VIOLENT INCIDENTS AFFECTING
THE DELIVERY OF HEALTH CARE

HEALTH CARE IN DANGER

JANUARY 2012 TO DECEMBER 2014

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ICRC

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JANUARY 2012 TO DECEMBER 2014

* This third interim report, part of the Health Care in Danger project,
was prepared by Marica Tamanini.

EXECUTIVE SUMMARY

Within the framework of the Health Care in Danger project, the ICRC has engaged in an exercise to collect data on violent incidents against health care in situations of armed conflict and other emergencies. The information collected is used by the ICRC, National Red Cross and Red Crescent Societies and relevant stakeholders to raise awareness about violence against health care at a global level. The aim of this report is to provide data that can inform operational strategies and encourage decision-makers to take action to prevent violence against health care. The ICRC also uses contextual data about violent incidents against health care to develop field strategies at its delegations and to tackle issues of concern.

Between January 2012 and December 2014, the ICRC collected data on incidents of violence against health care in selected operational contexts in which its field teams are present. The objective was to study and identify the main types of acts and threats of violence against health care in armed conflicts and other emergencies and their effects on people, health-care facilities and medical transports. The analysis contained in this report (2012-2014) is based on data on 2,398 incidents collected from various sources of information in 11 countries. The findings are based on aggregated information and highlight the main patterns of violence against the wounded and the sick, health-care personnel, health-care facilities and medical transports apparent in the contexts under analysis. In comparison with the previous two reports,[1] in which the analysis was based on 22 and 23 countries respectively, this third report is based on the analysis of data collected from 11 countries (a) from at least three different sources of information and (b) for which monthly reports covering the entire period under review had been received. Despite the different number of countries, the report confirms the patterns of violence affecting health care that were detected in the previous reports. Moreover, it adds details regarding the analysis of contextual information, such as incidents occurring during clashes or demonstrations, and focuses on identifying the dynamics of violence in different types of location where the incidents took place.

The most important findings in this report include the following:

a) **Most of the incidents on which data were collected occurred against, inside or within the perimeter of health-care facilities.** The following observations were made:
   - **Patients were killed, wounded and/or beaten**, as were their relatives and other bystanders;
   - **Health-care personnel were subjected to threats and coerced** to act against health-care ethics and/or to provide free treatment;
   - Health-care personnel were also subjected to threats and physical assaults by **patients and relatives**;
   - Facilities were directly **fired at, bombed and/or burnt** or indirectly harmed during the conduct of hostilities;
   - The **use of explosives and/or bombing operations** caused a consistent proportion of the victims in documented incidents against, inside or within the perimeter of health-care facilities;
   - **Disruptive armed entries** took, in particular, the form of break-ins and forced entry for the purpose of perpetrating violence against people inside health-care facilities, including forced removal of patients from the facilities and arrest operations;
   - Health-care facilities were subject to several acts of **looting and pillage**, often accompanying a **break-in** into the facility, and people inside were often subject to robberies;
   - Health-care facilities were **occupied and subject to misuse**, especially forced use of the services and use for military purposes;
   - Violence against, inside or within the perimeter of health-care facilities caused **loss of resources and severe damage,** often leading to the **suspension of health-care services**.

b) Many documented incidents occurred on the way to and from health-care facilities, at checkpoints and in public spaces.[2] In particular:

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[1] ICRC, *Violent incidents affecting health care – January to December 2012*, ICRC, Geneva, 2013; ICRC, *Violent incidents affecting the delivery of health care – January 2012 to December 2013,* ICRC, Geneva, 2014.

[2] Public space: any space in a town, village or rural area to which people from the community have access and would go for purposes other than health care, such as a market; this includes public and private offices used for professional activities other than providing health care.

- **Obstruction** of passage for ambulances, health-care personnel, drivers of medical transports and patients;
- Health-care personnel and patients were often subject to **threats**, **physical assault** and **deprivation of their liberty**;
- Violence against medical transports involved direct or indirect attacks and obstruction, which also occurred during **demonstrations**.

In addition, **follow-up attacks**[3] targeting medical transports were observed.

c) The documented incidents that took place in **other areas[4] or at unidentified types of location[5]** revealed the following:
- Several involved **coercing health-care personnel** to act in a manner contrary to health-care ethics, to provide free treatment or to deliver health care in insecure settings;
- **Health-care personnel** were particularly affected by threats and by deprivation of liberty.

The analysis contained in this report reflects the results of reporting on violence against health care. This is a recently established exercise that started in 2012; the results were presented in a first report on incidents affecting the delivery of health care published in 2013 and in a second published in 2014.[6] The exercise does not draw on previous baselines for comparison and cannot be deemed representative owing to the challenges of gaining access to information. Therefore, the data-collection method does not allow trends to be determined or the real number of incidents occurring in the contexts under analysis to be assessed. For the same reason, comparison between reports is not advisable for the purpose of identifying changes in the level of violence. The figures contained in this report represent only those incidents recorded, which should be considered as the "tip of the iceberg." **The primary value of this report is to describe the main patterns of violence against the delivery of health care.**

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[3] For the purpose of the project, "follow-up attacks" are defined as explosions intended to cause as many injuries and deaths as possible, including among people assisting the victims of a previous explosion. Follow-up attacks usually directly target first responders approaching the scene of an earlier attack to provide assistance or to secure the area.

[4] Other areas: a civilian residence, a non-medical compound, a refugee or IDP camp, a police station, an airstrip, on board a ship and non-physical areas such as incidents occurring as a result of communication or administrative decisions.

[5] Unidentified types of location: incidents for which it was not possible to determine the type of location (health-care facility, checkpoint, road, etc.). It is important to note that the type of location is different from the geographical location where an incident occurred, which must be determined for the incident to be included in the collection.

[6] See footnote 1.

A. INTRODUCTION

This document is the third in a series of reports published by the ICRC on violent incidents affecting provision of and access to health care in situations of armed conflict and other emergencies; the data were collected by ICRC field teams. These reports build on a study that was launched in 2008 and was based on the collection of data from media sources on incidents affecting health care. The study documented incidents from 16 countries over a three-year period. The 16-country study was presented at the 31st International Conference of the Red Cross and Red Crescent in 2011 and was the catalyst for a Resolution which gave the ICRC a mandate[7] to work on the issue. In the same year the ICRC initiated the Health Care in Danger project in collaboration with the National Societies and their Federation and with other global partners concerned with the safe delivery of health care. Since 2012 the ICRC has been collecting data on incidents in more than 20 contexts in which the institution has an operational presence and has issued a yearly report based on aggregated information.[8] Other health-care organizations, academic institutes and other stakeholders have studied the issue in specific contexts, publishing analytical and qualitative reports. The ICRC reports seek to complement such studies and to inspire possible future research.

