

# Violence against health care: insights from Afghanistan, Somalia, and the Democratic Republic of the Congo

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## **Abstract**

*This article explores the methodology and main findings of field studies conducted for the ICRC's Health Care in Danger project in Afghanistan, Somalia, and the Democratic Republic of the Congo between 2010 and 2013. It discusses some of the actions that the ICRC takes in its health programmes to facilitate access to health care, and its approach to promoting better respect for the laws protecting it. It then suggests what more needs to be done to curb the violence.*

**Keywords:** ICRC Health Care in Danger project, Afghanistan, Somalia, Democratic Republic of the Congo, DRC, access to health care, violence against health care, protected status of health care and patients, documenting violence.



\* Cornell University Press, Ithaca and London, 2002.

There are few violent incidents that shock the conscience more than a deliberate attack on a hospital, the murder of health workers carrying out a vaccination campaign, or the detonation of an explosive-packed ambulance at the scene of an accident to amplify the shock and carnage caused. Such events make world news amid expressions of outrage at these grave violations of international law. What is less recognised is that these dramatic events represent just a fraction of the violence carried out against health-care providers and facilities every day: it is a common occurrence that takes many more insidious forms than those reported in the media. This violence prevents millions of victims of armed conflict and other emergencies from reaching health care when they need it most.

In order to better understand the frequency and types of violence against the health system, the International Committee of the Red Cross (ICRC) launched the Health Care in Danger project in 2011 after a preliminary study in sixteen countries suggested that the problem was under-reported and under-analysed. ICRC delegations in twenty countries beset by armed conflict or other situations of violence were asked to gather information on such incidents. To complement this, the ICRC commissioned three in-depth studies to explore the issues in Afghanistan (2010), Somalia (2012), and the Democratic Republic of the Congo (DRC, 2013).<sup>1</sup>

This article discusses some of the main findings from these three internal studies. Some of the violence documented was intentional, aimed at preventing, disrupting, or refusing to facilitate medical assistance for those perceived to be the enemy and their supporters. But the vast majority of incidents concerned a lack of respect for the protected status of health care and patients. In other words, health structures and transport were damaged, looted, or closed not because they provided health services per se but because they were not spared or exempted from such aggression.

The first part of the article discusses what types of incidents were included in the scope of the Health Care in Danger studies, before looking into the findings. It then discusses how the ICRC is responding to the lack of respect for the sanctity of health care around the world and suggests what more could be done.

## Documenting violence against health care

As custodian of international humanitarian law (IHL), part of the ICRC's regular responsibilities include monitoring respect for the rules protecting health care. As described in more detail in other articles in this volume,<sup>2</sup> in times of armed conflict, IHL obliges all parties to an armed conflict to do the following:

- respect and protect medical personnel, units, and transport that are used exclusively for medical purposes;

1 Fiona Terry, 'Protecting health-care in Afghanistan: IHL violations and the ICRC's response, April 2009–April 2010', ICRC internal document, June 2010; Fiona Terry, 'ICRC Health-Care in Danger project: Somalia case-study', ICRC internal document, July 2012; Fiona Terry, 'ICRC Health-Care in Danger project: Democratic Republic of Congo case-study', ICRC internal document, March 2013.

2 See *inter alia* Alexandre Breitegger's article in this issue.

- provide medical care and attention without any adverse distinction based on grounds other than medical ones;
- respect the wounded and sick, protect them from attack or ill-treatment and ensure they receive adequate medical care;
- take all possible measures to search for, collect, and evacuate the wounded and sick without discrimination.

Human rights law also provides obligations for states to protect the wounded and sick from attacks, as well as to respect, protect, and fulfil the right to health.<sup>3</sup>

There are, however, many actions that impede or obstruct access to health care that do not constitute a violation of IHL, so the field studies enlarged the scope of inquiry to include both breaches of the law and lesser offences against health care. Incidents were grouped into the following categories:<sup>4</sup>

1. Violence against health facilities:

This included attacks on, or interference with, medical facilities such as clinics, hospitals, medical stores, laboratories, and pharmacies, including bombing, shelling, forced entry, shooting into buildings, destroying materials, and looting. It also included the cordoning off of an area containing a health structure that prevented access to it by health staff and patients.

2. Violence against health staff:

This included attacks on medical, paramedical (including first-aid volunteers), and support staff assigned to medical functions, including killing, kidnapping, harassment, threats, intimidation, robbery, and arrests and detention for performing medical tasks.

3. Violence against the wounded and sick:

This category comprised assaults on patients or those trying to access medical care, including killing and injury, harassment and intimidation, blocking or interfering with timely access to care, denial of medical assistance and discrimination, and interruption of medical care through arrest and/or detention of wounded fighters by forces who could not or would not assure a continuity of medical care.

4. Violence against medical transport:

This included attacks on ambulances, medical ships, planes, or evacuation helicopters, whether civilian or military, and interference with the transport

3 For more information, see *inter alia* the articles by Alexandre Breitegger, Amrei Müller, and Len Rubenstein and Katherine Footer in this issue.

4 These categories were also used in the ICRC publication *Health Care in Danger: Making the Case*, ICRC, Geneva, 2011, available at: [www.icrc.org/eng/resources/documents/publication/p4072.htm](http://www.icrc.org/eng/resources/documents/publication/p4072.htm) (all internet references were last accessed in June 2013).

of medical equipment and supplies. It also included the armed hold-up of medical aid organisations while travelling in marked vehicles.

