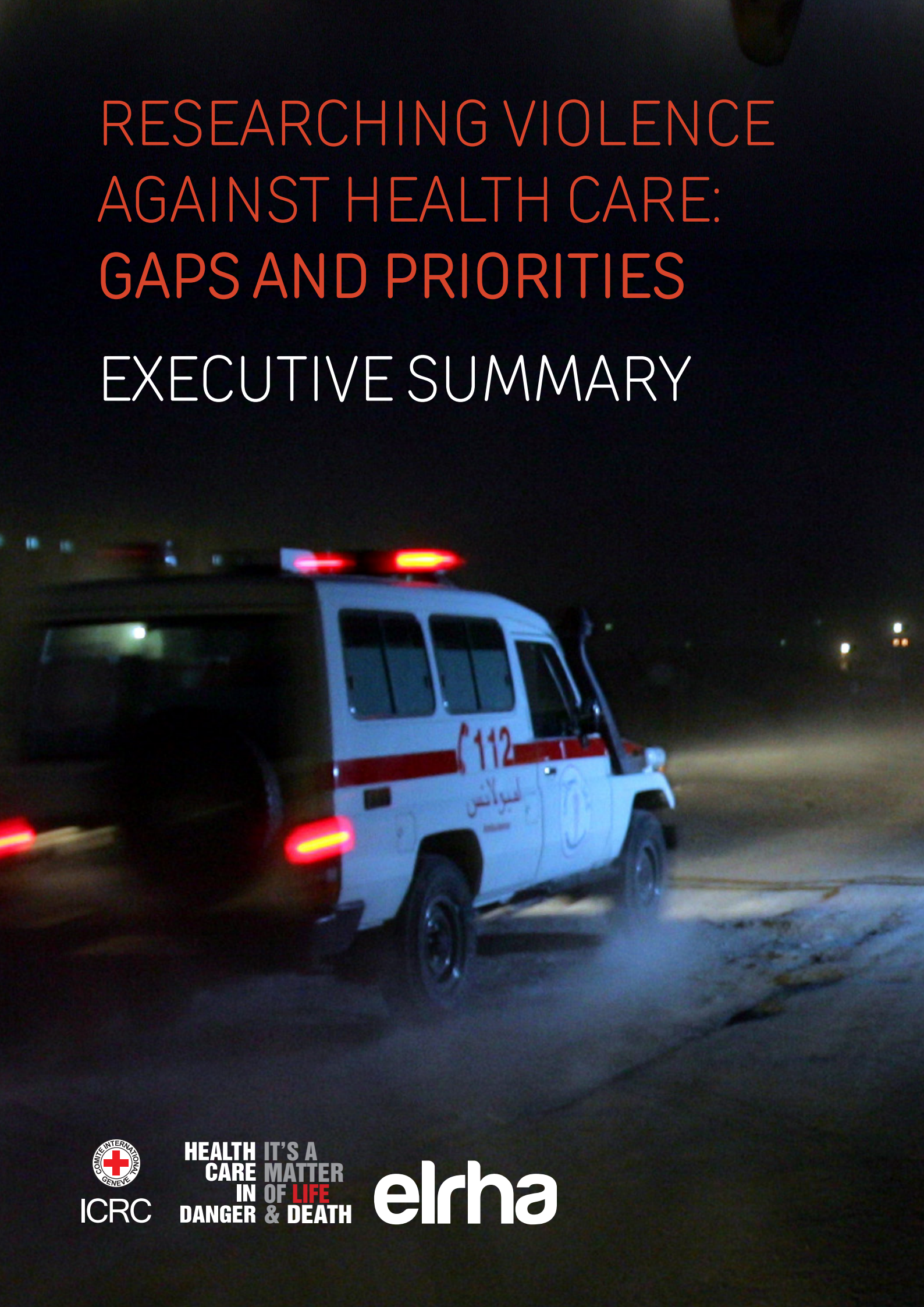
RESEARCHING VIOLENCE AGAINST HEALTH CARE: GAPS AND PRIORITIES

EXECUTIVE SUMMARY



ICRC

HEALTH CARE IN DANGER

IT'S A MATTER OF LIFE & DEATH

elrha

Cover Photograph credit: Ahmad Masood/Reuters

RESEARCHING VIOLENCE AGAINST HEALTH CARE: GAPS AND PRIORITIES

EXECUTIVE SUMMARY

ACKNOWLEDGEMENTS

ABOUT THIS REPORT:

This report is the result of research undertaken by RAND Europe, commissioned by the International Committee of the Red Cross (ICRC) and Elrha to provide a Situational Analysis and Review of the Evidence Base on violence against healthcare, as part of the ICRC's Health Care in Danger Initiative.

The report investigates the current status of research on violence against healthcare, identifies research gaps and conducts an initial prioritisation of future research. This is achieved through a combination of structured literature review, key informant interviews, and a series of internal workshops held at RAND Europe.

ABOUT ICRC AND HCID

The ICRC

The International Committee of the Red Cross (ICRC) helps people around the world affected by armed conflict and other violence, doing everything it can to protect their lives and dignity and to relieve their suffering, often with its Red Cross and Red Crescent partners. The ICRC also seeks to prevent hardship by promoting and strengthening humanitarian law and championing universal humanitarian principles. As the reference on international humanitarian law, it helps develop this body of law and work for its implementation.

People know they can count on ICRC to carry out a range of life-saving activities in conflict zones, including: supplying food, safe drinking water, sanitation and shelter; providing health care; and helping to reduce the danger of landmines and unexploded ordnance. The ICRC also reunite family members separated by conflict, and visit people who are detained to ensure they are treated properly. The ICRC works closely with communities to understand and meet their needs, using our experience and expertise to respond quickly and effectively, without taking sides.

Health Care in Danger initiative

The ICRC's Health Care in Danger (HCiD) initiative seeks to create a world where weapon bearers, political authorities and populations in countries affected by conflict and other emergencies respect the inviolability of health care at all times. To realize our vision and reach our objectives, the ICRC will work together with its partners along three axes of engagement:

OPERATIONALIZATION

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

EVIDENCE-BASED STRATEGIES

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

INFLUENCING AND COALITION-BUILDING

The ICRC will focus its mobilization efforts at the national and subnational levels, where selected delegations will create and foster "communities of concern" that bring together representatives of health-care providers affected by violence, health-care policymakers, and other stakeholders who can contribute to developing a solution to the violence. Local communities of concern will play a role in mobilizing a broader range of government and civil-society stakeholders, generating evidence, and jointly designing and implementing activities or responses aimed at providing more effective protection for health care.

www.icrc.org / www.healthcareindanger.org

Key Contact for this report:
Jessica Ramírez Mendoza
Data and Research Specialist, Health Care in Danger Initiative
gva_hcid@icrc.org

ABOUT ELRHA

Elrha is a global charity that finds solutions to complex humanitarian problems through research and innovation.

