



NO PROTECTION, NO RESPECT

HEALTH WORKERS AND HEALTH FACILITIES UNDER ATTACK
2015 AND EARLY 2016

**SAFEGUARDING
HEALTH
IN CONFLICT**

Center for Public Health and
Human Rights



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Cover photo: Destroyed medical facility in Aleppo, Syria. *Photo courtesy of Syrian American Medical Society.*

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A woman holds the hand of a child as she walks past a damaged van after a curfew was lifted following clashes between Turkish forces and militants of the Kurdistan Workers' Party (PKK) in the Kurdish-majority city of Cizre, in southeastern Turkey, on September 12, 2015.

Photo: ILYAS AKENGIN/AFP/Getty Images



A thirteen-year-old boy wounded during the US airstrike on a Médecins Sans Frontières hospital in Kunduz, Afghanistan, receives treatment at a hospital run by EMERGENCY, an Italian nongovernmental organization.

Photo: IWAKIL KOHSAR/AFP/Getty Images



Surgeons operate in a partially underground facility in the Idlib governorate of Syria.

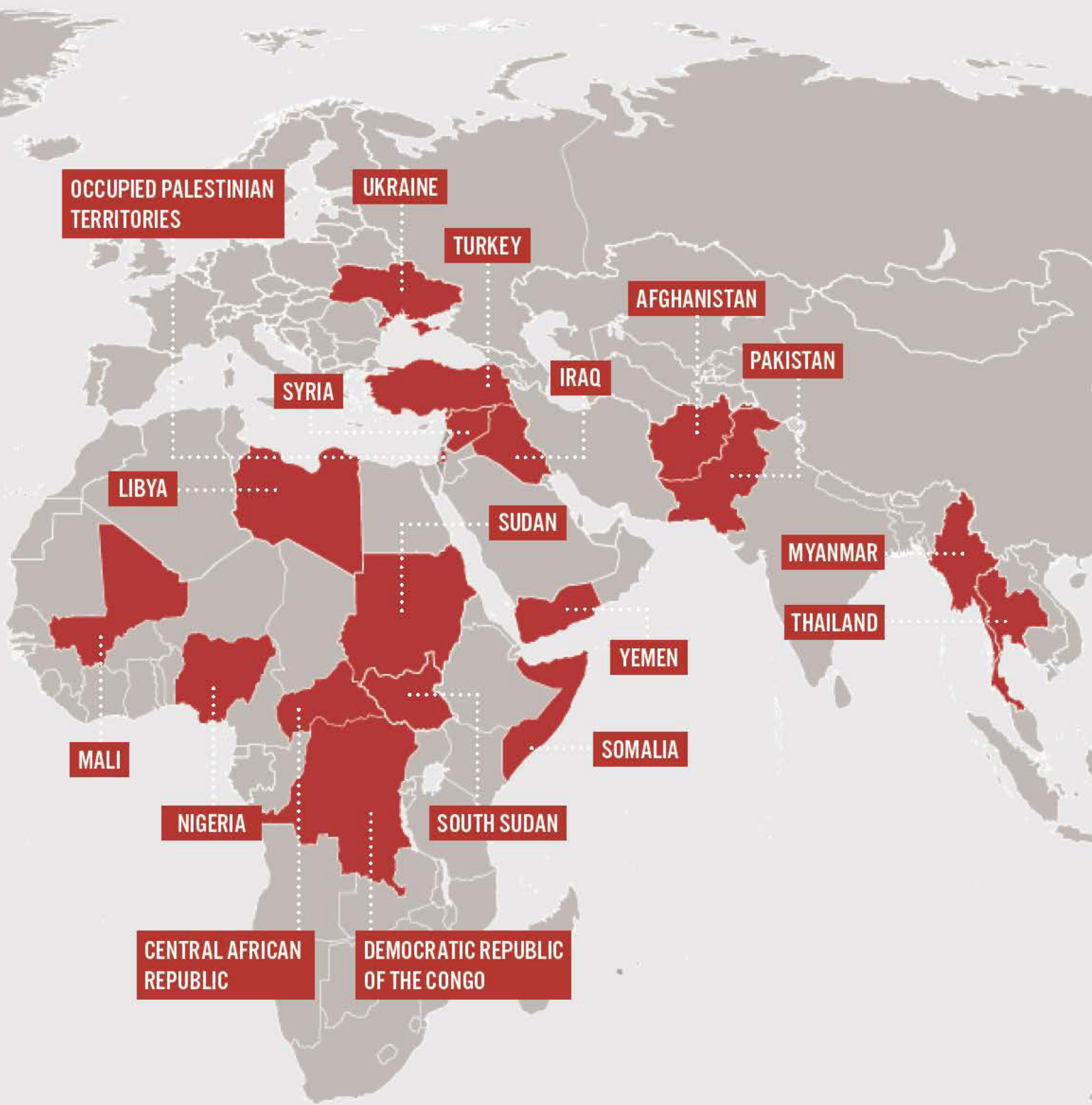
Photo: courtesy of the Syrian American Medical Society