5. Misuse of health facilities or protective emblems:

The final category covered incidents involving the improper use of the Red Cross or Red Crescent emblems and other signs designating medical facilities, transport, or personnel (including perfidy), and acts that compromised the neutral character of civilian health facilities. Carrying arms in a health structure, while not a violation of IHL per se, can compromise perceptions of the structure's neutrality.

Most incidents recorded in Afghanistan, Somalia, and the DRC affected more than one of the categories above. Breaking down each incident into these categories and entering them on a table provided an effective way in each context to visualise the trends in violence against health care. The patterns that emerged sometimes ran contrary to perceptions held in the ICRC delegations, which might have been coloured by one or two shocking events that were not necessarily representative of the larger problem. A deeper analysis of the trends permitted field teams to better tailor their subjects of discussion with belligerent parties in order to address the most pressing problems identified.

The documentation and field studies also helped to recalibrate the images associated with a specific context within the broader organisation. An enduring image of Somalia from the early 1990s, for instance, is of a pickup with mounted machine gun parked outside the operating theatre of Mogadishu's Medina hospital in order to prevent fighters from ordering surgeons at gunpoint to give their wounded comrade priority treatment. Twenty years of continuous conflict since then, and an absence of law and order, has given rise to the assumption that health care around the country must be under constant siege – yet this is not the case. There are grossly inadequate health services in many parts of the country, but not the violence associated with the past. Today visitors to Medina hospital agree to hand in their weapons at the entrance in exchange for a numbered chit. Moreover, health professionals interviewed in the capital said that medical structures were respected by fighters and the general population second only to mosques. Even issues of clan-based discrimination and retaliation against medical staff who failed to save a patient were much less prevalent than first assumed. Thus the project has not only shed light on failures to respect health-care but also raised interesting questions on why respect for it is better in certain contexts or among certain belligerent parties than others.

## Challenges to obtaining accurate data

Efforts to gain an accurate insight into the types and frequency of violence against health care have met with several important challenges. First and foremost among these challenges in Afghanistan, Somalia, and the DRC was simply that of obtaining information on incidents from the myriad of actors in the health field, particularly

in Somalia and Afghanistan, where whole swathes of territory are inaccessible to ministry of health staff and international aid organisations. It was only through talking to patients in Mirwais hospital in Kandahar, for instance, that the ICRC was able to have some idea of the state of health services in opposition-controlled regions of the south, and the problems patients faced trying to reach the hospital. Accessing health care outside major towns is difficult in all three countries at the best of times, involving long journeys on foot, by donkey, or by motorcycle. It is impossible to know how many sick and wounded never make it to a health centre.

Persuading other actors in the health field to share information on incidents has also proved surprisingly difficult. This can be partly explained by the sensitive nature of negotiations with warring parties or criminal gangs over security incidents, particularly ones involving kidnapping and demands for ransom payments. But it also reflects a certain competitiveness among aid organisations, which prefer to downplay problems they encounter in favour of retaining the image of success that is so essential to their fundraising efforts at home and towards their institutional donors. A proportion of all security incidents can be traced to the actions or image of a specific aid agency, whether revenge extracted for the dismissal of a national employee in Somalia, the repercussions of a bad deal with a local militia in Afghanistan, or community anger at broken promises by a non-governmental organisation whose ambitions outstripped its capacities in the DRC. There are few aid organisations willing to publicise such incidents in any detail. National health providers – both public and private – are an even more elusive source and yet, by their sheer number, are doubtless exposed to more incidents than international actors. Thus the sources of information on incidents remain quite limited, which presents an important bias in the data.

Second, the variety of incidents encountered in each context raised questions over the criteria for inclusion in the data set and generated much discussion among the ICRC teams. One view was that only cases of violence in which there was a motive linked to the medical function should be included. According to this view, the shooting dead of a doctor during an armed robbery at his house would not be included, nor would the kidnapping of a nurse if there was a demand for ransom, nor would the armed hold-up of an ICRC vehicle unless it was carrying medical staff or supplies. But the problem with narrowing the criteria in this way is twofold: first, the motive is rarely clear, and even purely criminal acts can have political overtones given that criminal gangs are unlikely to be able to operate in parts of Afghanistan, Somalia, or the DRC without the tacit or active agreement of the armed group controlling the territory. Second, and more importantly, the consequences of an incident such as the killing or kidnapping of a health professional can be just as detrimental for the population whether or not the motive was linked to the victim's medical function. This is particularly true for Somalia, which has only one doctor for every 25,000 people.<sup>5</sup> Hence the three case studies

5 World Health Organization, *World Health Statistics 2012*, Chapter 6, available at: [www.who.int/gho/publications/world\\_health\\_statistics/2012/en/index.html](http://www.who.int/gho/publications/world_health_statistics/2012/en/index.html).

looked at the consequences as well as the motives involved when determining whether to include an incident or not.

