VIOLENT INCIDENTS AFFECTING
THE DELIVERY OF HEALTH CARE

HEALTH CARE IN DANGER

JANUARY 2012 TO DECEMBER 2013

PROTECT HEALTH CARE
IT'S A MATTER OF LIFE & DEATH

ICRC

REPORT

ICRC

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JANUARY 2012 TO DECEMBER 2013

* This second interim report, part of the Health Care in Danger project, was prepared by Caroline Moulins.

SUMMARY

Between January 2012 and December 2013, the ICRC studied the effects of violence on health care during armed conflict and other emergencies in 23 countries. Information was collected, through various sources, on 1809 violent incidents that involved the use or threat of violence against health-care personnel, the wounded and the sick, health-care facilities and medical transports.

This second interim report analyses the main patterns of violence:

- Local, far more than international, health-care providers, bear the brunt of violence, as was the case in 2012.
- State armed forces and security forces, and armed non-State actors, are the main perpetrators, each of them being responsible for approximately one-third of all the recorded violence against the delivery of health care.
- The report on health-care facilities shows that they are affected mainly by looting, direct attacks, and disruptive armed entry.

The ICRC will continue to gather information on such incidents and publish, in 2015, an exhaustive analysis that will complement the final project report.

Introduction

This report aims to analyse the data collected by 23 delegations of the International Committee of the Red Cross (ICRC) from January 2012 to December 2013.

This is the second in a series of ICRC reports. The first, issued in May 2013, was titled *Violent Incidents against Health Care*[1]: it presented and analysed data – collected by ICRC delegations during 2012 – on violent incidents affecting the delivery of health care in 22 contexts.[2]

The methodology was the same as in 2012. The data were collected from a broad range of sources: people directly affected by or involved in the incident (victims, witnesses, directors of hospitals, and so on), National Red Cross and Red Crescent Societies, mass media (local and international), other humanitarian organizations, local health-care communities.

The Health Care in Danger project

The Health Care in Danger (HCiD) project is an ICRC-facilitated project running from 2011 to 2015. For the first two years, the ICRC concentrated on furthering its understanding of the problems faced by health-care providers and on raising awareness of these issues. The ICRC also sought – through a series of consultations with experts on various issues, such as security of infrastructure and management of ambulance services – to identify good practices and formulate recommendations for ensuring the safety of health-care providers.

In 2014, the project entered a new phase, during which all stakeholders will be encouraged to apply, in their contexts, the recommendations developed at the various meetings of experts. This should lead to greater engagement amongst the international community.

In 2013-2014, the data collected were used to prepare the background documents distributed during experts' meetings [3] , such as the Sydney workshop (December 2013) titled "Military practice: From training to operational orders," which focused on the obstacles to facilitating the work of health-care providers that armed forces might face while planning or conducting their operations.[4] The data also served to orient and develop ICRC delegations' operational response to HCiD issues in most of the contexts studied, and in contexts not included in the data collection exercise.

The volume of incidents documented may vary considerably from one context to the other: in 2012 and 2013, incidents were documented in 21 of the 23 countries covered – none was reported in two countries; six countries accounted for over 100 incidents each, while seven others accounted for fewer than 30 incidents each. These differences may be the result of different dynamics of violence in different contexts, but may also reflect bias in data collection, particularly where access to victims is problematic and information scarce and difficult to verify. The aggregated information is nevertheless essential to identify the main patterns of violence that affect the delivery of health care.

In 2013, one context was added to the data collection exercise, raising the number of countries studied to 23. In these 23 countries, combining the data from 2012 and 2013 yields a figure of 1809 documented incidents.[5] This interim report aims to present and compare the trends on violence against the delivery of health care in 2012 and 2013.

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[1] http://www.icrc.org/eng/assets/files/reports/4050-002_violent-incidents-report_en_final.pdf
[2] Beginning in 2013, data were gathered in 23 countries, as one more country was added to the data-collection exercise.
[3] To find the list of HCiD expert workshops, see the following link: http://www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-expert-consultations.htm
[4] In addition to consultations with military experts, ICRC delegations also discussed their own delivery of health care with armed non-State actors, within the framework of their bilateral dialogue.
[5] The report published in 2013 analysed 921 incidents collected throughout the previous year.

