



Aid Worker Security Report 2020

Contending with threats to humanitarian health workers in the age of epidemics

Humanitarian Outcomes

Summary of key findings

- ▶ Casualties in 2019 exceeded all past years recorded in the Aid Worker Security Database (AWSDB): 483 aid workers were attacked in 277 separate incidents.
- ▶ Victims comprised 125 aid workers who were killed, 234 wounded, and 124 kidnapped.
- ▶ Syria, for the first time, was the country where the most major attacks took place. The other highest incident countries were South Sudan, Democratic Republic of Congo (DRC), Afghanistan, and Central African Republic.
- ▶ Humanitarian health workers made up a disproportionate 42% of aid worker fatalities in 2019—higher than any previous year recorded.
- ▶ Health workers in humanitarian aid face a unique constellation of risks regarding both the potential perpetrators of violence (patients, families, community members) and the context/location of attacks (greater exposure to airstrikes and to targeted attacks on facilities).
- ▶ In DRC, 15 of 27 reported attacks were committed against health workers responding to Ebola, and of these, a third were committed by community members.
- ▶ People's fears of disease and mistrust of responders are often stoked and manipulated by armed groups and other political actors.
- ▶ Aid organisations' communication failures with communities created some of the risk to Ebola responders in DRC, reflecting some key lessons not learned from the West Africa outbreak six years ago.
- ▶ Successful programming methods and sound risk management for humanitarian health workers are tightly intertwined. Both require direct communication with the communities in their local languages and a collaborative approach to containment/treatment options, as well as multipronged efforts to identify and correct rumours and misinformation.

Introduction

Table 1: Major attacks on aid workers: Summary statistics, 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Number of incidents	130	152	170	265	192	149	163	158	228	277
Total aid worker victims	250	311	277	475	332	289	295	313	408	483
Total killed	73	86	71	160	123	111	108	139	131	125
Total wounded	84	127	115	179	88	109	99	102	146	234
Total kidnapped*	93	98	91	136	121	69	88	72	131	124
National staff	209	282	228	415	300	260	252	285	379	456
International staff	41	29	49	60	32	29	43	28	29	27
UN humanitarian staff	44	91	57	106	66	43	71	48	69	39
National NGOs and Red Cross/Crescent Societies	47	77	93	167	74	49	48	115	138	170
International NGO staff	149	135	97	142	152	173	159	98	183	260
ICRC staff	10	5	3	20	23	6	11	42	13	2

*Survivors.

The provision and protection of health care in conflicts is foundational to international humanitarian law (IHL), and in every humanitarian emergency, health workers represent a vital cadre of responders. Yet flagrant violations of these protections and commitments continue in war zones, and health workers can face threats not just from armed actors, but from aid recipients and their communities acting out of fear, misperception, or grievance.

Recent surges in attacks against health personnel, from ‘double-tap’ strikes on medics in Syria to assaults and shootings of Ebola workers in Democratic Republic of Congo (DRC), helped make 2019 the worst year on record for aid worker casualties. This year’s Aid Worker Security Report therefore focuses on humanitarians working in the health sector. We examine the data on attacks against health workers and discuss how the humanitarian sector is dealing with the new risks and disruptions caused by major epidemics occurring in contexts of broader complex emergency.

Research on violence against health workers by the International Committee of the Red Cross (ICRC)’s Health Care in Danger, the Safeguarding Health Coalition, and other initiatives have shone a light on this issue and driven important advocacy efforts. This report aims to complement the existing research with findings from the AWSD data (which tracks the violence against health care workers within specific emergency responses) and from the standpoint of humanitarian operational risk management.

After a global update of trends in attacks against humanitarian aid workers in Section 1, this report analyses: the current state of data on health workers affected by violence; recent incidents and new threats; and the security risk management responses by humanitarian organisations. We are grateful to the 16 humanitarian and global public health professionals who contributed their time to be interviewed for this research.¹

¹ As in past Aid Worker Security reports, interviewees are anonymous.

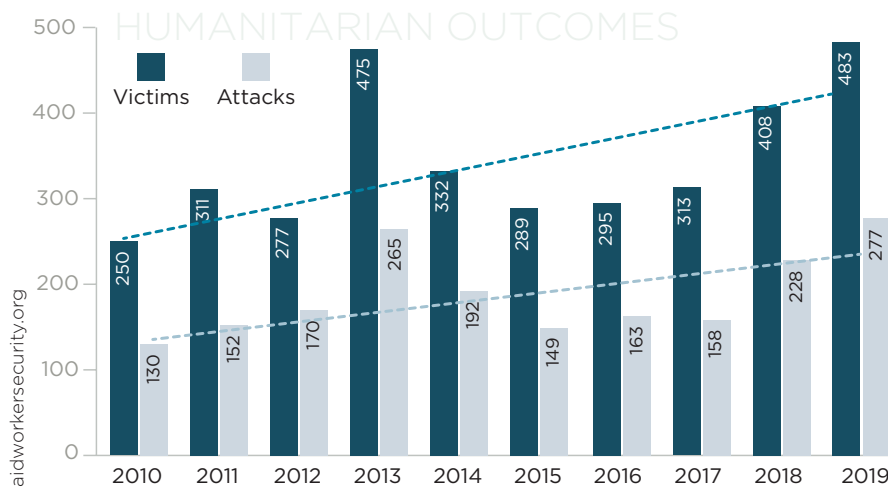
1 Aid worker attacks: Latest statistics

1.1 Global totals

2019 surpassed all previous recorded years in terms of the number of major attacks committed against aid workers. A total of 483 aid workers were killed, kidnapped, or wounded in 277 separate incidents of violence. Despite the higher number of total casualties, however, there were slightly fewer fatalities. In 2018, 131 aid workers lost their lives in attacks, as compared to 125 in 2019.

Prior to 2019, the previous peak in recorded violence against aid workers was in 2013, when armed conflicts escalated in both South Sudan and Syria, and as kidnappings in Afghanistan surged.

