

# GATHERING EVIDENCE-BASED DATA ON VIOLENCE AGAINST HEALTH CARE

HEALTH CARE IN DANGER  
IT'S A MATTER OF LIFE & DEATH



ICRC

**Disclaimer**

This study is based on research carried out by the International Committee of the Red Cross (ICRC). It does not single out countries or warring parties, but uses a combination of diverse data sources to show how violence against health care is analysed around the world. Increasing our knowledge and understanding of existing evidence is fundamental to truly comprehending how violence affects health-care personnel and patients.

The findings of this analysis do not necessarily reflect the official views of the ICRC.

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## EXECUTIVE SUMMARY

When the worst calamities or extreme events occur, health-care personnel are often the first point of contact for victims and their relatives. But shockingly, these same personnel are frequently the victims of violence when caring for those in need. Contrary to a widely-held belief, violence against health-care personnel occurs throughout the world, not just in armed conflict. Failure to respect those trying to help us when we need it most has become the norm. And emergency departments have become battlegrounds between frustrated patients and their relatives on the one side, and health-care staff on the other.

In the humanitarian sector, when we speak of “violence against health care” we are frequently thinking only of the most serious incidents perpetrated by weapon bearers. However, when the ICRC asked a group of health-care coordinators across all regions whether they had been subjected to violence at any point in their career, not one of them could say “no”. Furthermore, since the HCiD initiative started, violence against health-care personnel has increasingly been identified as the most frequent type of incident impeding progress in providing health care in certain contexts.

The question is therefore “How can the ICRC promote zero tolerance for violence and improve respect towards health care by weapon bearers, when the recipients of care are one of the major sources of violence?”

### LITERATURE REVIEW

This report starts with an overview of the issue. It reviews 66 publications produced between 2007 to 2019 on violence against health-care personnel around the globe; workplace violence against health care has been the subject of research on every continent. Doctors, nurses, technicians, support staff, paramedics, pre-hospital emergency teams, midwives, personal carers, health management, ambulance drivers, nurse assistants, community health workers and others were asked whether they had been victims of violence while performing their duties, to describe the possible causes of violence and to suggest corrective measures. Between them, these studies interviewed more than 106,900 health-care staff. Depending on the country where they worked, between 15% and 97% of them had experienced physical, sexual or psychological harm while performing their duties. Forms of violence included beating, kicking, slapping, stabbing, shooting, pushing, threat of physical force, verbal abuse, harassment, attacks with firearms or sharp objects, threats with weapons and forcing them to pay tribal penalties.

While it is difficult to compare results across the studies, common themes on the causes of violence do emerge:

- Junior personnel, women, personnel working evening shifts and those in emergency departments were more likely to experience violence. These factors may help hospital managers develop standard procedures to prevent and mitigate violence in hospitals.
- Long waiting times, staff shortages and dissatisfaction with the care provided were the top factors provoking violence in 26 countries.
- However, from Ethiopia to New Zealand, from Japan to Lebanon, and regardless of how services are organized, the performance of the health-care system or the level of violence in the country, health-care personnel are often on the receiving end of violence.
- Violence-management training, security measures and hospital reporting systems were the top recommendations for mitigating the effects of violence. These measures might well be applicable both to hospitals in industrialized countries and to those run by organizations providing humanitarian responses in difficult settings.

Although this literature review was limited in scope, significant research has been carried out on violence against staff working in health facilities. However, violence against those working in proximity to communities, such as paramedics, community health workers, midwives and vaccinators, is less well understood<sup>i</sup> and would be worth closer examination. Security measures for hospital settings will not help mobile health-care workers, so contextualized preventive measures need to be developed, tested and implemented to ensure their safety.

## **VIOLENCE AGAINST HEALTH CARE IN CONTEXTS WHERE THE ICRC OPERATES**

The literature review sheds light on the less visible incidents in countries of the Global South, with 71% of the research carried out on these geographical regions. Some of the studies were conducted in places experiencing conflict or other emergencies where the ICRC operates.

To provide a more comprehensive picture, the ICRC analysed what we are calling “events against health care” perpetrated in 16 countries where it operates between 2015 and 2017. Over that period, the ICRC recorded more than 1,200 incidents of violence against health care in those operations.

We record these incidents as part of our protection work and discuss most of them with the parties concerned.

Two points are worthy of note concerning the places where the events occurred:

- More than half occurred within a health-care facility.  
This indicates a need to strengthen security and boost preventive measures at such facilities.
- A quarter occurred in public places, at checkpoints or at border crossings, where both health-care workers and the sick and wounded are more vulnerable.  
One important measure that can safeguard timely access to the sick and wounded is therefore to improve acceptance of and respect for pre-hospital and ambulance services on the part of state authorities, non-state armed groups and local communities.

The most frequent acts against health care in those 16 operations during this period were:

- destruction of or damage to a medical facility or medical transport
- use of explosive weapons
- forced interference in a health facility
- threats
- denial of access to the sick and wounded.

These attacks on health care left an estimated:

- 3,290 people dead
- 1,750 wounded
- 170 abducted
- 100 detained
- 10 people victims of rape.

Numerically speaking, however, this is only the tip of the iceberg, as the data are not gathered in an exhaustive manner and this review provides only a snapshot of the problem from specific geographical areas and over a limited time.

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<sup>i</sup> Out of the 66 journal articles, only three focused on violence against paramedics, midwives and pre-hospital medical teams.

More recently, the ICRC has started gathering information from the health-care programmes it supports. From January to September 2019, almost 150 health-care personnel working within these programmes suffered violence, and we recorded 56 incidents involving medical facilities and transport. The ICRC needs to better understand the magnitude of the problem in our own health programmes, so we can better understand its impact. We need to establish reliable baselines regarding cases of violence and to quantify its impact at a local level. Only then can we take informed decisions about preventing and addressing violence against health care.

Violence against health-care facilities, personnel and ambulances is common throughout the world, as is the deliberate obstruction of efforts by the wounded to get help. While there is no simple and universal solution, the ICRC reminds states, the International Red Cross and Red Crescent Movement, weapon bearers, the health-care community, humanitarians, academics and communities that this demands a joint effort.

Everyone has a role to play in preventing violence against health care.

## THE HEALTH CARE IN DANGER INITIATIVE

The ICRC's Health Care in Danger initiative seeks to create a world where weapon bearers, political authorities and populations in countries affected by conflict and other emergencies respect the inviolability of health care at all times.

To realize our vision and reach our objectives, the ICRC is working with its partners along three axes of engagement:

### ***Operationalization***

The HCiD initiative supports the identification and implementation of concrete, practical measures and operational responses at national and local levels, to prevent violence and safeguard health care in armed conflict and other emergencies. This is done by focusing on countries where it matters the most, to achieve maximum impact.

### ***Evidence-based strategies***

It will not be possible to devise the right strategies to protect health care from violence, or to promote the use of these strategies on the proper scale, without the necessary evidence base. The ICRC's approach to generating evidence on violence against health care, and on the effectiveness of activities to prevent it, therefore focuses on partnering with public-health institutes and other research bodies embedded within the health systems of countries affected by conflict and other emergencies. Research conducted locally in this way will not only enable local prevention strategies to be based on a nuanced understanding of patterns of violence, but will, in time, contribute to a global overview of trends.

### ***Influencing and coalition-building***

The ICRC will focus its mobilization efforts at the national and subnational levels, where selected delegations will create and foster "communities of concern" that bring together representatives of health-care providers affected by violence, health-care policymakers and others who can contribute to developing solutions to the violence. Local communities of concern will play a role in mobilizing a broader range of government and civil-society entities, generating evidence and jointly designing and implementing measures to protect health care.

# DEFINITIONS

**Act:** An action or omission in the framework of an armed conflict or other situation of violence that causes loss, harm or suffering to a civilian or other protected person.

**Event:** An occurrence at a specific time and place. An event comprises one or several acts (qv).

## Health-care facility

- Hospital
- Laboratory
- Clinic
- First-aid post
- Blood transfusion centre
- Forensic medical facility
- The medical or pharmaceutical store of any of the above facilities

## Health-care personnel; health-care staff; health-care workers

- Doctor
- Nurse
- Paramedical staff
- First-aider
- Forensic medical staff
- Support staff assigned to medical functions
- Administrative staff of health-care facilities
- Ambulance personnel

## Medical vehicle

- Ambulance
- Medical ship or aircraft, whether military or civilian
- Any other vehicle transporting medical supplies or equipment

**Sick and wounded:** All persons, whether military or civilian, who need medical assistance and who refrain from any act of hostility. This includes pregnant women, newborn babies and the infirm.

