International Review of the Red Cross (2013), **95** (890), 331–340.
Violence against health care
doi:10.1017/S1816383113000684

INTERNATIONAL REVIEW of the Red Cross

OPINION NOTE

A way forward in protecting health services in conflict: moving beyond the humanitarian paradigm

Leonard S. Rubenstein*
Leonard S. Rubenstein, JD, is Senior Scholar and Director of the Program on Human Rights, Health and Conflict at the Center for Human Rights and Public Health of the Johns Hopkins Bloomberg School of Public Health. He is also Chair of the Safeguarding Health in Conflict Coalition. Before joining Johns Hopkins, Mr. Rubenstein served as President of Physicians for Human Rights.

Keywords: health care, health services, neutrality, impartiality, human rights, conflict, humanitarian law.

Attacks on health workers, clinics, hospitals, ambulances and patients during periods of armed conflict or civil disturbance pose enormous challenges to humanitarian response and constitute affronts to the imperatives of human rights and civilian protection. Violence inflicted on humanitarian aid workers is gaining the global attention it warrants. While the number of attacks on aid workers has decreased in recent years, in a handful of places, notably Sudan, Afghanistan, and Somalia, they have become more spectacular and frightening, with aid agencies targeted for kidnapping and subjected to use of explosives because of their

* Financial support for this essay was provided by the John D. and Catherine T. McArthur Foundation and the United States Institute of Peace.

© icrc 2014

perceived affiliation with Western governments.[1] The assaults have galvanised the humanitarian aid community to track attacks[2] and to engage in intensive and sophisticated discussion of means to increase operational security. After worldwide consultation, in 2011 the United Nations (UN) Office for the Coordination of Humanitarian Affairs (OCHA) issued a report that summarised the fruits of experience and stimulated consideration of security strategies for aid providers.[3] By contrast, however, until very recently the far larger number of incidents of violence inflicted on and interference with indigenous health services and on international and local development agencies by state and armed groups has received comparatively little attention.

In the past two years, the landscape of attention has begun to shift.[4] Notable milestones include a report by the International Committee of the Red Cross (ICRC)[5] and the launch of its Health Care in Danger campaign; a resolution at the 31st International Conference of the Red Cross and Red Crescent Movement urging action by states and the entire Red Cross and Red Crescent Movement;[6] a policy resolution by the World Health Assembly requiring leadership by the World Health Organization (WHO) in the collection and dissemination of data on attacks on health services;[7] inclusion of attacks on schools and hospitals in the UN Security Council's accountability mechanisms for protecting children in armed conflict;[8] recognition of the problem by the UN Secretary-General in his 2012 report on the protection of civilians in armed conflict;[9] and a new coalition devoted to the protection of health in conflicts. Assaults against health have been included in official investigations of human rights violations and war crimes. For example, an independent commission investigating atrocities in Syria identified the bombing

1 Abby Stoddard, Adele Harmer, and Victoria DiDomenico, *Providing Aid in Insecure Environments: 2009 Update*, Humanitarian Policy Group, 2009, available at: www.humanitarianoutcomes.org/resources/ProvidingAidinInsecureEnvironments20091.pdf. All internet references were last visited in August 2012, unless otherwise stated.

2 Humanitarian Outcomes, *Aid Worker Security Database*, 2012, available at: https://://aidworkersecurity.org/.

3 Jan Egeland, Adele Harmer, and Abby Stoddard, *To Stay and Deliver: Good Practice for Humanitarians in Complex Security Environments*, UN Office for the Coordination of Humanitarian Affairs, 2011, available at: http://ochanet.unocha.org/p/Documents/Stay_and_Deliver.pdf; see also Abby Stoddard and Adele Harmer, *Supporting Security for Humanitarian Action: A Review of Critical Issues for the Humanitarian Community*, Humanitarian Outcome, March 2010, available at: http://reliefweb.int/sites/reliefweb.int/files/resources/9B8094812827584485257719005804D4-HO-SupportingSecurityforHumanitarianActionMarch2010.pdf.

