

A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

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OPPORTUNITIES FOR BREAKTHROUGHS

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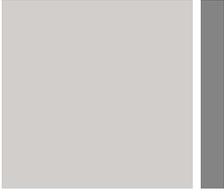
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PROTECTION OF HEALTH CARE IN ARMED AND CIVIL CONFLICT

OPPORTUNITIES FOR BREAKTHROUGHS

*Leonard S. Rubenstein*¹

During recent uprisings in Bahrain, Syria, and Libya, security forces obstructed access to health facilities; harassed, arrested, and prosecuted medical personnel; and even assaulted patients within hospitals.² In Ciudad Juarez, Mexico, where drug-related violence has escalated over the past three years, criminal organizations have killed and abducted health workers and interfered with patient care inside hospitals. As a result of the insecurity, doctors and nurses have fled, and 60 percent of the city's clinics have closed, jeopardizing the health of individuals in a city of 1.5 million people. In some areas of the city there are no clinics left at all, and night and weekend services have been severely compromised.³

Assaults like these have long been part of the landscape of armed and civil conflict.⁴ They jeopardize the lives and well-being not only of those directly attacked but of others who may never be able to access the health care they need. Yet, for decades, a paucity of regular reporting on the frequency, dynamics, and impacts of these assaults; lack of attention to strategies to prevent attacks; and absence of accountability mechanisms for those who perpetrate assaults has allowed these assaults to continue with impunity.

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² Amnesty International, *Health Crisis: Syrian Government Targets the Wounded and Health Workers* (London: Amnesty International, October 2011), <http://www.amnesty.org/en/library/asset/MDE24/059/2011/en/74190b0e-cbc4-4596-91fc-eb89863362d8/mde240592011en.pdf>; Human Rights Watch, *Targets of Retribution: Attacks against Medics, Injured Protestors, and Health Facilities* (New York: Human Rights Watch, July 2011), <http://www.hrw.org/reports/2011/07/18/targets-retribution>; Physicians for Human Rights, *Witness to War Crimes: Evidence from Misrata, Libya* (Cambridge, MA: Physicians for Human Rights, August 2011), https://s3.amazonaws.com/PHR_Reports/Libya-WitnessToWarCrimes-Aug2011.pdf; Bahrain Independent Commission of Inquiry, "Report of the Bahrain Independent Commission of Inquiry," Manama, December 10, 2011, <http://files.bici.org.bh/BICIreportEN.pdf>.

³ International Committee of the Red Cross (ICRC), "Mexico: medical provision in jeopardy in Ciudad Juarez," Geneva, May 8, 2011, <http://www.icrc.org/eng/resources/documents/feature/2011/mexico-feature-2011-08-05.htm>.

⁴ Leonard S. Rubenstein and Melanie D. Bittle, "Responsibility for Protection of Medical Workers and Facilities in Armed Conflict," *Lancet* 375, issue 9711 (January 2010): 329–340.

Human rights organizations occasionally write reports on attacks on health care, usually in high visibility conflicts, and consistently find severe violations of international law in connection with attacks on, threats against, or obstruction of health care services—but there is no international mechanism for systematic monitoring. Among humanitarian aid groups, which often collect data on security incidents involving their staff, underreporting is common, especially among smaller agencies. Moreover, despite improved cooperation on security among the groups, many organizations are reluctant to share information.⁵ Research on the intermediate and longer-term impacts of violence, or threats of violence, inflicted on clinics, hospitals, doctors, nurses, ambulances, and patients on access to and quality of health care is also scant, in part because relevant data is hard to obtain. For example, we know little about the connection between attacks on health care facilities and personnel and health worker migration, and even less about the impact of infrastructure destruction or health care worker flight on access to essential services.