## Violence against patients

- Killing, injuring, harassing or intimidating patients or those trying to access health care
- Blocking or interfering with timely access to care
- The denial of assistance or the deliberate failure to provide it
- Discrimination in access to and quality of care
- Interruption of medical care

## Violence against health-care facilities

- Bombing, shelling, looting, encircling, forcibly entering or shooting at or into health-care facilities
- Any other forcible interference with the running of such facilities (such as depriving them of electricity and water)

## Violence against health-care personnel

- Killing, injuring, kidnapping, harassing, threatening, intimidating or robbing health-care personnel
- Arresting anyone for performing their medical duties, including the impediment and arrest of forensic professionals while performing their forensic medical duties

**Violence against medical vehicles:** Attacks upon, theft of or interference with medical vehicles.

The lists in the definitions above are not necessarily exhaustive.

## ESTABLISHING A GLOBAL PICTURE OF VIOLENCE AGAINST HEALTH CARE

Health-care personnel, the sick and wounded, health facilities and medical transports are subjected to violence all over the world. Violence against health care takes place during protracted crises such as that in Colombia, where more than 100 incidents of damage to medical infrastructure have been registered over the 60 years of that country's armed conflict,<sup>1</sup> but it also occurs in more stable contexts such as France; in 2018, over 23,000 reports of harm were submitted to the French national observatory of violence in the health-care sector – almost 10,000 involved acts of physical violence.<sup>2</sup>

Violence against health care has multiple forms. The most blatant and horrific is undoubtedly the bombing of hospitals so often portrayed in the media. But denial of assistance or discrimination in the quality of health care provided, although less tangible, also have devastating consequences for entire communities.

So how often does violence against health care occur?

This report aims to answer that question by establishing a baseline of workplace violence against health personnel from cross-sectional studies, and by analysing patterns of violence against health care that the ICRC has collected for operational purposes.

*“When we’re in the field treating people,  
if we can cure them, they say thank you.*

*But if we can’t, they swear at you. So if I cure 20 people  
but 10 people don’t get well, I feel – why does it happen like this?  
I have to think: men die because of me? Or because ... why?*

*I think about this a lot... it’s troubling for me.”*

*28-year-old male medic<sup>5</sup>*

*(Edited for clarity)*

# UNDERSTANDING APPROACHES TO BUILDING EVIDENCE ON VIOLENCE AGAINST HEALTH CARE

There is no single methodology for measuring the full spectrum of violence against health care. However, academics, NGOs, ministries of health, United Nation bodies, humanitarian organizations and others are endeavouring to build evidence and understand the magnitude of the problem. Most data collection mechanisms have been developed for advocacy and awareness-raising purposes, while others are used at an operational level to tackle concrete issues and develop appropriate, contextualized responses. There is a bias towards gathering information on the more extreme or serious incidents, while incidents perceived to be less severe – such as attacks on the sick and wounded, misuse of emblems and attacks on medical transport – are underreported.

While no one approach can meet all requirements, peer-reviewed research is providing pockets of information on the burden of violence against local health workers. This report provides a review of research on interpersonal violence against health-care personnel, to build a worldwide baseline.

## VIOLENCE AGAINST HEALTH-CARE PERSONNEL

Health-care personnel suffer violence far too often – especially front-line staff. While those working in conflicts and other emergencies probably face the highest levels of violence, the profession as a whole considers violence to be part of the job. Staff suffer physical and verbal abuse, including death threats, in both industrialized and developing countries. The Health Care in Danger initiative is promoting respect for health-care personnel and seeks to influence the behaviour of perpetrators of violence, via evidence-based interventions. An in-depth analysis of the prevalence of violence, and its probable causes, was the first step.

### Research on health-care personnel subjected to violence

Workplace violence in the health-care sector is a global phenomenon.<sup>3</sup> Its effects range from poor morale and job satisfaction to a decrease in the quality of care. The ILO's joint programme on workplace violence in the health sector defines workplace violence as *"incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health"*.<sup>4</sup> The majority of cross-sectional studies reviewed used this definition. Most asked health-care staff to recall an experience of violence that had occurred during the 6 to 12 months prior to the survey, classifying violence as follows:<sup>4</sup>

#### Physical violence

The use of physical force against another person or group that results in physical, sexual or psychological harm. Includes beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching.

#### Psychological violence (emotional abuse)

Intentional use of power – including threats of physical force – against another person or group that can result in harm to physical, mental, spiritual, moral or social development. Includes verbal abuse, bullying/mobbing, harassment and threats.

## METHODS

This review examines 66 peer-reviewed articles on interpersonal violence against health care providers around the world, published in English, French or Spanish between 2007 and 2019.

It focuses on cross-sectional surveys of health-care personnel, including:

- doctors
- nurses
- technicians
- support staff
- paramedics
- pre-hospital emergency teams
- midwives
- personal carers
- health management
- ambulance drivers
- nurse assistants
- community health workers.

Most of the studies looked at emergency departments, while eight were conducted in psychiatric hospitals.

Multiple studies were conducted in Australia, Brazil, China, Ethiopia, India, Iraq, Israel, Nepal, Pakistan, Saudi Arabia, Turkey and the United States. Averages were calculated for each of those countries and this document reports those averages.

Some studies also reported instances of sexual violence against health-care workers.

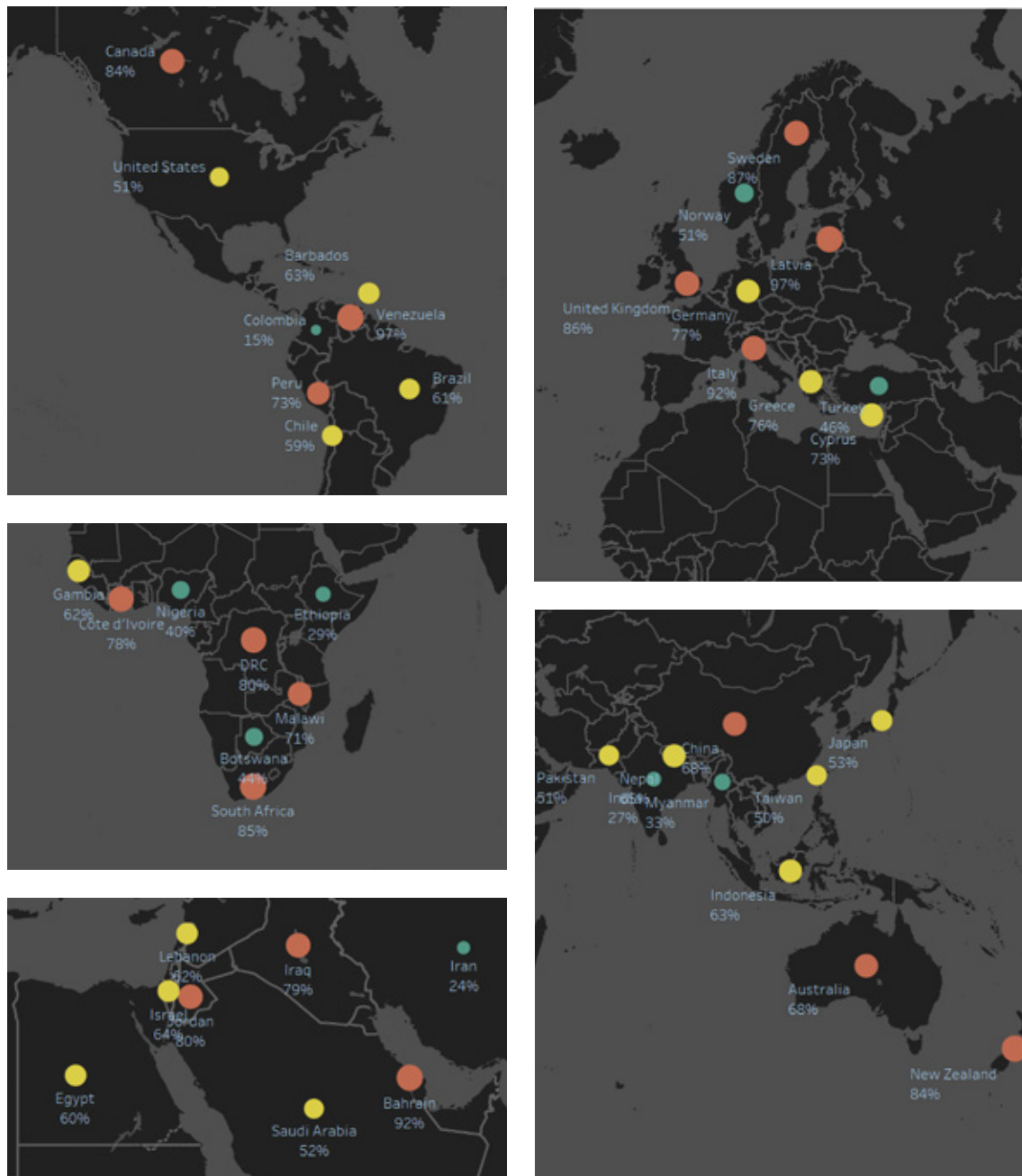
The review revealed that studies were different in scope, from the smallest, conducted in Myanmar,<sup>5</sup> with 30 participants, to the largest – also conducted in the Asia region<sup>6</sup> – in which over 26,000 nurses were interviewed. The 6-month to 12-month period-prevalence estimate of violence against health-care workers ranged from 15% in Colombia<sup>7</sup> to 97% in Latvia,<sup>8</sup> Israel<sup>9</sup> and Venezuela.<sup>10</sup>