ACRONYMS

ACBAR	Agency Coordinating Body of Afghan Relief and Development
AMISOM	African Union Mission in Somalia
ANSF	Afghan National Security Forces
CAR	Central African Republic
DMSC	Derna Mujahideen Shura Council
FARC	Revolutionary Armed Forces of Colombia
ICRC	International Committee of the Red Cross
ISIL	Islamic State of Iraq and the Levant
KTC	Kunduz Trauma Centre
MINUSMA	UN Multidimensional Stabilization Mission
MNLA	National Movement for the Liberation of Azawad
MSF	Médecins Sans Frontières
MUJAO	Movement for Unity and Jihad in West Africa
NGO	Nongovernmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the UN High Commissioner for Human Rights
POC	Protection of Civilians (South Sudan)
PHR	Physicians for Human Rights
PHR-I	Physicians for Human Rights – Israel
PKK	Kurdistan Workers’ Party (Turkey)
PMF	Popular Mobilization Forces
PRCS	Palestine Red Crescent Society
SCA	Swedish Committee for Afghanistan
SiDN	Security in Numbers Database
UN	United Nations
UNAMA	United Nations Assistance Mission in Afghanistan
UNMISS	UN Mission in South Sudan
WHO	World Health Organization

COUNTRIES WHERE ATTACKS TOOK PLACE IN 2015 AND EARLY 2016





EXECUTIVE SUMMARY

International law dating back more than 150 years holds that in all armed conflicts, whether internal or international, parties must not attack or interfere with health workers, facilities, ambulances, and people who are wounded or sick. The Geneva Conventions and customary international humanitarian law provide that parties have a duty to distinguish between military and civilian objects and to take precautions to avoid harm to hospitals even when a military target is nearby; that hospitals and clinics may not be taken over for military or security purposes—and that even if they are, parties to a conflict have an obligation to minimize harm to civilians inside; that health professionals may not be subjected to punishment for adhering to obligations to provide care consistent with their ethical duties, including treating the sick and wounded without discrimination; and that access to health care may not be obstructed through such practices as unreasonably delaying or blocking passage of ambulances, supply transports, medical staff, and the wounded and sick. International human rights law imposes similar obligations.

This report reviews attacks on and interference with hospitals, health workers, ambulances, medical supply transports, and patients in armed conflict and times of political violence that violated these obligations in 2015 and during the first three months of 2016.

ATTACKS ON AND INTERFERENCE WITH HEALTH CARE

Attacks on health services take many forms but can be grouped into four major categories:

1. Bombing, shelling, and looting facilities or transports, in some cases as a result of targeting the facility or transport, and in other cases because of an indiscriminate attack that failed to take precautions to avoid harm to the facility.
2. Violence inflicted on health workers independent of an attack on a facility or transport.
3. Military takeover of hospitals, or fighting in and around hospitals.
4. Obstruction of access to health care, medicine, and essential supplies.

