

## EDITORIAL: VIOLENCE AGAINST HEALTH CARE: GIVING IN IS NOT AN OPTION

An improvised explosive device is detonated as a military convoy passes by. While crowds of people and relief workers rush to the scene to assist the wounded, a second bomb explodes, timed so as to inflict the greatest possible damage on the emergency services.

Vehicles are being held up at an army checkpoint on a major highway: everyone – including an ambulance on its way to the hospital – is forced to queue for hours. It takes too long and the patient dies from lack of treatment.

A doctor is put in prison for having treated wounded demonstrators following violent clashes between an opposition movement and the police.

An armed group seizes a health-care centre, loots it, and kills the wounded members of the enemy group as well as the medical personnel. The local inhabitants have no access to health care and many of them have no choice but to flee the area.

These incidents could have taken place anywhere today, from the Central African Republic to Syria.<sup>1</sup> They are a part of the contemporary reality of warfare – so much so, in fact, that they barely stand out in the constant stream of news headlines. They are just a few examples of the types of threats, attacks, and obstructions that health services experience in armed conflicts and other emergency situations. Not only are medical personnel deliberately targeted, but wounded people, be they civilians or military, are not spared either.

The accumulation of such incidents creates insecurity – real or perceived – and their consequences go beyond their immediate impact. The lack of security creates ‘medical deserts’, depriving entire communities of access to health care and causing severe and lasting disruption to public health across geographical areas. The indirect consequences of violence against health care are thus diffuse, insidious, and silent, but may assume disastrous proportions.

Nonetheless, the protection of the wounded and of medical personnel is part of the common heritage of the world’s cultures and religions.<sup>2</sup> The respect traditionally shown for the work of those providing medical care has always been matched by the respect for medical ethics shown by medical personnel themselves. Medical ethics derive from the civilisation of ancient Greece, with the famous Hippocratic Oath; in Arabic medicine, the earliest surviving text on medical ethics is Ishāq ibn ‘Alī al-Ruhāwī’s tenth-century book *Practical Ethics of the Physician*.

Moreover, modern humanitarian work and international humanitarian law (IHL) were born out of indignation over the fate of the war-wounded abandoned on the battlefield. The creation of the Permanent International Committee for the Relief of Wounded Soldiers in 1863 – today known as the International Committee of the Red Cross (ICRC) – and the adoption of the original Geneva Convention of 22 August 1864 ‘for the Amelioration of the Condition of the Wounded in Armies in the Field’ were the direct outcomes of a general realisation that a modicum of humanity needed to be maintained even in wartime.

The most important principles in the 1864 Geneva Convention,<sup>3</sup> which were retained in the text of the subsequent Conventions, include the obligation to care for the wounded without distinction on the basis of nationality; the neutrality and inviolability of medical personnel and establishments; and the adoption of an emblem to distinguish and protect the latter.

The protection of the wounded and medical personnel and the organisation of relief operations were thus the primary concerns of those who pioneered modern humanitarian action. It took every ounce of their energy to mobilise civil society and the community of states at the time in order to establish national protection structures and international protection instruments.

Yet, exactly 150 years later, attacks on the wounded and on medical personnel, the obstruction of access to health care, and the deliberate destruction of medical facilities in armed conflicts and other emergency situations continue. Are we witnessing an increase in this type of violence, coupled with a decline in respect for IHL? Is the current extent of the phenomenon attributable to the nature of contemporary armed conflicts? Because no long-term statistics are available, we have no answer to those questions, but we can at least consider that violence against health care can be: (1) a persistent phenomenon; (2) a potential exacerbation of an old phenomenon; or even (3) the resurgence of this aspect of warfare. It is time for the international community to reaffirm that there are limits to inhumanity and to take a close look at the current causes of violence against health care, one of the major humanitarian challenges of the present era.