Initiatives on prevention of and accountability for attacks have also been weak. Humanitarian organizations are increasingly engaging in risk assessment, humanitarian negotiation, and active acceptance strategies to insulate programs from attack. These initiatives, however, require long-term investments for analysis and outreach and communication tools that are often unavailable.⁶ Moreover, they don't apply to indigenous health programs, which often have only haphazard access to information needed to improve their security. Although UN agencies have begun to play a more proactive role in security coordination for nongovernmental organizations (NGOs) working in emergencies, for the most part the international community has not made protection of health care a priority. The World Health Organization (WHO) and Human Rights Council occasionally pass resolutions expressing concern about attacks on health care, but they have never taken steps consistent with their mandates or expertise to track them or develop proactive strategies to prevent them. The UN secretary general's special representative on children and armed conflict, in conjunction with other UN agencies, reports attacks on health care facilities serving children, but its strict reporting protocols and narrow interpretation of international humanitarian law likely overlook many violations. Health has been a relatively low priority for the Office of the Special Representative, as reflected in its website, which except for HIV/AIDS does not mention health in a list of 11 concerns about the protection of children in armed conflict.⁷

⁵ Abby Stoddard et al., "Providing aid in insecure environments: 2009 update: Trends in violence against aid workers and the operational response," HPG Policy Brief 34, Overseas Development Institute, London, April 2009, <http://www.odi.org.uk/resources/docs/4243.pdf>.

⁶ Abby Stoddard and Adele Harmer, "Supporting Security for Humanitarian Action: A Review of Critical Issues for the Humanitarian Community," Humanitarian Outcomes/U.S. Agency for International Development, Washington, DC, March 2010, http://www.usaid.gov/our_work/humanitarian_assistance/disaster_assistance/consultations/fy2010/supporting_security_humanitarian_action.pdf.

⁷ UN Office of the Special Representative of the Secretary General for Children and Armed Conflict, "Issues," <http://www.un.org/children/conflict/english/issues.html>.

An opportunity was missed a decade ago, when medical and nursing organizations urged the Human Rights Commission to create a special rapporteur on attacks on health workers. The commission (now Human Rights Council) agreed, but expanded the mandate to include the right to the highest attainable standard of health generally. While the right to health warrants the attention of a special rapporteur, the result was that the two individuals appointed to the position have understandably devoted their attention to broader issues of the right to health and comparatively little to attacks on health care.

Further, as Michael Posner, assistant secretary of state for democracy, human rights, and labor, acknowledged in a 2011 speech, responses to attacks on health have not been prominent in bilateral human rights initiatives. The annual Country Reports on Human Rights Practices issued by the U.S. State Department since the 1970s did not solicit information about attacks on health care (though it did note attacks reported in unsolicited accounts). Nor are specialized bilateral tools akin to the global trafficking report, whose ratings of states affect levels of foreign assistance, in place to address the problem.

Lassitude about attacks on health among states, UN and other international agencies, NGOs and academia began to change in 2011, however. One major advance was the evidence base. In the first study to identify incidents of violence inflicted on health services across multiple states, the International Committee of the Red Cross (ICRC) released a report, *Health Care in Danger*, based on information obtained from 16 countries where it was operational over the course of two and a half years. The study found 655 discrete incidents of violence or threats of violence against health care services, leading to the deaths or wounding of more than 1,800 people. According to the ICRC, moreover, the number of incidents reported is likely a significant underestimate, as its methodology was based on reports from humanitarian organizations compiled for other purposes and on media accounts. In releasing the report, ICRC broke from its usual caution and sounded the alarm, declaring that “in terms of number of people affected, violence, both real and threatened, against health-care workers, facilities and beneficiaries is one of the biggest, most complex, and yet most under-recognized humanitarian issues today.”⁸

The report found 462 cases where health care facilities were damaged or entered by security forces for the purpose of making arrests, stealing supplies, or taking over the building. More than 700 people were killed during the course of 81 incidents, including more than 200 health care workers and almost 70 wounded and sick people (others killed included relatives, bystanders, and people whose identity could not be established); another 1,100 people were injured. The report stated that 166 people were kidnapped, the vast majority of them health care workers, almost all of them by armed groups. More than 60 other health care workers were arrested, almost all by police or other state agents. There were 65 events in which individuals in need of health care were denied access to

⁸ ICRC, *Health Care in Danger: A Sixteen-Country Study* (Geneva: ICRC, July 2011), <http://www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf>.

it, mostly by state armed forces, and almost 200 cases where violence was inflicted on medical vehicles or personnel en route to a health care facility.