We are an established actor in the humanitarian community, working in partnership with humanitarian organisations, researchers, innovators, and the private sector to tackle some of the most difficult challenges facing people all over the world.

We have supported more than 200 world-class research studies and innovation projects, championing new ideas and different approaches to evidence what works in humanitarian response.

We equip humanitarian responders with this knowledge, so that people affected by crises get the right help when they need it most.

www.elrha.org

Key Contact for this report:
Anne Harmer, Head of Research for Health in Humanitarian Crises (R2HC)
a.harmer@elrha.org / info@elrha.org

ABOUT RAND EUROPE

The report was authored by Kate Cox, Richard Flint, Marina Favaro, Linda Slapakova and Ruth Harris

RAND Europe is a not-for-profit policy research organisation that helps to improve policy and decision making through research and analysis. RAND Europe's clients include European governments, institutions, non-governmental organisations and others requiring rigorous, independent, multidisciplinary analysis.

Thank you to ICRC and Elrha for the support provided and the valuable insights offered by interviewees and fellow colleagues at RAND Europe. The authors would like to extend particular thanks to the following individuals: Anne Harmer and Kate Hart (Elrha), Maciej Polkowski and Jessica Ramirez Mendoza (ICRC), and Tom Ling, Sue Guthrie, Alexandra Hall, Kate Morley, Natasha Elmore, Jenny Newbould, Jenny George, Sarah Ball and Sarah Grand Clement (RAND Europe).

www.rand.org

Key Contact for this report:
Ruth Harris
Research Group Director, Defence, Security and Infrastructure
RAND Europe
Tel. +44 (0) 1223 353329
rharris@randeurope.org

SUGGESTED CITATION

Elrha and ICRC. (2020) 'Researching Violence Against Health Care: Gaps and priorities'. Elrha and ICRC: London/Geneva.

FOREWORD

Protecting healthcare from violence is imperative if we want communities across the globe to access the health services they are entitled to. Sadly, in conflict and other emergency settings where healthcare is most needed, attacks most frequently take place: ambulances are refused passage out of refugee camps resulting in patient deaths; surgeons are unable to operate when armed men refuse to leave operating theatres; and entire health care health structures are destroyed due to disregard for international norms by those in charge of military operations.. The objective of ICRC's Health Care in Danger initiative is specifically to protect healthcare from such inhumane violence.

Contrary to the spirit of humanitarianism, attacks against healthcare are a complex problem defying simple solutions. Preventing attacks often requires a disruption of established behaviour on the part of armed actors, health personnel and civilians alike. Solutions are usually context-specific and technical, requiring high-level policy change and health system reform.

Responding to this challenge, the ICRC partnered with Elrha to commission this situation analysis and evidence review. Our objective was to take stock of global knowledge on violence against healthcare and its impact, and to determine the availability, or otherwise, of preventive solutions. Both organisations are committed to advancing the knowledge of what works to protect health care from violence, through a deeper understanding of the complex factors at play and an assessment of the most promising solutions.
Research is a powerful tool to explore aspects of social reality and catalyse action to create positive change. At the ICRC, we believe that health care providers and researchers in countries affected by armed conflict and other humanitarian crises – many of whom have first-hand experience of violence themselves – play a critical role in filling evidence gaps and finding practical solutions to violence against health care. We also know that the approach and focus of response actors needs to be adapted if we are to collectively ensure that people get adequate care even in the worst of circumstances. Critical to this is that health centres must be respected by all parties across political fault lines. There is no grey area. Those taking care of the sick and the wounded should never be targeted.

This report Researching Violence Against Health Care: Gaps and Priorities describes current approaches that prevent violence against health care and, importantly, identifies the evidence gaps that need to be filled through rigorous research. We are sharing the report with the aim of facilitating learning across the global community, with the hope that resources can be generated to support meaningful research that will see an end to violence against health care.

Prof. Gilles Carbonnier,
Vice President, International Committee of the Red Cross

INTRODUCTION

Violence against healthcare has attracted considerable attention within the international humanitarian community and wider public discourse, in part as a result of high-profile attacks on healthcare professionals, workers, patients and infrastructure in countries such as Syria, Yemen and Democratic Republic of Congo. In spite of increased media attention and a global normative commitment to the protection of healthcare, violence against healthcare remains a common occurrence in many parts of the world. It is a global phenomenon that affects healthcare services not only in conflict areas, but also in non-conflict areas and across high-, medium- and low-income countries.

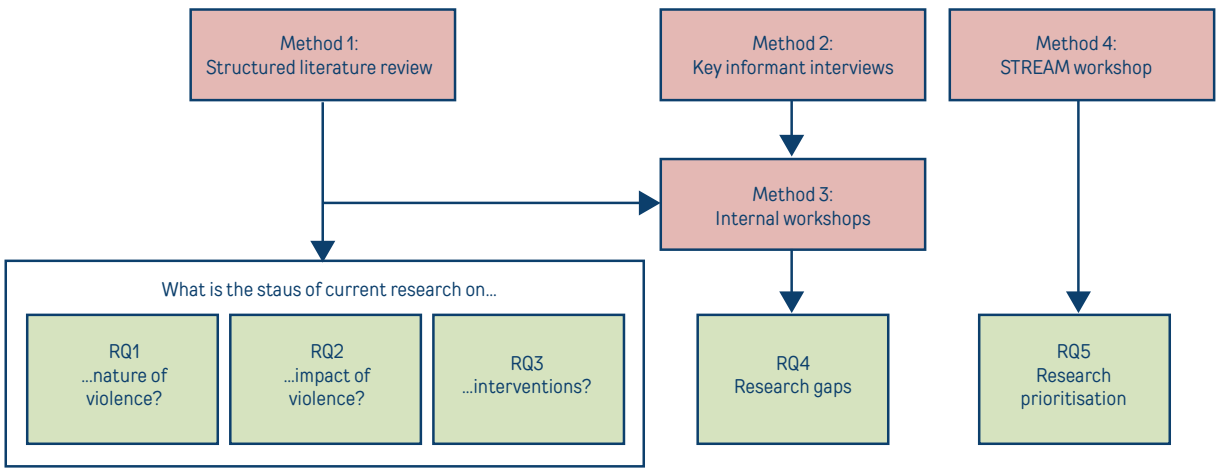
Research has much to offer in this space. It not only supports global advocacy efforts by highlighting the prevalence of violence against healthcare, but also increases our understanding of the nature, causes and impact of such violence, and supports the development of more effective countermeasures that help to safeguard healthcare workers, patients and infrastructure. The status of existing research, however, appears mixed, with few studies taking a comprehensive approach to examining the evidence base.