1. Objectives of the report

This report presents the results of the analysis of the data on violent incidents against health care that were collected in 11 countries in which the ICRC has a field presence.[9] The main objective of the analysis was to investigate the types of violence perpetrated against health-care personnel, infrastructure, medical transports and health-care programmes in areas affected by armed conflicts and other emergencies. In particular, the report focuses on violent behaviour against health-care personnel, the wounded and the sick, health-care facilities and medical transports in different types of location where incidents took place. The purpose of selecting this angle for analysis was to explore the issue from a different perspective than in the previous reports and to try to identify how the main categories of perpetrators, the most recurrent types of violence and the primary consequences of such violence change in accordance with the type of location in which the documented incidents took place. The ultimate goal of the report is to raise awareness and to build understanding about the humanitarian concerns for the safe delivery of health care. By providing insight into the issue, it is hoped

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Focus 1 – The Health Care in Danger project

The Health Care in Danger (HCiD) project is a project of the Red Cross and Red Crescent Movement that was launched in 2011 and is based on the mandate received at the 31st International Conference to tackle the issue of violence against health care.

For the first two years, the Movement concentrated on raising awareness of the issue and, building on the findings contained in the 16-country study and in the subsequent reports, on the expert consultations organized to tackle the main issues of violence against health care. Twelve workshops took place around the world, convening experts on topics such as military practice, national legislation, the safety of health-care facilities, ambulance and pre-hospital services, health-care ethics, the rights and responsibilities of health-care personnel, the role of civil society and the role of the National Societies. Consultations with non-State armed groups were also conducted. Thanks to these workshops and consultations, recommendations for specific interlocutors and/or on specific issues were identified. These recommendations are included in all reports published after each consultation process.

In 2014, the project entered a new phase, during which all stakeholders, and especially diplomatic representatives, took part in regional and international fora in order to assume ownership of the issue in their own contexts.

The project, which was initially meant to run until the end of 2015, has been extended until 2017 with the purpose of focusing on the practical implementation of the recommendations made and of encouraging greater practical involvement by the diplomatic community.

The reports containing the recommendations can be consulted here:

www.healthcareindanger.org

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[7] 31st International Conference of the Red Cross and Red Crescent, Geneva, 2011, Resolution 5.
[8] The data-gathering exercise was first established in 22 operational contexts in which the ICRC is present. The second study on violent incidents against health care, published in 2013, produced information based on the data collected on incidents in those countries. The third report, published in 2014, presented the results in an analysis of the data on the incidents collected in 23 operational contexts over a two-year period (an additional country had been included in the data-collection exercise).
[9] See section B.1 for an explanation.

that the report's findings will lead to the adoption of preventive measures conducive to ensuring a safer environment for the delivery of health care.

2. Preliminary definitions

For the purposes of this document, the following general definitions apply:

Health care

Prevention, diagnosis, treatment or control of diseases, injuries or disabilities, as well as measures to safeguard the health of mothers and young children. The term encompasses all activities that ensure, or provide support for, access for the wounded and sick to these health-care services, including searching for, collecting or transporting the wounded and sick, or the management of health-care facilities.

Health-care personnel

All people with professional health-care qualifications, e.g. doctors, nurses, paramedics, physiotherapists, pharmacists; people working in hospitals, clinics and first-aid posts; ambulance drivers; administrators at hospitals; personnel working in the community in their professional capacity; staff and volunteers of the International Red Cross and Red Crescent Movement involved in delivering health care; medical personnel of armed forces; medical personnel of armed groups; and personnel of health-oriented international and non-governmental organizations.

Health-care facilities

Hospitals, laboratories, clinics, first-aid posts, blood transfusion centres and the medical and pharmaceutical stores of those facilities. The term includes but goes beyond the different categories of "medical units" that are specifically protected under IHL and entitled to use the red cross, red crescent or red crystal emblems for protective purposes.

Medical transports

Ambulances, medical ships or aircraft, whether civilian or military, and generally any means of transport, including private means of transport, conveying the wounded and sick, health-care personnel and medical supplies or equipment. The term includes but goes beyond the different categories of "medical transports" that are specifically protected under IHL and entitled to use the red cross, red crescent or red crystal emblems for protective purposes.

Violence

Intentional or accidental use of physical force or power, threatened or actual, against oneself, against another person or against a group or community that results in or is likely to result in injury or death, psychological harm or deprivation. Forceful obstruction of health care is also included.

Violent incident against health care

A violent incident against health care may consist of one or several acts or threats of violence that hinder or adversely affect the provision of and/or access to health care.

Relevant definitions of the categories used in the analysis will be introduced in the report as required.

B. METHODS

1. From incident collection to incident analysis

Following the launch of the Health Care in Danger project in August 2011 and building on the 16-country study, the ICRC identified the need to establish an exercise to collect data on violent incidents against health care. The ICRC took advantage of its wide network of delegations to launch this exercise. It encouraged operational field teams to collect data on incidents at the country level. Each ICRC delegation that took part in the data-collection exercise was asked to select the relevant[10] sources of information in its context, to collect information and to verify it. A start was made on collecting information and the exercise has been in place since then. The information collected is consolidated in a semi-narrative monthly report that is sent to the information analyst at ICRC headquarters in Geneva, where it is then processed and turned it into quantitative information that can be fed into a database, thus allowing it to be cross-tabulated for different analytical purposes.

Focus 2 – Processing information and criteria for the inclusion of an incident

The information collected is structured by ICRC field teams into a semi-narrative report and then processed in Geneva. The information is turned into quantitative information, meaning that an incident is registered in a database and the relative information is entered into a codified category for analysis. For an incident to be recorded, the source report must always indicate at least when it happened, where it took place, what type of violence occurred, who and what was affected and the type of the source of information.

In order to be included in the collection, incidents must contain information concerning an act or threat of violence affecting the provision of health care. Violence perpetrated for purely private matters is excluded. Moreover, all cases linked to a situation of general violence and not specifically linked to health care, such as precautions taken by health-care personnel against widespread violence in the area, are also excluded. If it is not clear whether an incident is to be taken into account, a decision is taken by a review committee made up of members of the Health Care in Danger project team at the ICRC.

In the period from January 2012 to December 2014, a total of 24 ICRC delegations participated in the data-collection exercise. The number changed over time as new operational contexts were added and as others withdrew for operational reasons. The list of countries where the information is collected is confidential. For this reason, the analysis presented in the first (2013) and second (2014) reports was based on a sample of incidents collected by all ICRC field teams participating in the project. For the purpose of this third report, the sample chosen for analysis is different.[11] It was identified according to the following criteria: a) Incidents in countries where the ICRC field teams regularly documented incidents from January 2012 to December 2014; and b) Incidents collected by ICRC field teams which had been relying regularly on at least three different and satisfactory sources of information. The purpose of selecting incidents meeting the above criteria was to identify a more reliable sample, constituted by information continuously collected over three years. The sample was thus reduced to 11 countries with a total of 2,398 incidents. It is important to point out that the incidents documented do not represent all incidents occurring in the 11 countries chosen, but only those on which the ICRC was able to collect data, meaning that the real number of incidents occurring is higher. Moreover, although the criteria used to select the contexts under analysis did not aim to achieve geographical or contextual representation, it is worth noting that the 11 countries selected are from different geographical regions and are facing either an armed conflict or another emergency.[12]

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[10] Delegations consider relevant sources of information to be those interlocutors or media sources which they can trust for the credibility of the information provided, to which they have regular access and which have or are very likely to have information pertinent to violence against health care.

