VIOLENCE AGAINST
HEALTH CARE MUST END

IT'S A MATTER OF LIFE & DEATH

VIOLENT INCIDENTS AFFECTING HEALTH CARE

HEALTH CARE IN DANGER

JANUARY TO DECEMBER 2012

ICRC

REPORT

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* This interim report was commissioned by the Health Care in Danger project. The whole team was involved, particularly Caroline Moulins, who was in charge of entering and analysing the data.

SUMMARY

Over the course of 2012, the ICRC – through a variety of sources – collected information on 921 violent incidents affecting health-care during armed conflict and other emergencies in 22 countries. These incidents involved the use or threat of violence against health-care personnel, the wounded and the sick, health-care facilities and medical vehicles.

This interim report analyses the main patterns of such violence that were identified:

- Local health-care providers appear to be the group most affected, accounting for 91% of all cases (National Societies were affected in 16% of the cases); international health-care providers accounted for 7% of the cases.
- State security forces and armed non-State actors were responsible for a large proportion of the incidents. The proportion of acts or threats of violence attributed to armed non-State actors or to State security forces varies significantly.
- Health-care staff (doctors, nurses and paramedics) accounted for about 60% of the people directly affected.
- Two trends have emerged since a previous ICRC study: "follow-up attacks" affecting first-aiders and disruption of vaccination campaigns by violent means.

The ICRC will continue to gather incidents, in order to publish in 2015 a global analysis that will complement the final project report.

Introduction

In August 2011, the International Committee of the Red Cross (ICRC) launched Health Care in Danger, a project based on Resolution 5 of the 31st International Conference of the Red Cross and Red Crescent in 2011.[1] The resolution called upon the ICRC "to deepen its consultations with health-care experts from States and the health-care community, to formulate recommendations for making the delivery of health care safer in armed conflict and other emergencies."[2]

The project builds upon *Health Care in Danger: A Sixteen Country Study*, which was commissioned by the ICRC and published in 2011. The study, based on an analysis of 655 violent incidents in 16 countries,[3] provided further proof of the damaging effects of violence on access to and provision of health care. It also drew attention to the breadth of range of the incidents[4] affecting the safe delivery of effective and impartial health care in armed conflict and other emergencies: the wounded and the sick being denied access to health care, attacks on the staff of medical facilities, the shelling of hospitals, and so on.

Following up on the trends identified by the sixteen-country study is the basis for the Health Care in Danger project. Field teams in the 22 countries[5] where the ICRC is operational were asked to collect information, which was then centralized on a monthly basis.

This interim report analyses the results of a year's worth of data gathered by ICRC delegations: from January to December 2012, the ICRC collected information on 921 incidents.

The report is not exhaustive. It does not set out to replace the sixteen-country study; instead it seeks to give a snapshot of the data collected by the ICRC so far. The ICRC will continue to collect and assess such data for a report to be submitted to the next International Conference in 2015.

In almost all of the 22 countries selected for this exercise, health services were affected by violence, both actual and threatened. The number of incidents documented varied considerably from one country to the next. In eight countries, the ICRC received credible information about 40 or more incidents; in some of the other countries, only a few incidents of this kind could be recorded.

In many instances, a single incident involved the commission of various kinds of violence that affected people, infrastructure and vehicles simultaneously. For example, all of the following might take place during the same attack: an armed group might loot a hospital while also threatening staff and patients; an ambulance might be denied passage at a checkpoint and the patient and the person accompanying him taken out and beaten up.

Therefore, a single incident might affect 1) only people, 2) only infrastructure, and 3) both people and infrastructure at the same time. The data revealed the following:

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[1] http://www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm
[2] http://www.rcrcconference.org/en/addressing-barriers-to-health-care.html
[3] http://www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf
[4] An incident may consist of one or several acts or threats of violence that hinder or adversely affect provision of and/or access to health care. That is why the report cites 921 incidents but 1108 acts, or threats, of violence. A total of 1007 persons were directly affected by these acts or threats of violence.
[5] To avoid giving rise to political controversy, the 22 countries are not named: in seven contexts, data gathering took place within the circumstances of "other emergencies"; in the other 15, during "armed conflict."