Bombing, shelling, burning, looting, and other violence inflicted on health facilities and transports

Hospitals, ambulances, and medical supply transports have been attacked and looted in many countries, sometimes intentionally and sometimes due to attackers failing to take precautions to distinguish between military and civilian objects. These attacks have led to the deaths of health workers, medical staff, and others during initial attacks and during ongoing violence following the attacks.

In five countries—Afghanistan, Iraq, Libya, Syria, and Yemen—hospitals were subjected to aerial bombing, as well as to explosives launched from the ground. In Syria, where the most rigorous reporting has taken place, at least 122 attacks on hospitals were documented in 2015, with some facilities hit multiple times. Syrian government forces and their Russian allies engaged in vicious “double-tap” attacks, launching a second strike after rescuers came to the aid of those wounded in the first attack. In four such double-tap attacks, 31 people were killed and more than 150 wounded. In Yemen, health facilities were attacked at least 100 times; a Saudi-led coalition indiscriminately bombed many hospitals, including in one case unleashing a two-hour bombardment. Opposing Houthi and allied forces have committed violations as well, shelling hospitals from the ground.

In Afghanistan, at least 92 acts of violence against health facilities and health workers killed 55 people. Forty-two people, including 24 patients, 14 health workers and four caretakers, were killed as a result of a United States military air attack on the Kunduz Trauma Center, the only facility of its kind in northern Afghanistan (whose coordinates were known to all parties to the conflict). Médecins Sans Frontières (MSF), which operated the facility, phoned and texted US authorities during the strike seeking to stop the attack, to no avail. In Iraq, there were at least 61 attacks on health facilities and personnel. In one of them, Iraqi Security Forces bombed a maternity and children’s hospital, killing 31 people, including at least eight children, and wounding 39 others. In Libya, the kidney disease and internal medicine wards and staff dormitories of a hospital were bombed.

In Central African Republic, Democratic Republic of the Congo, Mali, Somalia, South Sudan, and Sudan, health facilities have been burned and/or looted, medical supply vehicles attacked on the road, and medical staff abducted;

these attacks have often forced the suspension of medical activities in the affected areas. In Central African Republic, there were more than 200 attacks on and looting of humanitarian compounds and transports, many of which were providing health care to a population in desperate need; there were 30 such attacks in Mali, as well. In South Sudan, health programs and nongovernmental organization (NGO) compounds in the Upper Nile region were repeatedly attacked during 2015, and multiple health workers were killed in separate incidents.

Violence inflicted on health workers independent of attack on a facility or transport

Horrific violence has been inflicted on health workers, patients and their families, and staff independent of the impact of shelling, bombing, and burning. In Democratic Republic of the Congo, seven patients and a nurse were brutally murdered inside a clinic. In one atrocity in Sudan, security forces attacked and looted the town of Golo in West Darfur, encouraging civilians to seek protection in a hospital. The security forces subsequently detained the civilians in the hospital for weeks, raped at least 60 women, and executed at least three people.

In Syria, 27% of the health workers killed in 2015 were shot, executed, or tortured to death. In Iraq and Libya, the self-proclaimed Islamic State of Iraq and the Levant (ISIL) has forced health workers, under threat of death, to give its fighters priority in treatment, including moving from their places of work at civilian hospitals to ISIL facilities housing injured fighters. ISIL executed at least 12 health workers in 2015. Health workers have been ambushed, abducted, and killed—often while in marked medical vehicles—in Afghanistan, Central African Republic, Iraq, Mali, Nigeria, Pakistan, Somalia, South Sudan, and Yemen.

Globally, health workers who participate in vaccination programs, as well as police and other security personnel charged with protecting them, are especially vulnerable to attack, particularly those involved in polio prevention (table 1). Their necessary travel to remote and dangerous areas puts them at a high risk of murder and abduction.

