

SAFEGUARDING HEALTH IN CONFLICT

2018

IMPUNITY REMAINS: Attacks on Health Care in 23 Countries in Conflict



Center for Public Health
and Human Rights



Center for Humanitarian Health



IntraHealth
INTERNATIONAL
Because Health Workers Save Lives.



Agency Coordinating Body for Afghan Relief and Development (ACBAR)	International Health Protection Initiative
Alliance of Health Organizations (Afghanistan)	International Rehabilitation Council for Torture Victims
American Public Health Association	International Rescue Committee
Canadian Federation of Nurses Unions	IntraHealth International
Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health	Irish Nurses and Midwives Organisation
Consortium of Universities for Global Health	Johns Hopkins Center for Humanitarian Health
Defenders for Medical Impartiality	Karen Human Rights Group
Doctors for Human Rights (UK)	Management Sciences for Health
Doctors of the World - Médecins du Monde	Medact
Egyptian Initiative for Personal Rights	Medical Aid for Palestinians
Friends of the Global Fund Africa (Friends Africa)	North to North Health Partnership (N2N)
Global Health Council	Office of Global Health, Drexel Dornsife School of Public Health
Global Health through Education, Training and Service (GHETS)	Pakistan Medical Association
Harvard Humanitarian Initiative	Physicians for Human Rights (PHR)
Human Rights Watch	Physicians for Human Rights–Israel
Insecurity Insight	Save the Children
International Council of Nurses	Surgeons OverSeas (SOS)
International Federation of Health and Human Rights Organisations	Syrian American Medical Society (SAMS)
International Federation of Medical Students' Associations (IFMSA)	University Research Company
	Watchlist on Children and Armed Conflict
	World Vision

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AB	Anti-Balaka
ADF	Allied Democratic Forces
CAR	Central African Republic
DRC	Democratic Republic of Congo
ES	Ex-Séléka
FPRC	Popular Front for the Rebirth of Central African Republic
HDX	Humanitarian Data Exchange
ICRC	International Committee of the Red Cross
ISIL	Islamic State of Iraq and the Levant
ISIS	Islamic State of Iraq and Syria
MINUSMA	United Nations Multidimensional Integrated Stabilization Mission in Mali
MONUSCO	United Nations Organization Stabilization Mission in the Democratic Republic of the Congo
MSF	Médecins Sans Frontières
NGO	Nongovernmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
oPt	occupied Palestinian territory
SELC	Saudi and Emirati-led Coalition
SPLA	Sudan People's Liberation Army
SPLA-IO	Sudan People's Liberation Army-In Opposition
SSA	Surveillance System of Attacks on Healthcare
UCDP	Uppsala Conflict Data Program
UN	United Nations
UNAMA	United Nations Assistance Mission in Afghanistan
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization



The connection between violence against health facilities and health workers and people's health has been brought home dramatically in the extremely difficult effort to bring the Ebola epidemic in the Democratic Republic of Congo under control. Attacks on clinics, health workers, police, and peacekeepers have severely impeded the work, resulting in suspensions of health programs for days or longer and restricting efforts to reach people to stop the spread of the disease.

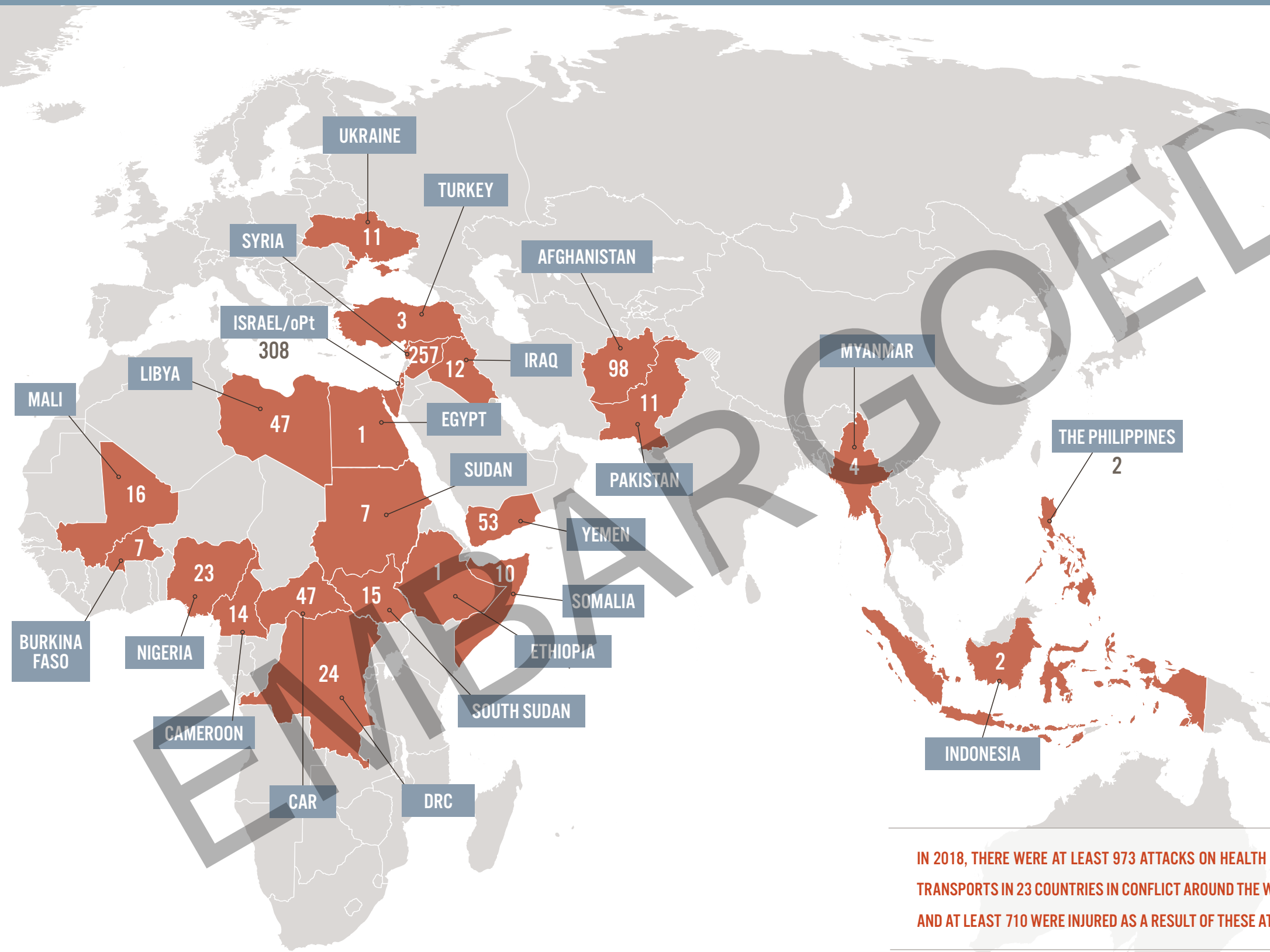
At the end of December, the Director-General of the World Health Organization, Dr. Tedros Adhanom Ghebreyesus, said that gains in stopping Ebola "could be lost if we suffer a period of prolonged insecurity, resulting in increased transmission. That would be a tragedy for the local population, who have already suffered too much."ⁱ Indeed, it has been, just as violence against health care has had tragic consequences for the people of Afghanistan, the Central African Republic, the occupied Palestinian territory, Syria, Yemen, and so many other places in the world.

The report shows what is happening in conflicts throughout the world. We have become accustomed to rhetoric that condemns attacks on health care as unacceptable. But the absence of tangible follow-up on United Nations Security Council resolution 2286 suggests that attacks on health, while illegal under international law, are becoming accepted. The report makes extensive recommendations to end this passivity, as we owe the wounded and sick, as well as the health workers who serve them, protection of their rights to life and health.

-Len Rubenstein, chair, Safeguarding Health in Conflict Coalition

ⁱ Ghebreyesus, Tedros Adhanom. Statement on disruptions to the Ebola response in the Democratic Republic of the Congo. WHO. December 28, 2018. <https://www.who.int/news-room/detail/28-12-2018-statement-on-disruptions-to-the-ebola-response-in-the-democratic-republic-of-the-congo>.

COUNTRIES WITH ATTACKS ON HEALTH CARE IN 2018



COUNTRIES	# OF ATTACKS
AFGHANISTAN	98
BURKINA FASO	7
CAMEROON	14
CAR	47
DRC	24
EGYPT	1
ETHIOPIA	1
INDONESIA	2
IRAQ	12
ISRAEL/oPt	308
LIBYA	47
MALI	16
MYANMAR	4
NIGERIA	23
PAKISTAN	11
THE PHILIPPINES	2
SOMALIA	10
S. SUDAN	15
SUDAN	7
SYRIA	257
TURKEY	3
UKRAINE	11
YEMEN	53

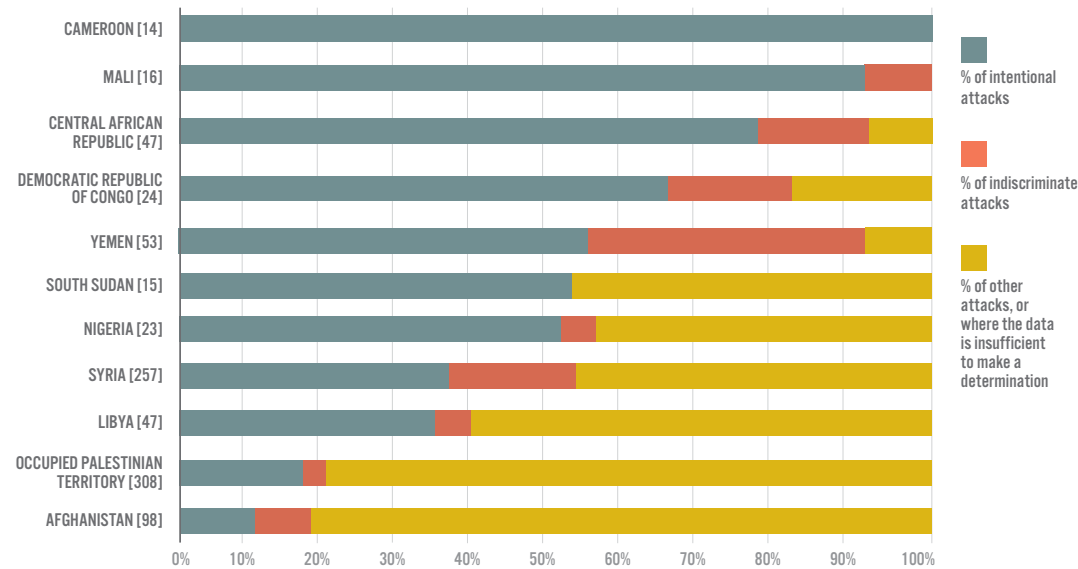
IN 2018, THERE WERE AT LEAST 973 ATTACKS ON HEALTH WORKERS, HEALTH FACILITIES, AND HEALTH TRANSPORTS IN 23 COUNTRIES IN CONFLICT AROUND THE WORLD. AT LEAST 167 HEALTH WORKERS DIED AND AT LEAST 710 WERE INJURED AS A RESULT OF THESE ATTACKS.

DATA OVERVIEW AND VISUALS

OVERVIEW



SUSPECTED INTENTIONAL VERSES SUSPECTED INDISCRIMINATE ATTACKS ON HEALTH CARE



This graph shows the proportion of suspected intentional attacks on health care compared to suspected indiscriminate attacks in countries where 14 or more attacks were documented. Totals attacks per country are shown in brackets.

DEATHS AND INJURIES OF HEALTH WORKERS BY WEAPON TYPE



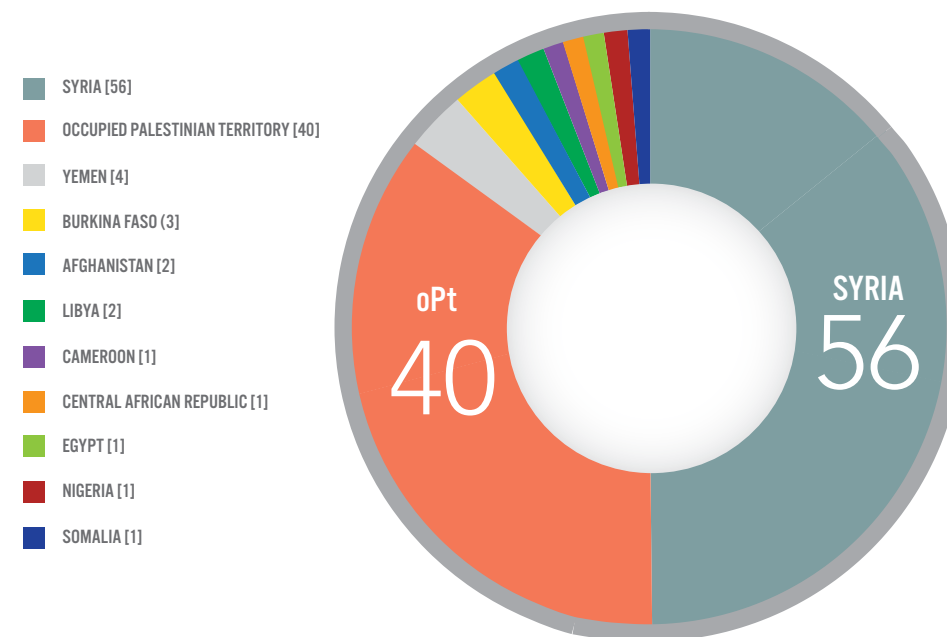
This graph shows the proportion of attacks where explosive weapons use caused death or injury to health workers in comparison to death and injuries of health workers caused by other known or unknown weapons in countries where health workers were reportedly killed or injured. Totals per country are shown in brackets.

DAMAGE TO OR DESTRUCTION OF HEALTH FACILITIES BY WEAPON TYPE



This graph shows the proportion of attacks where explosives weapons caused damage to or destruction of health facilities in comparison to damage or destruction caused by other known or unknown weapons in countries reporting health facility damage or destruction. Total numbers of attacks that either damaged or destroyed a health facility, per country are shown in brackets.

AMBULANCES DAMAGED OR DESTROYED IN 11 COUNTRIES



This graph shows the proportion of events where ambulances were reportedly damaged or destroyed. Totals per country are shown in brackets.

INTRODUCTION

In 2018, the Safeguarding Health in Conflict Coalition documented a **total of 973 attacks on health in 23 countries in conflict.**ⁱⁱ At least 167 workers died in attacks in 17 countries, and at least 710 were injured. Hospitals and clinics were bombed and burned in 15 countries. Aerial attacks continued to hit health facilities in Syria and Yemen. The number of documented attacks represents a significant increase from our last report of 701 attacks in 23 countries in 2017.ⁱⁱⁱ However, it cannot be determined whether this higher number signifies a greater number of attacks in 2018 than in 2017 or an improvement in reporting mechanisms, in light of the implementation of the World Health Organization (WHO)'s Surveillance System of Attacks on Healthcare (SSA). We incorporated data from six of the eight countries and territories that the WHO currently reports on, and it remains likely that the true number of attacks is even higher than reported overall.

This report documents attacks against vaccination workers, paramedics, nurses, doctors, midwives, patients, community volunteers, and drivers and guards, in violation of longstanding human rights and humanitarian law norms to protect and respect health care in conflict. Apart from the immediate human suffering they cause, attacks deprive populations of access to health care and jeopardize the achievement of the WHO's goals for universal health coverage. Vaccination workers were attacked in six countries, impeding the broad reach of crucial vaccines such as polio. Moreover, many of the countries in this report face acute shortages of health workers as measured by the WHO's standards,^{iv} and ongoing violence against health care will likely exacerbate the problem.

METHODS AND LIMITATIONS

This sixth report by the Safeguarding Health in Conflict Coalition focuses on attacks on health care in conflict, defined by the WHO as "any act of verbal or physical violence, threat of violence or other psychological violence, or obstruction that interferes with the availability, access and delivery of curative and/or preventive health

services."^v We used the Uppsala Conflict Data Program (UCDP) to determine if countries are considered in conflict. The report does not cover interpersonal violence in health care settings or the consequences of gang and other forms of criminal violence that are prevalent in a number of countries. Where the evidence is available, we provide information on the perpetrators of attacks and also whether the attack appears to have been intentional. Please see the Methodology section for more information.

This report contains data from a variety of sources: open source data compiled by Coalition member Insecurity Insight from the Attacks on Health Care Monthly News Briefs and the WHO; events provided for Syria by Coalition members Syrian American Medical Society and Physicians for Human Rights; information on attacks in the occupied Palestinian territory (oPt) provided by Médecins du Monde; data from the WHO's SSA for six countries: Afghanistan, Iraq, Libya, Nigeria, the oPt, and Yemen; research conducted by Coalition members to add information from the United Nations (UN) Office for the Coordination of Humanitarian Affairs (OCHA), the UN Office of the High Commissioner for Human Rights, and the UN High Commissioner for Refugees (UNHCR); and media reports deemed reliable. We are grateful to the organizations that shared information for this report.

Our dataset of incidents is available for open source access on the Humanitarian Data Exchange (HDX) at <https://data.humdata.org/dataset/shchealthcare-dataset>.^{vi}

We make every effort to include only attacks on health that are perpetrated by parties to a conflict, but in some countries, it is difficult to distinguish between criminal acts and politically motivated attacks. The SSA does not include any information on the perpetrator and as such, information on perpetrators has been excluded for incidents reported by the SSA. Additionally, there are significant variations in the data that may be attributable to differences in the robustness of local reporting systems. The SSA, for example, reported hundreds of attacks in the oPt but only a handful in Yemen, which may not be truly representative of the situation on the ground.

We were not able to obtain sufficient data to determine the number of wounded and sick people or the number of bystanders who were killed or injured in these attacks. Where such information is available, it is reported in the country-by-country sections.

OVERVIEW



The countries with the most reported attacks on health in 2018 are the oPt (308), Syria (257), Afghanistan (98), Yemen (53), Libya (47), and the Central African Republic (CAR) (47). In 2018, we found an increase in the number of reported incidents in Cameroon, Libya, the oPt, and Yemen from 2017 and a decrease in reported incidents in Iraq and South Sudan.

ATTACKS ON HEALTH FACILITIES AND TRANSPORTS

A total of 40 health facilities were destroyed across 11 countries, and 180 attacks that damaged health facilities were reported in 17 countries.

More than 120 aerial and surface-to-surface attacks were inflicted on health facilities in Syria, and at least 23 facilities were struck multiple times, most reportedly by government and Russian forces. During the government's final assault on Eastern Ghouta, one of the heaviest bombardments of the war, Syrian and allied forces hit four hospitals on February 19 and days later, hit four more.

