Don't Shoot the Ambulance: Medicine in the Crossfire

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PASCALE ZINTZEN/MSF

LANKIEN, South Sudan—The wounded started arriving in the evening. A rusted-out pick-up truck dropped off four young men with gunshot wounds, two with life-threatening wounds to the abdomen and the others with leg injuries, at the 100-bed Médecins Sans Frontières (MSF) hospital here. Just hours earlier, the hospital's team and local residents had been playing volleyball as the sun began to set on a 106-degree day.

But things change quickly in the northern reaches of South Sudan's Jonglei state, which, for the past decade now, has been the scene of increasingly deadly intercommunal fighting among the state's three main tribes—the Dinka, Murle, and Lou Nuer. It is also home to the first homegrown insurgency since South Sudan was born two years ago following a devastating civil war.

Sorting out the various parties can be dizzying. The men who arrived on this night had been wounded during fighting between two clans of the Nuer tribe. The injured included young men from both sides of the fight. While trying to stabilize the patients, the medical team quickly had to sort out their clan affiliation and separate them into different wards. The medical team leader Abdul Wasay, an Afghan nurse and former refugee, immediately changed the rules for visiting hours and the number of caretakers permitted to enter the inpatient department, a structure consisting of four concrete walls, a wood door, and corrugated steel roof. He restricted access to the wards with the wounded patients to one female caretaker per patient. Even with these changes, the South Sudanese staff felt it was necessary to search all men and women entering the inpatient care area for any kind of weapons. Women have been known to smuggle in weapons to settle scores.

The hospital in Lankien does not offer surgical services. The four wounded patients would have to be evacuated to another facility, in Nasir, Upper Nile state, where they could be operated on. The evacuation of the patients could also help defuse any tensions building in the community over this latest bout of fighting. But it would be at least another 12 hours before the single-engine Cessna would arrive to evacuate the patients since the planes do not land at night—hence Abdul Wasay's precautions.

This episode illustrates something of great importance to medical organizations working around the world. In South Sudan, like many of today's most violent conflicts, the fighting rarely stops at the hospital gates. Medical facilities and ambulances are often an extension of the battlefield, targeted just as military installations would be. Health workers not only here, but also in war zones as diverse as Afghanistan, the Democratic Republic of Congo, Syria, and Pakistan are frequently threatened or killed. The reasons can range—often with motives that are somewhat opaque—from classic conflicts to inter-tribal or ethnic rifts to battles over resources. These grave abuses of medicine raise serious challenges for all organizations seeking to deal with them, from the local to the international level.

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MEDICAL SECURITY

In many conflict zones, attacks on medical functions are part and parcel of a wider assault on civilians, while in others violence directed at medical facilities and staff are used to achieve a military advantage. Regardless of motives, combatants routinely fail to respect the ethical duty of health professionals to provide care to patients irrespective of political, religious, ethnic, or other interests.

In an age of asymmetric warfare and increasingly complex internal conflicts involving fragmented armed groups, who hold a tenuous monopoly on violence and often have weak chains of command, negotiating even the most basic acceptance and protection of medical staff, patients, and facilities in these environments is a frighteningly difficult challenge. Many armed groups and national armies ignore international humanitarian law, which makes it even harder to create a safe space to deliver medical care.

In other conflicts, the hospital has become part of the battlefield, more as an afterthought than as the main theatre of war. Medical organizations often face a complete ignorance of humanitarian law by the groups posing the gravest threats. It is incumbent upon medical organizations to play a role in building an understanding among armed groups of these principles and the importance of accepting the provision of impartial health care to all sides. Often the scope of the problem—even the nature of the threat—is poorly understood, given the weak reporting of incidents at national and international levels. Yet organizations operating in these zones must learn the power dynamics in place and leverage social, cultural, or religious norms, which can vary widely from one town to the next, let alone country to country. Only by accumulating such a base of knowledge can health care providers be in a position to navigate and dampen potential dangers for their staff, facilities, and patients.