The first section will examine the general trends of violence against health-care providers. The second will concentrate on the effects of violence on ambulances. The last section of the report will address the issue of violence against health-care facilities, a particular concern given that more than 40% of the incidents documented affected health-care facilities (708 incidents).[6]

[6] This analysis will contribute to the last experts' meeting, on the security and safety of health-care facilities, which will take place in Pretoria in April 2014 (follow-up to a previous meeting in Ottawa).

I. Aggregated data

The data collected from January 2012 to December 2013 reflects trends that are generally consistent with those identified by the 2013 report, which was based on data collected in 2012.

A. Sources of information

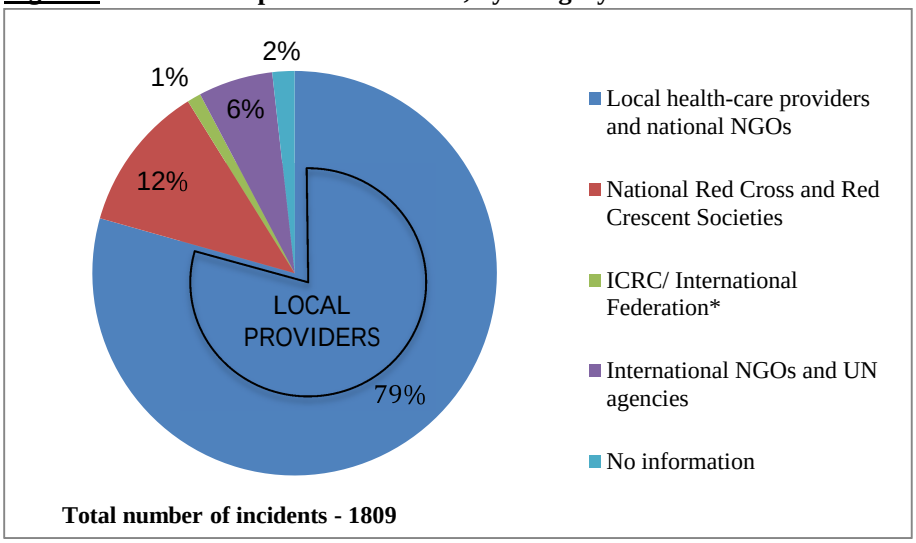
This report is based essentially on information collected in the field. Table 1 shows the distribution of incidents by sources of information.

Table 1: Sources of information	
ICRC – through dialogue with victims, health-care personnel and administrative and support staff	**881**
National Red Cross and Red Crescent Societies	**199**
Media (local and international)	**349**
Other reliable humanitarian actors	**178**
Local health-care community (including Ministry of Health)	**202**
TOTAL	**1809**

B. Types of health-care provider affected

The data collected show that local health-care providers, including National Society staff, were the group most affected by violent incidents: they account for 91% of the incidents documented. This may be regarded as validating the primary objective of the HCiD project, which is to increase respect for all health-care providers, including those working within their communities, and not to draw attention only to incidents affecting international humanitarian organizations, including the ICRC.

Figure 1: Health-care providers affected, by category



* International Federation of Red Cross and Red Crescent Societies

C. Types of violence affecting people

Of the 1809 incidents in total, ICRC delegations collected information on 1092 incidents affecting 2456 victims (medical personnel, patients, bystanders, and so on) in 2624 acts or threats of violence.[7]