Research on workplace violence has taken place across all continents. The following graphic shows overall violence (physical, verbal and/or sexual) as reported by health-care workers.

While the study reveals clear differences between the levels of violence against health-care staff in different countries, comparing results across countries and regions might not be feasible or appropriate:

- Some studies focused on a sub-sector of health-care specialists while others included technicians, administrative or support staff <sup>11-21</sup>
- Several studies focused on health-care staff working at psychiatric hospitals or those caring for psychiatric patients in the community<sup>21, 22-27</sup>
- Cross-sectional surveys tend to be resource-intensive, so many studies are limited geographically or target specific health-care facilities

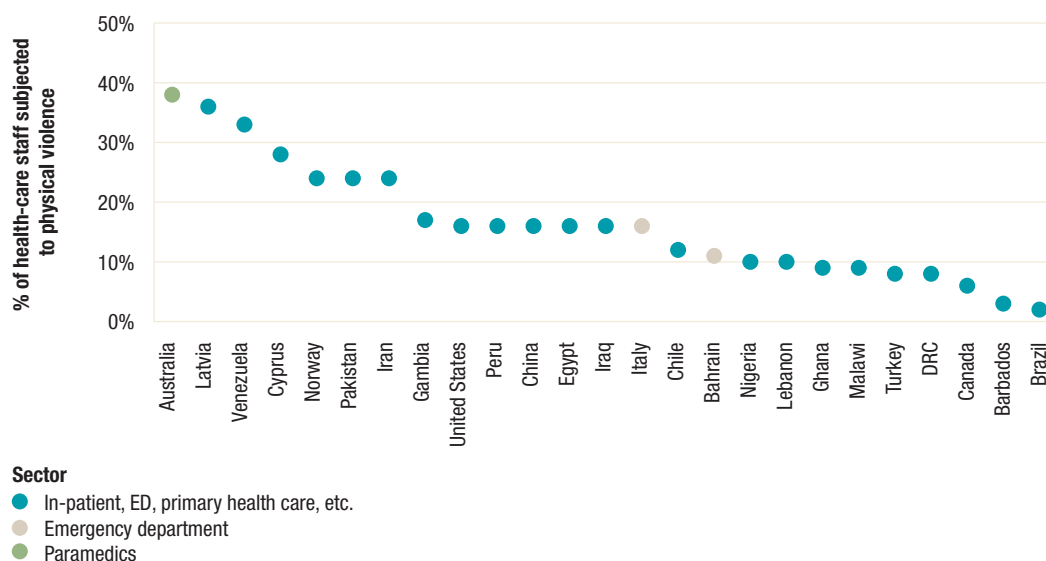
However, studies conducted in Iran,<sup>28</sup> Italy,<sup>29</sup> Peru,<sup>30</sup> Taiwan<sup>6</sup> and Turkey,<sup>31</sup> covering health-care workers nation-wide, provided a more comprehensive picture and made it possible to estimate national levels of violence against health-care personnel.



In 2015, a multi-country study was published that covered almost 20,000 health-care personnel from Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Guatemala, Honduras, Italy, Mexico, Nicaragua, Panama, Paraguay, Peru, El Salvador, Spain, the US, Uruguay and Venezuela.<sup>32</sup> Both doctors and nurses reported having experienced similar levels of aggressions (71%). Participants from Colombia and Paraguay experienced physical and verbal violence more often than those from Mexico, Peru and Uruguay. To our knowledge this is the only study that has been conducted on such a large scale. More importantly, it is the only study that allows us to compare results, to a certain extent.

Nevertheless, it is important to also consider intrinsic differences related to culture, exposure to generalized violence, the typology of violence and the existence – or absence – of standard operating procedures governing the reporting of incidents in the workplace, all of which can affect the results. Furthermore, interpretation of violence might vary from one person to another. It is difficult to clearly delineate what constitutes verbal violence, and in some settings physical violence might be part of the patient's symptoms as opposed to a deliberate act towards health-care personnel, for example when treating patients with certain mental illnesses.

The graphic below shows levels of physical violence as reported by health-care staff.



Percentage of health-care staff who experienced physical violence in each country included in the study. Excludes physical violence in psychiatric or geriatric facilities.

Perhaps not surprisingly, health-care personnel working at psychiatric or geriatric facilities were more likely to suffer physical violence, regardless of the country. However, the most important risks at these facilities were related to the use of manual restraint, which requires different preventive measures and protocols.<sup>11, 25</sup>

Physical violence towards health-care staff acting as a first point of contact with patients, such as paramedics and those working in emergency departments, acute care or primary care, occurs worldwide, with between 2% and 38% of staff in these categories experiencing physical violence.

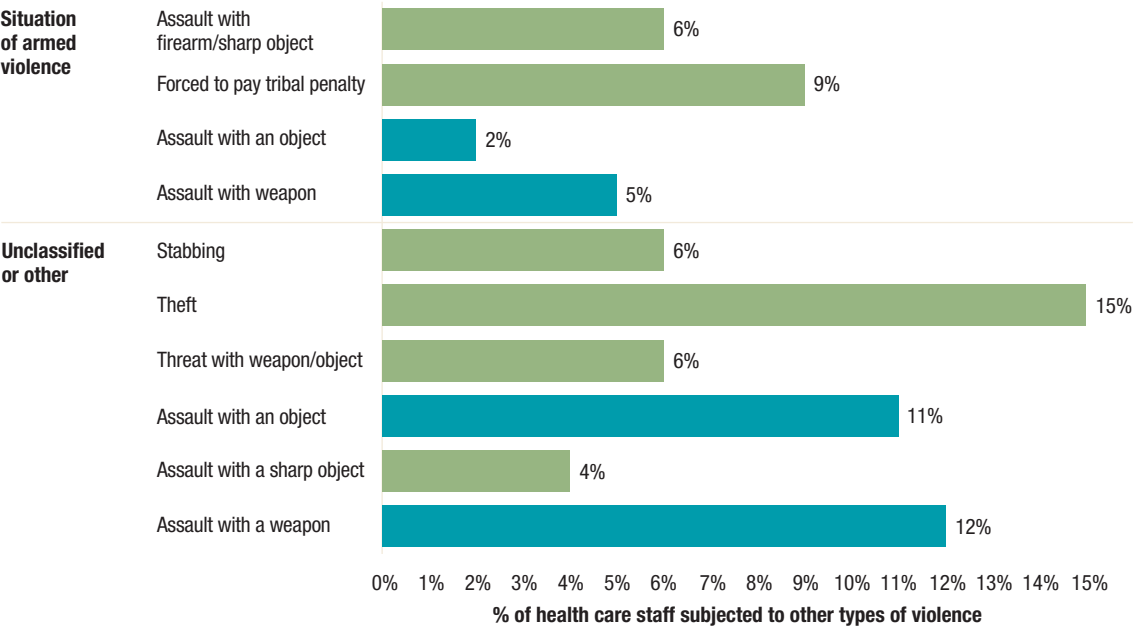
Some studies determined the percentage of health-care staff who had been subjected to other specific types of violence such as:

- the use of objects (including sharp objects)
- the use of weapons (without specifying the type of weapon)
- assault with a firearm or other weapon
- stabbing
- theft
- the imposition of tribal penalties.

