IJHPM
International Journal of Health Policy and Management

Perspective

Deadly professions: violent attacks against aid-workers and the health implications for local populations

Jason-Louis Carmichael[1,*], Mohammad Karamouzian[1,2]

Abstract
War has devastating implications for families, communities, cultures, economies, and state infrastructure. Similarly, the last decade has seen an increase in the number of attacks against health workers in conflict zones and unstable environments. Unfortunately, these attacks have grave consequences for local populations which often rely on foreign aid programs for their health and well-being. As such, this paper will examine why aid-workers have increasingly been targeted for abductions, ambushes, assassinations, and various forms of intimidation. Furthermore, examples of terminated health programs, as well as populations served by current medical and humanitarian interventions, will be provided to impart a sense of magnitude and importance of health programs to the reader. Lastly, suggestions will be presented which could serve to minimize aid-workers' risk and exposure to acts of violence in the field.
Keywords: NGO, Health, Attacks, Humanitarian Assistance, War, Impartiality

Citation: Jason-Louis C, Karamouzian M. Deadly professions: violent attacks against aid-workers and the health implications for local populations. *Int J Health Policy Manag* 2014; 2: 65–67. doi: 10.15171/ijhpm.2014.16

*****Correspondence to**:
Jason-Louis Carmichael
Email: j.carmichael@alumni.ubc.ca

Given the broad health implications of war, a three paper series will discuss select issues regarding War and Public Health. Specifically, attacks against aid-workers and the resulting health consequences for local populations, the use of chemical and biological weapons in war, and lastly, the use of rape as a tool of war. These issues are often overlooked and avoided as they are viewed by many as uncomfortable; but it is by challenging and pushing ourselves to address these vaguely understood and researched realms that we can find lasting, sustainable solutions to these vexing problems. The purpose of these papers is not to propose solutions, but merely to promote thought and stimulate curiosity among readers who will then hopefully take it upon themselves to learn more[1].

War and public health
In the past century war has generated over 190 million deaths, more than half of which were accounted for by civilians (1,2). In the last decade alone, approximately 200 wars have been fought, resulting in suffering, hardship, and loss (2). The new war paradigm where civilians are fought over, rather than for, increasingly puts unarmed civilians at the epicentre of conflicts. Millions have been forced into various forms of slavery, tortured, forcefully recruited into militias, or participated in genocide, not to mention being displaced from their countries, communities, and homes (2). Thus, war could be understood as an acutely fatal disease that disrupts lives, tears at the social fabric of communities and families, and causes undue morbidity among populations.

A question of distinction
The blurring of lines between humanitarianism and military intervention can easily be traced back to the North Atlantic Treaty Organization (NATO) led humanitarian effort during the Kosovo war of 1998–9 (3). More recently, however, the 2003 Iraq war blatantly politicized humanitarian aid, bringing many to question the aid communities departure from values advocate for by Henry Dunant over a century ago, namely, neutrality, impartiality, and independence (4). The portrayal of the Iraq war as a war of salvation where Iraqi's would be liberated from tyranny and provided food, medicine, and shelter irrevocably appended humanitarian aid to political objectives (5). Prior to the war, planning resolved that civilian agencies were to deploy in the shadow of the advancing military and implement programs that would win the "hearts and minds" of the Iraqi people (5). Given the existing international sanctions and restrictions imposed by Saddam's regime, however, little aid was initially provided as many NGOs were unable to deploy both prior to and immediately following the intervention. Regardless, the American military broadly publicized the surgical procedures and relief operations it carried out in the wake of its advancement, a strategy that was intended to legitimize and attest to the humane motives behind the intervention (5). Unfortunately, widespread unease ensued among many Iraqi's who considered the military intervention a mere sequel to the Gulf War, a sentiment, it should be said, which was amplified as reports of human rights violations began to mount and made aid-workers fair game in the fight against "colonialism".

The blowback
As in all wars, there are always unintended outcomes. One such consequence has been the deliberate targeting of aid-workers.

---

1. For the purpose of this document aid/humanitarian/medical workers will be used interchangeable since virtually all emergency interventions have health at the core of their programs.

Full list of authors' affiliations is available at the end of the article.