1 See Romaric Bekourou, ‘Central African Republic: thousands forced to flee, health facilities looted’, available at: [www.youtube.com/watch?v=-cck2zYeZII](http://www.youtube.com/watch?v=-cck2zYeZII); International Committee of the Red Cross (ICRC), ‘Somalia: Lifeline Mogadishu’, available at: [www.icrc.org/eng/resources/documents/audiovisuals/video/2013/05-27-somalia-health-care-in-danger.htm](http://www.icrc.org/eng/resources/documents/audiovisuals/video/2013/05-27-somalia-health-care-in-danger.htm); British Red Cross, ‘Call for an end to attacks on aid workers in Syria as International Red Cross and Red Crescent Movement marks 150th anniversary’, 29 October 2013, available at: [www.redcross.org.uk/About-us/News/2013/October/Solidarity-call](http://www.redcross.org.uk/About-us/News/2013/October/Solidarity-call).

2 In India, for example, the ancestral laws of Manu require the victor to spare the wounded. In Burkina Faso, custom prohibits the killing of people who do not take part in the fighting and requires that the wounded of both parties be cared for. For a brief summary of the different traditions, see, for example, Véronique Harouel-Bureloup, ‘Droit international humanitaire: la coutume’, in *Grotius International*, 7 March 2013, available in French at: [www.grotius.fr/droit-international-humanitaire-la-coutume/](http://www.grotius.fr/droit-international-humanitaire-la-coutume/).

3 Geneva Convention of 22 August 1864 for the Amelioration of the Condition of the Wounded in Armies in the Field, 75 UNTS 31, entered into force on 21 October 1950.

## What is the actual problem?

‘One of the first victims of war is the health-care system itself.’<sup>4</sup> The International Red Cross and Red Crescent Movement, which is a witness and sometimes a direct victim of repeated incidents of this kind, has taken note of the seriousness of the phenomenon, which has been highlighted by the work of experts such as Leonard Rubenstein and Robin Coupland.<sup>5</sup> Between 2008 and 2010, the ICRC carried out a study of a 655 violent incidents affecting health care in sixteen different countries.<sup>6</sup> The study drew attention to the different forms of violence that hinder the provision of medical care: direct attacks on patients, medical personnel, and medical facilities – particularly pillaging and kidnapping – or cases of arrest and refusal to grant access to medical care.

In 2013, new data collected by the ICRC<sup>7</sup> showed that the vast majority of violent incidents against health services that took place during 2012 – more than 80 per cent of the 900 or so incidents recorded in twenty-two countries – affected local health-care professionals. A quarter of the people affected by these incidents were killed or wounded, while the remainder of the incidents consisted of beatings, threats, arrests, kidnapping, and other violent occurrences. The data collected do not allow a single class of perpetrator to be identified as predominant but, conversely, indicate that those responsible include not only state armed forces and security forces but also non-state armed actors. In this issue of the *Review*, Fiona Terry analyses violence against health-care providers and facilities across three contexts in which access to health care is particularly difficult: Afghanistan, the Democratic Republic of the Congo, and Somalia. Similarly, based on six contemporary case studies, Enrico Pavignani, Markus Michael, Maurizio Murru, Mark Beesley, and Peter Hill analyse the consequences of state failure on health-care provision.

Abuse of the medical mission by criminal groups or parties to the conflict for trafficking purposes or as a cover for military operations contributes to the rapid erosion of the protection afforded to medical services as a whole. Indeed, when some ambulances are misused, the entire health-care system looks suspicious to combatants and suffers the consequences, which can range from ambulances having to wait a long time at checkpoints to doctors and facilities being directly targeted.

The effects of violence against health care extend far beyond the moment of the attack and its immediate consequences. Attacks on medical services affect not only the personnel directly targeted but also the entire population who depend on them for health care. On the one hand, for each health-care professional attacked, there are hundreds, sometimes thousands of patients who will not be able to receive

4 Marco Baldan, ICRC chief war surgeon, in *Health Care in Danger: Making the Case*, ICRC, Geneva, 2011, p. 7, available at: [www.icrc.org/eng/assets/files/publications/icrc-002-4072.pdf](http://www.icrc.org/eng/assets/files/publications/icrc-002-4072.pdf).

5 See their articles in this issue of the *Review*.

6 ICRC, *Health Care in Danger: A Sixteen-Country Study*, July 2011, available at: [www.icrc.org/spa/assets/files/reports/report-hcid-16-country-study-2011-08-10.pdf](http://www.icrc.org/spa/assets/files/reports/report-hcid-16-country-study-2011-08-10.pdf).