Where perpetrators could be identified, the study found that attacks by state armed forces and police combined slightly exceeded those inflicted by nonstate armed groups. Though well over half of the incident reports in the study came from international humanitarian agencies, the number of assaults on local health care services it found was higher than those inflicted on international NGOs.

The study reported that in almost half the cases, the delivery of health care was suspended, made impossible, or withdrawn for a finite period. It noted, too, that the indirect effects of violence on health personnel most deeply impact the countries that can least afford to lose them, as countries that experience sustained conflicts have the fewest health care workers.

The release of the study constituted the first step in a campaign by ICRC to raise awareness and develop pragmatic strategies to increase adherence to international and domestic law prohibiting attacks on health care. The campaign coincided with other major initiatives launched in 2011 that together have the potential to create a breakthrough in protection of health care in situations of pervasive violence through mutually reinforcing strategies of reporting, prevention, and accountability.

Expanding Reporting and the Evidence Base

As in all realms of global health and civilian protection, an effective response to the problem depends on a sound evidence base. Documentation is needed to identify violations, invoke mechanisms for protection and accountability, and develop the political will to use them. Scholarly research is essential to understand the motivations and dynamics of attacks; to determine their short-, intermediate-, and long-term impacts; and to assess the effectiveness of prevention strategies.

In 2011, multiple initiatives laid the foundation for the evidence base through regular reporting. At the urging of advocates, for the first time the U.S. State Department issued instructions to embassies to seek information about attacks on or obstruction of health care for inclusion in its annual Country Reports on Human Rights Practices. As a result, a record will begin to be developed as health care providers and personnel, as well as local NGOs and human rights organizations, learn about opportunities to include information on attacks on health care in the country reports. These in turn can provide a basis for demands for diplomatic action to governments and multilateral organizations.

The State Department initiative is an important step forward, but it is still insufficient to fill the documentation gap, which requires systematic reporting. A nascent initiative at the World Health Organization can strengthen the evidence base. Because of its responsibility to collect data on health globally, its priority on health systems development (including the health workforce), its coordinating role in humanitarian health response, and its presence in virtually every country, WHO is uniquely positioned among international agencies to collect and report data on incidents

of attacks on health workers and facilities and create a foundation for research. With leadership from the U.S. Office of Global Health Affairs, the World Medical Association, NGOs and academia, WHO's responsibility for collection and dissemination of data on attacks on health care was broached at the May 2011 meeting of the World Health Assembly. In her opening address, Director-General Margaret Chan acknowledged the problem of attacks on health as a challenge to the global health community. In addition, the secretariat agreed to convene a technical meeting to address means and methods for systematic collection of data on assaults on health, which will likely take place in 2012. Questions to be addressed at this meeting include appropriate methods and tools for data collection; the potential use of mobile and social media technologies; appropriate and feasible roles for WHO country offices, ministries, NGOs, and providers; and security of personnel and facilities in the reporting process. Moreover, in January 2012, the WHO Executive Board addressed the collection of data on assaults at a political level, forwarding a resolution, with lead sponsorship by the European Union, the United States, and Japan, for consideration by the World Health Assembly in May that would mandate a leadership role for WHO in collecting and reporting data on attacks on health facilities, health workers, health transports, and ambulances during complex humanitarian emergencies.⁹

Enhancing Prevention

Prevention is a multidimensional process, requiring understanding of attackers' motives, appreciation of and willingness to abide by international law, and the role attacks play in military strategy; assurance that military doctrine and training is consistent with protection responsibilities; analysis of incentives available to encourage adherence to legal obligations; pragmatic steps to increase safety in potentially dangerous situations; assurance of consequences to perpetrators for violations; and evaluation of strategies. Multiple actors need to be engaged to advance prevention, including conventional militaries and, in certain cases, police, health providers, governments (and state prosecutors who may improperly bring charges against doctors or nurses for giving care to an enemy), international organizations, and where feasible, nonstate actors.