1) In 319 of the 921 incidents, at least one person – health-care provider, patient or bystander – was affected (resulting in a total of 1007 direct victims).

2) In 355 incidents, a medical facility or vehicle was affected, without anyone being threatened or directly harmed.

3) In 200 incidents, a single incident affected people and infrastructure or vehicles simultaneously.

Lastly, in 47 of the 921 incidents, the health sector in general or a specific organization was affected, without anyone in particular being personally threatened or directly harmed – as happens when an organization is banned from an area by armed actors or when movement is restricted (curfew) even for medical evacuations.

The number of people indirectly affected by these violent incidents is incommensurably higher than those directly affected. Certain acts of violence can result in temporary or permanent disruption of health-care delivery (health-care workers might not return to work, medical facilities might close down, and so on). A "knock-on effect" of this kind can affect thousands of patients over time. Complex consequences of this kind are difficult to document with precision and not reflected in the data presented in this report.

Over the course of 2012, the ICRC learnt of 35 situations in which prevailing insecurity prevented health-care workers from performing their duties (there was no specific incident that directly affected health-care personnel or infrastructure, or medical vehicles). For example, medical personnel were unable to conduct home visits because they were reluctant to go out without adequate protection.[6] Because these situations did not involve a specific incident that had a direct bearing on health care or that directly affected health-care providers, they were not entered in the database. This is further proof of the fact that even when medical facilities, health-care personnel or patients are not directly attacked, delivery of or safe access to health care can be hindered, by uncertain security conditions.

[6] Concern over general insecurity and the extent of the risks health-care personnel may take surfaced in many of the experts' workshops organized by the ICRC in connection with the Health Care in Danger project. Measures for personal protection, such as wearing helmets or bullet-proof jackets, were debated during the workshops.

1. Sources of information

The sixteen-country study contained information collected mainly through the media (local and global); but this report is based for the most part on data gathered by ICRC teams in the field, who also evaluated the relevance of the information they had received. For the purposes of the report, the approach to gathering data was more field-based in the sixteen-country study, and that yielded a broader variety of sources.

More than 40% of all incidents were reported by what can best be described as a "bound community": medical personnel, administrative and support staff and victims – who had been identified by the various ICRC delegations as pertinent and reliable sources of information.

Some 27% of all incidents were reported by National Societies, ministries of health, and local and international organizations delivering health services, such as Médecins Sans Frontières (who contributed information on about 5% of the incidents).

About 10% were documented by ICRC staff in the field and 15% were reported by local media.

As a result of this broader and more inclusive approach, which goes beyond what the media report, some of the conclusions of the more media-reliant sixteen-country study have had to be adjusted slightly. As it was mainly local sources that provided the data, the disparity between local and international health-care providers, in terms of the number of violent incidents that affected them, is even greater than in the sixteen-country study. That study relied heavily on the international media and may have unintentionally emphasized incidents affecting international organizations. Similarly, threats of violence are more prominent in this report than in the sixteen-country study. Threats do not have the significance for the international media that they do locally, where they are a matter of great concern – because they might, for example, lead to health-care personnel leaving the area.

Table 1: Sources of information	
Bound community	422
Directly documented by ICRC	95
National Societies	133
Media (local and global)	155
Documented by other reliable humanitarian actors	91
Local health-care communities (including ministries of health)	25
TOTAL	**921**