At the same time, it is the responsibility of all armed groups—state and nonstate alike—to respect the safety of medical facilities and vehicles, health workers, and patients. Yet, many of today's most devastating conflicts have illustrated that these fundamental principles of international humanitarian law are being systematically ignored, resulting in populations being largely cut off from access to health care. The threats and attacks are coming not only from armed groups like the Taliban, Al Qaeda, and Congolese rebels, but also NATO, UN, and U.S. forces. By negotiating, though, with all warring parties, health care providers can succeed in keeping weapons and violence out of their hospitals. Only then will people in need of medical assistance feel secure enough to enter the health facilities, transformed into neutral, conflict-free zones, free from attack by all sides.

MEDICAL STAFF, PATIENTS, AND FACILITIES HAVE REGULARLY BEEN CAUGHT IN THE CROSSFIRE OF INTERCOMMUNAL VIOLENCE.

While negotiating with all sides and demonstrating medical impartiality by treating anyone who comes to the emergency room is critical, this hasn't been enough in many conflict zones today. From Syria to South Sudan, medical facilities and staff are being targeted for what they appear to represent—assistance for the "enemy." In the face of total war scenarios, medics on the frontlines can do little to stop the violence, regardless

of their adherence to principles of medical ethics. The burden truly falls on those responsible for these abuses. And there is complicity in these abuses on all sides in a wide range of conflicts.

HOSPITALS: FIGHTING-FREE ZONES

As the sun came up the next morning in Lankien, the news spread quickly among the hospital staff that the most seriously wounded young man—or boy, really, as he was just 14 years old—died around midnight. The second young man passed away a few hours later due to internal bleeding. They had been on opposite sides of the fighting. The local staff was restless, though, as the equal casualties on both sides did not dampen the prospects of a revenge attack inside the hospital.

Wasay, as medical team leader, crossed the dirt road from the hospital to the local commissioner's office to seek intelligence about any potential threats of violence that might be directed at the hospital and whether the fighting in outlying towns had the potential of spreading to Lankien. The neatly dressed commissioner sat behind his bare desk listening intently to Wasay and agreed to do his best to reinforce the message with the community that the hospital was treating anyone, regardless of tribal or clan affiliation, and that no one could bring weapons inside. MSF does not use any armed guards.

Wide acceptance of the principles of independence, impartiality, and neutrality are the organization's main means of protecting its facilities and staff. But in intercommunal conflicts, like those found in Jonglei state, where the principles of international humanitarian law are less understood, it is critical for medical organizations to work with all armed groups and communities to build a respect for the safety of medical facilities and staff by garnering acceptance for the need of all sides to access health care.

An anxious local intelligence officer, standing to the commissioner's left, offered to have his men check out the landing strip prior to the departure of the other wounded patients. The commissioner also agreed to provide a police escort for the mother of one of the casualties to bring the body to her village for burial. She was too afraid to leave the hospital on her own. A little past noon, radio confirmation came that an aircraft was approaching to evacuate the wounded. The entire town poured out onto the periphery of the landing strip that had been carved out of the bush. Hospital staff lined the several thousand yards of dirt to prevent children and cattle from crossing in front of the plane as it made its final approach to land. Wasay led the patients, carried on stretchers and in wheel chairs, the 500 yards from the hospital entrance to the strip. Among them were the two surviving wounded young men, a boy with a broken leg, and a pregnant woman with complications.

Just as the plane landed and the patients were brought onto the landing strip to be loaded, a tall young man edged toward the medical team with a barely concealed knife. Several local staff approached him and inquired about what he needed. The man tried to explain he was the brother of one of the wounded men being put on the plane and wanted to wish him well. After some tense moments, he finally relented and left.

As the plane took off, a call came through to Wasay on the satellite phone. Nine more wounded were on their way to the hospital from another round of fighting. The medical team would have to replay the scenario over again.

PART OF THE BATTLEFIELD

Unfortunately, South Sudan, both before and after the North-South civil war, has a long history of violence targeting medical facilities, health workers, patients, and medical vehicles. It is impossible to tell whether the problem is worse now than during the height of the conflict. The current trajectory is certainly not reassuring.

