ATTACKS ON HEALTH CARE

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REPORT ON ATTACKS ON HEALTH CARE IN EMERGENCIES

BASED ON CONSOLIDATED SECONDARY DATA
2014 AND 2015

World Health Organization

Design and layout: www.paprika-annecy.com

Executive summary

Currently there is no publicly available source of consolidated information on attacks on health care in emergencies. This report is a first attempt to consolidate and analyse the data that is available from open sources. While the data are not comprehensive, the findings shed light on the severity and frequency of the problem.

Over the two-year period from January 2014 to December 2015, there were 594 reported attacks on health care that resulted in 959 deaths and 1561 injuries in 19 countries with emergencies. More than half of the attacks were against health care facilities and another quarter of the attacks were against health care workers. Sixty-two per cent of the attacks were reported to have intentionally targeted health care.

However, the limitations of the available information highlight the need for more and better data collection. Standard definitions and classifications are needed to enable comparisons to be made of information from multiple sources, in order to better understand the full extent and nature of the problem.

The lack of information on the impact of attacks on health service delivery and the health of affected populations is a significant knowledge gap and a priority for information collection moving forward.

Finally, the findings underscore the need for intensified action from a broad spectrum of actors to ensure that health care is provided universally during emergencies to all those who need it, unhindered by any form of violence or obstruction.

1. Introduction

During emergencies, the delivery of health care is vital to the survival and longer-term well-being of affected populations. Health care is consistently identified by emergency-affected populations as among their top priorities for humanitarian assistance.[1,2] Addressing health needs during emergencies not only saves lives, it can improve longer-term health outcomes and strengthen global health security.

Health needs in emergencies are often urgent and service delivery is complex. In addition to delivering ongoing health programmes, health care workers must also address additional needs that can include conflict-related injuries, increases in infectious diseases and outbreaks, malnutrition, mental health problems and gender-based violence.

Meeting these life-saving health needs is increasingly challenging. In the current global context, the needs are unprecedented. In 2015, an estimated 125 million people affected by emergencies were in need of assistance – the largest number ever on record.[3]

The health emergency workforce, made up largely of national health workers but often also including international health care providers, strives to deliver these life-saving interventions during emergencies, working tirelessly in service to those in need of care. In doing so, they face many challenges including overwhelming demands, insufficient resources, ongoing insecurity, lack of training, supplies and medicines, heightened anxiety and fear on the part of patients and families, limited access, bureaucratic hurdles, stress and exhaustion.

The most disturbing challenge for health care providers during emergencies is when they themselves are the victims of attacks – real or threatened, targeted or indiscriminate. Yet we witness with alarming frequency a lack of respect for the sanctity of health care, for the right to health care, and for international humanitarian law: patients are shot in their hospital beds, medical personnel are threatened, intimidated or attacked, hospitals are bombed.

Such attacks not only endanger health care providers; they also deprive people of urgently needed care when they need it most. And while the consequences of such attacks are as yet largely undocumented, they are presumed to be significant – negatively affecting short-term health care delivery as well as the longer-term health and well-being of affected populations, health systems, the health workforce, and ultimately our global public health goals.

For this report, we compiled and analysed available secondary data from open sources on individual attacks on health care in emergencies. The findings aim to provide a better understanding of the extent and nature of the problem, to inform own priority actions, and to inform the actions of national authorities, decision-makers, health care providers, humanitarian health organizations, all parties to conflict and affected communities as we work together to ensure that health care is provided universally during emergencies to all those who need it – in safety.

2. Methods

The data reported here are the result of a review of secondary data from a variety of open sources on individual attacks on health care that reportedly took place from January 2014 to December 2015 in countries with emergencies. The data were consolidated into a single database for comparability and to eliminate duplication.

For the purposes of this report, attacks are defined as any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access and delivery of curative and/or preventive health services during emergencies. Countries included in this report are those facing acute or protracted emergencies with health consequences resulting from any hazard.

To gather information on individual attacks on health care, we conducted a web search using combinations of keywords including doctor, nurse, paramedic, medic, ambulance, physician, hospital, health care worker, health care clinic, health facility, health care facility, kill, attack, threaten, execute, assassinate, bomb, shot, ambushed, road side, kidnap or abduct.