In Yemen, there were at least seven aerial attacks on health facilities and one further aerial attack on an ambulance, as well as 15 cases of surface shelling on health facilities and transports. In one case, a Saudi-led coalition airstrike hit a Médecins Sans Frontières (MSF) cholera treatment center in Abs, despite it being clearly marked as a health facility. The attack destroyed a patient ward and damaged an adjacent unit, as well as the roof and walls, leaving the center nonfunctional. In Yemen, there were also at least two incidents of "double-tap" strikes, where first responders were killed after rushing to help victims of an attack. Five health workers were killed and one was injured in these strikes.

In Libya, the WHO reported that Benghazi's Al-Jala Hospital had been attacked four times and that attacks could result in the closure of this crucial hospital. In the

Democratic Republic of Congo (DRC), there were seven incidents of armed entry into health facilities, and in one incident, perpetrators sexually assaulted a nurse and a patient and attempted to assault another nurse. In the CAR, attacks affected 22 health facilities, causing many to temporarily close or suspend operations, some for long periods of time.

At least 93 ambulances or health transports were damaged in nine countries, and 20 were stolen or hijacked. A total of 18 health transports were destroyed in Burkina Faso, Egypt, the oPt, Syria, and Yemen. In both Syria and Afghanistan, improvised explosive devices were placed inside ambulances, causing damage. In one attack in Afghanistan in January, a suicide bomber raced an ambulance packed with explosives through a busy checkpoint on the pretext of carrying an injured patient, then detonated a bomb that killed at least 95 bystanders.

In Yemen, armed groups "militarized" hospitals. For example, in November, Houthi gunmen overtook the 22 May Hospital and placed gunmen on the roof, with subsequent retaliation from pro-government forces. Fighting then intensified across the city and came dangerously close to the government hospital of al-Thawra, resulting in hundreds of patients and health workers fleeing.

Attacks on health facilities have had a profound effect on access to health care. In Afghanistan, violence and threats forced 140 clinics to close between June 2017 and June 2018, denying an estimated two million people access to care. In Libya, Yemen, and four states in northern Nigeria, more than half of the health facilities are either closed or no longer fully functioning. In Syria, more than half of private facilities were not fully operational and more than a third of public hospitals were out of service by the second half of 2018.

ATTACKS ON HEALTH WORKERS

Health workers were killed in 17 countries: while traveling, by assassinations, by airstrikes, by bombs, and by soldiers. Syria and Afghanistan had the highest numbers of health workers killed. In total, 88 health workers were killed in Syria, more than half by airstrikes, and 19 health workers were killed in Afghanistan. In the oPt, three medics were killed by Israeli soldiers during the Great March of Return protests in Gaza. Health workers were also killed in Burkina Faso, Cameroon, the CAR, the DRC, Iraq, Mali, Myanmar, Nigeria, Pakistan, the Philippines, Somalia, South Sudan, Ukraine, and Yemen.

ii Please note that the WHO has updated its figures for the occupied Palestinian territory since our analysis of its data. As such, its figures for the occupied Palestinian territory are higher than those included in this report, meaning that the overall number of reported attacks against health is higher than what is presented in this report.

iii Although the number of countries in conflict with attacks on health care is the same in 2018 as in our 2017 report, the list of countries has changed according to the countries in conflict and the recorded attacks.

iv WHO. Health workers density and distribution. <http://apps.who.int/gho/data/node.sdg.3-c-viz?lang=en> (accessed March 14, 2019).

v WHO. Surveillance system of attacks on healthcare (SSA): Methodology. December 2018. <https://www.who.int/emergencies/attacks-on-health-care/SSA-methodology-6February2018.pdf?ua=1>.

vi Humanitarian Data Exchange. May 2019. <https://data.humdata.org/dataset/shchealthcare-dataset>

A total of 95 health workers were kidnapped, with 21 kidnapped in Nigeria and 17 in Afghanistan. In Nigeria, Hauwa Mohammed Liman, a midwife, was held captive from March 2018 until her execution by the Islamic State West Africa Province group in October.

We documented attacks specifically on vaccination workers in Afghanistan, the CAR, the DRC, Pakistan, Somalia, and Sudan—a higher number of this type of attack than reported in 2017. During these attacks, six vaccination workers were killed, and six were injured.

High numbers of health workers were injured across 15 countries by live ammunition; tear gas—both gas inhalation and being struck by gas canisters; rubber bullets; explosive weapons, including barrel bombs; airstrikes; knives; and bombs placed inside ambulances. In the oPt, more than 150 health workers were injured by nonlethal weapons such as rubber bullets and tear gas in the Great March of Return protests in Gaza. In Cameroon, Cameroonian forces reportedly opened fire at an ambulance transporting patients, leaving one nurse seriously injured.

DENIAL OF ACCESS

Though denials of access to health care are infrequently reported, we documented incidents in the CAR, Myanmar, the oPt, and the Philippines. These incidents included both physical and administrative barriers to accessing health care. In Ukraine, clean water supplies were bombed. In the CAR, Myanmar, the oPt, and the Philippines, non-state armed groups or state forces actively blocked the delivery of health services or a population's access to health services. In the oPt, Israel denied exit permits to people in Gaza who were attempting to access health care and blocked access of medical teams.

In eastern DRC, violence in and around health facilities resulted in many clinics closing for security reasons, meaning critical delays to delivering essential health services that lasted several days. These actions posed a great threat to containing the spread of the Ebola virus disease. The WHO remains deeply concerned about the security situation, with violence not only endangering the health workers and patients inside the clinics but also hindering contact tracing efforts and heightening the risk of the disease spreading further. In one incident, the armed Allied Democratic Forces launched an attack against UN forces close to an Ebola treatment center,

killing seven UN peacekeepers and resulting in the temporary closure of treatment centers in the area.

PERPETRATORS

For some countries, we have received enough information to name specific perpetrators. Overall, we received reports of specific perpetrators in 47% of incidents. Of these incidents, 71% were attributed to state forces, and 27% were attributed to non-state forces.

In Cameroon, Sudan, and Syria, over half of the total number of attacks were reportedly perpetrated by state forces; in Syria, this number includes both Syrian and foreign state forces. In one incident in Cameroon, the Cameroonian military allegedly burned down a health center, killing at least 13 patients, including a woman who had just given birth. In Syria, 174 attacks were reportedly perpetrated by state forces, including the Syrian government and Russian and Turkish forces, constituting 68% of total attacks.

In the DRC and Somalia, over half of the total number of attacks were attributed to non-state actors, with half of all incidents in Somalia reportedly perpetrated by Al-Shabab. In the DRC, 83% of reported attacks were attributed to non-state actors, including the Mai-Mai rebel group, and 88% of all reported attacks took place in the eastern provinces of North and South Kivu.

WEAPONS USE

Where possible, we captured information on the use of weapons, with perpetrators reportedly using some kind of weapon in 779 of the attacks. Perpetrators used firearms in 137 attacks and explosive weapons in 272 attacks—27% of these were surface launched explosives, 55% were aerial bombs, and 10% were improvised explosive devices. Perpetrators used other weapons, such as knives or fire, in 82 attacks. In Yemen, over half of the total attacks involved explosive weapons. In Afghanistan, there were at least two incidents of suicide attacks, both reported in the capital, Kabul. These attacks in Kabul caused a total of 124 deaths.

THIS REPORT REFLECTS OUR DATASET. WE HAVE FACT CHECKED ALL NUMBERS, BUT ERRORS MAY HAVE OCCURRED. WE INVITE READERS TO CONTACT US IF ANY ERRORS IN NUMBERS ARE NOTED.

ANALYSIS

The number of attacks on health care in 2018 (973) documented in this report far exceeds the number we reported last year for 2017 (701), which may be a result of more robust reporting.¹ The picture is very disturbing, and in the most affected countries—Afghanistan, Cameroon, the CAR, the DRC, Libya, Mali, Nigeria, the oPt, South Sudan, Syria, and Yemen—the attacks, along with the departure of health workers, has severely diminished access to health services. The violence against health care in Syria has largely fallen out of public attention, but the number of attacks there in 2018 exceeded 250.

The data reported here show that a wide range of attacks on health care occurred in 2018. We found incidents of airstrikes, ground shelling, and the burning and looting of hospitals; communal violence inside health facilities; attacks on transports and ambulances; kidnapping of medical staff; and the use of health infrastructure for military purposes. It is distressing to find that in at least six countries, vaccination workers were attacked. Efforts to contain and end the Ebola epidemic in the DRC have been hampered by the local population's distrust of the domestic and international response—which has on occasion led to the burning of clinics—as well as by threats and violence by non-state armed groups.

There was a significant development in reporting in 2018 with the introduction of the SSA; however, the SSA has limits that the WHO could address. More information needs to be publicly reported about the details of each incident and the identity of the perpetrator where known. Additionally, outside the oPt, incidents of threats or obstruction of access are rarely reported—a gap that could be filled. Despite these concerns, the WHO deserves international support for its implementation of the initiative.

In 2018, there were some encouraging developments to address the problem of violence and interference in health care. As part of its resolution in December on human rights and terrorism,² the UN General Assembly included a provision that calls on states to ensure that counter-terrorism laws do not impede medical and humanitarian activities. The resolution follows on a report by the Safeguarding Health in Conflict Coalition³ and partners showing that health workers around the globe are being punished under counter-terrorism and related laws for complying with their ethical duty to provide treatment to all in need.

Additionally, the nongovernmental organization (NGO) Geneva Call issued a Deed of Commitment⁴ to non-state armed groups to encourage them to protect and respect health care in conflict and to agree to monitoring of performance. The Deed is out for signature.

UN human rights institutions have become proactive in investigating violations of international humanitarian and human rights law. Moreover, the Special Representative of the Secretary-General for Children and Armed Conflict listed persistent perpetrators of attacks on schools and hospitals in her annual report.

There has been little progress, however, in member state follow-through on UN Security Council resolution 2286. Security Council members have not taken the straightforward steps that the UN Secretary-General urged in 2016 to implement the resolution. These steps include such basic actions as reforming laws that allow health workers to be punished for delivering impartial care, incorporating international standards for the protection of health care into domestic law, reforming military doctrine and training, strengthening investigations, and ensuring accountability. There has also been little action to conduct, much less strengthen, investigations, and impunity remains the pattern.

Arms sales by the United States and United Kingdom to Saudi Arabia continued in 2018, despite findings by UN investigators that the indiscriminate bombing of hospitals may amount to war crimes. Russia's use of its Security Council veto has prevented the referral of Syria to the International Criminal Court. Israel has declined to cooperate with a UN investigation of human rights violations in Gaza.

The Coalition appreciates the work of Poland, Sweden, France, and Germany for keeping the issue on the Security Council's agenda, but we urge all states to do their duty. For health care to be respected and protected, all states must implement Security Council resolution 2286 and act to safeguard health.

There are opportunities for action in 2019. Follow-up on the Security Council's Arria-formula meeting held by France and Germany in April 2019 and the open debate on the protection of civilians at the Security Council in May offer opportunities to consider concrete proposals for preventing attacks and ending impunity. Moreover, the September UN High-Level Meeting on Universal Health Coverage provides an occasion to integrate health care

vii Note: Though groups affiliated with the Islamic State share common associations, we have elected to use their country-specific names throughout the text.

security as a key marker in achieving the goal that every community around the world has access to all essential health services. Many of the countries in this report are already failing to meet the WHO's recommendation of at least 4.45 doctors, nurses, and midwives for every 1,000

people.⁵ Yet in 2019, attacks on health are still putting the lives of health workers and the wounded and sick at risk, and these attacks may force more health workers to flee the areas where they are so desperately needed.

COUNTRY	NUMBER OF ATTACKS	NUMBER OF HEALTH WORKERS KILLED	NUMBER OF HEALTH WORKERS INJURED	NUMBER OF HEALTH WORKERS KIDNAPPED	NUMBER OF HEALTH FACILITIES DAMAGED OR DESTROYED	NUMBER OF HEALTH FACILITIES EXPERIENCING ARMED ENTRY	NUMBER OF HEALTH TRANSPORTS DESTROYED	NUMBER OF HEALTH TRANSPORTS DAMAGED
AFGHANISTAN	98	19	25	17	8	0	0	2
BURKINA FASO	7	2	0	1	0	0	1	2
CAMEROON	14	2	2	2	4	2	0	1
CAR	47	2	1	2	7	4	0	1
DRC	24	3	0	8	4	7	0	0
EGYPT	1	0	2	0	0	0	1	0
ETHIOPIA	1	0	0	0	3	0	0	0
INDONESIA	2	0	0	1	1	0	0	0
IRAQ	12	5	3	0	2	0	0	0
LIBYA	47	0	10	2	5	2	0	2
MALI	16	1	0	3	1	0	0	0
MYANMAR	4	7	0	0	4	0	0	0
NIGERIA	23	6	4	21	4	0	0	0
OPT	308	3	564	0	6	1	1	39
PAKISTAN	11	7	5	4	1	0	0	0
SOMALIA	10	2	2	5	0	0	0	1
SOUTH SUDAN	15	9	1	14	2	0	0	0
SUDAN	7	0	5	0	0	0	0	0
SYRIA	257	88	75	13	102	5	14	42
THE PHILIPPINES	2	1	0	0	0	0	0	0
TURKEY	3	0	0	0	0	0	0	0
UKRAINE	11	2	7	0	2	0	0	0
YEMEN	53	8	4	2	17	2	1	3
TOTALS	973	167	710	95	173	23	18	93

ALL PARTIES TO CONFLICT SHOULD:

1. Adhere to the provisions of international humanitarian and human rights law regarding respect for and protection of health services and the wounded and sick and the ability of health workers to adhere to their ethical responsibilities of providing impartial care to all in need.
2. Ensure the full implementation of UN Security Council resolution 2286 and adopt practical measures to enhance the protection of, and access to, health care in armed conflict, as set out in the Secretary-General's recommendations to the Security Council in 2016.
3. In particular, as required by resolution 2286, "conduct prompt, full, impartial, and effective investigations" of attacks and other forms of interference with health care toward ensuring accountability and offering redress to victims.

THE UN SECURITY COUNCIL SHOULD:

1. Formally adopt the recommendations toward implementation of resolution 2286 made by the Secretary-General in 2016.
2. Urge the Secretary-General to report on adherence to the requirements of resolution 2286 and the Secretary-General's recommendations.
3. Refer UN expert findings in Syria and Saudi Arabia that identified possible war crimes against health care to the International Criminal Court for further investigation.
4. Schedule briefings on situations in the countries identified in this report, where health care is under the most severe attack. The briefings should include information on investigations and accountability steps the relevant member state has taken.
5. Use its authority to impose sanctions on perpetrators of violence against health care, where appropriate.
6. Urge member state governments to take steps recommended by the Secretary-General in 2016 to fully implement resolution 2286.

THE UN SECRETARY-GENERAL SHOULD:

1. Prepare a report on member state follow-through on the requirements of resolution 2286 and the prior Secretary-General's recommendations.
2. Provide country-specific briefings to the Security Council, as called for in recommendation 4 above. These briefings should be provided by UN agencies whose mandates embrace the identification of perpetrators of attacks.
3. Include as an appendix to his annual report on Children and Armed Conflict a list of all perpetrators of grave violations against children's rights in conflict, including attacks on hospitals and health workers.
4. Include in his annual proposed budgets the resources needed to ensure that existing investigation and accountability mechanisms have the financial and expert resources needed to carry out their tasks.
5. In furtherance of his 2016 report on resolution 2286 to strengthen the role of peacekeeping operations in contributing to an environment conducive to the "safe delivery of medical care" and to implement the 2019 Declaration of Shared Commitments on UN Peacekeeping Operations regarding civilian protection, take concrete steps to establish guidance and training for peacekeepers on specific actions and behaviors needed to protect health care.
6. Include a consideration of the means needed to increase the security of health care in fragile and conflict-affected states in the High-Level Political Forum on Sustainable Development toward achieving its Sustainable Development Goals (part of achieving Agenda 2030) and in the High-Level Meeting on Universal Health Coverage.

MEMBER STATES SHOULD:

1. Develop a national policy framework that builds upon best practices and establishes clear institutional authorities and responsibilities for protecting civilians and civilian objects in the conduct of hostilities, as recommended by the Secretary-General in his 2018 report on the protection of civilians.⁶ Include steps to fulfill resolution 2286 in their frameworks.
2. Through their ministries of defense and interior, as appropriate:
 - a. Review and revise military policies and training practices to ensure compliance with obligations to respect and protect health care with regard to armed entries into medical facilities, the conduct of armed forces at checkpoints, and other circumstances where health care is at risk from military operations.
 - b. Abide by the “no weapons” policies of hospitals and other health facilities.
 - c. Cooperate with and abide by guidance from Ministries of Health regarding steps that can be taken to protect health facilities from interference by state armed forces.
 - d. Discipline soldiers and other security personnel who interfere with, obstruct, threaten, or assault health facilities and personnel engaged in health care activities consistent with their mission and ethical obligations
 - e. Undertake comprehensive annual reviews of performance of all of its military, police, and other security forces with respect to the protection of health care in conflict, particularly with respect to instances where forces have intentionally or unintentionally interfered with or obstructed access to health care; inflicted violence on health facilities, health personnel, or the wounded and sick; or arrested or punished health workers for having provided care to an individual deemed to be an enemy.
3. Through their ministries of health:
 - a. Collect data on violence and threats to health facilities in conflict as part of regular health surveillance and quality assurance activities.
 - b. Develop systems to receive information from NGOs and civil society groups regarding acts that interfere with, obstruct, threaten, and assault health facilities and personnel engaged health care activities.
 - c. Actively support health facilities in seeking the means of maintaining their security, including through outreach to other ministries and actors who infringe or may infringe on the protection of health facilities from attack.
 - d. Act as an interlocutor with the Ministries of Defense and Interior to increase the security of health facilities and personnel.
4. In accordance with the General Assembly’s resolution on human rights and counter-terrorism A/Res/73/174, reform laws and police and prosecutorial practices so as not to impede humanitarian and medical services or punish those who provide them to people who are wounded or sick, regardless of their affiliation.
5. Refrain from arms sales to perpetrators of attacks on health services.
6. Strengthen national mechanisms for thorough and independent investigations into alleged violations.
7. Ensure that perpetrators are held accountable for violations.
8. Take forceful diplomatic actions, such as public statements and démarches, against perpetrators of attacks on health services.
9. Take actions toward carrying out their responsibility to ensure respect for international humanitarian law, as set forth in the very first article of each Geneva Convention. To that end, they should initiate investigations of instances where partner military forces or their own may have attacked hospitals or other health facilities.

10. Support the WHO’s SSA on health care.

11. Report to the Secretary-General on actions they have taken in furtherance of the purposes of resolution 2286.

THE WHO SHOULD CONTINUE TO DEVELOP ITS SSA ON HEALTH CARE AND:

1. Engage in outreach to new potential partners, including NGOs, to ensure that the system captures all attacks.
2. Provide information to describe the basic facts of the incident (withholding location information if needed for security reasons) and take steps to enable identification of the perpetrator where known.

