

VIOLENCE AGAINST HEALTH WORKERS IN COMPLEX SECURITY ENVIRONMENTS

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I. Introduction

Violence against health workers and facilities is a global problem that, by many accounts, is on the rise. Such violence includes direct attacks (murder, kidnapping, robbery and threats), obstruction (e.g. ambulances being stopped at checkpoints) and discrimination (e.g. staff being pressured to treat one patient instead of another). While such attacks occur in low-, middle- and high-income countries, this background paper focuses on the issue in complex security environments. Complex security environments are settings that are generally characterized by a combination of one or more factors, including violence (which may or may not be ‘armed conflict’ in the legal sense), extreme poverty, environmental disaster and weak governance.

Reliable access to health care is most needed in these settings; yet its delivery presents many challenges. In addition to the threat of targeted violence, many organizations operate in areas that are experiencing general violence and other security and safety issues. The follow-on effects of violence and insecurity within health care provision include poor staff-retention rates, delays in the transport of medication and supplies, and the overall diminished ability to deliver health services to the most vulnerable populations.¹ These problems also disrupt other health care facilities, which may be forced to accept more patients in order to offset the losses caused by attacks on other facilities.

In armed conflicts, international humanitarian law (IHL) presents a legal framework for the respect and protection of health care missions and for the right of civilians, wounded soldiers and prisoners of war to receive medical assistance in armed conflict. In addition to IHL, international human rights law (IHRL) provides the framework for protecting health care at all times, in both peace and conflict. While IHRL only in principle establishes obligations on states, IHL is binding on states as well as ‘organized armed groups’ (box 1).

Many complex security environments include non-state armed groups, as well as some governments, that may blatantly violate or use ambiguities in IHL and—in the case of governments, IHRL—to obstruct the provision of health care. Similarly, concern has been expressed over the violation of IHL

SUMMARY

● This background paper discusses violence against health workers and facilities in complex security environments, including armed conflict. It examines the scope and drivers of the issue as well as organizational responses to it.

The causality of violence against health workers (and humanitarian aid workers more broadly) operating in complex security environments is poorly understood and difficult to untangle. It is often directly attributed to three dynamics: the shrinking humanitarian space, the changing nature of warfare and the politicization of aid. However, such nebulous macro-concepts can mask the context-specific aspects of individual incidents. In doing so, they limit the understanding of the issue and how to effectively address it.

Several ongoing projects by aid organizations aim to combat violence against health workers through advocacy and research and by producing concrete recommendations to promote the safe delivery of health care. One specific tool to address violence against health workers is international law, whose full potential to address the issue remains unrealized.

¹ Coupland, R., ‘The role of health-related data in promoting the security of health care in armed conflict and other emergencies’, *International Review of the Red Cross*, vol. 95, no. 889 (Mar. 2013), pp. 61–71.

**Box 1. International Humanitarian Law and International Human Rights Law**

International humanitarian law (IHL) protects access to health care in times of armed conflict. In situations that do not reach the threshold of armed conflict only international human rights law (IHRL) and domestic law apply. In principle, IHRL applies at all times. Although less specific than IHL, IHRL contains several rules protecting access to health care. While IHL binds states as well as non-state armed groups, IHRL only applies to states.^a Relatively few provisions of IHL or IHRL refer specifically to health workers or humanitarian workers more broadly; instead these individuals are protected under laws that protect civilians and affirm the right to health.

International humanitarian law

International humanitarian law, also known as the Law of Armed Conflict, is based on treaties, in particular the Geneva Conventions of 1949 and their Additional Protocols, and a series of other conventions and protocols on specific topics. There is also a substantial body of customary law that is binding on all states and non-state parties to armed conflicts.

Most treaty-based IHL is applicable only in international armed conflict. Fewer treaty rules are applicable in non-international conflict. However, today most basic rules of IHL relating to the medical missions are considered customary law and as such they are applicable in international and non-international armed conflicts.^b Under these rules:

- the wounded and sick must be respected and protected and must not be attacked;
- the wounded and sick must be provided with medical care and attention, to the extent possible, with the least possible delay and without any adverse distinction on any grounds other than medical ones;
- the wounded and sick must be searched for, collected and evacuated, to the extent possible, particularly after the fighting has ended;
- health-care personnel must not be attacked, unless they commit, outside of their humanitarian function, acts that are harmful to the enemy;
- medical units, such as hospitals and other facilities that have been set up for medical purposes, must be respected and protected;
- medical units may not be attacked and access to them may not be limited;
- parties to an armed conflict must take measures to protect medical units from attack;
- the red cross, the red crescent or the red crystal symbols are the visible signs of the protection conferred by the Geneva Conventions and their Additional Protocols on medical personnel, medical units and medical transports;
- the passage of medical transports conveying the wounded and sick or health-care personnel must not be arbitrarily denied or restricted;
- medical units and transports will lose their protection if they are used, outside their humanitarian function, to commit acts harmful to the enemy; and
- health-care personnel must not be punished for carrying out activities compatible with health-care ethics.

and also humanitarian principles (box 2) regarding both counterinsurgency campaigns and comprehensive approaches to conflict management that have used relief efforts for political or strategic gains, which may blur humanitarian and military missions.²

The causality of violence against health workers (and humanitarian aid workers more broadly) who are operating in complex security environments is poorly understood and difficult to untangle.³ It is often directly attributed to three dynamics: the shrinking humanitarian space, the changing nature

² Brassard-Bourdreau, C. and Hubert, D., 'Shrinking humanitarian space? Trends and prospects on security and access', *Journal of Humanitarian Assistance* (Nov. 2010).

³ In this paper, the term 'health workers' refers to individuals who are involved in the provision of health care, such as doctors, nurses, ambulance drivers and translators. The category 'humanitarian aid worker' includes health workers as well as individuals who provide other types of humanitarian aid in armed conflict and other emergencies. Some research, such as the Aid Worker Security Database, does not differentiate between health workers and other humanitarian workers. Similarly, much of the literature on the subject does not differentiate between these categories. This



Box 1. Continued

International human rights law

International human rights law refers to a collection of international rules, most of which are treaty based, that recognize the inherent dignity and equality of all individuals and spell out the rights that individuals have by virtue of being human. Specific treaties include the 1948 Universal Declaration of Human Rights, the 1966 International Covenant on Economic, Social and Cultural Rights, and the 1989 Convention on the Rights of the Child.

IHRL is applicable at all times, in and out of conflict, although some governments may choose to suspend aspects of IHRL in emergency or conflict situations.^c IHRL protects the rights of individuals, but the state bears responsibility for protecting these rights. Non-state organized groups are not obligated to protect human rights, although this is currently an area of discussion. Individuals may be prosecuted for violations of IHRL (e.g. genocide or crimes against humanity). Specific aspects of the right to health include the ‘right of everyone to the enjoyment of the highest attainable standard of physical and mental health’; and the states parties to specific treaties within IHRL are responsible to ensure the ‘creation of conditions which would assure to all medical service and medical attention in the event of sickness’.^d

General comment no. 14 to the International Covenant on Economic, Social and Cultural Rights notes that the Right to the Highest Attainable Standard of Health (2000) elaborates on Article 12 of the International Covenant on Economic, Social and Cultural Rights, taking into account the right to health during armed conflict. Specifically, it:

- reaffirms the right to be free from torture;
- reaffirms the responsibility of states to ensure that third parties do not limit access to health services;
- prohibits states from ‘limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law’; and
- reaffirms the responsibility of states to ‘cooperate in providing disaster relief and humanitarian assistance in times of emergency’.

