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Entangled Geographies

Empire and Technopolitics in the Global Cold War

edited by Gabrielle Hecht

The MIT Press 2011
Cambridge, Massachusetts
London, England

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11 Cleaning Up the Cold War: Global Humanitarianism and the Infrastructure of Crisis Response

Peter Redfield

Sven Lindqvist's book *A History of Bombing* grimly details the brutal fantasies and colonial violence accompanying the advent of aerial warfare. It also incorporates counterpoint themes: growing concern for civilians and fitful claims to common humanity.¹ Sudden attack from the skies produced dramatic destruction, after all, creating a new theater for suffering. Once rendered visible, and matched with the proper structure of sentiment, scenes of broken bodies and panicked refugees could inspire moral response. Between the founding of the United Nations in 1945 and the breakup of the Soviet Union in 1991, the planet saw no shortage of dramatic human tragedy, particularly in the geopolitical margins where most of the Cold War's actual conflicts took place. Innovations in communications technology allowed the international transmission of images in close to real time by the middle 1960s. Among other things, the technical fact of satellite broadcast extended the potential range, speed, and intensity of war journalism. Whereas *Guernica* had been the exception to a rule of silence about civilian agony, especially in colonial settings, television audiences could now peer through screens to witness suffering at a distance.² In the metropolitan centers of former empires, the anguish of physically remote populations now flickered—still intermittently but more graphically—into public view. The contemporary drama known as “humanitarian crisis” emerged as a variation on the theme of charity, often amid the very colonized peoples Lindqvist's more extreme sources once hoped to eradicate.

After World War II, a globally oriented humanitarian infrastructure gradually came into being. Alongside “sharper” instruments (such as the AK-47) that refocused power through the threat of death amid proxy wars, a set of tools emerged to respond to human suffering, together with new international agencies and organizations to wield them.³ Sharing a longer lineage with military and industrial logistics, as well as common circuitry of international mobility and expertise, this humanitarian apparatus represents a

form of technical mutation and reconfiguration as much as innovation. By the final decade of the Cold War, it had coalesced enough to offer stable objects and routines designed for emergency settings. Although hardly a remedy for the upheaval and inhumanity accompanying geopolitical contestation, humanitarian equipment offered a means of temporary relief in particular locales, and thus literal, as well as figurative, sanitization.

In this essay I examine the emergence of this humanitarian infrastructure by focusing on the development of one significant component: mobile medical supplies. I do so primarily through the example of the nongovernmental organization Médecins Sans Frontières (Doctors Without Borders). The case of MSF is particularly germane to this endeavor for three reasons. First, although emergency response is no longer the group's only form of action, it remains its trademark of technical expertise. Second, MSF's ideology of outspoken independence means that it has often played the role of self-appointed humanitarian critic, commenting on humanitarian shortcomings while also seeking to provide aid. Thus MSF can serve as a barometer of sorts for the general state of the field. Third, MSF emerged during a geopolitical period that featured proxy wars between superpowers and significant crises along the borders of the state socialist bloc. The group's focus on civilian suffering and truth telling thereby exemplifies an internationalism of moral engagement amid political disillusionment, in marked contrast to earlier internationalisms committed to utopian politics.

Here I sketch the outlines of MSF's techniques for rapid medical intervention in adverse circumstances, including pre-assembled, standardized "kits" of equipment, guidelines for responding to varieties of public health crises, and minimal forms of health evaluation. Tracking the general story of the kit through a series of examples drawn from specific settings, I illustrate the manner in which the kit emerged amid a broader standardization and professionalization of humanitarian action. The product of modest inventors, and often engagingly simple in design, this technical assemblage nonetheless sustains the expansive ambition of reaching and stabilizing a population almost anywhere in the world within 48 hours. Although geographically mobile it is a temporally restricted set of instruments. Defined for a state of emergency, these tools remain limited by a concentrated concern for an uncertain present rather than an expansive future. In this sense they are, by their very design, not "sustainable," no matter what greater hopes they might absorb or how lengthy their actual use life might prove.

Considered from the perspective of technopolitics, the humanitarian response to suffering suggests a form of strategic engagement practiced in the name of ethics, contested, manipulated, and incorporated as the other

side of warfare.⁴ Humanitarian equipment thus represents a distinct variant of global technology, separated from those born of corporate growth or state ambition by its oblique relation to political economy. Directed neither at profit nor at power, these artifacts instead reflect a moralistic ethos and limited goals associated with welfare and basic public health. This is not to suggest that they lie beyond all market logic or ordinary political life, let alone that they only produce intended effects. Rather, I simply wish to echo other critical observers who note that nongovernmental organizations pursue good works primarily in the name of moral values, largely disavowing conventional political ends.⁵ By delineating and enacting a minimal politics of survival, I suggest, MSF's logistical efficiency reveals inherent tensions within any humanitarian project that offers only temporary relief from political and social failure. The organization's relative "success" in achieving a degree of instrumental standardization ultimately highlights the limits of its mobile biomedical project, even as it frustrates its aversion to institutional forms.

The appearance and standardization of mobile tools for aid also serves to highlight the manner in which the Cold War ran hot along its edges. It recalls the extent to which shifting military technology and political strategies produced civilian suffering, laying the groundwork for morally inflected practical action. The recent efflorescence of aid organizations, the prominence of humanitarian justifications for military action, and the mediated morality of emergencies all refer to an established precedent of expectation: by the last decade of the twentieth century, it had become technically possible to both identify distant suffering and mount a rapid response. However limited, contingent, and fragile, the material means for humanitarian action thus carries significant symbolic weight. The fact of its normalization, I suggest, is one of the lasting legacies of the Cold War era. Long overshadowed by nuclear weaponry and the new military-industrial prowess in death, this smaller constellation of artifacts associated with life subsequently emerged to play another defining moral role in geopolitical discourse.

A Prototype: *Materia Medica Minimalis*

Before proceeding to a description and analysis of my specific case, I will first introduce the general problem through an orienting moment of its prehistory. To understand the nature of the equipment MSF eventually set in place, as well as its spatial significance and temporal politics, it is helpful to return to World War II, and the advent of large-scale aerial warfare and

the landscape of mass destruction it produced. Humanitarian logistics has many obvious lines of descent, from military supply lines to industrial food distribution, or, amid colonial encounters, the naval surgeon's chest.⁶ But just as with bombing itself, the importance of a portable medical infrastructure became critically visible amid the rubble of European cities during the 1940s. An essential antecedent for this Cold War story thus appears in the fading centers of empire, newly pulverized by bombers.