NON-STATE ARMED GROUPS SHOULD:

1. Sign Geneva Call’s Deed of Commitment on the protection of health care and take steps toward compliance, monitoring, and accountability, as set forth in the Deed.

This sixth report of the Safeguarding Health in Conflict Coalition documents attacks on health care in 23 countries in conflict in 2018. We referred to the UCDP to determine if a country was considered to be in conflict in 2018 and included countries in conflict that experienced at least one event of an attack on health care in 2018. We discuss the 11 countries with the highest numbers of reported attacks individually in separate chapters, and the other 12 countries of concern are discussed together in the final chapter.

We used the same event-based approach to collecting data on attacks on health care as used in our 2018 report. We identified and consolidated data from multiple sources, then cross-checked to create one master dataset, with associated datasheets of recorded events for each country. We used standard definitions of different event types to categorize the incidents. The data presented in this report can be viewed in the document available at <https://data.humdata.org/dataset/shchealthcare-dataset> on Insecurity Insight's HDX.

We followed the WHO's definition of an attack on health care: **"any act of verbal or physical violence, threat of violence or other psychological violence, or obstruction that interferes with the availability, access and delivery of curative and/or preventive health services."** However, this report focuses on attacks in the context of conflict or in situations of severe political volatility, while the WHO focuses on attacks in emergencies. In accordance with the WHO's definition, attacks on health care can include bombings, explosions, looting, robbery, hijacking, shootings, gunfire, the forced closure of facilities, the violent searching of facilities, fire, arson, military use of health infrastructure, military takeover, chemical attack, cyberattack, abduction of health workers, denial or delay of health services, assault, forcing staff to act against their ethics, execution, torture, violent demonstrations, administrative harassment, obstruction, sexual violence, psychological violence, and the threat of violence. These categories have been included as far as they were reported; however, some, such as psychological violence, are rarely reported. We included attacks on patients in facilities or receiving medical care when that information was included in reports; we did not include attacks on the wounded and sick or on bystanders.

SOURCES

To identify events of attacks on health care in conflict to include in our report dataset, we used seven distinct sources:

1. Open source information identified by Insecurity Insight for the Attacks on Health Care Monthly News Briefs⁸ [<http://insecurityinsight.org/projects/healthcare/monthlynewsbrief>] and by the WHO
2. Information provided by Coalition member Syrian American Medical Society for events in Syria
3. Information provided by Coalition member Physicians for Human Rights for events in Syria
4. Information provided by Médecins du Monde for events in the oPt
5. Information provided by MSF for events in the CAR
6. Research conducted by a small team of Coalition members to identify additional events reported by UN agencies and in the media and other sources
7. Information from the WHO's SSA for six countries and territories: Afghanistan, Iraq, Libya, Nigeria, the oPt, and Yemen. Information from the SSA represents approximately a third of the data gathered for this report.

EVENT INCLUSION

We only included events in the report dataset that met our definition of an attack. We included the following types of events and details in the report dataset:

- Events affecting health facilities (recording whether they were destroyed, damaged, looted, or occupied by armed bodies)
- Events affecting health workers (recording whether they were killed, kidnapped, injured, assaulted, arrested, threatened, or experienced sexual violence); when available, we recorded the number of affected patients, though we acknowledge the likely serious underreporting of these figures.
- Events affecting health transport (recording whether ambulances or other official health vehicles were destroyed, damaged, hijacked or stolen, or stopped or delayed).
- Events from the SSA for the six countries/territories included in the system, if the WHO confirmed the events.

KEY DEFINITIONS

HEALTH WORKER: Any person working in a professional or voluntary capacity in the provision of health services or who provides direct support to patients, including administrators, ambulance personnel, community health workers, dentists, doctors, government health officials, hospital staff, medical education staff, nurses, midwives, paramedics, physiotherapists, surgeons, vaccination workers, volunteers, or any other health personnel not named here.

HEALTH WORKER AFFECTED: Describes events in which at least one health worker was killed, injured, kidnapped, arrested, or experienced sexual violence, threats, or harassment.

HEALTH FACILITY: Any facility that provides direct support to patients, including clinics, hospitals, laboratories, makeshift hospitals, medical education facilities, mobile clinics, pharmacies, warehouses, or any other health facility not named here.

HEALTH FACILITY AFFECTED: Describes events in which at least one health facility was damaged, destroyed, or subjected to armed entry, military occupation, or looting.

HEALTH TRANSPORT: Any vehicle used to transport any injured or ill person, or woman in labor, to a health facility to receive medical care.

HEALTH TRANSPORT AFFECTED: Describes events in which at least one ambulance or other health transport was damaged, destroyed, hijacked, or delayed, with or without a person requiring medical assistance on board.

CODING PRINCIPLES

We followed the general theory and principles of event-based coding to code events of attacks. We took care not to enter the same event multiple times and followed standard principles, as set out in the Safeguarding Health in Conflict Coalition 2019 Report Codebook. We only code an event once, as such, if a health worker is kidnapped and then killed, this is listed as "kidnapped" and not double counted as killed. See HDX <https://data.humdata.org/dataset/shchealthcare-dataset> for full coding and annexes.⁹

INDISCRIMINATE AND INTENTIONAL ATTACKS

KEY DEFINITIONS

INDISCRIMINATE ATTACK: Attacks without evidence that the perpetrator intended to harm a health worker or health facility. These events include military operations in the vicinity of health facilities or indiscriminate attacks on civilians that also affected health workers (such as a bomb in a public place).

INTENTIONAL ATTACK: Attacks where the mode of operation or the effect on the health worker or facility shows beyond a reasonable doubt that the perpetrator must have intended to cause at least a degree of harm to a health worker or health facility. These events include the targeted injury, killing, arrest, or kidnapping of health workers; the entry or occupation of a health facility; and the theft or robbery of medical supplies.

We coded events as suspected "indiscriminate," suspected "intentional," or "other or unknown" based on available information on the conflict and information included in reports. Coding the intention of the perpetrator would normally require direct information on the motive, which is rarely available. Instead, our coding approach was based on contextual information, such as the affiliation of the perpetrator, the weapons used, and the impact on health workers or facilities, to infer a plausible degree of intentionality.

We carried out two separate coding steps. First, we coded the conflict type and targeting categorizations based on actor category and UCDP conflict classification,¹⁰ distinguishing armed conflict between state or non-state actors from one-sided violence against unarmed civilians. We also used additional categories of administrative force, threats and intimidations, and takeover attacks. Second, we coded the strategic logic of perpetrators using the concepts of selective and indiscriminate violence: the former refers to targeted attacks on selected individual health workers, selected health providers, or specific programs (e.g., vaccination programs), while the latter refers to indiscriminate attacks against civilians among a larger population group (such as bombings or shootings on markets or concerts halls). Third, we combined the step one and step two classifications (on conflict context and strategic logic of the perpetrator, respectively) for the final coding used in the report. Given the nature of the WHO data, we did not have enough contextual information to infer intent, therefore we coded all SSA incidents as “unknown.” See Table 1 for the two-step and final classifications.

TABLE 1: Two-step method of data coding to arrive at attack classification

Conflict Context	+	Targeting Based on Strategic Logic Perpetrator Coding	=	Attack Classification
Active Conflict	+	Indiscriminate	=	Indiscriminate Attack
Direct One Side Violence	+	Indiscriminate	=	Indiscriminate Attack
Administrative Force	+	Indiscriminate	=	Indiscriminate Attack
Threats and Intimidation	+	Indiscriminate	=	Indiscriminate Attack
Direct One Side Violence	+	Selective Other	=	Indiscriminate Attack
Administrative Force	+	Assumed Selective	=	Intentional Attack
Administrative Force	+	Selective Program	=	Intentional Attack
Administrative Force	+	Selective Provider	=	Intentional Attack
Direct One Side Violence	+	Assumed Selective	=	Intentional Attack
Direct One Side Violence	+	Selective Program	=	Intentional Attack
Direct One Side Violence	+	Selective Provider	=	Intentional Attack
Takeover Attack	+	Selective Assets	=	Intentional Attack
Threats and Intimidation	+	Assumed Selective	=	Intentional Attack

The coding mechanism is detailed in the Safeguarding Health in Conflict Coalition 2019 Report Intentional and Indiscriminate Codebook.¹¹

INCLUSION AND CODING OF SSA-REPORTED EVENTS

Information from the WHO’s SSA was included for six countries/territories: Afghanistan, Iraq, Libya, Nigeria, the oPt, and Yemen. We accessed the SSA on January 26, 2019 and included the information available on that date for events reported in 2018. Any changes to the SSA system after that date are not reflected in the report dataset but may be noted in country profiles (e.g., the oPt).

The 139 SSA-reported events from Syria were not incorporated because their lack of detail made it too difficult to determine which SSA-reported events were the same as the 211 events in Syria collected by Coalition members.

We coded 314 SSA events from the six countries based on the information included on the online SSA dashboard.

Unlike many media reports we identified, the SSA does not provide information on perpetrators. We therefore could only assume that all of the SSA events we included were carried out by conflict actors (rather than private individuals) and therefore fulfilled the report inclusion criteria.

The SSA includes the fields of “Affected Health Resource,” “Type of Attack,” and “Affected Personnel,” with standard categories for each event. However, these fields were not consistently filled in, and for 116 of the 314 events, only one or two of the fields provided information. When one or more fields were left empty, it was usually not possible to grasp the nature of the attack. Therefore, 116 SSA events appear as recorded events without much further detail in the report dataset, and 198 events from the SSA are included with more details. See our HDX page for annexes detailing the inclusion of SSA events in the report dataset.¹²

LIMITATIONS OF THE RESEARCH

We based this report on a systematic event dataset of attacks on health care that has been carefully coded. The figures presented in this report can be cited as the total number of events of attacks on health in 2018 reported or identified by the Safeguarding Health in Conflict Coalition. These numbers are derived from trusted sources and provide a minimum estimate of the damage to health care from violence that occurred in 2018. However, the extent of the problem is likely much greater, as many incidents likely go unreported and are thus not counted here.

THE EXTENT OF THE PROBLEM IS LIKELY MUCH GREATER, AS MANY INCIDENTS LIKELY GO UNREPORTED AND ARE THUS NOT COUNTED HERE.

The report dataset suffers from the typical limitations of datasets that are largely built from open sources, including reporting and selection bias. First, the available information is likely to be underreported. Selection bias in open source means that not all events are reported and that events in more remote areas or those affecting less well-connected population groups are less likely to be reported. Second, it is likely that there are some

errors or misrepresentations in the event descriptions used. In particular, information related to the perpetrator and the context of the event is often missing or may be misrepresented in the original source, and this will affect the dataset. Additionally, in some cases, especially those involving robberies and abductions, it is often difficult to ascertain from available information whether the act was committed by a party to the conflict or by criminals. We based inclusion decisions on judgments about the most likely motivations. For 503 events, we were not able to determine the intent of the perpetrator.

Issues of possible selection and reporting bias are also present in the SSA data. The SSA provided a high number of events for our dataset for the oPt (196) and Afghanistan (79), very few events for Yemen (1) and Iraq (3), and some events for Nigeria (10) and Libya (25). These differences make it difficult to judge to what extent the number of reported events in these countries reflects an actual increase in incidents or simply better reporting mechanisms. It is likely that there is selection bias in favor of Afghanistan and the oPt due to the operation of in-country reporting mechanisms.

The possible reporting bias in the SSA could also influence the overall trends within our report dataset. The SSA data form a significant proportion of all information for Afghanistan, where 81% of all included events are from the SSA. The SSA provided 63% of all included events for the oPt, 53% for Libya, 42% for Nigeria, 3% for Iraq, and 2% for Yemen.

Another limitation is the fact that 116 SSA-reported events contained too little precise information to be included in the report dataset beyond the event count. The report dataset therefore suffers from the limitations associated with using preprocessed data without access to the original sources or additional detail, which would have allowed for potentially more accurate and consistent classification. There is therefore an additional potential reporting bias in the transfer of SSA data into our report dataset in 37% of all events from the SSA.

COUNTRY FACTORS INFLUENCING THE INFORMATION FLOW

A number of factors influence the extent to which events have been captured by this report. In countries and territories with good internet connectivity, higher levels of English, and preexisting contacts with human rights groups and research bodies, local health professionals are likely better placed to report events in vetted formats that can be considered a trusted source. This is one of the reasons why there are such a high number of reported events from Syria and the oPt.

A well-functioning SSA mechanism and a well-established presence of foreign aid agencies also tend to facilitate information flow on events, which may explain the high numbers of events reported for Afghanistan, the oPt, and Syria.

Conversely, in countries with poor internet connectivity, fewer English speakers, few foreign aid agencies on the ground, and/or a less active SSA mechanism, the level of underreporting of events will likely be very high, with only a small proportion of all events being recorded. This underreporting is likely one of the reasons why there are relatively few events registered for Yemen or Somalia and possibly also Ukraine.

NATURE OF EVENTS AFFECTING THE INFORMATION FLOW

Some types of events are more regularly reported than others. Therefore, the total number of events reported by category of concern should not necessarily be discussed in comparison to other categories. For example, killings and kidnappings of doctors are more likely to be captured by reporting systems than the looting of medical supplies, which may occur more frequently than event reports indicate. Difficulties in accessing health care are even less likely to be consistently reported.

AFGHANISTAN



The ongoing conflict in Afghanistan began in 2001 and involves a range of insurgents, as well as both national and international forces. Armed groups including the Taliban and Islamic State-Khorasan Province operate in Afghanistan and continue to contest territory and carry out attacks, with both groups making territorial gains in 2018.¹³ According to the Council on Foreign Relations, the US government estimates that the government in Afghanistan controls only 53% of Afghan districts, with 12% under the control of the Taliban, and 33% remaining contested.¹⁴ Human Rights Watch reported an overall intensification of attacks in 2018, perpetrated by national and international forces and insurgents.¹⁵ In 2018, more than 10,000 civilians were either injured or killed by violence,¹⁶ and over 365,000 people fled their homes due to the conflict.¹⁷

The buildup to the parliamentary elections in October 2018 resulted in an increase in violence, with attacks perpetrated against both candidates and voter registration sites, many of which were located in schools and health clinics.^{18,19} The United Nations Assistance Mission in Afghanistan (UNAMA) explained that this use of schools and health clinics made them more vulnerable to attack, but noted there was less impact on clinics than on schools.²⁰ UNAMA expressed concern over the continued use of clinics and schools in the 2019 presidential elections and the resultant impact this use may have on the rights to education and health if they continued to be targeted.²¹

In many countries, health transports, including ambulances, must pass through checkpoints and submit to searches. In some cases, access to emergency services is delayed or denied.

EMBAR



COUNTRIES EXPERIENCING THE MOST ATTACKS

Attacks on health care increased in 2018. In the June OCHA Humanitarian Bulletin, the representative of the WHO in Kabul, Dr. Rik Peepkorn, stated, "This year, the attacks on health facilities and health workers have been much more deliberate and violent."²² OCHA estimates that between June 2017 and June 2018, armed groups forced the closure of over 140 health facilities, resulting in two million people being denied access to health care.²³ In August, the WHO began collecting data on attacks on health in Afghanistan as part of its Attacks on Health Care Initiative.^{24,25}

RECORDED ATTACKS

In Afghanistan in 2018, we identified 98 reported attacks that affected health workers, facilities, and transports. Nineteen health workers were reportedly killed, 25 were injured, 17 were kidnapped, and two were assaulted. These 98 attacks affected at least 11 patients and beneficiaries, as well as eight drivers or guards. The attacks damaged at least seven health facilities, destroyed one health facility, and damaged or destroyed two ambulances. Vaccination workers were attacked in three separate incidents. These incidents resulted in one health worker killed, one health worker injured, and eight health workers kidnapped.

In 17 attacks, the perpetrators were identified; these included the Taliban, Islamic State-Khorasan Province, the Afghan National Army, and the Afghan Special Unit. At least 50 attacks were reported to have taken place at health facilities. These attacks at health facilities resulted in six health workers killed and 12 health workers injured.

Of the 98 attacks, we have reports of weapons use in 55 cases, with ten reported cases of explosive weapons and five reported cases of firearms use. In an incident on July 3, Islamic State-Khorasan Province claimed responsibility for a failed attempt to fire rockets at a hospital in Jalalabad that the President was there to open, missing the target.²⁶ In an incident involving firearms in July, unidentified gunmen attacked a midwife training center after letting off several explosions nearby. A resulting gun battle with security forces ensued that resulted in two people—a guard and a driver—being killed.²⁷ Our data include two incidents of suicide bombs, both of which took place in Kabul, that resulted in a total of 124 deaths.

We received sufficient contextual evidence to consider intent in only 19 of the 98 cases. Based on contextual evidence, we have coded 11 of these incidents as suspected intentional and eight as suspected indiscriminate.

CASE STUDY

On January 27, a suicide bomber hid a bomb inside an ambulance; raced the ambulance through a checkpoint, claiming to be carrying a patient; then struck a second checkpoint, detonating the explosives in a crowded part of Kabul. The attack killed at least 95 people and injured a further 150 people.²⁸ The Taliban claimed responsibility for this attack—the deadliest in Kabul in eight months.²⁹ While this attack did not target health workers or a health facility, the perpetrators deliberately misused health transportation and abused the trust held by security forces regarding the meaning of an ambulance, which could have long-term implications. The International Committee for the Red Cross (ICRC) condemned the attack on Twitter, stating "The use of an ambulance in today's attack in Kabul is harrowing. This could amount to perfidy under IHL [international humanitarian law]. Unacceptable and unjustifiable."³⁰

The Guardian reported in February 2018 that this attack had resulted in security forces being increasingly nervous and "strict" around ambulances, delaying their passage through checkpoints and checking that patients were "real" and not a dummy for explosives.³¹ The misuse of health transports such as ambulances abuses trust in conflict zones and can lead to a much greater loss of life, as security forces waste precious moments conducting extensive searches—moments that could be used to save a suffering patient's life.