Military takeover of health facilities and fighting around hospitals

In some cases, fighting took place directly on hospital grounds. In Iraq, there were at least two instances of firing directly at a hospital; in one of them, combatants were fighting from the roof while the opposing forces shelled the hospital. Also in Iraq, ISIL forces have taken over civilian hospitals for their own use, sometimes evicting all civilian patients. In Thailand, armed insurgents took over a hospital to stage an attack on a nearby government security post.

Military forces have entered hospitals to remove enemy fighters, often severely disrupting care and assaulting patients or staff. On one occasion, 300 fighters in Yemen entered a hospital and forced staff to reveal the location of two Houthi fighters, who were then removed and executed outside the hospital; Houthi forces retaliated by firing repeatedly at the hospital. In Afghanistan, Afghan National Security Forces took control of clinics five times to search for medical supplies or wounded enemies, disrupting care and intimidating patients and staff. In one case, two patients were removed from the hospital and health workers were arrested and beaten. Israeli security forces entered Palestinian hospitals on at least eight occasions to conduct investigations, during which they interfered with patient care and, on some occasions, assaulted patients and/or health workers.

Table 1. Attacks on polio workers and those accompanying them

Country	Incidents	Killed	Wounded	Abducted
Afghanistan	22	4	0	10
Nigeria	2	0	0	5
Pakistan 2015	37	11	5	2
Pakistan Q1 2016	2	17	24	2
Somalia	3	7	0	6

Obstruction of access to health care, medicine, and essential supplies

Obstruction of access to health care took place in many of the countries included in this report. This was carried out through blocking, unreasonably delaying, or threatening medical supply and aid transports, ambulances, health workers, and patients and their families.

Parties to each conflict have frequently restricted passage of health and other humanitarian aid, often in dire health situations. In Syria, the Assad government has continued to block humanitarian aid to besieged and hard-to-reach populations who are at risk of starvation. In South Sudan, parties to the conflict have periodically suspended or obstructed the flow of aid to people in desperate need, who have been displaced and are living in precarious settings. Sudan has severely restricted NGO access to areas of great need for health care aid in Darfur. The government of Iraq has prevented the delivery of health supplies to ISIL-controlled areas, including Mosul, Fallujah, and Anbar. And in the wake of violence in September 2015, medical teams in the Central African Republic were unable to reach many people in urgent need of medical care because of threats of violence or blockades.

Medical aid has been obstructed in low-intensity conflicts as well. The Turkish government, which is engaged in military action against armed Kurdish separatists, imposed a weeks-long curfew preventing all civilian movement in and out of the city of Cizre and other towns in the southeast. As part of the curfew, security forces prevented the evacuation of wounded and sick civilians, some of whom died as a result. In Ukraine, armed groups suspended MSF humanitarian medical programs for two months in 2015. Throughout the year, restrictions imposed by both sides on individuals crossing conflict lines severely curtailed civilian access to medical care and the delivery of medical supplies, including much-needed medication for HIV, tuberculosis, and drug addiction. In Jerusalem and the Occupied Palestinian Territories, Israeli security forces created new checkpoints and refused to allow priority of passage to Palestinian ambulances until receiving authorization through bureaucratic channels, thereby delaying the transport of patients who were in the midst of emergencies by up to an hour.

THE AFTEREFFECTS OF ATTACKS

In some cases, in addition to the deaths and injuries inflicted during attacks, the assaults have negatively affected the health of people in the area who need urgent care. In South Sudan, for example, shortly after an attack on Kodok Hospital, 11 people in need of surgery died. In Yemen, infants in a pediatric hospital died when ventilators cut out as a result of an airstrike. In Syria, local security forces would not approve the inclusion of surgical kits and intravenous fluids on a convoy to eastern Aleppo city, depriving more than 33,000 people of these vital medical supplies. The far-reaching effects of these attacks and strategies can be assessed in different ways:

1. Loss or lack of access to health facilities.
2. Flight of health workers.
3. People deprived of health care.
4. Increased mortality or morbidity risk.