The degree of devastation in World War II presented the newly formed Joint Relief Commission of the International Red Cross with a significant technical problem. Created to coordinate the efforts of the Red Cross's mosaic of national societies with those of the Swiss-based International Commission of the Red Cross, the commission found itself at a loss in the face of massive aerial bombardments that left civilian populations in urban centers medically bereft:

"There is a total lack of medical supplies here." It was by a summary appeal of this kind that the Joint Relief Commission of the International Red Cross was asked in the beginning of its activities to send medical relief to a capital which had just undergone an air raid. Such a request, put so tersely, left us somewhat nonplussed. What should be sent? What medicaments would be required by a large city which had been devastated by an air attack? What quantity of each medicament would be required? No statistics were there to enlighten us, no document on the problem was available. We had to improvise.⁷

How best to provision a landscape of total devastation? Most urgently, what medications to provide when the entire health infrastructure was knocked out? The commission first surveyed the national Red Cross societies about the medical requirements of their respective countries. The response was, however, "surprisingly diverse, one might almost say, disconcerting." No simple, uniform agreement could be found. Therefore the commission took it upon itself to quickly marshal medical experience and science, in an effort to determine what was "absolutely indispensable to ensure medical care and to meet the emergency needs of a population which has been deprived of food and medical supplies."⁸ Newly sensitized to local culture, the commission also took note of the fact that national preferences and therapeutics varied across the European continent. The Red Cross, then, needed a document that would be simultaneously encompassing and precise, allowing for regional differences and yet conducive to medical and pharmacological accuracy.

The condensed result was a booklet titled *Materia Medica Minimalis* (abbreviated *M.M.M.*). First issued in Latin, it subsequently appeared in

French, German, and English editions. For a European embroiled in war, the inherited tongue of Rome served as a convenient means of scientific expression.⁹ Balancing this scholarly touch with quartermaster's eye for practical detail, the authors offered estimated quantities necessary to treat a "population unit" of 100,000 persons for six months. They based their estimates on the consumption of medicaments in Switzerland, recognizing that these figures might prove controversial and might require alterations. In view of the urgent need for immediate use, however, they ventured into the messy realm of calculation. Since "circumstances and difficulties" might affect actual delivery, they further divided their listing into two categories, the first of which should receive the greatest priority. The *M.M.M.* itself included only the pharmaceutical end of medical supplies; bandages, cotton, and surgical instruments were to be handled in separate consignments.¹⁰ Nonetheless, its content lived up to its name, defining a baseline state of medical infrastructure.

Materia Medica Minimalis marks a catalytic moment in humanitarian thinking. While the Red Cross's international meetings had addressed a variety of training activities related to medical techniques in the past, it was now constructing a mobile template for crisis response around a principle of flexible standardization. The final report of the commission composed after the war mused that "this work, which was called into existence by the needs of the moment, possessed a usefulness which it seemed would outlast the war period," an assessment that would prove ultimately prophetic.¹¹ Although *M.M.M.* itself did not directly dictate later relief work, its conceptual descendents would proliferate in the coming decades.¹² As the zone of crisis recognition shifted beyond Europe, the reconstruction of a minimal biomedical infrastructure emerged as a central problem for all manner of disasters in resource-poor settings. Effective medical assistance required basic equipment and guidelines, preferably prepared in advance. Global mobility depended on it.

MSF and the Geopolitics of Suffering

Although the Holocaust shadows contemporary conceptions of human suffering and disaster, cameras never framed Auschwitz as a "humanitarian crisis."¹³ The close of World War II may have ushered in a new political configuration, and categories and institutions for its governance, but the era's massive relief works occurred in a time of less instantaneous and less visceral communications. Rather, the conventional watershed moment for televised suffering arrived with the Biafran war in Nigeria at the end of the

1960s, when satellite broadcast first brought starvation into middle-class living rooms worldwide. Whatever its complexities (which were rife with propaganda and manipulation as well as starving children), that moment of anguish provoked reflection and reorganization on the part of a number of existing humanitarian organizations and inspired the formation of others.¹⁴ In the subsequent decade, a generation of aid workers increasingly embraced media exposure for their causes.

By the time of Biafra, the term "humanitarianism" had narrowed, primarily identifying an impulse to alleviate suffering caused by human conflicts and natural disasters.¹⁵ The Red Cross movement's historic efforts to transform military medical practice and international law had rarely addressed colonial settings. Colonial warfare operated by different rules, as Sven Lindqvist makes acutely clear, and suffering beyond Europe was a largely a matter for missionaries and the civil service.¹⁶ The slow dismantling of European empires, however, created a new humanitarian terrain for the second half of the twentieth century. As the United Nations expanded fitfully to a patchwork institutional framework for international governance, it enlarged expectations, if not always results. The development of emergency medicine out of military medicine (institutionalized in the French case in the 1960s with the establishment of a national service known as the SAMU, which stood for *service d'aide médicale urgente*), and the routinization of air travel and rapid transport, extended the scope of potential action.¹⁷ Suffering, whether near or far, could now elicit a prospect of response.

Médecins Sans Frontières itself appeared at the end of 1971 in Paris, when journalists from a medical publication helped bring a small group of doctors who had volunteered for the French Red Cross in Biafra together with others concerned about disaster and conflict in Bangladesh. Troubled by the constraints of established relief organizations, they sought to establish an independent alternative to the Red Cross, unfettered by existing mandates. The veterans of Biafra, impassioned by their experience of what they considered genocide, also yearned to be more outspoken—particularly a telegenic young doctor named Bernard Kouchner. Publicity soon played an increasing role in MSF's operations, if not quite to the extent of later myth. At the outset MSF existed largely on paper, piggybacking on the interventions of others. By the end of the 1970s, however, it had mounted a number of short interventions into areas afflicted by natural disasters and war. It also achieved rapid prominence within France as a result of a *pro bono* publicity campaign by an advertising company that featured the slogan "2 billion people in their waiting room."¹⁸ The ambition of aid was now grandly global.

In keeping with its anti-establishment generational ethos, MSF soon presented itself as an alternative to both anti-colonial and Cold War loyalties. Rejecting all justifications for civilian suffering, it came to oppose the French intellectual romance of "Third Worldism" and denounced leftist regimes that proved inhumane. Amid the disillusionment of post-1968 France and the now apparent excesses of state socialism, MSF offered the prospect of ethical action to defend the life and well-being of ordinary people. A "rebellious" form of humanitarianism would be simultaneously non-aligned *and* thoroughly engaged through the practice of medicine. Thus Bernard Kouchner, a one-time student activist, could, as an outspoken physician noisily practicing "without illusion," discover both himself and the Third World. Rony Brauman, Kouchner's influential successor in the organization, could similarly trade street protests for clinical work in refugee camps.¹⁹ Although the group would experience loud internal squabbles and schisms, the various factions all shared a common ethical aversion to political justifications for human suffering.