Some prevention strategies can respond directly to the ICRC study's findings. For example, the study found that more than 90 percent of incidents where conventional militaries damage health care facilities through the use of explosives did not involve deliberate targeting. This finding suggests that the forces may not have understood the extent of their obligations under international law or lacked appropriate rules, protocols, training, or leadership commitment to assure compliance with their affirmative duties to respect health care, to discriminate between military and nonmilitary targets, and to use methods of war proportional to military objectives. Similarly, the study found that 23 health care workers were threatened by state armed forces or police, and in one state, 35 health workers were threatened by administrative officials. It is possible that the state

⁹ WHO Executive Board, "WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies," January 21, 2012, http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_R14-en.pdf.

agents either did not appreciate their legal responsibility to respect the ethical obligation and freedom of health professionals to provide impartial care irrespective of the patient's affiliation or faced no consequences for noncompliance.

In other cases, military and security forces that seek to abide by their obligations may engage in practices that nevertheless endanger health. For example, in some circumstances, placing a military perimeter around a hospital may jeopardize its security because the enemy then perceives it as no longer impartial; grounding security in community support may be more effective. Similarly, developing pragmatic means of improving inspection procedures for ambulances can meet armed forces' security needs while enabling the vehicles to proceed safely and quickly.

Through action taken in December 2011 at the 31st Quadrennial Conference of the Red Cross and Red Crescent, which also brings together all states parties to the Geneva Conventions, an opportunity exists to address the conduct, protocols, and training of militaries in connection with the security of health care. The conference adopted a resolution that calls on states "to ensure that their armed forces and security forces implement all applicable international legal obligations in relation to armed conflict, including situations of occupation, with regard to protection for the wounded and the sick, as well as for health-care services, including through the development and adoption of appropriate doctrine, procedures, guidelines and training."¹⁰ Toward that end, ICRC plans to convene a series of workshops with states to explore potential improvements in military doctrine, training, procedures, and instructions. The U.S. Department of Defense has offered to host a workshop on military practice, likely to take place in late 2012.

It will almost certainly be more difficult to induce armed groups to adhere to their obligations under customary international humanitarian law. The ICRC study found, for example, that armed groups entered health facilities in 85 instances, nearly twice as many times as conventional military forces, about half the time to appropriate them for their own purposes. In other cases, they stole supplies or vehicles or kidnapped health workers. Such behaviors often lead to skepticism whether nonstate actors can be induced to respect international humanitarian law, but there are examples of successful interventions. Through quiet negotiations, a variety of interlocutors have persuaded nonstate armed groups in the Democratic Republic of the Congo, El Salvador, Peru, and Afghanistan to cooperate in vaccination campaigns. Humanitarian groups and UN agencies have in some circumstances successfully created incentives for armed groups to refrain from attacks on clinics, hospitals, ambulances, and health workers. These strategies warrant study and potential replication.

Other steps toward prevention contemplated by the conference resolution include stronger legal measures by states to protect health care, more adequate marking of facilities with distinctive emblems, and increased training of health care workers to develop tools to enhance protection. The

¹⁰ ICRC, "31st International Conference 2011: Resolution 5—Health Care in Danger: Respecting and Protecting Health Care," Geneva, December 1, 2011, <http://www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm>.

resolution also calls for the Red Cross/Red Crescent movement to engage in awareness-raising and training activities both for the public and their own staffs. Increased reporting, of course, can also contribute to prevention, both through increased understanding of the factors that lead to or avoid attacks, and by naming and shaming perpetrators into compliance with the law.