Loss or lack of access to health facilities

In Afghanistan, 23 health clinics in six provinces were closed in early 2016 as a result of violence and insecurity. In Syria, 57% of public hospitals are not functioning or are only partially functioning; that percentage does not include the informal field hospitals established in opposition-controlled areas that have been subjected to relentless bombing. In Yemen, after a single year of war, 600 health facilities—representing 25% of the country's overall capacity to deliver health care—were not functioning because of destruction or a lack of staff and/or supplies. In Libya, 40% of all health facilities are closed because of damage, lack of supplies and staff, or insecurity. In South Sudan, a scorched-earth war has closed 55% of health facilities in the Upper Nile region, leaving one hospital to serve one million people.

Most health facilities are no longer functioning in Central African Republic. In Sudan, since 2011, the Sudanese Air Force has bombed 26 health facilities, including hospitals, clinics, and health units, leaving only two hospitals to serve 1.2 million people. In Mali, from August through September 2015, security incidents shut down all access to health care in the Mopti, Timbuktu, Kidal, and Gao regions. Additionally, targeted attacks forced Mali's main international health partner in the region to suspend its activities and relocate staff, resulting in a complete

lack of health assistance and the closure of all referral health centers in the districts of Tenekou and Youwaro. In Thailand, health workers have had to cut back evening hours to avoid being exposed to attacks by insurgent groups.

Flight of health workers

Attacks often lead to the flight of health workers and consequent loss of health services capacity. Half of the health workers who practiced in Syria prior to 2011 and 95% of physicians living in Syria's major city of Aleppo before the war have left the country. In Iraq, 45% of health professionals have emigrated since 2014. In Libya, 80% of the foreign nurses, who were the backbone of the country's medical staff before 2011, have been evacuated. In northern Nigeria, almost all health workers have fled areas controlled by Boko Haram, resulting in the closure of 450 health facilities.

People deprived of health care

One way of assessing the consequences of lost facilities and medical staff is to estimate the number of people who need access to health services but do not have it. Even single events or the loss of a single facility can lead to a dramatic decline in access for large numbers of people. In Democratic Republic of the Congo, for instance, an armed group looted a town and brutally murdered seven patients and a nurse in a clinic, leading to the closure of the only health facility that served 35,000 people. In another case, two MSF staff were robbed and kidnapped between Kitchanga and Mweso, Masisi Territory in North Kivu, temporarily suspending medical programs that had conducted 185,000 outpatient visits and 6,000 hospitalizations in the prior 10 months. In South Sudan, violence against a health clinic in Pibor forced movement of key health functions to a more distant location, depriving 170,000 people of access to secondary health care. The destruction of a single hospital in Yemen led to deprivation of services for 200,000 people.

More broadly, UN agencies report a staggering number of people in need of health care in emergencies. Several factors contribute to the need, including civilian injuries, population displacement, and lack of available resources

for humanitarian aid. But attacks on and interference with health care are major contributors to this enormous problem. In conflicts with some of the most pervasive attacks on health services, UN reports show the following figures for people deprived of health care:

- Iraq: 8.5 million people
- Libya: 1.9 million people
- Mali: 2.25 million people
- Somalia: 3.2 million people
- Syria: 11.5 million people
- Yemen: 14.1 million people.

Increased mortality and morbidity risk

Another way of measuring the impact of lost medical staff and facilities is by examining the increased risk of mortality and morbidity. Beyond attacks on health facilities and health workers, factors such as lack of food and clean water as a result of armed conflict are often highly significant. Yet diminished health capacity may well exacerbate the impacts of these and related factors.