Even as MSF found its collective calling, the geopolitics of the Cold War shifted increasingly in the direction of proxy wars after the United States left Vietnam.²⁰ Alongside the paralyzing shadow of nuclear apocalypse, irregular armies fought savagely in Angola, Mozambique, and Afghanistan during the 1970s and the 1980s. These confrontations only enhanced the international flow of conventional weaponry, fueling ancillary conflicts and alliances, while prompting the displacement of civilian populations. The number of refugees grew exponentially during those decades, providing a surplus of humanitarian need well beyond the capacity of UN agencies. A nongovernmental group with a global vision thus had plenty of opportunity to offer medical assistance.

Three early episodes proved particularly formative for MSF and for the technopolitical concerns of its operations. First, the exodus of "boat people" from Vietnam, combined with mass suffering in Cambodia under the Khmer Rouge, set the ground for an ethics of action that prioritized humanity over political ideology. As the longtime political opponents Raymond Aron and Jean-Paul Sartre marched together in Paris, young MSF volunteers worked in camps on the border of Thailand, becoming radicalized through encounters with suffering rather than revolution. The refugee crisis would emerge as a natural habitat for medical humanitarianism: massed populations in need of urgent, basic clinical care provided a ready stage for moral dramas of suffering. The "boat people" episode also provoked a schism within the organization when a younger contingent, disagreeing what would constitute the best response, overthrew the veterans of Biafra.²¹

In 1980, after this power struggle, Kouchner left MSF to found Médecins du Monde (Doctors of the World); later he would emerge as a significant French politician, championing a humanitarian "right to interfere" on the part of state and interstate actors. Kouchner's successors at MSF would struggle—not always successfully—to distance themselves from this full-throttle version of *sans frontières*, in part by resisting a complete embrace of the human-rights discourse and in part by emphasizing independence and operational efficacy.²²

Next, the Soviet invasion of Afghanistan only further confirmed the French humanitarian repudiation of state socialism. MSF undertook clandestine missions in the Afghan mountains, experiencing its own romance of Third World solidarity alongside the mujahideen, not to mention the CIA and the future al-Qaeda. Together with Kouchner's new group, they acquired the label "French Doctors" in American press reports of the era, an English phrase that remained iconic in France long after it was forgotten elsewhere. The Afghanistan period constituted a high-water mark in MSF's break with Red Cross discretion, as well as its engagement in Cold War politics. The Afghan adventure also involved a striking degree of local adjustment; in contrast to later practice, mission volunteers immersed themselves among the people with whom they worked, living and traveling in the same manner. Transport involved the torturous navigation of mountain passes with pack animals, medicines carefully packed into small parcels. Teams were isolated and re-supply difficult. In this case solidarity did not ultimately translate into political influence; the organization watched with dismay as its erstwhile partners baldly pursued their respective power games, and the country disintegrated into civil war after the Soviet troops withdrew.²³

Finally, during the mid-1980s famine in Ethiopia, the original French branch of MSF found itself evicted after denouncing the Derg regime's policy of forced resettlement. The episode, which resonated amid the televised glamour of the Live Aid concert, established the group's reputation as outspoken and willing to oppose all political orders that produced suffering. At the same time, MSF faced criticism suggesting that it was an amateurish organization, long on hot air but short on actual capacity. The charges stung enough that MSF redoubled its efforts to improve its technical abilities and professionalism.²⁴ By the end of the 1980s, the group had both a new logistics system and an epidemiological subsidiary in place. Once the French section had grudgingly accepted its newer European relatives as equal partners, the larger collective emerged as a truly multinational operation.²⁵ Increasingly it would be known not only for outspokenness but also for speed and efficiency.

Discovering Preparedness: Uganda, 1980–1986

What would effective humanitarian action entail at a material level? To illustrate the technical problems involved, I will focus briefly on another case from the early 1980s: that of Uganda. Uganda was never a central front in the Cold War; its post-independence turmoil had deeper colonial and regional roots.²⁶ Nonetheless, the country's crisis occurred at a transitional moment, and offers the comparative advantage of combining a less mythic profile with widely recognized inefficiencies.

At the beginning of the 1980s, the Karamoja and West Nile regions of Uganda experienced extreme famine. The crisis in Karamoja, an arid area bordering Kenya and peopled largely by semi-nomadic, photogenic cattle herders with a fierce reputation, received a good deal of media attention, and a number of aid agencies responded to the images of starvation by rushing teams and materials into the field. Amid the greater aftermath of the fall of Idi Amin, the general situation in Uganda was, in the words of a UNICEF official of the time, "at best chaotic," and the relief operation quickly encountered a host of problems. Subsequent analysis by a group of scholars and humanitarian workers identified a long list of specific setbacks as well as some general issues: lack of coordination and turf struggles between different organizations (and even branches of the same organization), a greater landscape of need extending beyond the targeted recipients of aid, and a "disaster within the disaster" of food supply and the greater infrastructure of logistics required in for its movement and distribution.²⁷ A former representative of another UN agency observed that many of the people who had worked alongside her in Uganda had participated in major relief operations elsewhere over the previous decade, and that their discussions identified a repeated pattern of failure: "One of the recurring themes was that time and time again the same problem arose in every disaster situation: logistics."²⁸ She imagined creating, within the UN system, a "strike force" of reservists—a cadre of experienced professionals, with access to stockpiles of equipment, who would be ready to leave at a moment's notice. The UNICEF official similarly concluded that responses should be "quick, rational and experienced" rather than "prolonged, irrational and nonexperienced," but doubted that his own agency, created for long-term activities, would be suitable for the task: "To use a metaphor, such a rapid shift in activities and allocation would amount to demanding a shipping company to turn into an airline overnight."²⁹

Among the many organizations briefly present in both the Karamoja and West Nile crises was Médecins Sans Frontières. Not yet ten years old, it

was still a relatively minor, if flamboyant, entity in the world of humanitarian affairs. The missions to Uganda were its first in a famine zone, and they were not particularly successful. As a leading participant dryly noted in an interview with me years later, "in that era we improvised; later we'd become more efficient." The group's bulletin report at the time summed up the general situation with the graphic image of a stranded, bullet-ridden bulldozer, its brand new tires stolen by raiders to make sandals.³⁰ Within ten years, however, MSF had grown into a large and complex organization, fully capable of both technical innovation and logistical efficiency in crisis settings. The professional system of logistics that it had developed enabled it to embody the UN administrator's vision of a global humanitarian strike force.

