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Conflict & Health Research Group

The ROYAL SOCIETY of MEDICINE
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SIPRI Workshop Summary

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PREVENTING VIOLENCE AGAINST HEALTH WORKERS: FROM THEORY TO PRACTICE

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OVERVIEW

Violent acts that directly affect the delivery of health care range from indiscriminate violence, to direct attacks against health workers (murder, kidnapping, robbery and threats), obstruction (e.g. ambulances being stopped at checkpoints) and discrimination (e.g. staff being pressured to treat one patient ahead of another), as well as damage to health facilities and vehicles. Although violence affects health care in all countries, there has been increasing attention paid to the issue during armed conflicts and in other violent situations.

On 2 December 2015, the Stockholm International Peace Research Institute and the Conflict and Health Research Group at King's College, London hosted a public seminar and research workshop jointly with the Royal Society of Medicine's Catastrophes and Conflict Forum to discuss this issue with representatives from key international non-governmental organizations (NGOs). The event was funded by the Global Health Working Group of the British International Studies Association (BISA).

The main aim of the event was to improve collaboration between the academic community and aid organizations. Although operational research is invaluable in advocacy efforts and can support change to internal policies, it is rarely 'scientifically valid.' Conversely, academic research, although methodologically and theoretically rigorous, is often communicated in a format that is not useful to aid organizations or fails to address the critical policy or operational issues facing NGOs. Throughout the day, participants discussed theoretical, methodological and ethical challenges in order to improve the translation of evidence into policy. They concluded that:

- Although there is a high degree of awareness of the issue, the research agenda is not well developed and there remains a need for systematic data collection and analysis of trends for attacks on patients, health workers, facilities and transport during armed conflict and in other violent contexts;
- Current data collection schemes do not always differentiate between health workers and other aid workers, which makes drawing sector-specific conclusions on threats difficult;

- There is a need to embed research into aid operations in order to change policy and practice;
- Although there are some global trends, the dynamics and motives for attacks, as well as the organizational responses, are highly context-dependent;
- Aid organizations could do more to make their anonymized data public in order to support global responses on prevention and accountability;
- There is also a need for systematic analysis of the immediate and longer-term impacts of violence—both targeted and non-targeted—on populations served during conflict, as well as on providers of health care.

SEMINAR

The day began with a seminar that was open to the public. There were 27 participants at the seminar, including representatives from both academia and aid organizations. Formal presentations were given by Olivia Blanchard (Médecins Sans Frontières, MSF), James Fairhead (University of Sussex) and Karl Blanchet from the London School of Hygiene and Tropical Medicine (LSHTM). After the formal presentations, the three speakers were joined by Benjamin Charlier from the International Committee of the Red Cross (ICRC) for a panel discussion.

Olivia Blanchard, Project Officer at MSF

Ms Blanchard discussed MSF's three-year long Medical Care Under Fire (MCUF) project, which is concluding. Based on the information available, without a baseline or historical data, it is not possible to definitely suggest that attacks against aid workers are increasing, as some organizations suggest in the current discourse. Drawing on the 11 country case studies from the MCUF project, it is difficult to make a general analysis or draw conclusions about global trends.

However, some patterns do recur across contexts, such as requests for preferential treatment at triage and violence linked to situations where the medical treatment provided does not meet patients' expectations or is in some other way unsatisfactory. In the latter case, in situations of unrest, there are few, if any, mechanisms for seeking compensation or making a complaint, and violence may seem to be the only recourse. Looting and destruction also appear to be universal methods of violence. Often, attacks do not happen in isolation and should be understood as extensions of armed conflict and other situations of violence. Other trends identified in the MCUF project include the persecution of patients and civilians seeking sanctuary in health facilities during conflict and the criminalization of health care provision. In the latter case, health workers can be arrested for treating members of non-state armed groups. Additionally, in some settings state authorities oblige health workers to report patients who are part of the conflict, while in other settings, for example Syria, hospitals and other health services have been used to track down protesters.

The MCUF project identified a range of perpetrators, from international and state military forces, to state authorities, other armed groups, organized criminals, community leaders, patients and their families and other health care workers.

However, knowledge gaps remain. There is often incomplete data on incidents, both qualitative and quantitative. This is in part because which incidents get reported and how is highly dependent on how individuals perceive risk and differentiate between 'everyday violence' and incidents serious enough to report. It is also difficult to confirm intentionality and the identity of perpetrators. Finally, it is difficult to assess the impact and consequences of violence, in terms of costs to facilities and impact on the population served.