7 ICRC, *Violent Incidents Affecting Health Care – January to December 2012*, 15 May 2013, available at: [www.icrc.org/eng/resources/documents/report/2013-05-15-health-care-in-danger-incident-report.htm](http://www.icrc.org/eng/resources/documents/report/2013-05-15-health-care-in-danger-incident-report.htm).

treatment, be it preventive (such as vaccination campaigns) or curative (such as surgery or rehabilitation). On the other hand, repeated acts of violence against health care may result in doctors leaving the area because they – justifiably – fear for their safety. Deprived of access to health care, communities are thus left to suffer the consequences over the long term.<sup>8</sup>

The evident erosion of the protection of medical personnel is of concern not only in conflict areas and emergency situations. For several years, serious problems of violence against medical personnel, particularly in the emergency services, have also been observed in peaceful countries. Health-care services may sometimes be the target of criminal activities, but it is often the patients and their families who are the cause of the problems and security incidents. If lack of security at hospitals tends to be trivialised in peacetime, what will happen in a time of crisis? This concern reinforces the need to adopt a preventive approach, also in countries that are not currently affected by armed conflict or other emergency situations.

While health-care professionals have rights that protect them, they also have obligations and responsibilities, which are tied to the rights of the wounded and sick in their care. They are thus bound by IHL and human rights law as well as by medical ethics. Respect for those ethics by medical personnel is another aspect of the problem of health care in times of conflict and in emergency situations. National medical bodies have an important role to play, particularly in order to avoid any state interference and to ensure that respect is shown for the code of ethics by the profession itself. In South Africa, for example, Dr. Wouter Basson, former head of the apartheid regime's bacteriological and chemical programme, was accused of developing chemical weapons designed to put anti-apartheid militants out of action. The ultimate aim of that research was to find a chemical means of stemming the rise in demographic power of the black population. In 2013 the Health Professions Council of South Africa found him guilty of violating medical ethics.<sup>9</sup>

## An increasing mobilisation

It is essential to tackle violence against health care as one single complex issue rather than as the simple sum of independent incidents. Mandated by the International Conference of the Red Cross and Red Crescent in 2011,<sup>10</sup> the ICRC launched a four-year project entitled Health Care in Danger with a view to encouraging the various parties concerned to take measures to remedy the state of affairs in the field, and to consulting a wide range of experts tasked with identifying solutions to the problem.

8 See the interview with the Liberian minister of health, Dr. Walter Gwenigale, in this issue of the *Review*.

9 See 'South Africa's "Dr Death" Basson found guilty of misconduct', in *BBC News Africa*, 18 December 2013, available at: [www.bbc.com/news/world-africa-25432367](http://www.bbc.com/news/world-africa-25432367).

10 See Resolution 5, 'Health care in danger: respecting and protecting health care', adopted at the 31st International Conference of the Red Cross and Red Crescent, 1 December 2011, available at: [www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm](http://www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm).

The *Review* asked Pierre Gentile, who is in charge of coordinating the project at the ICRC, to report on its progress in this issue.

Similarly, several non-governmental organisations (NGOs) have developed their own campaigns in this area. For example, Médecins sans Frontières (Doctors without Borders, MSF) has launched the project Medical Care Under Fire, which regularly provides information on security incidents affecting health care.<sup>11</sup> In this issue of the *Review*, Caroline Abu Sa'Da, Françoise Duroch, and Bertrand Taithe present a study of the way in which MSF tackles the issue of violence and attacks on it or on patients in its care. They advocate for the development of critical reflections on insecurity phenomena in the context of humanitarian action.

Another relevant group is the Safeguarding Health in Conflict Coalition, which is composed of NGOs, associations of health-care professionals, and an academic centre.<sup>12</sup> Its aim is to promote respect for IHL and human rights relating to the safety and security of health-care facilities, health workers, ambulances, and patients in armed conflicts and other situations of violence.