The Humanitarian Kit

When MSF reoriented its logistics system in the mid 1980s, it focused on creating modular, standardized kits. The concept of the kit itself has a long military and medical lineage. The Oxford English Dictionary suggests that by the late eighteenth century the meaning of the English term had expanded from a wooden vessel or container to the collection of articles in a soldier's bag. An equipment case or chest had long been the steady companion of naval surgeons and other mobile healers, and by the early twentieth century the Red Cross and other groups were assembling all-purpose first-aid kits, combining essential materials in a more modest version of the *M.M.M.* assemblage described above.

MSF's variant would be more comprehensive, recombinant and ambitious: collections of supplies designed for a particular need and preassembled into a matrix of packages. The organization could then stockpile these packages and ship an appropriate set rapidly to any emergency destination in the world. The mature MSF catalog of kits later summarized the conceptual approach it embodied as follows: "A kit contains the whole of the needed equipment for filling a given function. Intended for emergency contexts, it is ready to be delivered within a very short time frame."³¹ Thus the diffuse problem of acquisition was effectively translated into a concentrated one of transportation, more easily solved from a central office. Essential materials no longer had to be hastily assembled anew in response to every crisis, or uncertainly negotiated on site amid fluctuating availability, quality, and prices. Moreover, by preassembling materials with a checklist, the kit could function as a form of materialized memory whereby previous experience extends directly into every new setting without having to be

actively recalled. For an organization built around both crisis settings and a constantly shifting workforce of volunteers and temporary employees, such continuity would prove especially valuable.³²

From the perspective of MSF, the kit system was the product of a small number of early masterminds, now receding into organizational legend. Its immediate origin lay in the experience of Jacques Pinel, a French pharmacist posted to Cambodian refugee camps on the border of Thailand in 1980. Previously, MSF team members—a small appendage to a larger, often chaotic operation—had rotated responsibility for logistics; now that they were running their own independent mission, they created a new category of supervisor [*intendant*] positions.³³ Guerilla raids over the border led to periodic Vietnamese bombing runs, whereupon the Thai army would seal the camps, preventing access for several days at a time. In due course the MSF teams learned to assemble essential equipment until they had the process down to a system. As Pinel recalled in 2004, this evolved less from any grand design than from the "banal" practice of packing a bag for a series of weekend trips, and then translating such experience into anticipatory habit:

The kit, it's nothing more than someone who's leaving for the weekend . . . who needs his backpack with something to drink, something to eat, something to put on his feet if they get sore. He needs all that. So, how does he do it? The first time he imagines what will happen, and assembles his bag with that imagination. And then after that first experience, he sees that there are things that didn't amount to much and others he was missing. And then after the second, third time, he'll finally have a perfect bundle and he prepares it before the weekend, checks it, and then leaves and it works.³⁴

In its initial form, the proto-kit was a relatively heavy box made by local carpenters. Carried in the back of a pick-up truck, it quickly earned a nickname of the "semi-mobile endowment [dotation semi-mobile]."³⁵ MSF's general approach mirrored that of the French SAMU emergency system, which transported medical materials and expertise directly to the site of care. Its originality derived less from its form or content than from the setting in which it was deployed and the extent of its adaptation. Reworking a guide from the UN High Commission for Refugees and a nutritional package from Oxfam, MSF volunteers eventually assembled standard lists of medicine and supplies for a kit to meet the needs of 10,000 people for three months, along with instructional manuals for its use. The project of procedural simplification on site grew into one of standardization between locales. As Pinel later noted in published work, the kit now responded to an

"ecology" of humanitarian emergency as exemplified by the refugee camp, where a large number of people lived under temporary, crowded, and often precarious conditions, receiving care from a shifting group of personnel not all of whom might be familiar with the setting or the diseases.³⁶

Pinel went on to coordinate MSF-France's new central logistics operation in 1982, and, together with associates, applied the model developed in Thailand to analogous problems elsewhere. The key principle behind the kit approach was to break down a larger predicament (e.g., a flood in Central America), identifying its critical components and developing smaller, specific responses to each in turn. For example, a common health concern for displaced people living in crowded conditions is cholera. Anticipating this problem step by step in detail, the MSF logistics team developed a general kit for the disease:

We know that we were going to have a cholera epidemic there. OK, we get together people who have already worked on cholera, when we get there there's nothing of what we need to put in place for a cholera epidemic. So, we need a cholera camp, that is to say an isolation tent. . . . If there are thousands of people that's too many, so we'll create a unit to treat 500 patients. . . . What will be necessary? Some tents, OK, how many tents? OK, we'll need a hundred 50 square meter tents. We'll have perfusions because we're going to give infusions and on average there are those who have 2-3 liters and then there are those who have up to 20 liters. So we'll say 10 liters on average, OK. Out of 500 patients there are how many who will receive 10 liters. . . . OK, there will be a hundred. . . . When we finish planning, *voilà*, we have the kit. We try to really make this kit, in order to see how it is, how it fits into boxes, how much it weighs. We physically create this kit, and then we use it in the next cholera epidemic . . . and then an evaluation. And then we revise it. . . . It's like that that the kits advanced, succeeded, not so much because of the notion of the kit, which is really something supremely banal [*archi-banal*], but following many years where we imagined the kits and evaluated them in numerous situations. And then we divided the operations up like sausages [*saucissonné*], we cut, we sliced. That is to say, there's a cholera epidemic, a measles epidemic, put in place in a dispensary of a refugee camp. In doing all that, all the units like that, then when it's necessary to mount an operation we have all our equipment.³⁷

Through this combination of organic practice and assembly-line routine, MSF created a more global, component variation of the Red Cross's *M.M.M.* By the latter part of the 1980s, the concept of the kit had grown central to the group's emergency work.

