

Methodology

This eleventh report of the Safeguarding Health in Conflict Coalition (SHCC) covers 30 countries and territories and provides details on incidents involving threats and violence against health care in 18 countries, one administrative subdivision/region within a country, and one territory that experienced conflict in 2023.¹ For these 20 countries that have their own chapter, the 2023 report further provides information on the impact of violence on health care, including the impact on health workers, health care systems, and people's access to health care, based on multiple secondary sources.

To determine whether a country is considered to have experienced conflict in 2023, the report is based on the system of conflict determination adopted by the Uppsala Conflict Data Program (UCDP).² A country, territory, or region within a country is included in the SHCC report if it is included on the UCDP list of one of the three types of conflict (state-based armed conflict, non-state armed conflict, and one-sided violence),³ and if Insecurity Insight identified at least one attack on health care perpetrated by a conflict actor, which for the purposes of this report is defined as a person affiliated with organized actors in conflict. For 20 countries that reported more than 15 incidents in one year or more than 29 incidents over multiple years, a chapter is included in the report. Incidents from ten other countries are included in the total counts of violence against health care, but neither the incidents nor the situation in the affected countries is described in detail.

Fourteen of the countries covered in factsheets in 2023 were included with country chapters in the 2022 report. For the 2023 report, Israel, India's Manipur state, and Niger were added for the first time, while Ethiopia and Haiti were included again after they were not included in 2022, and their factsheets include data for 2022 and 2023. The reports on Somalia and Niger cover data for the period 2021 to 2023. Data from Azerbaijan, Colombia, Indonesia, Iraq, Kenya, Lebanon, Libya, Mexico, Mozambique, and Pakistan is included in the total count, but these ten countries do not have country chapters in 2023.

The report uses an event-based approach to documenting attacks on health care, which are referred to as "incidents" throughout the report. To prepare this report, event-based information from multiple sources was cross-checked and consolidated into a single dataset of recorded incidents that were coded using standard definitions. The data cited in this report can be accessed via [Attacks on Health Care in Countries in Conflict](#) on [Insecurity Insight's](#) page on the Humanitarian Data Exchange (HDX). However, this data does not include the information shared by the International NGO Safety Organisation (INSO), which specifically requested its data not to be included on the HDX. The data for the 20 countries included in this report is made available as individual datasets. The links are provided in the individual country profiles. For the ten countries mentioned above that do not have country chapters on them in the 2023 report, the data is also available via the Humanitarian Data Exchange [data grids](#) for the relevant countries, excluding any data shared by the INSO.

The report covers the impact of attacks on health care as far as available reports indicate. It cites secondary sources that usually used mixed-method approaches to summarize the known impacts of attacks on the delivery of and access to health care.

DEFINITION OF ATTACKS ON HEALTH CARE

This report follows 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."*

Methodology

The report focuses on incidents of violence against health care in the context of armed conflict, non-state conflict, or one-sided violence, as defined by UCDP, while the WHO focuses on attacks during emergencies.



INCIDENTS OF VIOLENCE AGAINST HEALTH CARE CAN INCLUDE

In accordance with the WHO's definition, incidents of violence against health care can include bombings, explosions, looting, robberies, hijackings, shootings, gunfire, the forced closure of health facilities, the violent searching of health facilities, fire, arson, the military use of health facilities, the military takeover of health facilities, chemical attacks, cyber attacks, the abduction of health workers, the denial or delay of health services, assaults, forcing staff to act against their ethical principles, executions, torture, violent demonstrations, administrative harassment, obstruction, sexual violence, psychological violence, and threats of violence.

All of these categories have been included insofar as they were reported in sources. However, some forms of violence, such as psychological violence, blockages of access, or threats of violence, are rarely reported. We also record incidents of violence against patients in health facilities when references to the effects of violence on patients are included in descriptions of incidents.