CAMEROON



Multiple parties threaten stability in Cameroon, with conflict between the country's predominantly francophone government and anglophone separatists occurring since late 2016, in addition to the presence and widespread impact of Boko Haram.³² In late 2017, violence and insecurity swept across the northwest and southwest regions, with the increased presence of non-state armed groups and the deployment of military forces to these regions.³³ Furthermore, insurgency from the armed group Boko Haram continues to affect the Lake Chad Basin region, which includes Cameroon.³⁴

OCHA has reported that since December 2017, the violence has forced almost 450,000 people in the northwest and southwest regions to flee their homes, and as of November 2018, 1.3 million people were in need of humanitarian assistance.^{35,36} According to UNHCR, by November, over 30,000 refugees had fled to Nigeria, with four out of five of those registered being women or children.³⁷ In November 2018, the World Food Programme estimated that a total of 3.9 million people were facing food insecurity, with 211,000 people being severely food insecure.³⁸

In addition to displacement and insecurity, civilians face multiple threats, including violence from armed groups, being caught in crossfire, and arbitrary arrest, as well as curfews and restrictions to their movement.³⁹

RECORDED ATTACKS

In 2018, we identified 14 attacks that affected health workers, health facilities, a health transport, and patients and beneficiaries. Two health workers were killed, two were injured, two were kidnapped, and one was assaulted. Fourteen patients and beneficiaries and one guard were affected. There were two incidents of armed entry into medical facilities, and two incidents of looting, theft, robbery, and burglary of health supplies. The attacks destroyed one health facility, damaged at least three health facilities, and damaged one ambulance. In addition, one attack reportedly carried out by Cameroon forces

in Momo county resulted in the forced closure of a clinic.⁴⁰ The specific location of attacks was reported in 13 of the 14 attacks. Of the attacks with a reported location, three occurred in the northwest region and three in the southwest region.

Of the 14 attacks that were reported in Cameroon, weapons use is known in seven cases. In four attacks, perpetrators used firearms, and in one attack, clubs, machetes, and nail pullers were used. In August, in one of the four attacks involving firearms, Cameroonian forces opened fire at an ambulance transporting patients, leaving a female nurse seriously injured.⁴¹ In another attack involving firearms, in February in Bamenda in the northwest of Cameroon, government soldiers reportedly shot a medical doctor in the back on her way to work. A gendarme opened fire while she was traveling in a taxi. Reports suggest that she survived the shooting, though it is not clear if she has fully recovered.⁴² In a further incident in August, unidentified perpetrators reportedly set fire to the Mbonge Hospital in Meme division in an arson attack that left at least one patient dead.⁴³

Both the armed group Boko Haram and Cameroonian forces reportedly perpetrated attacks against health care in Cameroon in 2018. Cameroonian forces reportedly carried out seven attacks. The Cameroonian forces were reportedly responsible for attacking a hospital in Labiale that killed a nurse.⁴⁴ On June 6, Cameroonian forces reportedly ransacked the local health unit in Meme in the southwest region of the country, resulting in the facility being destroyed. The health facility staff were manhandled, and one health worker was assaulted.⁴⁵ Boko Haram carried out or is suspected of carrying out two attacks on health. More broadly, according to Amnesty International, in 2018, Boko Haram carried out at least 150 attacks in Cameroon as part of a widespread and systematic attack on the civilian population.⁴⁶

Based on contextual evidence, we have coded all incidents as suspected intentional.

CASE STUDY

On September 17 in Tadu, southern Cameroon, Cameroonian military forces allegedly attacked the Catholic Health Center of Tadu, setting fire to the facility.⁴⁷ The attack led to the deaths of 13 patients, including a woman who had just given birth. A nurse present during the attack reported that Cameroonian military forces "forced me to leave the hospital and began to destroy the maternity pavilion. Then they set fire to the whole hospital." The source states that the Cameroonian military believed the hospital was harboring English-speaking independence forces.⁴⁸

COUNTRIES EXPERIENCING THE MOST ATTACKS

CENTRAL AFRICAN REPUBLIC



Since 2013, armed conflict in the Central African Republic (CAR) has continued in cycles of violent crisis and response. In 2018, parties to the conflict killed 697 civilians, subjected 431 others to human rights violations, and inflicted mass sexual violence, according to a report of the UN Secretary-General.^{49,50} UNHCR reported that more than 590,000 Central Africans are refugees in neighboring countries, and over 640,000 are internally displaced.⁵¹ According to UNICEF, two out of every three children need humanitarian assistance, neonatal death rates are the second highest in the world, and 43,000 children are projected to suffer severe acute malnutrition in 2019.⁵² The Global Hunger Index ranked the CAR's hunger crisis as the most severe in the world in 2018.⁵³

With armed groups controlling up to 80% of the country,^{viii} the violence that may prevent some patients from even accessing health services is just one of many challenges facing the health system. A 2016 rapid health assessment showed that of 1,009 health structures in the country, 40 had been fully destroyed and 236 partially destroyed in that year. Of the 83% of health structures at least partially functioning, 77% had no electricity and 43% had no access to a potable water source. There were only 204 doctors, 247 nurses, and 273 midwives in the CAR in 2016, with community health agents providing much of the frontline care to an estimated five million inhabitants.⁵⁴

RECORDED ATTACKS

In the CAR in 2018, we identified 47 attacks that affected health workers, facilities, and transports. Two health workers were killed (one midwife and one unknown health worker), two vaccination workers were kidnapped and tortured, two health workers were physically assaulted*, one health worker was injured, and at least ten health workers were threatened or intimidated. At least one patient caretaker was killed, one guard and one driver were assaulted, and one patient was removed during an armed entry into a hospital. Groups of patients were threatened with violence at least twice, and several patients died because armed conflict prevented their transfer to a higher-level health facility.⁵⁵

Attacks affected at least 22 health facilities, with six facilities destroyed and one facility damaged. Armed groups forcibly entered health facilities in four cases, and in two other incidents, groups directly threatened hospitals with violence. Actors looted or robbed teams of their vital medical supplies at least 21 times, with 12 of the incidents occurring in health facilities. Because of these attacks and the instability surrounding them, at least five health centers had to temporarily close their doors. In at least eight incidents, actors prevented or delayed patients' access to care through roadblocks, street violence, detaining transport vehicles, or attacks that forced organizations to suspend transport activities. In five cases, MSF or the ICRC were forced to reduce or temporarily suspend medical activities for up to a month at a time, which deprived scores of patients of access to health care.⁵⁶

These numbers, while significant, are likely far from painting the full picture of violence against health care in the CAR. Underreporting is a significant barrier in a country like the CAR, in which rebel groups control vast amounts of land, few resources are devoted to data collection, and international media attention is often lacking. Moreover, medical NGOs must make difficult decisions when speaking out publicly against attacks, balancing advocacy with concerns of staff security and maintaining access to a population.

Nine attacks occurred in Bambari, and eight occurred in Mbrés or its surroundings.

Anti-Balaka (AB) groups reportedly carried out five of the 47 attacks, including kidnapping and torturing two female vaccination workers in Gbama village in Haute-Kotto prefecture on November 24. The group accused the vaccination workers of spying on them, but eventually released them on December 3.⁵⁷ AB groups also allegedly assaulted a medical driver, made an armed entry into a hospital, looted and vandalized health NGOs, and blocked road access to a hospital.⁵⁸

Groups linked to the Ex-Séléka (ES) movement reportedly carried out nine events. For example, the Union for Peace

in the Central African Republic forced an armed entry into a hospital, and a member of the National Movement for the Liberation of the Central African Republic sexually assaulted a nurse.⁵⁹ The Popular Front for the Rebirth of Central African Republic (FPRC)^{ix} destroyed a health center in Ira Banda and threatened to burn down a hospital in Batangafo.⁶⁰ A coalition of FPRC forces, along with Central African Patriotic Movement and local Muslim self-defense groups, looted and destroyed three health centers and one hospital in a spate of violence against the town of Mbrés and villages along a neighboring axis.⁶¹ An unspecified ES faction also blocked access to one hospital in Bria.⁶²

The Revolution of Justice group was also responsible for one event during clashes with the National Movement for the Liberation of the Central African Republic, described below.

Based on contextual evidence, we have coded 37 of these 47 incidents as suspected intentional, seven as suspected indiscriminate, and in three cases, we lacked sufficient information to infer intent.

As an example of suspected intentional attacks, on October 31 in Batangafo, AB members allegedly used a machete to assault a motorcyclist on his way home from delivering vaccines to the hospital.⁶³ On the same day, ES members attacked the city and burned down all of its displacement sites, sending thousands of internally displaced people fleeing for shelter in Batangafo Hospital and forcing MSF to reduce activities in the area to only life-saving measures.⁶⁴ Subsequent fighting between AB and ES groups killed 15 people, wounded 29 people, and displaced over 20,000 people. Both AB and ES groups targeted access to health care in the following days, with AB blocking road access to the hospital and ES (with FPRC) threatening to burn down the hospital if the internally displaced people did not evacuate within 48 hours.⁶⁵

On January 9, in a suspected indiscriminate attack in Paoua and the surrounding areas of Ouham-Pendé prefecture, the Revolution of Justice and the National Movement for the Liberation of the Central African Republic clashed violently, leading to the temporary closure of seven health centers. Unknown perpetrators looted three of the health centers in the days following.⁶⁶

CASE STUDY

Bambari, hailed as a "city without weapons" after UN peacekeepers reported its successful disarmament in February 2017, plunged back into violence in mid-2018. On May 14 and 15, according to a UN panel of experts, intercommunal clashes supported by armed groups killed nine civilians and displaced 7,000,⁶⁷ and Arab News reported that an NGO worker and a midwife were killed.^x On May 15, armed men entered Bambari Hospital, where the wounded were being treated. The men were allegedly searching for Muslim patients,^{xi} who hid themselves in locked rooms for protection.⁶⁹ Again on June 6, after further clashes, Union for Peace in the Central African Republic members entered the hospital, repeatedly shot inside the building, and removed one of their members from among the wounded patients. Later, armed members of AB groups entered the hospital and pillaged the building. That day, all of the Muslim patients fled the hospital in fear.⁷⁰

One wounded patient, a Muslim, described living through both of these incursions into the hospital. "[On May 15] Armed men entered the hospital and we hid under our beds," he explained. "The Christian patients helped us and, fortunately, the hospital staff persuaded the group not to enter the room we were staying in." "[During the June 6 attacks] as soon as we heard that they were coming, we fled. We were too worried about what could happen. Because I couldn't walk with my wounded leg, people put me on a blanket and carried me," he said. "We should always feel safe at the hospital, but with what happened to us, we know that even here, we're not spared from the fighting."^{71,72}

ix The FPRC has a history of shifting alliances between ES and AB factions; however, they are included in groups linked to ES in this report because the events registered here were in the context of conflict with the AB (2) or were not specified (1).

x As Arab News does not specify the number of other deaths, it is unclear whether these two were among the deaths cited in the UN report.

xi Though motive was not explicitly stated in the article, retaliation by collective punishment against a community associated with an enemy group, often along religious lines, is a common feature of clashes in the CAR. It is unclear whether this was the case or whether any of the Muslim patients were members of a rival group.

ix The FPRC has a history of shifting alliances between ES and AB factions; however, they are included in groups linked to ES in this report because the events registered here were in the context of conflict with the AB (2) or were not specified (1).

viii Earlier reports estimated that 70% of the country was controlled by armed groups, but reports from February 2019 place the estimate at 80%. See: Marboua, Hippolyte. "Details from Central African Republic rebel deal released." Associated Press. February 8, 2019. <https://www.apnews.com/2dae27272e554eeabeaac5a3a6bdbbc39>.

*Note, we code each incident of an attack only once, as such a health worker would either be coded as injured or assaulted, and not as both.

COUNTRIES EXPERIENCING THE MOST ATTACKS

DEMOCRATIC REPUBLIC OF CONGO



The Democratic Republic of Congo (DRC) has been embroiled in conflict since civil war broke out in 1997. The country was ruled by the Kabila dynasty starting in 1997, with Joseph Kabila serving as president from 2001 to 2018, following the assassination of his father.⁷³ The elections in December 2018 saw moderate amounts of violence and unrest.⁷⁴ Much of the country remains in a precarious humanitarian situation, with instability coming from government forces, non-state armed groups, community violence, food insecurity, an outbreak of the Ebola virus disease, and an economic downturn.⁷⁵ According to OCHA, 12.8 million people need humanitarian assistance, including 5.6 million children, and four million people are internally displaced. In addition, the DRC is home to refugees from Sudan, Burundi, Rwanda, and the CAR.⁷⁶ In August 2018, the WHO and the DRC's Ministry of Health announced the country's tenth outbreak of the Ebola virus disease. This outbreak is located in the conflict-ridden province of North Kivu, which shares borders with Rwanda and Uganda—an area with over a million displaced people.⁷⁷

The Ebola outbreak has been characterized by high levels of violence against UN peacekeepers, health workers, and burial teams. There are international concerns about the heightened risk of the disease spreading, in a region with a highly mobile population and many armed groups. In September, responding to the increasingly poor security situation, the WHO elevated the national and regional risk level from "high" to "very high."⁷⁸ By November 2018, the WHO had declared this outbreak to be the second largest in history,⁷⁹ with a total of 539 cases reported by December 16 and a total of 53 health worker infections.⁸⁰ In October, the US Centers for Disease Control and Prevention pulled its staff members out of North Kivu province and returned them to the capital, Kinshasa,

citing safety concerns.⁸¹ Later that month, the UN Security Council adopted a resolution condemning attacks by armed groups that were "exacerbating the country's ongoing Ebola outbreak."⁸² With over 20 armed groups operating in North Kivu province, violence has continued to have a severe impact on the response, which has been further hindered by community mistrust for peacekeepers and medical teams.⁸³ Peter Salama, then-WHO Deputy Director-General of Emergency Preparedness and Response, highlighted the critical importance of winning community trust for the success of the response, stating, "Whenever there is a violent incident, we see a major drop in contact tracing."⁸⁴

IN ADDITION TO THE EBOLA OUTBREAK, THE DRC IS ALSO RESPONDING TO OUTBREAKS OF VARIOUS OTHER DISEASES, INCLUDING CHOLERA, MEASLES, AND MONKEYPOX.⁸⁵

RECORDED ATTACKS

In the DRC in 2018, we identified 24 attacks that affected health workers and facilities.⁸⁶ Three health workers were killed, eight were kidnapped, two were assaulted, and two were sexually assaulted; at least 13 patients were also affected, with 12 stabbed and one raped. In the incident in which a patient was raped, armed men in plain clothes entered a health facility, looted it, and attacked and raped one nurse and a patient, before attempting and failing to rape another nurse. After beating some of the patients, they stole some unspecified items and left the facility.⁸⁷

Attacks impeded access to medicines and health care for the population. In one incident in June, prior to the Ebola outbreak in North Kivu province, an MSF team in the Masisi-Nyabiondo axis (North Kivu) were ambushed and robbed, prompting MSF to halt its hygiene assistance work in the area as a result.⁸⁸ In September and November, attacks on the Norwegian Refugee Council, the WHO, and the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) personnel prompted the closure of medical facilities and paused the Ebola response, affecting access to health care for scores of people and heightening the risk of the disease's spread.⁸⁹

Of the 24 recorded attacks, 23 took place in the east of the country, with eight attacks taking place in the Ebola hotspots of the North Kivu and Ituri provinces following the outbreak of Ebola in August. Eleven of the attacks took place between October and December 2018, with seven attacks perpetrated in November alone. Perpetrators used firearms in six of the attacks, resulting in the deaths of all three of the health workers who were reportedly killed in 2018 from attacks. Other attacks included the use of explosive weapons, knives, and fire.

In an attack on February 4 in the city of Goma, unidentified assailants walked into two health centers and stabbed 12 patients with knives.⁹⁰ In 14 attacks, the reports did not cite the specific weapons used.

We received sufficient contextual evidence to consider intent in 20 of the 24 cases. Based on contextual evidence, we have coded 16 of these incidents as suspected intentional and four as suspected indiscriminate.

Information about perpetrators was reported for 20 attacks, with specific perpetrators named in nine cases. The named perpetrators include the Mai-Mai armed group (three attacks), the Allied Democratic Forces (ADF) (two attacks), and the Democratic Forces for the Liberation of Rwanda (two attacks). On October 21, Mai-Mai rebels shot and killed two health workers fighting the Ebola outbreak within the DRC army.⁹¹ On February 5, militiamen from the ADF attacked the locality of Kitevya, looting a hospital and killing three people not identified as health workers.⁹²

CASE STUDY

On November 15, in the city of Beni, North Kivu province, the non-state, armed ADF group attacked MONUSCO personnel close to the Ebola Emergency Operations Center and hotels where many Ebola responders were staying. This deadly attack killed seven UN peacekeepers and 12 members of the DRC military who had been carrying out joint operations against the ADF.⁹³

Members of the UN Security Council strongly condemned the killings, with members stating that the UN Security Council "reiterated their demand that all armed groups cease immediately all forms of violence, and immediately and permanently disband and lay down their arms."⁹⁴

While this attack did not target and injure or kill health workers, it resulted in Ebola treatment centers in the area being closed for two days.

In a statement dated December 28, 2018, Dr. Tedros Adhanom Ghebreyesus, WHO Director-General, stated, "These gains [in fighting the Ebola virus] could be lost if we suffer a period of prolonged insecurity, resulting in increased transmission. That would be a tragedy for the local population, who have already suffered too much... In general, the communities in affected areas have been supportive of the response. We ask for everyone to protect health facilities and provide access for responders to the affected populations so that we can stop this outbreak. The population must also have safe access to transit and treatment centres that save lives and stop the spread of Ebola."⁹⁵

COUNTRIES EXPERIENCING THE MOST ATTACKS

ISRAEL AND THE OCCUPIED PALESTINIAN TERRITORY (OPT)*



*Note: The numbers in this section include data from the WHO SSA as of January 26, our cut-off date for including SSA data in our report dataset. We understand the WHO SSA has since been updated, and as such, our numbers do not reflect the full extent of the WHO's reported incidents. As the SSA did not report location figures, we have been unable to determine the number of incidents that took place in Gaza, but we include an infographic from the WHO below (Figure 1).⁹⁶ For weapons use, we relied on our dataset.

Palestinians living in the occupied Palestinian territory (oPt) in Gaza and the West Bank, including East Jerusalem, face a severely deteriorating humanitarian situation.⁹⁷ By 2015, Israel's blockade and closure of Gaza had led to a 50% drop in Gaza's global domestic

product,⁹⁸ with 54% unemployment and 70% youth unemployment, the highest rates in the world.⁹⁹ Eighty percent of people depend on some form of foreign assistance,¹⁰⁰ 53% are below the poverty line,¹⁰¹ and 68% are food insecure.¹⁰² As of July 2018, 97% of the water in Gaza was deemed undrinkable,¹⁰³ and 10% of children were stunted by malnutrition.¹⁰⁴ The infant mortality rate has not improved since 2006, despite improvements in most areas of the world.¹⁰⁵

In February 2018, the WHO warned that health services in Gaza were "on the brink of collapse," with longstanding shortages of medical supplies, electricity, and fuel.¹⁰⁶ The capacity of the health system was further strained by the high number of traumatic injuries during the Great March

of Return protests beginning in March, with more than 8,000 elective surgeries being canceled or postponed.¹⁰⁷

In February 2019, a UN Commission of Inquiry into alleged violations of international humanitarian and human rights law during the military assaults on the protests found that 189 Palestinians had been killed between March 30 and December 31—183 of them killed by live ammunition fired by Israeli forces—and that more than 23,000 Palestinians had been injured. It also found that some demonstrators flew incendiary kites, causing extensive damage to Israeli civilian property, including houses, agricultural land, and empty educational institutions. Four Israeli soldiers were injured.¹⁰⁸

RECORDED ATTACKS

In the oPt in 2018, we identified 308 attacks that affected health workers, facilities, and transport. Three health workers were reportedly killed, at least 564 were injured,^{xii} two were assaulted, and two were arrested. There were six attacks that damaged five health facilities and destroyed one mobile health clinic. The reported attacks destroyed one ambulance and damaged 39 ambulances.