Using the Rule of Law in Armed Conflicts (RULAC) classification from the Geneva Academy of International Humanitarian Law and Human Rights,<sup>33</sup> studies were classified into those conducted in contexts of armed conflict (international armed conflicts, non-international armed conflicts and partial or total military occupation) and those conducted in contexts not classified as armed conflicts by RULAC but which might include fragile settings experiencing normalized violence.

The use of weapons and objects was reported in both categories of context, but health-care personnel working in armed conflict settings reported being assaulted with a firearm or sharp object or being forced to pay a tribal penalty, while those working elsewhere reported being victims of theft, stabbing and threats. As weapon types are not specified in all studies, it is difficult to conclude that the more violent and serious types of event are more prevalent in conflict settings. The use of firearms against health-care workers was only reported in conflict settings, however. An in-depth analysis of weapon use merits further exploration, as a step towards developing appropriate measures to protect health-care workers.

Understanding the short- and long-term harm to victims might provide a better indication of the severity of violence and might therefore result in more appropriate measures to support health-care workers.



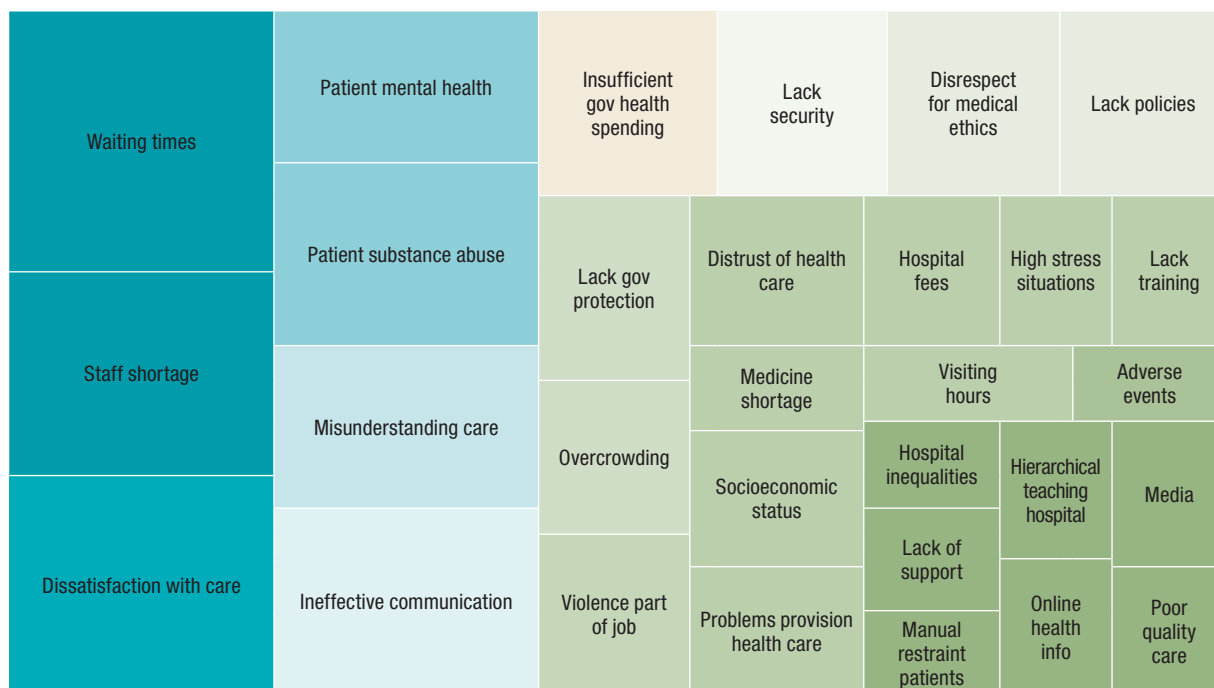
Average percentages of staff subjected to various types of violence, grouped according to RULAC classification. The figures are based on selected studies that reported other forms of violence.

Studies most frequently reported that young health-care personnel, less experienced personnel (which might correlate with “young”), female personnel and those working during an evening shift or in an emergency department were at greater risk of violence.



Factors contributing to violence, as reported by respondents in selected studies. Font size reflects the number of studies reporting a given factor.

In the majority of studies, patients or relatives were the most frequent perpetrators of such violence, and the perceived causes of violence were related to frustration about such issues as long waiting times, staff shortages and the health care provided (sometimes including a patient's demand for specific or specialized treatment). Studies also made frequent mention of conditions inherent to the patient, such as mental illness and substance abuse. Communication-related factors such as a patient's misunderstanding of the type of services provided at specific points of care and ineffective communication on the part of the health-care worker were also cited as factors contributing to violence.



Causes of violence, as reported by survey participants in selected studies. Box size reflects the number of studies reporting a given cause.

The effects of violence on the well-being of health-care workers included:

- emotional distress
- intention to leave the job
- diminished job satisfaction
- feelings of anger and frustration.

Some studies mentioned that victims of violence avoided talking about incidents and, more importantly, that they might well avoid even thinking about them or having feelings related to them.<sup>14, 24, 34, 35</sup> Victims might therefore be relatively unlikely to seek help, which makes it more difficult for them to receive legal or psychological support.<sup>36</sup>



The impact of violence as reported by health workers, based on selected studies that reported other forms of violence. Font size reflects the number of studies reporting a given effect.

Health-care workers who had suffered violence often recommended training in violence management and the introduction of security measures and protocols, including the setting up of reporting systems.

However, reporting systems alone were not perceived as effective; recommendations included the establishing of clear procedures to ensure that incident reports were acted upon.<sup>37</sup>



Participants' recommendations for measures to reduce/prevent violence. Font size reflects the frequency of studies reporting a given recommendation.

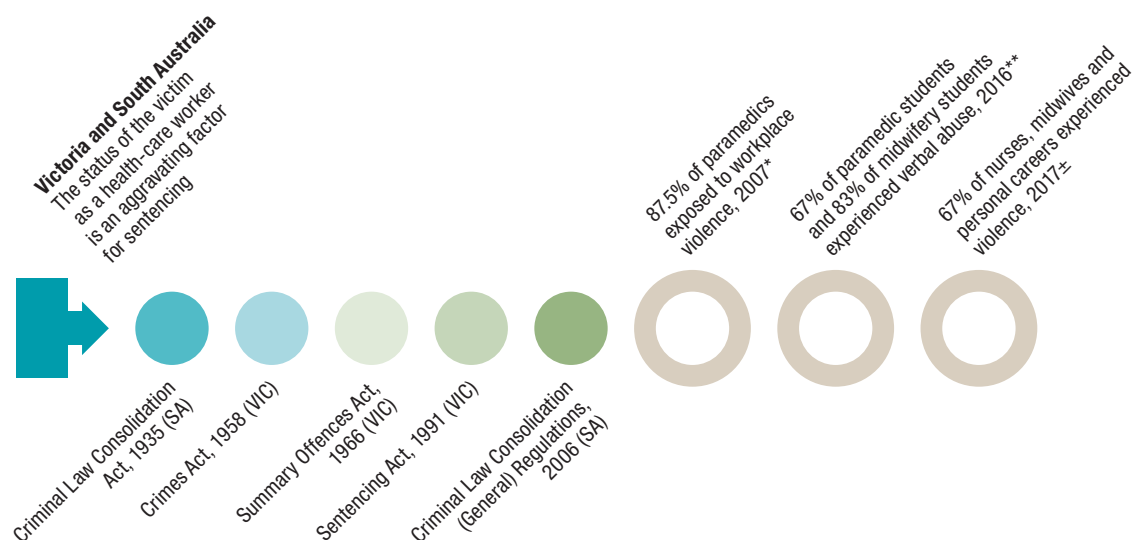
Other recommendations included:

- strengthening anti-violence policies with disciplinary action<sup>39</sup>
- promoting a human-oriented approach to treatment by nurses, paying attention to psychological needs in addition to physical, with recommendations including using the skills of more experienced nurses to train new nurses in coping skills<sup>40</sup>
- setting up violence-management committees that include counselling for patients and their relatives<sup>41</sup>
- providing training in service psychology, to understand clients' needs and promote service-oriented behaviour on the part of health-care personnel<sup>39</sup>
- conducting research, to understand:
  - the consequences of exposure, to attract urgent policy interventions<sup>38</sup>
  - the characteristics of those who engage in violence – one-off perpetrators/victims versus repeat perpetrators/victims<sup>22</sup>
  - the role of culture and religion as contributing factors to violence and to people not reporting incidents of violence<sup>5</sup>
- training to recognize possible aggressors.<sup>42</sup>

Although this literature review was not restricted to the areas of the world where the ICRC deploys its operations, nor to the more severe forms of violence associated with armed conflict or other emergencies, several of the recommendations in the studies correspond to measures that the Health Care in Danger initiative is promoting and implementing on the ground.