In 2007, MSF had a serious incident where several Murle patients and staff referred to a hospital in the state capital, Bor, a largely Dinka area, were killed inside the grounds of its compound as retribution for intercommunal violence. Since then, its medical facilities have been destroyed or looted numerous times. The perpetrators of these attacks have openly admitted the reason for targeting these facilities is a means to deny access to health care for the community. In this context, the destruction of medical services has become both a weapon and a tactic of war.

The threats to medical facilities, staff, and patients are far from isolated to Jonglei state. In April, in Eastern Equatoria's Budi County, South Sudan government forces (SPLA), dispatched to apprehend cattle rustlers, ended up getting into an armed confrontation with the local community, resulting in the killing of an unknown number of civilians and the looting and burning of entire villages. In the midst of the fighting, David Nailo Mayo, a member of parliament, later told a South Sudanese newspaper, "A medical doctor was dragged out of a hospital and killed in front of the hospital. Another two medical staff were also killed ... and a patient was also killed. In the hospital alone, four were killed before the soldiers set fire to the hospital." The incident demonstrates the dangers posed to medical staff and facilities anywhere in the country.

While medical staff, patients, and facilities have regularly been caught in the crossfire of intercommunal violence, some of the gravest abuses recently have come amid South Sudan's first internal conflict since independence. In southern Jonglei state's Pibor County, the SPLA is fighting the Yau Yau militia, a group calling on the government of South Sudan to address allegations of corruption and meet the needs of the largely marginalized Murle population from which it draws most of its fighters. Starting in March 2013, the frontline moved to less than half a mile from the gates of the MSF hospital. A major escalation in the combat between SPLA and Yau Yau resulted in heavy casualties on the government side. The fighting was so close that the wounded started pouring into the hospital with dirt still in their wounds. The medical team working in Pibor—with the support of a surgical team from the International Committee of the Red Cross (ICRC)—treated 123 war-wounded patients, including 105 SPLA soldiers.

> THE LOU NUER AND MURLE HAVE DESTROYED HEALTH FACILITIES SO THE OTHER SIDE COULDN'T ACCESS THEM.

This surge in admissions of SPLA war wounded coincided with a complete breakdown in the respect of combatants for the impartiality and neutrality of the medical team and other patients in the facility. International medical professionals spend a great deal of time in South Sudan (and most places where we work) explaining our intentions and approach, which is based on our sense of medical ethics and international humanitarian law. These both dic-

JASON CONE/MSF

tate that once a fighter is wounded, and if he or she is seeking medical care and not attempting to return to the battlefield in that moment, he or she must be treated and protected.

Throughout tense weeks during the Yau Yau-SPLA clashes, though, the medical staff was threatened, and patients were interrogated at night by wounded SPLA soldiers who were suspicious of anyone with gunshot wounds. Soldiers entered the hospital, sometimes with their weapons, a violation of our principles of not allowing weapons into medical facilities. The soldiers often demanded their comrades be treated first, regardless of the severity of other patients, creating both safety concerns and medical ethical problems for the staff.

A rocket-propelled grenade was fired over the top of the medical compound. And at one point, ex-combatants even left their beds to rejoin the battlefield, firing their weapons from just outside the hospital grounds, effectively militarizing the hospital and making it a viable target under international humanitarian law for the militia. The hospital was now a part of the battlefield.

CLEAR & PRESENT DANGERS

Besides the obvious dangers to the hospital staff and other patients, the degradation of respect for the neutrality and impartiality of the Pibor hospital staff and medical facility over the months of January, February, and March had a significant impact on the provision of medical care to the local population. During this period, the medical team saw a

50 percent reduction in inpatient consultations from that of previous months.

The proportion of consultations swung dramatically from February to March, from malaria cases to almost exclusively trauma-related cases. In the maternity ward, deliveries dropped from 42 in January to 22 the next month to only 11 in March. Too afraid to come to the hospital, pregnant women were left to manage any complications during delivery at home. The same situation played out for the outpatient therapeutic feeding program for malnourished children. Patient numbers dropped from 43 to 22 to eight, while the rate of people who did not finish their treatment rose month-to-month from 27 percent to 44 percent to 65 percent. The change in the environment in the hospital had a direct impact on access to medical care for a population totally dependent on this single facility.