For example, in Yemen, apart from death from traumatic injuries, lack of access to health care and lack of immunizations have resulted in the deaths of nearly 10,000 children under the age of five. UNICEF estimates that 2.5 million Yemeni children are at high risk of diarrheal diseases, 1.3 million are at risk of acute respiratory tract infections, 2.6 million are at risk of measles, and more than 320,000 are at risk of severe acute malnutrition. In Syria, lack of safe drinking water, sanitation, electricity, and fuel has made Syrians more vulnerable to outbreaks of diarrheal diseases, typhoid, hepatitis A, and other vaccine-preventable diseases. Inadequate or nonexistent treatment of chronic diseases—including diabetes, asthma, kidney disease, and cardiovascular disease—has increased the risk of death from these diseases. Shortages of skilled birth attendants and obstetricians have increased maternal and neonatal morbidity and mortality. In South Sudan, attacks on health clinics, humanitarian compounds, and aid workers led to a major decrease in health capacity at a time when there was an unprecedented outbreak of nearly 2.28 million cases of malaria.

RECOMMENDATIONS

ACTIONS TAKEN TO DATE TO ADDRESS ATTACKS ON HEALTH SERVICES

When the Safeguarding Health in Conflict Coalition began to promote awareness of the severity of this crisis in 2012, few members of the general public, aid agencies, and other stakeholders were fully aware of the extent of assaults on health care. Today, as a result of the work of the coalition, and colleague organizations including the International Committee of the Red Cross and MSF, as well as states that have taken leadership on the problem, no person or state can claim ignorance of the issue. The international community has taken some steps to respond. In 2014, for example, the UN General Assembly reinforced norms prohibiting attacks and interference with health care in all circumstances, and called for specific preventive measures by states. In 2015, the World Health Organization (WHO) completed a pilot project to collect data on incidents of attacks on health services. In 2011, the UN Security Council provided the Secretary-General's Special Representative on Children in Armed Conflict with greater authority to promote accountability for parties in conflict that engage in recurrent attacks on health facilities and personnel. The UN High Commissioner for Human Rights (OHCHR) has clarified the applicability of international human rights law to attacks on health care facilities and staff.

On May 3, 2016, the UN Security Council passed a resolution specifically addressing attacks on health facilities, health workers, ambulances, and patients. The resolution reaffirms principles of international human rights and humanitarian law that provide health services immunity from attack and demands that states and armed groups comply with their provisions. It reaffirms, too, that health workers should never be punished for following their ethical obligations to provide care, no matter the identity or affiliation of the patient. It calls on states to reform their domestic

laws, train their militaries and security forces in the requirements of international law, collect data, engage in measures to prevent violations, and investigate violations that take place. It demands an end to impunity, including criminal prosecution where warranted. It calls upon the Secretary-General to report violations in briefings to the council on country situations and in other reports relating to the protection of civilians, including recording specific acts of violence against health facilities and personnel and remedial actions and accountability measures taken. Finally, it asks the Secretary-General to advise the Security Council on measures being taken to prevent attacks and ensure accountability.

Progress has been made in terms of awareness of—and, to a certain extent, global reaction to—this crisis. But much more action is urgently needed.

URGENT ACTIONS NEEDED

Attacks on health care must be seen as unacceptable—not inevitable.

States, the Security Council, in cooperation with the Secretary-General, the General Assembly, and UN agencies, as appropriate, should take the following actions:

The Security Council must be fully and robustly implemented. Toward that end:

1. States should engage in all actions called for by the resolution to respect and protect the medical mission, reform laws, train military and security forces, investigate violations, collect data, and take other measures toward prevention and accountability. Law reform should include repeal of all laws that criminalize providing health care to individuals deemed to be enemies. Toward that end, states should be required to report on their actions, both to ensure implementation and to provide models for other states. The Secretary-General should report annually on these actions.
 - The Secretary-General should establish a comprehensive system for regular reporting of acts of violence against health facilities and personnel and remedial actions and accountability measures taken.
 - The Security Council should refer acts that may constitute war crimes and crimes against humanity involving attacks on health facilities, health workers, and health transports and obstruction of medical aid and care for criminal prosecution through the International Criminal Court or otherwise.
 - To further promote accountability, resources should be provided to enable the Secretary-General's Special Representative on Children in Armed Conflict to increase its capacity under its existing mandate to report on attacks on schools and hospitals and list and promote remedial action plans for persistent violators.
- The WHO should implement a global, robust system of data collection and reporting on incidents of attacks on health services to facilitate a comprehensive understanding of national and global trends. The system should be led and implemented by the WHO and based on methods developed under a pilot project initiated as a result of a 2012 resolution of the World Health Assembly. Member states should provide WHO with the resources and cooperation needed to put such a system into place.
2. The UN and member states should implement a mechanism to investigate, at the international level, all major attacks on health services through the International Humanitarian Fact-Finding Commission or otherwise.
3. OHCHR should increase its field investigations and training activities concerning attacks on health care.
4. The Security Council should declare that national laws that criminalize providing health care to individuals based on their claimed status as enemies are contrary to international law.

In addition, governments, citizens, the medical community, and NGOs should speak out and demand adherence to all health workers' rights of protection and immunity from attacks.

INTRODUCTION

“The delivery of food, water, medicine, essential health services, and shelter to civilians in need demands the highest respect and protection from the effects of hostilities. All too frequently, health care workers, facilities, transports, and patients are attacked, often with deadly consequences. We must do much more to reverse that deplorable trend.”

–*Secretary-General’s Report to the World Humanitarian Summit, 2015*

“The fact that these attacks have become so widespread must not be tolerated as the new normal.”

–*Dr. Margaret Chan, WHO Director, September 2014*

This is the third annual report by the Safeguarding Health in Conflict Coalition, documenting attacks on and interference with health workers, patients, facilities, and transports during periods of armed conflict and political violence. In recent years, attacks on health care services have escalated, usually with impunity, exacerbating the suffering that civilians experience during conflicts. The events of 2015 and early 2016 are especially alarming: parties to conflict bombed hospitals in five countries, killed health workers for seeking to provide impartial care, committed assaults in hospitals and against patients and staff, and violently obstructed access to health care. These attacks have had severe consequences on the lives and security of health workers, and on the health and well-being of people, families, and communities in need of care.

This report provides an overview of attacks on health care that took place in 2015 and during the first three months of 2016 in 19 countries. The information on which the report is based comes from United Nations agencies, research by independent NGOs, and the media. These sources provide insights into the scope, frequency, and variety of attacks, and the harms they inflict on people in need of essential health care and the health workers who seek to treat and assist them. In some cases, they identify the parties responsible for specific acts. Cumulatively, they reveal a shocking picture of rocket attacks, aerial assaults, lootings, burnings, executions, sexual violence, persecution, and wanton destruction of health facilities. They weaken health systems and can affect access to care for years to come. Millions of people have been deprived of health care as a result of these assaults.

This report does not quantify the global number of attacks on or interference with health care services, or the numbers of health workers and patients killed or injured by violence. Only a handful of countries collect data on these attacks. And when data are collected, definitions, time periods for reporting, and methods vary. Thousands of incidents have likely gone undocumented or underreported. For these reasons, one of our key recommendations is for the international community to commit to more thorough and systematic data collection and reporting that would facilitate a more accurate picture of national and global trends. This report chronicles documented attacks and interferences by country, stating the responsible parties and outcomes whenever possible.

METHODOLOGY

There is no standardized method for reporting or categorizing attacks on health in settings of conflict and insecurity, nor are there uniform definitions as to what constitutes an attack or interference with health care. In most countries, data on incidents of attacks, as well as deaths and injuries to health workers, patients, and families, are also lacking. Some attacks are never reported and others may not be reported comprehensively. Sometimes the information available is insufficient to determine how to categorize the attack and its perpetrator. This makes it difficult to produce a comprehensive report or to understand trends in the number and types of attacks over time.

