SAFEGUARDING HEALTH IN CONFLICT

2018

IMPUNITY REMAINS:

Attacks on Health Care in 23 Countries in Conflict

Executive Summary

SAFEGUARDING HEALTH IN CONFLICT

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)

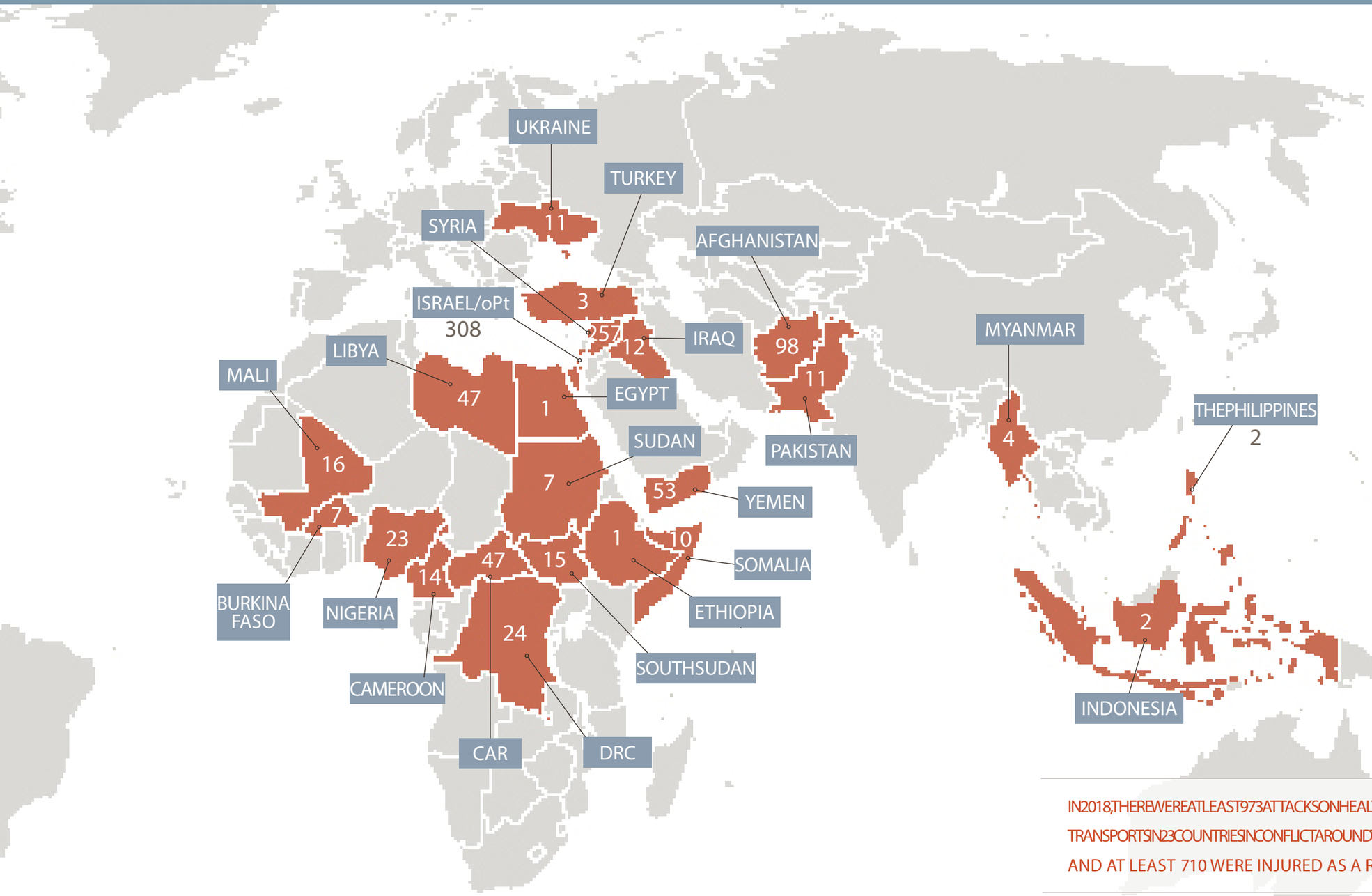
Syrian American Medical Society (SAMS)

University Research Company

Watchlist on Children and Armed Conflict

World Vision

COUNTRIES WITH ATTACKS ON HEALTH CARE IN 2018



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

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

EXECUTIVE SUMMARY

INTRODUCTION

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

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

METHODS AND LIMITATIONS

This sixth report by the Safeguarding Health in Conflict Coalition focuses on attacks on health care in conflict, defined by the WHO as "any act of verbal or physical violence, threat of violence or other psychological violence, or obstruction that interferes with the availability, access and delivery of curative and/or preventive health services."[v] We used the Uppsala Conflict Data Program (UCDP) to determine if countries are considered in conflict. The report does not cover interpersonal violence in health care settings or the consequences of gang and other forms of criminal violence that are prevalent in a number of countries. Where the evidence is available, we provide information on the perpetrators of attacks and also whether the attack appears to have been intentional. Please see the Methodology section for more information.