Then, in late April, the medical team running the hospital in Pibor was threatened by armed men seeking food in the middle of the night. Clearly no longer possible to ensure a basic level of safety for our staff, the hospital operations were suspended and the team evacuated to the capital, Juba. Three weeks later, SPLA soldiers systematically looted the hospital as they withdrew from the territory, tearing open pill bottles and scattering medicines around the hospital grounds. An estimated 120,000 Murle lost their only access to medical care at the height of the rainy season with malaria outbreaks on the horizon. Though not customarily counted as such, these people became, in essence, casualties of war.

One of the challenges for medical teams in such an environment is finding a way to analyze the intent behind these attacks in order to see if there are any actions that can be taken to protect themselves and their patients. There is a substantial difference between looting medical facilities for financial reasons and attacking the same facility because of what it represents to a population in conflict. Motives matter, even if it is very difficult to determine intent with any confidence. The decision to restart medical programs that have been suspended often depends on some combination of how intentional the previous attacks were—whether medical workers and facilities were directly and intentionally targeted—and the extent of the remaining threat of future violence.

ABUSES OF MEDICAL PRACTICES HAVE BREACHED THE TRUST OF PATIENTS WHO HAVE FOUND THEMSELVES UNDER ATTACK SIMPLY FOR SEEKING CARE.

The Lou Nuer and Murle have destroyed health facilities so the other side couldn't access them. Yet, raiding parties on both sides rarely seek to hold and maintain territory, so medical structures can be rebuilt and health staff can return to restart services deep inside territories controlled by each tribe. Of course, the killing of women, children, and men during the attacks overshadows any potential loss of life from short-term denial of medical services. But the pervasiveness of the threat to patients represented by the presence of SPLA soldiers in and around the main medical facilities in Pibor County has had the effect of depriving huge segments of the Murle population of any access to health care.

Even in the same geographic region the motivations for attacks on medical care are vastly different, and the means and strategies by which organizations may counteract or prevent these abuses are also varied.

GENEVA CONVENTION

Attacks targeting medical facilities, staff, and patients are nothing new. There is extensive documentation of medical facilities being bombed and wounded combatants being used as human shields dating back to the American Revolution and earlier. The first Red Cross Committee was founded by Henri Dunant, a Swiss businessman, after he witnessed the aftermath of the Battle of Solferino in Italy in 1859. His book inspired the creation of the ICRC in 1863—a copy of the first edition still stands in the entrance of its Geneva headquarters—and a year later, the 1864 Geneva Convention regulated the fate and care of the sick and dead left on the battlefields of war.

SOLDIERS SEARCHED THE HOSPITAL, FORCED BEDRIDDEN PATIENTS OUT OF ROOMS, EVEN TIED UP STAFF AND VISITORS.

It wasn't until after World War II in the Fourth Geneva Convention of 1949 and the first additional protocol of 1977 that international law was extended and strengthened to protect all wounded and sick, as well as civilian medical activities, facilities, and personnel. This protection also covered these groups in civil and internal conflicts. Today, these laws no longer distinguish civilian from combatant when treating the wounded and sick—to avoid debate and problems regarding the status of some members of non-state armed groups or cases of civilians who take direct part in hostilities. International humanitarian law states that medical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. This protection also encompasses medical transports, such as ambulances. But medical personnel, facilities, and transports lose their protection if they commit, outside their humanitarian function, acts harmful to an enemy. This is where the burden to respect the principles of neutrality, impartiality, and medical ethics falls not only on the shoulders of doctors and nurses, but also on combatants, non-state and state actors alike.

Furthermore, the additional protocols to the Geneva Conventions forbid the punishment of medical personnel for adherence to the profession's ethical standards and ban compelling health providers from engaging in acts that are inconsistent with medical ethics.

MEDICAL CAMOUFLAGE

Behind the documentation of incidents targeting medical facilities and transports, staff, and patients, is an effort to understand the collateral damage of these attacks—the loss of health services to communities and population who otherwise have nowhere else to turn.