This study aims to review the existing evidence base on violence against healthcare, and in doing so identify evidence gaps and prioritise areas for future research. This has been achieved through:

- A literature review (protocol-driven searches of CINAHL, SCOPUS and PubMed, together with searches of Google and Google Scholar in English, French, Spanish, Arabic and Chinese).
- Interviews with 15 stakeholders, including researchers, policymakers and practitioners.
- Internal workshops, including a prioritisation workshop involving senior RAND Europe researchers.

A broad approach was applied to the review, covering research on physical, psychological and structural forms of violence carried out against healthcare professionals, workers, patients and infrastructure. It employed a global approach that included research from both conflict and non-conflict environments, and focused on three thematic areas: i) the nature of violence; ii) the impact of violence; and iii) interventions to reduce, prevent and mitigate violence against healthcare. This approach is summarised in Figure 1 below.

Figure 1. Summary of research methods



THE LITERATURE REVIEW IDENTIFIED A NUMBER OF CHARACTERISTICS OF THE EXISTING EVIDENCE BASE

The literature review identified a total of 1,412 relevant sources, ranging from quasi-experimental evaluations of interventions to manage violence in hospitals to reviews of the prevalence of violence against healthcare in conflict areas. A number of characteristics of the existing evidence base were identified, with the key findings outlined in Figure 2 below.

The majority of existing research focuses on violence against healthcare in North America, Europe and East Asia, in high- and upper-middle-income countries, and in non-conflict areas. Where specified, the majority of sources examine violence carried out by patients and targeted towards healthcare workers (in particular nurses), and study either physical and/or psychological violence, and in particular interpersonal physical violence, verbal abuse and aggression. Only a small proportion of research focuses on violence against healthcare in conflict, post-conflict and fragile environments, and where specified, this research focuses primarily on countries in the Middle East. Research in conflict, post-conflict and fragile environments focuses primarily on physical violence, including interpersonal violence, violence with large weapons, theft, looting, kidnapping and robbery, primarily carried out by unaffiliated third parties (i.e. neither family nor friends of patients or healthcare workers).

Of the three broad themes under analysis (the nature of violence, the impact of violence, and associated interventions), the evidence base as a whole concentrates primarily on the nature of violence, and in particular on measuring the prevalence of violence in different healthcare settings, including hospitals (general), emergency departments and psychiatric settings.

Just over a quarter of existing sources examine the impact of violence, focusing mainly on the personal impact of violence and its immediate effects on the delivery of healthcare. Just under a quarter of studies examine interventions that seek to reduce the prevalence and/or impact of violence, with sources in this area focusing mainly on training for healthcare workers, and tools, measures and techniques to help healthcare workers manage individual instances of violence.

Similar themes are also observed within the literature specifically relating to conflict, post-conflict and fragile environments, with just over half of sources focusing on the nature of violence against healthcare, including measuring and understanding the prevalence of violence. Where present, sources that examine the impact of violence focus more on the impact on healthcare infrastructure and healthcare workers, and less on the related impact on patients or wider impacts beyond the immediate healthcare system. Sources that examine interventions mainly study existing interventions as opposed to new interventions, and focus more on policy, strategy and legislation. There are comparatively fewer studies that consider training interventions in conflict, post-conflict and fragile environments when compared to the overall evidence base. There are also relatively few existing systematic reviews and meta-analyses that focus specifically on violence against healthcare literature in conflict, post-conflict and fragile environments, which limits understanding of the quality of existing evidence.

These findings are summarised in Figure 2 (over).

Figure 2. Summary of research findings from the structured literature review

Overview of evidence base
The majority of literature is academic as opposed to grey
The volume of literature published each year has increased steadily over the last 10 years
Most sources are pubished in English, but literature is also available in non-English languages
Most sources focus on violence against healthcare either in North AMerica, Europe & Central Asia, or East Africa & the Pacific
The majority of literature focuses on high- and upper-middle-income countries
Surveys are the most common research design
Only a small proportion of sources focus explictly on conflict, post-conflict and fragile envirnments
Literature on conflict, post-conflict and fragie areas focuses mainly on countries in the Middle East
Research in conflict, post-conflict and fragile areas is based primarily on secondary analysis

Conceptualisation of violence
Most studies conceptualise violence as either physical and/or psychological violence
Sources that examine physical violence focus primarily on interpersonal physical violence
Sources that examine phychological violence focus primarily on verbal abuse and aggression
Most studies focus on violence towards healthcare workers as opposed to patients, infrastructure, etc.
Within literature that examines healthcare workers as targets, nurses are studied most frequently
Most studies focus on violence carried out by patients
Most studies focus on violence in healthcare facilities
Research in conflict, post-conflict and fragile areas focuses primarily on physical violence, including interpersonal physical violence, violence with large weapons, theft, looting, arrests, kidnapping, forced displacement and other forms of violence
Where specified, most studies in conflict, post-conflict and fragile environments focus on violence carried out by unaffiliated third parties

Evidence on the nature of violence against healthcare
Most studies focus on the nature of violence against healthcare
Most publications study the prevalence of violence against healthcare
Surveys are the most frequently used research design in studies on the nature of violence
There are a number of systemic reviews of the nature of violence against healthcare, but they focus on certain types of perpetrators, targets and types of violence
Research in conflict, post-conflict and fragie environments also focuses on the prevalence of violence
There is only one systemic review of the nature of violence against healthcare in conflict, post-conflict and fragile environments

Evidence on the impact of violence against healthcare
Around a quarter of publications study the impact of violence against healthcare
Most publications study the personal impact of violence on healthcare workers
Surveys are the most commonly applied research design when studying the impact of violence
There are fewer systematic reviews of the impact of violence, and they are similarly clustered within specific perpetrators, targets, types and locations of violence
Research on impact in conflict, post-conflict and fragile environments focuses primarily on the impact on healthcare infrastructure and healthcare workers
There is only one systematic review of the impact of violence against healthcare in conflict, post-conflict and fragile environments