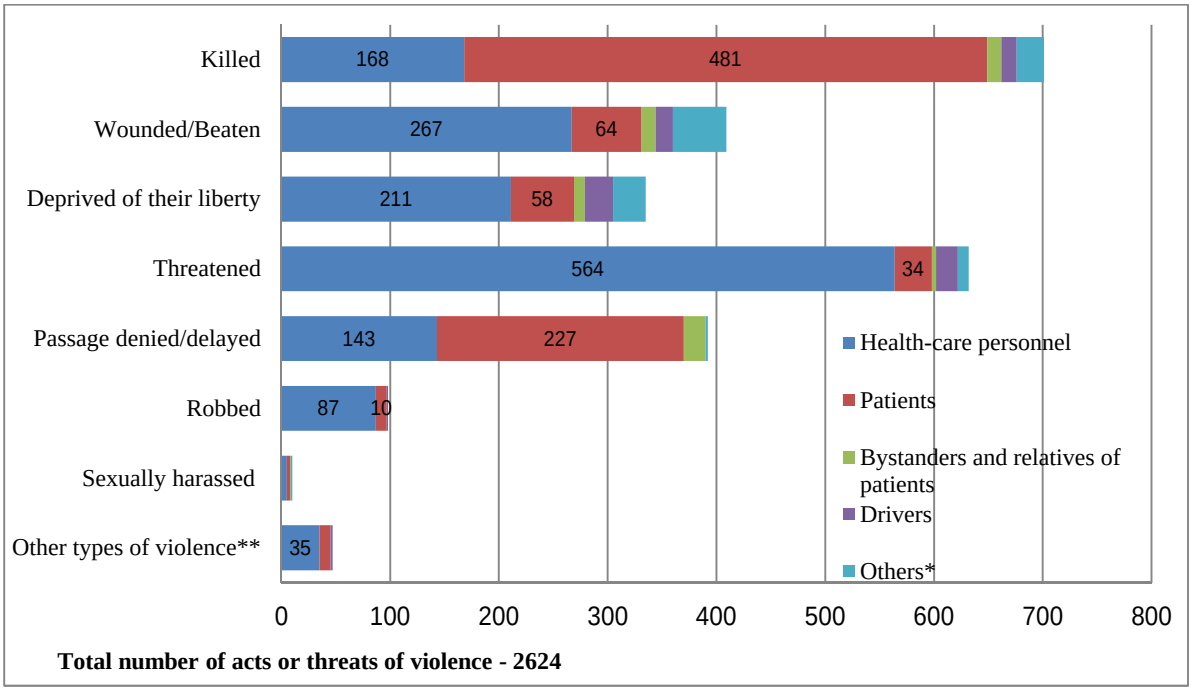
Mitigation measures

Among the recommendations arising from the experts' meetings, a few specifically addressed the issue of helping health-care personnel manage the stress caused by threats or violence at work. This may be one of many solutions for improving the handling of security incidents.

The chart below represents the types of violence directed against health-care personnel, patients and others. The data show that a high number of health-care personnel received threats (564). Threats should not be regarded as anything other than serious. They often have damaging consequences for the delivery of health care: when such incidents recur, they can cause the departure of health-care personnel, the closure of health-care facilities, and leave hundreds, even thousands, of people in need without access to health care, in areas already deserted by health-care personnel.

The chart also draws attention to the alarming number of patients who were killed (481) or to whom passage was denied (227): these are patterns of violence that have serious implications for the safety of people who are under treatment or seeking it.

Figure 2: Violence that affected at least one person



* *Others*: Aid workers, relatives of health-care personnel.

***Other types of violence*: Torture, forced displacement of patients, forced evacuation of health-care facilities, forced disappearance, attacks that failed.

Specific kinds of threat were identified, such as those used to force health-care personnel to violate medical ethics. This is a matter for serious concern: in 2012 and 2013, the ICRC recorded 59 cases of doctors being coerced to give certain patients priority and not being permitted to treat the most urgent cases first.

[7] One incident can have various categories of victim, affected by different types of violence. In some cases, people may be affected in more than one way by the same incident: for example, a person threatened with death if he continues to provide medical care to certain communities, who is being robbed at the same time.

v Sexual violence and HCiD

Sexual violence was not widely reported in the contexts covered by the ICRC's data collection exercise. However, it was possible to identify patterns that revealed a strong link between sexual violence[8] and HCiD issues, and to therefore confirm that in situations of armed conflict, sexual violence does not usually occur in isolation.