2. Health-care providers affected

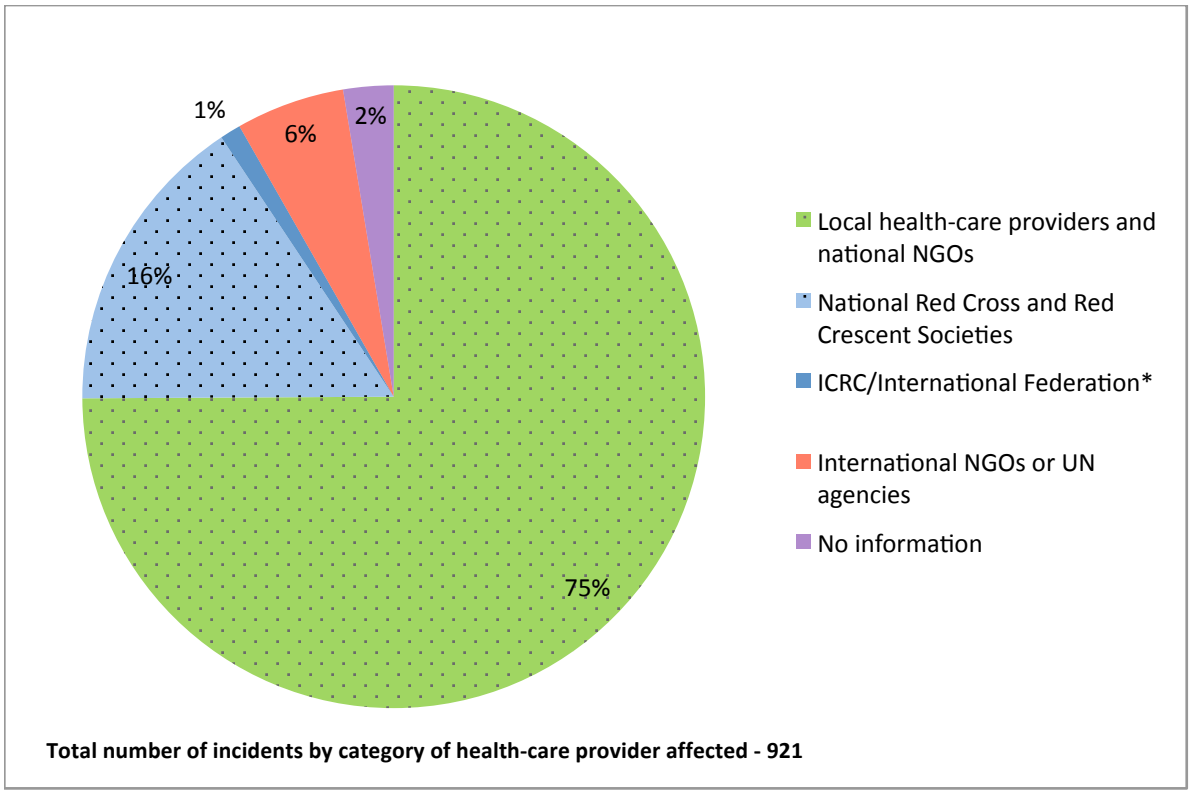

Figure 1: Health-care providers affected by category

* International Federation of Red Cross and Red Crescent Societies

The chart above, which illustrates the distribution of health-care providers affected by violence, shows that local health-care providers – that is, National Societies and local private and public health-care providers together – were directly affected by violence in slightly more than 90% of the 921 incidents.

This leads to an important conclusion: the Health Care in Danger project is not another way to discuss humanitarian access; its primary objective is to increase respect for all health-care providers, including those working within their communities.