Promoting Accountability

The year 2011 may also prove to have been a turning point in advancing accountability. For the first time, the UN Security Council applied a mechanism designed to protect children in armed conflict to attacks on health facilities and personnel. The mechanism was created in 2005 and includes reporting of violations by a special representative of the secretary general on children in armed conflict and, for some violations, listing states or nonstate actors who are persistent violators in the special representative's report. If listed, the party must establish an action plan toward achieving compliance and being de-listed. Even though compliance with the action plan requirement remains mixed, the procedures have shown promise in changing behavior.

Attacks on schools and hospitals are among six “grave violations” against children in conflict that the UN Security Council had named in earlier resolutions. Previously, though, such attacks were subject to reporting but not the accountability mechanism, and as noted, the reporting on attacks on health care has been constrained. But in July 2011, with leadership from Germany, the Security Council overcame political and technical objections and added attacks on schools and hospitals to the accountability mechanism. The resolution also clarified that personnel associated with these institutions are covered.¹¹ As a result, a formal tool of international accountability now exists to address attacks on health care facilities and personnel, at least to the extent they affect children. The existence of the new tool may also lead the special representative of the secretary general to improve reporting standards and give higher priority to attacks on health.

The 31st Quadrennial Conference resolution also called for increased accountability, including asking states “to ensure effective investigations and prosecution of crimes committed against health care personnel—including Movement personnel—their facilities and their means of transportation, especially attacks carried out against them, and to cooperate to this end, in conformity with their international obligations, at inter-state level and with international criminal tribunals and courts.”¹² The resolution sends a message to the prosecutors at international tribunals, as well as to domestic courts, to elevate the priority for prosecutions of these crimes—and represents a welcome shift from the too-common practice of prosecuting doctors for providing impartial care.

¹¹ UN Security Council, “Resolution 1998 (2011),” July 12, 2011, http://www.un.org/children/conflict/_documents/Res1998.pdf.

¹² ICRC, “31st International Conference 2011: Resolution 5—Health Care in Danger: Respecting and Protecting Health Care.”

Challenges Ahead

These actions, along with ICRC's campaign, provide a meaningful foundation for reducing attacks on health facilities, patients, medical personnel, and ambulances, and they can stimulate needed additional steps toward protection such as multilateral and bilateral mechanisms of accountability. To be successful, though, political, technical, and legal challenges must be addressed—chief among them, building political will and developing strategies for reporting that advance accountability while assuring protection. A true system of protection is needed that coordinates these new mechanisms and fills the gaps that remain.

Political Will

States are far more willing to support resolutions promoting civilian protection and human rights than they are to agree to robust compliance mechanisms. The enthusiasm reflected in the 31st Quadrennial Conference resolution could easily be superseded by states' resistance to perceived intrusive review of their military and police practices. Such resistance would likely extend to collecting data about attacks where they are perpetrators.

For example, as an organization governed by member states, and with its country representatives working in close collaboration with states, the World Health Organization has traditionally been cautious in taking actions that could antagonize governments. It has even found it difficult at times to secure cooperation from states on sharing basic health data, especially in politically charged circumstances. Moreover, its human rights commitment has always been tentative at best, exemplified in the few resources it has provided and the marginal role it assigns its human rights office. Resistance may be even stronger at a time when WHO is in a period of financial retrenchment and narrow focusing of its mission.