Evidence on interventions against violence
Around a quarter of publications study interventions against violence aainst healthcare
A similar proportion of publications study existing interventions and new interventions
Studies of existing interventions focus most frequently on training, policy, and tools, measures and techniques
Where specified, studies consider interventions to be effective to some degree
Research in conflict, post-conflict and fragile environments focuses primarily on existing interventions
Studies in conflict, post-conflict and fragile environments focus more on policy/strategy and legislation
There is only one systemic review of interventions countering violence against healthcare in conflict, post-conflict and fragile environments

23 RESEARCH GAPS WERE IDENTIFIED IN THE EXISTING EVIDENCE BASE

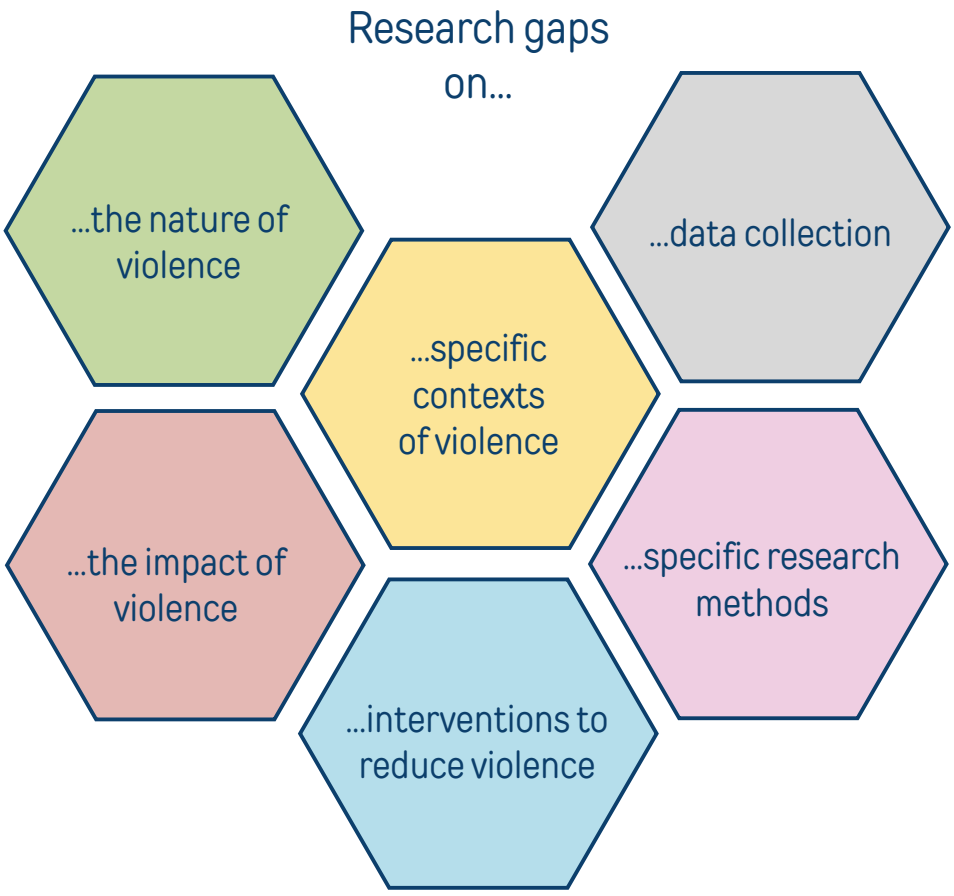
The study identified a total of 23 research gaps in the existing evidence base. These constitute areas of research where existing evidence is considered insufficient, and where additional research may lead to improvements in understanding and our ability to reduce, prevent and mitigate violence against healthcare.

The research gaps were clustered into the following six areas:

i) Research gaps on the nature of violence against healthcare
ii) Research gaps on the impacts of violence against healthcare
iii) Research gaps on interventions to reduce, prevent and mitigate violence against healthcare
iv) Research gaps on specific contexts of violence against healthcare
v) Research gaps in data collection
vi) Research gaps in specific research methods.

These clusters are described in more detail in the following sections.

Figure 3. Six clusters of research gaps



FIVE RESEARCH GAPS WERE IDENTIFIED RELATING TO RESEARCH ON THE NATURE OF VIOLENCE AGAINST HEALTHCARE

Five research gaps were identified on the nature of violence against healthcare: the motivations of perpetrators of violence (1); the contextual drivers of violence (2); the loss of legitimacy of service for healthcare workers in conflict areas (3); the gender dynamics of violence (4); and specific subsets of perpetrators, targets and types of violence (5).

Gaps in this area point to limitations in our understanding of the underlying dynamics and causes of violence against healthcare, and may limit the development of interventions that are effective across different contexts and for different types of violence. The associated research gaps are summarised in Table 1.

Table 1. Summary of research gaps on the nature of violence against healthcare.

Research Gap	Description
1 – Motivations of perpetrators	Existing research on the causes of violence against healthcare focuses primarily on antecedents or predictors of violence. While these considerations are useful for developing tools that enable pre-emptive and preventive strategies, there is a lower level of understanding as to why perpetrators commit violence against healthcare. This includes underlying factors (e.g. psychosocial, situational), how these factors interact with each other, and how they vary in different contexts.
2 – Contextual drivers of violence	Violence against healthcare does not occur as an isolated act but rather takes place within a wider ecosystem of contextual factors. In contrast to micro-level predictors, these meso- and macro-level contextual factors are less well understood in the literature. This refers, for example, to historical and socio-cultural factors, as well as wider conflict dynamics where applicable.
3 – Loss of legitimacy	Healthcare workers in conflict-affected areas perceive a loss of legitimacy of service, which is impacting on the delivery and safeguarding of healthcare in conflict-affected environments. This trend has not been examined extensively in the existing literature, and its drivers remain poorly understood.
4 – Gender dynamics	Whilst healthcare is often provided by female healthcare workers, there is an absence of research on the role of gender dynamics in violence against healthcare. This includes whether gender creates certain incentives to commit violence, whether female healthcare workers are targeted more often, and whether the impact of violence against healthcare disproportionately disincentivises women from seeking professional health care or working as service providers in certain contexts.
5 – Subsets of perpetrators, targets and types	Certain types of violence, victims and perpetrators feature prominently in the literature, such as interpersonal physical violence against nurses. However, other subsets are less commonly researched. This includes, for example, alternative forms of physical violence (e.g. theft, looting, blockades, arrests), violence carried out by third parties, and structural forms of violence.