3. Perpetrators

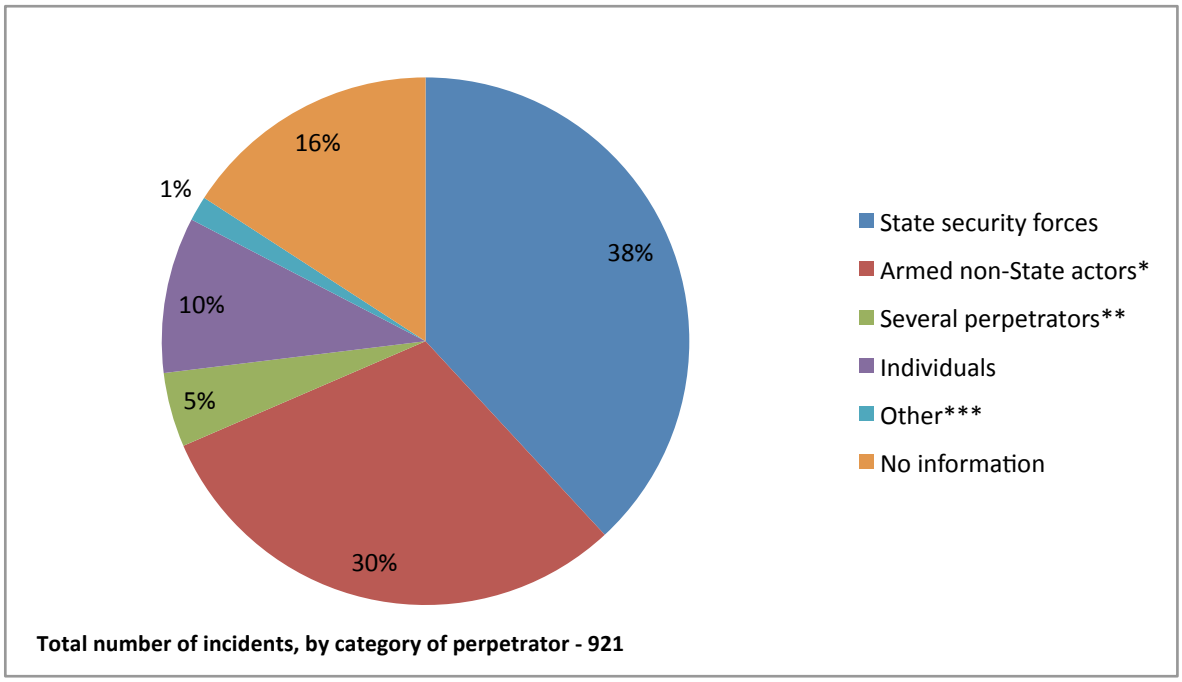

Figure 2: Perpetrators by category

* *Armed non-State actors*: Militias, private security, and rebel and guerilla movements[7]
***Several perpetrators*: More than one perpetrator involved/Shared responsibility
****Other*: Administrative measures, international military/police force

This chart shows that disregard for health-care is – irrespective of the context – not confined to one particular set of actors: State security forces and armed non-State actors are responsible for a large part of the recorded incidents. In many instances, singling out one particular actor is difficult, even impossible; these incidents are attributed to *several perpetrators* or fall into the category of *no information*. It is clear that aggregated data on perpetrators must be treated with caution, as circumstances can vary dramatically from one country to another.

A closer look at the eight countries for which 40 or more incidents were recorded reveals certain interesting variations. For instance, in one country, State security forces were the perpetrators in 80% of the cases; in another, armed non-State actors were responsible for 52% of reported incidents.

Violence perpetrated by relatives of the patient: this has become an issue in some countries, where ways must now be found to ensure the safety of personnel within and outside medical facilities. In the chart above, the category of *Individuals* includes a fair number of patients' relatives. The incidents reported often involve medical personnel being threatened or actually beaten up, by family members unhappy about the ordering of treatment priorities or the outcome of treatment: for example, a surgeon was beaten up by the uncle of a patient who died during an operation.

[7] See definition in *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence*, 2nd edition, ICRC, Geneva, 2013.

The issue has already been identified in medical journals as one that requires further attention. Incidents of this kind are not confined to conflict areas, but the risk of their occurrence increases during armed conflict and other emergencies.

4. Victims

The graphs and table below take a closer look at the incidents that affect various categories of victim.

As mentioned earlier, many incidents affect medical vehicles and infrastructure without directly harming people. A detailed analysis of such incidents will be included in the next interim report in early 2014.