Despite article 24 and 26 of the 1st Geneva Convention that maintains all medical and aid personnel be protected from violence, the last decade has seen a surge of violence against aid-workers in the form of abductions, ambushes, targeted killings, and intimidation, not to mention the pillaging of medical facilities and resources (6). Between July, 2008 and December, 2010, the International Committee of the Red Cross (ICRC) documented 655 attacks on health workers, whereas 921 attacks were recorded for the 2012 calendar year (7,8). The 2012 attacks alone generated over 1,000 victims, 614 of which were doctors, nurses, and paramedics (8). A recent report released by Humanitarian Outcomes outlines the increasing trend of violent attacks against humanitarian workers since the 2003 Iraq war (9). Given the context in which these acts of violence occur, and in the absence of a centralized reporting system, it is safe to assume that such figures are a gross underestimation. Such attacks have very real consequences for the local populations which these aid-workers are meant to serve. For example, the 2009 bombing of a medical graduation ceremony in Mogadishu, Somalia, which claimed the lives of 15 medical students and one medical doctor, translated into the loss of approximately 150,000 loss consultations per year as the average physician provides 250 consultations per week (7). More recently, the termination of activities by Médecins Sans Frontières (MSF) in Somalia due to targeted attacks on its healthcare workers meant that over 700,000 people will go without healthcare until belligerents can ensure the safety of its workers (10). A further vacuum in health systems is punctuated by the mass exodus of health workers due to insecurity in times of war, a scenario that played out in Iraq when 18,000 (over 50%) doctors fled as a result of conflict (11). The erosion of basic health services equates not only to increases in morbidity and death, but it also tears at the social fabric of communities, disenfranchises people, and perpetuates violence and competition for increasingly scarce resources (12).

Health in action

Basic medical care and health services during and following a humanitarian crises are essential. As war rages, the economic health of a state deteriorates; tax-based revenues begin to dwindle and governments are forced to reallocate resources to the war effort, often at the expense of health programs (13). The need for health professionals is amplified by upsurges in malaria, cholera, typhoid, various respiratory infections, and malnutrition that shadow forced displacement, the disruption of food supplies, and the lack of adequate water and sanitation brought about by conflict. The Democratic Republic of Congo (DRC), for instance, has an estimated 43% of children under the age of five currently suffering from malnutrition and whose demographic contributed approximately 47% of the estimated 5.4 million deaths between 1998 and 2007 (14,15). Somalia, on the other hand, has approximately 80% of its children under five years old suffering from malnutrition (16).

Hence, aid-workers and health programs are an essential figure in the conflict landscape. There are many examples of very successful programs implemented by a variety of organizations. In 2012 alone, United Nations Children's Fund (UNICEF) implemented WASH (Water, Sanitation, and Hygiene) programs which gave 17.1 million people access to potable drinking water and 4.5 million people access to basic sanitation services (17).

More specifically, 750,000 people gained access to sanitation in eastern DRC of Congo and 1.3 million access to water, whereas 950,000 internally displaced peoples from Somalia were provided water by UNICEF and partners (17). Similarly, Action Contre la Faim (ACF) feeding centres rehabilitated over 40,000 acutely malnourished children in the DRC in 2012 (18). The ICRC provided the resources required to conduct 14,200 weapon wounded and 114,300 non-weapon wounded surgical procedures in 2012, while MSF conducted 34,600 trauma related surgical procedures and 78,500 obstetric surgical procedures (19,20). Another example is the Syrian conflict that has generated over two million refugees since it began in early March, 2011 (21). Over 120 agencies, NGOs, and organizations work around the clock to provide these refugees with shelter, protection, water and sanitation services, food, education, mental health and psychosocial support, and basic medical care.