Using medical aid as a camouflage for military advantage threatens the lives of patients in the most precarious corners of the world. Providing health care to people in volatile and often remote areas requires painstaking daily work to gain their trust and prove one's independence and impartiality from highly politicized conflicts. All this work can be easily undone by states' misuse of medical activities and facilities for intelligence gathering—at a high cost of civilian lives and health. Once the slightest suspicion arises that a medical activity, like a vaccination campaign, may have motives beyond the provision of health care, the activity itself, and the people who carry it out, are put at risk.

In countries like Pakistan, humanitarian aid organizations have struggled to

gain access and acceptance within communities already skeptical of the motives of any outside assistance. Armed groups—state and non-state—have used any shift in the motives of aid organizations as a reason to deny access to locals. In 2011, the U.S. government is said to have employed a fake vaccination program in the search of Osama bin Laden. The damage was almost immediate and will be long lasting. Two years later, militant groups are still using this incident as justification for killing polio vaccinators in Pakistan and Nigeria, some of the last remaining bastions of this paralyzing virus.

Beyond Pakistan, similar abuses of medical practices have breached the trust of patients who have found themselves under attack simply for seeking care. In October 2009, hundreds of women and children who had gathered for a vaccination campaign in the Democratic Republic of Congo's North Kivu province came under fire in seven separate villages during attacks by the Congolese Army against the Forces Démocratiques de Libération du Rwanda (FDLR). These attacks occurred just after the medical teams had received security guarantees from all parties involved in the conflict to carry out the campaign in these areas, which were otherwise inaccessible to the national ministry of health.

This use of medical aid as bait for military purposes shattered the trust of patients in health services, causing only more suffering for people already confronted with violence and displacement. They didn't get their vaccinations then, and, given what transpired, they could be forgiven for thinking the next campaign was little more than a ruse.

The trust of patients in health facilities was also undermined in Bahrain in April 2011, when government forces used medical facilities to arrest and crack down on protesters, making those wounded during clashes too afraid to seek treatment. As the hospital became a military target, and the health system a tool for the security apparatus, patients could no longer realize their right to treatment in a safe environment, and medical staff could no longer fulfill their primary duty of providing health care regardless of patients' political affiliations.

Meanwhile in Dinsor, Somalia, in 2006, Ethiopian military forces, after taking control of the town, entered an MSF hospital and forced the local staff to hand over confidential medical records. The facility had been treating patients on all sides of the fighting in the region. This was a clear violation of international humanitarian law.

A BELLIGERENT ASSET

At the heart of counterinsurgency tactics has been competition for support of local populations, and nowhere has this been clearer than in Afghanistan. Throughout the presence of U.S. and NATO forces since the 9/11 attacks, the provision (or denial) of health services has been a key asset for all belligerents in the conflict. The lack of respect for health care workers and facilities shown by all of these belligerents has had deadly consequences. Hospitals, clinics, and medical personnel have been targeted by armed opposition groups like the Taliban, while Afghan government and international forces have repeatedly raided and occupied health structures.

In May 2009, a clinic in Nadir Shah Khot in Khost was destroyed and staff threatened by an armed group, and in November suspected militants burned a health clinic to the ground in the Daman district of southern Kandahar province. Armed opposition groups have also been linked to the murders, attacks, and abduction of aid

UNITED NATIONS

workers, including an increasing use of improvised explosive devices (IEDs).

Armed opposition groups aren't the only ones abusing health care. In late August 2009, Afghan and NATO forces raided a clinic in Paktika following reports of an opposition commander being treated inside, killing 12 insurgents with the support of helicopters firing at the building. One week later, U.S. forces raided a hospital supported by the Swedish Committee for Afghanistan in Wardak Province. Soldiers searched the hospital, forced bedridden patients out of rooms, even tied up staff and visitors. On their way out, they ordered the staff to report admissions of any suspected insurgents to the coalition forces. That same month, the director of Helmand Province's health department denounced the occupation of a clinic by Afghan and U.S. forces in Mianposhta saying, "People are scared and do not want to go to this clinic." The clinic was eventually closed.

It is important to note that medical facilities have been respected in some Taliban-controlled areas of the country. Yet because hospitals and clinics have been at the heart of coalition campaigns for hearts and minds in Afghanistan—and therefore symbols of the "opposition" rather than neutral and impartial centers for care of the sick and wounded—medical care has been part of the battle space, to varying degrees, throughout the conflict.