[11] For this reason, the findings may appear inconsistent with those of the previous reports. Although the patterns of violence against health care have generally been confirmed, some results might not be fully comparable with those obtained for the 22 and 23 countries.

[12] The term "other emergencies" refers to situations that fall short of the threshold for "armed conflict," in which security measures or incidents related to security can result in serious consequences for people in need of effective and impartial health care: death, aggravation of injuries, worsening of illnesses or diseases, obstruction of preventive health-care programmes, and so on. These measures or incidents might take a number of forms: violence against people in need of health care; violence against health-care personnel and facilities or medical transports; entry into health-care facilities by armed forces or security forces with the intent or effect of interrupting the delivery of health-care services; arbitrary denial of or delays in the passage

2. Interpreting results and sampling bias

This report aims to identify the main patterns of violence against health care reported in the incidents on which the ICRC was able to collect data. Its ultimate goal is not only to raise awareness about the impact of violence, but also to trigger qualitative contextual analysis as well as to help the ICRC, National Societies, NGOs, international and regional organizations, authorities, hospital managers, health representatives and other global and national stakeholders to identify the most important issues so that they can structure their work accordingly, for example operational strategies, policies, national legislation and security measures.

As with previous reports, this report does not aim to establish the existence of general trends at a global level. Indeed, although the sample has changed and collection practices have been strengthened, bias in the collection of information and in the amount of information received by context does not allow general conclusions to be drawn. In complex security environments such as those that are the subject of this incident-collection exercise, access to information depends on access to sources of information and territory. The absence of operational activities for ICRC field teams in certain areas often tallies with a lack of information about incidents occurring in that particular area, whether for a limited period or on a permanent basis. Moreover, the quality of dialogue of ICRC field teams with the different sources of information is also a determining factor, especially when information cannot be verified by another source. In addition, the number of incidents taking place varies from one context to another and it is difficult to assess the actual level of violence that the sample should represent. Furthermore, the level of detail reported for each incident varies considerably as it was not always possible to document additional information regarding, for example, the context in which the incident occurred, the weapons used, short-term impact and so on. Finally, globally aggregated information may be biased by specific high-impact incidents or highly recurrent context-specific dynamics, making it difficult to identify global trends that hold true for all contexts. While the results presented in this report should be read with those challenges in mind, the analysis does provide insight into the effects of violence against health care and the fundamental importance of data collection to better understand such violence.

3. Sources of information

Information was gathered by ICRC field teams from a broad range of sources, including people directly affected by or involved in the incident (victims and witnesses), National Red Cross and Red Crescent Societies, the media, other humanitarian organizations and local health-care providers. For the countries covered by this report, field teams used at least three of the sources listed in Figure 1.

Figure 1. Distribution of incidents by main source of information

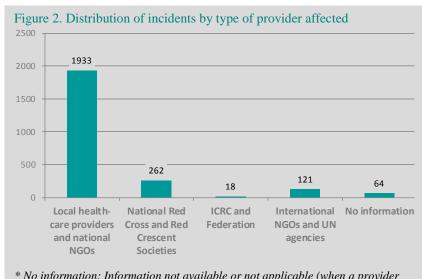| Sources	Description	Proportion
ICRC-related sources	Information was directly gathered by ICRC field teams through dialogue with victims, health-care personnel and administrative and support staff considered to be pertinent and reliable sources of information.	53%
Authorities	ICRC field teams received the information from law enforcement officers, members of military forces, parties to the conflict or government actors, including the Ministry of Health.	14%
Media	Information was documented through local and global newspapers, radio, TV news, social networks and other mass information tools.	14%
National Societies	Information was passed on to the ICRC field teams by National Red Cross and Red Crescent Societies which documented it directly or were themselves the victims of violence.	9%
Other organizations	Information was passed on to the ICRC field teams by other organizations which documented it directly or were themselves the victims of violence.	9%

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of medical transports at checkpoints; or simply the general insecurity prevailing in an area affected by an emergency situation. In these circumstances, and depending on the urgency of humanitarian needs, health-care personnel – including but not limited to staff or volunteers from the International Red Cross and Red Crescent Movement – may be called upon to prevent and alleviate human suffering.

C. RESULTS

1. Aggregated information: an overview of the issue

1.1. Total number of incidents and overall impact

The ICRC recorded 2,398 incidents of violence against health care in the 11 selected countries from the beginning of January 2012 to the end of December 2014. In total, at least[13] 4,275 people were victims of violence against health care in 4,770 acts or threats of violence.[14] Moreover, 728 medical transports[15] were affected in 785 acts or threats of violence.[16] In addition, it was found that 1,222 of the incidents took place against, inside or within the perimeter of health-care facilities. Finally, a matter that is consistent with previous reports, the findings confirm that

Figure 2. Distribution of incidents by type of provider affected

* No information: Information not available or not applicable (when a provider was not subject to violence in the incident).

violence mostly concerned local health-care providers, national NGOs and National Red Cross and Red Crescent Societies (overall, 91% of recorded incidents) rather than international providers (Figure 2), which are probably also proportionally less present in the areas affected.

1.2. Main categories of perpetrators

The incidents documented are broken down by perpetrator as shown in Figure 3. The ICRC collected data on 943 incidents allegedly perpetrated by State military, security and police forces (State armed forces and law enforcement bodies); 717 incidents attributable to armed non-State actors; and 86 incidents reportedly committed by organized criminal groups. 261 incidents were attributed to individuals. Most of the incidents attributed to individuals concerned obstruction during demonstrations and dissatisfaction by patients' relatives with medical treatment, delays, medical triage, doctor's decisions about treatment, the results of treatment and the conditions or the death of one of their relatives. It is important to emphasize that the proportion of incidents collected may not reflect the general distribution of incidents per perpetrator in all contexts of armed conflict or other emergencies. Indeed, the difference between the incidents collected per category of perpetrator might be attributable to limited access to information about incidents perpetrated by one actor rather than another and by the specific aspects of contexts chosen for this analysis. For this reason, the analysis that follows in this publication will avoid comparing accountability per perpetrator and will rather focus on describing the perpetrators' behaviour in specific circumstances.
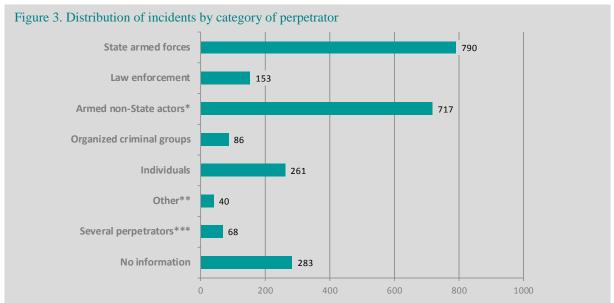
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[13] When the incident report indicates that more than one person was affected by violence, but without mentioning the exact number of people, the number of people affected by the incident is systematically registered as 2. This means that the number of people affected by the incidents documented is necessarily higher than the number assessed.