Figure 1: Major security incidents, 2010-2019



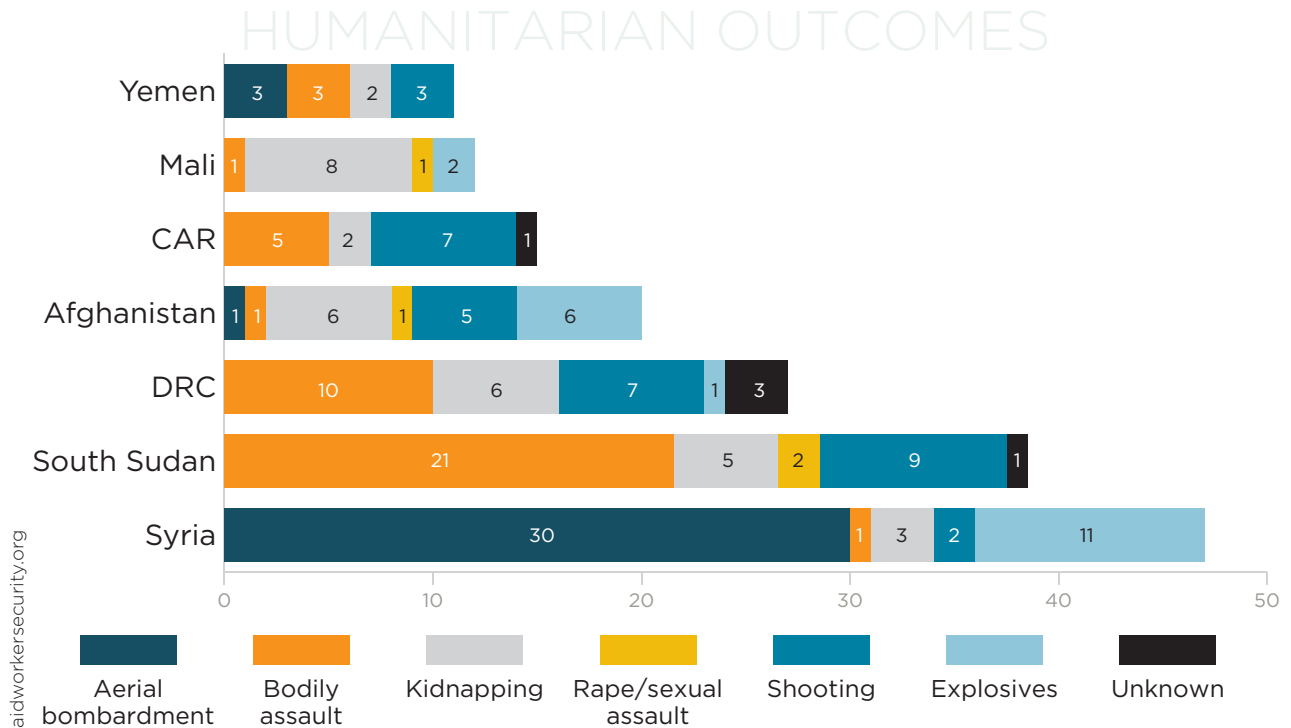
1.2 Country contexts and tactics

Thanks to a decline in incidents in South Sudan, Syria for the first time topped the list as the country with the highest number of attacks (47) as well as being the most lethal context for aid workers. There were 36 aid worker fatalities recorded in Syria, mostly caused by airstrikes, shelling, and other explosives used in the ongoing civil war.

The next highest incident contexts after Syria were, in descending order, South Sudan, DRC, Afghanistan, and Central African Republic (CAR). These were the same top five most dangerous contexts that accounted for over 60 per cent of all incidents worldwide in 2018, but in 2019 they were joined by Yemen and Mali, both of which saw a doubling of major attacks from the previous year (Figure 2).

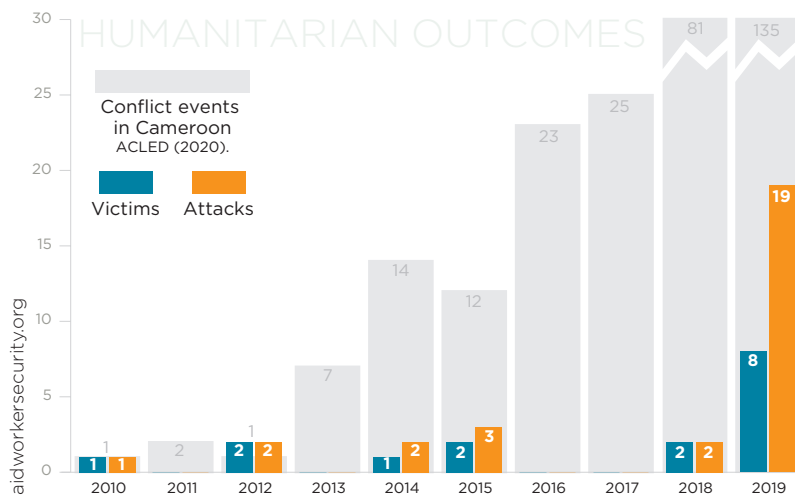
Adding to the spike in violence totals, attacks also occurred in a greater number of country contexts in 2019 (41) than in 2018 (35).

Figure 2: Highest incident contexts with types of attack, 2019



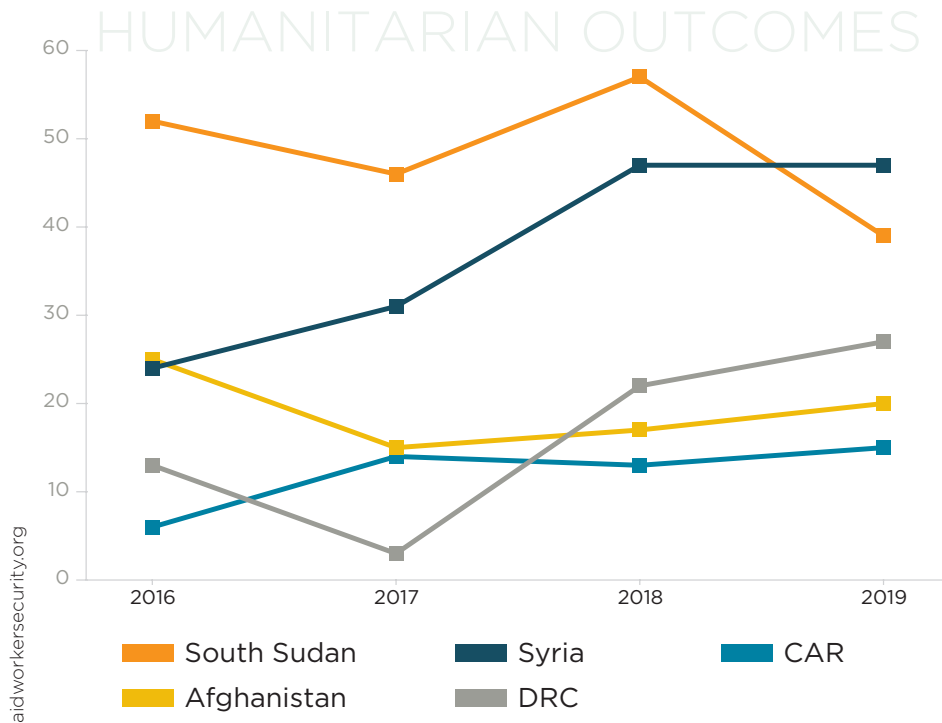
While not reaching the levels of violence seen in the above countries, Cameroon also saw a sudden spike in attacks affecting aid workers, reflecting increased insecurity and violence as Boko Haram and separatist forces began escalating hostilities in 2018. In most cases, the incidents involved aid workers being ambushed and taken hostage by armed groups while trying to transport relief supplies. Such attacks provide two relatively easy sources of revenue for non-state armed actors, and raise the spectre of ransoms and lootings of aid operations adding fuel to the conflict itself.

Figure 3: Growing conflict and aid worker attacks in Cameroon



The security situation remained unstable in CAR and Afghanistan, both of which experienced slight increases in violent incidents during 2019. South Sudan, which has had the highest number of incidents in each of the preceding five years, saw a decrease in aid worker attacks in 2019 as it continues to transition out of the violent civil conflict that began in 2013.