^a For more information on IHL and IHRL see Marks, S. P., *Health and Human Rights: Basic International Documents* (Harvard University Press: Cambridge, MA, 2004); International Committee of the Red Cross (ICRC), *International Humanitarian Law and International Human Rights Law: Similarities and Differences* (ICRC: Geneva, Jan. 2003); Breitegger, A., ‘The legal framework applicable to insecurity and violence affecting the delivery of health care in armed conflicts and other emergencies’, *International Review of the Red Cross*, vol. 95, no. 890 (June 2013), pp. 83–127; and International Committee of the Red Cross (ICRC), *Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law* (ICRC: Geneva, Mar. 2012).

^b See e.g. First, Second and Fourth Geneva Conventions of 1949; Additional Protocol I, Part II (articles 8–34); Additional Protocol II, Part III (articles 7–12) of 1977; and Henckaerts, J.-M., ‘ICRC study on customary international humanitarian law’, *International Review of the Red Cross*, vol. 87, no. 857 (Mar. 2005).

^c See e.g. the International Covenant on Economic, Social and Cultural Rights (1966), Article 4, <<http://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>>.

^d International Covenant on Economic, Social and Cultural Rights (note c), Article 12.

of warfare and the politicization of aid. However, such nebulous macro-concepts mask the context-specific aspects of individual incidents and, in doing so, limit understanding of the issue and how to effectively address it.

In order to combat violence against health workers, several ongoing projects by organizations—such as the Health Care in Danger project of the International Committee of the Red Cross (ICRC) and the International Red Cross and the Red Crescent Movement, and the Medical Care Under Fire project of Médecins Sans Frontières (MSF)—aim to mitigate the issue through advocacy and research and by producing concrete recommendations to promote the safe delivery of health care.⁴ One specific tool that has

paper focuses on the provision of health care, but uses the term ‘humanitarian aid worker’ when research and analysis apply to both terms.

⁴ The term ‘International Red Cross and the Red Crescent Movement’ refers to the ICRC, the International Federation of Red Cross and Red Crescent Societies (IFRC) and the 189-member Red Cross and Red Crescent societies.

**Box 2. Humanitarian principles**

The principles of humanity, neutrality, impartiality and independence are at the core of humanitarian aid work, including health care provision. The maintenance of humanitarian principles is universally vital, not only in areas of conflict: the same standards apply during peacetime and war, and in high-, middle- and low-income settings.

Humanity

All humans are born free and with equal rights.
Alleviating human suffering is the fundamental purpose of humanitarian action.

Neutrality

Humanitarian actors do not take sides in a conflict.
Humanitarian actors do not discriminate on the basis of ideology, creed, gender, race, age, disability, language, gender, class, sexual orientation, ethnicity, geographic origin, religion or political affiliation.

Impartiality

Humanitarian action is carried out on the basis of need alone: the most vulnerable are prioritized.
Aid or care is given to the most urgent and serious cases, regardless of ideology, creed, gender, race, age, disability, language, gender, class, sexual orientation, ethnicity, geographic origin, religion or political affiliation.

Independence

Humanitarian action is autonomous from political, economic and military objectives.
Humanitarian action is not to be used as a tool of foreign or security policy.
Aid must not be used to further political or religious viewpoints.

Sources: Adapted from the International Committee of the Red Cross (ICRC), the Sphere Handbook and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA). The fundamental principles of the International Red Cross and Red Crescent Movement are listed at <<https://www.icrc.org/eng/resources/documents/red-cross-crescent-movement/fundamental-principles-movement-1986-10-31.htm>>. For a description of the Sphere Project see <<http://www.spherehandbook.org/en/the-handbook-structure/>>. OCHA's humanitarian principles are described at <https://docs.unocha.org/sites/dms/Documents/OOM_HumPrinciple_English.pdf>.

been discussed within these initiatives is international law: specifically, international humanitarian law and international human rights law, whose full potential to address the issue remains unrealized.

This background paper discusses targeted violence against health workers and facilities in complex security environments, including armed conflict. Section II examines the scope and drivers of the issue, and section III describes the organizational responses to it. Section IV concludes with a discussion of international law.

II. The scope and drivers of the problem

The scope

This section discusses the historical context of violence against health workers, describing types of incident, numbers and trends, such as kidnapping. It also examines individual dynamics: gender aspects of violence, the different experiences of expatriate, local and national staff, and the types of perpetrator.



The issue of violence against health workers, specifically, and humanitarian aid workers, more broadly, is not new.⁵ For example, doctors and nurses were killed during the 1870–71 Franco–Prussian War, and, in the 1935–36 Second Italo–Ethiopian War and in World War II, military forces targeted staff from the Red Cross movement. In 1969 an aircraft associated with the International Committee of the Red Cross (ICRC) was shot down during the 1967–70 Nigerian Civil War.

However, much current research and activism starts with the assumption that there was a shift in the scope and drivers of violence against health workers, and humanitarian aid workers more broadly, in the mid-1990s, with some suggesting that the murder of six ICRC staff in the aftermath of the First Chechen War (1994–96) marked a turning point. In that December 1996 incident, masked men, using weapons equipped with silencers, killed six expatriate staff members at a hospital compound in Novye Atagi in the middle of the night in what was clearly seen as a premeditated and targeted attack.

There is an assumption in some humanitarian circles that prior to the Novye Atagi killings targeted violence against health workers was infrequent, not necessarily targeted at humanitarian aid workers and committed outside of the normal repertoire of violence. This belief has been further reinforced by the notion that violence against health workers and other humanitarian aid workers has not only increased in scope but has also become normalized over the past two decades. However, given that reporting before the 2000s was limited, it is not possible to definitively state that violence against humanitarian aid workers has increased or changed in nature since Novye Atagi. Nevertheless, these perceptions have pushed the issue of violence against humanitarian aid workers onto the agenda of aid organizations, governments and multilateral forums.

