Control of Aid in Syria:
How the Assad Regime hijacked the UN-led Humanitarian Response to the Syrian Crisis

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Background

Syria, historically described as the cradle of civilization, is now better known for the armed conflict characterized by Assad's atrocities driving the mass exodus of refugees and creating the world's largest humanitarian crisis.

In its eighth year, few remember the origins of the violence, when the Syrian government met the mass demonstrations protesting for basic human rights with armed violence, which even included arrest and torture of children responsible for anti-Assad graffiti. The brutal crackdown extended to medical personnel who treated civilians shot by Assad's armed forces, in violation of government policy. The first doctor and ambulance driver were killed on March 22, 2011.

Sanctions and International Aid

In May 2011 the first sanctions were imposed by the US government and European Union – travel bans and asset freezes of those in the military and intelligence forces deemed responsible for this violent repression. Since then, as Assad's use armed force expanded, economic sanctions were imposed and the list of 'Specially Designated Individuals' extended to include President Bashar al-Assad and First Lady Asmi al-Assad, senior ministers, heads of the security apparatus, businessmen and entities funding Assad's military and intelligence forces. Other countries joined, imposing bilateral sanctions.

Seven years on, the international campaign of targeted sanctions, strengthened and lengthened after the most egregious violations of IHL is now the most comprehensive effort to date. Other than diplomatic efforts to broker ceasefires, sanctions are the only viable alternative to military force for states attempting to put pressure on other states committing systematic abuse human rights abuses or violate the laws of war designed to limit the impact of war on civilians

The UN-led humanitarian response begun in 2012, to date costing donors more than US$ 12 billion. (This excludes the cost of the regional response and the price paid by the EU to Turkey to keep refugees there). This massive multibillion dollar effort has been unable to access millions of civilians inside Syria, nor have its advocacy efforts been able to protect civilians or mitigate the suffering of those in greatest need've[i] \
The US, the EU, and the UK Treasury - the most important regulatory bodies imposing sanctions – are also the top three funders of the aid response.

In Syria, the failure of targeted economic sanctions to curb Assad's systematic crimes against humanity is evident in Assad's ongoing crimes against humanity, most recently in chemical attack on civilians in Duma, 10 miles from Damascus, in April. Children are the most vulnerable to the effects of war, visible in the in the obscene suffering caused by Assad's chemical weapons, mostly

invisible in the starvation caused by Assad's illegal use of siege warfare against more than one million civilians living in opposition-held areas.
the broad sanctions imposed on Iraq after the Gulf war are remembered for limited efficacy and for increasing the burden on civilians. The same questions should now be applied to Syria's targeted sanctions.

While the impact of economic sanctions is offset to some degree by the financial support from Russia, China and Iran; the role of the massive UN-led multi-billion-dollar relief effort in undermining sanctions must be examined, particularly in light of

- the increasing cost of the Damascus-based relief effort
- the assertion of UN agencies that their failure to reach only 50% of the millions in need is a result of lack of funds and resources,
- future costs to donor governments posed by the reconstruction of Syria's destroyed healthcare system and public infrastructure destroyed by Assad's war-crime strategy.

Public Health Catastrophe

The prevailing and popular narrative that the main impact of the sanctions is to hurt the humanitarian response and claims by the Assad regime that the public health crisis is the result of the sanctions are especially important to review. The public health catastrophe is evident in the unprecedented outbreaks of polio and radical fall in life expectancy.

- Wild polio, eliminated in 1995 in Syria in reappeared in 2013, and spread to Iraq. It was brought under control by the efforts of the cross-border vaccination campaigns from Turkey by the Polio Control Task Force.
- Vaccine derived polio, a reflection of the vulnerability and widespread vaccination failure, appeared in June 2017, and is ongoing.
- Life expectancy has dropped from 71 years to 55, a radical fall that puts Syria behind Libya, Somalia, Sudan, Democratic Republic Congo – even Haiti's babies born today have a better chance of reaching 60.

Effective Aid in Conflict Zones

- The imperative for unobstructed humanitarian aid during armed conflicts is well established. The importance of allowing doctors to treat sick and wounded combatants led to the creation of the International Committee of the Red Cross (ICRC) in 1863 and drove the development of international humanitarian law.
- Delivery of effective aid in war zones demands adherence to the four key humanitarian principles laid out by the International Federation of Red Cross and Red Crescent Societies in 1965. The first two, humanity (alleviating suffering) and impartiality (prioritizing those in greatest need), are ethical principles that make the difference between doling out charity and providing humanitarian relief. The second two, neutrality (not taking sides) and independence (from the government), are pragmatic principles for operating in conflict settings.

- In combination with international humanitarian law governing the conduct of warring parties, and which affirms the right to give and receive assistance, the four principles generate the humanitarian space required to operate in war zones.
- Providing humanitarian relief in Syria's war is particular difficult, since getting aid to those in greatest need contradicts the government's military strategy of attacking civilians in opposition-held areas with the goal of maximizing civilian suffering, and the government denies humanitarian workers access to suffering populations.