Domestic legislation to protect health care services from violence is one such measure. Some states and territories included in the studies have adopted such legislation.

## THE STATES OF VICTORIA AND SOUTH AUSTRALIA



**Notes:** \*38% of paramedics reported physical abuse<sup>43</sup>

\*\*The main forms of workplace violence were verbal abuse (18%) and intimidation (17%) during clinical placements<sup>44</sup>

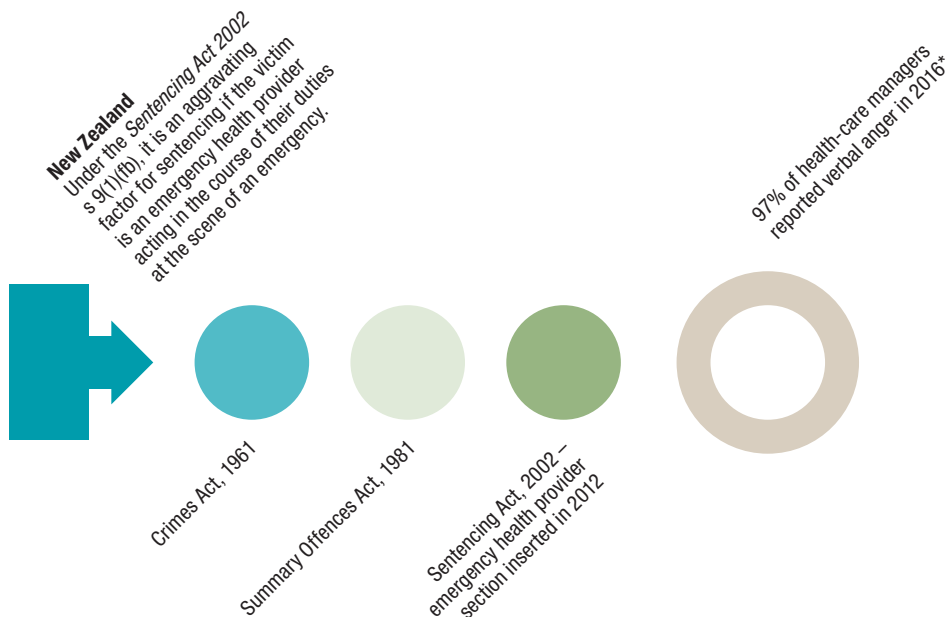
±Nearly 20% of nurses, midwives and personal carers experienced violence on a weekly or daily basis<sup>45</sup>

In Australia, the prevalence of violence against health-care staff has been investigated in the states of Victoria and South Australia. In South Australia, a person can be charged with an aggravated offence if the victim of the offence was vulnerable owing to their occupation. The specific occupations mentioned in the Criminal Law Consolidation (General) Regulations 2006,<sup>46</sup> include: “(a) emergency work, (b) employment as a person (whether a medical practitioner, nurse, midwife, security officer or otherwise) performing duties in a hospital (including, to avoid doubt, a person providing assistance or services to another person performing duties in a hospital); (c) employment as a person (whether a medical practitioner, nurse, pilot or otherwise) performing duties in the course of retrieval medicine; (d) employment as a medical practitioner or other health practitioner (both within the meaning of the Health Practitioner Regulation National Law (South Australia)) attending an out of hours or unscheduled callout, or assessing, stabilising or treating a person at the scene of an accident or other emergency, in a rural area”.<sup>47</sup> Soon after the 2006 amendment, a study reported that 48 paramedics had experienced physical abuse in South Australia,<sup>44</sup> and although the number of incidents officially reported with a view to pursuing criminal charges is unknown, we could see this study as a baseline for evaluating the efficacy and implementation of the law in South Australia. Further studies are therefore needed.

In 2015, the Victorian Auditor-General’s Office assessed measures to protect health-care workers against occupational violence taken by the Department of Health and Human Services, WorkSafe, Ambulance Victoria and health services. Systematic failures were found in collecting, analysing and investigating quality data.<sup>47</sup> Incidents were underreported because of cumbersome systems and perceived management inaction. As part of overall efforts to address the issue of violence, the Victorian Branch of the Australian Nursing and Midwifery Federation (ANMF) put together a 10-point plan to end violence and aggression in 2017, and encouraged staff to report all incidents through formal channels.<sup>48</sup> This was accompanied by a WorkSafe Victoria campaign to change the behaviour of the public towards health-care workers.<sup>49</sup>

In 2017, Shea *et al.*<sup>45</sup> published the results of a survey covering almost 5,000 members of the Victorian Branch of the ANMF, and although it is not clear exactly when the survey was conducted or when the incidents took place, its results might provide a baseline for evaluating the effectiveness of the strategies and policies in place.

## NEW ZEALAND



\*Other forms of violence included physical aggression, destructive behaviour, attempted assault, injury and sexual assault.<sup>23</sup>

Assaults on emergency health or fire service personnel performing their duties at the scene of an emergency also incur more severe penalties in New Zealand.<sup>50</sup> A 2016 study asked unit managers from various health-care settings about aggression from patients; verbal anger was the most frequent form of violence, with 97% of respondents reporting occurrences. Despite the legal repercussions for perpetrators, managers of District Health Boards, Aged Care and NGOs reported attempted assaults, assaults and injuries.<sup>23</sup>

The study examined not only the prevalence of violence in health-care settings but also the availability of security measures such as panic buttons, personal alarms, security personnel and police assistance. These resources were commonly available in most settings except for community services, where the most readily available option was to call in police assistance when violence occurred.<sup>23</sup>

Reasons for aggressions were classified into three categories:

- organizational
- patient
- staff.

Organizational factors included high-risk exposure to violence in remote rural areas with limited resources.<sup>23</sup> (Similar risk levels are encountered in rural areas in conflict settings or during complex emergency responses, where measures to protect community health-care personnel are almost non-existent, much less tested for their effectiveness.) While health-care managers stated that prevention management training was available in public health-care settings, such training was rarely offered to NGO staff.

The efforts of subnational organizations to gather and analyse information as a step towards developing targeted, multidisciplinary strategies are commendable and, more importantly, are replicable to other contexts. We have highlighted Australia and New Zealand as examples of contexts in which there is domestic legislation to protect health-care services. Research on the level and forms of violence occurring in these countries could help us better understand the effectiveness of legislation and areas in which amendments or recommendations could be of value. Future time series analyses may be necessary.

Cross-sectional studies on interpersonal violence are one of many approaches to determining the prevalence of violence in the health-care sector.

Like other data collection mechanisms, self-reporting surveys have their own limitations:

- the comparability of results, which is limited by methodological and cultural differences
- the ability of the participants to recall events within a specific timeframe, which might vary
- the sensitivity of the subject matter, which might result in reporting bias.

In some cultures, perceiving oneself as a victim could be a source of shame, and this could be exacerbated by gender roles. Previous studies have demonstrated gender differences in health-seeking behaviour<sup>51</sup> but as far as we are aware, the role of gender in the ability of a health-care worker to seek help or to discuss safety and security at their workplace is still unknown.

A first step towards reducing violence is recognizing the magnitude of the problem. This literature review provides a baseline for analysing violence against health-care workers and demonstrates that such violence is not only endemic in countries affected by conflict. The studies we report on here focus on the perspectives of doctors and nurses, and gaps remain in our understanding of the magnitude of violence against those working more closely within communities such as paramedics, forensics personnel, vaccinators and community health workers.