By definition, humanitarian aid workers operate in settings where they may face risks from general crime and violence as well as other threats, such as road traffic accidents. They are also subject to intimidation, threats and what has been termed ‘everyday violence’ that affects aid work, such as the denial of visas to aid workers or obstructions (e.g. checkpoints, roadblocks and curfews) which prevent patients from receiving care.⁶ Violence includes physical violence such as shooting and bombing (suicide bombing, aerial bombardment, grenade attacks and improvised explosive devices, particularly on roads), looting, landmines, carjacking, rape and other sexual assault, kidnapping, torture, arrest and imprisonment by authorities. Attacks occur at homes, offices and compounds, health care facilities, in the community and on the roads. Road attacks and ambushes are consistently the most common.⁷

⁵ Dandoy, A. and Pérouse de Montclos, M., ‘Humanitarian workers in peril? Deconstructing the myth of the new and growing threat to humanitarian workers’, *Global Crime*, vol. 14, no. 4 (2013), pp. 341–58; and Davey, E., ‘A history of the humanitarian system: Western origins and foundations’, HPG Working Paper (Overseas Development Institute: London, June 2013).

⁶ Fast, L., *Aid in Danger: The Perils and Promise of Humanitarianism* (University of Pennsylvania Press: Philadelphia, PA, 2014).

⁷ Humanitarian Outcomes, ‘Aid worker security report 2014, unsafe passage: road attacks and their impact on humanitarian operations’, 2014, <<http://www.humanitarianoutcomes.org/sites/default/files/Aid%20Worker%20Security%20Report%202014.pdf>>.

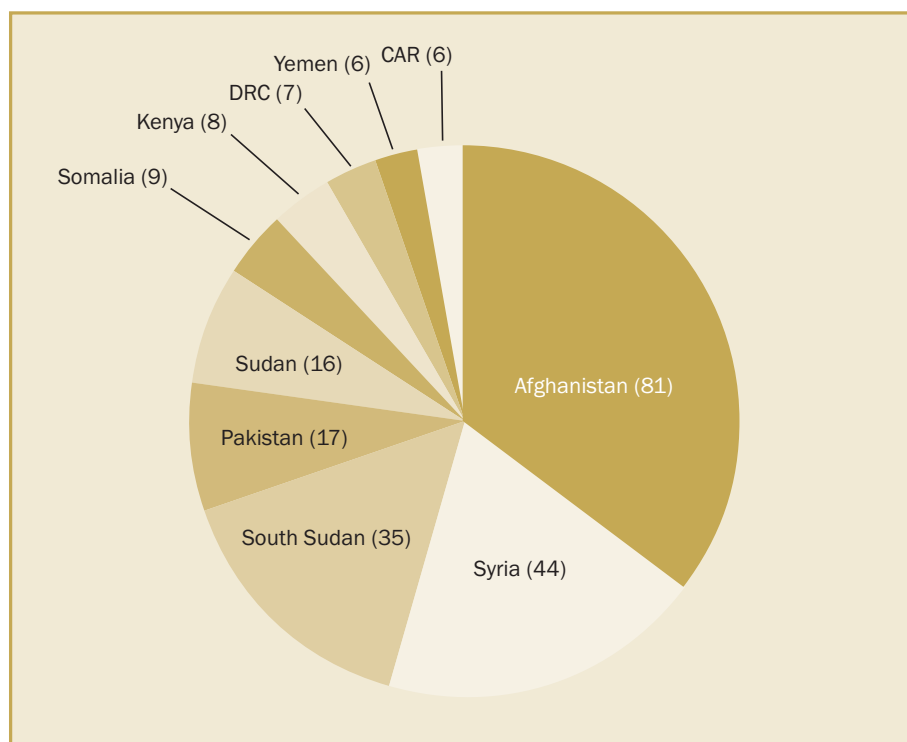


Figure 1. Countries with the most attacks on aid workers, 2013
CAR = Central African Republic; DRC = Democratic Republic of the Congo.

Source: Humanitarian Outcomes, Aid Worker Security Database, 1 Oct. 2014, <<http://www.humanitarianoutcomes.org/awsd>>.

According to Humanitarian Outcomes, in 2013 Afghanistan, Pakistan, South Sudan, Sudan and Syria accounted for 75 per cent of attacks (figure 1).⁸ According to their study, in the same year there were 251 individual attacks, affecting 460 humanitarian aid workers—the highest number since data collection began in 1997 (figures 2 and 3).⁹ These numbers represent ‘verified incidents’, suggesting that the numbers are certainly higher. Indeed, using a different methodology, focusing solely on the delivery of health care and looking at 23 countries, the ICRC found that 1809 incidents had occurred in 2012 and 2013 combined.¹⁰

An increasing trend is kidnapping. Although the majority of kidnapping victims are released, kidnapping is particularly disruptive, both to individuals and at the institutional level. It typically involves a prolonged process of

negotiation, often with multiple governments, which often takes place in the public spotlight. Moreover, it requires resources to negotiate ransoms and release and the provision of service may be curtailed or even stopped during the negotiations. How the release of staff is negotiated also has broader implications for how an organization negotiates with local communities in the future.¹¹ Between 2002 and 2012 the number of kidnapping incidents quadrupled, with 92 staff kidnapped in 2012, comprising about 25 per cent of all attacks on humanitarian aid workers globally.¹²

Although media attention often focuses on expatriate staff, the reality is that national and local staff are disproportionately affected by violence.¹³

⁸ Humanitarian Outcomes (note 7).

⁹ Humanitarian Outcomes is a consultancy that provides research and policy advice for humanitarian aid organizations and donor governments. It maintains the Aid Worker Security Database, which is supported by Canada’s Department of Foreign Affairs, Trade and Development, the United States’ Office of US Foreign Disaster Assistance, and Ireland’s Irish Aid. See also Humanitarian Outcomes (note 7).

¹⁰ International Committee of the Red Cross, ‘Violent incidents affecting health care: health care in danger, January to December 2012’, 2013, <https://www.icrc.org/eng/assets/files/reports/4050-002_violent-incidents-report_en_final.pdf>.

¹¹ Humanitarian Outcomes, ‘Aid worker security report 2013: the new normal, coping with the kidnapping threat’, 2013, <https://aidworkersecurity.org/sites/default/files/AidWorkerSecurityReport_2013_web.pdf>.

¹² Humanitarian Outcomes (note 11).

¹³ Humanitarian Outcomes, ‘Aid worker security report 2011: spotlight on security for national aid workers, issues and perspectives’, 2011, <<https://aidworkersecurity.org/sites/default/files/>>



Of the 460 humanitarian aid workers who were victims of major attacks in 2013, 401 were national staff. This is not unexpected since national and local staff comprise the vast majority of front-line workers, particularly in settings where access is denied to international staff. This increased 'remote management' transfers risk to local and national partners.¹⁴ Thus, when aid organizations depart, it is local- and national-level staff who are left behind, along with local partner organizations. Generally, national and local staff do not have the same access to security resources, insurance or emergency evacuation as international staff. They also face risks that are unique to doing work 'at home' or, in the case of staff from a different part of the country, as outsiders with different ethnic, language or religious identities from the community they serve.

There appears to be a gender dynamic to incidents. For example, women are more likely to face violence in urban environments and in compounds, while men are more likely to face violence in rural settings and on roads. Women experience more crime and threats; men experience more injuries, deaths and arrests.¹⁵ It has also been suggested that in some contexts, particularly those characterized by gender inequality, women are more at risk.¹⁶ Additionally, the disruption of services affects women, men and children differently. However, gender data is not typically recorded or disclosed, in part to respect privacy; thus, there is a knowledge gap regarding the gender aspect of violence against health workers and facilities.