Reducing harm

Indeed, providing aid in war zones is challenging, and sometimes government assisted security is a necessary evil that we must come to terms with, but there are measures that can be taken to minimize the likelihood of being viewed as an extension to accomplishing political goals. One such measure is for organizations to reduce their reliance on governments to fund their programs and interventions. Regardless of the country, NGOs receive, on average, a quarter of their financial resources from governmental funds (22). The degree to which NGOs are funded by governments, however, varies dramatically per country and organization. For example, the International Rescue Committee (IRC) receives upward of 70% of its funding from the US government, whereas CARE (Cooperation for Assistance and Relief Everywhere) receives approximately 50% of its funding from the same source. On the other hand, MSF and Oxfam US/GB receive between 20–30% of their funding from government sources (22). Regardless of where the funding comes from, NGOs are accountable to the funder. However, receiving large amounts of funds from government sources restricts an organization's ability to innovate and operate in certain environments and with certain groups. For example, organizations may be unable to safely access a region in crisis due to its perceived affiliation with the opposition, as is the case with Afghanistan, Somalia, and Iraq, to name a few. Gaining permission and right of entry to a region from warring factions is a critical process that must be undertaken to ensure the safety and security of aid personnel. All parties, regardless of creed, ideology, and affiliation, need to be involved in the dialogue that not only authorizes the entry of aid but ensures the safety of its workers during its delivery. In order for this to happen, however, NGOs must be viewed as independent of governments that are viewed as an antagonizing force.

Secondly, a centralized reporting system where organizations could report incidents of violence based on universally-accepted definitions could serve to prevent future attacks on healthcare workers. A few such initiatives exist, albeit in their juvenile stages, such as the United Nations Security Incident Reporting Service (SIRS), the World Vision sponsored Virtual Research Associates (VRA), and CARE's SIMS (23). This type of reporting system could integrate Geographical Information Systems (GIS) to map "hot spots" in real time and help coordinate the safe movement of personnel. It would also help identify the type

and amount of personnel and resources needed for an outreach program based on recent, localized security events. The system could also include micro-level information on the key players operating in a region so that relationships may be created, rekindled, or issues addressed as they arise. Nevertheless, such a comprehensive system is yet to be made available to the broader aid community.

NGOs and agencies should also reconsider the branding phenomena which permeates humanitarian culture. Depending on the context in which a program finds itself, this can put local and international aid-workers at great risk by groups that equate an organization's logo with foreign policy objectives (23). On the other hand, branding may confer a degree of safety upon organizations depending on their reputation and history among local populations. Regardless, these are considerations which should be assessed prior to an intervention and which should be malleable as per the environment, rather than dictated by donors who are often out of touch with the realities of the field.

Concluding remarks

It is clear that attacks against both medical and humanitarian workers, in general, pose a great risk to local populations who depend on their programs for survival. The 2012–3 attacks against polio vaccination workers in Pakistan alone left several million children unvaccinated and at risk of contracting the crippling virus. The onus is now on the aid community to reassess its role in the humanitarian sector and regain the legitimacy it once had as a neutral, independent, and impartial body aspiring to solely help those most affected by strife. Reducing dependence on governments for funds, security, logistics, and other resources would be a great starting point. The autonomy and independence provided by this would permit novel, and sometimes controversial initiatives (i.e. various harm reduction initiatives), be developed and rolled-out independent of government agendas, views, and intervention priorities. This would increase our ability to include and consult precisely those attacking our workers, and create partnerships where they currently do not exist. Aid should not have a predetermined agenda set by governments, and civilians should be able to clearly distinguish between military personnel, contractors, political authorities, and NGOs and UN agency staff (24). Until we do demarcate ourselves, however, we can expect continuance of attacks, abductions, and terminated programs that will ultimately affect the people who have the least to do with the wars which are fought.

Ethical issues
Not applicable.

Competing interests
The authors declare that they have no competing interests.

Authors' contributions
Both authors contributed equally to the drafting and revising the manuscript.

Authors' affiliations
¹School of Population and Public Health, Faculty of Medicine, University of British Columbia, Vancouver, BC, Canada. ²Regional Knowledge Hub, and WHO Collaborating Center for HIV Surveillance, Institute for Futures Studies in Health, Kerman University of Medical Sciences, Kerman, Iran.

References

1. Oxford Dictionaries [internet]. Oxford University Press. [cited 2013 Dec 10]. Available from: http://www.oxforddictionaries.com/definition/english/war

2. Levy BS, Sidel VW. *War and public health*. New York: Oxford University Press; 2008.

3. Lischer SK. Military intervention and the humanitarian "force multiplier". *Glob Gov Rev Multilateralism Int Organ* 2007; 13: 99–118.