Attacks on health care must be considered first and foremost as a *humanitarian* problem and not merely as a problem encountered by *humanitarian workers*. After years of efforts, it is extremely encouraging to see that this subject has now been taken up outside the International Red Cross and Red Crescent Movement and NGOs: many other influential actors and states are tackling the problem. For instance, the International Council of Nurses<sup>13</sup> and the World Medical Association<sup>14</sup> are now partners in the ICRC's Health Care in Danger project, and the topic was recently discussed at the World Health Assembly.<sup>15</sup> In his report on the protection of civilians submitted to the United Nations Security Council in May 2012,<sup>16</sup> the Secretary-General also made numerous references to attacks on medical services and asked the Security Council to be more proactive in that area. Several states, such as Norway, Australia, and South Africa, are actively supporting the Health Care in Danger project at the global level.

In addition, efforts have been made at the national level, in partnership with the ICRC and the National Red Cross and Red Crescent Societies. We also have a lot to learn from some states which, faced directly with the problem, have already

11 See the Medical Care Under Fire' website, available at: [www.msf.org/topics/medical-care-under-fire](http://www.msf.org/topics/medical-care-under-fire).

12 See the Safeguarding Health in Conflict Coalition website, available at: [www.safeguardinghealth.org](http://www.safeguardinghealth.org).

13 See [www.icn.ch/news/whats-new-archives/safeguarding-health-in-conflict-coalition-1506.html](http://www.icn.ch/news/whats-new-archives/safeguarding-health-in-conflict-coalition-1506.html).

14 The World Medical Association (WMA) states: 'Medical ethics constitute a major area of cooperation between the ICRC and the WMA. This was formalised by a Memorandum of Understanding signed on the 26th of June 2013. With this agreement, the WMA aims to contribute to the development of the project, especially by addressing the responsibility of health-care personnel in armed conflicts and other emergencies.' See World Medical Association, 'Health Care in Danger Project', available at: [www.wma.net/en/20activities/60campaigns/11HealthDanger/index.html](http://www.wma.net/en/20activities/60campaigns/11HealthDanger/index.html).

15 International Federation of Health and Human Rights Organisations, 'World Health Assembly adopts resolution on WHO's role in documenting attacks on health workers and facilities', 30 May 2012, available at: [www.ifhro.org/news-a-events/360-world-health-assembly-adopts-resolution-on-whos-role-in-documenting-attacks-on-health-workers-and-facilities](http://www.ifhro.org/news-a-events/360-world-health-assembly-adopts-resolution-on-whos-role-in-documenting-attacks-on-health-workers-and-facilities).

16 Report of the Secretary-General on the protection of civilians in armed conflict, UN Doc. S/2012/376, 22 May 2012, paras. 33–34. See also the Report of the Secretary-General on the protection of civilians in armed conflict, UN Doc. S/2013/689, 22 November 2013, para. 23.

started to introduce solutions to reduce violence against health workers. For instance, in this issue the *Review* has made space for the views of the National Permanent Roundtable for the Respect of the Medical Mission in Colombia, whose experience is making it possible for practical recommendations to be worked out for the future.

## Seeking solutions

While there is clearly much work that remains to be done, there is a body of legal and ethical rules protecting health care in peacetime and in wartime.

Under IHL, the parties to an armed conflict are required to protect, collect, and care for the wounded and sick, as well as to protect medical personnel, medical units, and medical means of transport against attack, to show respect for them, and not to impede the provision of treatment. In order to guarantee that protection, IHL precisely defines the use of distinctive emblems protected by the Geneva Conventions and their Additional Protocols. It also requires respect to be shown for the principles of medical ethics, by banning, for example, the use of coercion to compel health-care professionals to provide treatment that contravenes those ethics.

In situations below the threshold of an armed conflict, access to health care is protected by human rights law and national law, in particular through the right to health. At all times and in all circumstances, states are under an obligation to guarantee their populations an effective system of health care.