To get a sense of the level of detail involved, let us briefly examine MSF's mature cholera Kit 001, designed for refugee camps and capable of being modified for either rural or urban displaced populations. Designed

to provide 625 treatments, it weighs in at just over 6,000 kilograms and includes an array of medicine (e.g., 6,500 sachets of oral rehydration salts and 10,000 tablets of the broad spectrum antibiotic doxycycline) as well as materials for taking patient samples (e.g., dissecting forceps and a permanent black marker) and performing basic medical procedures (e.g., surgical gloves, tunics, trousers, and boots in several sizes, ten 500-gram rolls of cotton wool, 25 arm splints, and catheters and bandages galore). But the kit also features support items—for example, more than 100 buckets and 100 disposable razors, not to mention such logistical articles as notebooks, pens, wire ties, and staplers. The degree of anticipation evident in this collection of trunks and boxes would put most Boy Scouts to shame.³⁸

In addition, MSF has accompanied the kits with short, informative instruction books and pamphlets detailing responses to practical problems. These guides are available in international languages common where the group works: English, French, Spanish, and sometimes Russian or Arabic. The subject matter addresses clinical and engineering dilemmas volunteers might encounter in the field, such as how best to conduct minor surgery in a war zone or how to set up a simple water sanitation system. The guideline system acknowledges that even volunteers with established general expertise may possess inadequate technical background for unfamiliar conditions; neither a nurse from Lille nor a logistician from Toronto, for example, is likely to have much training in combating cholera or in building a pit latrine. The guides further seek to address audiences with different levels of knowledge, and to do so in a concentrated way that does not require access to larger libraries. Simple to copy or replace, in a pre-digital era their minimal form guarded against the potential disintegration facing more expensive books in humid climates.³⁹

MSF also developed a wider supply chain and communication infrastructure. Upon taking over logistics for the group's operations in 1982, Jacques Pinel became aware that Thailand had been a relatively simple environment in which to operate. There the team had easily acquired vehicles and drugs locally, and the phone system had functioned reliably. Much of Africa proved a different story, as its crisis zones generally lacked phone service, transport, and even basic drugs. Pinel and his associates created a radio communications network, standardized drug lists, and a vehicle pool. They restricted vehicle purchases to Toyota Land Cruisers, already deployed in many Red Cross and UN missions, both to simplify their parts list and to use the garages of these other organizations.⁴⁰ Simplification and standardization were their watchwords. MSF-France also established a logistics depot in 1986 in order to provide a standing reserve of equipment

for emergency operations. One of several "satellite" organizations created during this period, the depot moved around several locations in France before settling near the Bordeaux airport. From this base the logistics team could—political conditions permitting—quickly launch mission material toward any corner of the world with the assistance of a chartered plane.

While the MSF's different sections have pursued slightly different logistics strategies, the kit system expanded throughout the overall organization to produce a set of relatively stable forms. Kits are now available for all manner of eventualities. The Toyota Land Cruiser, still MSF's workhorse vehicle, comes as a kit (modified for either warm or cold climates); so too does a collection of stickers and flags to mark its affiliation. Members of a mission can order an "Emergency Library Kit" and request items from a field library list that includes such assorted titles as "How to Look After a Refrigerator," "Human Rights in a Nutshell," and "Blood Transfusion in Remote Areas."⁴¹ Governing the overall design are principles of quality, efficiency, and simplicity of maintenance. In some domains a spirit of standardization dictates a particular brand of product (for example, MSF still orders only Toyota vehicles); in others a desire for flexibility of procurement allows substitution of any generic equivalent (most articles are "open" rather than brand specific).

The kit system has never operated in a vacuum. MSF also boasts a long tradition of improvisation and of modifying designs to fit its needs. In an office setting this primarily implies working to simplify systems and reduce their cost.⁴² At local mission sites logisticians serve as more general "bricoleurs," tinkering with the means at hand to achieve a desired result. A capacity for improvisation remains essential, though less pronounced in an era of improved communications, professional training, and ubiquitous guidelines. "Either you do the job or you don't do the job," a logistics coordinator told me emphatically in 2004, referring to a temporary structure he had once had to construct with logs and mud in the absence of recommended materials.⁴³ Once in the field, kits can be pulled apart, partially used, and reordered. But even when emptied and enjoying an afterlife—such as the bench I once sat on in northern Uganda—their battered modules serve as a material reminder of a larger, mobile network.

Partly derived from the artifacts of other organizations (if not a master plan), MSF's logistics system in turn influenced the larger humanitarian enterprise. In 1988 the World Health Organization endorsed MSF's classic kit by adopting it as the "new emergency health kit," and the International Committee of the Red Cross (ICRC), where several former MSF figures migrated, purchased many of its corresponding guidelines.⁴⁴ Unlike

the WHO's more scientific guides, MSF's were emphatically operational in outlook and directed to teams in the field. Early editions invited users to copy them, and consequently borrowed elements circulated widely, some even reappearing in the WHO's growing repertoire.⁴⁵ However unorthodox, MSF's journey to professional respectability was now complete.

Technopolitics of Emergency

The first point I wish to stress analytically is that MSF's kit system represents a self-consciously *global* system, mobile and adaptable to "limited resource environments" worldwide. Though parts of it may be flexible in application, the result is not at all fluid in the sense of flowing around community involvement.⁴⁶ Indeed, the kit system is the exact opposite of local knowledge in the traditional sense of geographic and cultural specificity in place. Rather, it represents a mobile, transitional variety of limited intervention, modifying and partially reconstructing a local environment around specific artifacts and a set script. Though in practice it may require considerable negotiation to enact (in keeping with actor network theory), its very concept strives to streamline that potential negotiation through provisions that reconstitute a minimal operating environment. The cold chain system used in vaccine distribution serves as a useful general analog in this regard. Just as a cold chain extends the essential environment of a vaccine alongside the vaccine itself with different forms of refrigeration, the kit system extends the essential environment for biomedicine into the landscape of a disaster. To ensure reliability and quality, MSF is willing to ship almost anything anywhere during an emergency.

Deeply invested in a practical logic of standards, the kit system reflects something of Bruno Latour's analysis of circulating inscriptions as "immutable mobiles."⁴⁷ MSF's guidelines and toolkits collect and distill local clinical knowledge into a portable map of frontline medicine. Developed and refined through practice, they connect one outbreak or crisis to another. In this sense the cholera epidemic in Thailand travels to stabilize the cholera epidemic in the Congo. Together, as a vast chain, the kit assemblage standardizes disaster through responding to it worldwide. Such a characterization reveals the degree to which biomedical knowledge and practice depends on infrastructure, and the background work necessary to translate it into a new setting. MSF's classic emergency formation generated a "culture of standardization" (as one logistician proudly put it to me) in which speed and control were paramount values. Beyond obvious incompatibilities, local concerns could emerge later.

Second, I wish to emphasize that the kit system is not the product of either corporate or state need, economic goals, or defined political strategy. Rather, it stems from a humanitarian focus on the moral imperative of responding to immediate human suffering. To be sure, the greater logic of standardization has a long history in both military and business settings. Moreover, MSF's tool chests draw from commercial commodities, and the group's administration maintains plenty of balance sheets. However, the central motivation for its decisions derives from valuing human life rather than profit.⁴⁸ And although MSF may often find itself in a position of temporary governance relative to a population in crisis, that governance remains ever partial and impermanent as it refuses the responsibility of rule. Thus any analysis should never lose sight of the fact that the kits were designed to respond to emergency settings in which the instrumental goal is temporary stabilization. Standardization was never an end to itself, nor was it part of an effort to reshape or capture economic terrain.