TWO RESEARCH GAPS WERE IDENTIFIED RELATING TO RESEARCH ON THE IMPACT OF VIOLENCE

Two research gaps were identified with regards to the impacts of violence against healthcare: the wider impacts of violence (6); and the impacts of security policy on healthcare (7).

A lack of understanding of the full scale of impacts of violence against healthcare poses clear challenges to designing effective interventions in this space. A limited or narrow understanding of impact may, for example, lead to under-investment in specific prevention or mitigation measures, or conversely, may result in misdirected over-investment in ineffectual interventions.

The evidence base may also benefit from further research specifically on the indirect impacts of security policy and legislation on healthcare. This was identified as a tension in existing national and international policy and legislation, with several interviewees expressing uncertainty regarding the potential impact of security policy and legislation on the ability to deliver healthcare services, in particular in conflict areas. The associated research gaps are summarised in Table 2.

Table 2. Summary of research gaps on the impact of violence against healthcare

Research Gap	Description
6 – Wider impacts of violence	Though violence against healthcare is suspected to have wide-ranging impacts, these are not well understood beyond the immediate and measurable outcomes of violence on its victims. Existing research appears to focus on the personal impacts of violence and the immediate impact on healthcare delivery, while the second- and third-order impacts, such as the wider economic cost of violence or the prolongation of conflict, are significantly less well understood.
7 – Impacts of security policy	National-level security policies are known to have indirect but potentially detrimental impacts on healthcare delivery. These impacts, including the criminalisation of healthcare in the context of counterterrorism,[1] remain under-researched. Such policies may, however, have profound impacts on healthcare, including by exerting psychological pressures on healthcare workers and challenging medical neutrality.

[1]This refers to instances where healthcare workers may be prosecuted for providing healthcare services to terrorists or individuals affiliated with terrorist organisations.

THREE RESEARCH GAPS WERE IDENTIFIED RELATING TO INTERVENTIONS TO REDUCE, PREVENT AND MITIGATE VIOLENCE AGAINST

Three research gaps were identified regarding interventions to reduce, prevent and mitigate violence against healthcare: the design and evaluation of organisational aspects of interventions (8); longitudinal evaluations of interventions (9); and the role of different stakeholders in addressing violence against healthcare (10).

Research in this area may have direct applications for designing more effective interventions to address violence against healthcare.

Understanding the organisational and long-term aspects of interventions may, for example, support the development of more comprehensive and sustained interventions that not only protect healthcare workers and patients from individual instances of violence, but may also lead to the development of interventions to reduce the long-term frequency and impact of violence against healthcare. Understanding the role of different stakeholders is also considered a key component of reducing violence against healthcare, in particular in conflict areas. The associated research gaps are summarised in Table 3.

Table 3: Summary of research gaps on interventions to reduce, prevent and mitigate violence against healthcare

Research Gap	Description
8 – Organisational aspects of interventions	Research on interventions focuses primarily on tools and techniques to support individual healthcare workers manage individual instances of violence. There is less research on organisational-level interventions that address wider issues, such as organisational culture or systemic power imbalances.
9 – Longitudinal evaluations	The majority of research that evaluates interventions is cross-sectional by design, with relatively few longitudinal evaluations of interventions. An absence of longitudinal studies limits a continual understanding of the effectiveness of interventions over a more extended period of time.
10 – Roles of different stakeholders	Addressing violence against healthcare is inherently interdisciplinary, and necessarily involves stakeholders such as the military, NGOs, police, government and local actors. There is, however, little research on the role of actors who are not involved in the immediate delivery of healthcare.

FIVE RESEARCH GAPS WERE IDENTIFIED RELATING TO RESEARCH ON SPECIFIC CONTEXTS OF VIOLENCE AGAINST

Five research gaps were identified that relate to different contexts of violence against healthcare: uncertainty as to whether violence against healthcare in conflict and non-conflict environments should be considered fundamentally the same or fundamentally different phenomena (11); violence against healthcare in areas of generalised/collective violence (12); research in non-Western settings (13); violence against healthcare in conflict areas, in particular in lower-profile conflict areas (14); and translating research findings from one context to another (15). Research gaps in this category not only refer to research on violence against healthcare in specific contexts, such as conflict areas and non-Western settings, but also consider more broadly the definition of different contexts and the transferability of research from one context to another. The associated research gaps are summarised in Table 4.

Table 4. Summary of research gaps on specific contexts of violence against healthcare

Research Gap	Description
11 – Conflict vs. non-conflict environments	There is disagreement as to whether a single logic underpins violence against healthcare in all contexts, or whether violence against healthcare in conflict and non-conflict environments is governed by fundamentally different underlying logics. Research in this area may provide conceptual clarity, in particular to the academic literature.
12 – Generalised/ collective violence	There is a lack of research and clear conceptualisation of violence against healthcare in contexts that are not defined as conflict environments, but nonetheless experience high levels of violence. These environments may be qualified as areas of generalized/collective violence. This includes areas with high levels of gang-related violence, organised crime, and powerful local militia/non-state armed groups.
13 – Non-Western settings	The majority of existing research focuses on violence against healthcare in Western settings and in countries in the northern hemisphere (see findings from the literature review). There is a comparatively less research on violence against healthcare in non-Western settings.
14 – Low profile conflict environments	There is comparatively less research on violence against healthcare in conflict areas, and existing research in conflict areas focuses primarily on countries in the Middle East. Other conflict areas (such as those in Africa, Central and South America and Asia) feature less frequently in the literature.
15 – Translating context-specific research	It is unclear to what degree and in which ways research on violence against healthcare may be translated and applied from one context to another. Research is often necessarily highly localised to specific contexts of violence, but there would be value in understanding the ways in which research findings may be translated to other contexts of violence, in particular when studying interventions.

FOUR RESEARCH GAPS WERE IDENTIFIED RELATING TO LIMITATIONS IN DATA COLLECTION

Four research gaps were identified that relate specifically to data collection: the quantity and quality of surveillance data in conflict environments (16); data on violence against healthcare in non-urban/rural environments (17); data on lower-intensity but higher-frequency violence in conflict areas (18); and the variety of data collection methods in non-conflict environments (19).

Although data collection mechanisms have improved in recent years, several gaps were identified in this area.