Figure 4: Attacks in high-incident contexts, 2016-2019



Of all the high-incident contexts, the number of attacks increased most steeply in DRC, primarily driven by violence against health workers responding to the Ebola outbreak in the northeast of the country, which started in August 2018.² What is different about the attacks against health workers in humanitarian contexts, specifically against those working to contain deadly diseases, is that the attackers are often aid recipients as well as armed groups. The remainder of this report explores the causes and consequences of this type of violence, as well as the more ‘traditional’ attacks against health personnel and facilities by conflict actors in violation of IHL.

² The last two years have seen two separate outbreaks of Ebola in DRC—the tenth and eleventh outbreaks of the highly contagious and fatal disease suffered by the country in 40 years. The August 2018 outbreak was more serious and sustained than the latter, which occurred in Equateur province. Both were declared over on 25 June 2020 (See: www.msf.org/drc-ebola-outbreak-crisis-update).

2.1 Available data and its limitations

The Aid Worker Security Database records major attacks against humanitarian workers, with data going back to 1997, when violent incidents first started to be systematically reported by aid organisations. Healthcare is only one of the operational sectors of humanitarian assistance, so the victims identified as health workers comprise a subset of the database population. But in reviewing the incident reports, we were able to identify the attacks that specifically affected health workers, i.e. the staff of humanitarian organisations engaged in medical or health assistance, or the staff of public health facilities that are supported by humanitarian actors such as the World Health Organization (WHO), UNICEF, or other, which are counted in the aid worker attack statistics.

For all years of verified data (1997-2019), the AWSD records 423 major attacks on health programmes, transport, or facilities. These attacks affected 808 victims identified as health workers, either working in public health systems involved in, or supported by, the humanitarian response or staff of NGOs engaged in health or medical programming (Table 2). For all years, these humanitarian health workers (HHWs) comprise roughly 15 per cent of total aid workers affected by major violence.

Table 2: Victims 1997-2019

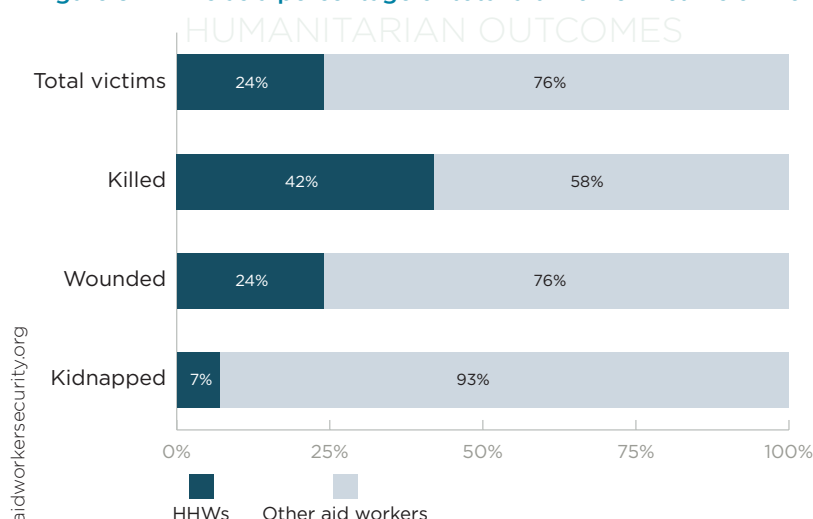
	Total	Nationals	Internationals	HHWs
Killed	1,966	1,763	203	315
Wounded	1,935	1,700	170	297
Kidnapped	1,483	1,163	193	196

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Without knowing the number of health workers as a proportion of the total aid worker population, it is impossible to know with any certainty if they suffer attacks at different rates than aid workers providing other types of assistance. However, given there are at least ten other humanitarian sectors, including some, such as food assistance, which take up a greater percentage of global humanitarian resources than the health sector, the 15 per cent of victims figure is not negligible.

In 2019, due to a spike in attacks on Ebola workers in DRC and continued airstrikes in Syria affecting first responders, HHWs comprised 24 per cent of the total number of humanitarian worker victims of violence, and a startling 42 per cent of fatalities (Figure 5).

Figure 5: HHWs as a percentage of total aid worker victims of violence, 2019



As mentioned, the AWSD database only contains a subset of the data on violence against health workers. To be recorded in the AWSD, the attack would first have to entail ‘major’ violence, in which victims were killed, kidnapped, or seriously injured as a result. Additionally, the health workers affected would have to be personnel of a humanitarian organisation (including staff, volunteers, community outreach workers, or public sector employees supported by an international humanitarian agency or donor as part of an emergency response). Maintaining these data parameters is necessary to provide a rigorous and comparable set of figures each year regarding our subject population (aid workers), but it means we do not capture attacks that were known to have killed or seriously hurt health personnel who do not fall within the parameters.

Other research and advocacy initiatives collect and publicise data on violence against health workers more broadly, not just as a subset of humanitarian workers. In 2012, Médecins sans Frontières (MSF) launched the Medical Care Under Fire project across all five of its operational centres, which was aimed at deepening its understanding and analysis of the attacks and violence faced by MSF staff and patients.³ ICRC leads the [Healthcare in Danger Initiative](#) (HCID), which is ‘aimed at addressing the issue of violence against patients, health workers, facilities and vehicles, and ensuring safe access and delivery of healthcare in armed conflicts and other emergencies’.⁴

WHO operates the [Surveillance System for Attacks on Healthcare](#) (SSA), which collects data from 11 countries and territories, using a standardised form for country-based volunteer reporters to report a wide range of security incidents—not just those involving major violence.⁵ The advantage of this methodology is that, in places with many contributors providing good coverage and consistent reporting, it has the potential to provide a much more comprehensive and detailed situational picture vis-à-vis the risk to health workers. The disadvantage is that more minor incidents are often unreported, and there is wide variability of reporting across contexts, preventing good comparability and broader tracking of trends.

Another initiative, the [Safeguarding Health in Conflict Coalition](#), is a group of NGOs and research institutions ‘working to protect health workers, services, and infrastructure,’ and its mission includes strengthening data collection on the issue.⁶ The Coalition issues annual reports on attacks on health care in conflicts based on incident reports from the SSA and other sources, and covers a larger number of countries (i.e. all conflict-affected countries according to the Uppsala Conflict Data Program). Its 2020 report found ‘more than 1,203 reported incidents of violence against or obstruction of health care in 20 countries and territories experiencing

³ For further information see: <https://www.msf.org/medical-care-under-fire>

⁴ For further information see: <http://healthcareindanger.org/hcid-project/>

⁵ Afghanistan, Burkina Faso, Mali, the occupied Palestinian territories, Syria, Libya, Mali, Nigeria, South Sudan, Myanmar and Yemen.