Research by the ICRC in 2012 and 2013 found that government actors (military and police) and armed non-state actors (militia, private security and rebel and guerrilla movements) are equally guilty of perpetrating violence, with each group representing approximately a third of attacks globally on both individuals and facilities. Aside from organized groups,

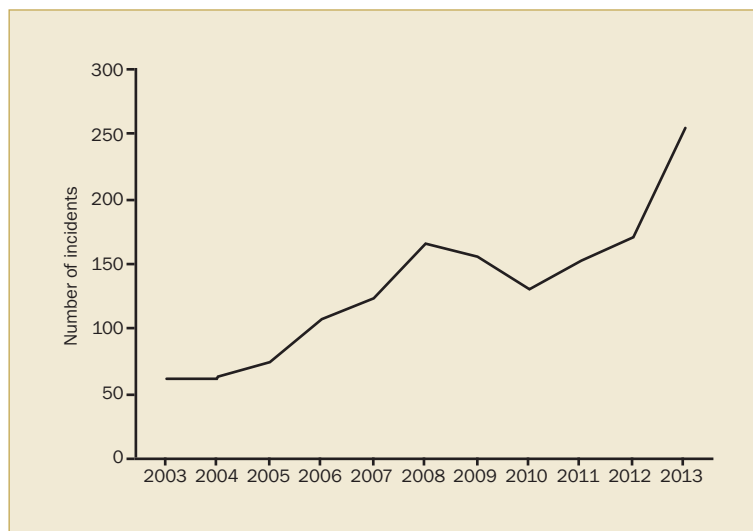


Figure 2. Incidents of violence against humanitarian aid workers, 2003–13

Source: Humanitarian Outcomes, Aid Worker Security Database, 1 Oct. 2014, <<http://www.humanitarianoutcomes.org/awsd>>.

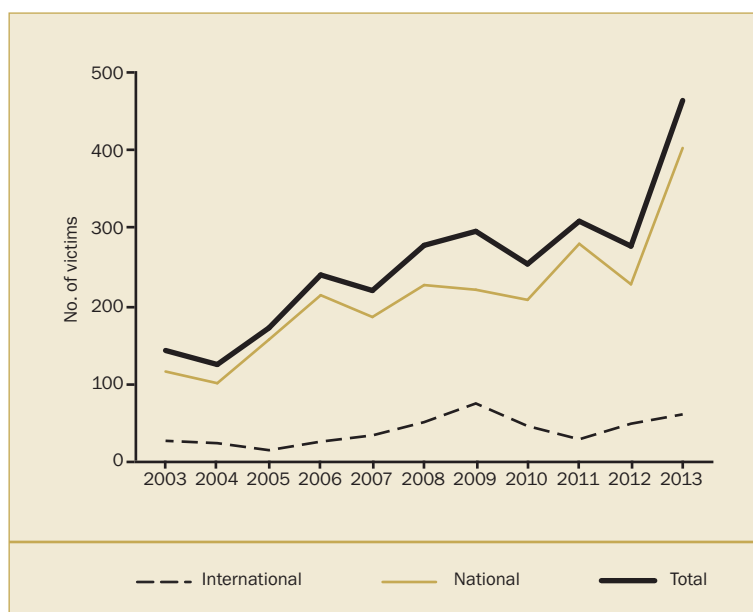


Figure 3. Number of victims by type of staff, 2003–13

Source: Humanitarian Outcomes, Aid Worker Security Database, 1 Oct. 2014, <<http://www.humanitarianoutcomes.org/awsd>>.

AidWorkerSecurityReport2011.pdf 6>.

¹⁴ Fast (note 6).

¹⁵ Wille, C. and Fast, L., 'Aid, gender and security: the gendered nature of security events affecting aid workers and aid delivery', *Insecurity Insight*, 2011, <<http://www.insecurityinsight.org/files/Security%20Facts%20%20Gender.pdf>>.

¹⁶ Humanitarian Outcomes (note 11).



roughly 10 per cent of perpetrators include individuals, such as family members of patients who are unhappy with their treatment or care.¹⁷ However, the types of perpetrator and causes of violence are highly context-specific. For instance, research by Physicians for Human Rights has found that government security forces have been largely responsible for violence against health workers and facilities in Syria during the civil war (2011–present), although opposition forces have also carried out attacks.¹⁸

Methodological issues

It is important to note that there are several caveats to the figures above. Namely, there are difficulties with using globally aggregated data and, to some extent, the statistics reflect changes in humanitarian working practices and better reporting, rather than increased violence.

Aid workers are more exposed to violence because humanitarian action is more likely to take place on the front lines

First, globally aggregated data can mask individual conflicts and incidents. Annual data is often skewed by specific high-impact incidents, making it difficult to identify long-term trends. For example, in 2002 a suicide bomber killed 19 people attending a graduation ceremony for medical students at Benadir University in Mogadishu, Somalia. Between December 2012 and February 2013, over 20 workers in polio vaccination teams were murdered in Pakistan. On 19 August 2003—now commemorated as World Humanitarian Day—the United Nations Headquarters in Baghdad was bombed, killing 22 people and wounding over 100. The Syrian civil war is also part of the reason for the sharp rise in incidents from 2012 to 2013 in globally aggregated data.

Second, the fact that some settings have high numbers of attacks may be more a reflection of the size of humanitarian missions, rather than of the political and security situation. High numbers might also indicate better reporting or awareness of risks. Settings with low numbers may reflect the fact that the aid organizations have pulled out of the region or country.

Third, the nature and scale of humanitarian work have changed. Although the attack rate has risen by most measures, the number of humanitarian aid workers in the field has also increased over the past two decades.¹⁹ Indeed, the attack rate per humanitarian aid worker in the field has remained mainly stable since 2006.²⁰ Since the 1980s, aid organizations have increased their presence in conflict areas and are more willing to remain in insecure environments than in the past; this is tied to the trend for governments, at times, to prefer funding humanitarian action to taking political or military action.²¹ Workers are also more exposed to violence because humanitarian action is more likely to take place on the ‘front lines’, not least in situations where there are not clear lines. This is in contrast to earlier work which was primarily based in refugee camps.

Furthermore, awareness of the issue has increased and reporting has improved. Recent initiatives to collect data have been much more systematic

¹⁷ International Committee of the Red Cross (note 10).

¹⁸ ‘Syria’s medical community under assault’, Physicians for Human Rights, Oct. 2014, <<http://physiciansforhumanrights.org/library/other/syrias-medical-community-under-assault.html>>.

¹⁹ Fast (note 6).

²⁰ Humanitarian Outcomes (note 7).

²¹ Fast (note 6).



in their approaches and reporting is far better. These are certainly positive steps, but they also make it difficult to compare current reports with those from before the mid-1990s, which makes analysing long-term trends and coming to conclusions about an increase in attacks difficult.