DEFINITION OF CONFLICT

The SHCC report covers three types of conflict as defined by the UCDP for countries that reported at least one incident of violence against health care perpetrated by a conflict actor. The SHCC report includes a country chapter when there have been at least 15 incidents of violence in a country or region and territories or more than 29 incidents over multiple years perpetrated by a conflict actor:⁴

- **State-based armed conflict** is defined as *"a contested incompatibility that concerns government and/or territory where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths in one calendar year."*
- **Non-state conflict** is defined as *"The use of armed force between two organized armed groups, neither of which is the government of a state, which results in at least 25 battle-related deaths in a year."*⁵
- **One-sided violence** is defined as *"The deliberate use of armed force by the government of a state or by a formally organized group against civilians which results in at least 25 deaths in a year."*

This report is limited to violence perpetrated by conflict actors. Interpersonal violence and violence by patients against health care providers are not included in this report, even when they occurred in conflict-affected countries.

Events are only included when (a) the perpetrator was a member of a party to a conflict, and (b) available evidence suggested that the incident occurred either in the context of a contested incompatibility of territory or as a one-sided act of violence by security forces included on the UCDP list of countries with more than 25 reported deaths from one-sided violence attributed to security forces or non-state armed actors.

CONCEPTUALIZATION OF THE IMPACT OF ATTACKS ON HEALTH CARE

The impact of incidents of violence against patients is far-reaching and affects health workers, the functioning of the relevant health system, patients' physical access to health care, and people's perceptions that influence their choices around seeking health care.

Attacks on health care affect health workers psychologically and physically, which frequently results in qualified staff leaving the profession or the area where attacks occurred. Therefore, all violence against health workers perpetrated by conflict parties is included in this report, ranging from incidents that occurred within a health facility, on their way to work or at home, or while out shopping, because all of these incidents affect the wellbeing and sense of safety of health workers and consequently their ability to provide care or willingness to continue to work in highly insecure environments.

The damaging and destruction of physical health infrastructure affect the quality of care that can be provided. Damage can be direct when a health facility is damaged in an attack, or indirect as a consequence of damage to other infrastructure such as electricity or water supplies or the looting of medicines. The impact of individual violent events is spread over time and location, and it is often the cumulative impact of multiple incidents and their diverse effects that create the most concerning impacts that reduce the extent and quality of the care provided.

Insecurity and fear of health systems being the target of attacks also affect how and when people decide to seek medical help. Delays in accessing care can make treatment harder and thereby contribute to worse health outcomes. Various studies focus on different aspects of the impact of attacks on health care and cover different points in time, and the complex consequences of individual incidents remain limited in many cases.

No single data-collection method can fully cover such wide-ranging impacts. The SHCC incident-monitoring system provides the basis of information on incidents that need to be considered, and mixed-method approaches provide the best option to understand the complex impact chains.

DATA ETHICS

The SHCC applies strict principles to ensure responsible, safe, ethical, and effective data management. These principles are based on the [IASC Operational Guidance on Data Responsibility in Humanitarian Action](#) and the work of the [Data Responsibility Working Group \(DRWG\)](#), and center around the principles of data security, data privacy, and data use, taking into account that the SHCC's work has a responsibility to health workers, health systems, and humanitarian health care providers.

The key objectives are that:

- data is used to make more informed decisions to protect health workers and the health system; the privacy and security of the information related to people at risk are protected;
- data is shared and disseminated to improve stakeholders' understanding of how conflict affects the delivery of health care; and
- transparency in data sources contributes to the collective improvement of data and information.

Methodology

The SHCC applies data ethics to identify solutions to data dilemmas when competing principles require it to take priority decisions guided by the principle of doing no harm. Based on these considerations, the SHCC reports the available information on the perpetrator of violence. Information on the perpetrator is not only important methodologically to determine if an incident is conflict-related but, most significantly, it provides key information required to develop preventive strategies and mitigation measures that reduce the incidence and impact of attacks and support accountability processes. Because we believe that the key objective of all data work has to be that it can be used to address harm, the SHCC considers the information related to perpetrators and the locations of incidents in countries to be of primary importance. Strict data security principles are applied to personally identifiable information and any information that links to people or organizations at risk from any potential repercussions from conflict parties.

INCLUSION OF INCIDENTS

To describe attacks on health care, the report includes only the incidents that met the inclusion criteria for UCDP-defined types of conflicts and conflict-related perpetrators. Based on this principle, we included the following types of incidents and details in the report dataset:

- incidents affecting health facilities, recording whether they were destroyed, damaged, looted, or occupied by armed individuals/groups;⁶
- incidents 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, although we acknowledge the likely serious under-reporting of these figures);
- incidents affecting health care transport/vehicles, recording whether ambulances or other official health care vehicles were destroyed, damaged, hijacked/stolen, or stopped/delayed; and
- incidents recorded by the WHO Surveillance System for Attacks on Health Care (SSA) for the ten countries included in the system if the WHO confirmed the incidents.