SYRIA: HUNTING DOCS

Perhaps no contemporary conflict has featured such concerted and sustained attacks against health care facilities as the one continuing to unfold in Syria. The country experienced its first major protests on March 15, 2011, in the town of Damas. As the weeks wore on, the number of protesters multiplied, but they soon found themselves under fire as security forces attempted to quell the then-peaceful uprising. Injured activists assumed that they could seek care at public or private hospitals should they need it, as health structures had the technical means, expertise, and resources necessary to treat trauma. After all, Syria's health care system had once functioned at a high standard. Yet health care has morphed from a system meant to heal to a central part of the government's strategy to repress any opposition.

Accounts from doctors and patients reveal that hospitals are being scrutinized by the security forces, and that people are being arrested and tortured inside them. Doctors risk being labeled "enemies of the regime" for treating the injured, which could lead to their arrest, imprisonment, torture, or even death. People hurt at protests therefore have stopped going to public hospitals with similar fears of being tortured, arrested, or refused care, and are

essentially forced to entrust their health to clandestine networks of medical workers.

In Deraa, Homs, Hama, and Damascus, medical care is still provided out of public view. Makeshift hospitals have been set up inside homes near protest sites. Health centers treating the injured provide false official diagnoses to hide the fact they are treating people wounded at demonstrations. The major concern for doctors working in these underground networks is their safety.

As fighting began and later intensified, a rising number of medical facilities have been affected. In July 2011, the Syrian army deployed tanks in the city of Homs. In February 2012, the city was under constant attack by snipers, shelling, and aerial bombing by the government's air force. Aid efforts have continued clandestinely, however, with medics working to treat the injured even as bombs rain down around them. The authorities still refuse to allow international humanitarian aid into the country. A ceasefire to evacuate the wounded has also been rejected.

A handful of makeshift hospitals provide health care close to the conflict zones—set up in caves, individual homes, farms, and even in underground bunkers. Following initial treatment and stabilization, patients are transferred to hospitals in safer locations.

As the repression of peaceful protests became a clear government policy, the opposition took up arms, eventually beginning to take control of certain areas, which spurred the conflict into even more brutal territory. Again, the health sector has been gravely affected. Medical structures are still being targeted and destroyed while health care workers are threatened or killed. Providing medical care has been transformed into an act of resistance, a crime, as medical structures become military targets.

In July 2012, a new front opened in Aleppo. The economic capital of the country was ravaged by aerial bombardments and ground fighting. Buildings, including medical facilities, were decimated. The blood bank supplying the region's hospitals was among the first to go up in smoke. Dar El Shifa, the largest private hospital in Aleppo, was situated in an opposition-controlled area in the east of the city. It provided care for victims of violence until it was bombed during an air raid that August. Although the operating theater was destroyed, the emergency ward continued to operate and saw about 200 people per day. But in late November, it, too, was demolished by bombing and rendered inoperable.

THE PRIMARY RESPONSIBILITY TO STOP THE TARGETING, OBSTRUCTION, OR ABUSE OF MEDICAL SERVICES LIES WITH STATES AND PARTIES ENGAGED IN CONFLICT.

Opposition military bases have been established close to some makeshift hospitals—even, in some cases, in the same building. These hospitals are at serious risk of being caught in the middle of fighting, or even directly hit in an attack. According to Syrian authorities, of 91 public hospitals across the country, 55 have been affected, of which 20 have been damaged, and 35 are out of service, as of June 2013. For a complete picture of the devastation, though, makeshift hospitals set up by the opposition and subsequently destroyed by the army should also be added to the tally.

SCALE

Attacks on the medical mission—the entire set of medical activities aimed at the civil-

ian population, as well as the wounded and sick—have been a striking feature of recent conflicts in Afghanistan, Bahrain, the Democratic Republic of Congo, Pakistan, Syria, and Yemen just to name a few, and these incidents vary significantly not only from country to country, but also within borders.