4 Leonard S. Rubenstein, *Protection of Health in Armed and Civil Conflict: Opportunities for Breakthroughs*, Center for Strategic and International Studies, 2011, available at: http://csis.org/files/publication/120125_Rubenstein_ProtectionOfHealth_Web.pdf.

5 ICRC, *Health Care in Danger: A Sixteen-Country Study*, 2011, available at: www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf.

6 31st International Conference of the Red Cross and Red Crescent Movement, Resolution 5, 'Health Care in Danger: Respecting and Protecting Health Care', 2011, available at: www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm.

7 WHA Res. 65.20, 26 May 2012.

8 UNSC Res. 1998, 12 July 2011.

9 *Report of the Secretary-General on the Protection of Civilians in Armed Conflict*, UN Doc. S/2012/376, 22 May 2012, paras. 13, 14, 33, 34, 74.

of hospitals and attacks on medical personnel as among 'the most alarming features of the conflict'.[10]

It is often assumed that responding to the vulnerabilities of indigenous health service providers and development agencies simply requires extending the humanitarian aid protection paradigm to them. Common ground certainly exists, particularly insisting on the respect for health services by all parties under international law and adapting humanitarian agency security strategies to local needs. Yet in certain key respects, circumstances and governing principles differ between humanitarian missions on the one hand and indigenous health services and development programs on the other. Unless these differences are recognised, global approaches to the protection of local health service providers and development actors may be ineffective or paradoxically exacerbate threats to them. Most fundamentally, to assure the safety of these health providers, we need to expand our vision beyond the humanitarian aid paradigm and, in appropriate circumstances, expand the use of the tools of reporting, protection and accountability that derive from human rights movements.

The humanitarian security paradigm and local health services providers

The dominant health security paradigm in complex environments is understandably rooted in the work of humanitarian aid agencies, as well as local Red Cross and Red Crescent societies, which have become a fixture in response to war and disaster. That paradigm focuses on adherence to humanitarian principles, securing and maintaining access, and developing sophisticated ongoing security analysis and programming.[11] Strategies for increasing the security of humanitarian aid organisations include rigorous risk assessment, articulation of acceptable levels of risk, proactive methods to gain acceptance and rootedness in communities, negotiation with combatants for access, devolved management, protective measures, deterrence through armed security, and demonstrated strict adherence to humanitarian principles of impartiality and neutrality.[12] Additionally, analysts have focused on extrinsic factors, particularly the need for humanitarian space, especially in circumstances where Western militaries are operating, and the relaxation of restrictions on aid group interaction with organisations deemed by governments to be engaged in terrorism.[13]

In designing security strategies, the OCHA report emphasises, the aid groups' goal is to stay in the region in need in order to provide services. Because the access of aid organisations to affected populations is frequently dependent on the permission of governments or armed groups that control territory, such

10 *Report of the Independent National Commission of Inquiry on the Syrian Arab Republic*, UN Doc. A/HRC/22/59, 5 February 2013, para. 138.
11 J. Egeland, A. Harmer, and A. Stoddard, above note 3.
12 *Ibid.* Also see A. Stoddard and A. Harmer, above note 3.
13 J. Egeland, A. Harmer, and A. Stoddard, above note 3.

organisations often face constraints in employing potential security measures that involve public protest or criticism. Although there is ongoing debate about whether and how aid groups take steps to reveal or protest human rights violations they see or experience, there is little doubt that in many situations, a direct trade-off exists between speaking out and maintaining access. Further, public attention to denial of or interference with an agency's humanitarian work can stimulate retaliation or further violence against it. Thus, with some exceptions, aid agency security strategies do not generally invoke public mechanisms such as naming and shaming through the media or UN civilian protection or human rights mechanisms. Even sharing of security data raises concerns for aid organisations.