Whilst extremely challenging to implement in a reliable manner, existing surveillance data in conflict environments was criticised by several interviewees as providing incomplete information, inadequate levels of disaggregation, and failing to capture important information such as perpetrators, locations and types of violence. Data in conflict environments also appears to focus predominantly on high-impact attacks, while less attention is given to frequent but lower-impact types of violence. There also appears to be a bias towards data in urban as opposed to rural environments, and data collection in non-conflict areas is largely conducted through self-reported surveys and questionnaires. The associated research gaps are summarised in Table 5 below.

Table 5. Summary of research gaps on limitations in data collection

Research Gap	Description
16 – Surveillance data in conflict environments	Existing surveillance data (i.e. data collected on an ongoing basis) on violence against healthcare in conflict areas is limited in quality and quantity, and does not capture key information such as the perpetrators and specific locations of attacks.
17 – Rural/ urban environments	Existing literature on violence against healthcare is biased towards urban environments. This may be driven by dominant collection practices that focus on the perspectives of large, urban-based NGOs and international institutions at the expense of local, rural-based actors.
18 – Low intensity high frequency violence	Healthcare workers in conflict zones face a wide spectrum of violence ranging from high-intensity attacks (e.g. aerial bombing) to more frequent but less high-impact types of violence (e.g. looting, blockade and arrest). Such low-intensity but more frequent forms of violence feature less prominently in the literature.
19 – Data collection in non-conflict environments	Data collection in non-conflict settings is primarily carried out through surveys and questionnaires. This limits the development of the evidence base as such research methods can suffer from recall or intentionality biases, and may lead to inaccurate or unrepresentative reporting of violence.

FOUR RESEARCH GAPS WERE IDENTIFIED RELATING TO LIMITATIONS IN RESEARCH METHODS

Four research gaps were identified that relate to research methods: interdisciplinary approaches to research (20); systematic reviews of research in conflict areas (21); evaluations of interventions in conflict areas (22); and perspectives from Critical Theory (23).

These research gaps refer to methodological shortcomings in existing research. The incorporation of novel perspectives and narratives from other disciplines, including Critical Theory, may lead to more rigorous and robust evidence that interrogates the existing assumptions that underpin research on violence against healthcare.

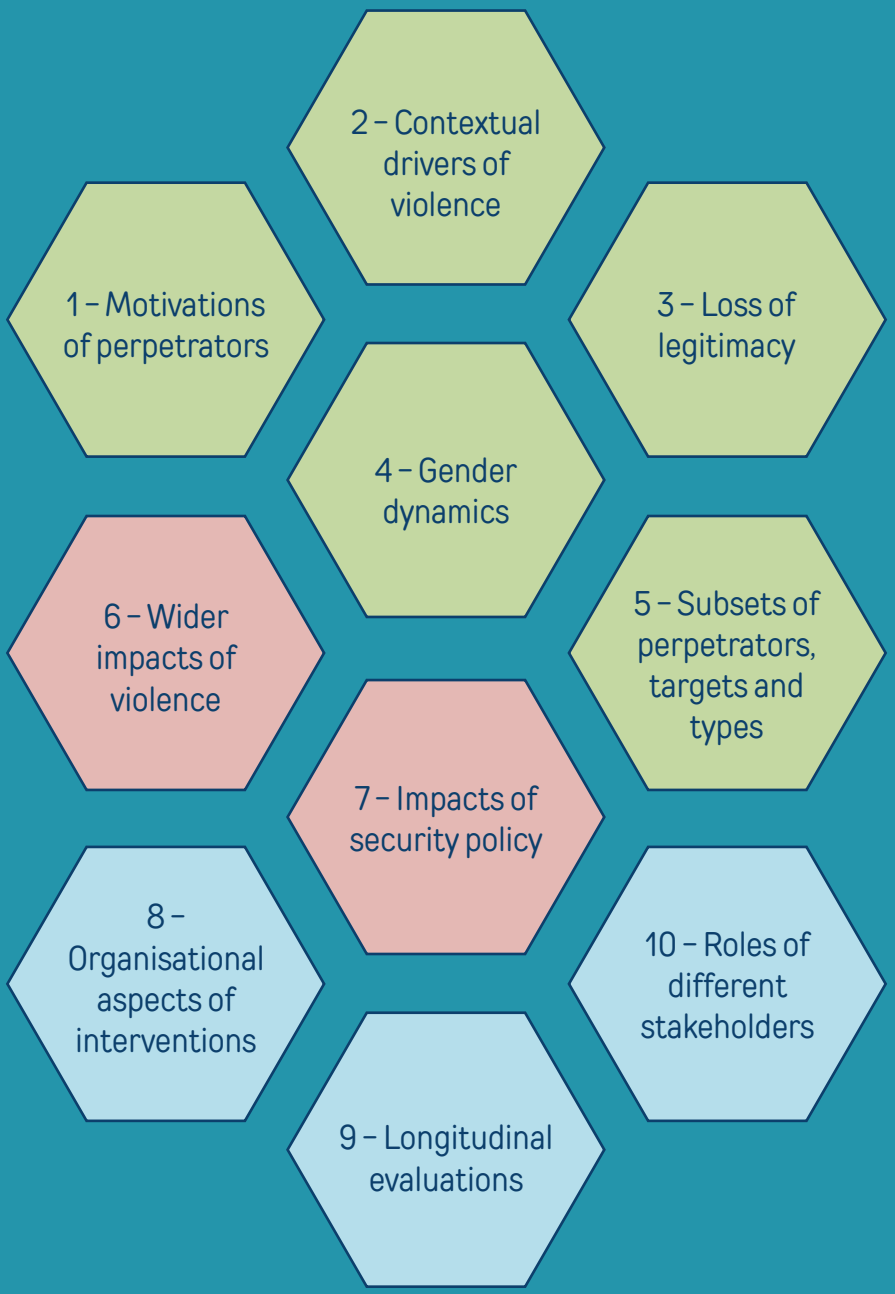
Research in this area would also benefit from collaborative approaches with stakeholders from associated fields, including political science, international relations and economics. An absence of interdisciplinary perspectives may overlook relevant insights or neglect opportunities to uncover biases in existing research. Systematic reviews and evaluations of existing interventions in conflict areas may provide greater clarity on the status of the evidence base and the degree to which existing interventions are supported by rigorous research. The associated research gaps are summarised in Table 6 below.