The WHO also reports that in Gaza alone, 565 health workers were injured, three were killed, 85 ambulances were affected, and three health facilities were affected, including one hospital.

Our dataset contains reports of weapons use in 254 cases, including 45 reported cases of firearms use and five reported incidents of explosive weapons use from aerial attacks. Five of these aerial attacks caused damage to health facilities, all in Gaza. These health facilities included two hospitals, a clinic, a medical point, and an ambulance station, which resulted in damage to 15 ambulances and the entire destruction of one ambulance.

Of the 45 attacks where perpetrators reportedly used firearms, a total of three health workers were killed. In one case, Israeli forces shot and killed a 21-year-old female medical volunteer, Razan al-Najjar, while she was trying to reach injured demonstrators at the protest close to Israel's perimeter fence. Witnesses stated and footage shows that her hands were in the air and that she had been displaying her identification card when struck.^{109,110}

In a further 43 attacks, perpetrators reportedly used a variety of weapons, with 42 of these incidents reportedly perpetrated by Israeli forces. Health workers were injured in these incidents from rubber-coated metal bullets, bullet fragmentation or shrapnel, live ammunition, and from

tear gas—both from gas inhalation and being struck by gas canisters.¹¹¹ The WHO also reports that 372 health workers in Gaza suffered tear gas inhalation [Figure 1].

ACCESS TO HEALTH CARE

Available data indicate there were multiple incidents of Israeli forces and Israeli authorities blocking Palestinian ambulances and health workers from entering particular areas, as well as denying people exit permits to seek medical care outside Gaza in the West Bank, in Israel, and abroad. During one incident, an elderly woman died from a heart attack while inside the Al-Aqsa Mosque in occupied East Jerusalem after Israeli security forces reportedly prevented a Palestine Red Crescent Society ambulance from reaching her for eight minutes.¹¹² On July 5, Israeli forces cut off access to the Palestinian Bedouin community of Khan al-Ahmar, restricting movement and preventing the entry of medical teams. As the situation intensified, health workers traveled through a sewage pipe to enter the community; however, they were prevented from taking any medication with them.¹¹³ Access of health teams to Khan al-Ahmar was denied at least a further eight times.

IN 2018, THE APPROVAL RATING FOR EXIT PERMITS ISSUED BY ISRAELI AUTHORITIES TO PALESTINIANS SEEKING MEDICAL TREATMENT OUTSIDE GAZA WAS THE SECOND LOWEST SINCE THE WHO BEGAN COLLECTING AND REPORTING THAT DATA IN 2008. TWO IN FIVE PATIENT PERMIT APPLICATIONS WERE UNSUCCESSFUL, WITH 39% OF APPLICATIONS DENIED¹¹⁴ OR DELAYED PAST THE DATE OF APPOINTMENT.

We received information regarding perpetrators in 114 of the attacks; 112 attacks were reportedly perpetrated by Israeli forces. Hamas reportedly perpetrated one attack against health in the oPt, preventing two Israeli forces' Technology and Logistics Division trucks transporting medical supplies from entering Gaza.¹¹⁵ The Palestinian Authority also reportedly limited or prevented people from the oPt from accessing health care. According to the Al Mezan Center for Human Rights, a Palestinian human rights organization, in August 2018, health service providers announced that, due to a serious shortage of medical supplies coming from the Palestinian Authority, chemotherapy would no longer be available to cancer patients in Gaza.¹¹⁶

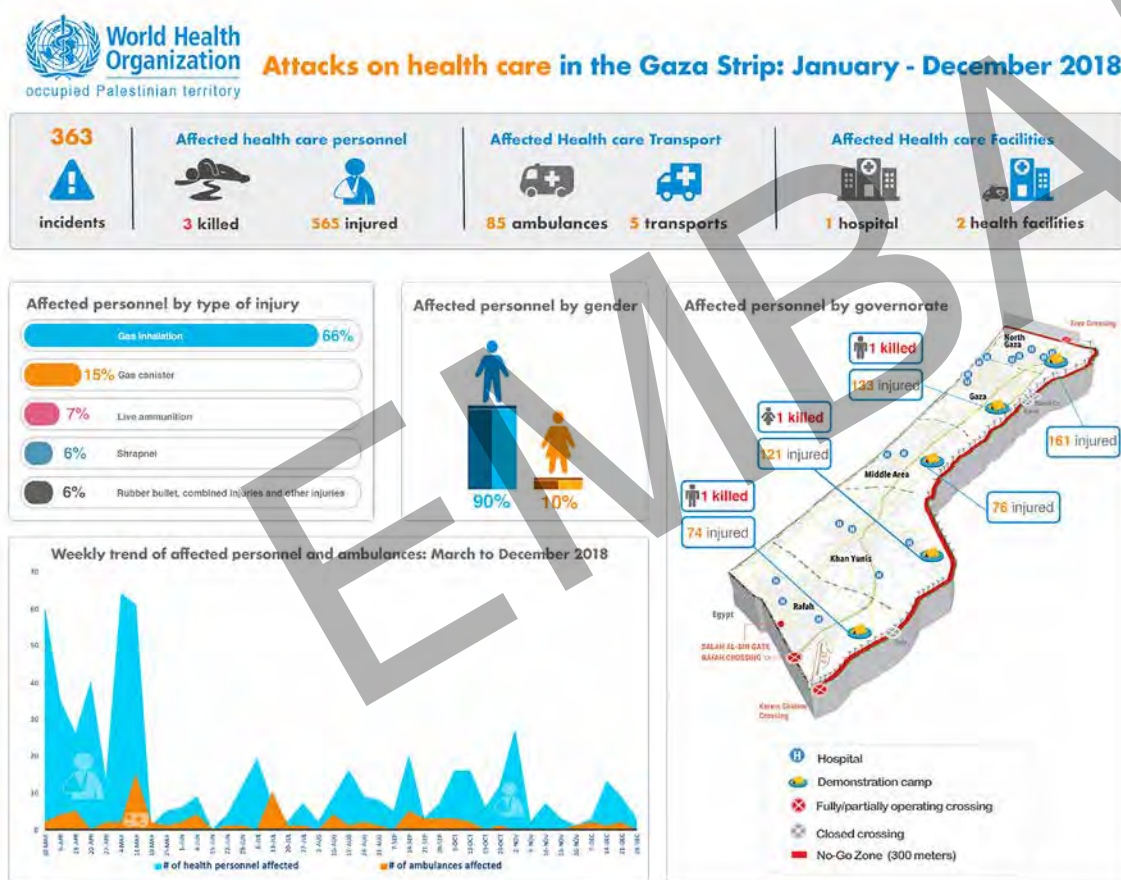


FIGURE 1: Attacks on health care in the Gaza Strip in 2018 (source: WHO)

xii Note: the WHO reports that 565 health workers were injured in Gaza alone.

COUNTRIES EXPERIENCING THE MOST ATTACKS



During the "Great March of Return" health workers in Gaza were killed and injured by Israeli forces while trying to reach, treat and evacuate wounded demonstrators. Photo credit: Medical Aid for Palestinians.



The WHO estimates that over 370 health workers in Gaza were injured by inhaling tear gas during protests. Photo credit: Medical Aid for Palestinians.

Based on contextual evidence, we have coded 55 incidents as suspected intentional and nine as suspected indiscriminate. In addition to our own coding system, a recent UN Commission of Inquiry into the protests,

found "reasonable grounds to believe that Israeli snipers intentionally shot health workers, despite seeing that they were clearly marked as such."¹¹⁷

CASE STUDY

On May 14, field paramedic Musa Abu-Hassanin, 34, was fatally shot by Israeli forces while trying to evacuate wounded demonstrators east of Gaza City. Witnesses said Musa was approximately 200 meters from the perimeter fence at the time. An hour before his death, Abu-Hassanin had helped a member of his team, a Canadian-Palestinian doctor named Tarek Loubani, who had been shot in both legs.¹¹⁸

Dr. Loubani stated, "About an hour after [Abu-Hassanin] rescued me, he was trying to get another patient, and ended up getting shot in the chest. Unfortunately, he died... [W]e, as a medical team, always hope for and expect some protection. We're not there politically. We just want to make sure that if people get into trouble, we're there to help them."¹¹⁹

In another incident during a mass demonstration on April 6, at least 33 health workers were injured. Health facilities and transports were attacked, with five ambulances damaged when struck by live ammunition. Four paramedics were injured, with three paramedics being struck by direct fire on their lower limbs, and one paramedic was injured when a tear gas cartridge struck their head. A further 29 health workers suffered from tear gas inhalation.¹²⁰

LIBYA



Violence and unrest has persisted in Libya since 2011, when the government was overthrown and then-President Muammar al-Gaddafi was killed.¹²² In this "forgotten war,"¹²³ OCHA describes the country as having a "vacuum of effective governance" that has left hundreds of thousands of civilians in precarious situations, with unstable living conditions, and vulnerable to surges in violence.¹²⁴ The conflict is multifaceted, with clashes between forces loyal to the UN-backed Government of National Accord and the rival interim government supported by the Libyan National Army, in the east and west.¹²⁵ Additionally, armed groups such as the Tebu and Tuareg, continue to clash in the south of the country, as they vie for territory and resources.¹²⁶ Armed groups continue to carry out extrajudicial executions and attacks on civilians, including one incident in 2018 in which Islamic State of Iraq and Syria (ISIS) perpetrators publicly executed two civilians.¹²⁷

In August and September 2018, there was heightened violence in the capital of Tripoli, which resulted in high civilian casualties: at least 120 people were killed and

400 wounded.¹²⁸ During this period, an estimated 5,000 families left their homes as the violence continued in the city.¹²⁹

In addition to the unrest caused by political instability and armed groups, large numbers of migrants and asylum seekers from across Africa continue to flock to Libya in an attempt to cross to Europe. By July 2018, Human Rights Watch estimated that between 8,000 and 10,000 people were in official detention centers, where they faced "abysmal, overcrowded and unsanitary conditions" and a lack of access to adequate health services."¹³⁰

By the end of 2017, UNHCR estimated that there were over 200,000 internally displaced people in Libya, in addition to over 40,000 refugees and asylum seekers.¹³¹ The health system in the country remains stretched, with almost 75% of all health facilities in Libya closed or only partially functioning by the end of 2017.¹³² Frequent attacks on health facilities by armed groups have further strained the health system, leading the UN Support Mission in Libya to condemn the attacks, warning that they "may amount to war crimes."¹³³



Perpetrators used explosive weapons in 272 attacks on health care in 2018.

COUNTRIES EXPERIENCING THE MOST ATTACKS

RECORDED ATTACKS

We identified 47 attacks that affected health workers, facilities, and transports.¹³⁴ Ten health workers were injured, two were kidnapped, one was arrested, and two were threatened or intimidated. Additionally, three guards were shot and injured, and at least two patients were injured in attacks. Five health facilities were damaged, there were two incidents of armed entry into medical facilities, and in one incident, a health center was looted. At least two ambulances were intentionally attacked and damaged, and in another incident, unidentified armed perpetrators hijacked an ambulance. There were at least two incidents where armed groups forced the closure of health facilities, and two further incidents where a facility was temporarily closed following a brutal attack.

We received information on weapons use in 30 cases, with perpetrators reportedly using firearms in at least eight of the attacks and explosive weapons in a further four attacks. The attacks involving firearms resulted in six health worker injuries, with all six being shot by perpetrators. In two of these incidents, unidentified militia shot and injured the health workers following either a mistake made by the health worker or the death of a patient on the health worker's watch.¹³⁵ Three of the

attacks involving explosive weapons appear to have been indiscriminate, with stray shells of unknown origin falling onto health facilities, causing damage to three health facilities and injuring one health worker.¹³⁶ In the final incident involving explosive weapons, the Sirte Protection Force discovered and dismantled five improvised explosive devices planted at Ibn Sina Hospital.¹³⁷

The location was reported for 22 incidents, with seven attacks being perpetrated in Tripoli. The number of reported attacks increased in the second half of the year, with 31 of all attacks taking place between July and December, and 23 being perpetrated in November and December alone.

We received sufficient contextual evidence to consider intent in only 19 of the 47 cases. Based on contextual evidence, we have coded 17 of these incidents as suspected intentional and two as suspected indiscriminate.

Information about perpetrators was reported in only five cases, with two attacks attributed to state actors and three incidents attributed to non-state actors: the Awlad Suleiman and Tebu militia, ISIS, and Rijal al-Karama.

CASE STUDY

On December 25, after being prevented from entering Benghazi's Al-Jala Hospital, unidentified gunmen stormed the building and opened fire inside the intensive care unit.¹³⁸ They caused panic and fear inside the health facility and, while nobody was injured, the perpetrators damaged some equipment with stray bullets.¹³⁹ The WHO warned that this attack—the fourth on the same facility—displayed a “worrying trend” that could lead to the closure of this crucial hospital if attacks did not cease.¹⁴⁰

According to UN News, “The trauma hospital [was] already struggling with resources and suffering from a lack of medical supplies. The attack marks the latest incident in a wave of attacks by armed groups in the country's eastern pocket in recent months, prompting the volatile city to remain on a state of high alert.”¹⁴¹ This incident came only a month after unidentified gunmen entered the Al-Jala Maternity Hospital in Tripoli where they shot one doctor and threatened hospital staff, which resulted in a three-day halt of all non-emergency health services.¹⁴²

THE UN STATEMENT ON ATTACKS AGAINST MEDICAL FACILITIES AND PERSONNEL, DATED NOVEMBER 5, 2018, STATES, “PERSISTENT VIOLENCE AGAINST MEDICAL FACILITIES; INCLUDING SHELLING AND BOMBING OF HOSPITALS, ATTACKING AND INTIMIDATING MEDICAL STAFF, LOOTING OF MEDICINE, EQUIPMENT AND AMBULANCES, AND CLASHES INSIDE HOSPITALS ALL COMMITTED WITH IMPUNITY BY ARMED GROUPS—MUST STOP IMMEDIATELY. THE HEALTH SYSTEM OF LIBYA IS ALREADY UNDER-RESOURCED AND OVERSTRETCHED, THESE ATTACKS ARE COSTING LIVES OF INNOCENT PATIENTS AND STAFF ALIKE.”¹⁴³

MALI



Mali's current conflict began with the Tuareg revolt in 2012. In addition to violence in the north of the country, intercommunal violence in the central region reached “a whole new level” in 2018, resulting in serious loss of life and the displacement of thousands of people.¹⁴⁴ The United Nations Multidimensional Integrated Stabilization Mission in Mali (MINUSMA) is one of the most dangerous peacekeeping missions in the world;¹⁴⁵ attacks against MINUSMA have killed 177 people since 2013.¹⁴⁶

As of December 2018, 145,000 people were internally displaced, with 20,000 people newly displaced following intercommunal violence in November.¹⁴⁷ According to the World Food Programme, 25% of families are moderately to severely food insecure,¹⁴⁸ and the vast majority of displaced people will require food assistance in 2019.¹⁴⁹ Between January and October 2018, OCHA reported 177 security incidents affecting aid workers.¹⁵⁰

In June 2018, six international aid groups suspended activities in the Ménaka region due to the increase in violence against humanitarian workers, which had reportedly been on the rise since November 2017. OCHA stated that along with the UN Humanitarian Coordinator, it was “in discussion with aid organizations, peacekeeping, foreign and national armed forces on ways to improve humanitarian access.”¹⁵¹

RECORDED ATTACKS

In Mali in 2018, we identified 16 attacks that affected health workers, facilities, and transport. One health worker was killed, three were kidnapped, and four were assaulted. In total, these 16 attacks affected four drivers, of whom two were kidnapped and two were threatened.

CASE STUDY

On May 1, unidentified gunmen attacked three health workers from Tarkint, as they were on their way to Bourem for a mission. The attackers stole the health workers' motorbikes and other material goods.¹⁵⁶

In an incident on March 19, an NGO decided to suspend work in the region after attackers robbed two mobile health teams.¹⁵⁷

The attacks reportedly damaged one health facility, and there were eight incidents of health transportation being stolen or hijacked.¹⁵² On April 10, in the Mopti region of Mali, unidentified armed assailants abducted two health workers and two drivers for unknown reasons. The armed assailants held them for seven days, then released them.¹⁵³

The location was reported in all 16 of the recorded attacks. The central and northern regions of Mali experienced the most attacks, with six attacks in Gao region and five in Timbuktu.

Perpetrators used firearms in seven of the recorded incidents. Of these incidents involving firearms, three health workers were assaulted and one was kidnapped. In the nine other incidents, no information was reported on the type of weapons used.

We received information regarding perpetrators in four of the 16 incidents. Two incidents were perpetrated by unknown non-state armed groups. The non-state armed group the Movement for the Salvation of Azawad reportedly perpetrated one attack, assassinating a health worker and stealing a vehicle. This attack was allegedly because the health worker had criticized the abuses carried out by the group.¹⁵⁴ In an attack in December, militants presumed to be from the non-state armed group Katiba Macina abducted a merchant and a nurse.¹⁵⁵

Based on contextual evidence, we have coded 15 of these 16 incidents as suspected intentional.

COUNTRIES EXPERIENCING THE MOST ATTACKS

NIGERIA



In Nigeria, the ten-year conflict between the armed group Boko Haram and various government and civilian security forces continues to threaten stability.¹⁵⁸ In the northeast, the center of the insurgency, Boko Haram has attacked health facilities and health workers, leaving the health system barely functioning.¹⁵⁹ In Borno, Adamawa, and Yobe, the most affected states, only 46% of health facilities are currently functional,¹⁶⁰ and nearly eight million people need humanitarian assistance, more than half of whom are children.¹⁶¹ Approximately 2.4 million people are displaced, with 1.9 million people internally displaced in the northeast.¹⁶² Health facilities in areas hosting internally displaced people are strained by increased caseloads.¹⁶³

According to OCHA, more than 20,000 people have died during the conflict.¹⁶⁴ Indiscriminate attacks by all forces—along with Boko Haram’s attacks on communities, hospitals, and schools and its forced recruitment of

women and children as suicide bombers—have claimed the lives of thousands of civilians.¹⁶⁵ Boko Haram has kidnapped thousands of women and girls,¹⁶⁶ including three female health workers in 2018.¹⁶⁷

According to Human Rights Watch, ongoing intercommunal conflict between herdsman and farmers also intensified in 2018.¹⁶⁸

RECORDED ATTACKS

We identified 23 attacks that affected health workers, facilities, and transports. Six health workers were reportedly killed, four were injured, and one was assaulted. Nigeria had disproportionately high numbers of health workers kidnapped, with 44% of all incidents resulting in the kidnapping of a health worker, and with 21 total health workers kidnapped. At least one health center was destroyed, and three health facilities were damaged.