The situation for indigenous health providers such as local clinics, hospitals, nurses, doctors, and ambulance services, however, often differs from that of humanitarian aid organisations. For the purpose of this discussion, these are local groups or individuals, not national or local staff of aid organisations or members of Red Cross or Red Crescent Societies that identify with and affirm the humanitarian mission and values, including neutrality.[14] First, the assumption that local health providers should adhere to the humanitarian principle of neutrality is misplaced, and indeed it is often impossible to follow. All health services and personnel should adhere to the principle of impartiality, which means providing services 'on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions'.[15] The principle of impartiality is reflected not only in the Geneva Conventions and Additional Protocols but also in international medical ethics codes. The World Medical Association's Declaration of Geneva, the modern version of the Hippocratic Oath, for example, provides that: 'I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.'[16]

Unlike humanitarian aid providers, however, local doctors, nurses and other health workers need not and often cannot be neutral – that is, they cannot refrain from 'tak[ing] sides in hostilities or engag[ing] in controversies of a political, racial, religious or ideological nature'.[17] Neutrality, particularly exemplified by the work of the ICRC and often Red Cross or Red Crescent Societies, is increasingly embraced – and indeed, seen as essential to security – by other humanitarian providers, especially where armed groups view their fight as against all groups allied

14 Abby Stoddard, Adele Harmer, and Katherine Haver, *Safety and Security of National Humanitarian Workers*, 2011, Annex to J. Egeland, A. Harmer, and A. Stoddard, above note 3, pp. 14–15, available at: http://ochanet.unocha.org/p/Documents/Safety%20and%20Security%20for%20National%20Humanitarian%20Workers,%20PDSB,%202011,%20English.pdf.

15 OCHA, *Humanitarian Principles*, 2010, available at: http://ochanet.unocha.org/p/Documents/OOM_HumPrinciple_English.pdf.

16 World Medical Association, *Declaration of Geneva*, as amended, 2006, available at: www.wma.net/en/30publications/10policies/g1/. See also World Medical Association, *Regulations in Times of Armed Conflict*, as amended, 2006, paras. 4, 11, available at: www.wma.net/en/30publications/10policies/a20/.

17 OCHA, *Humanitarian Principles*, above note 15. Other humanitarian principles, including humanity and operational independence, also apply to local health programmes.

in some way with what they perceive as Western interests. Indeed, critics of the humanitarian community have argued that breaches of the principle of neutrality by UN and aid agencies contribute to their vulnerability.[18] Insistence on the neutrality of indigenous health providers, however, is both unnecessary from ethical and legal standpoints and counterproductively may serve to increase their vulnerability to attack by imposing a standard that is impossible to meet.

Local health providers may be affiliated with a government that is under attack, as in Afghanistan, a protest movement, as in Bahrain, or an insurgency or a side in civil war, as in Myanmar and Syria. In many of these contemporary conflicts, moreover, providers from a national, religious or ethnic group in conflict with state forces either do not have the choice of neutrality because of their identities or harbour a political allegiance to one of the parties to the conflict. These affiliations have no bearing on their right to provide health services so long as they do not take part in hostilities – for example, by using health facilities for military purposes. Further, as Frits Kalshoven explains in his review of the history of the idea of medical neutrality, Professor Louis Renault told the conference considering the 1906 Geneva Convention that the term 'neutrality' implies that doctors 'are indifferent with respect to the conflict that sets the fate of their country at stake; they are, in actual fact, enemies, albeit with a special task, and protection and special immunities must be accorded to them precisely to enable them to perform that task'.[19] Renault therefore urged that the Convention forgo the use of the word 'neutrality' in favour of the terms 'respect' and 'protect' in articles concerning the sick and wounded, medical personnel, and medical units.[20] He prevailed, and the word 'neutrality' has not appeared in subsequent Geneva Conventions or Additional Protocols in connection with medical services.