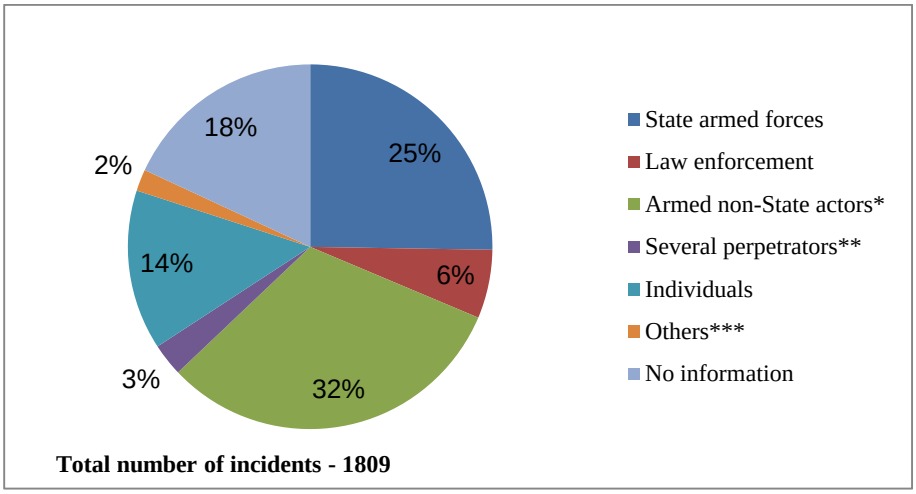
The ICRC documented ten instances of sexual violence against health-care personnel and patients in medical facilities. Threats of sexual violence against personnel and patients were also recorded in some of the 632 cases of threats. The data collected also supported the view that targeted attacks on health-care facilities could make it difficult for victims of all types of violence, including sexual violence, to access the necessary health care and support, and prevent medical staff from providing effective treatment for victims.[9]

These findings complement conclusions reached by the ICRC in contexts other than the 23 covered by this report, about the difficulties that victims of sexual violence may encounter while trying to access health care. For instance, while access to medical services might not be easily available for victims of all types of violence during armed conflict, the 'invisibility' of the wounds caused by sexual violence creates an additional and severe barrier for its victims who try to seek medical attention. Furthermore, the silence of victims – owing to feelings of shame and the fear of stigmatization and rejection by their family and communities, and therefore of isolation – can prevent them from sharing their experiences and complicate efforts to help them gain access to health services. Their silence also hinders the collection of accurate data, which can make it difficult to develop effective and targeted programmes to prevent and respond to sexual violence.

D. Perpetrators

The distribution of perpetrators remained roughly the same in 2012 and 2013. As in 2012, State armed forces and security forces (military and police) and armed non-State actors are equally culpable, each accounting for approximately 30% of the total number of incidents (see chart below).

Figure 3: Perpetrators by category



* *Armed non-State actors*: Militias, private security, and rebel and guerrilla movements that are not part of a State's law enforcement, military, or security apparatus.
***Several perpetrators*: More than one perpetrator involved/Shared responsibility
****Others*: Administrative measures, international military/police force, peacekeepers

[8] "Sexual violence in armed conflict: Questions and answers," ICRC, 2013. http://www.icrc.org/eng/resources/documents/faq/sexual-violence-questions-and-answers.htm
[9] Unimpeded access to health-care facilities is especially important for victims of sexual violence, as they require urgent medical care (preferably within 72 hours) to reduce the risk of sexually transmitted diseases and unwanted pregnancies.

The 2013 report drew attention to the issue of attacks against health-care personnel by relatives of patients – because they were unhappy about delays, the nature of the treatment and its results, and so on. The trend in this regard was unchanged: 18 such attacks in 2012, and 20 in 2013[10].