⁶ For further information see: www.safeguardinghealth.org

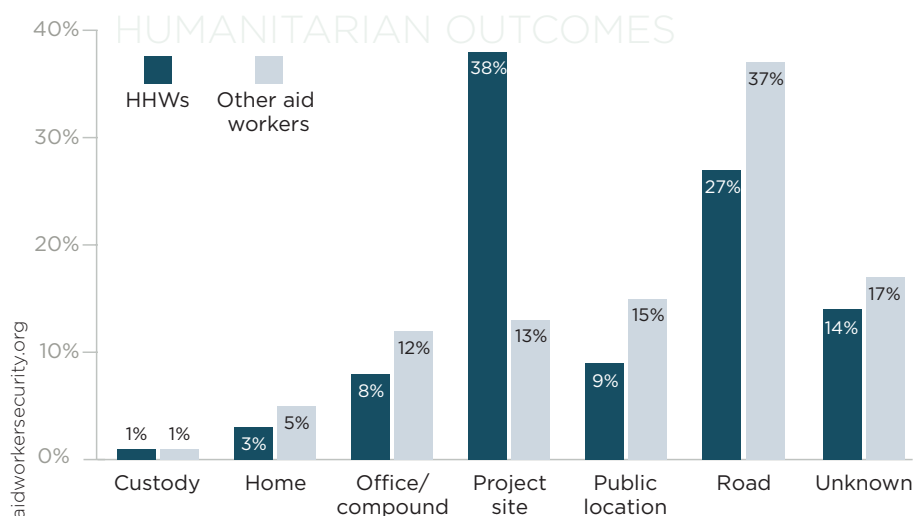
conflict in 2019.’ As for numbers of victims, the report states, ‘At least 151 health workers died in 2019 as a result of incidents in 18 countries and territories, and 502 health workers were injured in 17 countries.’⁷

All of the above initiatives make clear that their datasets do not fully capture all incidents affecting health workers globally. Having full, accurate numbers is not strictly necessary to illustrate the severity of the problem and to advocate for action, however, and that is their primary objective. For the purposes of this report, we will use the AWSD data to explore the issue of the unique threats and risk management responses for health workers in humanitarian response. Our analysis is informed by the literature produced by these initiatives as well as interviews with humanitarian security staff and international public health experts.

2.2 Contexts and locations

The most dangerous place for aid workers in general remains the road, where law enforcement often does not extend, and where armed groups and criminal elements can easily set up illegitimate checkpoints, roadblocks or improvised explosive devices (IEDs) for ambushing humanitarian actors and convoys.⁸ HHW victims, however, have more often encountered major violence at their project site, whether that is a health facility, in a community setting or on the scene of first response.

Figure 6: Victims by attack location, 2010-2019



Medical first responders such as emergency medical technicians (EMTs) and ambulance drivers can face extreme risk exposure in conflicts, including aerial bombardment of civilian areas. In Syria, Syrian and Russian air forces have not only targeted hospitals and aid convoys, but have also engaged in ‘double-tap’ strikes that involve a second bombardment to target the responders on the scene who are trying to save the civilian victims of the first strike. In 2019, at least 15 health workers in Syria lost their lives to airstrikes.

Armed actors will sometimes flout IHL and attack hospitals or health centres if they believe their enemies are receiving special treatment, or simply because the facility provides a viable target in their operational vicinity. Civilians have sometimes used health structures as places to flee to in attempts to find protection, which in turn can leave facilities vulnerable to attack—such as in South Sudan. In Myanmar, local Rakhine communities have harassed health staff and prevented Muslim Rohingya from reaching health facilities.

⁷ Safeguarding Health in Conflict Coalition. (2019). Impunity remains: attacks on health care in 23 countries in conflict.

⁸ Stoddard, A., Harmer, A., Ryou, K. (2014). Aid worker security report 2014—Unsafe passage: Road attacks and their implications for humanitarian operations. Humanitarian Outcomes.

2.3 Perpetrators and motives

As discussed in [Aid Worker Security Report 2017](#), most violence against aid workers is committed by non-state armed groups in conflict-affected countries.⁹ These non-state actors are responsible for 21 per cent of all attacks in the AWSD where the perpetrator is known. The second largest perpetrator group is unaffiliated attackers, followed by state actors (militaries and police), disgruntled staff or ex-staff, aid recipients, and organised criminal groups.

State and non-state armed actors

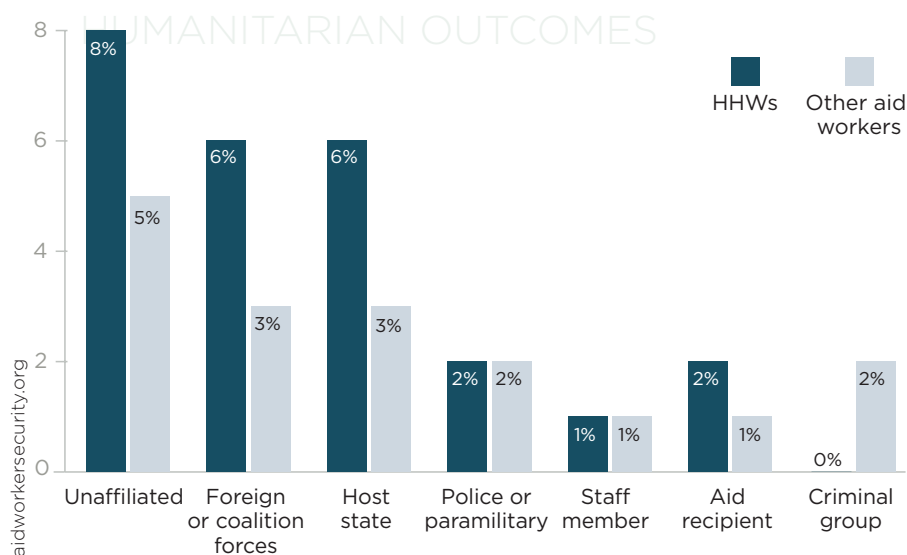
Health workers providing medical assistance to civilians and wounded combatants on all sides of the conflict, such as in ICRC and MSF field hospitals, can often achieve better access in active conflict zones than other humanitarian actors. The reason for this is that all sides have a vested interest in allowing these services to be provided, as their fighters all benefit from it. As we have seen repeatedly, however, this access comes with a very real risk of violence, both in the form of collateral damage and directly targeted strikes. The US airstrike on an MSF hospital in Kunduz in 2015 that killed over 40 people was reportedly ordered on the basis of deliberate misinformation provided to the US forces by Afghan National Army members displeased that Taliban fighters were being treated there.

Unaffiliated

Unaffiliated attackers include individual criminals and members of the affected population that bear some grievance or who mistrust the aid workers. The attacks by crisis-affected people can include mob violence in refugee or displaced persons camp settings when the aid provided is inadequate, poor quality or perceived as unfairly distributed. Such attacks are relatively rare, and when they occur, they can be a significant red flag for aid groups to address problems with their programming. In the case of health workers, however, they can face additional risks even when delivering high quality services. These stem from health context-specific factors such as the complaints of patients or their family members about treatment decisions or outcomes, or fears and misperceptions about the activities and motives of the health workers.

Figure 7, below, shows how humanitarian health worker victims are more likely than other aid workers to be affected by violence from state actors (reflecting casualties from airstrikes), unaffiliated individuals and aid recipients. It leaves off the largest perpetrator group, non-state actors (which affect HHWs and other aid workers equally), so these differences can be more easily visualised.