[14] One person might be affected by one or more acts or threats of violence in the same incident, such as being threatened and robbed by the same perpetrator.

[15] As indicated under "Preliminary definitions" (section A.2), medical transports include not only ambulances, but also any other vehicles used for the delivery of health care, such as private cars used to transport the wounded and the sick, vehicles used to transport medical supplies and people-carriers transporting medical staff to places of work.

[16] A medical transport might be affected by one or more acts or threats of violence in the same incident, such as an ambulance being denied access and attacked by the same perpetrator.
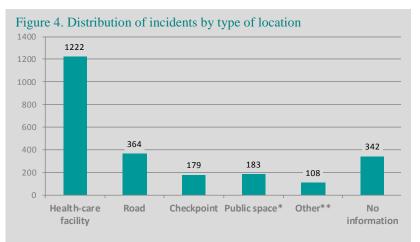
Figure 3. Distribution of incidents by category of perpetrator

Category	Value
State armed forces	790
Law enforcement	153
Armed non-State actors*	717
Organized criminal groups	86
Individuals	261
Other**	40
Several perpetrators***	68
No information	283

Armed non-State actors include organized non-State armed groups that are party to a conflict (which are not State organs or do not belong to a State party to the conflict) and non-State actors that do not necessarily fulfil the organizational requirement to be considered party to the conflict, such as other opposition movements or unspecified groups of armed people.
*** Other: Administrative measures, international military/police forces, peacekeepers.*
**** Several perpetrators: More than one perpetrator involved/shared responsibility.*

1.3. Types of location

The distribution of incidents by type of location (Figure 4) shows that 1,222 of the incidents recorded occurred against, inside or within the perimeter of health-care facilities. This suggests that the potential consequences of such violence are huge: health-care personnel may not feel safe at their workplace and may flee or ask to be relocated; the wounded and sick may be afraid to go to these facilities for health care because they fear becoming victims of such violence; health-care facilities themselves that are not used for military purposes at the outset can be put at risk of being the direct objects of attacks when violent acts are committed by armed actors against, inside or within their perimeter; loss of supplies or other material, damage to the infrastructures and equipment, and the disruption of health-care may cause the service to function badly. However, violence in other areas should not be underestimated. As shown in Figure 4, violence against health-care services and the wounded and the sick also often takes place on the way to and from

Figure 4. Distribution of incidents by type of location

Location	Value
Health-care facility	1222
Road	364
Checkpoint	179
Public space*	183
Other**	108
No information	342

Public space: Any space in a town, village or rural area to which people from the community have access and would go for purposes other than health care, such as a market; this includes public and private offices used for professional activities other than providing health care.
***Other: A civilian residence, a non-medical compound, a refugee or IDP camp, a police station, an airstrip, on board a ship and non-physical areas such as incidents occurring as a result of communication or administrative decisions.*

health-care facilities (364), at official and unofficial checkpoints (179), in public spaces (183) and at other types of location (108). It was not possible to determine the location type for 342 incidents.[17]

The analysis contained in the following sections is based on three different sets of information, each of which comprises all incidents that occurred at different types of location. The final section presents the analysis of those incidents that occurred in underrepresented locations ("Other") or for which it was not possible to determine the exact type of location ("No information").

2. Incidents taking place against, inside or within the perimeter of health-care facilities

2.1. Aggregated information

The analysis in this section refers to the total number of incidents (1,222) against, inside or within the perimeter of health-care facilities, including hospitals, health-care centres, clinics, first-aid posts, pharmacies and any other facilities involved in the delivery of health care. Of the total number of health-care facilities affected, at least 1,121 were open at the time of the incident.

The analysis of perpetrators found that State armed forces and armed non-State actors were responsible for most of the incidents documented (839). Law enforcement bodies perpetrated 65 of the incidents collected, while individuals were responsible for 106 incidents, mostly against people. Responsibility for 55 of the incidents was shared between two or more perpetrators. The analysis has shown that of the 55 incidents caused by several perpetrators, at least 46 incidents occurred during active clashes and 37 of them were deemed incidental, meaning that they were caused by a lack of adequate planning to avoid, or at least minimize, harm of this kind.

> *For example, the report of an incident stated that a clinic was hit by small arms fire during crossfire between an armed group and a passing convoy of military security forces.*

Overall, the ICRC documented at least 120 incidents against, inside or within the perimeter of health-care facilities that were described as occurring during clashes, of which at least 68 were considered of an incidental nature[18] and 30 involved misuse of facilities.

2.2. Perpetration of violence

Types of violence and their effects on people

In the documented incidents against, inside or within the perimeter of health-care facilities, the overall number of people affected was at least 2,195[19] in 2,400 acts or threats of violence.[20] Unsurprisingly, the people most affected were patients (1,069),[21] followed by health-care personnel (760) and relatives of patients and other bystanders (279). At least 892 people[22] were subjected to violence in incidents involving the use of explosives and/or bombing operations inside or against health-care facilities. Figure 5 shows the distribution of types of violence by category of people.

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[17] As stated in footnote 5 above, while the type of location might not be recorded, the geographical location (town, department, region, etc.) must be known for an incident to be included in the collection.
[18] These incidents include indirect attacks as well as incidents in which the facilities were at risk of being attacked because active fighting or because a military objective was located nearby.
[19] See footnote 13.
[20] See footnote 14.
[21] Different numbers of people in the various categories are, of course, present at a health-care facility: there are likely to be patients than health-care personnel. Therefore, this is not an indication that patients were targeted more than other categories.
[22] See footnote 13.

Figure 5. Types of violence affecting people by category

	Killed	Wounded and/or beaten	Threat-ened	Coerced	Robbed	Deprived of their liberty	Passage denied and/or delayed	Sexual violence	Other types of violence**
Patients	678	204	45	0	29	67	69	2	20
Bystanders and relatives	96	151	5	0	0	7	3	1	19
Health-care personnel	87	202	303	121	47	58	25	5	61
Drivers	2	0	0	0	0	1	2	0	0
Others*	16	47	9	2	1	10	0	1	4
Total	**879**	**604**	**362**	**123**	**77**	**143**	**99**	**9**	**104**

* Others: Aid workers not directly involved in the provision of health care, relatives of health-care personnel, security guards at health-care facilities, administrative and maintenance staff.
** Other types of violence: Torture, forced disappearance, general harassment.