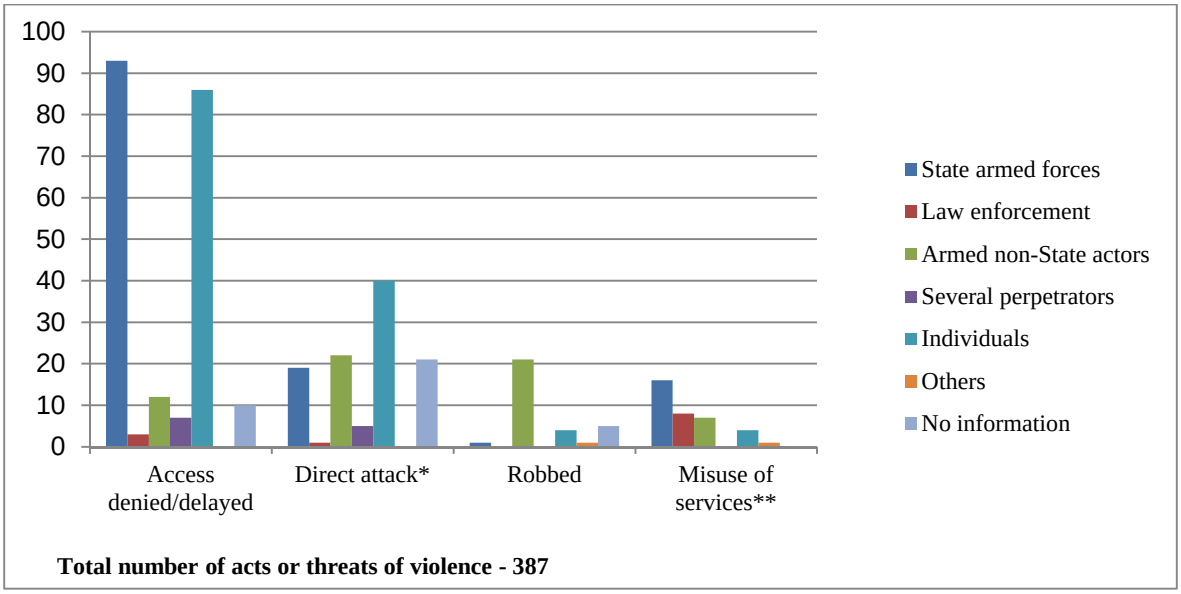
[10] This is a comparatively low figure in relation to the total number of incidents documented; however, these incidents were restricted to only a few contexts, where they seriously affected the security of health-care personnel, and access to health care for the population.

II. Ambulances

Most cases documented refer to violence directed against formal means of transportation – that is, ambulances. In many contexts, however, the wounded and the sick are transported by private vehicles or other unofficial and sometimes informal means. Violence against such means of transportation is usually underreported. In total, the ICRC identified 391 incidents where means of medical transportation were affected: ambulances were affected in 302 incidents (387 acts or threats of violence in total), non-land-based formal means of transportation (ships, aircraft) in nine, and alternative vehicles (private taxis, NGOs' vehicles) in 80. Only ambulances will be included in the analysis that follows.

The chart below shows the types of violence affecting ambulances exclusively, and their distribution by perpetrator. In 2012 and 2013, *Access delayed/denied* and *Direct attack* were the most common forms of violence directed against ambulances. When the violence is broken down by perpetrator, we see that *Individuals*[11] played a significant role in delaying and attacking ambulances. This is a category consisting mainly of demonstrators, or tribesmen, hampering the delivery of health care.

Figure 4: Types of violence affecting ambulances, by category of perpetrator



**Direct attack*: The ambulance was fired at, shelled, stoned, and so on.

*** Misuse of services*: Takeover, storing or transporting weapons, launching an attack from it, use for purposes other than medical ones.

v Consequences

An incident affecting an ambulance can take various forms: denial of passage to patients, beating up or arrest of medical personnel, material damage to the ambulance, and so on.

v Denying or delaying access

In most cases, access was denied or delayed either by individuals or by State armed forces. Of the 75 incidents in which access was delayed to ambulances, 62% occurred in the vicinity of a military checkpoint. In more than 74% of these incidents, the ambulance was held up for less than an hour, but even such a comparatively short delay can be fatal.

[11] *Individuals*, in this definition, are not members of a State's armed forces or security forces, and not affiliated to any armed non-State actors.

Measures to make it safer for ambulance services to deliver health care

The workshop in Mexico made recommendations for improving the management of ambulance services in emergency situations. These entailed: increasing acceptance among the community for emergency services and consolidating these services, especially through trust-building activities and by identifying and coordinating the work of the various providers.