We also gathered information from the following publicly available sources:

- Aid Worker Security Database[4] (AWSD) that records major incidents of violence against aid workers;
- Armed Conflict Location and Event Data Project[5] (ACLED) that collects data on political violence and protests in Africa and parts of Asia;
- Council on Foreign Relations[6] (CFR) that provides information on world events including through interactive maps; and
- Physicians for Human Rights[7] (PHR) that documents mass atrocities and severe human rights violations including against medical institutions and health professionals. PHR provided data on attacks on medical facilities for the Syria section of this report.

Not included in this report are data that were collected and reported in confidentiality or that were available only in aggregate figures rather than by individual incident.

During data collection, deaths and injuries were tracked separately and were subject to the following conditions:

- when deaths and/or injuries were reported as a range, the mean figure was recorded (e.g. "20–40 deaths" was recorded as 30 deaths);
- when minimum deaths and/or injuries were reported, the minimum figure was recorded (e.g. "at least five deaths" was recorded as five deaths); and
- when the record did not indicate deaths and/or injuries, or was described as unknown or undetermined, zero deaths and injuries were recorded.

The term "object of attack" refers to the people, infrastructure, vehicles and other health-related items that were subjected to the violence, obstruction or threat of violence. The object types were grouped as follows:

- Health care facility – hospital, clinic or health post;
- Heath care provider – physician, nurse, midwife, vaccinator, other health care worker including laboratory worker, health care security, maintenance or cleaning staff;
- Health care transport – ambulances and other health care transport;
- Health care recipient – patients or visitors; and
- Health care entity - political or academic (Minister or ministries, health authorities, medical academic or educational institutions).

The term "intentionality of attack" refers to whether the attack was reported to have been directly targeted at a health object. Reporting on this information was recorded as follows:

- Intentional;
- Unintentional; and
- Unreported, unknown or undetermined.

3. Results

(a) number of attacks on health care in emergency settings

The consolidated figures for 2014 include 338 records of attacks on health care in 19 countries facing acute or protracted emergencies. For 2015, the records indicate 256 attacks in 16 countries with acute or protracted emergencies. Over the two-year period, there were reports of 594 attacks in 19 countries. The figures by country and year are in Table 1.

Over the two-year period, 16 of the 19 countries had attacks reported both years. The three countries that did not have attacks reported in the second year were Liberia, Myanmar and Sierra Leone.

The Syrian Arab Republic had the most reported attacks on health care each year: twice as many attacks as any other country or territory in 2014 and nearly four times as many attacks in 2015.

Only the Syrian Arab Republic and the West Bank and Gaza Strip had higher numbers of reported attacks in 2015 than in 2014.

Table 1: Number of reported attacks on health care in emergencies in 2014 and 2015

2014-2015 Attacks on Health Care in Emergencies Countries and Territories (n = 19) and Attacks (n = 594) (number and percentage of total)		
Syrian Arab Republic	228	38%
West Bank and Gaza Strip	53	9%
Iraq	43	7%
Pakistan	43	7%
Libya	33	6%
Ukraine	32	5%
Central African Republic	30	5%
Yemen	22	4%
Sudan	20	3%
Afghanistan	19	3%
South Sudan	18	3%
Guinea	11	2%
Democratic Republic of the Congo	10	2%
Nigeria	10	2%
Colombia	7	1%
Somalia	6	1%
Liberia	5	1%
Sierra Leone	3	1%
Myanmar	1	0%
	594	**100%**

2014 Attacks on Health Care in Emergencies Countries and Territories (n = 19) and Attacks (n = 338) (number and percentage of total)		
Syrian Arab Republic	93	28%
Iraq	35	10%
Pakistan	27	8%
Ukraine	26	8%
Central African Republic	24	7%
Libya	19	6%
West Bank and Gaza Strip	19	6%
South Sudan	15	4%
Afghanistan	14	4%
Yemen	13	4%
Sudan	12	4%
Guinea	8	2%
Nigeria	8	2%
Colombia	6	2%
Democratic Republic of the Congo	6	2%
Liberia	5	1%
Somalia	4	1%
Sierra Leone	3	1%
Myanmar	1	0%
	338	**100%**