Interestingly, there are commonalities in the risk factors and the causes of violence between all contexts and settings; threats against health-care workers may stem from the same frustrations and dissatisfaction with care, for instance. Given that the risks and causes are similar, mitigation and prevention measures might be effective not only in industrialized and stable health-care settings but also in conflict-affected areas.

The second step is therefore to find ways of reducing exposure to violence and reducing its effects on the well-being of both health-care workers and communities in need.

# WHAT HAPPENS DURING CONFLICT AND OTHER EMERGENCY SITUATIONS?

## IS RESPECT FOR HEALTH CARE IMPROVING OR IN DECLINE?

The current discourse on violence against health care usually focuses on that small number of contexts in which the most blatant attacks on health-care provision occur, suggesting that respect for health care is in decline. However, although global data collection efforts have increased exponentially, none can affirm with certainty that violations of the rules protecting health care are becoming more prevalent – or less so.

All organizations collecting data on incidents against health care in conflict and emergencies suffer multiple constraints.<sup>ii</sup> Several entities have tested novel means of data extraction to address these constraints, but the accuracy of the data obtained by these means is unclear. On the other hand, this is also true of global efforts to collect data in such areas as disease, violence in general or basic statistics. Instead of gathering mountains of data or developing new technologies to add to the vast amount of information available, why not focus on examining the patterns of violence against health care revealed by emerging pockets of information?

Organizations collecting information on incidents against health care often perceive a need to demonstrate that medical facilities and vehicles are being attacked at a higher rate now than ever before, without conducting historical analyses that would allow them to draw solidly-based conclusions, or without a careful examination of changes in data collection and reporting practices, and the availability of information.

The bigger questions should always be:

- Why is the protection of health care being disregarded?
  - What are the precursors and enablers of such disregard?
- and, most importantly,
- How can we prevent it?

Examining specific events<sup>iii</sup> or even a single context could help establish whether events against health care are the result of deliberate targeting or reckless disregard.

The ICRC gathers protection information to analyse patterns of abuse, understand the circumstances, causes and consequences and devise the appropriate responses. For the Health Care in Danger initiative, those responses have included long-term prevention approaches and practical measures such as [changing behaviour](#) towards health-care personnel and facilities<sup>52</sup> and understanding domestic legislation that may interfere with ethical principles of impartiality or non-discrimination in care for patients with [gunshot wounds](#).<sup>53</sup>

The patterns of violence against health care presented below constitute no more than a glimpse of the overall reality. One should not see ICRC data-collection activities as an active and exhaustive monitoring mechanism.

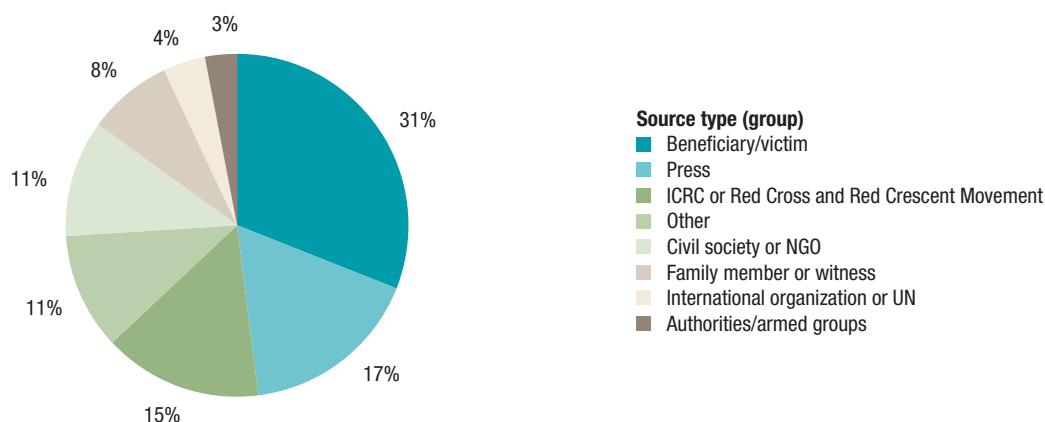
Events of violence against health care<sup>iv</sup> are identified using pre-determined definitions. An *event* is an occurrence at a specific time and place, linked to one or more *acts* against health care. Multiple events that occur at the same place and time are regarded as a single event. However, if multiple events affect different individuals and/or communities, or occur at different times or places, they are seen as separate.

ii As in previous ICRC reports, the information that the ICRC gather depends to a large extent on the geographical areas where we operate, our capacity, the priority we accord to the issue and the access we have to local sources of information, particularly in highly restricted security environments. As a result, the incidents recorded are merely a subset of those that occur.

iii An **event** is an occurrence at a specific time and place and is necessarily linked to one or several acts. An **act** is an action or omission in the framework of an armed conflict or other situation of violence that causes loss, harm or suffering to a civilian population or other protected person.

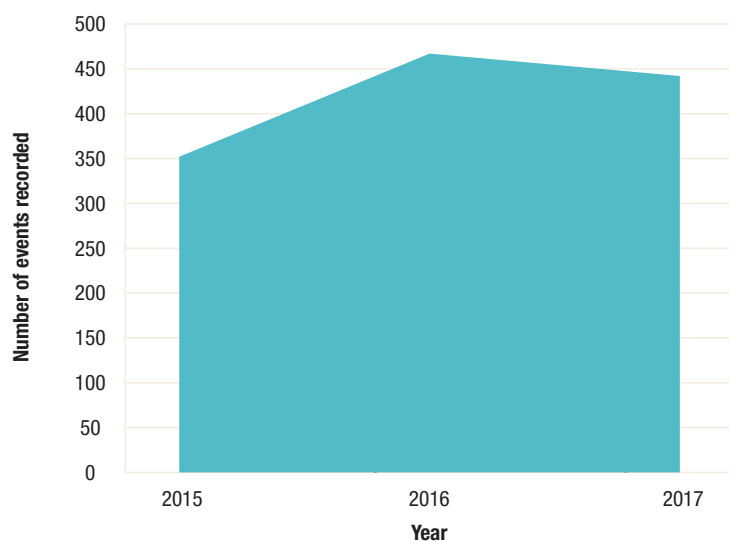
iv Referred to from this point forward as “events against health care”.

The ICRC collected data from 1,261 events against health care from multiple sources across 16 of its operations between 2015 and 2017. Almost 40% of the sources of information were direct beneficiaries, victims, their family members or witnesses.



Source: Data collected for protection activities in 16 operations. ICRC, 2015–2017.

The number of events registered in 2016 and 2017 was similar. Fewer events were registered in 2015, but this was a period of transition to a new database system at some ICRC delegations. Based on the data gathered over the period of analysis, there was not a single day without an event against health care.

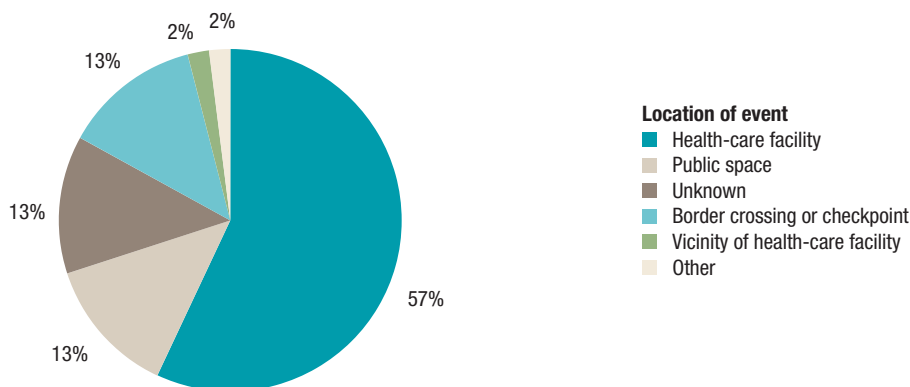


Source: Data collected for protection activities in 16 operations. ICRC, 2015–2017.

## THE NEED TO STRENGTHEN THE SECURITY OF HEALTH-CARE FACILITIES

Not surprisingly, more than half of all events occurred within a health-care facility. A further 13% took place in public spaces; most of these affected medical transports or community health workers. For a similar percentage of events, however, it was difficult to pinpoint the exact location.

This figure demonstrates the need to prevent violence at these locations and to mitigate its impact when it does occur. The ICRC has therefore developed a [risk assessment tool for health-care facilities](#), which details measures for enhancing the security and preparedness of such facilities.<sup>54</sup>



Data collected for protection activities in 16 operations. Source: ICRC, 2015–2017.