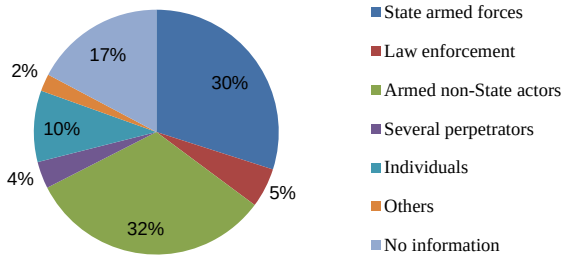
The workshop for armed forces organized in Sydney in December 2013 tackled the vital issue of preventing or minimizing delays or denials of passage for medical transports, particularly at checkpoints, as this could have serious consequences for the sick and the wounded being evacuated. There was general agreement amongst participants that medical evacuations should be given priority and ambulances allowed to pass through checkpoints as quickly as possible. Participants recognized from the outset that the checking of ground vehicles inevitably entailed the causing of some delay. The discussion therefore focused on means to ensure that such delays were minimized and alternative routes communicated, should passage be denied for imperative military reasons.

III. Health-care facilities[12]

Of the 1809 incidents documented, 708 (more than 40%), were attacks against, or within, health-care facilities. It is therefore important to take a closer look at the violence affecting health-care facilities and possible solutions for reducing the risk of attacks and improving delivery of and access to health care.

In these 708 incidents, which consisted of 737 different acts or threats of violence, the main perpetrators were State armed forces and security forces (35%, including law enforcement agencies) and armed non-State actors (32%). These findings correspond roughly to the distribution of responsibility revealed by the aggregated data for all types of violence (see Figure 3).

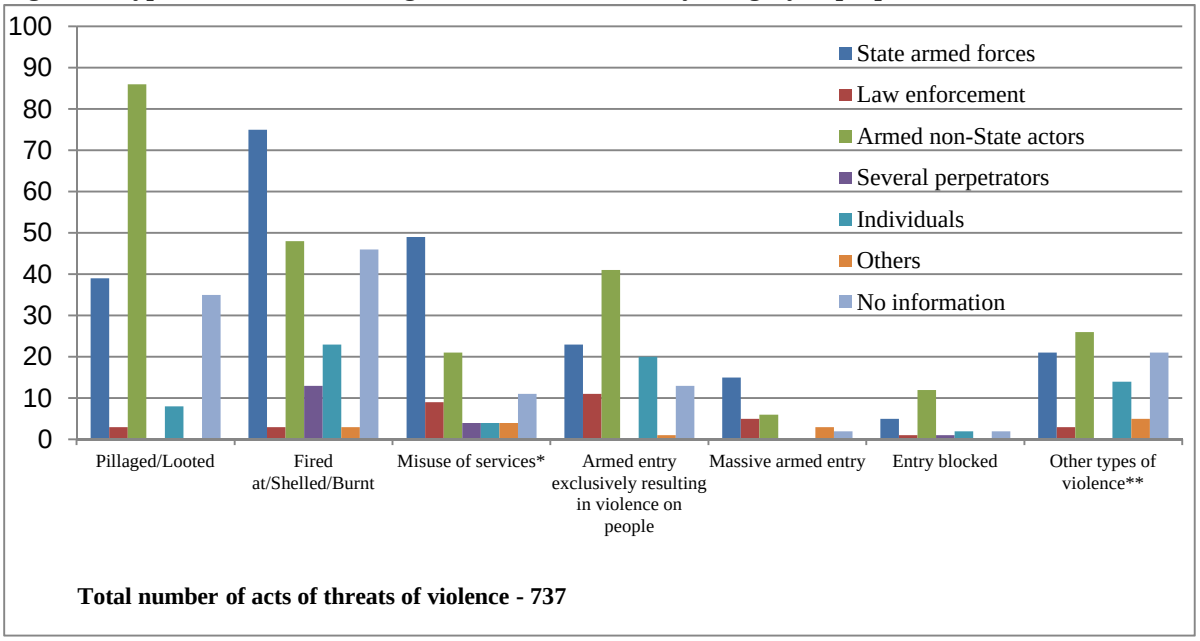
Figure 6: Perpetrators by category affecting health-care facilities



Total number of incidents- 708

The chart below shows the types of violence affecting health-care facilities by category of perpetrator: the main categories reported are direct attacks in the form of bombing or shooting (211 out of 737) and pillage/looting (171 out of 737). In the chart below, we have removed the cases of disruptive armed entry, since most of them involved other types of violence (robbery, misuse of services, attacks, and so on). They will be examined later in the report to get a better understanding of the issue of armed entry, by itself, separate from other types of violence.