The defining role of crisis has grown all the more clear as MSF has extended its activities beyond emergency interventions into an array of other projects: targeting specific diseases over a longer term, advocating policy positions, and even facilitating pharmaceutical research and production. In these contexts, the logic of the kit no longer holds sway. Instead MSF missions purchase a greater variety of materials from local sources and place orders for items in bulk rather than in prepackaged assemblies. Even the kits themselves have experienced alterations, with outsourcing and flexibility playing an increased role in their production.⁴⁹ Once beyond emergency settings, MSF missions re-enter a larger world of exchange and circulation, and standardization melts away.

To illustrate this last point, let us return again to Uganda in the post-Cold War period. Two decades after the initial forays there, several sections of MSF ran a variety of programs in the country. Among these were a garage to maintain and repair vehicles and for a project providing anti-retroviral medications to an increasing number of AIDS patients.⁵⁰ Located in Kampala, the garage was the domain of a veteran French logistician, a taciturn but dedicated man who nursed it as a longer-term venture amid MSF's many short-lived interventions. In addition to servicing the vehicles of MSF-France and MSF-Switzerland based in Uganda, it also cared for some in Sudan and some in the Democratic Republic of Congo, volatile settings where parts were not available. To further augment its bottom line, it undertook contract work for other NGOs. Well equipped with standards, catalogs, and a computerized ordering system connecting it to MSF's depot, the garage exemplified stabilized humanitarian infrastructure. At the same

time, however, its continued existence was under continual threat, not only from the turnover rate of MSF's fluid administration and their varying visions but also from the pressures of competing interests on the part of the local mechanics who labored there. Once trained, they would often leave for a better-paying position, and even when on the job they did not always work with the fervor the director expected. As the director noted wryly, they were, after all, driven less by humanitarian ideals than by a search for their livelihoods. The garage also faced potential competition from commercial rivals that threatened to undercut it, and the impatience of field personnel in project sites who wanted to circumvent central control and make purchases directly. "It's a constant battle," the director acknowledged, especially since some parts could be found more cheaply in local markets, and their quality was improving. Though he was a firm believer in the value of the kit system and in the advantages of using standard, well-selected materials, the director emphasized that MSF's logistics network was really designed for emergency missions. A stable entity such as the garage regularly interacted with the local economy, each small transaction pulling it away from the institutional orbit.

Similarly, efforts to address specific diseases and broader health inequities altered MSF's technical circulatory system, exposing its limits. The project in the northern town of Arua was part of an ambitious, worldwide foray into HIV/AIDS medicine. After years of resisting extensive involvement with the disease, the organization threw itself into the movement to demonstrate the feasibility of treating poor people in "resource limited settings," rolling out a wave of anti-retroviral projects in 2001. MSF added Uganda to the list a year later, locating the project in a region in which it had extensive experience. By 2004, the Arua clinic served more than 1,000 patients, and it was set to expand further. In one sense the AIDS clinic constituted a meta-kit. By combining experience from multiple locations, MSF could create a mobile set of treatment protocols, less dependent on full-scale laboratory support and adapted to shifting personnel. In this way no project would be open to the charge of representing only an anomaly, since the larger chain was clearly replicable. In another sense, however, the AIDS clinic exposed the limits of the kit approach. MSF's initial commitment was to five years of treatment. The therapy provided, however, would have to last a lifetime, since the drugs produced temporary remission rather than a cure. MSF's approach depended on imported materials, personnel, and funding, none easily substitutable in a provincial town. Members of the team worried about these issues, even as they worked frenetically to expand patient rolls in the face of tremendous demand. "It's not an emergency

project, but most days we work at this speed," the mission head told me, wondering how it would all keep going. At the same time, as patients improved they began to refocus on the hardships of their everyday life, and to seek support and counsel well beyond medical therapy. Although sympathetic, MSF was poorly equipped to respond to matters of poverty, unemployment, and family expectations. The translation of treatment from rich countries to poor ones could not alter the structural imbalance between contexts in economic terms. That particular crisis exceeded the boundaries of a shipping container.

For some members of MSF, the kit system can now appear a constraint, a self-created frontier limiting the organization's creativity and the larger humanitarian project. A humanitarian affairs officer with MSF-Holland described the general dilemma to me in 2006:

The kit made us good specialists in a closed camp setting. . . . We just don't seem to know what to do with open settings. Whether urban Rio or Chad, when we have low density and widely dispersed populations we have more problems. What I see is an institutionalization of closed settings. . . . We're used to thinking we have to have kit to act.⁵¹

A pointed blog posting written in 2009 by an individual in MSF-France's research arm related a caustic anecdote of field experience: What a triumphal headline hailed as the donation of "60 metric tons of essential drugs" from a UN agency appeared on the ground as one hastily delivered box, its instructions in a language that mystified the Congolese aid workers who unpacked it and its contents conforming to outdated protocols. The author of the posting queried the bureaucratizing force of what he termed "kit culture," noting that "in Congo as well as many other places, the kit has become more than a tool, it is increasingly the embodiment of THE humanitarian gesture itself, as if dropping a kit constitutes the *raison d'être* of humanitarian interventions." UN agencies, he added in conclusion, were hardly alone in this regard.⁵² If MSF was also guilty of lapsing into kit culture, as he implied, the rise of military humanitarianism further unsettled the organization by combining life and death into a single logistical form. When the US Air Force appeared over Afghanistan after the attacks of September 2001, its planes dropped aid packets as well as bombs. The different strands in Lindqvist's story had woven back together.

The end of the Cold War featured high-profile episodes of humanitarian crisis, along with a proliferation of NGOs responding to them. By then a template for global humanitarian action was well established, with the means to extend a minimal medical apparatus worldwide. The general form

of this apparatus and its components were less surprising or innovative than their combination, orientation, and effects. In response to perceived conditions of emergency, efforts at standardization focused on basic provisions for life and medical care. The result was a limited and temporary infrastructure for interruption, highly mobile and concentrated on immediate needs. Amid the debris of decolonization and superpower struggles, humanitarians devised means for crisis response that were simultaneously effective and ephemeral.

Discussing MSF's kit system with me in 2003, Rony Brauman described it as "an apparatus [*dispositif*] in Foucault's sense" as well as "a logic for action." Widely read and resolutely critical, the former president of MSF-France attributed a degree of strategic coherence to the organization's material engagement, however contingent its origins and practice.⁵³ A faith in action has defined MSF's ethics, and a sense of emergency has delineated its ethos. Its goal, as Brauman reiterated at the end of the 2006 documentary film *L'aventure MSF*, is not to transform the world, but simply to assist people in moments of distress so that they might be alive for any future reconstruction. To this end the kit system has proved an admirable asset, at least for certain conditions. Yet how does this ethical action fit into a larger political calculus, and into the broader "kit culture" of humanitarianism?