## PATTERNS OF VIOLENCE AGAINST HEALTH CARE

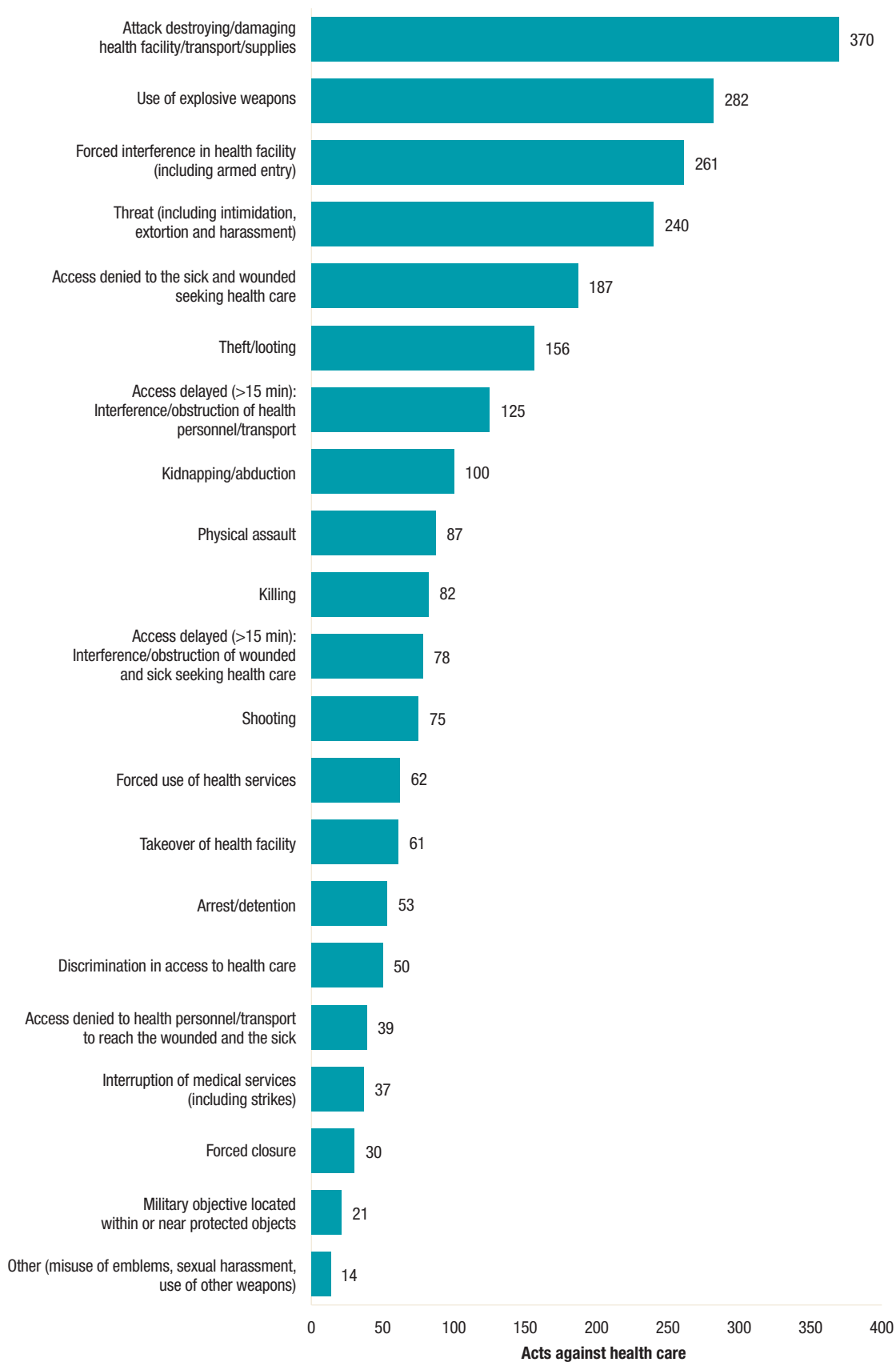
To better understand the patterns of violence collected, it is important to know that 36% of the 1,261 events against health care consisted of a single act. All other events consisted of between two and five acts.

For example, an event might be reported as “Armed men entered a health facility demanding a ransom and closing the facility for several hours.” Multiple acts were perpetrated during this single event; armed entry, threats and forced closure.

To better understand the patterns or types of violence, we have therefore classified acts into categories for further analysis. The data reports on a total of 2,410 acts against health care.

The five most frequent acts were:

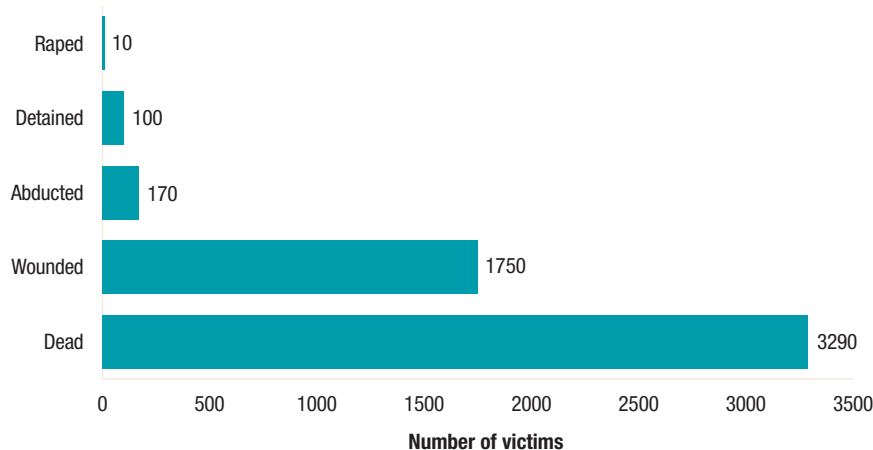
- destruction of or damage to a medical facility or medical transport
- use of explosive weapons
- forced interference in a health facility
- threats
- denial of access to the sick and wounded.



Source: Data collected for protection activities in 16 operations. ICRC, 2015–2017.

## DIRECT CONSEQUENCES: THE VICTIMS

It is very difficult to determine with certainty the total number of victims resulting from the events against health care that the ICRC records. We estimate that approximately 3,290 people died as a direct or indirect consequence of the events reported. This figure includes those who were killed in the incident itself and those who died as a consequence of the incident (where such information is available); it includes 2,000 injured people estimated to have died as an indirect consequence of an event, because they were prevented from seeking medical attention. The figures below have been rounded and should be treated with caution.

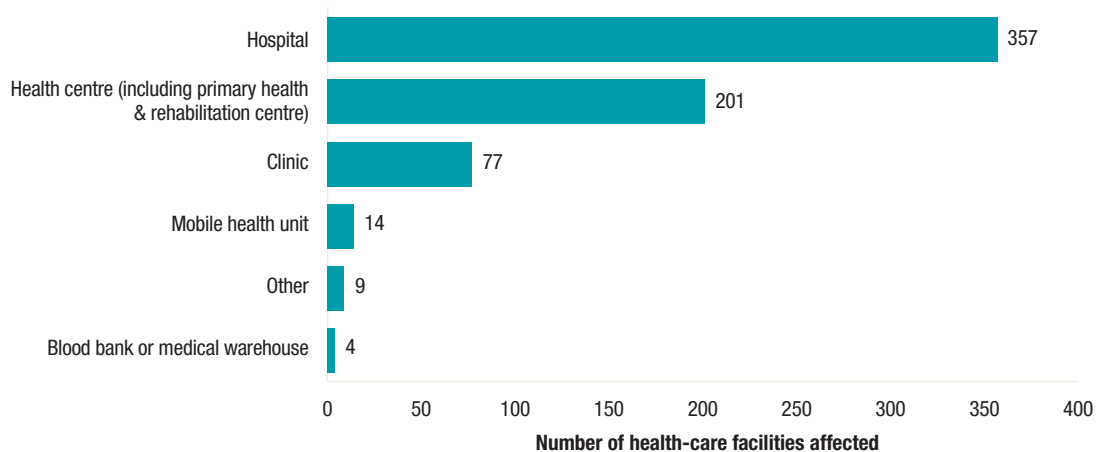


Source: Data collected for protection activities in 16 operations. ICRC, 2015–2017.