These categories are not mutually exclusive. For example, health workers may be attacked while in a health facility, while using official health transport, or elsewhere.



KEY DEFINITIONS

Health worker: Refers to 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-related personnel not named here.

Health worker affected: Refers to incidents in which at least one health worker was killed, injured, kidnapped, or arrested, or experienced sexual violence, threats, or harassment.

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

Methodology

Health facility affected: Refers to incidents in which at least one health facility was damaged, destroyed, or subjected to armed entry, military occupation, looting, or bombing in the vicinity.

Health transport/vehicle: Refers to any vehicle used to transport any injured or ill person or woman in labor to a health facility to receive medical care.

Health transport/vehicle affected: Refers to incidents in which at least one ambulance or other health transport/vehicle was damaged, destroyed, hijacked, or delayed with or without a person requiring medical assistance on board.

SOURCES FOR REPORTED INCIDENTS OF ATTACKS ON HEALTH CARE

The aim of this report is to bring together known information on individual attacks on health care from multiple sources. Access to sources differs among countries, and each source has its own strengths and weaknesses. Some differences can be found in the definitions of what constitutes attacks on health care used by the different sources that were used to compile the SHCC dataset. Each source introduces unique reporting and selection biases, which are discussed below.

To identify incidents that meet the inclusion criteria, we used a range of distinct sources that provide a combination of media-reported incidents and incidents reported by partners and network organizations:

1. information included in Insecurity Insight's *Attacks on Health Care Monthly News Briefs*, consisting of a combination of media sources, identified through tailor-made AI technology, and other publicly shared information from partner networks, such as the *Aid Worker Security Database* (AWSDB) for global data from international aid agencies coordinating health programs; *Airwars* and the *Syrian Observatory for Human Rights* (SOHR) and *Syrian Network for Human Rights* (SNHR) for data on Syria; the *Civilian Impact Monitoring Project* (CIMP) for data on Yemen; and databases such as that of the *Armed Conflict Location & Event Data Project* (ACLED);
2. research conducted by a small team of SHCC members to identify additional incidents reported by UN agencies, the media, and other sources;
3. incidents affecting health care shared by the Conflict and Humanitarian Data Centre (CHDC) of the International NGO Safety Organisation (INSO) for 14 countries: Afghanistan, Burkina Faso, Cameroon, the CAR, the DRC, Haiti, Iraq, Mali, Niger, Nigeria, Somalia, South Sudan, Syria, and Ukraine;⁷
4. incidents affecting health care in Somalia shared by the casualty recording network for Somalia, including the Omeria Community Development Organization (OCDO), the Somali Human Rights Association (SOHRA), the Somali Women Development Organization (SOWDO), the Somali Awareness and Social Development Organization (SASDO), the Somali Action for Human Rights Organization (SAHRO), and the Kalkal Human Rights Development Organization (KAHRDO);⁸
5. incidents affecting health care in India's Manipur state shared by the Humanitarian Support and Documentation Project (HSDP), a research collective based in Lamka town, Churachandpur district, Manipur state;
6. incidents affecting health care in Yemen shared by Mwatana for Human Rights, Yemen;
7. information from the WHO SSA on ten countries or territories: Armenia, Burkina Faso, the CAR, Libya, Myanmar, the oPt, South Sudan, Sudan, Ukraine, and Yemen;⁹ and

Methodology

8. information from casualty recorders in the oPt that tended to be based on names and Israeli ID numbers, but gave no information on the date and location of a particular death, which required complex matching. This work is ongoing.

INCIDENT CODING PRINCIPLES

The general theory and principles of event-based coding were followed. Firstly, care was taken not to enter the same incident more than once. Secondly, the information in text-based event descriptions was turned into data by coding the “six Ws”: who did what to whom, where, when and with what weapon. The standard coding principles are set out in the SHCC Overview Data Codebook. Please see www.insecurityinsight.org/projects/healthcare/shcc for full details of SHCC coding and annexes.