Control of International Aid by Syrian Government

On top of this, the UN-led aid is tightly controlled by Assad regime through a combination of asserting sovereignty and control of humanitarian access. This undermines the effect of the sanctions and provides new economic opportunities to the Assad regime to profit from violence.

The government's control of the international aid effort reflects:

- An authoritarian state with a long history of repression and violence (the US designated Syria as a state sponsor of terrorism in 1978).
- The effective security apparatus behind the survival of the Assad regime, since Hafez-al Assad seized power through military force in 1969, purges of political opponents and ruthless suppression of civil society relies on military and intelligence forces headed by Assad's extended family, friends, and members of his community and business allies.
- The control of civil society by a combination of intelligence forces and the Ministry of Social Affairs and Labor.
- The Syrian Arab Red Crescent (SARC), the official government partner through which all UN and international agencies must work, is a central organization in this national policy.
- The restrictions and control on the presence and operations of international aid agencies

Sovereignty or Impartial Delivery of Humanitarian Aid?

UN OCHA, the Office for Coordination of Humanitarian Affairs, is responsible for coordinating the international aid effort.Although OCHA, UNHCR and other UN agencies involved in emergency response are mandated to deliver aid according to the principles of humanity, impartiality and neutrality, This mandate, laid out in UN General Assembly Resolution GA 46/182 requires that aid can only be delivered in accordance with the principle of sovereignty.

- In acknowledging the sovereignty asserted by Syrian Government, the UN agencies permitted the Assad regime to manipulate the humanitarian effort.
- UN agencies had to base operations i Damascus and submit to the terms of conditions imposed through the combination of the Ministries, SARC, and the intelligence forces.
- The appointment of pro-regime staff into key positions such as the Ali Za'atari, OCHA's Regional Humanitarian Coordinator key staff and expulsion of those considered politically unhelpful are controlled by the Ministry of Foreign Affairs.

- The High Relief Committee for the coordination of humanitarian aid, a forum where international agencies meet with Ministries (all on the sanctions list) and SARC, is in fact controlled by the most powerful intelligence forces, military and airforce security, all sanctioned. (see list of security forces in supporting documents).
- The lack of UN sanctions, means UN agencies are instrumentalized to bypass the sanctions, providing the regime with critical resources and funding.
- All aid delivery in government areas is done by SARC or by National NGOs under the control of the Assad regime, including:

  - Al Cham for Health (Ministry of Health)
  - Syria Trust (Asma al-Assad)
  - Lamset Shifa (Asma al-Assad)
  - Al Bustan (Rami Maklouf)
  - Monastery Saint James the Mutilated ('Sister' Agnes)

Al Bustan is remarkable as first NGO on the US sanctions list (money-laundering by Rami Maklouf)

WHO is particularly compromised. This is evident in tost egregious example - WHO's funding the National BloodBank controlled by the Ministry of Defense:

- Ministry of Defense is responsible for airstrikes on hospitals, civilian infrastructure, shops, schools – for trauma → huge need for safe blood transfusion and services (blood/plasma transfusion hardware & software, screening tests for bloodborne diseases HIV, Hepatitis B, C, Syphilis)
- None of these services are permitted to reach IDPs in government-controlled areas, camps, besieged, hard to reach, areas under 'local agreement' (a euphemism for besieged areas surrendering to policy of starvation + military force)
- WHO is effectively and egregiously just subsidizing war effort, and
- Indirectly fostering the spread of bloodborne disease within Syria and region.

- Despite concerns raised at WHO HQ by Legal Counsel in 2013 on ethics and propriety of WHO supporting Blood bank controlled by MoD, this arrangement went ahead.
- MoU never signed: since 2013 all purchases by WHO on behalf of MoD –("as you know due to sanctions they cannot deal directly with the manufacturing company ABBOTT)"
- Repeated denials and false statements by WR Syria, repeated and defended by Special Envoy support Jan Egeland
- Proof of direct relationship published Nov 2016 eroded trust by Syrian XB NGOs, and Woos Hubs other than Damascus,
- Donor outrage: eg in 2014 DFID funds used by WHO to purchase US $847,816 Blood Safety Kits for Blood bank in 2014. DFID subsequently reviewed WHO funding.
- Despite escalation of hostilities effectively drenching NGCA in blood, persistent refusal of HRC to permit blood products/ safety kits/ screening tests to NGCA, 5-6 options available to MoD as alternatives to Abbott, WR Syria continues arrangement with MoD (March 2018).

Other examples are provided in supporting documents.

Ironically, the more protracted the conflict, the more profitable for the regime, as it siphons from humanitarian funds, saves through UN procurement, and use the profits to fund the war, support the economy, and stabilize the Syrian pound. Creating the humanitarian crisis in full view of the international community could even be designed to cue the UN response, given the financial incentives.