The number of dead includes those who were killed during an event itself and those estimated to have died as a consequence of an event.

## DIRECT CONSEQUENCES: HEALTH-CARE FACILITIES AND MEDICAL TRANSPORTS

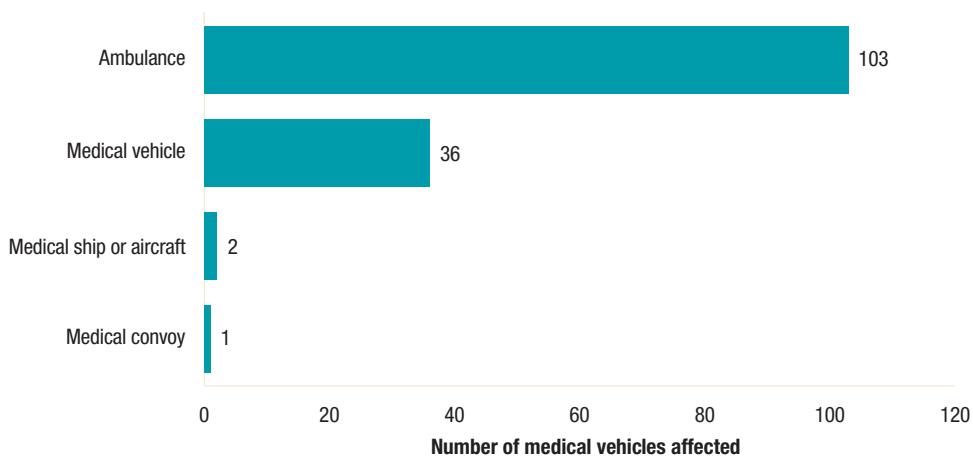
Most events affected hospitals or health centres, but other types of facility were also affected, including clinics, mobile health units, pharmacies, ambulance stations and forensic departments.



Source: Data collected for protection activities in 16 operations. ICRC, 2015–2017.

“Other facilities” include pharmacies, ambulance stations and forensic departments.

Events against medical transports most often involved ambulances, but some involved specialized medical vehicles used to transport persons with weapon wounds, medical equipment or supplies such as vaccines.



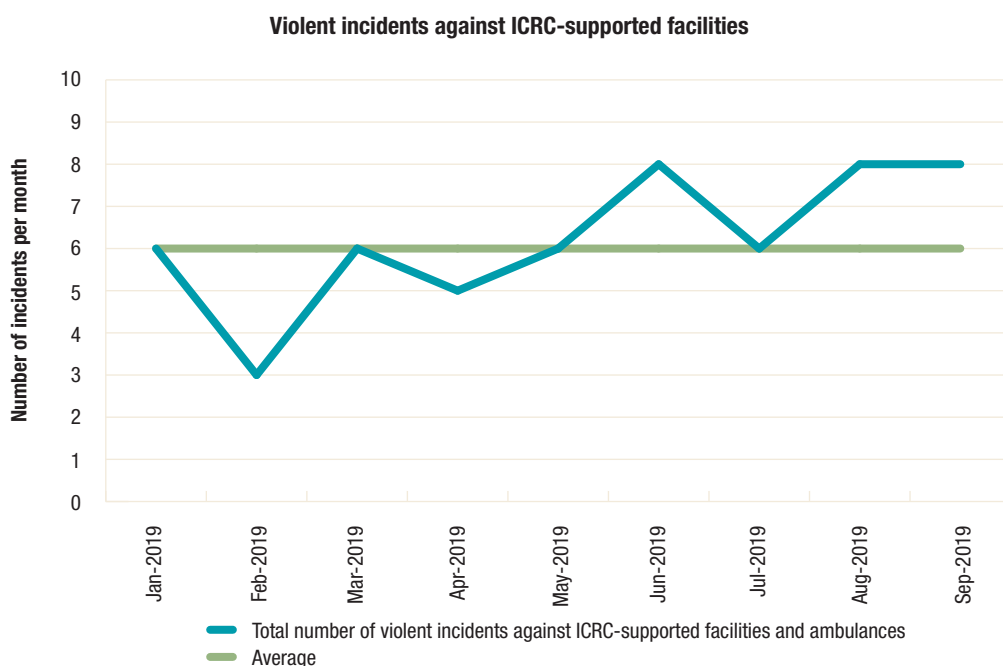
Source: Data collected for protection activities in 16 operations. ICRC, 2015–2017.

## VIOLENCE AGAINST ICRC-SUPPORTED FACILITIES

The ICRC's assistance work includes caring for the sick and wounded during armed conflict and violence. The organization supports first-aid and pre-hospital emergency care, primary health care, hospital services, physical rehabilitation, mental health, psychosocial support and health care in detention.<sup>55</sup>

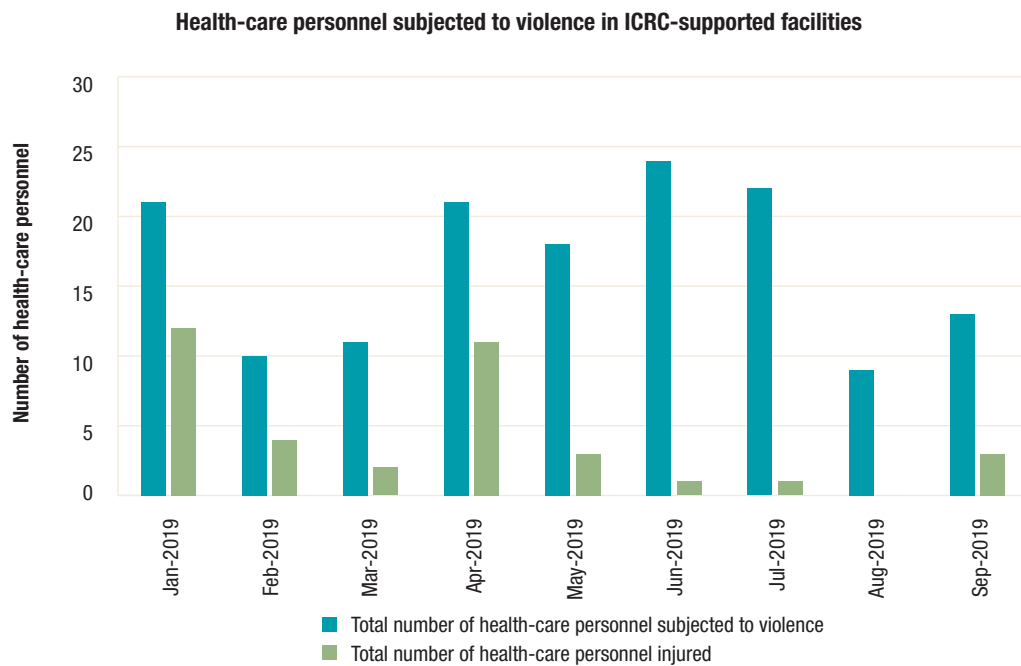
During 2019, the ICRC gathered information from ICRC-supported first-aid and pre-hospital emergency care, primary health care and hospital programmes worldwide. This information provides a baseline for monitoring violence against ICRC-supported programmes and will make it possible to assess the effect of violence on health-care personnel and on the quality of health care provided. Such information will also help identify the most appropriate measures for our programmes.

A total of 56 incidents against ICRC-supported hospitals, primary health facilities, ambulances, first-aid posts and mobile units were recorded between January and September 2019. That is an average of six incidents per month. Once new data collection systems and indicators are introduced, we can expect to obtain more data of a higher quality over time.



Source: ICRC Medical Administrative Database. January to September 2019.

Over the same period, 149 health-care personnel working in ICRC-supported facilities were subjected to violence, and 42 of them were injured or killed. All categories of health-care personnel were affected: qualified health-care staff such as doctors, nurses, dentists, physiotherapists, psychologists, pharmacists, lab technicians and midwives, plus support staff including security personnel and administrative staff. The events occurred at ICRC-supported health-care facilities forming part of the first-aid and pre-hospital emergency care, primary health care and hospital programmes in different contexts of the world. In other words, the victims are not only ICRC health staff but also include other health workers.



Source: ICRC Medical Administrative Database. January to September 2019.

On every continent where the ICRC supports health-care programmes, there was at least one incident of violence against health-care personnel every single month. Physical and verbal attacks on health-care personnel have become routine occurrences.

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