2015 Attacks on Health Care in Emergencies Countries and Territories (n = 16) and Attacks (n = 256) (number and percentage of total)		
Syrian Arab Republic	135	53%
West Bank and Gaza Strip	34	13%
Pakistan	16	6%
Libya	14	5%
Yemen	9	4%
Iraq	8	3%
Sudan	8	3%
Central African Republic	6	2%
Ukraine	6	2%
Afghanistan	5	2%
Democratic Republic of the Congo	4	2%
Guinea	3	1%
South Sudan	3	1%
Nigeria	2	1%
Somalia	2	1%
Colombia	1	0%
	256	**100%**

(b) deaths and injuries

Over the two-year period, with 594 attacks in 19 countries, 959 people died and 1561 were injured.

In 2014, attacks on health care in emergency settings resulted in 525 deaths and 1024 injuries; the numbers of deaths per country ranged from zero (in three countries) to 179 (in the Syrian Arab Republic). In 2015, attacks on health care resulted in 434 deaths and 537 injuries; the numbers of deaths per country ranged from zero (in six countries) to 173 (in the Syrian Arab Republic). These figures by country and year are shown in Table 2.

Table 2: Number of reported deaths and injuries by country in 2014 and 2015

Countries and Territories	2014			2015			2014-2015		
	Number of attacks recorded	Total deaths	Total injuries	Number of attacks recorded	Total deaths	Total injuries	Number of attacks recorded	Total deaths	Total injuries
Afghanistan	14	25	22	5	44	28	19	69	50
Central African Republic	24	26	17	6	4	0	30	30	17
Colombia	6	5	18	1	0	1	7	5	19
Democratic Republic of the Congo	6	8	8	4	27	3	10	35	11
Guinea	8	8	77	3	0	3	11	8	80
Iraq	35	71	159	8	43	39	43	114	198
Liberia	5	0	0	0	0	0	5	0	0
Libya	19	16	45	14	39	20	33	55	65
Myanmar	1	0	0	0	0	0	1	0	0
Nigeria	8	14	20	2	9	0	10	23	20
Pakistan	27	57	43	16	45	23	43	102	66
Sierra Leone	3	2	10	0	0	0	3	2	10
Somalia	4	4	6	2	7	0	6	11	6
South Sudan	15	51	2	3	1	1	18	52	3
Sudan	12	0	24	8	0	7	20	0	31
Syrian Arab Republic	93	179	346	135	173	322	228	352	668
Ukraine	26	9	20	6	8	8	32	17	28
West Bank and Gaza Strip	19	11	141	34	3	47	53	14	188
Yemen	13	39	66	9	31	35	22	70	101
Totals	**338**	**525**	**1024**	**256**	**434**	**537**	**594**	**959**	**1561**

(c) object of attacks

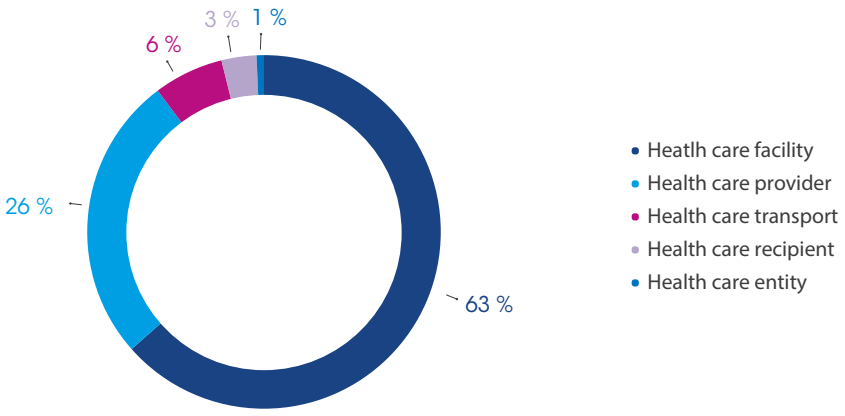
The object of the majority of reported attacks in both 2014 and 2015 were health care facilities. Another quarter of objects were health care providers. The available information suggests that a very small proportion of reported attacks – 4% or less each year – were against patients and their families. The comparative numbers of attacks by object and year are shown in Table 3.