## The studies' main findings

In the decades of armed conflict in Afghanistan, Somalia, and the DRC, fighters have committed some very serious violations of the laws protecting health-care facilities, personnel, and transport. The First Congo War (1996–1997) that destroyed the Rwandan refugee camps in the eastern DRC, for example, began with soldiers entering the Lemara hospital in South Kivu on October 6 and slaying over 30 patients and hospital staff. In Somalia, the looting and expulsion of many large aid agencies in 2011 dramatically reduced health services at a time of food shortages throughout the south and central regions, triggering a rise in the number of vaccine-preventable diseases that compounded the ravaging effects of malnutrition. And in Afghanistan, perfidy has been committed on several occasions, including in April 2011, when an ambulance was used in a suicide attack on a police training academy on the outskirts of Kandahar.<sup>6</sup>

In the periods under review in each case study (Afghanistan from April 2009 to April 2010, Somalia from 2006 to 2012, and the DRC in 2012), such grave incidents were relatively rare, although the consequences of the ban on many health-oriented aid agencies in parts of Somalia continues to be felt to the present. But unlike the two other incidents mentioned above, health care in the Somalia case does not appear to have been misused, attacked, or withheld as part of a military strategy to harm the opposing side: aid organisations were not expelled in order to deprive the population of health care.<sup>7</sup> In fact, none of the countries studied experienced the scale of attacks on medical facilities and staff, with the alleged aim of deliberately depriving the opposition of medical care, that can be seen in Syria today.<sup>8</sup> Nevertheless, some such incidents did occur, and they are discussed in the following section; the article then turns to the most common forms of violence encountered, which stem more from a lack of respect for the protected status of health care rather than an overt desire to misuse it or attack it.

## Strategic use of violence against health care

Intentional violence or threats of violence against health-care structures and staff for military purposes occurred more in Afghanistan than in Somalia or the DRC. This is no doubt linked to the asymmetrical nature of the conflict waged there

6 ICRC, 'Afghanistan: ambulance used in attack on Police Training Compound', ICRC News Release 11/85, 7 April 2011, available at: [www.icrc.org/eng/resources/documents/news-release/2011/afghanistan-news-2011-04-07.htm](http://www.icrc.org/eng/resources/documents/news-release/2011/afghanistan-news-2011-04-07.htm).

7 The ban itself did have some military rationale, however, with the militant Islamist group Al Shabaab concerned that the personnel of some aid agencies were spies and would report on the location of leaders, who would then be the target of drone attacks.

8 See Jonathan Whittall, 'My enemy's doctor is my enemy', in *The Huffington Post*, 10 April 2013, available at: [www.huffingtonpost.co.uk/jonathan-whittall/syria-medicins-sans-frontieres\\_b\\_2829593.html](http://www.huffingtonpost.co.uk/jonathan-whittall/syria-medicins-sans-frontieres_b_2829593.html).

between a heavily armed, well-equipped, and well-trained international force and their Afghan allies on one side, and a fragmented but shrewd collection of groups on the other. Although the Taliban acknowledged that the use of an ambulance in the April 2011 attack near Kandahar was wrong and ‘would not happen again’,<sup>9</sup> it was not the first time a vehicle painted as an ambulance had been used in an attack,<sup>10</sup> and perfidy is actually encouraged in the Taliban’s *Layha* or Code of Conduct. The rules which allow for a suicide bomber to feign civilian status and fighters to adapt their physical appearance in order to blend in with the local population remained unchanged from the 2009 to 2010 versions of the Code, whereas other clauses were altered and many added which seemed to reflect a desire to be better perceived by the Afghan population (such as the removal from the 2010 version of the article which condoned attacks on aid organisations).<sup>11</sup> Health structures and personnel often bear the brunt of the frustrations evident in fighting such an elusive enemy. First-aid posts and clinics have been raided by international and government forces looking for wounded opposition fighters, and staff have been threatened with reprisals if they refuse to report on the presence of such fighters in the future. In some instances, one violation provoked another: when staff at a hospital in Baghlan Province in the north were ordered not to treat opposition fighters or their families, the latter kidnapped a doctor to treat their wounded.

The overt Coalition’s policy of using ‘humanitarian’ assistance to win the hearts and minds of Afghan civilians and of extending the legitimacy of Hamid Karzai’s government around the country compromised the neutrality of medical and other assistance and became a target of the opposition. Several incidents in the 2009–2010 period in which health staff were threatened, pharmacies and clinics were ordered shut, or warnings were issued to the population not to use a certain health structure seemed to be directly aimed at undermining the Coalition’s claims that stability had been brought to an area. Moreover, Afghans seen to be collaborating with foreign troops or the government were threatened or ‘punished’. Even after a ‘successful’ military campaign to clear insurgents from Marjah in Helmand Province in February 2010, safety for health staff was far from assured. Local doctors refused to assist US Marines in restoring health care to the area, saying it involved too much risk. ‘To get here I was stopped three times by the Taliban who asked me where I was going, if I was working for the Americans. It’s too dangerous’, one doctor said.<sup>12</sup> By mid-2010, however, a change of tactics by the armed opposition could be observed; rather than interfering with or closing health facilities

9 ‘Afghanistan: Taliban rue ambulance attack’, in *IRIN*, 12 April 2011, available at: [www.irinnews.org/PrintReport.aspx?ReportID=92446](http://www.irinnews.org/PrintReport.aspx?ReportID=92446).

10 On 18 January 2010, for instance, an attack against a government building in Kabul was carried out in this way.

11 See Thomas H. Johnson and Matthew C. DuPe, ‘Analysing the new Taliban Code of Conduct (*Layeha*): an assessment of changing perspectives and strategies of the Afghan Taliban’, in *Central Asian Survey*, Vol. 31, No. 1, March 2012, pp. 77–91; and Muhammad Munir, ‘The *Layha* for the Mujahideen: an analysis of the code of conduct for the Taliban fighters under Islamic law’, in *International Review of the Red Cross*, Vol. 93, No. 881, March 2011, pp. 81–120.