Patients were mostly killed (678) and wounded and/or beaten (204) together with their relatives and other bystanders (151). Patients were also deprived of their liberty (67), which means that they were arrested or abducted inside the health-care facility while undergoing medical treatment. Armed non-State actors and State armed forces were mostly responsible for such incidents, and especially for the arrest of wounded fighters from the opposition.

> *For example, one incident report stated that an air-strike on a hospital caused the destruction of part of the building, including the paediatric and premature babies section. At least five babies and three accompanying mothers were among those killed. In another incident, it was reported that a police agent arrested a patient who was receiving treatment in the emergency department.*

Health-care personnel were especially affected by threats (303 people) and by coercion to act against ethical principles in health care[23] and/or to provide free medical treatment (121). Many of them were also wounded and/or beaten (202).

> *For example, a doctor working in a hospital was intimidated by death threats made by an armed group which demanded that two patients from another armed group be handed over and that injured combatants of that group be denied health care.*

Individuals were responsible for 64 of the threats and for 45 of the acts of wounding/beating. As previously explained, this was mostly attributable to violent reactions to the death of a relative, the nature of the treatment and dissatisfaction with having to wait one's turn for treatment.

> *For example, an incident report stated that the head of the orthopaedic department at a hospital was beaten and threatened verbally by members of a patient's family, who claimed that the doctor had treated their relative improperly.*

Of the total threats in each perpetrator category, threats by individuals and armed non-State actors against people inside health-care facilities were directed almost exclusively against health-care personnel (94% of threats by individuals and 87% of threats by armed non-State actors).

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[23] Health-care ethics is the branch of ethics that deals with moral issues in the practice of health care. Principles for ethical decision-making in health-care practice include impartiality; confidentiality; respect for the dignity of the patient; acting in the patient's best interests; avoiding inflicting harm on patients; fair treatment of individuals and groups.

Focus 3 – Recommendations for the safety of health-care facilities

The ICRC will soon make available a publication on issues relevant to the security of health-care facilities in contexts of armed conflict and other emergencies: *Ensuring the safety of health-care facilities* **(2015)**. The publication is the result of two experts' workshops held in Ottawa (2013) and Pretoria (2014) and addresses managers and administrators of health-care facilities, architects and civil engineers working on health-care infrastructure, health-care personnel, and national and international health-care providers.

It contains recommendations of measures to enhance the preparedness and security of health-care facilities in order to mitigate the risk of disruption to the delivery of health care. For example, it is recommended that measures be adopted to manage access and entry to health-care facilities to avoid unwanted disruptions and control flows into and within the health-care facility. It also suggests instituting procedures for reception and triage to help manage the flow of entries. A third example of recommendations is for managers of health-care facilities to ensure that environments for patients' relatives are welcoming and cooperative.

Attacks against or inside health-care facilities[24]

Among the 1,222 incidents against, inside or within the perimeter of health-care facilities, 403 facilities were fired at, bombed and/or burnt. 108 of these attacks were deemed incidental.

> *For example, a mortar hit a health-care facility located in the vicinity of public administration offices that were subjected to targeting.*

In addition, 87 facilities were subject to other types of attacks, including the use of gas inside health-care facilities, acts of vandalism, raiding and unspecified types of attacks, while 55 received a direct or indirect threat of attack.[25] At least 254 incidents involved the use of explosives and/or bombing operations against or within the perimeter of health-care facilities. State armed forces accounted for 144 incidents involving the use of explosives and/or bombing operations. Overall, the ICRC documented 200 attacks carried out by State armed forces (the distribution percentage per country varies significantly).

Focus 4 – Recommendations for State armed forces: precautions during attack

The ICRC published a report on practical measures for State armed forces following the expert consultations on military practice held in Canberra in 2014: *Promoting military operational practice that ensures safe access to and delivery of health care* **(2014)**. The report compiles a complete set of practical measures to be adopted when planning and conducting military operations, with a view to avoiding the negative impact of such operations on the delivery of health care in armed conflict.

The recommendations contained in the report focus particularly on delays in or denial of passage of medical transports, affecting the ground evacuation of the sick and wounded; the negative impact of military search operations in hospitals and other health-care facilities; harm to health-care personnel, medical transports and facilities or their patients caused by deploying military objectives inside or in close vicinity to health-care facilities, or when attacking enemy military objectives located within or in close vicinity to health-care facilities.
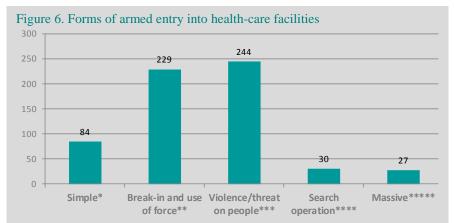
With regard to precautions during attacks, the recommendations are that specific measures be adopted in the event of an attack on a military objective in the vicinity of a health-care facility or a health-care facility that has lost its protection, in particular to guarantee the exceptional character of such an attack, to enhance understanding of the operational environment, to coordinate with health-care professionals and relevant authorities providing health-care assistance for the wounded and sick in order to minimize the impact of attacks and to guide the planning and conduct of such an attack.

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[24] A facility might be subject to different acts or threats of violence, for example it might be bombed and fired at the same time, as well as being subject to another type of violence.

[25] The perpetrator threatened to attack them or acted in a manner that put the facility at severe risk of being attacked, for example positioning a military objective next to it.

Armed entry

Armed entry affected 522 health-care facilities. Disruptive armed entry is defined as any incursion of an armed actor into a health-care facility that disrupts the functioning of the facility and/or prevents delivery of or access to health care. Such acts are often accompanied by violence against health-care personnel, pillaging and damage to the facility. Four types of armed entry could be identified depending on their purpose and consequences.[26] Figure 6 shows that the most disruptive types of armed entry were break-in and forceful entries (229), which usually accompanied acts of looting (168).

Figure 6. Forms of armed entry into health-care facilities

* *Simple: The facility was entered by one or more armed actors and, although violence was not used, health services were disrupted.*
** *Break-in and use of force: The facility was entered against the will of the health-care provider by breaking through the entrance or by using violence.*
*** *Violence/threat against people: The facility was entered by one or more armed actors with the main purpose of subjecting people to violence.*
**** *Search operation: Armed entry into a health-care facility for purposes such as arresting a criminal suspect, conducting an interrogation, looking for members of the opposition and so on.*
***** *Massive armed entry: The facility was entered by a large number of armed actors who disrupted the health service (regardless of whether violence was used or not); search operations are excluded.*

For example, one incident report stated that unknown armed men threw grenades into a hospital's compound, made their way inside shooting indiscriminately and, once inside, prohibited the medical staff from providing health care and looted medical equipment.

Severe disruption was also caused by entry into facilities with the purpose of subjecting people to violence and/or threats, including the arrest of patients, health-care personnel or other people inside the facility (244). 30 incidents involving disruption to services caused by search operations were also recorded, 27 of whom were carried out by State armed and security forces (State armed forces and law enforcement).