Figure 7: Victims by perpetrator group (not including non-state actors) 2010-2019



⁹ Stoddard, A., Harmer, A. Czwarno, M. (2017). Behind the attacks: a look at the perpetrators of violence against aid workers.

A study by ICRC in 2015 similarly found that state armed forces, law enforcement, and armed non-state actors made up the majority of perpetrators of violence targeted at health care.¹⁰ However, attacks by criminal groups and individuals were still significant, and 'most of the incidents attributed to individuals concerned obstruction during demonstrations and dissatisfaction by patients' relatives with medical treatment, delays, medical triage, doctor's decisions about treatment, the results of treatment and the conditions or death of one of their relatives'.

MSF's Health Care Under Fire project, based on eleven case studies, included a review of incidents that found that issues fell into five broad categories:

- requests for preferential treatment and violence at the moment of intake
- violence linked to perception of unsatisfactory treatment
- looting and destruction of health centres for economic gain or other reasons
- attacks on health centres as part of the battlefield
- persecution of patients or civilians seeking sanctuary in health centres.

The MSF research observed that the admission and triage process can sometimes be particularly fraught and is a moment when demands for treatment can escalate into security incidents. Armed groups can demand preferential treatment and threaten staff. Perception by patients, their families and communities around the quality of care can also lead to incidents. An unpublished MSF report for the Medical Care Under Fire project found that in both CAR and Lebanon, shouting matches, fights and violent incidents are commonplace in and around medical facilities.¹¹ In Lebanon, a survey found that 70 per cent of emergency department workers had been exposed to at least one violent incident in the preceding 12 months.¹² The Syrian refugee crisis has raised tensions with more people seeking care, waiting rooms becoming more crowded and confrontations becoming more frequent.¹³

This type of violence is not limited to humanitarian crisis contexts. WHO notes that globally between 8 per cent and 38 per cent of health workers suffer physical violence at some point in their careers.¹⁴ In 2017, 15 per cent of National Health Service (NHS) staff in the UK stated they had experienced physical violence from patients, relatives or members of the public over the previous 12 months.¹⁵ And in the United States, 75 per cent of workplace assaults reported annually occur in health care and social service settings, with health workers four times more likely to be victimised than workers in private industry. The National Crime Victimization Survey (NCVS) showed health care workers have a 20 per cent higher chance of being the victim of workplace violence than other workers.¹⁶

There is a specific type of fear-driven violence, however, that threatens humanitarians who work trying to prevent or control infectious disease, and which was behind some of the surge in attack numbers in 2019 and which we examine the next section.

¹⁰ ICRC. (2015). *Health care in danger: Violent incidents affecting the delivery of health care, January 2012 to December 2014*.

¹¹ MSF (2016). *Medical care under fire: An analysis of MSF's experience of violence and insecurity in the field*, Internal Report, March 2016.

¹² Alameddine, M., Kazzi, A., El-Jardali, F., Dimassi, H., Maalouf, S. (2011). Occupational violence at Lebanese emergency departments: prevalence, characteristics and associated factors. *Journal of Occupational Health*, 53 (6).

¹³ Fadel, Z., Hachem, N., El Ramy, C., Abi Nader, G., and Haykal, D. (2014). Evaluation and prevention of violence in the emergency department in Lebanon. *Critical Care*, 18 (suppl 1).

¹⁴ WHO (2020). WHO calls for healthy, safe and decent working conditions for all health workers amidst COVID-19 pandemic. Retrieved from: www.who.int/news-room/detail/28-04-2020-who-calls-for-healthy-safe-and-decent-working-conditions-for-all-health-workers-amidst-covid-19-pandemic [last accessed 10 August 2020].

¹⁵ Royal College of Nursing. (2018). Violence and aggression in the NHS: Estimating the size and the impact of the problem.

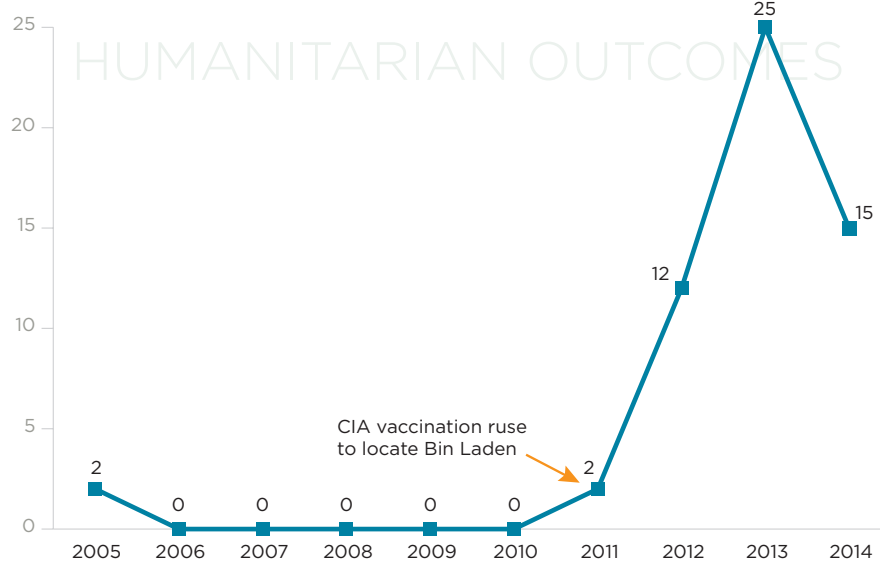
¹⁶ Joint Commission. (2018). *Sentinel Event Alert 59: Physical and verbal violence against health care workers*.

3.1 Xenophobic responses to disease and contagion control efforts

As long as there have been communicable diseases, socially destabilising fear, uncertainty, and violence have accompanied them. And when an external aid response to a disease arrives in a location at the same time as it begins spreading, or even before, it is only natural for inhabitants to suspect the contagion and the outsiders are somehow related.

Such suspicions are not always ill-founded. When cholera began ravaging Haitian communities still recovering from the 2010 earthquake, people rioted in anger, accusing the international aid responders of having brought the disease with them. At first the UN put out statements denying the link until epidemiological analysis proved the perception correct—the disease had been introduced by a Nepalese peacekeeping contingent. In South Sudan, the first Covid-19 case was identified in an international UN aid worker, from the Netherlands, sharpening pre-existing resentments toward the international organisation and provoking calls for reprisals. And when the CIA tracked down Osama bin Laden in Pakistan using a phony immunisation programme as a cover, attacks against polio vaccinators spiked.

Figure 8: Vaccinators attacked, 2002-2014



From Stoddard, A. (2020). *Necessary Risks: Professional humanitarianism and violence against aid workers*. Palgrave Macmillan. <https://doi.org/10.1007/978-3-030-26411-6>

An interviewee for this report underscored that ‘often, attacks happen because of fears [that] outsiders can bring disease into an area. Those fears need to be taken seriously and aid agencies have both a duty of care to staff and also a duty of care to the people where they work.’