12 Karim Talbi, ‘Uphill task for US Marines on Afghan healthcare’, in *AFP*, 24 March 2010, available at: [www.afghanistannewscenter.com/news/2010/march/mar252010.html#23](http://www.afghanistannewscenter.com/news/2010/march/mar252010.html#23).

in regions they had taken, they allowed such facilities to continue in order to gain the allegiance and support of the local population.

The DRC also saw some instances of violence against health care that seemed to form part of a larger strategy aimed at either punishing a population for its perceived allegiance to an armed group, or creating an uninhabitable ‘no-man’s land’ on disputed territory. The latter is particularly evident in the Masisi region of North Kivu, where whole villages have been emptied of their inhabitants and set on fire, including health facilities, in violence between the Hunde and Hutu communities. A strong political agenda was presumably also behind the attempt to assassinate world-renowned gynaecologist Dr Denis Mukwege at his home in Bukavu in October 2012. His legitimacy as a doctor working with victims of severe sexual violence lends considerable weight to his criticisms of the impunity reigning in the DRC for such crimes, and he and members of his staff have received threats as a direct result of the work they undertake. There were also a few incidents in the DRC of health staff being kidnapped in order to gain treatment for rebel fighters.

Although not falling within the period of time analysed by the field study, just a few years earlier the DRC was the site of one of the worst manipulations of health services for military ends ever encountered. On one day in October 2009, government forces attacked seven vaccination sites in the Masisi region where the families of rebels fighters from the *Forces démocratiques de libération du Rwanda* (Democratic Forces for the Liberation of Rwanda) were lined up for measles inoculations. Members of the *Médecins sans Frontières* (Doctors without Borders, MSF) team who had organised the campaign, and had obtained security ‘guarantees’ from all sides, felt as if they had been used as bait.<sup>13</sup> The immediate consequences were devastating enough, but MSF also wondered what longer-term impact this betrayal of trust would have on the organisation’s ability to conduct vital vaccination campaigns and other health programmes in the future.

Evidence of the deliberate misuse or destruction of health-care facilities for military gain in Somalia was much harder to find than elsewhere. Human Rights Watch (HRW) alleged that damage caused to three hospitals in Mogadishu during the Ethiopian occupation of the city in 2007 was intentional, and suggested that this was because the Ethiopians suspecting the facilities of treating insurgents.<sup>14</sup> All three hospitals were badly damaged and looted, and one of them, Al Arafat, stayed closed for years. But interviews with former hospital staff who were present at the time suggest that the rationale for the Ethiopians’ behaviour was not as clear as HRW suggests.<sup>15</sup> They claim that Ethiopian officers wanted to use at least one of the hospitals as a vantage point and treated the staff well, and that it was lower-ranked soldiers who looted the hospital. The staff denied having heard accusations that the hospitals were aligned to Al-Qaeda or that there was graffiti to this effect painted

13 ‘DR Congo: MSF vaccination used as bait in unacceptable attack on civilians’, MSF press release, 6 November 2009, available at: [www.doctorswithoutborders.org/press/release.cfm?id=4055&cat=press-release](http://www.doctorswithoutborders.org/press/release.cfm?id=4055&cat=press-release).

14 See Human Rights Watch (HRW), *Shell-Shocked: Civilians under Siege in Mogadishu*, HRW, New York, August 2007, pp. 51–57.

15 Interviews with staff of the hospitals took place in Mogadishu in June 2012.



on the walls as HRW claimed. Nevertheless, the Ethiopian troops were responsible for not respecting these health facilities as they were obliged to do under IHL, nor protecting them from looting by others.

## Non-respect for the protected status of health care and patients

The most frequent problem witnessed in the health field in all three case studies was the inability of the wounded and sick to obtain health care when they needed it. There were different types of obstructions identified in each case study, discussed below, but one common to all was the general failure of combatants to assist wounded civilians to obtain medical assistance in the wake of a military confrontation. In all contexts there seemed to be efforts made to evacuate wounded fighters from the scene, give them first aid, and organise onward transportation to a medical facility, often by a member of the Red Cross and Red Crescent Movement. But it was rare to see military personnel making similar efforts to ensure that civilians received care. This is undoubtedly the most overlooked obligation under international law of all fighting forces in these three contexts.

### *Impediments to patients reaching health care*

Heavy fighting in the Somali capital, Mogadishu, in 2007, 2009, and 2010 caused some of the worst impediments to reaching health care seen in any of the case studies. The shelling and street battles were so intense in March 2007 that people dared not venture from their houses and the injured and dead lay where they fell. Bodies rotted in the streets. Again in August 2010, heavy fighting in various parts of the city prevented people from leaving their homes for an eight-day stretch. Until late 2008, there was no ambulance service in Mogadishu and most wounded arrived at hospital by wheelbarrow, by donkey-cart, or on foot. Since 2009, a couple of ambulance companies have been active and have helped save many lives. However, most are ill equipped, and the drivers and ‘medics’ lack any kind of medical training.<sup>16</sup> Furthermore, transporting the wounded and sick at night is dangerous: there are few vehicles on the roads after dark due to the climate of fear and suspicion of insurgent attacks. In light of all this, being able to reach a health facility when needed, even in the relatively vibrant capital, remains a major challenge.