It was reported that in one incident, for example, large numbers of armed military security forces entered a hospital and arrested a wanted person who was receiving care at that health-care facility. Allegedly, the arrested patient received no further health care.

Focus 5 – Recommendations for State armed forces: search operations

The report ***Promoting military operational practice that ensures safe access to and delivery of health care (2014)*** also contains recommendations with regard to search operations by State armed forces (see Focus 4). The recommendations include, in particular, adopting measures to guarantee the exceptional nature of searches of health-care facilities and the removal of patients. When an operation is carried out, coordination with health-care providers should be ensured and measures undertaken to regulate the behaviour of military personnel during search operations.

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[26] These types are not mutually exclusive; for example, a facility could be entered by use of force with the purpose of perpetrating violence against a patient inside.

Health-care facilities taken over

Takeover and misuse of health-care facilities[27] disrupt health-care services and discourage patients from seeking care at such facilities if they are still functional. It can also result in the facility losing its protection, putting it at risk of being attacked. The ICRC documented 222 incidents in which a health-care facility was taken over in different ways.[28] In 16 incidents the perpetrators took the health service over but maintained its exclusive medical function, while in 114 incidents it was forcibly used, for example, to obtain free treatment or for parties to the conflict to treat their own wounded.

The report of an incident stated, for example, that after a security incident, because there was no military hospital in the area, armed military forces entered the civilian hospital, insisted that their injured be given immediate treatment and threatened staff to force them to disregard triage procedures.[29]

Figure 7. Forms of misuse of health-care facilities

*Other forms of misuse: Camping in the facility for a limited of time, guarding the facility in order to conduct interrogations and identify the opposition, keeping hostages and exercising ill-treatment, stocking drugs.

Furthermore, several forms of misuse were documented (Figure 7). In 60 incidents, the health-care facility was occupied and military control was established, causing obstructions to the delivery of health care and to access by patients to the facilities. In 41 incidents the perpetrators were State armed forces. In 24 incidents, facilities were also used by one party to the fighting as shelter from the other party's attack (in 17 incidents the context was identified as one of active fighting). In 39 incidents, the facilities were used to install weapons and/or to launch attacks.

For example, it was reported that a health-care centre was occupied by security forces for several days; during that period, patients had no access to medical treatment.

Looting of health-care facilities

One of the most common types of violence against health-care facilities is looting and pillage of medical supplies and equipment. Overall, 219 facilities were looted, of which 111 by armed non-State actors.

Other types of violence and other incidents inside health-care facilities

Other forms of violence documented are the hampering of access to health-care facilities by beneficiaries and/or health-care personnel (39), in some cases also on a discriminatory basis (impeding, for example, access by members of a specific origin or ethnicity). In 75 incidents, the incident involved violence against people inside the health-care facility, without amounting to disruptive armed entry or a takeover. These incidents were caused by individuals (37), most of whom were relatives of patients and/or angry patients (30).

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[27] Misuse of health-care facilities includes any use for purposes other than the exclusive function of providing health care, i.e. prevention, diagnosis, treatment or control of diseases, injuries or disabilities and measures to safeguard the health of mothers and young children. Takeover of a health-care facility occurs when an armed actor establishes control – often by means of force – over a facility that was previously under the control by another actor. This may occur for the purpose of taking over the running of its health-care function while maintaining that function or for military purposes, such as for using it as a base for launching weapons, for storing weapons, or for establishing a military command and control centre. If it is taken over for military purposes, this takeover would transform a health-care facility into an object serving other purposes than those exclusively associated with health care.

[28] The different forms of takeover are not mutually exclusive; for example, a facility could be occupied and health-care providers forced to deliver treatment.

[29] Triage is the procedure applied at health-care facilities to prioritize health care on the basis of patients' medical needs.

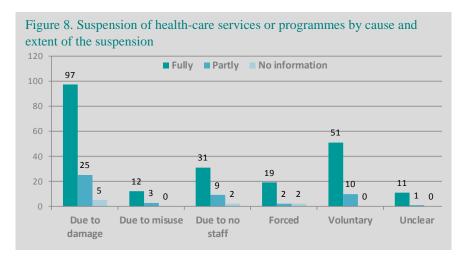**Damage to health-care facilities and loss of resources**

The primary consequences of violence against, inside or within the perimeter of health-care facilities is damage to infrastructure and the loss of medical supplies, equipment, information, financial revenues and basic utilities required for the facilities to function properly, such as water and electricity. 375 facilities were damaged as a direct consequence of violence. In 71 incidents, the entire facility was destroyed. The damage was estimated to be partial in 97 incidents and superficial in 104. In 103 incidents, it was not possible to determine its extent. Full and partial damage was a consequence of direct attacks in 121 incidents causing damage.

> *For example, an incident report stated that a field hospital was raided and burnt down; as a consequence, the hospital was completely destroyed.*

Moreover, 310 facilities experienced a loss of material resources, such as medical supplies, equipment, information, financial revenue and/or basic utilities, 218 of them because of looting. Overall, for 133 facilities the loss of resources was considered to be a decisive obstacle to the provision of health care and 46 were described as not functional at all after looting.

2.3. Impact on health delivery and access

In 109 reports, the sources referred to a change in security measures following the incident, meaning that measures were taken by the health-care provider or local authorities to avoid more violence of the same type at the health-care facility affected. As a consequence of the incidents, patients were evacuated, staff relocated or dismissed and movement outside the facility was restricted. In 65 of the 109 incidents the security measure applied consisted of the suspension of the health-care service.

Figure 8. Suspension of health-care services or programmes by cause and extent of the suspension

> *For example, due to a security incident in front of a hospital, the health service was suspended for three days.*

However, preventive suspension for security reasons was not the only reason why services in health-care facilities were suspended. Overall, the sources mentioned that for 280 facilities the service had to be suspended, the majority of them due to the damage suffered (127); services were suspended permanently at 97 of the 127 damaged facilities. In at least 73 incidents, the facility was closed due to damage for more than one week. In other incidents, services were interrupted because of the absence of staff, who fled or went on strike, because closure was forced by an external actor (23) or due to misuse of the facility (15). Services were preventively suspended (voluntary suspension) as a consequence of 61 incidents, although the suspension lasted less than a week for at least 34 of them.

Focus 6 – Recommendations on the domestic normative framework

The ICRC published the report of the legal experts' workshop held in Brussels in 2014: ***Domestic normative frameworks for the protection of health care* (2015)**. The objective of the workshop was to identify practical domestic measures and procedures, in particular legislative and regulatory ones, that could be established by State authorities in order to implement the existing international framework for protection of the provision and access to health care in armed conflict and other emergencies. The recommendations presented in the report revolve around three main types of measures: legislative measures for the implementation of the existing international legal framework; dissemination and training; and coordination between the stakeholders concerned. Recommendations also include specific measures to effectively repress and sanction all forms of violence against health care. It is important that State authorities identify which of the recommendations are relevant in their own contexts and choose appropriate means to implement them.