In 2012, most of those directly affected were health-care personnel (614 out of 1007). Patients – war-wounded persons and others – accounted for about 30% of all victims: this category includes people who were actively prevented from getting access to health care.

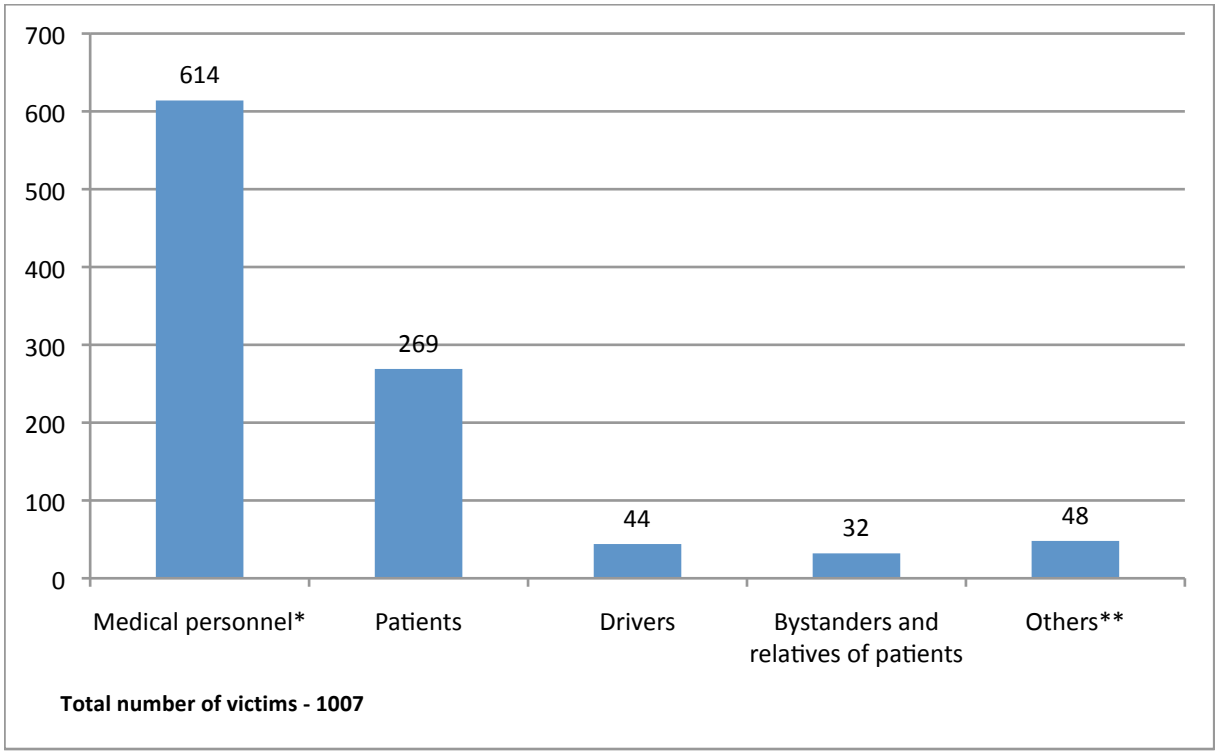

Figure 3: Victims by category

* *Medical personnel*: Doctors, nurses and paramedics

** *Others*: Aid workers, relatives of medical personnel, and unspecified persons.

Patients includes a few cases of wounded persons who were unwilling to face the risks involved in getting treatment.

Bystanders and relatives of patients refers to relatives of the wounded and the sick and persons assisting the wounded and the sick.

In 2012, the ICRC recorded 150 killings and 73 kidnappings of health-care personnel; but most of the incidents linked to medical personnel involved their being directly threatened. The making of threats may seem less a serious matter than killing and kidnapping; but its consequences, for people in the areas affected, can be far-reaching because it may result in the departure or flight of health-care personnel. The recurrence of such threats in regions affected by violence and conflicts of long standing can lead to a chronic absence of health-care personnel in these areas, and limit access to health care for entire communities.