The lack of respect for the provision of impartial care to individuals perceived as enemies is already a major source of intimidation, arrest, and prosecution of health workers,[21] as has been evident in conflicts as diverse as Syria, Kosovo, Chechnya, Bahrain, Iraq, and Myanmar. Inappropriately claiming neutrality can exacerbate health workers' vulnerability, as it may be seen by state armed forces, law enforcement agencies, and armed groups as an effort to mask affiliations and loyalties. In sum, insistence on adherence to the principle of neutrality at a minimum leads to confusion about whether health workers are protected and at worst may serve as justification for attacks on them.

18 Antonio Donini, 'Between a rock and a hard place: integration or independence of humanitarian action', in *International Review of the Red Cross*, Vol. 93, No. 881, 2011, pp. 141–157; Feinstein International Center, Briefing Paper, *Navigating Without a Compass: The Erosion of Humanitarianism in Darfur,* 2011, available at: http://dl.tufts.edu/ProxyServlet/?url=http://://repository01.lib.tufts.edu:8080/fedora/get/tufts:UA197.005.005.00009/bdef:TuftsPDF/getPDF&filename=tufts:UA197.005.005.00009.pdf.

19 Frits Kalshoven, 'International humanitarian law and violation of medical neutrality', in *Reflections on the Law of War: Collected Essays*, Brill Academic Publishers, Leiden, Netherlands and Boston, MA, 2007, p. 1002.

20 *Ibid*.

21 Leonard S. Rubenstein and Melanie D. Bittle, 'Responsibility for protection of medical workers and facilities in armed conflict', in *The Lancet*, Vol. 375, 2010, pp. 329–340.

Second, as noted above, one of the fundamental goals of emergency aid agencies is to obtain and maintain access to affected populations in order to serve them. That goal often drives decisions about security strategies. For example, aid groups often maintain a low profile and engage in careful calculations as to whether access is jeopardised by public criticism of states or armed groups for interfering with access or committing human rights violations. The experience of aid groups expelled from Darfur for allegedly cooperating with human rights investigators is the most dramatic but hardly the only example of the trade-offs between access and human rights reporting. Although every context must be addressed individually, the problem for indigenous health providers is quite different because they largely remain present in the conflict-affected area. Their access may be impeded because of fighting, pervasive insecurity, or security restrictions, but not typically by being thrown out. Moreover, although research is needed on the question, generally it does not appear that local providers' access to people in need of health care is dependent on their silence.

In some circumstances, vocal protest by health providers can be a means of protection by stimulating international action to demand respect for their work.[22] And even when reporting does not bring immediate cessation of attacks, it can be a source of support. People in desperate straits want to know that others care about their fate. I spoke to health workers in Myanmar who have been subjected to attacks by the Myanmar military for years, most of which go unreported by any but local health or human rights organisations. The health workers well know that additional reporting will not bring protection in the near term, but uniformly reinforced its importance in terms of showing that people around the world care about them, affirm their mission, and seek to support them.

Third, indigenous groups often lack the resources, experience, capacity, and support that enable large humanitarian aid organisations to engage in expensive security analysis and activities. Especially in rural areas, health workers and clinics are isolated and operate on shoestring budgets with small staffs. Security coordinators, and even access to security information, may well be beyond the reach of these groups.

International development organisations that support the strengthening of health systems in conflict areas share many characteristics of humanitarian aid agencies (and differences from indigenous providers), such as values that stress community participation, capacity to engage in security strategies, and vulnerability based on their Western identification. They differ from humanitarian aid agencies, however, in a key respect: they are not and cannot claim to be neutral. Though impartial, both may be targeted for advancing health programmes associated with one side of the conflict. In Afghanistan, the goal of constructing a national system of primary care inevitably meant the agencies' allegiance to the government; further, these services were significantly funded by the United States, one of the parties to the conflict.