One driver was kidnapped along with one of the health workers, and one official health vehicle was hijacked.¹⁶⁹

Of the 21 kidnapped health workers, at least six were doctors, three were nurses, two were midwives, and one was a registrar and one a provost of medical training institutions. At least two of the kidnappings—of a doctor and a registrar—led to protests by doctors and the Nigerian Medical Association,¹⁷⁰ which likely disrupted the provision of health services. On January 8, in Calabar, Cross River state, unidentified perpetrators kidnapped Dr. Emem Udoh, a senior female registrar in the Department of Pediatrics at the University of Calabar Teaching Hospital.¹⁷¹ According to reports, in response to her kidnapping, more than 150 doctors protested on January 10 and refused to return to work over the high numbers of recent kidnappings of their colleagues and the inadequate response of the state government.^{172,173} The chairman of the Nigerian Medical Association declared that all hospitals in the state would remain

closed until Dr. Udoh was released, stating, “We are not safe and we want people to know that we cannot go to work because we are not safe.”¹⁷⁴ State police reportedly rescued Dr. Udoh on January 12.¹⁷⁵

Where we received information on weapons use, reports indicated that perpetrators used surface-launched explosives in one attack and firearms in six attacks. Boko Haram carried out at least two of the attacks.¹⁷⁶

We received sufficient contextual evidence to consider intent in 13 of the 23 reported attacks, with the remaining ten incidents lacking sufficient information. Based on contextual evidence, we have coded 12 of these incidents as suspected intentional and one as suspected indiscriminate.

Three attacks, the most violent documented, occurred in Borno state. Reports did not include location information for ten attacks.¹⁷⁷

CASE STUDY

On March 1 in the Kala Balge local government area of Rann, Borno state, Boko Haram insurgents armed with automatic weapons, rocket-propelled grenades, and gun trucks attacked an internally displaced persons camp housing 55,000 people.¹⁷⁸ The insurgents killed at least two Nigerians working for the International Organization for Migration and a doctor working for UNICEF.^{179,180} They also kidnapped two female midwives—Saifura Hussaini Ahmed Khorsa and Hauwa Liman—working at a health center supported by the ICRC in Rann, and a female nurse—Alice Loksha—working at another health center supported by UNICEF.^{181,182}

Following this incident, on March 2, MSF announced the suspension of its medical activities in the town and evacuated 22 national and international staff.¹⁸³ MSF reported it was unclear how many people were killed and injured in the violent attack, but reported that its staff had treated nine injured patients.¹⁸⁴ MSF said 40,000 people in Rann were relying almost entirely on its services to access health care, and 60 children enrolled in its nutrition program would be left without medical care.¹⁸⁵

On September 17, Boko Haram militants killed one of the kidnapped midwives, 25-year-old¹⁸⁶ Saifura Hussaini Ahmed Khorsa, and released a video of the execution.¹⁸⁷ The ICRC condemned the killing and urged the captors to release the remaining health workers.¹⁸⁸

“Saifura moved to Rann to selflessly help those in need,” said Eloi Fillion, head of the ICRC delegation in Abuja. “We urge those still holding our colleague Hauwa and Alice: release these women. Like Saifura, they are not part of the fight. They are a midwife and a nurse.”¹⁸⁹

On October 16, the Islamic State West Africa Province, a militant group affiliated with the Islamic State and a faction of Boko Haram, killed the other abducted midwife, 24-year-old Hauwa Liman.¹⁹⁰ According to the BBC, the ICRC said Liman was a “dynamic and enthusiastic woman who was much loved by family and friends. She was truly dedicated to her work helping vulnerable women in her family’s home area.” The ICRC also said, “Hauwa and Saifura’s deaths are not only a tragedy for their families, but they will also be felt by thousands of people in Rann and other conflict-affected areas of north-east Nigeria where accessing health care remains a challenge.”¹⁹¹

UN Secretary-General António Guterres condemned the kidnappings and killings and said, “All parties to the conflict must protect aid workers who provide life-saving humanitarian assistance to the millions of people in need in north-east Nigeria.”¹⁹²

Based on reports of Hauwa Liman’s execution, nurse Alice Loksha remains in captivity.^{193,194}

Health workers were kidnapped in 14 countries, including Afghanistan, Libya, Mali, and Nigeria.



NIGERIA

COUNTRIES EXPERIENCING THE MOST ATTACKS

SOUTH SUDAN



The brutal civil war in South Sudan continued into 2018. It began in 2013 with a political dispute between President Salva Kiir and then-Vice President Riek Machar, leading to clashes between forces loyal to each. Although a new peace deal was signed in October 2018,¹⁹⁵ and violence has since decreased, more than five years of armed conflict between the Sudan People's Liberation Army (SPLA, loyal to President Kiir) and the SPLA-In Opposition (SLPA-IO, loyal to Machar) has left the country in humanitarian crisis. More than seven million people remain in need of humanitarian assistance.¹⁹⁶ As of February 2019, nearly seven million people were at risk of severe food insecurity.¹⁹⁷ Almost 4.2 million people are displaced, with approximately two million people internally and 2.2 million people outside of the country.¹⁹⁸

According to the UN, all parties to the conflict have violated international humanitarian law and perpetrated serious human rights abuses.¹⁹⁹ Twenty percent of health facilities are currently nonfunctional, and one primary health center serves about 50,000 people.²⁰⁰ Only approximately one in five women deliver their babies with a skilled health care worker,²⁰¹ and the maternal mortality ratio is one of the highest in the world—estimated at 789 deaths for every 100,000 live births.²⁰²

According to OCHA, if the nearby Ebola outbreak in the DRC spreads to South Sudan, the health system will not be able to cope.²⁰³ Twelve counties in South Sudan are at high risk for an Ebola outbreak, and if an outbreak occurs, it would likely lead to an epidemic across the country.

According to Humanitarian Outcomes, South Sudan was ranked the most dangerous place for humanitarian aid workers for the third year in a row, with 46 attacks on aid workers in 2017.²⁰⁴

RECORDED ATTACKS

In South Sudan in 2018, we identified 15 attacks that affected health workers and facilities.²⁰⁵ Nine health workers were killed, 14 health workers were kidnapped, one health worker was injured, at least one health worker was assaulted, and one facility guard was killed. Attacks impeded access to medicines and health care for the population. Three NGO vehicles delivering medicines to health facilities were confiscated. One primary health clinic was completely destroyed. Four NGOs suspended medical activities in four states, limiting access to health care for thousands of people.

Weapons use was reported in 12 incidents, with perpetrators reportedly using firearms in eight of the attacks. All attacks with firearms resulted in the killing of at least one health worker or facility guard. For example, on April 26 in Leer county, Western Upper Nile state, unidentified perpetrators shot and killed a South Sudanese aid worker and a community volunteer, both working for the NGO Medair, in separate incidents at two different locations.²⁰⁶

We received sufficient contextual evidence to consider intent in eight of the 15 reported attacks, with the remaining seven incidents lacking sufficient information. Based on contextual evidence, we have coded these eight incidents as suspected intentional.

Perpetrators are named for only two of the 15 attacks. The SPLA-IO claimed responsibility for one attack, and the SPLA and armed opposition groups are reportedly responsible for one attack. On March 25 in Yei, Central Equatoria state, SPLA-IO forces abducted seven South Sudanese aid workers from the South Sudan Health Association and confiscated three of their vehicles. The NGO workers were part of a convoy and en route to deliver supplies to health centers in Kupera, Limuro, Wuji, and Koyoko,^{207,208} which, according to Reuters, serve thousands of people.²⁰⁹ An SPLA-IO spokesperson said the group detained the workers because some of them were government spies.²¹⁰ On April 15, the SPLA-IO released the NGO workers on the orders of Machar.²¹¹ On April 26 in Padeah, Unity state, government forces shot and killed an NGO staff member when he was returning to his clinic after evacuating the town earlier in the day due to armed conflict between the SPLA and armed opposition groups.²¹²



In 2018, attacks on health destroyed 40 health facilities.

CASE STUDY

On July 23 in Doro village, Maban county, Upper Nile state, a group of unidentified, armed men broke into an MSF compound, looted property belonging to the organization and staff, burned down a tent full of equipment, and destroyed most of the vehicles and communication devices. It is unknown if the vehicles were used to transport patients or supplies.^{213,214}

Although there were no injuries or fatalities, MSF suspended most of its medical activities in the local communities and for the refugee population in the area, including running a hospital in Doro refugee camp and providing primary health services at Bunj State Hospital. MSF's head of mission in South Sudan, Samuel Theodore, said, "As the safety of health care personnel and facilities cannot be guaranteed, we have no other choice but to suspend the rest of our activities, which will leave 88,000 people with limited access to much needed medical services."²¹⁵

At least ten other organizations in the area were also attacked and looted on July 23, including UNHCR. UNHCR said the attackers complained the aid groups had overlooked local residents when hiring staff.²¹⁶

COUNTRIES EXPERIENCING THE MOST ATTACKS

SYRIA



As the crisis in Syria enters its ninth year, parties to the conflict have continued to disregard civilian life by perpetrating human rights abuses and violating international humanitarian law. With the conflict beginning to wind down, the international community has shifted the conversation on Syria toward one of return and reconstruction; however, 2018 was still a year with periods of extreme violence. While the Syrian government moved to consolidate its hold over much of Syria's territory, the government and other parties to the conflict attacked both health facilities and health workers, and the civilian population continued to suffer the consequences.

The humanitarian and human rights context in Syria remains one of the worst globally. According to OCHA, 13.2 million people in Syria are in need of health assistance, 2.1 million children are out of school, and 83% of Syrians live below the poverty line.²¹⁷ Nearly half of Syria's prewar population is displaced—6.2 million people internally and 5.3 million registered refugees living in neighboring countries.²¹⁸ OCHA estimates that nearly 4,500 people were displaced per day in 2018.²¹⁹ Humanitarian access has continued to be a challenge, with 1.1 million people in need residing in hard-to-reach areas and widespread attacks on humanitarian workers.²²⁰

Following years of relentless attacks, more than half of the country's private facilities were not fully operational and more than a third of public hospitals were out of service by September 2018.^{221,222} According to Coalition member Physicians for Human Rights, there have been at least 553 attacks on 348 separate medical facilities since the conflict began, and many health workers have been killed—at least 88 in 2018 alone.^{223,224}

There was an uptick in violence in early 2018. February marked the beginning of the Syrian Arab Army's Rif Dimashq offensive, which involved one of the heaviest bombardment campaigns of the war. This campaign led to the government's recapture of Eastern Ghouta from rebel factions. Idlib was another focal point of the Syrian government's targeting in 2018, with the governorate enduring a fierce assault on its health facilities in the first few months of the year.

RECORDED ATTACKS

In Syria in 2018, we identified 257 attacks that affected health workers, facilities, and transports. Eighty-eight health workers were reportedly killed, 75 were injured, 13 were kidnapped, and 28 were arrested. These 257 attacks affected at least 170 patients and beneficiaries, as well as 2 drivers or guards. There was at least one incident of a

FIGURE 2: Location of attacks by month

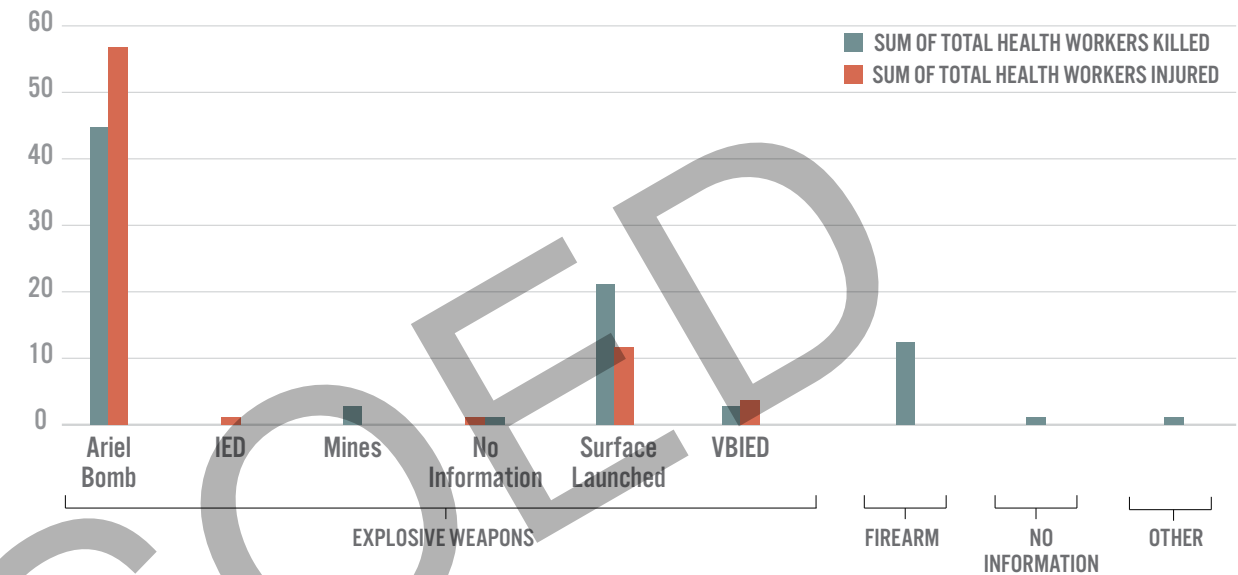
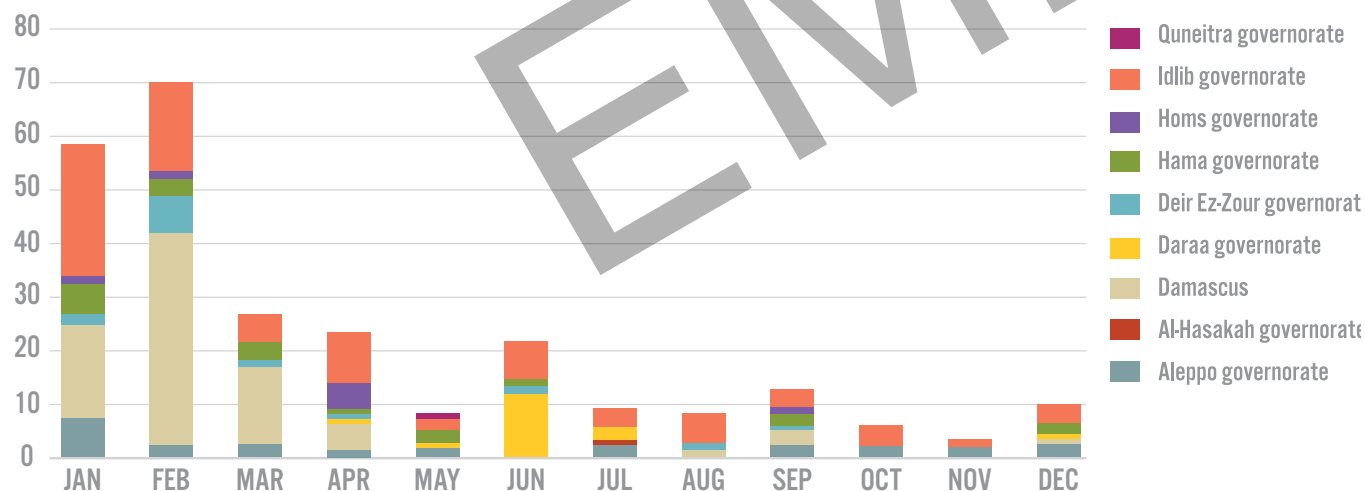


FIGURE 3: Health workers injured and killed by weapon type. IED = improvised explosive device; VBIED = vehicle-borne improvised explosive device.

military occupation of a health facility and five incidents of armed entry into health facilities. The attacks damaged at least 114 health facilities and destroyed 21 health facilities. At least 42 health transports were damaged, 2 were stolen or hijacked, and 14 were destroyed.

More than half of the total number of attacks reported in 2018 took place in January and February. The highest number of attacks took place in Idlib, with a significant spike in attacks noted in Rif Dimashq (including Eastern Ghouta) in February. Figure 2 shows the location of incidents over time.

Of the 257 reported attacks, information on weapons was reported in 253 cases. A total of 208 attacks involved explosive weapons—132 were aerial bombs and 46 were surface launched explosives; others included hand grenades and mines. Perpetrators used firearms in 14 cases and other weapons—including fire and torture—in a further 15 cases. Of the 88 health workers killed, 73 were killed by explosive weapons, 45 of which were aerial bombs. Explosive weapons accounted for all 75 health worker injuries. Figure 3 shows the number of health workers killed and injured by different types of weapons.

We received sufficient contextual evidence to consider intent in 133 of the 257 cases (Figure 4). Based on contextual evidence, we have coded 93 of these incidents as suspected intentional and 40 as suspected indiscriminate. In 124 cases, we did not receive sufficient information to infer intent. Nearly 90% of the incidents coded as suspected indiscriminate were the result of explosive weapons, with 40% of the total number the result of airstrikes. In one incident in January, coded

as suspected indiscriminate, the Turkish army artillery reportedly fired several mortar shells, some of which landed on an ambulance belonging to the Kurdish Red Crescent Society, causing damage to the ambulance and putting it out of use.²²⁵ In a "double-tap" strike coded as suspected intentional, on February 15, a male paramedic was reportedly killed in a bombing by suspected Russian forces as he was tending to people wounded by a previous shelling by the same warplanes.²²⁶

Information about perpetrators is reported in 194 of the 257 incidents (Figure 5). At least 174 of these incidents are suspected to have been perpetrated by state forces, including Syrian forces, Russian forces, international coalition forces, and Turkish forces. Of these 174 attacks, 162 were reportedly carried out specifically by Syrian and/or Russian forces, constituting 63% of all incidents reported in Syria.