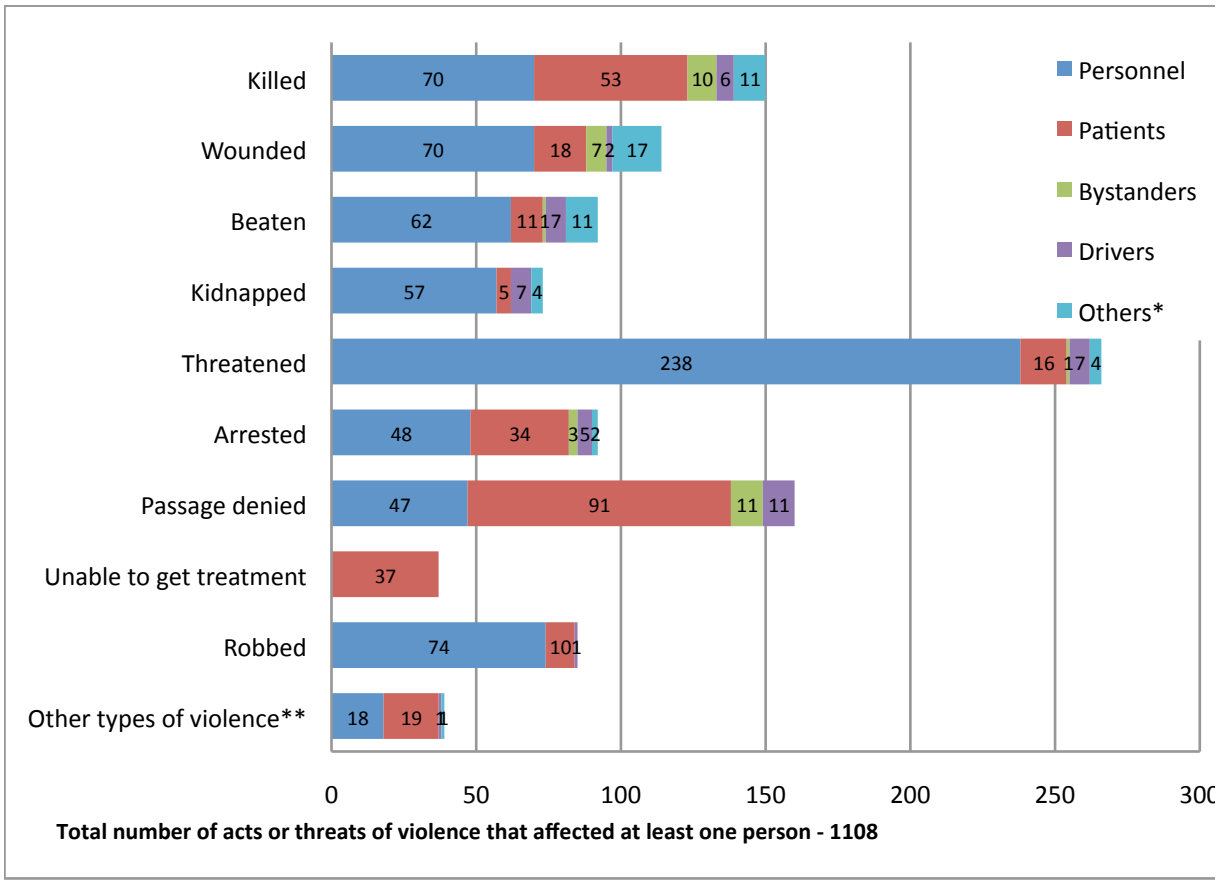

Figure 4: **Types of violence that affected at least one person**

* *Others*: Aid workers, relatives of medical personnel, and unspecified persons.

**Other types of violence: Sexual harassment, torture, forced displacement of patients, forced evacuation of a medical facility, forced disappearance, attacks that failed.