IDENTIFYING THE KILLED HEALTH WORKERS: INCIDENT- AND CASUALTY-RECORDING APPROACHES

The SHCC uses an incident-based approach to identify and then classify information. Using the unique place and time of an incident as the key information, all reported information is given a unique classification identification (ID) number. The number of health workers killed during this incident is recorded under the incident details. Multiple health workers killed in the same event are always recorded under the same incident ID number. Under incident-based recording, individuals are recorded as numbers of people killed without necessarily recording their names or ages.

Many human rights/casualty-recording organizations take an individual-based approach to casualty recording. In this approach, each killed individual is recorded under a unique ID number that usually includes the victim’s name and age, and circumstances of their death (date and location). Most do not routinely record information regarding the victim’s profession.

These two approaches to documentation result in different numbers of conflict deaths that may fuel unhelpful discussion about the “true number.” For example, [Healthcare Workers Watch - Palestine](#) based its counts on the names of Palestinians killed, using their Israeli-issued personal ID number to identify unique individuals. However, these lists do not include the location or date of the deaths. According to [Healthcare Workers Watch - Palestine](#), 398 health workers were among the individuals killed in 2023, while the [UN](#) reported 490 as of and up to April 19, 2024.

Insecurity Insight has recorded 146 health workers killed by analyzing all fatal incident reports where health workers were known to have been among the dead. However, this incident-based approach undercounts the number of health workers killed, because it does not include any killed in incidents where the victim’s profession was not immediately identified.

The efforts to combine and reconcile these two separate approaches are extremely time consuming and complex. Both approaches miss vital information, such as names, official ID numbers, profession, or date and location of incidents that would help to match information. The increased standardization of methods for both incident-based and individual-based casualty recording would help to improve the reliability of data and information. Insecurity Insight is working with [Airwars](#) on cross-checking all recorded names using a tool designed specifically for this purpose to match partial and full names across multiple datasets, which can then be used to locate individuals across different records where information such as profession might not otherwise have been identified.

INCLUSION AND CODING OF WHO SSA-REPORTED INCIDENTS

On January 15, 2024 the WHO SSA reported a total of 1,486 attacks on health care in 19 countries and territories for 2023. Information on 174 of these 1,486 incidents was included. A total of 1,312 attacks reported by the SSA could not be included, because the lack of detail made it impossible to determine the nature of the incidents.¹⁰ Any changes to the SSA system after that date are not reflected in the SHCC dataset, but may be noted in the country profiles.

We coded 174 SSA-reported incidents from the ten previously mentioned countries and territories based on the information included on the online SSA dashboard. Since the SSA does not provide information on perpetrators, we assumed that all the SSA-reported incidents we included involved conflict actors (rather than private individuals) and therefore fulfilled the SHCC inclusion criteria. The SSA also does not provide any information on location, except for the country where the incident occurred. The SSA-reported incidents could therefore not be included in the maps showing the affected regions or provinces in the individual country profiles.

SOURCES ON THE IMPACT OF ATTACKS ON HEALTH CARE

Mixed-method studies from a variety of bodies were included in the review of the impact of attacks on health care. These include:

- academic studies;
- applied studies focusing on affected populations or security risk perceptions among health workers; and
- a dedicated study carried out with the International Rescue Committee (IRC) and the Researching the Impact of Attacks on Healthcare (RIAH) project entitled “The Impact of Violence against Health Care on the Health of Children and Mothers.” The study is available in [English](#) and [French](#).

ANALYTICAL APPROACHES

This report describes the patterns of violence against health care for selected countries based on available information on what happened during these incidents. Most of the details about violence against health care are provided by those who experienced or observed the violence and reported it to others, who then shared this information as an incident report. Only in exceptional cases do perpetrators provide any information about incidents. As a result, all described patterns are those based on the observed facts, such as what uniforms the perpetrators wore, whether they operated alone or in groups, and what weapons systems they had access to. In addition, some details of the location and nature of the attack suggest possible motives. For example, if an armed group forcibly enters a health facility and only loots medicine, it is possible that they carried out the attack because they needed medical supplies for their own fighters. If doctors are kidnapped and a ransom is demanded, it is possible that the health workers were attacked for their perceived wealth. In many other cases, the location of the attack may provide few reliable clues about motives. For example, the fact that a health worker was attacked outside of a health facility is no indication that the attack specifically targeted the health worker because of their profession. The attack may only have been a random one targeting people in the street that happened to be directed at a health worker and happened to occur outside of a health facility, but could have targeted anyone and happened anywhere