James Fairhead, Professor of Anthropology

Drawing on fieldwork from Guinea, Professor Fairhead presented research on violence against Ebola teams, using the killing of eight members of an Ebola awareness team in September 2014 as a starting point. Professor Fairhead examined the active resistance of villagers in the context of several breakdowns in he termed 'social accommodations' related to: (*a*) burial practices and hospital medicine; (*b*) local political structures and external political subjugation; and (*c*) mining and conservation interests and the local communities.

In the first accommodation, Professor Fairhead discussed how Guineans were used to visiting hospitals to help provide care for their relatives, and how funeral practices were highly complicated, with different rites depending on the individual's role in society and type of death. Most Ebola Treatment Centres were not organized to take these practices into account, and post-death care was chronically under-resourced, which led to practices that were regarded as immoral by the communities in rural Guinea.

The outbreak took place within a historical and contemporary context of neoliberal exploitation—by the French colonial powers and later the government in Conarky, international mining interests and land grabbers—which has led to suffering among local communities. In this setting, white people and Western-educated Guineans were seen as sorcerers, which led to the belief that Ebola had been introduced to gain further power over local resources.

In this context of broken accommodations and historical exploitation, Ebola Treatment Centres and teams were seen as immoral extensions of outsider-led sorcery. Furthermore, Ebola response worked through the state, and provided another example of outsiders taking control. There had been a failure on the part of Ebola workers to understand the significance of these accommodations.

Karl Blanchet, Lecturer in Health Systems Research

Dr Blanchet discussed the challenges of research in humanitarian crises, focusing on the relationship between data, evidence and action. Generally speaking, there is too much data but not enough evidence, which can be defined as data that has been turned or processed into support for an

argument. Issues around what data to collect, how to define attacks and how to address differences in risk perception are all relevant to violence against health care provision and providers. There is also a need to trace how data is used, for instance, by looking at the chain from an incident report to a prosecution.

He also presented findings from his team's recent report, *An Evidence Review of Research on Health Interventions in Humanitarian Crises*. The project examined 697 articles published between 1980 and 2012. It found that there was uneven distribution between health topics and that only 35 per cent of the studies were assessed as high quality. It also found only limited use of experimental/quasi-experimental data, cohort data and economic data, as well as poor collection of routine data.

This lack of evidence is partly due to the challenges related to collecting data in humanitarian crises: it is dangerous and there are difficulties with logistics and limited resources. Particularly in the case of violence affecting the delivery of health care, there would be situations in which researchers were collecting data on government actors as perpetrators of violence. That there was an uneven distribution between health topics suggests that it is easier to do research in some areas than others, both practically and due to cost. There are also ethical concerns in working with populations in situations of vulnerability. Delivering care in emergency settings is, by definition, complicated and there may not be the resources to collect routine data. Finally, it is not part of the culture to question the impact of humanitarian action.

Dr Blanchet also expressed the need for good and genuine collaboration between practitioners and advocacy groups, and increased funding for research into humanitarian crises. In spite of these challenges, Dr Blanchet ended the presentation on a positive note, suggesting that the research environment is generally improving.

Benjamin Charlier, Operations adviser for the HCiD Project

Benjamin Charlier spoke briefly about the Health Care in Danger Project (HCiD), an initiative of the International Red Cross and Red Crescent Movement. The project began in 2011 after the adoption of a resolution at the 31st International Conference of the Movement that gave a specific mandate to the ICRC with that respect. One of the main roles of the ICRC as part of its mandate the HCiD project has been is to lead expert consultations to identify practical recommendations on how to improve the safety of health care delivery. The HCiD project has been using international workshops to research this problem from different angles. The results of these international workshops are now accessible to all (www.healthcareindanger.org) and the ICRC strongly encourages the implementation of their recommendations at the national level. The HCiD project is not limited to those regions affected by armed conflict, but also includes 'other situations of violence' where health care professionals, infrastructure and patients may be vulnerable. A recent study on health care-related violence in Karachi was cited.

Benjamin Charlier noted that, although the HCiD project sits within the ICRC and the broader International Red Cross and Red Crescent Movement, the issue belongs first and foremost to states, or in case of armed conflict to the parties to that conflict and to many other stakeholders. He therefore

welcomed the involvement of research institutes and others who can 'bring pieces to the jigsaw puzzle'. He also stated that the involvement of academic research is particularly welcome because violence affecting health care is still an under researched field where practitioners and academics have different but complementary comparative advantages.

WORKSHOP

In the afternoon, a closed workshop was held in conditions where it was agreed that no statements would be directly attributed. The affiliations of the 13 participants, however, are listed below. In addition to the representatives from the host organizations, there were representatives from: Médecins Sans Frontières, the University of Sussex, the LSHTM, the ICRC, Medical Aid for Palestinians, the University of Cambridge, the Picker Institute and the Karolinska Institute. Participants brought a range of perspectives, such as advocacy, communications, and Operational and academic research. Among the disciplines represented were: anthropology, international relations, law, medicine, politics and surgery. Participants had a range of experience gained from around the world, mainly in the Middle East and North Africa, sub-Saharan Africa and Europe.