Table 6. Summary of research gaps on limitations in research methods

Research Gap	Description
20 – Interdisciplinary approaches	The issue of violence against healthcare is inherently interdisciplinary, requiring insights and perspectives that bridge security, public health, law, humanitarian aid and other fields. However, there is an inadequate level of interdisciplinary research on violence against healthcare.
21 – Systematic reviews in conflict areas	There are few systematic reviews of available literature on violence against healthcare in conflict areas. This makes it more difficult to understand the degree to which existing assertions on violence against healthcare are supported by evidence in the literature, and makes it more challenging to identify future areas of research that address key limitations in the existing evidence base.
22 – Evaluations of interventions	There are few evaluations of interventions and ways of working that safeguard healthcare workers in conflict areas, with this information typically held as tacit knowledge by experts and individuals/organisations with experience in delivering healthcare services in such areas. There is a lack of evidence on the extent to which different interventions are effective, and a lack of transparency on the nature and quality of evidence supporting existing recommendations.
23 – Perspectives from Critical Theory	Approaches and ideas from Critical Theory do not feature strongly in existing research on violence against healthcare. The inclusion of more critical perspectives may lead to a more complex and nuanced understanding of the field and may confer a higher degree of context specificity.

Figure 4. Summary of all 23 research gaps

Note: The colours used in this figure correspond to the six overarching clusters of research gaps. Green indicates research gaps on the nature of violence; red indicates research gaps on the impact of violence; blue indicates research gaps on interventions; yellow indicates research gaps in specific contexts of violence; grey indicates research gaps in data collection; and pink indicates research gaps in research methods.




11 – Conflict vs. non-conflict environments
16 – Surveillance data in conflict environments
15 – Translating context-specific research
17 – Rural/ urban environments
12 – Generalised/ collective violence
18 – Low intensity high frequency violence
14 – Low profile conflict environments
19 – Data collection in non-conflict environments
13 – Non-Western settings
20 – Interdisciplinary approaches
21 – Systematic reviews in conflict areas
23 – Perspectives from Critical Theory
22 – Evaluations of interventions

FUTURE RESEARCH MAY BE PRIORITISED BASED ON EXPECTED IMPACT, FEASIBILITY OF IMPLEMENTATION, AND RELEVANCE TO DIFFERENT STAKEHOLDERS

The final stage of this study sought to prioritise areas of future research based on the 23 identified research gaps. The research team carried out a series of internal workshops with senior researchers from RAND Europe, during which participants scored research gaps against three criteria: impact, feasibility of implementation, and relevance to policymakers, practitioners and researchers. Participants were selected based on relevant experience in healthcare and/or security research, and included individuals with previous experience as practitioners and policymakers. Nonetheless, it should be acknowledged that there is a potential bias in the scores towards the perspective of current researchers, and that the overall sample size was relatively small (n=8).

Table 7. Summary of prioritisation criteria

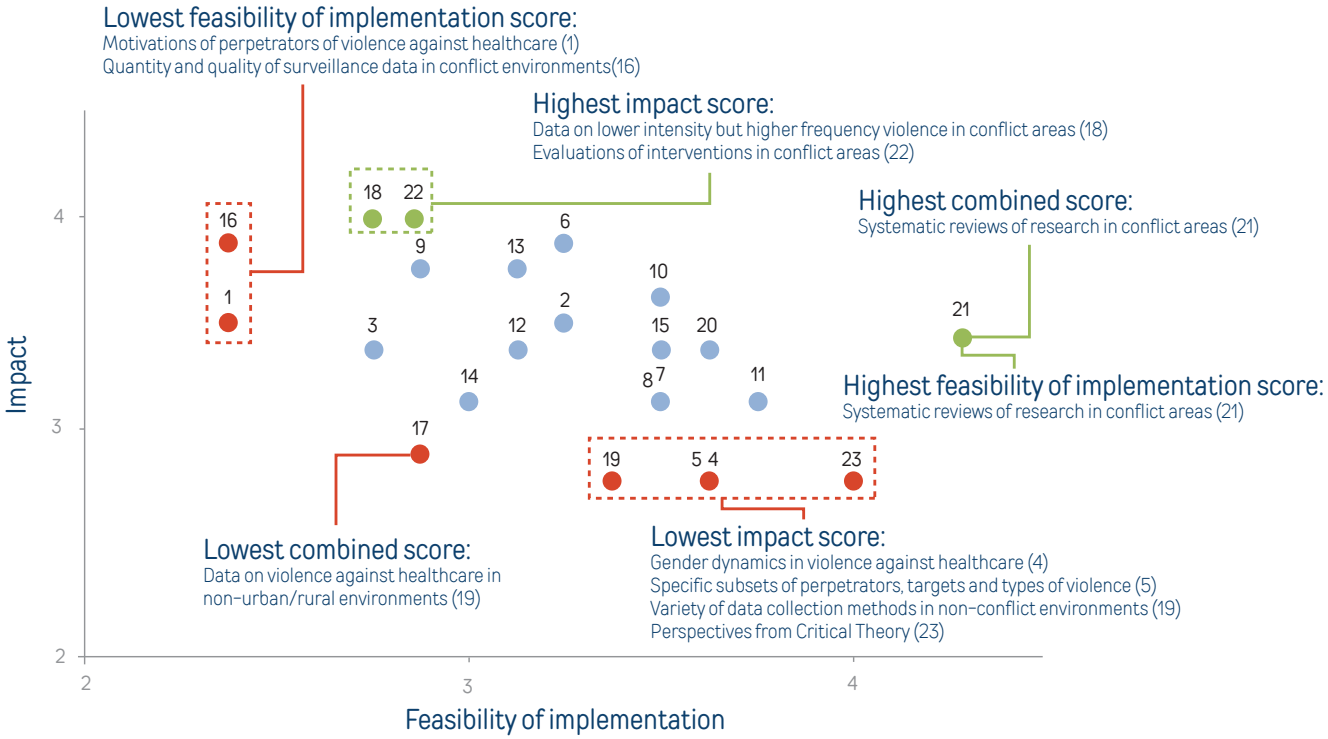
Criteria	Description	Scoring range
Impact of research	This criterion assesses the overall magnitude of impact, were the research gap to be addressed.	1 (no impact) to 5 (ground breaking research)
Feasibility of implementation	This criterion assesses the feasibility of carrying out the research that addresses the research gap, including the presence and scale of any barriers to implementation. Note that this does not refer to the feasibility of implementing research findings.	1 (impossible to implement) to 5 (no barriers to implementation)
Relevance to practitioners/ policy-makers/ researchers	This criterion assesses the degree to which research findings would be of interest and usable to three different stakeholder groups: practitioners/ policymakers/researchers.	1 (no relevance) to 5 (highly relevant)

The results of the research prioritisation are illustrated in Figure 5 and Figure 6, which also highlight a number of research gaps that received particularly high or particularly low scores:

- Systematic reviews of research in conflict areas (21), for example, received the highest overall combined score, which suggests that research in this area may not only have a relatively large impact on our existing understanding of and ability to counteract violence against healthcare, but may also be carried out whilst overcoming relatively low barriers to implementation.
- Data on violence against healthcare in non-urban/rural environments (17) received the lowest overall combined score, which suggests that research in this area may have a relatively low impact and may be relatively difficult to implement.