In the southern and central regions of Somalia, it is the limited number of health facilities and constraints to supplying them with drugs and equipment that present the main obstacles to the wounded and sick receiving timely assistance. Medical supplies and equipment were stolen from several UN compounds in 2009 and again in 2011 when all UN agencies were expelled from Al Shabaab-controlled territory. The 2009 targets included UNICEF’s central store in Jowhar, which held supplies for over 100 clinics run by local aid agencies and communities. The theft of cold-chain equipment destroyed thousands of vaccines, and expensive nutritional

<sup>16</sup> ‘Life and death on the streets of Somalia’, in *Forgotten Diaries*, 28 August 2010, available at: <http://forgottendiaries-ethiopia.blogspot.ch/2010/08/life-and-death-on-streets-of-somalia.html>.

supplies destined for 40,000 malnourished children in 200 therapeutic and 80 supplementary feeding centres also disappeared.<sup>17</sup> Nobody has a clear picture of how many people in southern and central Somalia are without access to health care today or what the consequences are in terms of mortality and morbidity. Several cases of wild polio were recently detected in Somalia,<sup>18</sup> raising fears of the virus spreading among this pool of unvaccinated children and reversing the gains made towards eradicating the disease worldwide.

Looting of health facilities and resupply vehicles is also a major cause of insufficient health services in the eastern DRC. More than half of all lootings were allegedly committed by government soldiers of the *Forces armées de la République démocratique du Congo* (Armed Forces of the Democratic Republic of the Congo, FARDC), and the rest by non-state armed actors, whether linked to an armed group or bandits. This looting – which does not just target health centres but extends to shops, churches, and private houses – is symptomatic of broader structural problems in the DRC linked to the weakness of the state. Members of the armed forces do not receive a regular salary and hence support themselves through other means such as illegal mining and trade in endangered wildlife and other contraband. They, and members of non-state armed groups, prey on the local population, forcibly taking what they want. Health centres, with their medicines, equipment, and cash, are easy targets, and the loot is taken as ‘spoils of war’. Incidents of looting tend to increase in times of heightened tension, when troops are on the move from one region to another. There was an upsurge of incidents from May 2012 after the M23 rebel group began attacking government positions in North Kivu and FARDC reinforcements moved up from the south. As they did so, other armed groups moved into the vacated territory, sometimes looting along the way. The FARDC’s retreat from Goma was also accompanied by serious incidents of pillage and rape, especially in the lakeside town of Minova,<sup>19</sup> although the MSF-supported hospital in the town was fortunately spared.

The main obstacles to reaching health-care facilities in Afghanistan were directly related to insecurity, in several different ways. First, a lack of reliable security guarantees in peripheral regions prevents government health staff and many local and international aid agencies from providing health services there. The wounded and sick are obliged to travel long distances to reach the care that they need. Second, the planting of improvised explosive devices along roads impedes the safe circulation of patients and health staff,<sup>20</sup> even in areas where adequate

17 ‘Hostilities against aid work in Jowhar put lives of Somali children and women at risk’, UNICEF press release, Nairobi, 17 June 2009, available at: [www.unicef.org/media/media\\_50020.html](http://www.unicef.org/media/media_50020.html).

18 ‘Polio outbreak spreads in Somalia’, Polio Global Eradication Initiative, 30 May 2013, available at: [www.polioeradication.org/tabid/488/iid/305/Default.aspx](http://www.polioeradication.org/tabid/488/iid/305/Default.aspx).

19 See Pete Jones, ‘Congo’s army accused of rape and looting as M23 rebels win image war’, in *The Guardian*, 26 November 2012, available at: [www.guardian.co.uk/world/2012/nov/26/drc-army-accused-rape-murder-congo](http://www.guardian.co.uk/world/2012/nov/26/drc-army-accused-rape-murder-congo).

20 ‘Afghanistan: mines prevent resumption of normal life in Marjah’, ICRC News Release 10/34, 5 March 2010, available at: [www.icrc.org/eng/resources/documents/news-release/2010/afghanistan-news-050310.htm](http://www.icrc.org/eng/resources/documents/news-release/2010/afghanistan-news-050310.htm).

health services exist. And third, checkpoint procedures and road closures constitute a major barrier to the wounded and sick obtaining rapid medical assistance. Lengthy searches of vehicles at checkpoints create long queues and often a wait of several hours to pass through. In the 2009–2010 period there was no system for fast-tracking medical emergencies, and bypassing the queue was perilous: in 2009, several civilians were shot dead when trying to overtake the clogged traffic. Road closures during security sweeps also prevent the wounded getting to health care on time. A girl injured by an explosion in the Chahar Dara district of Kunduz died soon after arriving at the hospital on 3 February 2010, having been carried on foot for an hour because the road was cordoned off.

A final area of concern noted in Afghanistan and the DRC was the arrest of wounded and sick patients (suspected or actual ex-combatants) and their removal from health facilities against the advice of medical staff. While being *hors de combat* does not provide immunity from arrest and prosecution, the detaining authority is obliged by law to ensure the continuity of health care for those it detains, something that was not always respected. In the DRC, there were several incidents of the wounded being taken away from a medical structure, one of whom was still on intravenous antibiotics following an operation. Follow-up of his case suggested that he did not receive the treatment he required. In Afghanistan, the security forces face a delicate balance between ensuring the security of towns at which wounded men arrive and respecting their right to rapid health care. The opposition's penchant for disguise exacerbates the wariness of security forces, and the wounded sometimes face long interrogation before receiving any medical treatment.