The drivers of violence

At the macro-level, the research and humanitarian communities and the media use three overlapping narratives to explain the increase in attacks: the changing nature of conflict, the shrinking humanitarian space, and the politicization and militarization of aid. Changes in ways of delivering humanitarian aid, as discussed above, follow on from this evolving context of conflict and humanitarian aid provision. This section examines these narratives, as well as criticism of their usefulness in analysing the underlying causes of the issue. Overall, it can be difficult to attribute the cause of specific incidents of violence to these nebulous, macro-level concepts. As a complement to the macro-level analysis, this paper draws on Larissa Fast's relational approach: it is revealing to unpack the individual narrative of each incident to understand the web of social relationships in which humanitarian aid work takes place and to analyse the linkages between the macro- and micro-level causes of violence (figure 2).²² Although this section presents examples from health workers, much of the analysis refers to humanitarian aid workers, as well as development aid workers, more broadly. The final part of this section focuses on drivers specific to the delivery of health care. The main reservation in the analysis of both macro- and micro-level causes is that there is often little information on the perpetrators, and research is dependent on victims' perceptions of why an attack occurred.

Macro-level drivers

The first macro-level narrative is about the changing nature of conflict. Rather than interstate conflict, the nature of conflict is increasingly intra-state or mixed interstate and intrastate, with a variety of non-state actors as combatants. One assumption is that these non-state actors may be less aware of, or less inclined to, follow international law—particularly with regard to the protection of civilians and health care. As John Ging, the Director of Operations for the UN Office for the Coordination of Humanitarian Affairs, stated: 'More and more we're seeing parties to conflicts around the world ignore the rules of war to achieve a political end—directly targeting civilians, carrying out collective punishment, inciting ethnic violence, impeding the delivery of lifesaving humanitarian supplies to affected people and attacking humanitarian actors themselves'.²³

Without a doubt, the nature of warfare is different from the situation at the time of the post-World War I drafting of the Geneva Conventions. Since then, three significant geopolitical changes have affected warfare: decolonization in the 1950s to early 1970s, the end of the cold war in 1991, and the terrorist attacks on the United States of 11 September 2001. However, the nature of

²² Fast (note 6).

²³ Whiting, A., 'Attacks on aid workers worldwide hit worst levels on record', Trust.org, 19 Aug. 2014, <<http://www.trust.org/item/20140818174026-7mao9/?source=fiHeadlineStory>>.



warfare has been changing for a long time and claims of ‘new wars’ should be tempered with a historical perspective.²⁴ There have also been changes in the materiel of war. For instance, there has been a growing focus on the significant role of small arms and light weapons (SALW) and anti-vehicle mines in armed conflict; the use of these weapons in violence against aid workers is a particular concern in this context.²⁵ Additionally, suggestions that perpetrators of violence are predominantly non-state actors are flawed, as governmental actors are equally or even more likely to carry out attacks, depending on the setting. Regardless of how novel this type of warfare may be, current complex security environments are often characterized by one of the following aspects that make humanitarian aid work challenging, both from operational and legal perspectives.

First, one of the basic principles of IHL is the distinction between combatants and civilians. However, ‘new wars’ tend to be protracted and involve multiple state and non-state actors and shifting positions. This also means that there is confusion over who is a combatant and who is a civilian, as civilians and even children take up arms. Lines may also be blurred between organized armed groups and ‘regular’ criminal gangs. Second, humanitarian aid is increasingly being used as a replacement for political solutions. This puts more burden and responsibility on humanitarian aid workers, who are pushed into more violent environments, thus increasing their exposure to violence.²⁶ Third, the availability of SALW, along with both anti-personnel and anti-vehicle mines, makes it easier to carry out attacks.

The second and third narratives are intertwined and place focus on the notion that violence against humanitarian aid workers takes place in the wider context of decreasing humanitarian space, part of which is caused by the politicization and militarization of aid.²⁷ The term ‘humanitarian space’ remains somewhat ambiguous but tends to be used by humanitarian actors to refer to the environment in which humanitarian aid agencies are free to operate independent of external political or security agendas. It is both a conceptual space, in which humanitarian principles are respected, and a physical space in which it is safe to carry out humanitarian missions.²⁸

An example of ‘shrinking humanitarian space’ is the blurring of the humanitarian agenda with the political one.²⁹ Humanitarian aid should be based solely on need and without consideration of ethnicity, political ideology or other factors (see box 1). In contrast, political aid is tied to political,

²⁴ Newman, E., ‘The “new wars” debate: a historical perspective is needed’, *Security Dialogue*, vol. 35, no. 2 (June 2004), pp. 173–89.

²⁵ Wezeman, P. D., ‘The UN conference on the illicit trade in small arms and light weapons’, *SIPRI Yearbook 2002: Armaments, Disarmaments and International Security* (Oxford University Press: Oxford, 2002); Muggah, R., ‘Reconsidering the tools of war: small arms and humanitarian action’ (Overseas Development Institute: London, 2002); and Geneva International Centre for Humanitarian Demining (GICHD) and SIPRI, ‘The humanitarian and developmental impact of anti-vehicle mines’, 2014, <http://www.gichd.org/mine-action-resources/publications/detail/publication/the-humanitarian-and-developmental-impact-of-anti-vehicle-mines/#.VD4_PYvLeGg>.

²⁶ Pantuliano, S., ‘Humanitarians are paying the price for political inaction’, Trust.org, 19 Aug. 2014, <<http://www.trust.org/item/20140818135735-64vut/?source=fiBlogs>>.

²⁷ Whiting (note 23).

²⁸ For a discussion of this term see Brassard-Bourdreau and Hubert (note 2).

²⁹ Hofman, M., ‘Dangerous aid in Afghanistan’, *Foreign Policy*, 12 Jan. 2011, <http://southasia.foreignpolicy.com/posts/2011/01/12/dangerous_aid_in_afghanistan>.



military, or strategic and security goals, such as ‘winning hearts and minds’, combating terrorism, state-building and peacebuilding.

An extreme example is the fake vaccination campaign of the US Central Intelligence Agency (CIA) in Abbottabad, Pakistan. The CIA sought to confirm Osama bin Laden’s hiding place and hired a Pakistani doctor to collect DNA from bin Laden’s family under the guise of providing free vaccinations for hepatitis B. The ramifications of this fake vaccination campaign were particularly acute. The Global Polio Eradication Initiative (GPEI) was already failing in Pakistan due to a lack of trust in vaccines, religious objections and action against polio vaccination teams in retaliation for US drone strikes in Pakistan, along with governance failures of the health ministry. The fake vaccine campaign worsened the situation and in the period between December 2012 and February 2013 alone, over 20 polio vaccinators were killed.³⁰

More common examples of activities that erode the humanitarian space include the distribution of aid or aid-drops by troops in ‘winning hearts and minds’ initiatives. Military actors, such as the North Atlantic Treaty Organization (NATO), also use humanitarian discourse to legitimize military missions. In the middle of this dichotomy between political and humanitarian aid are non-governmental organizations (NGOs) that accept government funding or cooperate in wider comprehensive strategies for conflict management. Privately contracted companies are increasingly providing humanitarian services, and some service providers use private security companies for security, in contrast to the International Red Cross and Red Crescent Movement and Médecins Sans Frontières (MSF), which as a rule do not use armed protection or military escorts. Moreover, the UN itself can be a party to conflict at times, which calls into question the impartiality of UN aid actors.