The graph above shows a breakdown of various kinds of violence and of persons affected: a total of 1007 people were affected by 519 incidents involving 1108 acts or threats of violence.[8]

[8] Note: This figure inevitably contains some double counting, the result of people being affected in more than one way by the same incident.

Table 2: Types of violence, by category of perpetrator, that affected at least one person during 519 incidents										
	Killing	**Wounding**	**Beating**	**Kidnapping**	**Threatening**	**Arresting**	**Denying passage**	**Responsible for lack of access****	**Robbing**	**Other types of violence*****
State security forces	33	32	44	1	56	71	127	23	31	17
Armed non-State actors	60	32	23	61	116	17	6	3	31	7
Several perpetrators	1	8	0	0	10	0	2	5	0	4
Individuals	13	12	19	1	38	0	17	6	4	6
Other*			1		2	0	4	0	10	2
No information	43	30	5	10	44	4	4	0	9	3
TOTAL	150	114	92	73	266	92	160	37	85	39

Total number of acts or threats of violence that affected at least one person - 1108

The table above shows a breakdown of various kinds of violence and of perpetrator: a total of 1007 people were affected by 519 incidents involving 1108 acts or threats of violence.
**Other*: Administrative measures, international military/police force
***Responsible for lack of access: patients that were not taken charge of by a specific provider because of the presence of enemy combatants.
****Other types of violence*: Sexual harassment, torture, forced displacement of patients, forced evacuation of a medical facility, forced disappearance, attacks that failed.

Matching types of incident with perpetrators reveals consistency of conduct across the various contexts. State security forces were involved mainly in *denying passage* while *threats* and *kidnappings* were associated for the most part with non-State actors.

5. Two issues of particular concern

Follow-up attacks

Follow-up attacks, for the purposes of the Health Care in Danger project, result in explosions intended to cause as many injuries and deaths as possible, including amongst those assisting the victims of a previous explosion. These follow-up attacks have consequences for ambulance services and first-aiders. This was a subject that came up during many of the consultations that the ICRC had with National Societies and other health-care providers in 2012 and early 2013.

In three of the 22 contexts where data were collected, health-care providers were reported to have been affected by such incidents. In 15 incidents, first-aiders trying to evacuate casualties became victims of follow-up attacks. Responsibility for attacks of this kind varies with the context: usually, either armed opposition groups or government forces are involved. Although the number of such incidents is comparatively small, the issue is thought to be serious enough to be tackled by the Health Care in Danger project.

Vaccination

Vaccination programmes were affected by 27 incidents in 7 contexts. In some instances, vaccinators were targeted: they were threatened and sometimes beaten up. In other instances, the perpetrators issued explicit threats and stole materials and supplies with a view of shutting down the programme.

Given the potential consequences of these incidents for entire communities, it is important to determine how best to restore acceptance for basic – perhaps life-saving – health services amongst armed actors throughout the world.

Conclusion

This interim report sets out the results of a year's worth of field-based data collection. The report could not have been prepared without the systematic work of dozens of staff members.

The various findings that emerge from the data collected in the field will serve as the basis for the operational strategies implemented by ICRC delegations to address the issue of violence affecting health care.

These findings will be used in various experts' workshops, which have been taking place since 2012 in connection with the Health-Care in Danger project.[9] The purpose of these workshops is to develop practical recommendations for making access to health care safer. The findings will also be made public, in order to raise awareness of the complexity of the issue. The report will help inform and mobilize organizations and other actors working on the issue.

In 2014, the ICRC will release another report of this kind. Until then, this interim report will serve as a basis for discussions and consultations related to the Health Care in Danger project, and for securing the involvement of the 'community of concern.'

This report demonstrates the necessity of involving all health-care providers and of reaching out and mobilizing a wide range of actors - national and international NGOs, authorities, private and public health-care providers, and others.

The ICRC will publish a global analysis in 2015 – at the end of the project – as a supplement to the global report to be issued at that time.

[9] www.healthcareindanger.org

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