22 James Orbinski, Chris Beyrer, and Sonal Singh, 'Violations of human rights: health practitioners as witnesses', in *The Lancet*, Vol. 370, pp. 698–704.

Human rights strategies for the protection of indigenous health workers and development agencies

These three differences render models of humanitarian organisation protection only partially applicable to indigenous health workers, including local partners of development agencies. To be sure, many security strategies employed by the humanitarian community, such as rootedness in communities, negotiating with armed groups, and armed deterrence, can in many cases apply to or be adapted by indigenous health providers and facilities and development programmes. Additionally, in some circumstances public protests can put those health providers in greater jeopardy. But the circumstances of many local health providers, including local NGOs engaged in health development activities – lack of neutrality, being in place, and absence of security resources – sometimes suggest the availability of additional strategies derived from the maturing, complementary field of human rights that extend beyond traditional protection interventions used by humanitarian aid providers. The field has developed institutions and tools to deter violence against people who are protected under law through monitoring, reporting, and accountability.

To begin with, human rights and civilian protection do not assume that protection is linked in any way to neutrality; whether a local health provider or development agency is affiliated with one side is irrelevant. On the contrary, one of the central features of the human rights and civilian protection regimes is to assure the rights of dissenters, minorities, and the marginalised, who often take sides. Unlike humanitarian aid security regimes, both human rights and civilian protection are generally premised on public reporting of data, sometimes on specific incidents and sometimes on aggregate trends. Reporting serves multiple functions: establishing the facts about violations and when they are committed systematically, showing their scope; countering misinformation that seeks to re-characterise victims as perpetrators; providing a source of support to the victims; and triggering accountability mechanisms. As in all human rights and civilian protection initiatives, of course, sensitivity and discretion is required to assure that people already in jeopardy are not subjected to new or greater threats because of public reporting. Next, accountability must be invoked. Civilian protection and human rights are premised on stimulation of pressure on perpetrators to stop violations and to deter future violations through public exposure, diplomatic interventions, and imposition of formal penalties. Humanitarian security also benefits from accountability, which is why the UN Secretary-General has called for criminal prosecutions and other forms of accountability for perpetrators of attacks on aid workers as well as health services providers.[23] But whereas humanitarian aid groups (and for access reasons, international development agencies) often need to avoid finger-pointing at specific perpetrators and invocation of international or domestic compliance mechanisms, indigenous groups are often in a position to take public stands against impunity for violence inflicted on them.

23 *Report of the Secretary-General*, above note 9, paras. 74(e), 80(e), 82.

In the human rights field, over the course of sixty years since the Universal Declaration of Human Rights, UN and regional mechanisms[24] for reporting and accountability for violations of human rights have proliferated. Moreover, 'naming and shaming' of perpetrators has extended far beyond reports in media and by human rights organisations, now extending to actions by governments and multilateral organisations. For example, the United States government issues an annual report on the human rights record of states throughout the world and the UN Special Representative of the Secretary-General on Protection of Children in Armed Conflict issues an annual report identifying 'grave violations' and their perpetrators. Assuring the effectiveness of such interventions remains a constant challenge, but there is little doubt that even the most recalcitrant governments and armed groups wish to avoid accusations of major departures from universal human rights values. Moreover, over the last two decades, the original focus of the human rights movement on individual victims and political prisoners has expanded to protections of entire populations from assault. Further, the emergence of international criminal jurisdictions increases the possibility of individual accountability for deliberate attacks on health services as war crimes and crimes against humanity.

The emergence of global civilian protection strategies using human rights approaches is of more recent vintage. In 2005, the World Summit adopted the 'Responsibility to Protect', which mandates that the international community, through the UN, has responsibility to use the authority of the Security Council to protect populations from genocide, war crimes, ethnic cleansing, and crimes against humanity, including taking action where national authorities are manifestly failing to do so.[25] While still controversial, both because of its direct infringement on national sovereignty and the need to develop international consensus case by case, the Responsibility to Protect remains a powerful marker.[26] It has contributed to more robust action by the Security Council to protect civilians through the expansion of peace-keeping mandates to include civilian protection and specific mechanisms such as monitoring and accountability for grave violations against children in armed conflict.