Table 3: Numbers and percentages of attacks by object and year

Object	2014		2015		2014-2015	
Health care facility	221	65%	156	61%	377	63%
Heath care provider	83	25%	73	29%	156	26%
Health care transport	19	6%	19	7%	38	6%
Health care recipient	13	4%	6	2%	19	3%
Health care entity	2	1%	2	1%	4	1%
Totals	**338**	**100%**	**256**	**100%**	**594**	**100%**

Over the two-year period combined, the majority of objects (63%) were health care facilities. More than a quarter of objects were health care providers (26%), and 6% of objects were health care transport. The proportions by object type are illustrated in Figure 1.

Figure 1: Proportion by object type 2014–2015



(d) intentionality

Of the 594 attacks reported over the two-year period, 366 (62%) were reported as intentional; 116 of the 594 attacks (20%) as unintentional; and for 112 of the 594 reported attacks (19%), intentionality was not reported or was unknown or undetermined. According to the 2014 reports, 204 out of 338 attacks (60%) were intentional; and according to the 2015 reports, 162 out of 256 (63%) were intentional.

(e) perpetrators

Of the 594 attacks reported over the two-year period, 53% were reportedly perpetrated by State actors, 30% by non-State actors, and 17% of the perpetrators remained unknown, unreported or undetermined.

4. Discussion

This report is based on available open source information on individual attacks on health care over the two-year period from January 2014 to December 2015.

Consolidating this information from multiple open sources has the following limitations:

- Information is collected and recorded in a non-standardized manner using different classifications, focusing on different geographical areas, and for different purposes;
- Not all available secondary data provide information about their source and verification process;
- Some sources, particularly from news agencies, expire, making it difficult to authenticate some records when other sources are lacking;
- Language bias – information was primarily from English language sources;
- Among duplicate records from different sources, content sometimes varied substantially; and
- In most cases follow-up is not recorded or linked to the attack report, making accurate initial death and injury counts challenging and follow-up clarification on ultimate victim outcomes unknown; also deaths and injuries are not always recorded separately.

The number of attacks that were reported and available from open sources in 2015 is substantially lower than in 2014. This may in part be attributed to the time required to make data available; 2015 reports might not have been fully available by the first quarter of 2016 when this data was consolidated. This may be due to the time and resources required to collect, verify and report data, indicating the need for sufficient resources for data collection mechanisms to report over time.

As attacks were reported in 16 of the 19 countries in both years, there is an awareness of the issue of attacks in these countries and a willingness within these countries to monitor and report. As 62% of the attacks over the two-year period were reported as intentionally targeted at health care, this finding also suggests a consistent problem in certain countries with emergencies related to the sanctity and protection of health care and the application of international humanitarian law and human rights law.

Underreporting of attacks is assumed due to limited awareness of the possibility, means and use of reporting, limited resources and time, fear of reporting, complexity and limitations of existing reporting systems, lack of standardized definitions for use in data collection, perceptions of the usefulness of reporting, and cultural perceptions of violence. This suggests the need for more leadership on this issue in the health sector in emergency settings, more sensitization of stakeholders at country level to raise understanding of the value of reporting, and standard definitions for gathering comparable data.

Regarding deaths and injuries, in some countries a single attack resulted in a significant proportion of the total deaths and injuries for that year. For example, in the Central African Republic, of the 26 deaths attributed to attacks on health care in 2014, 16 occurred in a single attack on 28 April 2014 during an armed robbery on a Médecins Sans Frontières (MSF) hospital in the northern town of Boguila.[8] In Iraq, of the 71 reported deaths in 2014, 18 occurred when the obstetrics section of the Hawija Hospital was bombed on 6 September;[9] and of the 43 deaths in Iraq in 2015, 31 occurred during a bombing on Fallujah's maternity hospital on 13 August.[10] In Libya, of the 39 deaths in 2015, 34 occurred on 14 August when 12 care providers and 22 patients were executed.[11]

Most of the available data do not clearly differentiate between types of health care providers (e.g. doctors, nurses, paramedics) who were the object or victim of the attacks. This indicates the need for more detailed reporting on deaths and injuries and object type.

