali at that time. The people of Kigali were now the living dead. Their trembling revealed not simply their fear of pain, or physical trauma, but worse. It revealed that they knew deeply, and well beyond what mere words can ever describe, that they were truly alone, and they knew the malevolence and the sheer calculated cruelty of not only the killers, but also of the policies of nations such as France, the USA, and the UK.

These states pursued their foreign policies—knowingly—through genocide. They themselves did not hold the machetes, did not rape women, and did not sever the hands and feet of children. But they are culpable. They are guilty of not only being silent bystanders as were many other nations, and they are guilty not only of acquiescence, but they are also guilty of complicity. France armed and trained the genocidal army, and all three countries obstructed, and denied the political and material means to support the UN Assistance Mission for Rwanda. Theirs is a complicity that is revealed by the remark of François Mitterrand, then president of France, who said to an aide in the summer of 1994: "In such countries, genocide is not too important..."⁹

As doctors, we could not stop the genocide, but we refused to remain silent. We were witnesses, and we spoke out to the world about the horror of genocide as it was happening. Unlike the little girl in the toilet, we had a voice and could not watch in silence. Nor could we turn

away in acquiescence, or become complicit by reducing our presence to the simple silent technical medicine of suturing the wounds of deliberate savagery. In Rwanda, we demanded a military intervention to stop the genocide. Why? Because humanitarianism cannot end war, create peace, or clear consciences of the politically indifferent. It is a human response to political failure—an immediate, short-term act that cannot absolve political responsibility for public security either nationally or internationally. Respect for both the living and the dead necessitates that we demand international intervention and local accountability in cases of mass human rights abuses, and refuse to accept otherwise.

Sonal Singh, Nepal, 2006

The Himalayan kingdom of Nepal has been undergoing rapid and tumultuous political change in the past decade. The political struggle has been accompanied by a violent insurgency, in which nearly 20 000 lives have been lost, 200 000 people have been internally displaced, and an estimated 2 million people have migrated to India.¹⁰

The present conflict brought widespread health and human rights abuses, many directly affecting children.¹¹ Health workers including doctors have borne witness to this historical transformation in Nepal, and have endeavoured to ensure health as a human right in the overall macroeconomic and political picture.¹² The activities of the 1990 revolution that ushered in multiparty democracy in Nepal were sparked by a group of dedicated health professionals.¹³ Health providers in Nepal have shown the power of, and dangers faced by, witnesses of health and human rights violations.

Although health-care facilities had not been directly targeted by insurgents, services housed in government buildings were targeted, such as Village Development Committee offices.¹⁴ Several community-health centres were destroyed and several health workers lost their lives in the conflict.¹⁵ Health workers also reported intimidation, harassment, extortion, and threats by insurgents.¹⁵ They were also threatened by the Nepalese Government for treating victims of the violence. In November, 2001, the Nepalese Ministry of Health issued a directive that doctors would be liable to government action if they treated victims of the violence without first obtaining permission from the security forces.¹⁶ This order created a dilemma for health professionals in Nepal;¹⁷ some doctors continued to document human rights abuses and torture by both sides. For taking this stance they were supported by the Nepal Medical Association and other physician's advocacy groups around the world including Physicians for Human Rights.

In great political change in April, 2006, the autocratic regime of King Gyanendra was ousted and replaced with a representative government; the earlier revolution in 1990 had limited some of the powers of the monarchy. This change happened in response to widespread protests around the country, which disrupted the fragile



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Nepalese protesters march against the autocratic regime of King Gyanendra

health-care infrastructure.¹⁸ Doctors and other members of civil society including lawyers, journalists, engineers, professors, teachers, and business people, were at the forefront of this movement for the restoration of parliament, and as in the earlier conflict, health professionals were threatened because they treated people injured during the protests.¹⁹ The Nepal Medical Association and the Nepal Nursing Association, Nepal Paramedic Association, and Nepal Ayurvedic Doctors' Association called for treatment of victims and health professionals responded promptly in providing this care. The Tribhuvan University Teaching Hospital, Kathmandu Model Hospital, Binayak Hospital, and many other hospitals in Kathmandu provided treatment to the victims. Health professionals associated with Physicians for Social Responsibility in Nepal, the Nepali affiliate of International Physicians for the Prevention of Nuclear War, and several other health workers throughout the country who were not affiliated with any organisation participated in the movement for the restoration of peace and democratic rights in Nepal.

Earlier that month, on April 8, 2006, the government of Nepal detained seven physicians for peacefully protesting the autocratic actions of the Nepali regime and defying an imposed curfew. Dr Mathura Prasad Shrestha, the president of Physicians for Social Responsibility Nepal had been imprisoned for the previous 2 months on frivolous charges. On April 10, 2006, 20 medical students

were arrested during a peaceful demonstration. Later that night about 30 armed police, backed by the Royal Nepalese Army, entered the hostel of the main medical institution in Nepal, the Tribhuvan Institute Teaching Hospital, and tortured and terrorised 20 medical students and a doctor. On receiving this news I immediately contacted my colleagues in different parts of the world and apprised them of the developments in Nepal. The outpouring of support for our Nepalese colleagues in distress was instantaneous. In an expression of solidarity more than 1400 physicians from more than 50 countries signed our online petition demanding the immediate release of our imprisoned colleagues.²⁰ However, a few of my Nepalese colleagues expressed serious reservations about the role of these Nepalese doctors in the human rights movement. They felt that the imprisoned doctors had overstepped their boundaries and lost their scientific neutrality.