A key characteristic of the conflict in Syria is the repeated nature of the attacks, with some health facilities being struck multiple times. The Saraqib blood bank, which provided services to at least 700 people a month, was hit twice, once in January and again in February.²²⁷ Similarly, the Owdai Hospital (also known as al-Ihsan Hospital), the only public hospital in the Saraqib district, was attacked twice in January.²²⁸ The two airstrikes, just over a week apart, severely damaged the hospital and put it out of service. The hospital was previously serving a population of 50,000, providing 3,800 consultations per month.²²⁹ After the cluster of attacks in January, Idlib health care authorities declared that the city of Saraqib was in a "state of medical emergency."²³⁰

COUNTRIES EXPERIENCING THE MOST ATTACKS

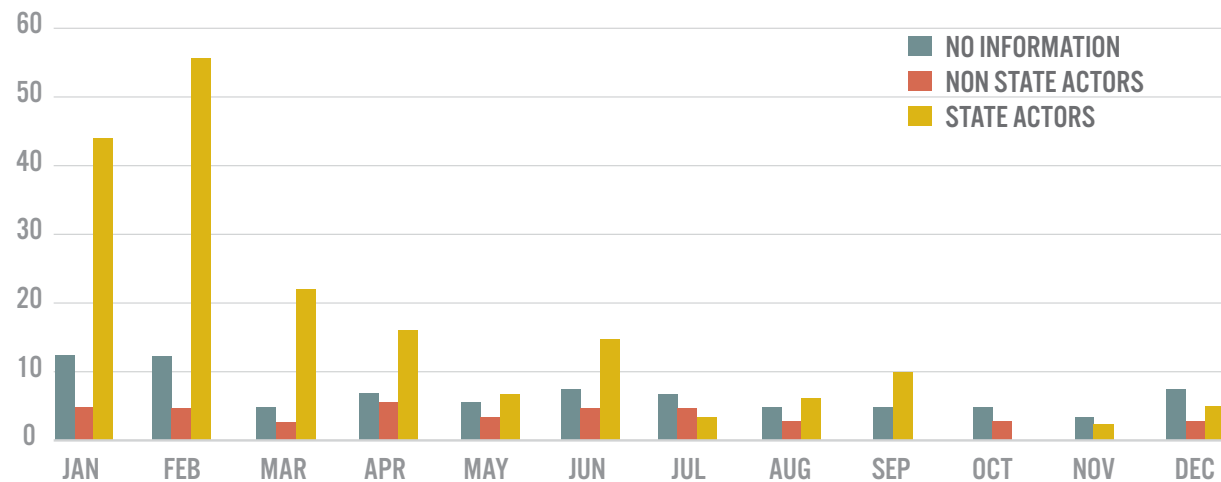


FIGURE 4: Number of attacks reportedly perpetrated by state or non-state actors over time

CASE STUDY

In an example reflecting the intensity of the bombing campaign during the Syrian Arab Army's Rif Dimashq offensive, three medical facilities—al-Hayat Hospital in Kafr Batna, Saqba Hospital in Saqba, and al-Marj Hospital in Douma—were all attacked on February 19.²³¹ The airstrikes caused severe damage that resulted in the temporary closure of all three facilities. Over the following days, from February 20 to 23, Syrian and Russian forces reportedly attacked at least 15 health facilities in Rif Dimashq and Damascus, including: Al Maghara Cave Hospital, Anwar Hospital, Ehia Nefs Hospital, Irbeen Surgical Hospital, Al-Yaman Hospital, Saqba Hospital, Beit Sawa Primary Health Centre, Dar al-Shifaa Hospital, Jesrin Hospital, Alrahma Medical Centre, the Syrian Arab Red Crescent Centre, an obstetric center, Ehyaa Annafes Hospital, a spinal cord injuries rehabilitation center in Eastern Ghouta, and “point 140,” a clinical center affiliated with the Ihya’ Medical Network.²³²

These consecutive and geographically concentrated incidents point to a systematic and potentially deliberate pattern of attacks on health facilities and are representative of the general manner with which the parties to the conflict, mainly the Syrian government and its allies, have behaved in this conflict since 2011. During these attacks, at least six health workers were killed and 11 were injured; at least 11 health facilities were damaged, and two were completely destroyed; and nine ambulances were damaged, and at least three were destroyed. During these attacks, the region's health infrastructure was seriously crippled as part of a concerted military campaign to recapture territory.

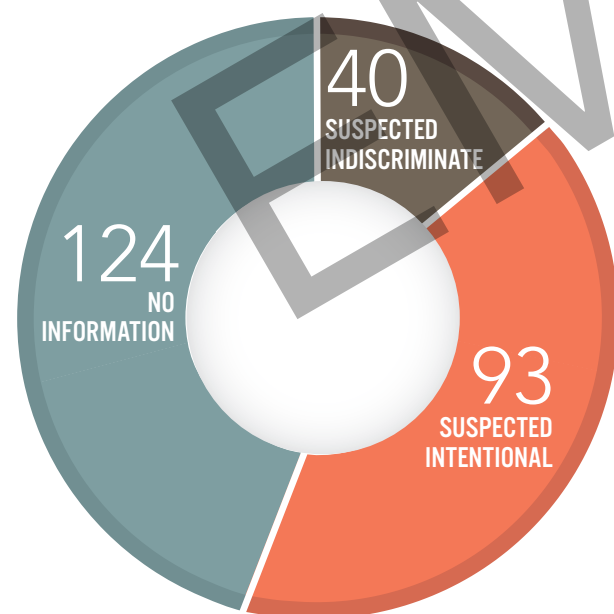


FIGURE 5: Proportion of reported attacks in Syria that are suspected to be indiscriminate or intentional.

The aftermath of an attack on a SAMS-supported hospital in Arbin, East Ghouta, Syria, January 2018. Photo courtesy of the Syrian American Medical Society (SAMS).



DR. TEDROS ADHANOM GHEBREYESUS, WHO DIRECTOR-GENERAL, STATES, “THIS HEALTH TRAGEDY MUST COME TO AN END...EVERY ATTACK SHATTERS COMMUNITIES AND RIPPLES THROUGH HEALTH SYSTEMS, DAMAGING INFRASTRUCTURE AND REDUCING ACCESS TO HEALTH FOR VULNERABLE PEOPLE. WHO CALLS ON ALL PARTIES TO THE CONFLICT IN SYRIA TO IMMEDIATELY HALT ATTACKS ON HEALTH WORKERS, THEIR MEANS OF TRANSPORT AND EQUIPMENT, HOSPITALS AND OTHER MEDICAL FACILITIES.”²³³

DOCTORS AND NURSES COLLAPSE AS MEDICAL RESPONSE IN EAST GHOUTA REACHES LIMITS

During five days of intense bombing and shelling from February 18 to 23, 2018, MSF-supported hospitals and clinics in East Ghouta saw more than 2,500 wounded people. Thirteen MSF-supported medical facilities were hit by bombs or shells.

Medics were pushed to the brink, working for six days straight, with no hope of being able to adequately treat their patients. MSF called for an immediate ceasefire to enable the basic human act of helping the sick and wounded.

“As a nurse who has worked through extremely grim conflicts, I am devastated to hear doctors and nurses in East Ghouta saying they have 100 wounded patients and no hospital because it has just been reduced to rubble by bombing,” says nurse and general director of MSF, Meinie Nicolai.

“There is a level of desperation and exhaustion that comes from working round the clock, finding no time to sleep, no time to eat, permanently surrounded by bombing, and simply being in the middle of absolute distress. Adrenaline can only keep you going for so long. If doctors and nurses collapse, humanity collapses. We must be determined to not let that happen.”

Adapted from: Médecins Sans Frontières. “Doctors and nurses collapsing as medical response in East Ghouta reaches its limits.” February 24, 2018. <https://www.msf.org/syria-doctors-and-nurses-collapsing-medical-response-east-ghouta-reaches-its-limits>.

COUNTRIES EXPERIENCING THE MOST ATTACKS

YEMEN



Three years of conflict in Yemen have led to the near total collapse of the country's health system. In this civil war, government forces and the Saudi and Emirati-led Coalition (SELC) are fighting the Houthi rebels, who control sections of the country, including the capital city of Sanaa. More than half of health facilities are no longer functional,²³⁴ and 16.4 million people do not have access to adequate health services.²³⁵ Twenty-two million people require humanitarian assistance,²³⁶ and 14 million people are on the brink of starvation.²³⁷ In April 2018, UN Secretary-General António Guterres referred to Yemen as "the world's worst humanitarian crisis."²³⁸

Since then, the situation has only worsened, with threats to the health of the Yemeni people coming from all sides. An air, land, and naval blockade imposed by the SELC has prevented medical evacuations and the import of crucial medical supplies and fuel to run hospital generators.²³⁹ The economy is crumbling, and there is a dire lack of food and clean water, yet still, parties to the conflict continue attacking health facilities and health

workers as a tactic of war.²⁴⁰ Health workers not only face the threat of attack, but tens of thousands have not been paid in months.²⁴¹ Overall, civilians have endured an average of 15 airstrikes a day, with a total of 16,749 air raids recorded between March 26, 2015 and March 25, 2018.²⁴² The Yemen Data Project documents that 68% of all bombings in Yemen take place in the northwestern city of Sa'ada and the western port city of al-Hudaydah.²⁴³

RECORDED ATTACKS

In Yemen in 2018, we identified 53 attacks that affected health workers, facilities, and transports.²⁴⁴ Eight health workers were reportedly killed, four were injured, two were kidnapped, two were threatened or intimidated, and one was arrested. In total, these 53 attacks affected 23 patients and beneficiaries. There were two incidents of armed groups occupying medical facilities.^{245,246,247} The attacks damaged at least 15 health facilities and destroyed two more, and damaged or destroyed four ambulances.

At least 18 facilities were destroyed by aerial strikes in Syria and Yemen in 2018. In Syria, at least 23 facilities were struck multiple times.



The location of attacks is known in 52 of the 53 incidents. Of these 53 incidents, 20 were reported in al-Hudaydah and 14 were reported in Taiz, both in the western region of the country.

Of the 53 reported attacks, information on weapons use was reported in 48 cases. Perpetrators reportedly used explosive weapons in 30 attacks, which represent more than half of the total attacks. Of these, 16 explosives were surface launched, 11 were aerial bombs, two were hand grenades, and one was unknown. These attacks using explosives were reportedly responsible for all eight of the health worker deaths listed. Perpetrators reportedly used firearms in nine of the attacks. Of these nine attacks involving firearms, one health worker was injured, one was kidnapped, and two were threatened or intimidated.

We received sufficient contextual evidence to consider intent in 49 of the 53 cases. Based on contextual evidence, we have coded 29 of these incidents as suspected intentional and 20 as suspected indiscriminate.

Information about perpetrators is reported in 31 of the 53 attacks. Of these, pro-Houthi forces were reportedly responsible for 14 attacks, and state forces, including the SELC, are suspected to have perpetrated 13 attacks. At least one attack was reportedly perpetrated by both pro-Houthi and state forces. The SELC forces also reportedly perpetrated "double-tap" strikes that killed five health workers. In these incidents, the SELC targeted first-responders as they came to assist those injured in a SELC airstrike.²⁴⁸

CASE STUDY

On July 11, SELC forces launched an airstrike that hit an MSF cholera treatment center in Abs, despite it being clearly marked as a medical facility.²⁴⁹ The attack destroyed a patient ward and damaged an adjacent unit, as well as the roof and walls, leaving the center nonfunctional.²⁵⁰ There were no casualties, as the facility was newly constructed and had yet to receive patients, but MSF temporarily froze all activities in Abs until the safety of staff could be guaranteed.

MSF's head of mission said, "This morning's attack on an MSF cholera treatment center (CTC) by the Saudi and Emirati-led coalition (SELC) shows complete disrespect for medical facilities and patients. Whether intentional or a result of negligence, it is totally unacceptable. The compound was clearly marked as a health facility and its coordinates were shared with the SELC. With only half of health facilities in Yemen fully functional, nearly ten million people in acute need, and an anticipated outbreak of cholera, the CTC had been built to save lives."²⁵¹

According to the Yemen Data Project, on average, 32% of all Saudi-led air raids targeted non-military areas, with this number rising to 48% in September, the highest rate of civilian targeting since 2015.²⁵² Despite many NGOs and UN bodies adding the locations of their health facilities to the SELC "no-strike list," the Human Rights Council stated that field combatants "routinely failed to consult" the list.²⁵³

A CANADIAN NURSE ON YEMEN'S BROKEN HEALTH SYSTEM

"It seems like everyone has lost people because of this conflict, whether it has been from direct violence or the secondary impacts that conflict can have, such as barriers to accessing health care," says Mariko Miller, a Canadian nurse who worked at the Médecins Sans Frontières (MSF) hospital in the city of Taiz during the enduring civil war.

Many of the patients Miller saw were suffering from infections that can be prevented by effective vaccination programs. But the war has cut many people off from essential health services.

"One patient in particular I recall was a little boy with diphtheria. Diphtheria is something we should never see, because it's so easily preventable by vaccination," says Miller. "The little boy's grandmother sat by his side for days. He didn't make it. His airway eventually closed in on him."

While the security situation in Taiz means that MSF is currently unable to conduct vaccination campaigns in the community at large, it still provides immunizations as an outpatient service in the hospital.

"We were able to stabilize traumas, and admit the pediatric and neonatal emergency cases and patients who otherwise had limited access to services. The conflict has put that out of reach for so many," Miller says.

Adapted from: Médecins Sans Frontières. "Yemen: A Canadian nurse on how MSF provides a lifeline to people trapped by conflict in Yemen". Dispatches: MSF Canada Magazine, 23(1); Spring 2018. https://www.doctorswithoutborders.ca/sites/default/files/msf_dispatches_spring2018_eng_final_0.pdf



In the oPt, Syria, and Yemen, health transports were destroyed and damaged in aerial attacks. Ambulances were also destroyed in Afghanistan, Burkina Faso, Cameroon, the CAR, Egypt, Libya, Nigeria, and Somalia by a range of weapons including firearms.

BURKINA FASO

Internal violence and instability have persisted in Burkina Faso since 2014, when an uprising ousted then-president Blaise Compaoré from power. Throughout 2018, Burkina Faso faced security threats in several regions from multiple non-state armed actors, concentrated in the north, where the government has a sparse presence.²⁵⁴ In recent years, there has been an increase in political violence in the far east of the country.²⁵⁵ The security situation in Burkina Faso has deteriorated partly due to violence from armed groups spilling over the border from Mali, and partly due to the lack of government presence and organization.²⁵⁶

RECORDED ATTACKS

In Burkina Faso in 2018, we identified seven attacks that affected health workers. Two health workers were killed and one was kidnapped. In one attack on July 27, assailants assumed to be from the armed group Ansaroul Islam reportedly abducted a nurse, who was released unharmed the following day in Gomde-Fulbe town, Sahel

area.²⁵⁷ Based on contextual evidence, we have coded all of the seven incidents as suspected intentional.

EGYPT

Since the largely contested presidential elections in March 2018, President Abdel Fattah al-Sisi has maintained control of the country and has attempted to silence protestors as well as religious, social, and political dissidents by invoking the country's anti-terrorism laws. Journalists and civil society activists have been arrested and tried in what Human Rights Watch has referred to as flawed military court systems on trumped-up charges.²⁵⁸

Military forces have been particularly active in Sinai, where a new campaign against the ISIS-affiliated group known as Sinai Province led to the destruction of churches and homes and a restriction of resources such as food and fuel.

RECORDED ATTACKS

We identified one attack in Egypt in 2018, which was coded as suspected indiscriminate. On August 27, ISIS

militants detonated an improvised explosive device that destroyed an ambulance of the Egyptian army near the Faydi checkpoint south of Al-Arish in North Sinai province.²⁵⁹ A paramedic and the ambulance driver were both injured in the attack, which marked the first time the Province of Sinai has claimed responsibility for an attack on an ambulance since warning health workers against transporting injured police and armed forces personnel.²⁶⁰

ETHIOPIA

Since 2015, political unrest has fueled a conflict in Ethiopia's Oromia, Somali, and Amhara regions, which has been exacerbated by drought and a long-standing state of emergency, under which security forces have repressed citizens and torture has been commonplace.²⁶¹ In June 2018, Abiy Ahmed, the new prime minister, lifted the state of emergency and released thousands of political prisoners. There is also a long history of intercommunal violence in Ethiopia. Currently, there are two million internally displaced people in the country, one million of whom were displaced in April and June 2018 due to intercommunal violence.²⁶²

RECORDED ATTACKS

We identified one attack in Ethiopia in 2018. On July 15, in Moyale town, Somali region, members of the National Youth Movement for Freedom and Democracy and the Oromo Liberation Front reportedly burned health posts in Chamuq, Maleb, and Lag Fure, three villages surrounding Moyale, in the midst of a series of attacks against Somali civilians. This attack resulted in damage to three health facilities. Based on contextual evidence, we have coded this attack as suspected intentional.²⁶³

INDONESIA

In Indonesia, there is an ongoing independence-related conflict in West Papua, in the far east of the country.²⁶⁴ In recent years, the country has also suffered a number of deadly attacks linked to Islamic militants.²⁶⁵ According to Human Rights Watch, religious minorities face harassment and violence from Sunni militants, government officials, and security forces. Security forces rarely face justice for serious abuses, particularly in Papua.²⁶⁶

RECORDED ATTACKS

In Indonesia in 2018, we identified two attacks that affected a health worker and a facility. One health worker was kidnapped and then killed*, and one facility was set on fire. Both attacks occurred in Pengunungan Bintang district and Mimika regency, both in Papua province.

On March 29 in Yabasorum area, Pengunungan Bintang district, Papua province, an armed group abducted a health worker from the Protestant aid group the Advent Foundation from his home and then stabbed him to death. Indonesian police suspected the perpetrators were separatists who mistook the victim for a government spy.^{267,268} On April 1 in Utikini village, Mimika regency, Papua province, the West Papua National Freedom Army reportedly set fire to a hospital, along with an elementary and junior high school and residences. Shooting then broke out between the army and the Indonesian military in Banti, Mimika.^{269,270} Based on contextual evidence, we have coded these two incidents as suspected intentional.

IRAQ

In late 2017, the Iraqi government concluded major military operations against the Islamic State of Iraq and the Levant (ISIL),²⁷¹ but conflicts involving Iraqi forces, multinational military coalitions, and extremist groups continued throughout 2018. In 2018, Iraq faced new sources of instability and conflict, including an unpredictable political landscape, rising poverty rates, and delayed community reconciliation efforts.²⁷² While there were still attacks by extremists, the country refocused efforts toward rebuilding and bringing ISIL extremists to justice.²⁷³ Human Rights Watch noted that such attempts to bring ISIL agents to justice resulted in human rights violations. Examples of these included Iraqi forces arbitrarily detaining citizens in areas where ISIL was previously active and imposing stringent security measures on families with ties to suspected ISIL sympathizers.²⁷⁴

According to OCHA, the violence has resulted in millions of internally displaced people, with four million people returning to their areas of origin, and two million people remaining displaced; a total of 6.7 million people remain in need of humanitarian aid.²⁷⁵

*Health workers kidnapped and then killed in captivity are coded in our dataset only as kidnapped.

