

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.