### *Violence against health-care personnel*

All three contexts saw incidents in which health personnel were threatened or attacked for having performed their functions of treating all wounded and sick fighters in need of assistance without discrimination as to the side on which they fought. In the DRC and Afghanistan, some health staff were also kidnapped by opposition fighters in order to treat their wounded. But the vast majority of violent incidents affecting health personnel were related more to their proximity to fighting or their exposure to banditry by virtue of having a job, rather than being targeted for the functions they perform per se. The most exposed to crossfire and suspicion are the Red Cross and Red Crescent volunteers in each context, who often find themselves having to be near the site of fighting in order to evacuate the wounded, administer first aid, or identify and bury the dead. In the DRC and Afghanistan, such volunteers often faced threats stemming from suspicion of what they are doing, despite wearing vests clearly identifying their affiliation with the Red Cross and Red Crescent Movement. Although less involved in administering first aid in Somalia than in other contexts, Somali Red Crescent personnel are also wary of the risks associated with their job. In some areas, the clinics they run limit the extent to which they offer pre-hospital care and medical transfers to critically ill or injured

patients because of fear of the potential repercussions for staff of failing to save the patient's life.

The killing and kidnapping of aid agency personnel, including health workers, has caused major repercussions on the health sector in Afghanistan and Somalia, and to a lesser extent the DRC. National health staff in Afghanistan and Somalia have faced being killed because of their work with 'foreign infidels' and kidnapped to extract ransom from their families or organisation. Many quit their posts following violent incidents against themselves or their colleagues, leaving health posts understaffed. Some incidents, such as the bombing of the Benadir University graduation ceremony in Mogadishu in December 2009, have long-lasting and far-reaching consequences. The founder of the medical faculty, Dr Shahid, as well as several of the teaching staff perished in the blast at the Shomo Hotel, and six of the graduating doctors left to work abroad following the incident, three of them after receiving intensive treatment for their injuries.<sup>21</sup> These doctors and students were not the target of the attack – it was aimed at the four government ministers present at the prestigious graduation ceremony, which was only the second to have occurred over the past twenty years. All four ministers died in the attack. But the repercussions of the bomb extended far beyond the range of the blast, as Somalia still struggles to train and retain health-care professionals. In 2011, more than forty Somali doctors were working in Nairobi, concerned for their safety and that of their families if they were to return to Somalia.<sup>22</sup>

The kidnapping and killing of expatriate health workers also has far-reaching secondary effects as international aid organisations scale down their assistance or close their programmes altogether in the wake of a violent incident. The killing of three MSF staff in the coastal Somali town of Kismayo in January 2008, for instance, provoked the withdrawal of MSF's eighty-seven international staff from fourteen projects across the country. Similarly, the murder of two MSF staff in Mogadishu in December 2011 prompted the closure of all health projects run by the Belgium section of MSF. And the kidnapping of two Spanish MSF workers from the Dadaab refugee camp in Kenya in October 2011 and their transfer to Somalia has put a halt to all MSF's non-emergency medical programmes throughout the country until the women are released. The consequences of these 'knock-on' effects of violence against health-care are impossible to quantify but undoubtedly deprive tens of thousands of Somalis of quality medical assistance.

A final common problem encountered in the studies, particularly in the DRC and Afghanistan, was the presence of armed and/or uniformed men inside medical facilities. This not only compromises the neutral image of health facilities but also poses a threat to health personnel and other patients. A common complaint heard in the DRC was that the presence of uniformed soldiers in hospitals, performing the function of care-taker (*garde-malade*) for sick or wounded

21 Interview with Mohammed Nur, Vice-Rector of Benadir University, Mogadishu, 12 June 2012.

22 M. Arte, 'Exodus of medical professionals from Somalia', in *Somalia Report*, 5 November 2011, available at: [www.somaliareport.com/index.php/post/715/Exodus\\_of\\_Medical\\_Professionals\\_from\\_Somalia](http://www.somaliareport.com/index.php/post/715/Exodus_of_Medical_Professionals_from_Somalia).

colleagues, causes additional psychological trauma and stress to hospitalised rape victims, given that so many of the rapists were men wearing uniforms.

## **The ICRC's activities to safeguard health care**

The field studies found that the ICRC, through its medical and protection work, is already addressing some of the main concerns highlighted by the research: the difficulties faced by the wounded and sick when trying to access health care, and violence against health facilities and personnel. The ICRC integrates actions aimed at protecting health-care personnel, facilities, transport, and patients into its health projects. These range from physical protection such as fixing film to hospital windows to prevent a bomb blast from turning glass into deadly projectiles and constructing safe areas in health centres for staff and patients, through to negotiating the safe passage of ambulances through checkpoints or discussing attacks on health centres with leaders of the armed group responsible. Strict adherence to the humanitarian principles of neutrality and impartiality is vital to the ICRC's ability to cross front lines to rescue wounded fighters and civilians, and to the ICRC's credibility when raising violations of IHL with all parties to a conflict in the hope of curbing abuses.