- Additional areas of research are also highlighted in Figure 5, including data on lower-intensity but higher-frequency violence in conflict areas (18) and evaluations of interventions in conflict areas (22), both of which scored highest for impact; motivations of perpetrators of violence against healthcare (1) and surveillance data in conflict environments (16), both of which scored lowest for feasibility of implementation; and gender dynamics in violence against healthcare (4), specific subsets of perpetrators, targets and types of violence (5), variety of data collection methods in non-conflict environments (19), and perspectives from Critical Theory (23), all of which scored lowest for impact.

Figure 5. Scores from prioritisation of research gaps



Note: the labels refer to the research gap numbers listed in Figure 4.

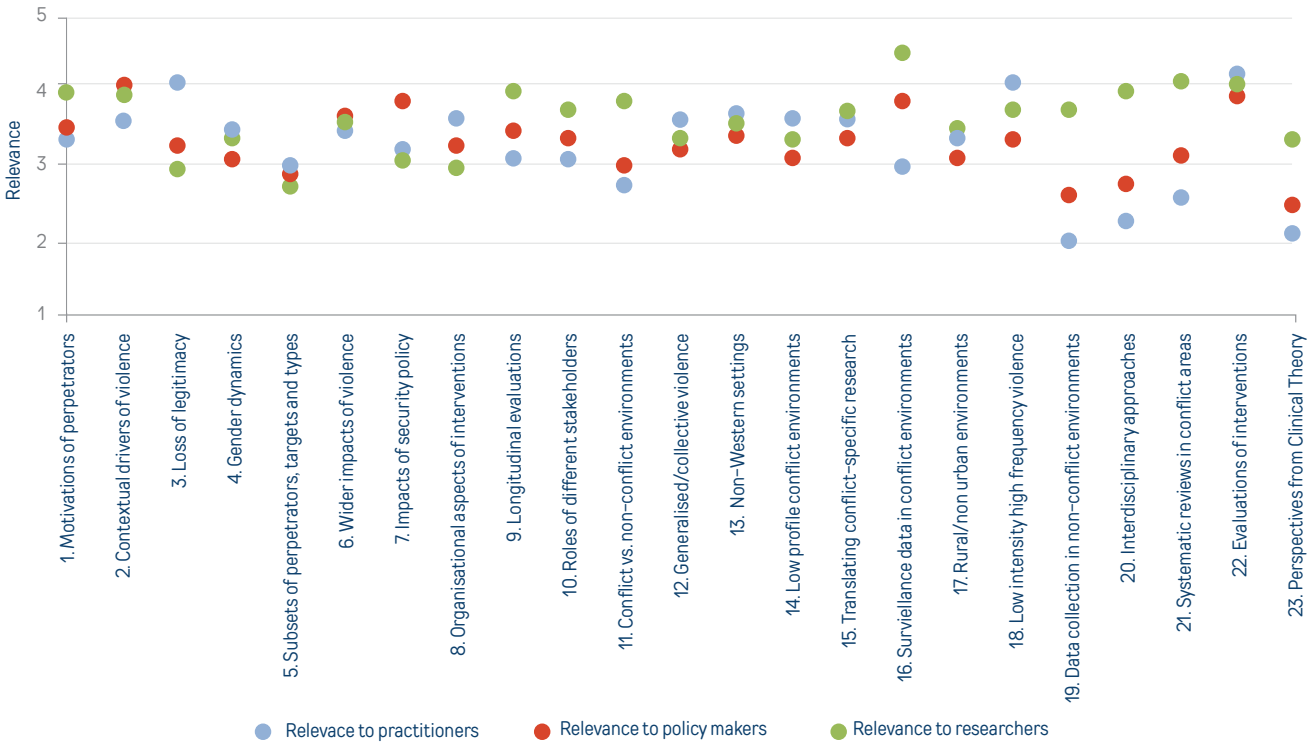
Workshop participants also scored the relevance of each research gap for practitioners, policymakers and researchers, the results of which are summarised in Figure 6. A number of research gaps scored comparatively highly for each stakeholder:

- Research on the loss of legitimacy of service for healthcare workers in conflict areas (3) and data on lower-intensity but higher-frequency violence in conflict areas (18) both scored in the top three for relevance to practitioners.
- Research on the contextual drivers of violence against healthcare (2) and on the indirect impacts of security policies on healthcare (7) both scored in the top three for relevance to policymakers.
- Systematic reviews of research in conflict areas (21) and the quantity and quality of surveillance data in conflict areas (16) both scored in the top three for relevance to researchers.
- Evaluations of interventions in conflict areas (22) scored in the top three for relevance to practitioners, policymakers and researchers alike.

Figure 6 also highlights that some research gaps are considered equally relevant for all three stakeholders, whereas others are considered relevant to one or two stakeholders only. Research on the wider impacts of violence against healthcare (6) and in non-Western settings (13), for example, received relatively similar scores for all three stakeholders, whereas research on violence against healthcare in conflict and non-conflict environments as fundamentally the same or fundamentally different phenomena (11) and interdisciplinary approaches to research (20) both received a wider spread of scores for different stakeholders.

When identifying and selecting areas for future research on violence against healthcare, it is suggested that the relevance scores in Figure 6 should be considered alongside the impact and implementations scores in Figure 5, including the relevance to individual stakeholders and the broader relevance across all stakeholder groups. This should also be combined with broader considerations, such as individual and organisational research objectives and constraints.

Figure 6. Relevance of research for different stakeholders



Note: research gaps are numbered according to Figure 4.

Through the review of available literature, identification of research gaps and prioritisation of future research, it is hoped that the findings of this summary and the corresponding report will support the development of new studies that address limitations in the existing evidence base. It is recommended that additional 'deep dives' are conducted in relation to one or more of the identified research gaps, as this may lead to the development of concrete research proposals. Ultimately, it is envisaged that this will support a more systematic and informed approach to developing future research that enables both policymakers and practitioners to provide healthcare services that are open, secure and free from violence.

ICRC

HEALTH CARE IN DANGER

IT'S A MATTER OF LIFE & DEATH

elrha