While 62% of attacks were reported as intentionally targeting health care, more detail of the evident or presumed reasons for such attacks would help to enable better understanding of attacks on health care. Some of the possible reasons might include military/political gains, religious beliefs, theft, vandalism, fear, anger or dissatisfaction with the provision of health services. A standardized list of motives would improve data collection and allow for aggregation and trend analysis.

The available data were not aggregated by type of attack due to the lack of a standard classification. The available data include descriptions of attacks on health care that involved bombings, explosions, looting, robbery, hijacking, shooting, gunfire, forced closure of facilities, violent search of facilities, fire, arson, military use, military takeover, chemical attack, cyberattack, abduction of health care 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 threat of violence. A simplified and standardized classification of types of attacks would allow for aggregation and would enable a better understanding of the nature and frequency of different types of attacks.

The most significant gap in the available data is the lack of information on the consequences of attacks on health care delivery, on the health of affected populations, on health systems, on the health workforce, and on longer-term public health. While the consequences are difficult to estimate and quantify due to constantly changing catchment populations and limited baseline information, a priority for data collection on attacks on health care should be to document and describe these consequences.

5. Conclusions

Even one attack on health care is one too many. Therefore, the number of reported attacks reflected in this report is tragic. The high tolls of death and injury to our health colleagues and the inevitable impact on health service delivery call for greater action. The main conclusions to be drawn from the analysis of the available data are the following:

Standardize information. The data represented in this report from multiple sources allow us to conclude that a more standardized approach is needed for gathering information on attacks on health care and their consequences to health service delivery. This approach should include standard definitions for attacks on health care, for health care workers and for health care facilities. Also necessary are agreed classifications for object types, attack types, intentionality, perpetrator types and motives. Standardization would allow for improved aggregation, comparative analysis, trend analysis and a more comprehensive evidence base. A more complete set of data would in turn lead to more effective and targeted advocacy to stop attacks, and concrete actions to reduce the risk and impact of attacks during emergencies.

Document health impact. As noted, the most significant knowledge gap related to attacks on health care is the impact on health care workers and their families, the health workforce, health service delivery, public health, and long-term health development goals. Data and analysis in this area must be a priority moving forward.

Establish a global repository. A single repository that consolidates all related information, initiatives, articles and studies from all regions and from multiple language sources would serve as a one-stop shop for information sharing. This global repository should be established and available to all on an open source website.

Advocate at all levels. Strong advocacy from Member States, the Secretary-General, United Nations agencies, health clusters, nongovernmental organizations and consortia, and, importantly, from MSF and the International Committee of the Red Cross (ICRC), has been instrumental in highlighting the gravity of the alarming frequency of attacks on health care and the profound importance of international humanitarian law. However, more advocacy is required at community, national, regional and global levels to uphold the norms that safeguard health care facilities and workers and patients, including international humanitarian law, human rights law, the Humanitarian Charter, humanitarian principles, medical ethics and duty of care.

Document and apply good practice to reduce risk. Such practices include adapting emergency response planning, engaging communities, conducting security analyses, training, making hospitals safer, removing administrative and legal obstacles to health care delivery, and implementing the Sendai Framework for reducing risks before, during and after emergencies. More work is needed to define the roles and responsibilities of various actors. Building on the strong work of key initiatives including the Health Care in Danger project of the ICRC and its "community of concern" and the Medical Care Under Fire project of MSF, the health community is well positioned to reduce the likelihood of attacks and strengthen the resilience of our colleagues and the health systems in which they work.

Together with national authorities, health care providers, humanitarian health organizations, all parties to conflict and affected communities, we must ensure that health care is provided universally during emergencies to all those who need it, in safety, unhindered by violence or obstruction.

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For more information:

Erin Kenney
Attacks on Health Care
World Health Organization
Geneva, Switzerland
+41 22 791 2448
kenneye@who.int

WHO/OHE/ERM/PPE/2016.2