Recall that the technical safety net produced in the name of medical humanitarianism has few claims to long-term "development" or "capacity building." It promises no utopian liberation, and offers few political guidelines. Rather, it remains relentlessly focused on present suffering and basic health, deferring future states in favor of assuring survival. The politics of life and death here is a minimalist one, concentrated on the maintenance of survival rather than on the extension of a more complex political regime.⁵⁴ This point is most graphically embodied by one of MSF's simplest tools: a thin strip used to measure the middle upper arm circumference (MUAC) of children below the age of 5. When tightened around the arm, the MUAC bracelet provides an indication of child's nutritional state, providing one means for rapid assessment of malnutrition in a population. Cheap to produce, easy to comprehend, and brightly colored (with a warning scale running from safe green into dangerous red), it is a compelling object in technical and visual terms. MSF-USA has featured this tool in a publicity campaign aimed at children, calling it "The Bracelet of Life." The sense of life involved, however, remains as thin as the means used to measure it. Painfully lean arms may result in access to a therapeutic feeding center, or at least a package of the high-protein peanut mixture known as Plumpy'nut—a potential means to continued survival. They may also

contribute to the statistical representation of population's distress. But the safe measure of green only indicates reasonable nutrition at the moment of measurement. It can promise nothing more about overall health, let alone a full or happy childhood. That would take a far more expansive set of tools, and a less attenuated sense of politics.

Rather than nuclear annihilation, the global Cold War ultimately bequeathed a new era of lower-intensity suffering along the edges of political power and economic exchange.⁵⁵ The establishment of a fast and efficient logistics system for humanitarian action changed everything and nothing, altering the landscape of civilian anguish without resolving it. Particular lives could now be spared, at least in the short run, from certain forms of distress. The situations that imperiled them, however, too often found eternal return, as emergencies grew "chronic" or re-emerged. Since the demographics of suffering usually far outweigh any response, it would be a gross misnomer to call the greater humanitarian apparatus anything like a solution to global states of disaster. Rather, the humanitarian kit culture represents nothing more—and also nothing less—than the means to effective measurement of the human agony of political failure through its temporary alleviation: a "bracelet of life" for a suffering planet.

Notes

1. See Lindqvist 2001.
2. Lindqvist 2001: 72–73. On the significance of visual media to conceptions of suffering, see Boltanski 1999; Sontag 2003.
3. On the AK-47, see Clapperton Mavhunga's essay in this volume. For more on proxy wars and their significance during the post-Vietnam period, see Westad 2005; Mamdani 2004. I follow MSF's historiographic perspective.
4. For more on the concept of "technopolitics," see Hecht 1998.
5. See Barnett and Weiss 2008; Fassin 2007; Feher et al. 2007; Fisher 1997; Fox 1995.
6. See Druett 2000; Lynn 1993.
7. JRCIRC 1944: i.
8. JRCIRC 1944.
9. JRCIRC 1944: i.
10. JRCIRC 1944: ii.
11. JRCIRC 1948: 245.

12. The 2004 edition of the Red Cross Logistics Field Manual does not mention this historical antecedent, though it does note the dispatching of family parcels during the war, and the gradual evolution of purchasing and transport between the late 1970s and the early 1980s (ICRC 2004: 24). For other discussions of humanitarian logistics see Cock 2003; Kaatrud et al. 2003; Payet 1996.
13. Brauman (1996: 76) and Rieff (2002: 75, 86, 166) caustically suggest how little protection this would offer. The apotheosis of the Holocaust as the extreme of evil may well have occurred a generation later, in the 1960s. See Rabinow 2003: 22; Novick 1999.
14. See de Waal 1997; Rieff 2002. The case of Biafra is both paradigmatic and complex; although remembered as a televised war, Benthall (1993: 102) suggests that newspaper and magazine photos may actually have been more influential. Like Benthall, Waters (2004) emphasizes the significance of religious actors in influencing European and American perceptions of the conflict. Here I merely follow the mythic version of MSF's origin. For a more complete history of the group's origins and early squabbles, see Vallaey 2004.
15. See Calhoun 2008.
16. Lindqvist 2003. For more on colonial medicine in Africa, see Headrick 1994 and Vaughn 1991. On the complex colonial history surrounding the term "civil society," see Comaroff and Comaroff 1999. While the Red Cross focused on civilizing conflicts between "civilized" countries, it helped transform both military medicine and international law. See Forsythe 2005; Hutchinson 1996.
17. The SAMU system emphasized mobile intensive care units that could offer rapid treatment by doctors, a step closer to Dominique-Jean Larrey's *hôpital ambulant* of the Napoleonic Wars than to the American model of paramedic transport to the emergency room. See Haller 1992; Zink 2006. When recounting MSF's history, as in my own interview with him, MSF-France's former leader and *philosophe* Rony Brauman often emphasizes the significance of SAMU, travel, and media technologies. See, e.g., Brauman 2006: 58; Tanguy 1999: 226–244; Emmanuelli 1991: 21–25. Bertrand Taithe further emphasizes the significance of SAMU in shaping MSF's particular sense of emergency (2004: 150–151).
18. "Dans leur sale d'attente 2 milliards d'hommes." The publicity campaign is outlined in *Bulletin Médecins Sans Frontières* 6 (1977).
19. Kouchner 1991: 327. Brauman 2006: 39–70 provides a more detailed and critical self-reflection. Although often opposed on such matters as a "right to interference" and state humanitarianism as described below, Kouchner and Brauman have both defined their ethics around a response to suffering, understood in medical terms.
20. Westad 2005; Mamdani 2004.