In the Ebola response in DRC, clear security threats emerged from what some termed ‘community resistance’, described as ‘spontaneous attacks targeting response teams or facilities triggered by fear or emotion’.¹⁷ Such incidents escalated in 2019, ranging from verbal harassment, to assaults, to health centres burnt down. Risks were particularly acute in

¹⁷ Kalenga, O. (2019). The Ongoing Ebola Epidemic in the Democratic Republic of Congo, 2018-2019, *New England Journal of Medicine, Special Report*, July 25, 2019; 381:373-383

responses involving direct contact with community members: giving vaccinations, ensuring safe burials, and promoting IPC (infection prevention and control). Community resistance can stem from a number of factors,¹⁸ and in DRC they included not only disease fears and misinformation, but also political tensions and anger over how the response was conducted.

One member of the international response described scenes in villages that explained these security threats and the anger behind them: '[The responders] roll in to do a vaccination program with seven huge Land Cruisers, jump out speaking French, and just start trying to vaccinate people.' At other times, the interviewee continued, 'There were over-reactions when family members were trying to bury their dead and someone would push a policeman and then police would start shooting.'

When the target population of an external health intervention is children, fears and mistrust can be heightened further. Resistance to vaccinations has led to violence in a number of contexts, with particular challenges in Pakistan (as noted), Afghanistan, and Nigeria.

In April 2020, a UN agency vehicle transporting Covid-19 samples in Myanmar's Rakhine state was attacked and the driver was killed. Overall, however, the number of major attacks against humanitarian health workers related to the Covid-19 response remains very low. Interviews with staff of humanitarian organisations revealed that violence relating to Covid-19 was something organisations were concerned about and had been tracking, but did not yet consider it a significant problem. Most security incidents have been minor, such as shouting and stone throwing, though rumours and conspiracy theories abound. In contrast to Ebola, with Covid-19 there is far less danger associated with burials, and responders have had less invasive contact with communities.

Aggression, threats, and sometimes violence from the public follow previous patterns where health workers were attacked 'as a consequence of community distrust, widespread panic, and narratives of denial and stigmatization.'¹⁹ ICRC noted instances of health workers being prevented from returning home after work because they are seen as carriers of disease, and instances of excessive use of force to dispel protests aimed at requesting better personal protection equipment.²⁰

3.2 Influences of politics and corruption

Public fears exist within a political context, and can be stoked and manipulated by political forces. In Northeast DRC, pending national elections meant that the atmosphere was already politically charged. When the Ebola-affected cities of Beni and Butembo were barred from participating in the presidential election, it fueled rumours that the epidemic was a political ruse to disenfranchise voters. Armed escorts (armed police or UN forces) for community response teams in insecure areas exacerbated tensions and distanced communities from the response efforts.

In addition, communities were often affiliated with one of the several militias operating in the region, so community resistance could manifest in armed violence from the militias. Both state actors and non-state armed groups exploited the outbreak for political reasons, and violence escalated as elections grew nearer. In a forthcoming book about public health in humanitarian contexts, Leonard Rubenstein devotes a chapter on the relationship between bad governance, state military forces, and community violence, using the DRC Ebola-related violence as an example.²¹

¹⁸ Nguyen, V.K. (2020). An Epidemic of Suspicion — Ebola and Violence in the DRC. *New England Journal of Medicine*. Retrieved from <https://www.nejm.org/doi/full/10.1056/NEJMp1902682> (Accessed: 13 August 2020).

¹⁹ Forgione, P. (2020). New patterns of violence against healthcare in the Covid-19 pandemic. *BMJ*. <https://blogs.bmj.com/bmj/2020/05/15/new-patterns-of-violence-against-healthcare-in-the-covid-19-pandemic/>

²⁰ COVID-19: An explosive situation in terms of the number and volume and humanitarian needs, ICRC New Delhi Blog, 10 July, 2020.

²¹ Rubenstein, L. (Forthcoming). *Perilous Medicine*. Columbia University Press.

Many locals perceived the Ebola response to be a business venture, benefiting the rich and powerful. This perception held more than a grain of truth, according to reports²² from people involved in the response and media articles, which describe widespread corruption among Ministry of Health and local officials colluding with the staff of aid agencies. Community frustrations also stemmed from perceptions of corruption and profiteering from what was seen as the 'Ebola business'. A CASS perception survey found high levels of mistrust of health care workers, related to the perceived high salaries of health work, the fact that they did not always speak local languages, and perceptions of profiteering from the response. In some places, anger over corruption was larger factor in community violence than fear of the disease. In fact, the survey showed 47 per cent of respondents did not believe that Ebola was real, and thought that the outbreak continued to be spread for financial gain.²³

3.3 The role of rumour

Rumours that spread through social media can pose a particular threat. Insecurity Insight reports have been sharing key trends and insights from media monitoring carried out by Novetta Mission Analytics in DRC and CAR.²⁴ For both Ebola and COVID-19 they suggest that misinformation on social media is contributing to community mistrust of aid workers in the DRC and CAR. Agencies interviewed also reported monitoring social media at country office levels. In 10 countries, UNICEF is partnering with private sector companies to monitor information circulating on social media which can be used to tailor risk community and community engagement (RCCE) messages to counter misinformation.²⁵

Since the capture of Osama Bin Laden using the vaccination ruse, the Taliban and other Islamist militant groups have reinforced growing distrust of vaccines with anti-Western rhetoric and used anti-vaccination sentiment as a tool in their anti-Western messaging. A 2012 Pakistani Taliban fatwa incited the killing of polio workers. Other false rumours have also circulated for several years, including that the polio vaccine either contains ingredients forbidden in Islam (such as pork), or toxic ingredients that induce sterilisation or make children sick, have also circulated for several years. Militant groups have killed approximately 90 health workers in Pakistan since 2012.²⁶

²² Corrupt aid workers exploit Congo crisis. (2020). The New Humanitarian. <https://www.thenewhumanitarian.org/investigation/2020/06/12/Congo-aid-corruption-abuse-DFID-DRC-UN-NGOs>.

²³ Cellule D'Analyse En Sciences Social CASS, Social Science Support for COVID-19, Lessons Learned Brief, Social Sciences evidence on barriers to healthcare seeking during the DRC Ebola outbreak.

²⁴ Insecurity Insight (2020). Social Media Monitoring: Democratic Republic of Congo, 12 June 2020, Bulletin 7; Insecurity Insight (2020). Security media trends, Central African Republic, Bulletin 3, April 2020

²⁵ https://www.unicef.org/appeals/files/UNICEF_Global_COVID19_Situation_Report_No_6_15_28_May_2020.pdf

²⁶ Toppa, S. (2020). Pakistan's secret weapon against polio

4 Risk management responses and gaps

Acceptance-based strategies to operational security risk management require that humanitarian actors actively engage with all influential actors and potential threat sources in the location to build familiarity and earn trust—or at least tolerance. In volatile environments, aid responses that proceed without first gaining acceptance run a much greater risk of encountering violence. Emergency epidemic responses are no different, but in the Ebola efforts in DRC, as a recent article analysed ‘strategic security risk management approaches appear to be largely absent from the response, in part due to a failure by leading response agencies to recognise the DRC as a complex humanitarian emergency, as well as a public health crisis.’²⁷

The response to the Ebola in DRC outbreak became heavily securitised, with UN agencies relying on military escorts and NGOs finding it difficult to maintain an independent stance. MSF complained about this ‘militarisation’ of the response, and IFRC noted that increasing armed protection for Ebola responders could aggravate tensions and called for IFRC partners to limit their use of security or military support as much as possible.²⁸ A report for the UN High Commissioner for Human Rights noted the ‘disproportionate use of force’ by police and army personnel in dealing with protests against Ebola responders.²⁹ Interviewees recounted issues, not just with the use of armed escorts, but with the use of militarised language in the response with responders described as ‘soldiers’ and ‘brothers in arms.’