The discussion revolved around five questions, which are discussed below.

- Is the sanctity of health care being eroded?
- What are the analytical challenges to researching the issues?
- From an academic perspective, what are the practical challenges to researching the issue?
- From an organizational perspective, what challenges exist to facilitating data sharing between organizations?
- What is the impact of violence on the delivery of health care?
- What research is necessary in order to inform and change policy? How should it be conducted?

Is the sanctity of health care being eroded?

Although there seems to have been a perceptible increase in the number of attacks, without baseline data—or data that differentiates between health care and other types of aid—it is impossible to be certain. However, referring to the morning's presentations, it is clear that violence has always affected health care and it is also clear that in some cases, such as Syria, attacks are increasing. Participants noted that the strategic use of the term 'sanctity' is new.

Conflict is characterized by a breakdown of multiple institutions, not just health care, and many current conflicts are characterized by mass acts of violence against civilians and disregard for International Humanitarian Law (IHL)—which again raises the question of a general erosion of respect for IHL. Whether health care is more at risk than other types of aid depends on the context. Participants noted situations in which negotiating with armed groups to access a population in need in order to deliver health aid was less difficult than attempting to deliver other types of aid, but also noted situa-

tions in which the reverse was true. Similarly, whether affiliation with an international aid organization provides protection is also context-specific.

In addition, there is room for manoeuvre within IHL. For example, if a hospital has combatants operating inside it, then it might lose its protection. However, this does not happen immediately and a warning period is required. One complex case mentioned was that of a hospital in South Sudan in which combatants who were out of uniform, and thus classified as civilians under IHL, were sheltering in a hospital. This made the facility a target—but not a legitimate one. Other grey areas were also discussed in the context of armed conflict, when IHL applies, and in 'other situations of violence'. For example:

- If a health structure is run by a group designated as a terrorist group, does it become a legitimate target? An example given was that of Hamas running the Ministry of Health in Palestine.
- If a combatant works as an ambulance driver, then he or she is afforded protection during working hours, but this can become blurred.
- During the Arab Spring protests in Egypt, protesters were arrested in hospital, which led to an underground network of nurses and doctors who would treat them. What kind of protection should they have?
- What if clinics provide aid to Islamic State? Individuals have joined IS as medics, but there is documentary evidence of forced organ and blood donations in these facilities. Are IS facilities protected by IHL or do they represent a breakdown of medical ethics?

What are analytical challenges to researching the issues?

Dr Blanchet's presentation discussed a hierarchy of evidence, in which Randomized Control Trials and quantitative studies are ranked higher than qualitative research. However, participants were unanimous that a mixed method approach is necessary, which includes a case-based understanding of the issue. The two main analytical challenges discussed were: (*a*) risk perceptions and subjectivity in reporting; and (*b*) determining intentionality. Disaggregating gender was mentioned as an additional challenge.

Reporting can be highly subjective. Incident reporting is dependent on how individuals perceive risk and differentiate between 'everyday violence' and incidents serious enough to report. Similarly, there is a need to better understand the impact of perceived threats. It was suggested that in the course of conducting an interview on a specific incident, other incidents that were not reported may also come to light. There is also a need to better understand the impact of perceived threats—if individuals do not come to work because of perceived threats, this might not be recorded. People also do not report violence because they fear reprisals, there is no guarantee that it will be taken seriously and, at times, violence is committed by other members of staff.

The importance of determining intentionality was also discussed. One example given by a participant was a hypothetical hospital that experiences three lootings in a week. Each of these lootings could have very different impacts and responses. Did the perpetrators steal or destroy? Was it an iso-

lated incident or part of a wider attack? These details often get lost in quantitative records. Participants discussed a hierarchy of intentionality, which would require different responses. For example, a hospital could be bombed intentionally or by accident; or a clinic could be overrun by an untrained militia with no knowledge of IHL.

Similarly, participants discussed the need to understand the viewpoint of perpetrators, especially as many are aware of IHL but still commit acts of violence. There is a need to understand the military doctrine and the perspectives of other perpetrators. In settings of asymmetric warfare, perpetrators have a strong idea of morality and immorality, and more research is needed to understand this. Although real-time analysis would be difficult, retrospective analysis would be extremely useful.

Finally, there is very little gender- or age-disaggregated data. Collecting this can be challenging, in part due to the need to protect the confidentiality of victims. The proportion of women workers in some locations is low, so they could be identified from an incident report by their roles. It is also difficult to untangle intentionality. One example given was that in armed conflict, young men tend to be targeted in general. A person may be being targeted because of his role as a health worker, or because he is a young man or because of his ethnicity.