In this issue, Vivienne Nathanson analyses the ethical challenges faced by medical practitioners in times of conflict by comparing them with peacetime situations. The legal aspects of health-care protection are presented and discussed in several articles in this edition of the *Review*. Alexandre Breitegger presents an overview of the legal framework applicable to health care in times of conflict and other emergency situations; Amrei Müller analyses the complementarities between the rules of IHL and the right to health, specifically in situations of non-international armed conflict; and Katherine Footer and Leonard Rubenstein affirm the importance of human rights for the protection of health care in situations to which IHL does not apply, or as a complement to it. The question of criminal justice is addressed in an account by Judge Miroslav Alimptic, a Serbian investigative judge at the Novi Sad district court in the case of the massacre at Vukovar Hospital during the war in the former Yugoslavia. Lastly, Marisela Silva Chau and Ekaterina Ortiz Linares analyse Colombian case law relating to the prohibition of punishment for carrying out medical activities that are in keeping with medical ethics.

Even in wartime or during violent uprisings, it must be possible to ensure that the wounded and sick have rapid access to health care, and practical measures may be taken by the various actors concerned (doctors, political leaders, academics, military staff, representatives of civil society, and so on). The ICRC has conducted a series of workshops with these actors in different parts of the world, with a view to

proposing future solutions.<sup>17</sup> The measures taken by these actors, depending on the context and if implemented, could save thousands of lives throughout the world. A non-exhaustive list of such measures is presented in the following box:

- Establish a full and consistent legal framework in each country so as to protect the provision of health care in all circumstances.
- Take measures in the fields of education, training, and dissemination of the relevant rules so as to contribute to preventing incidents.
- Include a combination of criminal, administrative, and disciplinary sanctions in the suppression of attacks against health care.
- Establish control mechanisms for the use of the protective emblems by the medical mission at the national level.
- Institute a system for following up data concerning threats and attacks against medical personnel, patients, facilities, and means of transport at the national and/or international level.
- Take prioritisation measures at checkpoints, such as the identification and the clear and consistent designation of medical transport.
- Identify standardised procedures among security forces, suppliers of health care, and authorities in order to provide a framework for operations carried out by security forces in health-care facilities (such as searches and tracking down suspects).
- Improve the planning and conduct of attacks on military objectives located in the immediate vicinity of health-care establishments (or on such establishments that have lost their protection against attacks because they have been used for military purposes) in order to minimise the impact on health care.
- Exempt health-care professionals from the legal obligation to divulge certain information obtained in the course of their work, and define precisely exceptions to medical confidentiality in national legislation.
- Have National Societies play an important role, including in efforts to protect the emblem and to prevent its abuse, in the areas of sensitisation, monitoring of abuses, and the implementation of national legislation.
- Ensure that volunteers from emergency services, including those from the Red Cross or Red Crescent, benefit from a health insurance plan.

17 The ICRC has also established an interactive web-based network of organisations and people working to provide safe access to health care in armed conflict and other emergency situations. The network gives its members access to a resource centre devoted to the publication of documents and tools and enables them to contribute to it. Members may also exchange their practical experiences, share a community calendar and follow the recommendations drawn up at workshops on health care in danger. For more information, see: [www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-expert-consultations.htm](http://www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-expert-consultations.htm).

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Each individual can contribute to improving the protection of health care by sharing information and proposing solutions. The *Review* has chosen to take part in this project by inviting people who have witnessed violence against health care, academics, humanitarian workers, members of the judiciary, government representatives, and medical experts to contribute to this thematic issue. The journal thus brings together operational, legal, and ethical perspectives. The articles in this issue make it possible to (1) illustrate the humanitarian problem by presenting the results of several case studies from the field; (2) review the relevant legal and ethical frameworks; and (3) outline different solutions at the legal, operational, and policy levels. Opening this issue, Dr. Walter Gwengale, director of a hospital that was attacked during the conflict in Liberia and current minister of health and social protection, recounts his experience. He analyses the dangers faced by health-care professionals in times of conflict, the long-term consequences of such violence, and the measures that can be taken to prevent it.

Violence against health care: there are few subjects that draw attention so vividly and radically to the worst and the best of our humanity. The worst is the abuse of force against those who need treatment or those who are there to give it. The best is the commitment of volunteers and medical personnel who brave widespread insecurity, oppression, and direct violence to provide treatment out of respect for their ethics. To facilitate awareness of the problem is just a first step towards identifying solutions that can be disseminated and implemented. All the risks to which these men and women are consciously exposed cannot simply be put down to 'fate'.

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