Also troubling was the alleged direct payments by UN agencies to local police, Congolese armed forces, and militia groups to provide security and access. An interviewee for this study described hundreds of thousands of dollars per month going in cash payments to these forces, saying, ‘Direct payments to police and military creates huge risk. If you are an organisation you sign a contract with the Ministry of Defense; you don’t pay the soldiers directly. Otherwise, when payments stop, you are in big trouble.’

Even aside from this example of dangerously bad practice, the gaps in security risk management (SRM) vis-à-vis health emergency responses, according to humanitarians and public health professionals we interviewed, are many and deep. For one, as already mentioned, the psychological element of public fears and behaviours around disease is not included in most organisations’ acceptance strategies and toolkits. As one interviewee said, ‘MSF has full time staff that do nothing but go into communities and try to explain what they’re doing. But very few groups do that.’

There is also little by way of health worker training on managing security threats from patients or community-based violence that happens inside facilities. When aid organisations work inside public health facilities (which is far more often the case than an NGO establishing their own hospital, for example) the SRM measures are usually not under their control. While they can require their own staff to follow organisational security guidelines, they cannot do the same for Ministry of Health staff, who they sometimes support with incentives. Where organisations are only supporting part of a facility (one ward within a hospital for example) it can be difficult for them to put in place measures that would help to improve security for the whole facility. More often it is patients, not health workers, that are the direct targets of violence inside the facilities. Said one medical NGO interviewee, ‘Often you don’t realize the security issues until after you start working. In Yemen we had to deal with Houthis coming in with their guns and it took a long time to reduce these incidents.’

²⁷ Fairbanks, A. (2020). Security and Access in the DRC: implementing an acceptance strategy in the Ebola response, Humanitarian Exchange, Number 77, March 2020, HPN, ODI.

²⁸ IFRC (2019). IFRC calls for “reset” of Ebola response as cases surpass 2,000, ReliefWeb.

²⁹ The New Humanitarian (2019). In Congo a ‘militarised’ Ebola response has fuelled community resistance.

The wider literature on violence against health workers is mainly focused on developed world settings and in these places, it is violence by patients (particularly those with mental health conditions), health care workers and affiliated third parties that is most common. This is much less studied in conflict, post conflict and fragile settings (ICRC and ELHRA 2020). The lack of research and evidence on this issue raises the possibility that this form of violence is also common in conflict settings but is under-reported. Sexual violence in the workplace is globally under-reported and is also likely to be an under-reported issue in health care facilities.

4.1 Communication failures and lessons unlearned from West Africa Ebola

Everyone we spoke to in the intersection of humanitarian and public health programming underscored the critical importance of community engagement and good communications, from security risk management as well as effective health emergency response.

Unfortunately, communication and knowledge continuity failures hindered the response and added to security risk. A great deal of the learning by responders in the Ebola response in West Africa in 2014-2016, and knowledge and data contributed by public health sociologists and anthropologists, were not taken forward in the DRC case, according to international responders involved in both responses. Even more recent lessons-learned were not absorbed. Said one interviewee, 'Prior to latest outbreak in DRC, WHO had produced a very good document on "Risk Communication and Ebola in Congo in 2018" in French and English with super-useful information, and no one read it. There was another one produced in Swahili, but it was Kenyan Swahili which didn't make sense to people [in northeast DRC].'

Language issues proved to be a particular problem ('a bigger obstacle than they should have been', said one UN representative), with many Lingala-speaking staff hired from Kinshasa to work in areas where that language was not spoken and was seen as a language of oppression. Forms were sometimes in French and Lingala and not in local languages.³⁰ Research by Translators Without Borders found that the use of Lingala was one of the main reasons why people avoided Ebola response teams,³¹ and that following public health education messaging, target members of the community had failed to understand some of the foreign words used for very basic terms, such as 'bloody'.

The international agencies made mistakes not just in how they spoke, but to whom, adding to legitimate community resentments. According to interviewees, respected community leaders who could have been useful in passing messages were bypassed in favour of corrupt officials and other interlocutors who put themselves forward in pursuit of profit. In communities with longtime, trusted community health workers (CHWs) the government sent brand new CHWs of their choosing from Kinshasa, on generous per diems paid by international emergency funding. Meanwhile local volunteers did not receive their stipends, which led in some cases to mini-riots.

An Independent Oversight and Advisory Committee (IOAC) report for the WHO Health Emergencies (WHE) Programme found that, 'community feedback was not used to shape and reshape the strategy driving the response by WHO, the government and all other partners. This made it difficult to correct elements of the response that had provoked deep community resentment and mistrust.' Feedback that could have been used to adjust the response was not discussed beyond the communication pillar.

The ultimately successful quelling of DRC's latest Ebola outbreak and use of the new vaccine is reason for no small celebration, yet it cannot be allowed to obscure the many missteps, which are important not to repeat in future. The insecurity surrounding the response was responsible for increased transmission, prolonging the outbreak, and leading to more deaths: 'Since late

³⁰ Social Science in Humanitarian Action (2019). Social Science and Behavioural Data Compilation (#5), Ebola outbreak eastern DRC, September 2019

³¹ TWB (2019). We need to talk, Effective Ebola risk communication requires respect and transparency and remains as vital as ever: An assessment of changing communication needs and preferences in Beni, North Kivu.

February 2019, a sharp rise in cases and increased transmission have been observed. These coincide with organized attacks by armed groups targeting response teams, deteriorating security, and the population's increasing distrust of the response effort.³²

4.2 Good practices and emerging lessons for programming and risk management

Though the contexts are different, there may be scope for humanitarian actors to learn from measures that have proved successful in reducing violence in other settings.

Some INGOs make a point of engaging with respected community and religious leaders to persuade them to talk to people and disabuse them of wrong beliefs, such as the health workers brought the disease. It is not an easy task, and 'there's nothing worse than a half believer who then spreads additional rumours', so this engagement needs to be intense and sustained. One organisation recruited trusted people from within communities and provided them training in active listening and communications. 'We found that acknowledging and addressing issues of poverty and injustice, and using examples drawn from the questioners experience, went a long way to allaying the concerns'.

At the same time, aid organisations need to ensure that they do not give truth to people's fears and endanger communities by spreading disease themselves. In the age of Covid-19, this entails looking at safety issues from the non-health programming perspective as well, for instance how to do safe food distributions.

One (very well accepted) NGO in the DRC Ebola response was encouraging the other agencies to consider community-based home care rather than bringing people to treatment centres. In some places the security situation in the areas made it dangerous to travel out of communities to these centres, so there is a security argument as well as an acceptance one to keep people in their homes. A lesson from this experience for the Covid-19 response is to be careful about a rush to develop treatment centres and supporting communities to institute safe practices for self-isolation.