General Recommendations

1. For the benefit of future efforts of the United Nations to meet its absolutely essential mandate to provide humanitarian assistance "in accordance with the principles of humanity, neutrality and impartiality", lessons learned from Syria need to be applied.
2. Humanitarian service providers, in particular the UN, need strict know-your-customer and anti-money laundering frameworks and compliance when screening potential partners. In the case of Syria, this would result in the identification of links to the regime and money laundering, much sooner.
3. Inevitably, to protect its own budget, when the UN moves to block-chain based solutions, smart contracts will need to be established for procurement that exclude purchases from countries that have imposed sanctions. 'If' supplier is from a country imposing sanctions on exports from that country, 'then' the transaction does not proceed.
4. Financial forensic audits should be undertaken that include disclosure of all contracting partners, and clear explanation of expenditures. Generic terms like 'treatments' and 'convoys' as outputs re inaccurate at best and misleading at worst.
5. Cross-border operations can offer viable alternatives to operating under regime control. The UN Security Council could replicate the decision of 2014 to further endorse such interventions. UN entities and INGOs could themselves choose to relocate and provide cross-border support.

Specific short-term recommendations include

1. WHO and other UN Agencies must stop funding National NGOs clearly controlled by the government & intelligence forces
2. WHO should coordinate efforts with UNHCR and UNICEF especially for **Al Cham for Health** (controlled by Dr. Al Hajjaj at Ministry of Health, responsible for deletion of life-saving items from convoys) for maximum leverage.

Medium / Long-term Recommendations include

1. Renewal of UNSC Resolution 2165

Public health requires pragmatism—doing what works to protect people from preventable diseases. WHO's efforts in Damascus are controlled, official surveillance by EWARS clearly unreliable means there is a public health imperative to shift WHO base, staff and operations to Gaziantep Hub in Turkey. Renewal of UNSC 2165, a binding resolution which provides the legal authority to prioritize delivery of aid to over adherence to sovereignty would permit:

- Surveillance & effective response to global threats including polio, TB and cholera
- Population-based health innovations to improve resilience of Syrians to infectious diseases and the growing threat of Anti-Microbial Resistance posed by Iraqibacter and other germ 'warfare'
- Control of health threats and programming for Non-Communicable Diseases is also in the interests of Turkey

2. Financing of rehabilitation of Health System absent control of Assad regime

Ethical financing / other involvement in reconstruction of healthcare with goal of providing access to health (as per ICESCR and General Comment 14) requires

- human resources, and
- capacity independent of government of Syria. Pre-war public hospitals and primary healthcare clinics did not provide access to healthcare large areas of population.

3. Development of WHO-led accreditation program independent of Government

A WHO-accreditation would provide:

a) incentive for doctors to return to Syria
b) human resources to staff reconstructed health system
c) Capacity for surveillance and control of global health threats
d) universal healthcare coverage
e) Innovative public health mass interventions such as measles / BCG vaccination that offer protection against communicable and potentially also NCD.
f) Reliable monitoring of attacks on Healthcare – a good example of innovation from pilot to policy

4. Attacks on healthcare

The Monitoring Violence against Healthcare (MVH) project developed by Syrian cross-border partners in 2015[1] in response to systematic targeting of hospitals & medics grew into a tool adopted by the Health Cluster and recognized as reliable tool w/ identification of perpetrator. (it was not taken up by WHO Syria). See Lancet article.

This is right now being replaced with WHO's **Surveillance System of Attacks on Hea**lthcare (SSA) "The SSA will allow for the production of regular reports with consolidated data, identify global and context-specific trends and patterns of violence and allow comparisons between regions and contexts".

The rationale outlined by WHO for its Attacks on Healthcare Project is clear, especially the 'most significant knowledge gap' - the impact on population health. This applies to Syria, Yemen, CAR, Gaza, etc.

However, while SSA offers some technical gains, the insistence on a global / uniform tool is inappropriate given context-specific attacks, role of State/ Non-State actors, intentionality & war crimes vs collateral damage.

- No ability to identify perpetrator
- Issue of confidentiality of clinical site / safety of hospital, staff & patients not addressed.
- WHO's ownership, control of SSA and ability to reliably report = grave concern: political proximity to perpetrator has affected WHO's willingness to call out perpetrator(s) & intentionality over 7 years.
- No incentive for on-ground rescue personnel (egg White Helmets) to report.
- High risk of under-reporting & normalization by WHO of these war crimes.
- SSA has no real use if simply to count (undercount) attacks. This is apparent in UNICEF's experience of UNICEF with MMVR (attacks on health education) – lack of transparency, reporting, ownership of partners, even without the years of distrust of WHO Syria. Political weakness shown by WR Syria/ unwillingness to report. This posture not limited to WHO but shared by other agencies egg OCHA – but in WHO's case its' moral authority and responsibility as guardian of global health is deeply compromised by WHO's constitutional mandate to support Government & its political proximity to perpetrator. This is to date incompatible with integrity of reporting and any demonstrable impact of passive advocacy.