The consequences attributed to the politicization of aid create situations that clearly put humanitarian aid workers at risk. For example, if some aid organizations use armed guards or participate in government conflict-management initiatives, it can be very difficult for other aid organizations to promote themselves as neutral, independent humanitarian actors that are outside the conflict. Cases of mistaken identity have occurred in which perpetrators have inadvertently attacked a specific target because of an organization’s proximity to other actors, or attacks have been carried out on humanitarian aid workers who were simply on the road at the wrong time. Additionally, patients who seek aid or care from military-affiliated groups may be targeted.³¹

The politicization and militarization of aid are fundamental problems, not least because they are often characterized by the violation of humanitarian principles. However, when considered in global terms, grand narratives of the changing nature of conflict, shrinking humanitarian space and the politicization and militarization of aid are to some extent exaggerated and ahistorical.³² Aid has always been political and, as discussed above, the issue

The politicization and militarization of aid are fundamental problems

³⁰ Irwin, R., ‘The polio endgame: update from the 123rd Executive Board meeting’, *Global Health Diplomacy Monitor*, vol. 4, no. 1 (Feb. 2013), pp. 4–5.

³¹ Hofman (note 29).

³² Dandoy, A. and Pérouse de Montclos, M., ‘Humanitarian workers in peril? Deconstructing the myth of the new and growing threat to humanitarian workers’, *Global Crime*, vol. 14, no. 4 (2013),



is not so much that the humanitarian space is not shrinking, but rather that there have been changes in humanitarian work and the scale of efforts.³³

These narratives warrant further scrutiny as explanatory factors for violence against humanitarian aid workers as a global phenomenon. Therefore, it is also useful to examine the interplay between these nebulous concepts and organizational and individual behaviours within a specific community or aid context (see figure 4).³⁴ Further, it is important to look in depth at the concrete aspects of these issues, such as the proliferation of SALW.

Micro-level drivers

Fast argues that grand narratives, as discussed above, can hide the organizational and individual behaviours that contribute to poor security management. She also argues for a relational approach to understanding the issue. That is, while humanitarian aid workers and organizations ostensibly stand independent of a conflict, aiming to provide aid without prejudice to any one side, they are embedded in the community in which they live and work. First, attacks can occur because of interpersonal disputes that may have nothing to do with health care delivery or for economic reasons, particularly in the case of kidnapping. Second, perpetrators of crime do not necessarily distrust individual humanitarian aid workers or organizations. Rather, they may be mistrustful of organizations that pay high salaries to expatriate and even local staff, which can increase inequality within the community. Perpetrators, too, may not recognize the red cross or red crescent as emblems of neutrality, but rather see them as religious symbols. Third, perpetrators may view individuals as disrespectful or morally questionable if they, at times, exhibit behaviours that are not in line with local practice, such as drinking to excess or dressing in a certain way. Such an approach does not seek to blame the victim, but it is essential to analyse each incident within its specific local context, as well as within a global context.³⁵

Health care-specific drivers

Disease and illness are both social and biological realities (i.e. culture, social structures and economic conditions shape concepts of health and the experience of illness). For instance, although polio is caused by a virus, the way individuals experience the disease and understand its causes differs by setting. In this way, the provision of health care lends itself to conspiracy theories.

In northern Nigeria, for example, religious and political leaders boycotted the polio vaccine in 2003 because they claimed the vaccine was contaminated with HIV and could cause sterilization.³⁶ A main finding of a study in north-western Pakistan looking at polio vaccine refusals in 2007 was the existence of rumours that the vaccine was a form of birth control, was contaminated by bacteria or pork, or was a 'plot against Muslims by foreign

pp. 341–58.

³³ Davey, E., 'Humanitarian history in a complex world', Policy Brief no. 59 (Overseas Development Institute: London, 2014); and Collison, S. and Elhawary, S., *Humanitarian Space: A Review of Trends and Issues*, HPG Report no. 32 (Overseas Development Institute: London, Apr. 2011).

³⁴ Fast (note 6).

³⁵ Fast (note 6).

³⁶ Larson, H. et al., 'Addressing the vaccine confidence gap', *The Lancet*, vol. 378, no. 9790 (6 Aug. 2011), pp. 526–35.