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

Our dataset of incidents is available for open source access on the Humanitarian Data Exchange (HDX) at https://data.humdata.org/dataset/shcchealthcare-dataset.[vi]

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

ii Please note that the WHO has updated its figures for the occupied Palestinian territory since our analysis of its data. As such, its figures for the occupied Palestinian territory are higher than those included in this report, meaning that the overall number of reported attacks against health is higher than what is presented in this report.
iii Although the number of countries in conflict with attacks on health care is the same in 2018 as in our 2017 report, the list of countries has changed according to the countries in conflict and the recorded attacks.
iv WHO. Health workers density and distribution. http://apps.who.int/gho/data/node.sdg.3-c-viz?lang=en (accessed March 14, 2019).
v WHO. Surveillance system of attacks on healthcare (SSA): Methodology. December 2018. https://www.who.int/emergencies/attacks-on-health-care/SSA-methodology-6February2018.pdf?ua=1.
vi Humanitarian Data Exchange. May 2019. https://data.humdata.org/dataset/shcchealthcare-dataset

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

OVERVIEW

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

ATTACKS ON HEALTH FACILITIES AND TRANSPORTS

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

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

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

In Libya, the WHO reported that Benghazi's Al-Jala Hospital had been attacked four times and that attacks could result in the closure of this crucial hospital. In the Democratic Republic of Congo (DRC), there were seven incidents of armed entry into health facilities, and in one incident, perpetrators sexually assaulted a nurse and a patient and attempted to assault another nurse. In the CAR, attacks affected 22 health facilities, causing many to temporarily close or suspend operations, some for long periods of time.

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

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

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

ATTACKS ON HEALTH WORKERS

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

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; airstrikes; knives; and bombs placed inside ambulances. In the oPt, more than 150 health workers were injured by nonlethal weapons such as rubber bullets and tear gas in the Great March of Return protests in Gaza. In Cameroon, Cameroonian forces reportedly opened fire at an ambulance transporting patients, leaving one nurse seriously injured.

DENIAL OF ACCESS

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

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

PERPETRATORS

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

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

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

WEAPONS USE

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

THISREPORTREFLECTSOURDATASET.WEHAVEFACT CHECKEDALLNUMBERS,BUTERRORSMAYHAVEOCCURRED. WEINVITEREADERSTOCONTACTUSIFANYERRORSIN NUMBERS ARE NOTED.

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

ANALYSIS

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

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

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

In 2018, there were some encouraging developments to address the problem of violence and interference in health care. As part of its resolution in December on human rights and terrorism,[2] the UN General Assembly included a provision that calls on states to ensure that counter-terrorism laws do not impede medical and humanitarian activities. The resolution follows on a report by the Safeguarding Health in Conflict Coalition[3] and partners showing that health workers around the globe are being punished under counter-terrorism and related laws for complying with their ethical duty to provide treatment to all in need.

Additionally, the nongovernmental organization (NGO) Geneva Call issued a Deed of Commitment[4] to non-state armed groups to encourage them to protect and respect health care in conflict and to agree to monitoring of performance. The Deed is out for signature.

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

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

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

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

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

security as a key marker in achieving the goal that every community around the world has access to all essential health services. Many of the countries in this report are already failing to meet the WHO's recommendation of at least 4.45 doctors, nurses, and midwives for every 1,000 people.[5] Yet in 2019, attacks on health are still putting the lives of health workers and the wounded and sick at risk, and these attacks may force more health workers to flee the areas where they are so desperately needed.

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

ALL PARTIES TO CONFLICT SHOULD:

1. Adhere to the provisions of international humanitarian and human rights law regarding respect for and protection of health services and the wounded and sick and the ability of health workers to adhere to their ethical responsibilities of providing impartial care to all in need.

2. Ensure the full implementation of UN Security Council resolution 2286 and adopt practical measures to enhance the protection of, and access to, health care in armed conflict, as set out in the Secretary-General's recommendations to the Security Council in 2016.

3. In particular, as required by resolution 2286, "conduct prompt, full, impartial, and effective investigations" of attacks and other forms of interference with health care toward ensuring accountability and offering redress to victims.

THE UN SECURITY COUNCIL SHOULD:

1. Formally adopt the recommendations toward implementation of resolution 2286 made by the Secretary-General in 2016.

2. Urge the Secretary-General to report on adherence to the requirements of resolution 2286 and the Secretary-General's recommendations.