Methodology

else. Nonetheless, it remains possible that the attack was indeed directed at a health worker because of their profession, and that the location was chosen for strategic reasons, e.g. because a private home or moving vehicle is a 'softer' target than a more secure health facility where a doctor or nurse may work on wards that are some distance from the entrance. Moreover, there are suggestions that phone tracking may allow targeted attacks to be scheduled at times and locations where health personnel are at their most vulnerable. However, despite this uncertainty as to motive in cases such as these, the location of an attack remains a very important element of the information used to design strategies to improve the safety of health workers.

LIMITATIONS OF THE RESEARCH

This report is based on a dataset of incidents of violence against health care that has been systematically compiled from a range of trusted sources and carefully coded. The figures presented in the report can be cited as the total number of incidents of attacks on health care in 2023 reported or identified by the SHCC. These numbers provide a minimum estimate of the damage to health care from violence and threats of violence that occurred in 2023. However, the severity of the problem is likely much greater, because many incidents probably go unreported and are thus not counted here. Moreover, differences in definitions and biases in individual sources suggest that the contexts that are identified are also not representative of the actual contexts and that the SHCC dataset suffers from reporting and selection bias.

REPORTING AND SELECTION BIAS

"Reporting bias" is the technical term for the possible selective reporting of those who bring the information together. While the SHCC research process tries to avoid any obvious selection bias and focuses the selection process exclusively on selecting incidents based on the inclusion criteria, the SHCC dataset contains selection bias because by bringing together available information from different sources on violence and threats of violence against health care, the SHCC inevitably introduces all the selection bias inherent in the original sources it combines into one dataset. Those who report individual incidents may select or ignore specific incidents for a range of reasons, including editorial choices, when the source is a media outlet; lack of knowledge, because the affected communities had no connection to the body compiling the information in the first place; and because of deliberate censorship, or disruption of the internet in the country in question, or simple errors of omission. These biases mean that the SHCC's collection of incidents is neither complete nor representative. This has important implications for the conclusions that can be drawn from the data.

The reported numbers of incidents by country should not be compared to those of other countries without considering the factors that affect information flows and possible selection bias. For example, in Ukraine, highly skilled researchers are able to document many incidents without fear of reprisal from authorities in the parts of Ukraine that remained under Ukrainian government control. In the occupied Palestinian territory, courageous reporters continued to document violence and destruction around them, while diaspora networks from Myanmar, Sudan, and Cameroon are important for sharing information with the outside world. In Somalia, strong civil society casualty documentation affects data collection. This resulted in higher numbers of reported incidents reaching the SHCC related to incidents the researchers have access to.

Methodology

In a number of countries, among them Myanmar and Sudan, health professionals jeopardized their and other people's safety by publicly reporting incidents, which is likely to result in more incidents going unreported despite the effective diaspora information networks. Repeated internet blackouts of the kind that occurred in Myanmar and Gaza are also likely to result in some information not being transmitted. Overall, low internet penetration and fear of reprisals are likely to affect reporting from the Sahel and surrounding countries. Parts of northern Nigeria were not easily accessible to outside actors, and this is likely to have impacted information flows from these areas. The withdrawal of registration authorization for key organizations in South Sudan is also likely to have affected the total number of incidents that could be made available to the SHCC in 2023.

ACCURACY OF INFORMATION AND DIFFERING DEFINITIONS

Some organizations record only certain types of incidents, e.g. those involving health facilities or those affecting international aid agencies, while the incident descriptions that are available may also contain errors. In addition, not all organizations that compile information on relevant incidents include all the details that would be necessary to systematically code all aspects of these incidents. In particular, information related to the perpetrator(s) and context of a particular incident is often missing or may be biased in the original source. Also, 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 our inclusion decisions on judgements about the most likely motivations for an attack.

For some countries, combining available information is challenging when various data collection efforts do not share data in ways that allow information to be cross-checked. Moreover, not all contributors provided access to their original sources and many details were lost in the process, affecting our ability to ensure more accurate and consistent classification.