3. Incidents taking place on the way to and from the health-care facility, at checkpoints and in public spaces

3.1. Aggregated information

The analysis presented in this section refers to the total number of incidents collected that took place on the way to and from health-care facilities (364), at checkpoints (179) and in public spaces (183), meaning any space in a town, village or rural area to which people from the community have access to and go for purposes other than health care, such as a market, a neighbourhood, etc.; this includes public and private offices used for professional activities other than delivering health care.

> *As an example of incidents perpetrated in a public space, one incident recorded involved the misuse of a clearly marked ambulance for the purpose of an arrest operation during a raid in an urban neighbourhood.*

The ICRC collected data on 173 incidents allegedly perpetrated by armed non-State actors and 130 incidents attributable to individuals, of which 106 and 98 respectively occurred on the way to and from the health-care facility. State armed forces were deemed responsible for 252 incidents and law enforcement for 66, of which 120 and 29 respectively took place at checkpoints. This is probably linked to the relative ease of collecting data on incidents involving official checkpoints staffed by State armed and security forces (State armed forces and law enforcement bodies) in comparison to unofficial checkpoints staffed by other actors. 106 incidents occurred during demonstrations and protests, mostly on the way to or from the health-care facility (82); individuals were the alleged perpetrators in 90 incidents occurring during demonstrations, blocking access to health services in transit or expressing violent reaction against them.

> *For example, an incident report stated that a policeman injured during demonstrations was on board an ambulance on its way to the hospital when protesters attacked the ambulance with the intention of removing the policeman. The ambulance was partly damaged.*

The analysis also reveals that explosives and/or bombing operations were used in at least 68 incidents and that in 22 incidents the incident was a follow-up attack.[30]

> *In another report it was stated, for example, that two bombs exploded in a busy market. The second bomb exploded as first responders were rushing to the site to help the victims of the first explosion.*

3.2. Perpetration of violence

Types of violence and their effects on people

1,426 victims were registered in incidents taking place on the way to and from health-care facilities, at checkpoints and in public spaces. Of the victims, 580 were health-care personnel, 177 were drivers[31] and 503 were patients. Overall, people were subjected to 1,620 acts or threats of violence. Their distribution by type and by category of people affected can be observed in the table below (Figure 9).

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[30] See footnote 3.
[31] At checkpoints, drivers are not counted as victims when they have a patient on board; the primary target of the violence of denying/delaying passage is considered to the patient.

Figure 9. Types of violence on the way to and/or from the health-care facility, at checkpoints and in public spaces

	Killed	Wounded and/or beaten	Threat-ened	Coerced	Robbed	Deprived of their liberty	Passage denied and/or delayed	Sexual violence	Other types of violence**
Patients	74	138	21	0	0	28	291	0	14
Bystanders and relatives	15	15	2	0	0	9	18	0	1
Health-care personnel	53	130	109	16	57	104	179	2	12
Drivers	18	38	24	6	5	34	81	3	8
Others*	11	12	3	3	0	80	5	1	0
Total	**171**	**333**	**159**	**25**	**62**	**255**	**574**	**6**	**35**

Others: Aid workers not directly involved in the provision of health care, relatives of health-care personnel, security guards at health-care facilities, administrative and maintenance staff.
**Other types of violence: Torture, forced disappearance, general harassment.*

Health-care personnel and drivers were mostly denied or delayed passage (260) and were often wounded and/or beaten (168) or threatened (133). 138 were also deprived of their liberty and 62 robbed.

Similarly, patients were often denied passage or their access to health-care services delayed (291); they were sometimes killed (74) or wounded and/or beaten as well (138).

> *In one incident, for example, two paramedics from the National Society and one patient were denied passage while on their way to the hospital for medical treatment.*

For 130 people, passage was denied or delayed by individuals. This was generally linked to situations of protest or demonstration in which community members did not allow health-care personnel and patients to pass through quickly (120 of 130 people affected during demonstrations). Overall, the analysis shows that 130 people of 574 who were denied passage were subject to this type of violence in the context of demonstrations.

> *For example, in one of the incidents recorded, an ambulance was stopped by protesters at an informal checkpoint during a demonstration; the officials at the checkpoint did not authorize the passage of the ambulance and forced it to turn back, threatening to remove the patient from the ambulance.*

At checkpoints, 377 people were affected. Of these, 293 were subjected to denial or delay of access.

> *For example, one incident report stated that the passage of an ambulance transporting a three-year-old child and a relative was delayed for one hour because of lack of coordination at the checkpoint.*
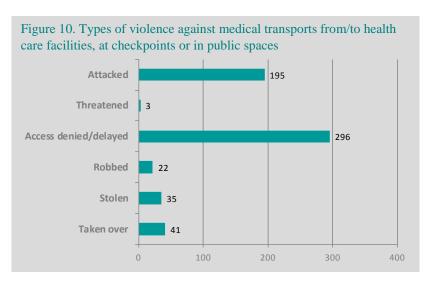
Focus 7 – Recommendations for State armed forces: safe passage at checkpoints

The ICRC report *Promoting military operational practice that ensures safe access to and delivery of health care* (**2014**) also contains recommendations for checkpoint management by State armed forces. For example, it recommends striking a balance between security requirements and the necessity for patients to access health-care facilities as quickly as possible. To that end, measures to regulate checkpoints need to be pre-defined and training on them provided.

Violence against medical transports

543 medical transports, 426 of which were ambulances, were affected by violence while travelling to or from health-care facilities, at checkpoints or in public spaces. Figure 10 shows the types of violence affecting medical transports. 195 medical transports were attacked, while 296 were affected by denial or delay of passage. 136 were denied or delayed access at checkpoints. Overall, 112 transports were affected by passage being obstructed during demonstrations; individuals were responsible for 94 of those incidents.

Figure 10. Types of violence against medical transports from/to health care facilities, at checkpoints or in public spaces

Type	Value
Attacked	195
Threatened	3
Access denied/delayed	296
Robbed	22
Stolen	35
Taken over	41

Damage to transports

Violence caused damage to 130 medical transports, 103 of which were ambulances.

Focus 8 – Recommendations for ambulance services in risk situations

Within the framework of the HCiD project, a report on ambulance service was also published: *Ambulance and pre-hospital services in risk situations* (2013). It serves as a practical tool, articulating a range of recommendations aimed at making the delivery of health care services and access to them safe. The recommendations focus on three areas: legal initiatives; coordination with stakeholders including State armed forces; and best practices for ambulance and pre-hospital services. With respect to the recommendations on best practices, implementing the Safer Access Framework is of specific relevance for National Societies. This framework is a tool for National Societies and identifies a series of measures and actions that they can take to improve the security of and access to those in need.