Yet, there is very little analysis of the scope of the problem today. The ICRC, through its Health Care in Danger project, has been trying to fill this void. The ICRC data from 2012 shows that more than 80 percent of some 900 violent incidents recorded in 22 countries affect local health workers. In some cases, secondary attacks are launched to target first responders. These incidents involved the use or threat of violence against health care personnel, the wounded and the sick, health care facilities and medical vehicles.

The ICRC analysis also found:

- International health care providers account for 7 percent of the cases.
- State security forces and armed non-state actors are responsible for a large proportion of the incidents. The proportion of acts or threats of violence attributed to armed non-state actors or to state security forces varies significantly.
- Health care staff (doctors, nurses, and paramedics) accounted for about 60 percent of those directly affected.

Last year, the World Health Assembly—the governing body of the World Health Organization—adopted a resolution calling on the agency "to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies." The goal of all such studies is to close the information gap on the medical impact of attacks on health care and understand where the problem is most acute. And then, once we understand the scale of the problem, the next step is to act on this data.

Understanding the frequency and severity of attacks also allows medical organizations – national and international – to engage those responsible in a dialogue. This is what MSF did in a number of regional conferences over the past year in Yemen by bringing together representatives from armed groups, government officials, religious leaders, medical practitioners, and other elements of civil society to seek a consensus around the need to protect medical activities. There was broad recognition among the participants that violence plays a significant role in deterring patients from accessing care. But the exact impact of violence on civilians seeking out health care was not fully analyzed.

The reality in Yemen is that violence has long been a deeply engrained part of the social and political fabric, requiring extensive networking by medical organizations among diverse armed groups, and religious and community leaders. In Mexico, the ICRC convened 45 experts from 21 countries to discuss new procedures for dealing with ambulance services—to allow them safe passage through armed check points and front lines.

WHERE WE GO

The collateral damage of attacks on patients, wounded, sick, personnel, ambulances, and medical structures extends far beyond those injured from these violent abuses. These incidents have the power to create "deserts" in terms of access to health care in many of today's bloodiest conflicts.

While it is difficult to ascertain the scale of this phenomenon, the real challenge is to find ways to prevent these acts from happening. The primary responsibility to

stop the targeting, obstruction, or abuse of medical services lies with states and parties engaged in conflict. Health workers must be supported in carrying out their medical duties. States must ensure that all possible measures are taken to protect medical action through national legislation and that these measures are implemented.

States and non-state actors alike must implement and respect weapons-free policies within health premises; abstain from using force against demilitarized health or humanitarian structures, vehicles, and premises; and commit not to arrest or seek information from patients during their stay in medical facilities.

When armed teams provide security or medical aid to win "hearts and minds," or hospitals are militarized, the results can be potentially lethal for patients and health care workers. When some schools, health facilities, or aid convoys become militarized by one side, they all become potential targets for the other side. All belligerents must make a commitment to recognize health structures and ambulances as "demilitarized sanctuaries," and thereby off-limits from combat, police, and intelligence operations. And such commitments must be implemented at the very outset of any conflict.

Rhetoric is also critical. It is essential that states and non-state actors in their public discourse and modes of military deployment maintain an explicit distinction between partisan deliverers of relief and impartial humanitarian actors. Mixing motives for providing aid is a slippery slope that undermines the acceptance of the entire spectrum of medical assistance. Furthermore, medical and humanitarian organizations have a responsibility to remain true to their principles and not allow the politicization of their services.

But attacks on medical care won't always fall into neat categories. Medical aid organizations must continually analyze risks and threats to ensure, while adhering to the fundamentals of medical ethics, that they are aware of social, economic, and power dynamics afoot in the terrain where they are operational. Recent years have shown a propensity for states—even those that have served as the very architects of the laws of war—and non-state actors to ignore the need for even the most basic respect for the practice of medicine and right to medical care in conflict areas. The protection of the sick and wounded lies at the heart of the Geneva Conventions. It is incumbent upon medical aid organizations to find a means of negotiating safe space for their staff and patients.

Violence in all its forms—against health facilities and personnel—represents one of the most serious, complicated, and neglected contemporary humanitarian and security issues. The medical act benefits everyone, and anyone in need should be able to access it unconditionally. ●