The reported categories of the contexts in which incidents took place should not be read as describing the full range of particular incidents or how frequently they occur. For example, the killings and kidnappings of doctors or bombings of hospitals are more likely to be captured by reporting systems than the harassment of health workers or looting of medical supplies. These incidents are therefore likely to occur more frequently than reports indicate.

Moreover, this report focuses exclusively on threats and acts of violence committed by conflict parties and does not cover violence by patients, by their families, or linked to workplace settings. This means that the violence observed covers conflict-related violence and reflects patterns of violence committed by conflict actors. This means that it may not reflect the full range of violence experienced by health workers for whom threats and violence by patients, families, and potentially superiors may be a more common experience than attacks by a soldier, policeman, or member of a non-state armed actor group.



KNOWN REPORTING AND SELECTION BIASES IN SHCC SOURCES

The dataset on which this report is based suffers from the limitations inherent in the contributors' data sources used to compile the dataset. Some data sources use media reports, while others collect and collate reports through a network of partners, direct observation, or the triangulation of sources. Many information providers use a combination of these methods. Seven possible reporting biases affect the flow of information:

1. In some countries, the media frequently report a wide range of attacks on health care, while in others, formal media outlets report hardly any incidents.
2. In some countries, citizen journalists who carry out their own documentation and investigations are key sources of information. Government-imposed shutdowns of the internet can disrupt such information flows during specific time periods.
3. In some countries, there are very active networks of SHCC partner organizations that contribute information, while in others no such networks exist. Building up networks takes time, and these networks are better developed in countries experiencing long-standing conflicts. Changes in personnel or funding shortfalls can disrupt information flows.
4. In some countries, numerous parallel data-collection processes exist that publish different numbers because of differences in geographic coverage or the ability to reach information providers. If the original data is not shared, it is impossible to cross-check for double reporting of the same events.
5. In some countries, data-collection initiatives may publish data in one year that leads to a sudden rise in reported incidents. If they do not continue this work in subsequent years, the numbers of reported incidents then drop.
6. Incidents occurring in the early stages of conflicts need to be found in a variety of sources until data-collection networks are established.
7. Some organizations do not share incidents, in order to protect their independence and neutrality. In countries where such organizations are key health care providers, information flows can remain very limited.

Methodology

- 1 In the interests of simplicity, these will all be referred to as “countries” in the discussion that follows.
- 2 Department of Peace and Conflict Research, Uppsala University. Uppsala Conflict Data Program. <https://ucdp.uu.se/>, accessed April 21, 2023.
- 3 <https://ucdp.uu.se/>. Because the 2023 UCDP country conflict list was not publicly available when this report was being written, we consulted UCDP staff via email to obtain information on the changes related to countries included in the UCDP list for 2023.
- 4 Department of Peace and Conflict Research, Uppsala University. UCDP Definitions. <https://www.pcr.uu.se/research/ucdp/definitions/>.
- 5 Under this definition, gang violence in Haiti and Mexico are included because gangs are classified as “organized groups” whose activities have resulted in at least 25 battle deaths. However, only Haiti is included as a country chapter for which our monitoring identified 40 incidents, because our monitoring only identified 12 acts of violence against health care attributed to gang violence in Mexico.
- 6 In the case of the Gaza Strip in the occupied Palestinian territory, the methodology exceptionally also includes incidents of violence, damage, and destruction that occurred in the close vicinity of health facilities, because the geographic characteristics of this narrow strip of land meant that any incident of violence on the limited artery roads directly impeded access for ambulances and individual patients and affected health workers’ travel to and from work in important ways.
- 7 Based on INSO’s request, these incidents are not included in the publicly available datasets.
- 8 [CRN members - Somalia - Every Casualty Counts](#)
- 9 Incidents taken from the WHO SSA do not include any geographic information beyond the country’s name, and these incidents are therefore excluded from any maps.
- 10 The lack of detail in the 715 SSA-reported incidents from the oPt made it too difficult to determine which of these incidents overlapped with the 761 oPt incidents reported by SHCC members. The lack of detail in the 309 SSA-reported incidents from Ukraine made it too difficult to determine which of these incidents overlapped with the 394 Ukrainian incidents reported by SHCC members. Thus, the 761 and 309 SSA-reported incidents from the oPt and Ukraine, respectively, were not incorporated into the report.