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4. Incidents taking place in other or unidentified location types

4.1. Aggregated information

The final section of this report analyses 450 documented incidents that occurred in types of locations other than those analysed above or for which it was not possible to identify the type of location. It is important to note that 66 of these incidents took place through means of communication[32] (mostly for threatening purposes) and for 342 of them information about the type of location at which they took place was not specified by the sources.

> *For example, in one documented incident it was reported that the health-care provider received a telephone call from an armed group requesting the names of the wounded who had been treated. In another incident, it was stated that a health-care provider received a telephone call threatening to bomb the hospital.*

The distribution of incidents by perpetrator category shows that 189 of the incidents were carried out by armed non-State actors and 90 incidents were perpetrated by State armed forces. A link can be made here between

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[32] "Means of communication" includes telephone calls, letters, messages and so on.

incidents perpetrated by armed non-State actors and for which no information on the type of location was available. Indeed, it may be more difficult to determine where armed non-State actors operate.

> **Focus 9 – Practices and relevant law concerning non-State armed groups**
>
> The most recent thematic publication in the HCiD project pertains to armed groups: *Safeguarding the provision of health care – Operational practices and relevant international humanitarian law concerning non-state armed groups* **(2015)**. It is based on consultations carried out with 36 armed groups in 10 contexts. The report examines armed groups' understanding of access to health care, presents armed groups' legal obligations and provides practical measures that can be adopted by armed groups to improve the safety and delivery of impartial and efficient health care. In particular, the report tackles the issues of respect for and protection of health-care personnel, respect for health-care facilities and respect for the wounded and sick and medical transports.

4.2. Perpetration of violence

Types and effects of violence on people

Overall, 654 people were affected by violence in 750 acts or threats of violence in other or unidentified location types. 539 of the people affected were health-care personnel and 61 were patients.

Figure 11. Types of violence in public spaces affecting people by category

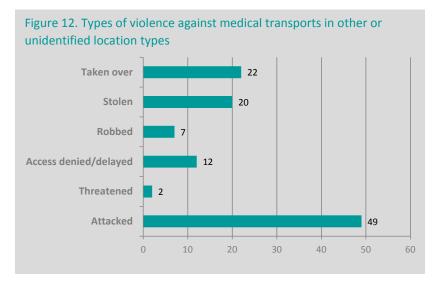|	Killed	Wounded and/or beaten	Threat-ened	Coerced	Robbed	Deprived of their liberty	Passage denied and/or delayed	Sexual violence	Other types of violence**
Patients	2	1	0	0	0	0	0	0	0
Bystanders and relatives	5	4	9	5	1	8	5	0	1
Health-care personnel	47	79	284	32	8	128	13	2	16
Drivers	4	3	6	0	2	11	2	0	0
Others*	19	3	5	0	0	7	38	0	0
Total	**77**	**90**	**304**	**37**	**11**	**154**	**58**	**2**	**17**
* Others: Aid workers not directly involved in the provision of health care, relatives of health-care personnel, security guards at health-care facilities, administrative and maintenance staff. *** Other types of violence: Torture, forced disappearance, general harassment.*									

Figure 11 gives an idea of the types of violence suffered by health-care personnel, including killing, wounding and/or beating. In particular, 284 were subjected to threats and 154 were deprived of their liberty.

Armed non-State actors were allegedly responsible for threatening 150 of 284 health-care professionals and for the abduction of 65 health-care personnel. 32 health-care personnel were allegedly coerced to act in a manner contrary to health-care ethics, to provide free treatment or to deliver health care in unsafe settings. The findings reveal that armed non-State actors coerced 24 of 32 health-care personnel.

> *For example, one incident report stated that an armed group forced a member of the health-care personnel to leave the health-care centre and go with them to an unidentified location type; the group forced the staff member to provide health care for their own wounded and sick without adequate medical equipment.*

Violence against medical transports

Figure 12. Types of violence against medical transports in other or unidentified location types

Type	Value
Taken over	22
Stolen	20
Robbed	7
Access denied/delayed	12
Threatened	2
Attacked	49

The findings about violence against medical transports in other or unidentified location types (Figure 16) show that overall, 108 medical transports were affected, of which 87 were ambulances. 49 medical transports were attacked, 34 of which by State armed forces. Other medical transports were subject to obstructions (12) or takeover (22) or were stolen (20).

D. CONCLUSIONS

As demonstrated in the previous reports, the findings in this report confirm that violence against health care is a serious humanitarian concern with devastating short and long-term consequences:

- **Patients are** killed, wounded, beaten and arrested;
- **Health-care personnel are threatened, physically assaulted and subjected to arrest** – they are also subjected to coercion and forced treatment;
- Incidents against health care most often take place **against, inside or within the perimeter of health-care facilities** and these facilities are often subject to **attack, armed entry, takeover or looting**;
- **Obstructions and attacks against medical transports** take place on the way to and from a health-care facility, at checkpoints and in public spaces.

In particular, this third report shows that the types and effects of violence change according to the location at which it is perpetrated. Regarding health-care facilities, State armed forces were especially responsible for attacks and takeover, while many acts of break-in and looting were attributed to armed non-State actors. On the way to and from health-care facilities, at checkpoints and in public spaces, obstructions played a decisive role in delaying access for patients and health-care personnel. Ambulances were also subject to attacks; among these, follow-up attacks were also documented. In other or unidentified location types, health-care personnel were threatened by telephone or were kidnapped and forced to provide health care at unidentified location types.

The analysis also drew particular attention to the fact that a link can often be made between active fighting and incidental damage. This is particularly the case with regard to incidents against, inside or within the perimeter of health-care facilities where damage is often due to a lack of adequate planning to avoid, or at least minimize, such damage by the parties to the clashes.

Furthermore, the analysis pointed out the issue of violence perpetrated by individuals, who mainly addressed their violence against health-care personnel through threats and beatings in connection with complaints relating to the nature of the treatment received. A lack of efficient service can be the result of the violence to which the health-care facility and personnel were subjected. Moreover, individuals were also responsible for the obstruction of ambulances on the road and in public spaces, often during demonstrations. Several reasons were given for this, such as lack of coordination for safe transit of ambulances or lack of understanding of the issue by the community itself.

These findings are helpful when seeking to tackle the problem. The issues identified can promote the implementation of relevant measures. However, such findings can only raise awareness about the main patterns of violence and be used to identify general issues. Policy-makers, NGOs, humanitarian agencies and other stakeholders willing to act at the national level are encouraged to undertake a more comprehensive and context specific analysis, including an analysis of the root causes of violence against health-care providers, if they are to be fully able to address the problem. It is hoped that the results presented in this report can contribute to that endeavour.

Local stakeholders, including State authorities, might wish to undertake further data collection in their country in order to observe the dynamics of violence against health care in their own context and to tackle the issue. This could result in setting up a national system for collecting data on the occurrence of violence against health-care personnel, health-care facilities and medical transports as well as against patients, which includes all types of interference with the provision of health care.

MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.