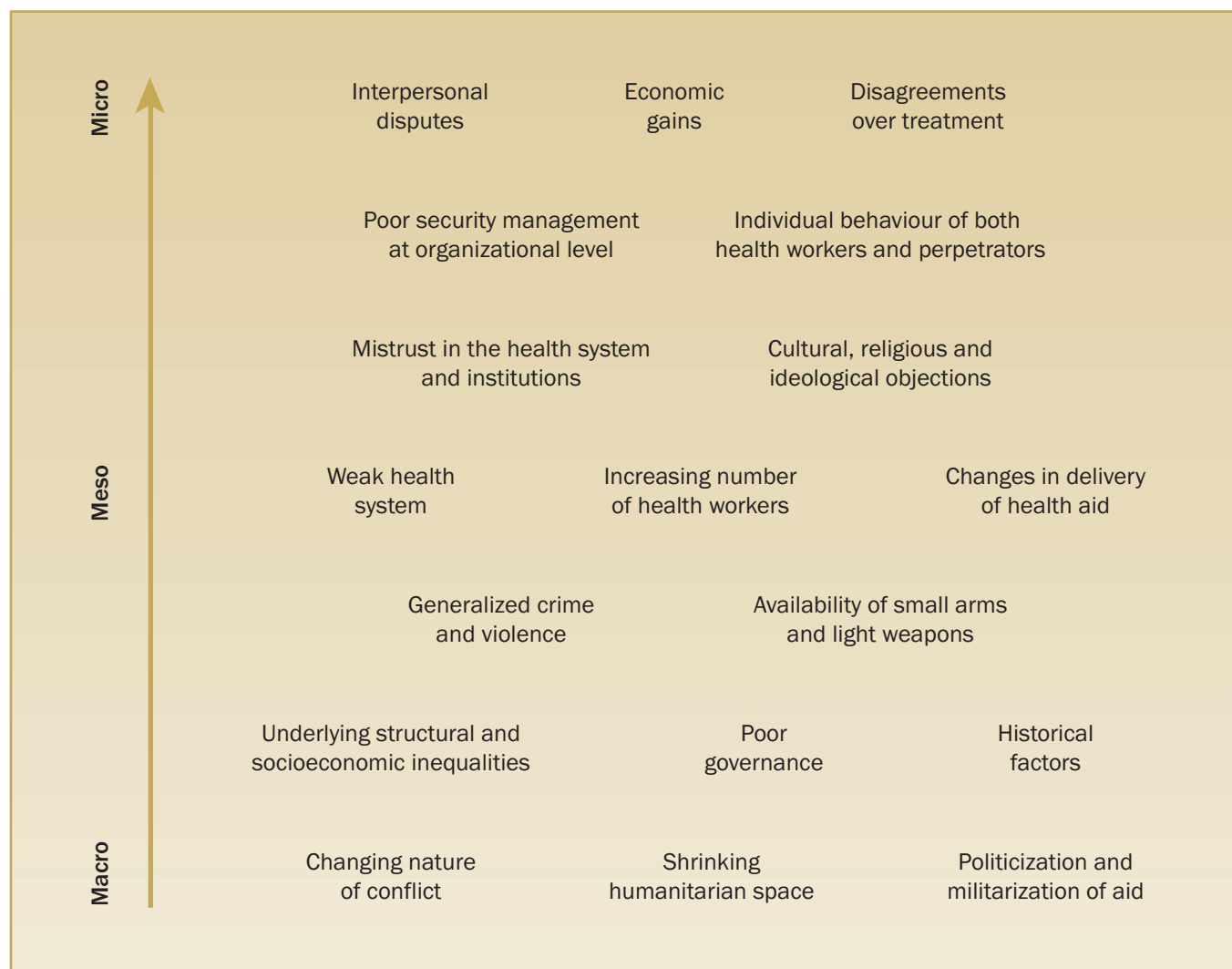


Figure 4. The drivers of violence against health workers in complex security environments: macro- to micro-level factors

and central powers'.³⁷ In both these settings, violence has been perpetrated against health workers from the GPEI, largely attributed to mistrust and conspiracy theories. Similarly, in the 2014 Ebola outbreak in West Africa, eight health workers in Guinea were killed. These murders were largely attributed to suspicions that health workers were spreading the disease.³⁸

Such conspiracy theories do not develop in a vacuum. The fundamental basis for a relationship between a health care provider and patient (and the patient's family) is reaching a consensus on the cause of illness and the best course of treatment.³⁹ Culturally, conspiracy theories can arise when there are competing ideas about disease risks and the aetiology and treatment

³⁷ Murakami, H. et al., 'Refusal of oral polio vaccine in northwestern Pakistan: a qualitative and quantitative study', *Vaccine*, vol. 32, no. 12 (10 Mar. 2014), pp. 1382–87.

³⁸ 'Ebola outbreak: Guinea health team killed', BBC, 19 Sep. 2014, <<http://www.bbc.com/news/world-africa-29256443>>.

³⁹ Kleinman, A., *Patients and Healers in the Context of Culture* (University of California Press: Berkeley, Los Angeles and London, 1981); and Anderson, W. T. and Helm, D. T., 'The physician-patient encounter: a process of reality negotiation', ed E. G. Jaco, *Patients, Physicians and Illness* (Free Press: New York, 1978), pp. 259–71.



of disease. Politically, such theories are related to wider issues about trust in the government and the health system. Mistrust of the health system takes place in contexts in which there have been failures of medical ethics, such as medical trials that have resulted in deaths or have been unethically conducted. This is particularly the case in sub-Saharan Africa, where the legacy of colonial medicine persists today. Colonial medicine introduced ideologies and practices that, at times, were dehumanizing and contributed to the creation of power structures that benefited health providers and other authorities to the detriment of the general population and created the basis for inequalities.⁴⁰ More recently, in many complex security environments, health systems are weak or non-functional. There is no faith that the system, whether governmental or non-governmental, will provide adequate care. In turn, this climate of mistrust sets the stage for violence against health workers.

Overall, this paper suggests that the drivers of violence against health workers, and humanitarian aid workers more broadly, are a combination of ideological, social, economic, religious and—particularly in the case of conspiracy theories—historical factors. The narratives of individual incidents should be unpacked and focus needs to be placed on the multiplicity of factors at play in any situation and the mixed motives of perpetrators. Such an approach allows the macro-level factors to set the stage on which the micro-level factors play out their roles.

III. Organizational responses

At the political level, World Health Organization (WHO) officials and delegates to meetings of the WHO's governing bodies have been outspoken in their condemnation of attacks on health workers, particularly those that have occurred within the context of both Syria and the GPEI. However, there has been frustration that the WHO has come to the issue relatively late and that action is slow.⁴¹

In 2002 the World Health Assembly, the WHO's highest governing body, adopted Resolution WHA55.13 on the protection of medical missions during armed conflict. More recently, as part of a wider overhaul of the WHO's work in humanitarian emergencies, it has developed draft methods for the 'systematic collection and dissemination of data on attacks on health facilities, health workers, health transport and patients in humanitarian settings'.⁴²

The WHO's action in this area has taken place together with other UN resolutions, including UN Security Council Resolution 1998, which condemns the denial of humanitarian access, with a focus on children, and UN General Assembly Resolutions 65/132 and 68/101 on the safety and security

⁴⁰ Vaughan, M., *Curing Their Ills: Colonial Power and African Illness* (Oxford Polity Press: Oxford, 1991); and Comaroff, J. and Comaroff, J., *Ethnography and the Historical Imagination* (Westview Press: Boulder, CO, 1992).

⁴¹ Rubenstein, L. and Bittle, M. D., 'Responsibility for protection of medical workers and facilities in armed conflict', *The Lancet*, vol. 375, no. 9711(23 Jan. 2010), pp. 329–40.

⁴² World Health Assembly Resolution WHA65.20, 26 May 2012, <http://apps.who.int/gb/ebwha/pdf_files/WHA65-REC1/A65_REC1-en.pdf#page=25>; and World Health Organization, 'Progress reports: WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies', A67/40, 12 Mar. 2014, <http://who.int/gb/ebwha/pdf_files/WHA67/A67_40-en.pdf>.



of humanitarian personnel and the protection of UN personnel.⁴³ Violence against health workers was also a key topic of discussion during the UN General Assembly meeting in September 2014.⁴⁴

Initiatives by the ICRC, MSF and other organizations have focused more on operational changes and advocacy efforts. Specifically, the ICRC's Health Care in Danger Project and MSF's Medical Care Under Fire (MCUF) Project are discussed below. Other initiatives include Safeguarding Health Care in Conflict, a coalition of NGOs formed in 2012, documentation and research by Physicians for Human Rights and internal processes at many other organizations. Overall, organizations are already implementing recommendations and staff are more engaged with this issue, but it will take time to see concrete results.

In 2008, the ICRC identified that there was no systematic attempt to get an overview of the problem. This led to its 16-country study, *Healthcare in Danger*, which looked at the impact of violent events on health care in countries where insecurity was of concern to the ICRC.⁴⁵

In turn, this study has served as the basis for the Health Care in Danger project, running from 2012–15. The project, mandated by Resolution 5 of the 31st International Conference of the Red Cross and Red Crescent in 2011, aims to improve 'the efficiency and delivery of effective and impartial health care in armed conflict and other emergencies'.⁴⁶ It is an extensive global project that entails a series of consultations, workshops and other events with states parties to the Geneva Conventions, academics, medics, civil society and those who bear weapons (e.g. armed groups and militaries). The final findings and practical recommendations will be presented to the 32nd International Conference of the Red Cross and Red Crescent in 2015.