The doctors who took part in the protests for democracy used human-rights arguments to justify their participation as necessary for the eradication of poverty and repression. Many physician leaders have been at the forefront of this ongoing political transformation in Nepal. The Maoist rebels and the political parties drafted a historic new Nepalese constitution in response to the mass uprising against the monarchy. The new constitution was based on equality, and enshrined the right to health as a fundamental human right. Although the practical realisation of these rights for millions of Nepalese people is far in the future, this gesture might be the fruits of the constant labour of health professionals in the human-rights movement in Nepal.

One might question the role of physicians in a political movement, but can health professionals in a poor, undemocratic country like Nepal avoid politics? Can one simply treat illness without taking into account the social context in which it occurs? These are questions that need to be tackled by physicians around the world wherever humanitarianism is needed. The success of the revolution in Nepal poses a dilemma far beyond that of Nepal. As Vincanne Adams¹³ questioned: "Can medicine be politicised and still be an objective science?"

I had witnessed a great deal of the Maoist insurgency unfold in Nepal. Though once famous for its mountains, Nepal had gained worldwide recognition because of people disappearing. I had witnessed and painfully documented both gross violations of human rights (such as torture of women, children, and marginalised people) and subtle erosion of human dignity (poor people unable to bury their dead).¹⁰⁻¹³ A few months later, one of my colleagues who had been freed reminded me that the gesture of solidarity shown by doctors from around the world had kept his spirits, and those of his colleagues, high even during the most challenging times. Although the act of witnessing seemed distant and aloof, and paled by comparison with the personal sacrifices that these doctors and most ordinary Nepalese made in these

turbulent times. However, witnessing and sharing these historic events in Nepal revealed what solidarity meant to both doctors in need and their patients when health professionals across the globe could find common cause with their colleagues and fellow human beings in a far-away land.

What does it mean to bear witness?

The health-care provider acting as a witness serves the patient first, not a political project, and in doing so, honours the dignity of all people, and calls on others to do the same. In this one goal, the actions of humanitarians are apolitical, that is, they do not take political sides in the conflict, and they always represent and advocate for the victims. And yet, in the call to others, the potential effects of bearing witness become or could become political because they demand that the methods of the political projects are changed to avoid further affronts to the victim. The potential political effects of humanitarian action lie in this dialectic, not in the sentiment felt by the humanitarian provider. The humanitarian health worker can be seen as an outsider to both medicine as a purely technical skill, and to society as a political project. They are probably committed to freedom, both their own freedom and that of their patients whose freedom is encumbered by preventable unnecessary suffering. And the health worker who both witnesses and experiences human rights violations becomes an outsider to medicine as a purely technical pursuit, because they can see the role that health providers can have in instigating change for the better.

We have few epidemiological instruments to measure the extent of human-rights' violations of individuals or of communities.²¹ The standard hierarchy of evidence, which places randomised trials and systematic reviews at the top, does not apply in this context. The patients' narrative might be given most importance in sudden widespread violations of human rights.²¹ Narrative reveals the sense, the sentimental feeling, and the humanity of the experience. First-person narrative from the victims and perpetrators can reveal the processes of life—the humane and the inhumane—and these stories, in combination with justice, can invite reconciliation and contribute to political change.

Health researchers often feel that they have little to contribute to humanitarian crises, because the immediate needs of affected populations seem to relate to trauma or neglected clinical programmes. However, researchers and clinicians also have skills that advance the practice of humanitarianism and human rights. The Iraq mortality studies,²² responses to the Asian tsunami in 2004,²³ and documentation of systematic torture of refugees²⁴ are examples of humanitarian crises in which researchers have documented the state of health and human rights by scientific methods. Funding for health research related to human rights and humanitarian crises is not always available. States might not be interested in providing

support to neglected populations. This attitude, however, should not be a barrier to research. The Cochrane Collaboration is an example of how largely unfunded research can have an effect on health and international policy.²⁵ Appropriate systematic review techniques can overcome the criticisms of some states about the inconsistencies of fact-finding missions and reports by non-governmental organisations, and provide information about the state of human rights within certain populations.²⁶

Health practitioners are frequently among the first witnesses to both subtle and gross humanitarian and violations of human rights. Inadequate knowledge of principles of human rights can contribute to inability or unwillingness to bear witness in some repressive settings, and physician tolerance and participation in human rights abuses in others. Some people have advocated for mechanisms to hold health-workers personally responsible if they engage in human-rights' violations.²⁷ Health workers should be held accountable to the same legal standards as other people, but bearing witness is a further responsibility, and has risks in politically ambiguous places.

Health practitioners around the world, in places where human rights are routinely violated or human dignity is eroded subtly, might relate to our testimonies. Our responsibility as human beings and as health professionals, whether physicians, nurses, logisticians or researchers, is to bear witness honestly to the reality of inhumanity, and to speak out against the moral dearth of political inaction or complicity. What is good or right has no moral neutrality when one is confronted with attempted or actual genocide, wilful ignorance of public-health threats, or the intimidation of caregivers. Speaking out might not definitely save lives, but silence certainly kills. Silence kills today, and it will kill tomorrow. Our testimonials should encourage health professionals to bear witness, and encourage others to stand in solidarity with them. Knowledge of human rights principals, documentation and bearing witness can be the first step in addressing the social, political, and economic forces that constrain human dignity.

Conflict of interest statement

We declare that we have no conflict of interest.

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