The benefits of this integrated approach are clearly evident in the ICRC's work in the Kivu region of the DRC. In 2012, the ICRC evacuated 370 seriously wounded fighters and civilians from conflict areas and transferred them to the referral hospitals in Goma and Bukavu that the ICRC supports financially and with expertise and training from surgical teams. The evacuations were carried out by plane, by helicopter, and by road, but also on foot from remote regions with the help of Congolese Red Cross volunteers. One such evacuation took thirty-five volunteers several days to complete, carrying the wounded on stretchers across very rough terrain. Despite the ferocity of the fighting in the eastern DRC and frequent violations of IHL, only one of these evacuations encountered a security problem. A convoy of ICRC trucks carrying thirty-four wounded fighters was stopped and threatened while travelling through territory controlled by an opposing side. But having notified all armed groups of its movements and gained assurances that the convoy would be respected, the 'misunderstanding' was soon diffused once a more senior soldier appeared. Respect for the neutrality of the ICRC-supported hospital in Goma is also clearly on show when touring the wards: young men with their legs in traction recovering from gunshot wounds lie quietly in beds adjacent to their mortal enemies. The fighters understand that group allegiances are left at the door and that patients are to remain *hors de combat* until discharged.

Security constraints in Afghanistan and Somalia do not permit the ICRC or the Red Crescent Societies to conduct evacuations from battle zones as in the DRC. Hence in Afghanistan the ICRC requests taxi drivers who are able to travel in relative safety in these regions to do so, and reimburses their costs according to strict criteria. In Somalia, the ICRC has deployed surgical teams to various hospitals around the country when they were overwhelmed by an influx of wounded,

operating on all regardless of the side on which they fought. The ICRC-supported Keyseway Hospital in Mogadishu that is run by the Somali Red Crescent has seen its neighbourhood change hands many times over the past 20 years but apart from some damage caused by stray bullets and mortars, it has been spared the destruction inflicted on so much of the city. The staff are adamant that the hospital has been protected because everyone knows they might need it one day and will be able to receive treatment no matter which clan they belong to. Consistently applying this principle of impartiality has been essential to the hospital's survival.

Giving training in first aid to combatants is another way in which the ICRC seeks to reduce casualties of conflict, and this programme – offered to all sides – also provides an excellent platform from which to discuss the importance of health care and the need to respect and protect it. In Afghanistan, such training is given to Taliban and other opposition fighters as well as government security agencies and police. The ICRC is able to tailor its messages to address the specific problems witnessed by different groups. Hence government forces were encouraged to respect medical ethics that ensure the confidentiality of patients and to prioritise medical care over interrogation of wounded suspects, while the opposition fighters were encouraged to respect the protective Red Cross emblem, health structures, and staff. This contact with average fighters, to speak to them about the law and to hear their views, complements more formal interventions aimed at the upper echelons of armed groups and military forces which occur in the wake of violent incidents against health care. Such verbal and written reports on incidents have had considerable success in Afghanistan, influencing, for instance, changes to the US forces' rules of engagement in health facilities.

Thus the ICRC's broad palette of activities in the health field, combined with its protection work, provides an ideal basis from which to investigate further avenues for reducing violence against health care. The systematic data collection introduced through the Health Care in Danger project is helping delegations to better understand the types and frequency of violent acts against health care and to adapt their operational programs and the content of discussions with belligerent parties accordingly. Furthermore, the involvement of all Red Cross and Red Crescent partners in the process has facilitated the sharing of issues and best practice across dozens of different contexts.

## **Conclusion and way forward**

The scope and number of violent incidents perpetrated against health care in the three field studies is clearly a cause for concern. At best, there has been widespread disregard for the right to health care and the protected status of health facilities, personnel, and transport. At worst, health care has been manipulated, attacked, or prohibited in order to harm a perceived enemy. And every violent attack on health-care facilities, personnel, or transport has wider repercussions than on those directly involved: the suspension or closure of health services because of security concerns has undoubtedly affected millions of lives.

Because data on violence against health care have never been compiled by any international organisation in the past,<sup>23</sup> it is impossible to judge whether the situation is worse now than in previous decades. Past conflicts have seen their share of horrific assaults on health-care facilities, personnel, and patients: over 200 bodies were found in a mass grave after the hospital in the Croatian town of Vukovar was emptied in 1991;<sup>24</sup> wounded Tutsis were hauled from the backs of ambulances and executed at checkpoints during the Rwandan genocide of 1994;<sup>25</sup> the only functioning hospital in the north of Sri Lanka during the conflict was shelled in February 2009,<sup>26</sup> killing and wounding many of the 500 people seeking treatment there; and just one month earlier, emergency workers were prevented from helping the wounded and dying in destroyed houses in Gaza city.<sup>27</sup>

But what is certain is that the instrumentalisation of aid in the ‘war on terror’ has cast suspicion on the motives and agendas of aid organisations in Afghanistan and further afield, including Somalia. This suspicion was exacerbated for health-care providers by the role that a doctor played in locating Al Qaeda leader Osama bin Laden in his hideout in Abbottabad in Pakistan in 2011 through the collection of DNA samples during a fake vaccination campaign. The number of attacks on vaccination teams has certainly increased, notably in Pakistan, since then. And to make matters worse, US officials who supported the misuse of medical services in this way show no remorse for their actions. One interviewed by *The Guardian* said:

The vaccination campaign was part of the hunt for the world’s top terrorist, and nothing else. If the United States hadn’t shown this kind of creativity, people would be scratching their heads asking why it hadn’t used all tools at its disposal to find Bin Laden.<sup>28</sup>

It is this kind of mentality that is going to pose the greatest challenge to improving the safety of health care in conflicts around the world. Once the act of providing health care loses its neutrality like this, or its impartiality through discrimination as to who is accepted for treatment and who is not, its protected status is compromised and it is vulnerable to attack.