Similarly, MSF launched the Medical Care Under Fire (MCUF) Project, which is an internal process to collect data and analyse best practices. In the course of the MCUF project, the organization analyses security incidents in 15 countries where it operates. The analysis includes a classification of attacks according to their nature and impact, as well as a study of how the organization has adapted its security management strategies in each specific context. A targeted advocacy component to promote respect for the medical mission is also included.

Some examples of best practice are concrete and universal and include varying routes travelled, both on foot and in vehicles, using blast film on windows, designating health care facilities as no-weapon zones and negotiating

The drivers of violence against health workers are a combination of ideological, social, economic, religious and historical factors

⁴³ UN Security Council Resolution 1998, 12 July 2011; UN General Assembly Resolution 65/132, 15 Dec. 2010; and UN General Assembly Resolution 68/101, 13 Dec. 2013.

⁴⁴ International Committee of the Red Cross, 'Debate on "Health care and violence: the need for effective protection"' at the 69th session of the United Nations General Assembly, 18 Sep. 2014, <<https://www.icrc.org/en/document/debate-health-care-and-violence-need-effective-protection-69th-session-united-nations#VD0tnEtUFFI>>.

⁴⁵ International Committee of the Red Cross (ICRC), *Healthcare in Danger: A Sixteen-Country Study* (ICRC: Geneva, July 2011).

⁴⁶ The International Conference brings together the ICRC, 189 Red Cross and Red Crescent Societies, the IFRC and the 196 States parties to the Geneva Conventions to examine and decide on humanitarian matters of common interest. This project is described at International Committee of the Red Cross, 'Health care in danger', <<https://www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-health-care-in-danger-project.htm>>.



access with local communities. Applying best practice with regard to international law encompasses training military and security forces about their obligations under IHL and IHRL to not hinder medical missions. In other cases, best practice is context-specific: aid organizations have switched from using SUVs to older, smaller cars that are less desirable as hijacking targets. In some settings, organizations may choose to display their logo boldly; in others, the use of a logo may make them targets.

Efforts to address violence against health workers need to be context specific

Aid organizations have started to focus more on their duty to prepare staff for work, understanding the differences in risk for international, national and local staff, and designing human resource policies accordingly.⁴⁷ There has also been a pushback on 'bunkerization'. After the attacks on the UN Headquarters in Baghdad, the tendency was to increase security by moving humanitarian aid workers into fortified compounds and restricting movement. Yet, there is increasing understanding that being cloistered distances humanitarian aid workers from the community, which can increase mistrust and also increase the risk of violence.⁴⁸

More broadly, there has been a focus on branding and public relations work with the beneficiaries of aid. In other words, aid organizations are constantly assessing better ways to negotiate access and show that they are neutral and impartial outsiders to a conflict. At the organization level, aid organizations also need to embody these humanitarian principles: for example, as a rule neither the ICRC nor MSF use armed guards, and MSF does not accept funding from governments that are party to a conflict.

IV. Conclusions

It is difficult to determine the relationship between individual attacks and nebulous concepts, such as the changing nature of conflict or the shrinking humanitarian space. The reality is that attacks on health workers take place in highly complex environments and efforts to address violence against health workers need, therefore, to be context specific. There are also calls for the continued improvement of research methods in order to better understand the intricacies and nuances of the problem and to adapt new solutions accordingly.

Although it can be difficult to link specific attacks to macro-level factors, the shrinking of humanitarian space and the politicization of aid remain negative forces in and of themselves. Humanitarian practice needs to find solutions, rather than exacerbating existing problems, which means it is important to remain true to humanitarian principles despite violence. Thus, governments can and should push back against comprehensive approaches to crisis management if they will lead to a mixing of humanitarian and military tasks. Of course, health can be a peace dividend and the humanitarian mission can contribute to state-building and peace, but the aim and intent of the health care mission are, first and foremost, humanitarian. States must

⁴⁷ Egeland, J. et al., *To Stay and Deliver: Good Practice for Humanitarians in Complex Security Environments* (United Nations Office for the Coordination of Humanitarian Affairs: Geneva, Mar. 2011).

⁴⁸ Egeland et al. (note 47); and Fast (note 6).



ensure that the provision of humanitarian aid, including health aid, is not used to advance foreign policy.

In summary, the potential of IHL and IHRL to prevent violence against health workers and end impunity for perpetrators of violence remains underdeveloped. Resolution 5 of the 31st International Conference of the Red Cross and Red Crescent, held in 2011, is entitled ‘Health care in danger: respecting and protecting health care’. It reiterates the obligations of states under international law and urges them to adopt domestic implementation measures that are based on international legal obligations pertaining to the protection of health care. Specifically, the resolution calls on states to use legal measures to protect medical facilities and vehicles marked with the emblems of the International Red Cross and Red Crescent Movement, to ensure that armed and security forces respect IHL, and to also ensure the investigation and prosecution of crimes committed against health workers and facilities, including transport, at international, interstate and domestic levels.⁴⁹

Arguably, both IHL and IHRL could go further in protecting access to health care, not least because within the letter of the law significant discretion remains for states to deny humanitarian assistance. However, negotiating new treaties could lead to the loss of protection. Instead, one solution would be to ensure that appropriate domestic legal and policy frameworks exist so that states can carry out their treaty obligations and ensure that minimum standards for the protection of workers are met. Such efforts would also include reviewing counterterrorism legislation that can inadvertently harm humanitarian response.⁵⁰ It would also make sense to treat violence against health workers as a domestic issue, as the vast majority of those affected by violence are nationals of the country in which they are providing care. Strengthening existing, and creating new, regional and domestic legal regimes to carry out the implementation of international law can help lead to an end to impunity for perpetrators of violence against health workers and humanitarian aid workers more broadly.

The potential of IHL and IHRL to prevent violence against health workers and end impunity for perpetrators of violence remains underdeveloped

⁴⁹ 31st International Conference of the Red Cross and Red Crescent, Resolution 5, 1 Dec. 2011, <<https://www.icrc.org/eng/resources/documents/resolution/31-international-conference-resolution-5-2011.htm>>.

⁵⁰ Bernard, V., ‘Editorial: violence against health care—giving in is not an option’, *International Review of the Red Cross*, vol. 95, no. 890 (June 2013), pp. 5–12; and Breitegger, A., ‘The legal framework applicable to insecurity and violence affecting the delivery of health care in armed conflicts and other emergencies’, *International Review of the Red Cross*, vol. 95, no. 890 (June 2013), pp. 83–127.



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SIPRI BACKGROUND PAPER

VIOLENCE AGAINST HEALTH WORKERS IN COMPLEX SECURITY ENVIRONMENTS

RACHEL IRWIN

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