4. Taipale I. *War or health?: A Reader*. New York: Zed Books; 2002.

5. De Torrente N. Humanitarian action under attack: reflections on the Iraq war. *Harv Hum Rts J* 2004; 17: 1.

6. Paust JJ. Legal Aspects of the My Lai Incident: A Response to Professor Rubin. *Rev* 1970; 50: 138.

7. Coupland R. Health Care in Danger: a sixteen country study [Internet]. International Committee of the Red Cross; 2011 [cited 2013 Dec 10]. Available from: http://www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf

8. Moulins C. Health Care in Danger: Violent Incidents Affecting Health Care [Internet]. International Committee of the Red Cross; 2012 [cited 2013 Dec 10]. Available from: http://www.icrc.org/eng/assets/files/reports/4050-002_violent-incidents-report_en_final.pdf

9. Major Attacks on Aid Workers: Summary Statistics (2003-2013) [Internet]. Humanitarian Outcomes; 2013 [cited 2013 Dec 10]. Available from: https://aidworkersecurity.org/incidents/report/summary

10. Kulish N. Doctors Without Borders to Pull Out of Somalia. The New York Times [serial on the internet]. 2013 Aug 14 [cited 2013 Dec 8]. Available from: http://www.nytimes.com/2013/08/15/world/africa/doctors-without-borders-to-pull-out-of-somalia.html

11. Hitchen L. Contract has not meant better care, say doctors. *BMJ* 2007; 334: 865.

12. Pedersen D. Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being. *Soc Sci Med* 2002; 55: 175–90.

13. Ghobarah HA, Huth P, Russett B. The post-war public health effects of civil conflict. *Soc Sci Med 2004*; 59: 869–84.

14. Coghlan B, Brennan RJ, Ngoy P, Dofara D, Otto B, Clements M, *et al.* Mortality in the Democratic Republic of Congo: a nationwide survey. *Lancet* 2006; 367: 44–51.

15. Coghlan B. An ongoing crisis [internet]. [cited 2013 Dec 13]; Available from: http://206.188.2.178/sites/default/files/migrated/resources/2007/2006-7_congomortalitysurvey.pdf

16. Brennan RJ, Nandy R. Complex humanitarian emergencies: a major global health challenge. *Emerg Med* 2001; 13: 147–56.

17. UNICEF. Water, Sanitation and Hygiene. 2012 annual report [Internet]. United Nations Children's Fund; 2013 [cited 2013 Dec 10]. Available from: http://www.unicef.org/wash/files/2012_WASH_Annual_Report_14August2013_eversion_%281%29.pdf

18. Democratic Republic of the Congo [Internet]. Action Against Hunger. [cited 2013 Dec 9]. Available from: http://www.actionagainsthunger.org/countries/africa/democratic-republic-congo

19. ICRC. ICRC 2012 Annual Report Volume 1 [Internet]. International Committee of the Red Cross; [cited 2013 Dec 10]. Available from: http://www.icrc.org/eng/assets/files/annual-report/icrc-annual-report-2012.pdf

20. Médecins Sans Frontières (MSF). International Activity Report 2012 [Internet]. Medecins Sans Frontieres; 2013 [cited 2013 Dec 10]. Available from: http://www.msf.org/international-activity-report-2012

21. UNHCR Syria Regional Refugee Response [Internet]. UNHCR Syria Regional Refugee Response. [cited 2013 Dec 13]. Available from: http://data.unhcr.org/syrianrefugees/regional.php

22. Stoddard A. Humanitarian NGOs: challenges and trends [internet]. 2009 [cited 2013 Dec 13]; Available from: http://dspace.cigilibrary.org/jspui/handle/123456789/22644

23. Stoddard A, Harmer A, Haver K, Overseas Development Institute. Providing aid in insecure environments: trends in policy and operations. London: Overseas Development Institute; 2006.

24. Abiew FK. Humanitarian Action under Fire: Reflections on the Role of NGOs in Conflict and Post-Conflict Situations. *Int Peacekeeping* 2012; 19: 203–16.