RECORDED ATTACKS

In Iraq in 2018, we identified 12 attacks that affected health workers and facilities. Five health workers were killed, and three were injured. Two health facilities were damaged or destroyed. Five of the 12 attacks occurred in January.

On January 19, a government employee working for the provincial health department was assassinated by ISIL militants in the area of Sharwain.²⁷⁶ On May 13, a paramedic was killed, and another was wounded when the remnant of an ISIL bomb exploded in Badush town.²⁷⁷

On December 14, the head of the health committee in the provincial council of Basra was besieged by demonstrators and shot while exiting the building. His motorcade was subjected to heavy gunfire from some of the infiltrators within the demonstration, and he suffered a bullet wound to his arm.²⁷⁸

Based on contextual evidence, we have coded six of the 12 incidents as suspected intentional and three as suspected indiscriminate; three lacked sufficient information for coding.

MYANMAR

Despite promises made by State Counsellor Daw Aung San Suu Kyi and the election of the National League for Democracy in November 2015, little progress has been made in resolving the long-standing ethnic conflict within Myanmar.²⁷⁹ Several rounds of peace negotiations between the predominantly-civilian Myanmar government and ethnic armed groups in Kachin, Shan, and Karen states have repeatedly dissolved due to a lack of trust regarding the role of the Myanmar National Armed Forces (Tatmadaw) in this new government and its commitment to a true national ceasefire.^{280,281}

Exacerbating this mistrust is the recent Rohingya crisis, which has been manipulated by the Tatmadaw to foment xenophobic sentiment among the majority-Buddhist, Bamar populace. This trend, coupled with the legislative power held by the Tatmadaw, has granted the military impunity in indiscriminately persecuting non-Bamar, non-Buddhist ethnic groups in the interest of national defense and home affairs.^{282,283}

The conflict has escalated since the beginning of 2018, increasing the level of internal displacement within Myanmar, particularly in the country's northeastern Kachin and Shan states and in the western region in Rakhine state.²⁸⁴ Movement restrictions and overcrowded shelters have resulted in deplorable living conditions. There is a severe lack of adequate access to health care, education, and livelihoods, with women and children disproportionately affected.

RECORDED ATTACKS

In 2018, we identified four attacks on health facilities and health workers. In these four incidents, seven health workers were reportedly killed, three health facilities were destroyed, and one was damaged.^{xiii} Six of these deaths reportedly occurred after the Myanmar Army detained six female medics of the Ta'ang National Liberation Army, who had accused the military of killing prisoners of war.²⁸⁵ Their bodies were later discovered dumped in a forest near the township of Nam Khan.

We received information on perpetrators in two of the reported incidents: one incident was reportedly carried out by the Myanmar Army and the other by a state soldier. Based on contextual evidence, we have coded three attacks as suspected intentional and one as suspected indiscriminate.

PAKISTAN

Throughout 2018, the government of Pakistan continued to suppress dissenters from civil society organizations and the media, contributing to an environment of threatened freedom of expression. Women, religious minorities, and transgender people remain particularly vulnerable to persecution and violence.²⁸⁶

Women and girls experienced violence including rape, acid attacks, and forced marriage—part of systemic, institutionalized gender inequity that leaves women and girls excluded from education and vulnerable to domestic violence. The inequitable access to humanitarian assistance and education has contributed to inadequate nutrition and poor health outcomes for women, especially for the poorest and most vulnerable women.²⁸⁷

The Taliban, ISIS, and Al-Qaeda remain active in Pakistan. The period leading up to the parliamentary elections in July brought violence at political rallies, polling stations, and election meetings.²⁸⁸

RECORDED ATTACKS

We identified 11 attacks in 2018 that affected health workers and facilities. In these attacks, seven health workers were killed, five were injured, and four were kidnapped. One health facility was damaged. Six of the 11 incidents were against polio vaccination workers, posing a risk not just to the health workers, but to global efforts to eradicate this disease.

Unidentified, armed men in the Ali Khel area of Qila Saifullah district shot a health worker dead on January 14.²⁸⁹ On January 18, in the city of Quetta in Balochistan province, unknown gunmen on motorcycles shot and killed two polio vaccination workers, a mother and a daughter, in the head as they were administering anti-polio drops.²⁹⁰ Nobody has claimed responsibility for this attack. In response, Lady Health Workers staged a protest against the attack outside the Charsadda Press Club in Quetta four days later.²⁹¹

On March 18 in a remote tribal region, unspecified militants ambushed a seven-member polio vaccination team, killing two of the health workers and seriously wounding another two. Two others disappeared after the attack, but later returned unharmed. Jamaatul Ahrar, a faction of the Pakistani Taliban, claimed responsibility for this attack.²⁹² In two separate incidents on August 10, polio vaccination workers were held hostage and harassed in Nowshera.²⁹³ Female staff at Khesghi Rural Health Centre were taken hostage, and two young men chased and harassed a polio vaccination team in the village of Kalenger in Risalpur, brandishing pistols at the police working alongside the health workers.

On December 13 in Shahbaz Town, in the city of Quetta, Balochistan province, unidentified perpetrators abducted Dr. Ibrahim Khalil, a neurosurgeon, sparking widespread concern over the safety of health workers in the region.²⁹⁴ Doctors associated with the Pakistan Medical Association and other similar organizations announced a strike on December 18 and 19, 2018 in government-run hospitals across the region to protest his abduction.²⁹⁵

Based on contextual evidence, we have coded ten of these incidents as suspected intentional and one as unknown.

THE PHILIPPINES

The conflict in the Philippines has changed focus over time, with the main actors historically being the three Muslim separatist groups—the Moro National Liberation Front, the Moro Islamic Liberation Front (MILF), and the Abu Sayyaf—and the communist group, the New People's Army, against government forces.²⁹⁶ In 2017, fighting intensified on the island of Mindanao between government forces and an armed group affiliated with ISIL, in a five-month-long battle that left the city of Marawi dilapidated and suffering.²⁹⁷ Immediately following the defeat of this group, President Duterte announced that the military forces would turn their attention to fighting the New People's Army, subsequently freezing peace talks with the communist group.²⁹⁸ Martial law has been in place on the island since May 2017, and despite it being set to expire in December 2018, President Duterte extended martial law until the end of 2019.²⁹⁹

Many civilians, including the indigenous Lumad population, have been affected by the militarization of the island and have been accused of backing anti-government communist forces.³⁰⁰

RECORDED ATTACKS

The number of reported attacks against health in the Philippines decreased from 2017 to 2018, with a total of two reported incidents taking place. Both of these incidents occurred in the southern region of the country, in Sulu province and on Mindanao island. On April 12, the human resource management officer of the Integrated Provincial Health Office was shot and killed while riding a motorcycle in Jolo town, Sulu.³⁰¹ The health ministry branded this as a "direct attack" against the medical community.³⁰² On December 14, a military checkpoint in Mindanao island stopped two vehicles, one with teachers and supplies of food and the other containing medical supplies, and denied them permission to continue.³⁰³ This access constraint reportedly deprived the indigenous village of Sitio Dulyan of much-needed food and medicine. Based on contextual evidence, we have coded both incidents as suspected intentional.

xiii Note: The source was not able to report whether all of these clinics were burned down in 2017 or 2018.

SOMALIA

In Somalia, there is continued armed conflict involving state security forces and militia, the African Union Mission in Somalia and foreign troops, and the Islamist terrorist group Al-Shabab.³⁰⁴ According to Human Rights Watch, approximately 2.7 million people are now internally displaced, increasing their vulnerability to violence.³⁰⁵

RECORDED ATTACKS

In Somalia in 2018, we identified ten attacks that affected both health workers and transports. Two health workers were reportedly killed, two were injured, and five were kidnapped. One civilian riding in an ambulance was shot and killed. One health transport vehicle was reportedly stolen, and another was damaged in the attacks.

The Mogadishu region experienced the most attacks (6). Four attacks involved the use of firearms. These attacks were reportedly responsible for the death of one health worker, the injury of one health worker, the kidnapping of one health worker, and the death of the civilian riding in the ambulance. Two attacks involved the use of a vehicle-borne improvised explosive device, one of which reportedly injured a health worker.

Both Al-Shabab and the Somali National Army perpetrated attacks against health in Somalia in 2018. Al-Shabab reportedly carried out five of the ten incidents, including kidnapping four health workers and hijacking a health transport. The Somali National Army carried out or is suspected of carrying out one attack, in which soldiers reportedly shot and killed the civilian riding in an ambulance.

Based on contextual evidence, we have coded seven of these incidents as suspected intentional. Examples of these suspected intentional attacks include the reported abduction by Al-Shabab of three international NGO staff members working at a health center in Balet Hawa.³⁰⁶ On November 9, Al-Shabab claimed responsibility for four car bombs that exploded outside a hotel in Mogadishu, killing at least 53 people and injuring more than 100. The fourth blast hit medics attempting to rescue survivors.^{307,308}

SUDAN

In Sudan, armed conflict in the Darfur, Southern Kordofan, and Blue Nile regions continued in 2018. More than two million people have been displaced since the conflict between armed opposition groups and government forces began in 2003.³⁰⁹ According to OCHA, 5.2 million people need humanitarian health assistance, 4.8 million people are food insecure, and 2.3 million children suffer from acute malnutrition.³¹⁰ OCHA also reports that approximately 36% of primary health care facilities are not fully functional due to staff shortages or poor infrastructure; only 24% of Sudan's primary health care facilities offer the minimum primary health services package; only a third of the population has access to an adequate number of midwives; and approximately 820,000 children under five need access to health services, including vaccinations.³¹¹ The WHO estimates there are only 1.5 primary health care centers for every 10,000 people.³¹²

Sudan's president Omar Hassan al-Bashir has ruled since coming to power via a military coup in 1989.³¹³ He faces two arrest warrants issued by the International Criminal Court on charges of genocide, war crimes, and crimes against humanity in Darfur from 2003 to 2008.^{314,315} Sporadic protests against al-Bashir escalated throughout 2018. On December 19 in Khartoum, doctors led a country-wide strike with the recently established Sudanese Professionals Association to protest the deterioration of health services and the increased cost of living, and renewed calls for the president to step down. In several locations, Sudanese forces responded with excessive force to disperse unarmed protestors.^{316,317,318,319} Protests continued through the month, and security forces arrested doctors in late December and into 2019; security forces continue to target doctors for arrest and even torture.³²⁰

RECORDED ATTACKS

In Sudan in 2018, we identified seven attacks that affected health workers. Five health workers were injured, two were assaulted, and six were arrested, and two guards or drivers were also affected.³²¹ Based on contextual evidence, we have coded all seven incidents as suspected intentional.

Five of the seven attacks occurred in December after doctors led a nationwide strike.

On December 26 in Port Sudan, police and security forces used excessive force to disperse people gathered at vigils organized by doctors and lawyers.³²² On December 30 in Khartoum, Sudanese security forces targeted protesters demanding that President Bashir step down, shot a doctor in his thigh, and killed two other demonstrators.³²³ On December 31 in Khartoum, security forces arrested four doctors,³²⁴ reportedly for providing health care to injured protesters.³²⁵

TURKEY

The conflict in Turkey has been focused in the southeastern region of the country, with armed clashes between the Kurdistan Workers' Party and the military.³²⁶ In July 2018 President Recep Tayyip Erdoğan lifted a two-year state of emergency that had been in place since a coup attempt in 2016.³²⁷ Human Rights Watch reports that the lifting of the state of emergency has fed into an expansion of counterterrorism legislation that has granted increased powers to provincial governors, the executive branch, and police.³²⁸ In addition, Human Rights Watch notes that the government has increased its use of the law to condemn those who speak out against the government—including health workers—with a dramatic increase in the number of people prosecuted for, and convicted of, insulting the President since 2014.³²⁹ As a result of these new powers, Human Rights Watch reports that as of June 2018, "almost one-fifth (48,924) of the prison population had been charged with or convicted of terrorism offences."³³⁰ In November 2018, the government's health commission approved a controversial bill that would ban the 7,000 medical professionals fired since 2016 under the state of emergency from working in either public or private institutions, effectively meaning they would not be able to work.^{331,332} This bill was later amended to allow the fired medical professionals to apply for work in private institutions.³³³

RECORDED ATTACKS

In Turkey in 2018, we identified three attacks that affected health workers. In December 2018, two prominent Turkish physicians and human rights activists were convicted of "propagandizing for a terrorist organization" after they signed a petition from Academics for Peace titled, "We will not be a party to this crime!"^{334,335} This petition condemned the violence in the southeast of the country and called for "the state to abandon its deliberate

massacre and deportation of Kurdish and other peoples in the region. We also demand the state to lift the curfew, punish those who are responsible for human rights violations, and compensate those citizens who have experienced material and psychological damage."³³⁶

On December 11, Dr. Gençay Gürsoy, a former professor of the Medical School of Istanbul University, was sentenced to two years and three months in prison.³³⁷ On December 19, Dr. Şebnem Korur Fincancı, a physician and chairwoman of the Human Rights Foundation of Turkey, was sentenced to two years and six months in prison.³³⁸ Physicians for Human Rights denounced the sentencing of Dr. Fincancı and the 63 other academics who have been imprisoned for signing the petition.³³⁹

Based on contextual evidence, we have coded these incidents as suspected indiscriminate.

PHYSICIANS FOR HUMAN RIGHTS EXECUTIVE DIRECTOR DONNA MCKAY STATES, "TODAY'S RULING IS JUST ONE MORE EXAMPLE OF HOW THE TURKISH AUTHORITIES HAVE BEEN TARGETING HUMAN RIGHTS DEFENDERS AND MEDICAL DOCTORS IN AN ATTEMPT TO SILENCE THEM AND TO SUPPRESS THEIR FUNDAMENTAL RIGHT TO FREEDOM OF EXPRESSION. WE SEE THIS WITH DR. FINCANCİ'S SENTENCING TODAY, AND WE'VE SEEN IT IN THE PAST WITH THE TARGETING OF DR. GÜRSOY AND OTHERS."³⁴⁰

UKRAINE

The ongoing war in Donbass—which continues to intensify in its fourth year—is threatening to break out into a "full-scale war" between Ukraine and Russia, with Ukraine now declaring martial law in some areas of the country.³⁴¹ The origins of this conflict lie in the 2013 renunciation of a long-negotiated European Union association agreement by then-president Victor Yanukovich, in favor of Russia's Eurasian Economic Union.³⁴² The subsequent Euromaidan movement protesting this political decision triggered a wave of Russian-led interventions to preserve pro-Russian sentiment in eastern Ukraine.³⁴³ The Luhansk and Donetsk regions (collectively known as Donbass) have since become one of the most heavily militarized areas in the

world, with a volatile security zone acting as a contact line between Ukrainian forces to the west and Russian-backed separatist forces to the east. While a ceasefire agreement (Minsk II) was established between the two forces in 2015, the accord is violated almost every day and has resulted in over 10,000 casualties and an estimated 1.5 million displaced persons since 2014.^{344,345} Those remaining in the Donbass region experience a starkly diminished quality of life.

By the end of 2018, 5.2 million people were affected by the conflict, with 3.5 million in need of humanitarian relief.³⁴⁶ Local power and water supply stations, along with basic health and sanitation facilities, are often targeted by separatist forces, and the delivery of humanitarian assistance is regularly obstructed at security checkpoints.⁶ In particular, the elderly, disabled, and those with health needs from chronic diseases and other life-threatening conditions are facing immense difficulty accessing appropriate health services.^{6,347} Long-term difficulties in accessing health services in the eastern part of the country have impacted the appropriate treatment of infectious diseases, with the country seeing a dramatic increase in the number of measles cases, from 4,800 in 2017 to over 27,000 by August 2018.³⁴⁸ In 2018, there were 88 incidents affecting water and sanitation supply, with some incidents affecting the supply of clean water to over 1.1 million people.^{7,349}

RECORDED ATTACKS

In 2018, we identified 11 attacks on health workers and health facilities. The majority were in eastern Ukraine, with nearly half of the incidents occurring in Donetsk. In these 11 incidents, two health workers were reportedly killed, seven were reportedly injured, three were reportedly threatened and intimidated, and three guards or drivers were affected.³⁵⁰ Additionally, two health facilities were reportedly damaged, with four forced closures of health facilities.³⁵¹

In nine of the reported incidents, the perpetrator remains unknown. We received information on perpetrators for only two incidents, with one incident reportedly carried out by Russian-backed militants and the other by Russia's hybrid military forces. In this attack, a Ukrainian military nurse was killed in a militant shelling while providing treatment to civilians in the Donbass conflict zone.³⁵² In an incident on April 17, a bus carrying 30 water treatment workers of the Donetsk Filter Station was shot at, resulting in five workers being injured, one critically.³⁵³

Based on contextual evidence, we have coded seven of these incidents as suspected indiscriminate and one as suspected intentional.

This report was produced by members of the Safeguarding Health in Conflict Coalition.

Carol Bales of IntraHealth International and Christina Wille of Insecurity Insight oversaw the report. Leonard Rubenstein of the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health was the executive editor. Carol Bales and Jessica Turner of IntraHealth managed production of the report. Christina Wille and Helen Buck of Insecurity Insight led on gathering, collating, and analyzing data for the report.

The report was written by several Coalition members:

- The Executive Summary was written by Leonard Rubenstein and Jessica Turner
- The Methodology section was written by Christina Wille
- The country profiles were written by a team led by Jessica Turner and including Carol Bales; Casey Bishopp of IntraHealth; Erica Burton of the International Council of Nurses; Brittany Evans of IntraHealth; Roisin Jacklin of Medical Aid for Palestinians; Sarah Kashef, an IntraHealth-Global Health Corps Fellow; Sandra Hsu Hnin Mon of the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health; and Sarah Woznick, a graduate student at the Johns Hopkins Bloomberg School of Public Health.
- The following members of the Coalition contributed research, data, and/or writing for specific sections of the report:
 - > Joseph Amon of the Dornsife School of Public Health, Drexel University, for the Recommendations section
 - > Laurence Gerhardt of Insecurity Insight for Cameroon and Yemen profiles
 - > Hiba Ghandour and Zad Alnqsan of the International Federation of Medical Students' Association for the Egypt profile
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- > Rami Hatoom of the European Centre for Democracy and Human Rights for the Iraq profile
- > Roisin Jacklin and Rohan Talbot of Medical Aid for Palestinians, Dana Moss of Physicians for Human Rights-Israel, and Marcos Tamariz of Médecins du Monde for the oPt profile
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SAFEGUARDING HEALTH IN CONFLICT

The Safeguarding Health in Conflict Coalition is a group of 40 organizations working to protect health workers and services threatened by war or civil unrest. We have raised awareness of global attacks on health and pressed United Nations agencies for greater global action to protect the security of health care. We monitor attacks, strengthen universal norms of respect for the right to health, and demand accountability for perpetrators.

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