21. The Biafrans planned to sail a hospital ship to the rescue—something they subsequently did amid considerable media coverage. Their critics within MSF, more focused on improving field capacity, denounced this as an overly symbolic and superficial gesture. See Vallaey 2004: 275–306.
22. Although consistently popular with the French public, Kouchner has long been a controversial figure. The French journalist Pierre Péan (2009) has accused him of naïveté, corruption, and neo-conservatism. For another caustic assessment of Kouchner as a generational icon, see Ross 2002: 147–169. See also Allen and Styan 2000; Taithe 2004: 147–158. Within MSF, Kouchner's public legacy has proved a source of continued frustration; for example, when the organization won the Nobel Peace Prize in 1999, it found itself misidentified in the press with his positions. (See Vallaey 2004: 749–50.) Nonetheless, Kouchner has undeniably presented a coherent vision of moral intervention, one implicit in the phrase “sans frontières” if no longer embraced by MSF.
23. For a portrayal of the ethos and images of the time, see Guibert et al. 2009.
24. Vallaey 2004; de Waal 1997.
25. Though there are now 19 national sections of the larger movement, the central five remain European: MSF-France (founded in 1971), MSF-Belgium (1980), MSF-Switzerland (1980), MSF-Holland (1984), and MSF-Spain (1986). For the purposes of this essay I am treating MSF as a single entity, since the national sections share a general logistical approach. However, the sections remain effectively autonomous, even if linked by flows of funds and personnel, by a charter, and by a loose international association. There have been moments of extreme acrimony and near civil war, particularly among the largest three national sections (France, Belgium, and Holland).
26. Leopold 2005.
27. See the papers collected in Dodge and Wiebe 1985. Karl-Eric Knutsson uses the evocative phrases “at best chaotic” and “disaster within a disaster” in his chapter, “Preparedness for Disaster Operations.” As a number of the contributors note, the Karamoja famine could be traced not only to drought, but also to a background of social factors, including colonial land management policies in the region and increased availability of automatic weapons that altered the balance of cattle raids. For an incisive analysis of the principle of preparedness in an American context, see Lakoff 2007.
28. Well 1985: 177–182. The model for Well's strike force was a Swedish government team known as the Swedish Special Unit, whose efficient work in the West Nile region received accolades from several contributors to the volume.
29. Knutsson 1985: 187–188.

30. Brauman 1980: 9–12. Unlike Oxfam or Action Contre la Faim (Action Against Hunger, or ACF), MSF focuses primarily on therapeutic aspects of nutrition. Nonetheless, famine relief has played a significant role in its history, notably in Ethiopia in 1985.
31. This and all other descriptions refer to the 2003 English edition of the MSF Catalogue.
32. Though MSF may remain an association of doctors in nominal terms, in 2001–02 only 25% of its expatriate volunteers fit that category, another 32% being nurses or paramedics. In addition to the 1,605 field posts that cycle, the organization counted 13,320 “national” staff hired locally. See *MSF Activity Report 2001–2*: 97.
33. Pinel and Nzakou 2006; Vallaey 2004: 374–384.
34. This account of the origins of MSF's kit system draws from an interview with Jacques Pinel conducted in French by Johanna Rankin on December 21, 2004. Ms. Rankin, then working as an intern with MSF, kindly included questions about the kit system on my behalf. The translation is mine, from the transcript of the exchange included as an appendix in Ms. Rankin's undergraduate honors thesis (2005: 152–170). In this interview, Pinel—like every MSF logistician I have ever queried—presents the kit system as an inspired but ultimately matter-of-fact response to an inherent technical problem.
35. Vidal and Pinel 2009: 30–34.
36. Vidal and Pinel 2009: 32.
37. Rankin 2005: 166–67.
38. MSF Catalogue, 2003 edition.
39. Vidal and Pinel 2009: 34.
40. Pinel 2006.
41. MSF Field Library List, as recorded by the author in Brussels, July 2003.
42. Innovations include insect netting on vehicle grilles to simplify maintenance and experiments to improve a portable system for mixing food used in nutritional therapy. In 2003, the logistics director of MSF-Belgium told me: “One of MSF's luxuries is that we have the means to do R&D. Many others don't, but we have both will and resources. . . . The market usually favors things that are expensive and use a lot of energy. We want to try and find things that are less so, for example solar panels or a bike as an energy source.”
43. Field notes, Kampala, 2004. The point extends to medical action as well. Describing a 1983 mission in Sudan for a special issue of MSF-France's house journal on surgery, an MSF veteran outlined the challenge of adapting surgical discipline to

field conditions, including harmonizing surgeons from different backgrounds around a common standard of suture thread. See Falhun 2007.

44. The ICRC also began significant logistics developments in the late 1970s, and established a unit to centralize vehicle purchase and management in 1984. See ICRC 2004: 24. After the 1996 crisis in eastern Zaire, the UN established a Joint Logistics Center to better coordinate between agencies. See Kaatrud 2003.
45. Vidal and Pinel 2009: 33. As an example of its field focus, MSF's cholera kit diverged from WHO's model, in part because the former derived from the group's experiences in Malawi, as opposed to the latter's reliance on the findings of a research institute in Bangladesh. Since MSF had encountered higher incidence rates than expected in its own epidemiological studies and was running emergency programs, it emphasized treatment of acute cases and included more intravenous treatments relative to oral ones (Corty 2009: 84–85).
46. de Laet and Mol 2000.
47. Latour 1987: 226–227; Latour 1999.
48. By the end of the century, MSF had emerged as a relatively wealthy and financially independent NGO, with over 340 million euros in annual income, 80% of it derived from private sources (*MSF Activity Report 2001–2002*: 96). It could thus maintain a high measure of independent capacity rather than relying on donor agencies or foundations for the bulk of its operations. Although private fundraising through public appeals entails image management and thus responds to market logic in the broader sense suggested by Pierre Bourdieu, it is not reducible to economic profit.
49. For example, now that the kit concept has spread and the humanitarian market has expanded, many kits are no longer manufactured in-house at either MSF-Logistique in Bordeaux (the primary logistics depot for MSF-France, MSF-Switzerland and MSF-Spain) or MSF Supply in Brussels (a similar unit for MSF-Belgium, formerly named Transfer). Instead of maintaining a proprietary logistics center, MSF Holland largely relies on agreements with established suppliers to provide it with materials on a flexible, rapid-response basis.
50. Observations and quotations are drawn from author's field notes, Kampala, July 2003 and May 2004.
51. Field notes, Amsterdam, July 2006.
52. See Jean-Hervé Jézéquel, "Kit Culture," at <http://www.msf-crash.org>.
53. Foucault's use of the term "dispositif" is notoriously slippery. In a 1977 interview he described it as a "heterogeneous ensemble" involving a range of discursive and non-discursive elements, and as a formation that "has as its major function at a given historical moment that of responding to an *urgent need*." See Foucault 1980: 194–195; Rabinow 2003: 49–55; Cock 2005. Here I take Brauman's observation seri-

- ously to situate MSF's moral reasoning about emergency—its "regime of living" (Collier and Lakoff 2005)—amid the larger humanitarian enterprise it both enacts and criticizes.
54. For an elaboration of the theme of life in crisis, see Redfield 2005. Humanitarians, it is important to note, approach survival from the opposite direction of Agamben's deadly sovereign (1998), refusing to justify killing. At the same time, as Fassin suggests (2007), the politics of human inequality can reveal an uncomfortable limit in their moral reasoning.
55. On landscapes of conflict, extra-formal networks, and civilian suffering, see Nordstrom 2004.