With sufficient political will, galvanised by demands by health workers themselves, these mechanisms can be employed to increase respect for health-care providers in the interest of safeguarding health itself. No new international law is required to bring attacks on health services within the mandate of these

24 There is one mechanism with a specific mandate to address attacks on health-care services, the Special Representative of the Secretary-General for Children in Armed Conflict. Other global mechanisms include the Human Rights Council, treaty-based committees on torture and children, and regional mechanisms such as the Inter-American Commission on Human Rights, the European Court of Human Rights, and the African Commission on Human Rights.

25 *2005 World Summit Outcome*, UN Doc. A/60/L.1, 2005, paras. 139–140, available at: http://responsibilitytoprotect.org/world%20summit%20outcome%20doc%202005(1).pdf.

26 Paul R. Williams, J. Trevor Ulbrick, and Jonathan Warboys, 'Preventing mass atrocities: the responsibility to protect and the Syrian crisis', American University, Washington College of Law Research Paper No. 2012-45, 1 November 2012, available at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2174768 (last visited 27 February 2013).

mechanisms.[27] But only recently has there been any effort to utilise existing human rights mechanisms to advance protection of health services in armed conflict. In 2011, the Security Council extended the accountability mechanisms available to advance protection of children in armed conflict to attacks on schools and hospitals and associated personnel.[28] The mandate on the WHO to collect data on attacks on health facilities, personnel, and ambulances, and the patients they serve, can provide a new impetus to invoke human rights mechanisms in order to increase respect for health. These two mechanisms should just be the start as protection of health services comes to occupy a deserved place in the human rights and civilian protection regimes. International criminal prosecution for attacks on health workers, patients, and hospitals is available, and it must be initiated where violations warrant it.

Much more needs to be done at the national level, starting with the needed recognition of state obligations to respect and protect medical care offered by non-neutral health providers. The 31st International Conference of the Red Cross and Red Crescent urged states to implement international legal obligations through legislative, regulative, and practical measures.[29] To carry that mandate out, states should incorporate into domestic law the provisions on protection and respect for health contained in international humanitarian law. Additionally, and crucially, states should repeal laws that permit punishment of health workers for affiliation with or providing medical care to members of an organisation deemed an enemy of the state or a terrorist group. Legal reform should also include criminal sanctions for attacks on or interference with health-care services. Military, police, and prosecutors need to be educated about their responsibilities under the law, and courts and human rights bodies should have jurisdiction to hold violators accountable.

We should recognise, too, that just as protection strategies used in the humanitarian community can often be employed to advance the security of local providers and development agencies, so too are human rights tools being invoked to advance the safety of humanitarian organisations. Increasingly, agencies and the UN cluster system responsible for civilian protection employ human rights methods such as public reporting on attacks on health services, as is the case in Afghanistan. These areas of convergence warrant further exploration as we seek to assure respect for health services in situations of conflict.

Conclusion

Local health providers and development agencies can learn a lot from the negotiating and security methods increasingly employed by international aid

27 On this topic, see the article by Katherine H. A. Footer and Leonard S. Rubenstein, 'A human rights approach to health care in conflict', in this issue and the *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/68/297, 9 August 2013.

28 UNSC Res. 1998, above note 8.

29 31st International Conference of the Red Cross and Red Crescent Movement, Resolution 5, above note 6.

organisations. We need to move beyond exclusive reliance on the humanitarian paradigm for protection of health services, however, by taking elements from human rights. With their powerful norms and growing reach, civil society groups, professional organisations, and health providers can turn a concern about security into a demand for the protection that is their right. This approach, in turn, can add to the tools available for the security of humanitarian aid agencies.