From an academic perspective, what are practical challenges to researching the issue?

As discussed in the morning seminar, there are obvious practical challenges to carrying out research during humanitarian crises. A major question is: who does the research? Operational research is often carried out in field offices. While this can help to establish patterns, this kind of research is often not of a good enough quality or detailed enough about specific incidents to draw robust conclusions. There is also a perception that smaller organizations do not have the necessary capabilities or expertise to conduct the sort of fieldwork that is required. One option is for NGOs to build a research component into their projects, and also to get researchers into the field through secondments and other working arrangements. Participants noted that in some cases it is easier to access research informants as a researcher than as a representative of an advocacy group or an aid group.

Risk assessment and getting ethical approval are also complicated. There are questions about what confidentiality entails and concerns over patient confidentiality. Archival/historical research is a partial solution, but may not be relevant to current challenges. There were also concerns that research might inadvertently support policies could hinder aid, such as 'bunkerization' and increased remote management

Funding research during humanitarian crises is also difficult, as current academic schemes are not adequate. There is also a perception by NGOs that donors do not see research as a valuable part of aid delivery, and there is work to be done to sensitize donors. Overall, more dialogue is needed between funders, academics and organizations to understand the expectations of all parties. Another option discussed was developing schemes for a conflict that is yet to happen, for when people are needed on the ground immediately.

From an organizational perspective, what challenges exist to facilitating collaboration between organizations?

Most large organizations have good informal and formal relationships in which to discuss health care-related violence solutions, but resist data sharing. Organizations typically only collect information on incidents in their own facilities, not on neighbouring ones run by other organizations. From a research perspective, it is almost impossible to combine datasets from different organizations because they use different formats and indicators, and much of the data is aggregated in order to protect confidentiality.

While a standardization of terminology and the scope of study would be welcome, this has proved difficult. Participants used the example of the Bellagio Workshop on the issue, convened by the Center for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health in 2013. The idea of organizations working together and using common indicators was rejected. Participants noted that it can be difficult to reach internal agreement about the format of a database, let alone work to do so with other organizations. While organizations coordinate, they have their own priorities and agendas that drive data collection. In addition, more research can open organizations up to scrutiny about their policies on security and human resources.

One point raised during the panel discussion was the role of the World Health Organization (WHO) in providing a global overview of the issue. WHO is currently finalizing the field-testing of a methodology and tools for gathering data on attacks, which should be available on its website in the first quarter of 2016. It is also establishing a repository for reports from any source. Although it may seem that WHO is acting slowly, it is important to understand that WHO's structure necessitates that these processes take time. It is the role of aid organizations to encourage WHO in this endeavour.

What is the impact of violence on the delivery of health care?

Participants called for increased research on the impact of violence on both facilities and organizations, and also on the populations served. At the facility or organizational level, there is the question of understanding what leads to a decision to cease operations. Is it many small incidents that lead to a tipping point or are one or two larger incidents more often the trigger? There is also a need to study how violence affects the internal workings of aid organizations, from field offices to headquarters. On a broader scale, more work is needed to understand the impact on populations, in terms of lack of access to health care, and the impact of Western humanitarian intervention.

There is also a need to look at positive cases studies. One example is how the WHO is managing polio vaccination in Islamic State-held territory in Syria, and, again in this context, what has been learned about delivering the Global Polio Eradication Initiative in conflict-affected northern provinces of Pakistan, such as the Federally Administered Tribal Areas, for example.

CONCLUSIONS

- Incidents of violence against health workers are part of a wider narrative of conflict. It is important to understand where health care fits into this wider picture.
- A better typology is needed that takes account of incidents, intentionality and impact.
- It is already an achievement that the visibility of the issue has increased; this is leading organizations to expand their focus beyond frontline workers to look at other areas, such as logistics, and legal and back office support.
- Although researchers and aid organizations cannot necessarily change the nature of a conflict, vulnerabilities and the impact on the delivery of care can be minimized.

SUGGESTED RESOURCES

International Red Cross and Red Crescent Movement, Health Care in Danger Project, <http://healthcareindanger.org/the-issue/>.

MSF, Medical Care Under Fire, <http://www.msf.org/topics/medical-care-under-fire>.

Humanitarian Outcomes, The Aid Worker Security Database, <https://aidworkersecurity.org>.

The Guardian, 'Secret aid worker', <http://www.theguardian.com/global-development-professionals-network/series/secret-aid-worker>.

World Health Organization, Violence and Injury Prevention, 'Violence against healthworkers', <http://www.who.int/violence_injury_prevention/violence/workplace/en/>.

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