3. Refer UN expert findings in Syria and Saudi Arabia that identified possible war crimes against health care to the International Criminal Court for further investigation.

4. Schedule briefings on situations in the countries identified in this report, where health care is under the most severe attack. The briefings should include information on investigations and accountability steps the relevant member state has taken.

5. Use its authority to impose sanctions on perpetrators of violence against health care, where appropriate.

6. Urge member state governments to take steps recommended by the Secretary-General in 2016 to fully implement resolution 2286.

THE UN SECRETARY-GENERAL SHOULD:

1. Prepare a report on member state follow-through on the requirements of resolution 2286 and the prior Secretary-General's recommendations.

2. Provide country-specific briefings to the Security Council, as called for in recommendation 4 above. These briefings should be provided by UN agencies whose mandates embrace the identification of perpetrators of attacks.

3. Include as an appendix to his annual report on Children and Armed Conflict a list of all perpetrators of grave violations against children's rights in conflict, including attacks on hospitals and health workers.

4. Include in his annual proposed budgets the resources needed to ensure that existing investigation and accountability mechanisms have the financial and expert resources needed to carry out their tasks.

5. In furtherance of his 2016 report on resolution 2286 to strengthen the role of peacekeeping operations in contributing to an environment conducive to the "safe delivery of medical care" and to implement the 2019 Declaration of Shared Commitments on UN Peacekeeping Operations regarding civilian protection, take concrete steps to establish guidance and training for peacekeepers on specific actions and behaviors needed to protect health care.

6. Include a consideration of the means needed to increase the security of health care in fragile and conflict-affected states in the High-Level Political Forum on Sustainable Development toward achieving its Sustainable Development Goals (part of achieving Agenda 2030) and in the High-Level Meeting on Universal Health Coverage.

RECOMMENDATIONS

MEMBER STATES SHOULD:

1. Develop a national policy framework that builds upon best practices and establishes clear institutional authorities and responsibilities for protecting civilians and civilian objects in the conduct of hostilities, as recommended by the Secretary-General in his 2018 report on the protection of civilians.[6] Include steps to fulfill resolution 2286 in their frameworks.

2. Through their ministries of defense and interior, as appropriate:

    a. Review and revise military policies and training practices to ensure compliance with obligations to respect and protect health care with regard to armed entries into medical facilities, the conduct of armed forces at checkpoints, and other circumstances where health care is at risk from military operations.

    b. Abide by the "no weapons" policies of hospitals and other health facilities.

    c. Cooperate with and abide by guidance from Ministries of Health regarding steps that can be taken to protect health facilities from interference by state armed forces.

    d. Discipline soldiers and other security personnel who interfere with, obstruct, threaten, or assault health facilities and personnel engaged in health care activities consistent with their mission and ethical obligations

    e. Undertake comprehensive annual reviews of performance of all of its military, police, and other security forces with respect to the protection of health care in conflict, particularly with respect to instances where forces have intentionally or unintentionally interfered with or obstructed access to health care; inflicted violence on health facilities, health personnel, or the wounded and sick; or arrested or punished health workers for having provided care to an individual deemed to be an enemy.

3. Through their ministries of health:

    a. Collect data on violence and threats to health facilities in conflict as part of regular health surveillance and quality assurance activities.

    b. Develop systems to receive information from NGOs and civil society groups regarding acts that interfere with, obstruct, threaten, and assault health facilities and personnel engaged health care activities.

    c. Actively support health facilities in seeking the means of maintaining their security, including through outreach to other ministries and actors who infringe or may infringe on the protection of health facilities from attack.

    d. Act as an interlocutor with the Ministries of Defense and Interior to increase the security of health facilities and personnel.

4. In accordance with the General Assembly's resolution on human rights and counter-terrorism A/Res/73/174, reform laws and police and prosecutorial practices so as not to impede humanitarian and medical services or punish those who provide them to people who are wounded or sick, regardless of their affiliation.

5. Refrain from arms sales to perpetrators of attacks on health services.

6. Strengthen national mechanisms for thorough and independent investigations into alleged violations.

7. Ensure that perpetrators are held accountable for violations.

8. Take forceful diplomatic actions, such as public statements and démarches, against perpetrators of attacks on health services.

9. Take actions toward carrying out their responsibility to ensure respect for international humanitarian law, as set forth in the very first article of each Geneva Convention. To that end, they should initiate investigations of instances where partner military forces or their own may have attacked hospitals or other health facilities.

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

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

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

1. Engage in outreach to new potential partners, including NGOs, to ensure that the system captures all attacks.

2. Provide information to describe the basic facts of the incident (withholding location information if needed for security reasons) and take steps to enable identification of the perpetrator where known.

NON-STATE ARMED GROUPS SHOULD:

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