23 See Leonard Rubenstein and Melanie Bittle, ‘Responsibility for protection of medical workers and facilities in armed conflict’, in *The Lancet*, Vol. 375, January 2010, pp. 329–340.

24 See International Criminal Tribunal for the former Yugoslavia, *Mrkšić et al.*, (‘Vukovar Hospital’ case), IT-95-13/1; and the *Ovčara* cases before the War Crimes Chamber of the Belgrade District Court.

25 ‘Rwanda 1994: la vraie vie est absente’, talk given by Philippe Gaillard, Head of ICRC delegation in Rwanda during the genocide, at the Red Cross and Red Crescent Museum, Geneva, 18 October 1994, available at: [www.icrc.org/eng/resources/documents/misc/5xkca5.htm](http://www.icrc.org/eng/resources/documents/misc/5xkca5.htm).

26 ‘Patients killed in cluster bomb attack on Sri Lanka hospital’, in *The Guardian*, 4 February 2009, available at: [www.guardian.co.uk/weather/2009/feb/04/srilanka-terrorism](http://www.guardian.co.uk/weather/2009/feb/04/srilanka-terrorism).

27 ‘Gaza: ICRC demands urgent access to wounded as Israeli army fails to assist wounded Palestinians’, ICRC News Release 09/04, 8 January 2009, available at: [www.icrc.org/eng/resources/documents/news-release/palestine-news-080109.htm](http://www.icrc.org/eng/resources/documents/news-release/palestine-news-080109.htm).

28 Saeed Shah, ‘CIA’s fake vaccination programme criticised by Médecins Sans Frontières’, in *The Guardian*, 14 July 2011, available at: [www.guardian.co.uk/world/2011/jul/14/cia-fake-vaccination-medecins-frontieres](http://www.guardian.co.uk/world/2011/jul/14/cia-fake-vaccination-medecins-frontieres).

The recurring incidents of violence faced around the world indicate that much more needs to be done to enhance respect for the laws protecting health care and patients. First, there needs to be much greater awareness among health agencies, ministry of health staff, and private health providers of the protection accorded to health care under international law and the corresponding responsibilities of health staff to uphold medical ethics. Health staff and agencies need to come together in a concerted way to address the violence and to put more mechanisms in place to prevent it. It was striking to see how few health centres and hospitals in the DRC, for instance, had established rules to prevent the entry of weapons into the facility. When suggested, the idea was immediately well received by the health personnel. Such procedures need to become the norm in health facilities and transport around the country so that they raise fewer objections over time.

Second, the health community needs to get behind communication initiatives aimed at educating the population on the consequences of perpetrating violent acts against health care. One dissuasive message could be clearly stating that such acts may amount to war crimes and can incur severe punishments on the perpetrators. Perhaps this message needs to be dissociated from aid organisations operating in the field, though, to avoid creating suspicions that evidence of such acts will be forwarded to the International Criminal Court – a fear that has already led to threats against health staff in the DRC and expulsions of aid agencies from Sudan. This message could be complemented by a second message in a more persuasive vein that appeals to reciprocity: that if you respect the health care of your enemies, they will be more likely to respect yours. Radio soap operas and other popular vectors could be used to carry messages aimed at allowing local health providers to do their job of helping the wounded and sick without impediments.

Third, one international agency should undertake the responsibility for monitoring violence against health care in a more systematic way than is done at present. Health organisations, both national and international, should be strongly encouraged to report on such incidents so that the problems can be better understood and addressed. More clarity is needed on the type of incidents to be reported so that subjectivity in this area can be minimised.

Fourth, aid organisations need to consider ways in which their actions and statements might impact upon perceptions of their neutrality in conflict settings. A recent statement by a senior official of the World Health Organization, for instance, linked vaccination to the defeat of Al Shabaab forces by African Union troops, stating publicly that ‘when al-Shabab is forced out, health agencies rush in and vaccinate children’.<sup>29</sup> This type of comment is unlikely to assist in efforts to scale up polio vaccinations in Al Shabaab-held regions in the wake of the recent polio outbreak. Many other aid agencies pay only lip service to the humanitarian postures that they need to adopt in order to safely operate in conflict zones,

29 ‘Somalia launching new five-in-one child vaccines’, in *AP*, 25 April 2013. This article was picked up by newspapers the world over, including Somali ones like *Hiiraan Online*: ‘New push against polio and new vaccines in Somalia’, in *Hiiraan Online*, 26 April 2013, available at: [www.hiiraan.com/news4/2013/Apr/29046/new\\_push\\_againt\\_polio\\_and\\_new\\_vaccines\\_in\\_somalia.aspx](http://www.hiiraan.com/news4/2013/Apr/29046/new_push_againt_polio_and_new_vaccines_in_somalia.aspx).



and many incidents occur due to miscommunication and insufficient acceptance by the local population. Given the broad repercussions that can result from one violent incident against an aid agency, all have a responsibility to improve their acceptability in the contexts in which they work.

Last but certainly not least, humanitarian organisations need to come together and object in bilateral discussions and publicly to any and all political initiatives that undermine the neutrality of health care. Just as the use of an ambulance in a suicide attack causes mistrust of all ambulances thereafter, to the detriment of those requiring a rapid transfer to hospital, so the engagement of a doctor in an act of espionage generates mistrust of health professionals, to the detriment of all. The more health care is misused, the more violence it will attract. It is in the interests of the whole health and broader humanitarian community to come together and fight for respect of medical ethics and the laws protecting health care.