In West Africa, community engagement work has supported people in making their own masks to prevent the spread. Helping the community to protect their own safety can be an effective way of generating engagement and acceptance. And because social distancing is not possible in every context, especially in slums or where families live together in small rooms, consulting with communities can help to jointly identify the most effective way to respond to emerging health threats.

In the same vein, communities can be supported to safely bury their own dead. With training and PPE provision, said a humanitarian worker, 'there are ways to help people do their own dignified burials rather than coming in and doing it for them' which is so deeply upsetting it can seem inhumane. A report on the Social Science in Humanitarian Action Platform (SSHAP), notes:

'The standard WHO model of response, and the way it has been enacted in western countries through lockdowns, can be experienced very, very differently in a remote Ugandan village—and indeed can legitimate violence and injustice. Responses from below, supported by community-led communication, which make sense to people and are more ethical and humane, could change the experience of this, and future, disease burdens into something more manageable for these villagers.'³³

With Covid-19, issues of staff care have increasingly come to the forefront. One organisation reported seeing a 25 per cent uptick in requests from staff for mental health support, and it is looking for ways to better support its health workers on the ground.

³² Kalenga, O. (2019). The Ongoing Ebola Epidemic in the Democratic Republic of Congo, 2018-2019, *New England Journal of Medicine*, Special Report, July 25, 2019; 381:373-383

³³ Akello, G., Baluku, M. (2020). How the 'disease of the radio' is the next burden impacting the lives of those on the Uganda-DRC border. *Social Science in Humanitarian Action Platform* <https://www.socialscienceinaction.org/blogs-and-news/covid-19-uganda-disease-radio-next-burden-impacting-lives-uganda-drc-border/>

When assessing risks to health care in humanitarian settings, there's a tendency to focus on the most serious and spectacular instances of violence—attacks by armed forces. Looking at the issue across all types and cases of violence, however, shows a wide range of threats and perpetrators which humanitarian aid agencies need to be alert to and develop mitigation strategies for in their security management systems.

Threat	Possible mitigation measures
Attacks by armed forces	<ul style="list-style-type: none"> • Direct negotiation with conflict parties • Deconfliction • Adopting common rules of engagement among aid actors (e.g., no military escorts) • Protective measures for health facilities (guards, walls, lighting) • IHL advocacy and training for conflict parties
Attacks by communities relating to fears (or resentments) about epidemic control efforts	<ul style="list-style-type: none"> • Advance consultation with communities prior to response team arrival • Tracking and countering misinformation through public health and risk communication campaigns • Accessible and transparent feedback and accountability mechanisms • Active acceptance and community engagement strategies • Measures to minimise corruption • Protective measures for health facilities
Violence at the moment of intake and relating to perceptions about medical care	<ul style="list-style-type: none"> • No weapons policies and signs • Negotiation with and training for parties to conflicts around impartiality • Measures to reduce crowding and wait times in facilities • Enhanced security, alarms and lighting, panic buttons, safe rooms, barrier protection, etc. • Adequate security and mental health personnel at facilities • Staff training in how to deal with workplace violence and de-escalation techniques • Develop protocols, guidance and training on workplace violence • Ensure reporting of all events and remove all impediments to reporting incidents of violence • Community engagement and communications about treatment procedures
Violence related to criminality and looting	<ul style="list-style-type: none"> • Procedures to minimise cash held on the premises • Measures to enhance physical security and protect valuable assets
Threats from staff and ex-staff related to hiring, firing and contracting	<ul style="list-style-type: none"> • Ensuring transparency and fairness in key processes. • Measures to minimise corruption • Accessible and transparent feedback and reporting mechanisms for staff • Clear exit strategies in place in the event of programme closure or relocation due to insecurity

Many of these measures do not lie solely in the domain of security risk management and require security managers to work across organisations on issues such as public health communications and community engagement processes.

A report by Adelia Fairbanks for the Humanitarian Practice Network found evidence of efforts to deepen feedback and engagement mechanisms such as work by IFRC and the Communications Commission, the MoH led and UNICEF supported Cellule Analyses—Science Sociales (CASS) and the need for better social science research and feedback data to inform security strategies.

Much of this knowledge already exists. The Social Science in Humanitarian Action Platform, for example, is a deep resource of behavioural data and applied research on community-centred programming in disease emergencies.

IFRC put in place a system to systematically collect and document community feedback drawing on what mobilisers and volunteers were hearing and other data sources such as interactive radio and it was seen as the first time community engagement was really central to an operation.³⁴ The feedback data did help to indicate shifting levels of risks and threats and showed high levels of frustration, but failed to lead to real strategic change in the overall approach before attacks happened. The fact that, ‘spikes in negative feedback preceded attacks against responders suggests such a system could serve an early warning function in challenging contexts.’³⁵

What these emerging examples of good practice suggest is the need to more systematically connect security management approaches and systems with efforts at community engagement and accountability to affected populations (AAP). Too often, security management is seen as separate from community engagement and AAP efforts, when instead they should be guiding and informing each other.

Finally, humanitarian SRM practices and systems need to consider and manage the risk of violence in health care settings and health emergencies—in assessment, training, acceptance approaches and mitigation strategies. Some useful knowledge may be found outside the humanitarian sector in the broader public health sphere, particularly for facility-based SRM. The US Occupational Safety and Health Administration (OSHA) has developed guidelines for preventing workplace violence for healthcare and social service workers and the Crisis Prevention Institute has a list of Top 10 de-escalation tips.³⁶ Conversely, health responders that are new to the humanitarian world could learn from the SRM approaches used by humanitarian actors in conflict settings.

While attacks against health care in contexts such as Syria are often outside of the control of response actors, there are other situations in which health responders can have significant agency in mitigating the security risks they face. A key tenet of humanitarian operational risk management, which sometimes goes underemphasised, is that acceptance-based security for humanitarian operations is directly related to the quality of services provided. In epidemic emergencies we have seen that no matter how good the medical programming is, if it is not communicated and structured in a way that facilitates direct community engagement, it will contribute to fear, fuel legitimate anger, and potentially lead to violence.

Covid-19 is likely not the last pandemic that will threaten humanity, most of all people who are already affected by crisis or conflict. To manage the range of risks faced by humanitarian health workers responding to future health crises, particularly in complex crisis settings, organisations must bring together the knowledge and best practices from humanitarian SRM, public health, and social science fields.

³⁴ Social Science in Humanitarian Action (2020). Real-Time Ebola Community Feedback Mechanism, Issue 10, May 2020

³⁵ Ibid

³⁶ OSHA (2015). Guidelines for preventing workplace violence for healthcare and social service workers, Occupational Safety and Health Administration; Crisis Prevention Institute, Top 10 De-Escalation tips <https://www.osha.gov/Publications/OSHA3148.pdf>; The Joint Commission (2012). Improving Patient and Worker Safety. <https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/patient-safety/tjc-improvingpatientandworkersafety-monograph.pdf>

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