Figure 7: Types of violence affecting health-care facilities, by category of perpetrator



Total number of acts of threats of violence - 737

* *Misuse of services*: Takeover, storing weapons, launching an attack from the facility, use for purposes other than medical ones.

** *Other types of violence*: Forced closure of the facility, threat of attack, break in, administrative decision.

[12] For the purpose of the report, the following paragraph will analyse only fixed, not mobile, health-care facilities.

v Damage to health-care facilities

Of the 737 acts or threats of violence, 244 involved material damage to health-care facilities. In 88% of these cases, one facility was materially damaged by an attack; in 12% of the cases, health-care facilities suffered collateral damage.

v Pillage/Looting[13]

Pillage accounted for 171 of the 737 acts or threats of violence affecting health-care facilities. Health-care facilities – stocked with medical equipment and supplies, as well as cash – are a tempting target for unlawful violence. Pillage can have damaging consequences for the provision of medical care: health-care facilities are often left without the equipment or supplies needed to treat patients and such incidents can also result in health-care personnel, fearful for their safety, leaving the area. It is not always possible to know whether medical equipment and supplies were stolen to limit a facility's ability to provide care or for use by the perpetrators to deliver health care themselves.

In 52% of the cases, acts of pillage were carried out by armed non-State actors; in 20% of the cases, the perpetrator has not been identified.

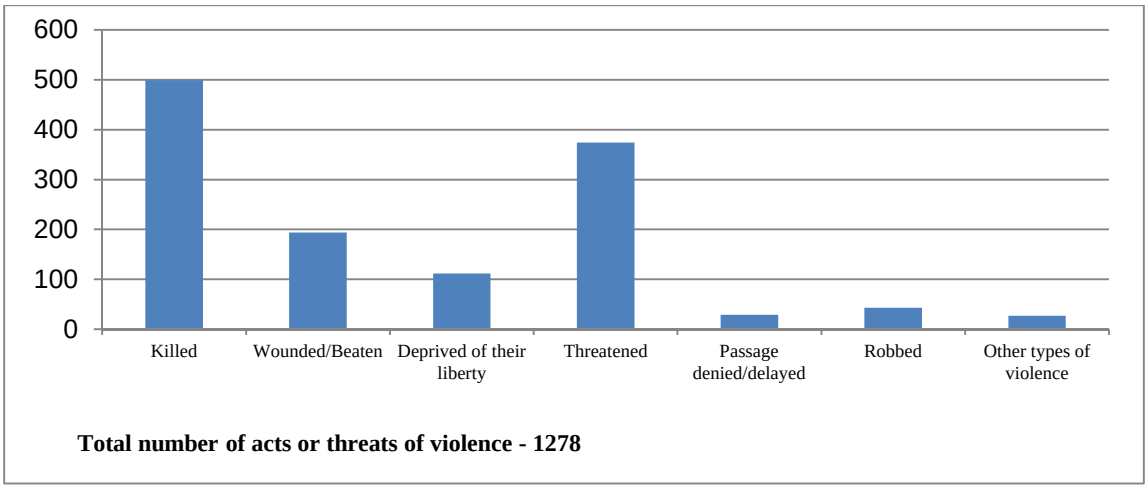
A total of 171 health-care facilities were pillaged. It is worth noting that 44% of these incidents resulted in a loss of equipment, and 46% in the health-care facility's medical supplies (mainly medicines) being stolen. Very few cases involved theft – of money or of documents from the archives – or the cutting off of water or electricity.

v Disruptive armed entry

Disruptive armed entry is defined as any incursion of an armed actor into a health-care facility that disturbs the functioning of the facility and/or prevents delivery of or access to health care. Such acts are often accompanied by threats against health-care personnel, pillage, damage to the facility, and the killing of patients. They instil fear among patients and health-care personnel.