Political concerns are even more acute in the context of internal violence that falls short of armed conflict, where states strongly resist international reporting on judgments about their security practices. At the 31st Quadrennial Conference, some states successfully blocked efforts to include commitments to stop attacks on health services in what ICRC called “other situations of violence,” which was meant to foster action not only in armed conflict but in circumstances such as those described above in Mexico, Bahrain, and Syria. Other states insisted on affirming their control of the activities of Red Cross and Red Crescent Societies through language asserting “the auxiliary role of National Societies to their public authorities in the humanitarian field” and pointedly noted that ICRC itself “acts only with the full knowledge and consent of the State concerned.”¹³ States are also likely to resist demands to repeal laws that penalize doctors for providing impartial care in cases where the patient is seen as a security threat.

These challenges are hardly new. Over the past 50 years, many efforts to develop effective mechanisms to protect people from health threats or infringement of human rights have been

¹³ Ibid.

greeted by complaints about interference in a state's internal affairs. At WHO, some states resisted the revised International Health Regulations, which require states to permit more intrusive reporting and monitoring of contagious diseases. Nevertheless, the protection position has often carried the day in establishing formal institutions and enforcement mechanisms, from the International Health Regulations to the International Criminal Court, and prevailed in the recent actions by the Security Council and WHO Executive Board. The outcome tends to depend on mobilization to demand greater protection. There is little doubt that to overcome the resistance of some states to more robust action, health providers, professional associations, NGOs, civil society organizations, and human rights groups, along with partners in governments and the academic community, will have to strengthen their own commitments to organizing, education, analysis, and advocacy.

Advancing Accountability while Assuring Protection

Reporting attacks on health care is a key element of protection, as it can deter attacks and stimulate accountability. But reporting sometimes carries risks for health providers of retaliatory attacks on facilities or staff or restrictions on access to vulnerable populations. Attention from social media, such as crowd sourcing of violations, can inadvertently add risks to the security of health care facilities by identifying their location and creating new targets. The potential of vulnerability through reporting is evident in the ICRC report itself, which refused to identify the 16 countries it studied, “for reasons of political sensitivity.”¹⁴ ICRC also declined to identify the humanitarian organizations providing information to it.

The dilemma is serious, but as we have learned in responding to other crimes committed in conflicts, from gender-based violence to ethnic cleansing, the answer is not to remain silent, but to find ways to report without placing the subject of the attack in jeopardy. This is necessary not only for accountability but because reporting itself can be a source of protection. So the health community needs to examine methods that reconcile the power of information to increase protection with its potential role in undermining the very security it seeks. One part of the answer is to develop guidelines for situational analysis together with ground rules, including appropriate roles for different actors such as providers, UN agencies, human rights organizations, and civil society groups. The application of such rules may, for example, suppress public reporting of coordinates of a particular facility where doing so could place it at risk but provide information to understand the aggregate level of attacks. At the same time, there must be a strong international commitment through accountability mechanisms not to tolerate retaliation for reporting. The experience of humanitarian organizations provides some foundational knowledge for such guidelines, but much more work needs to be done.

¹⁴ Ibid., p. 4, note 11.

Conclusion

Health care services and the health workers who provide them are never more desperately needed, yet never more vulnerable, than when violence convulses a society. The mere hand-wringing that has largely greeted attacks on health care in the past can and must be replaced by concerted international action and a system on documentation, protection, and accountability. We have seen encouraging steps in the past year toward effective responses in UN Security Council Resolution 1998, reporting initiatives at WHO and the U.S. State Department, and the ICRC campaign. During the coming year, it will be important to track whether the commitments made are sustained and developed and, even more important, whether protection of health care is strengthened in 2013 and beyond. At the same time, we need to recognize how partial these initiatives are. Other institutions, including the Human Rights Council and the International Criminal Court, need to develop more effective ways to advance the protection of health in situations of pervasive violence. Bilateral diplomatic pressure, possibly including aid conditionality, will have to be ratcheted up. Donors must support research into the dynamics of attacks and potentially effective responses to them.

The groundwork for protection has been laid, though, and the prospect that health care can be better protected in times of conflict is palpable. The global health, humanitarian, and human rights communities, along with governments committed to health and to human rights, must insist that the prospect be realized.



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