The Safeguarding Health in Conflict Coalition is a group of more than 35 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.

www.safeguardinghealth.org
Agency Coordinating Body for Afghan Relief and Development (ACBAR)
Alliance of Health Organizations (Afghanistan)
American Public Health Association
Canadian Federation of Nurses Unions
Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health
Consortium of Universities for Global Health
Defenders for Medical Impartiality
Doctors for Human Rights (UK)
Doctors of the World - Médecins du Monde
Egyptian Initiative for Personal Rights
Friends of the Global Fund Africa (Friends Africa)
Global Health Council
Global Health through Education, Training and Service (GHETS)
Harvard Humanitarian Initiative
Human Rights Watch
Insecurity Insight
International Council of Nurses
International Federation of Health and Human Rights Organisations
International Federation of Medical Students’ Associations (IFMSA)
International Health Protection Initiative
International Rehabilitation Council for Torture Victims
International Rescue Committee
IntraHealth International
Irish Nurses and Midwives Organisation
Johns Hopkins Center for Humanitarian Health
Karen Human Rights Group
Management Sciences for Health
Medact
Medical Aid for Palestinians
North to North Health Partnership (N2N)
Office of Global Health, Drexel Dornsife School of Public Health
Pakistan Medical Association
Physicians for Human Rights (PHR)
Physicians for Human Rights–Israel
Save the Children
Surgeons OverSeas (SOS)
Syrian American Medical Society (SAMS)
University Research Company
Watchlist on Children and Armed Conflict
World Vision
In 2018, there were at least 2197 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.
EXECUTIVE SUMMARY

INTRODUCTION
In 2018, the Safeguarding Health in Conflict Coalition documented a total of 973 attacks on health in 23 countries in conflict. 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. 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’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 polo. Moreover, many of the countries in this report face acute shortages of health workers as measured by the WHO’s standards, 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.”

We used the Uppsala Conflict Data Program (UCDP) to determine if countries are considered in conflict. The report does not cover interpersonnel 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/shcchealthcare-dataset.

We make every effort to include only attacks on health that are perpetrated by parties to a conflict. 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 truly representative of the situation on the ground.

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 in 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 and walls, leaving the center nonfunctional. In Yemen, there were at least seven aerial attacks on health facilities in 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.

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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.

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 guerillas overthrew 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, andBurma, 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.

EXECUTIVE SUMMARY
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; air strikes; knives; and explosions inside ambulances. In the DRC, 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 repeatedly fired 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 DRC, and the Philippines. These incidents included both physical and administrative barriers to accessing health care. In Ukraine, clean water supplies were reportedly bombed in the capital, resulting in the departure of health workers, 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 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 included a provision that calls on states to ensure that humanitarian workers can have access to health care.

## WEAPONS USE

Where possible, we captured information on the use of weapons, with perpetrators reportedly using sums of money to buy weapons from those who have lived with 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 number of 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 the data set we have fact checked. All numbers by terrorism may have occurred. We invite readers to contact us if any numbers are not noted.
EXECUTIVE SUMMARY

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. 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.

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<th>NUMBER OF HEALTH WORKERS INJURED</th>
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<th>NUMBER OF HEALTH FACILITIES DAMAGED OR DESTROYED</th>
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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. 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. 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.