Responsibility for disrupting the functioning of health-care facilities, by bringing weapons into them, is, once again, shared among armed actors. Figure 9 below shows the consequences for people of violence that takes place in a health-care facility...

Figure 9: **Consequences for people of violence occurring within health-care facilities**



[13] Pillage/Looting: Forcible acquisition of private or public property for purely private gain or personal use. It includes robbery, burglary, or breaking into a health-care facility.

Measures to make health-care facilities safer

Preventing unauthorized armed men, women and children from entering a facility is almost impossible. However, there are measures to make disruptive armed entry more difficult. The simplest is a boundary wall or fence with fixed entry points controlled by staff; this would prevent people from casually wandering into the health-care facility. Other measures could be taken as well: chicane barriers along the approach to the facility; a buffer zone at the entrance to inspect people entering the facility; prominently displayed 'No weapons' signs; and so on. Adopting such safety measures is important; but it is just as important to maintain regular contact and open lines of communication with local military and police forces.

- ***Search operations***

Disruptive armed entry can also take the form of search operations: this depends entirely on the way these operations are conducted. Armed entry of this sort was given particular attention at the workshop in Sydney on military practice. The ICRC recorded 35 incidents involving disruptive armed entry by State armed forces and security forces: they were conducting search operations, to arrest or remove patients from hospitals, or in pursuit of rebels thought to be hiding in the vicinity of the facility. The ICRC also collected 30 cases of patients being arrested inside health-care facilities against the wishes of their doctors, and prevented from receiving treatment.

On the whole, participants at the Sydney workshop took the view that military search operations in hospitals and other health-care facilities should be an exceptional measure, and that it was important to find a balance between the military advantage to be gained from such actions and their impact in humanitarian terms. A number of recommendations were made, for minimizing the adverse impact of such searches: for instance, that they should be coordinated with health-care personnel.

In light of the data gathered on incidents involving health-care facilities, it is more important than ever to draw attention to the need to make health-care facilities safer. The complexity of this issue must be recognized, and a comprehensive approach for tackling it has to be developed.

Conclusion

The purpose of this two-year data collection exercise by ICRC delegations was to provide a tool for advocacy and for raising awareness of the issues connected with the HCiD project. It should also be of use in influencing decision-makers, drawing attention to the urgent need for action, facilitating dialogue with potential perpetrators, and mitigating risks.

Within the context of the HCiD project, a final report will be published in 2015 and presented at the 32nd International Conference of the Red Cross and Red Crescent that year.

v Outstanding issues

The report issued in 2013 highlighted the growing number of 'follow-up attacks' and of attacks on health-care personnel involved in vaccination campaigns. Initially, these issues were not matters of priority for the HCiD project; however, the increasing number of such incidents and their humanitarian consequences have changed that.

- **Follow-up attack**

For the purpose of the project, 'follow-up attacks' are defined as explosions intended to cause as many injuries and deaths as possible, including amongst those assisting the victims of a previous explosion. They usually directly target first responders[14] approaching the scene of a prior attack to provide assistance or to secure the area. In 2012 and 2013, the ICRC recorded 26 follow-up attacks. The perpetrators were mainly armed non-State actors (34%) and State armed forces (31%); it should be kept in mind that no one claimed responsibility for 23% of the attacks.

- **Vaccination**

In 2013, attacks against health-care personnel involved in vaccination programmes were a source of growing concern. A total of 64 attacks of this kind in in eight contexts were collected. The incidents varied from attacks, or threats of attack, against persons providing vaccinations to the theft of medical supplies. Given the far-reaching consequences of such incidents, it has become imperative to restore acceptance for vaccination campaigns amongst armed actors throughout the world.

[14] The term 'first responders' refers to medical staff and paramedics – and in some instances, to non-medical personnel – who arrive at the scene of an incident first and provide emergency care.

The HCiD project and monitoring trends in violence affecting health care

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. 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."

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

MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.

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