Nevertheless, some reliable sources of information are available. Information for this report comes from NGO and UN agency reports, reliable local and international periodicals, and other sources unique to particular countries. The research team conducted Google searches using both general search terms and those applicable to particular countries. Social media platforms were also searched to identify relevant links to verifiable attacks. References are provided for all incidents found on these platforms. In Afghanistan and Syria, coalition members tracked incidents; that information is also reported here. For the Occupied Palestinian Territories, a coalition member investigated certain incidents; the member's findings are reported in the relevant country section. Coalition member Insecurity Insight provided incidents from its Security in Numbers Database (SiND), part of the Aid in Danger project covering the year 2015. SiND is a collaboration between Insecurity Insight and 15 humanitarian agencies that pool their confidential security incident data. These data are combined with publicly available information. The database covers all incidents that affect the delivery of aid, which includes violence affecting aid workers (kidnapping, death, and injuries) as well impediments to aid delivery and access (e.g., damage to infrastructure or supplies and the impact of insecurity on access for humanitarian agencies). For the purpose of this report, 78 incidents that affected health programs were made available. Regular updates on all incidents affecting aid delivery are available in the Aid Security Monthly News Brief.

Where it is possible to identify parties responsible for the attack and the exact circumstances (including intentionality), we do so. In other cases we state that an attack occurred.

Country-specific sections of the report were reviewed by in-country experts and experts familiar with attacks on health workers and facilities in those countries.

ATTACKS ON HEALTH FACILITIES, HEALTH WORKERS, AND PATIENTS IN HIGHLY-AFFECTED COUNTRIES

AFGHANISTAN

Armed conflict in Afghanistan continues to take an unrelenting toll on the civilian population. The Office for the Coordination of Humanitarian Affairs (OCHA) reports that fighting affects the lives of 6.3 million Afghans and that, in 2015, almost 200,000 fled their homes, a 64% increase from the previous year. More than 8.1 million people are now in need of humanitarian assistance and 3.9 million people suffer from malnutrition or food insecurity.¹

In 2015, the United Nations Assistance Mission in Afghanistan (UNAMA) and the Office of the UN High Commissioner for Human Rights (OHCHR) documented 11,002 civilian casualties, including 3,545 deaths and 7,457 injuries. UNAMA and OHCHR also documented 63 incidents wherein antigovernment groups targeted hospitals, clinics, and health personnel—an alarming 47% increase from 2014. These incidents have led to multiple closures of health centers and the resignation of many female health workers, depriving civilians of access to health care.²

According to the joint UNAMA/OHCHR report, the Taliban perpetrated 36 of the incidents, the ISIL fighters perpetrated 12, and Tehreek-e-Taliban (Pakistan) perpetrated one incident. UNAMA and OHCHR could not attribute responsibility to any group in 14 of these cases. The incidents included looting of medical equipment, extortion of salary, and abduction and resulted in the closure of 11 health clinics. UNAMA/OHCHR also reported that Afghan Special Forces, supported by international military forces, conducted two searches on clinics in Helmand and Logar provinces, and documented the United States military airstrike on an MSF hospital in Kunduz city on October 3, 2015.³

Data collected from NGOs by the Agency Coordinating Body of Afghan Relief and Development (ACBAR) during March 1, 2015 – February 10, 2016, however, recorded an even greater number of incidents—at least 92 incidents of attacks or interference with hospitals, clinics, pharmacies, medical personnel (including doctors, nurses, dentists, and support staff), medical vehicles, and medical supplies.⁴ The differences between ACBAR's figures and those of the UN can be explained by different data collection methods and reporting periods.

In the 92 incidents ACBAR recorded, at least 55 people were killed and 48 were wounded. The incident that killed the most people was the US airstrike on the MSF-run hospital in Kunduz;⁵ MSF confirmed 42 people were

killed, and 27 staff and many patients and caretakers were wounded. The remaining 13 people killed in attacks on health services were a result of targeted killings, abductions, or fighting in the vicinity of health facilities.

The majority of the incidents recorded by ACBAR were initiated by armed opposition groups, and intimidation was the most common tactic used. Many of these incidents took place in the Eastern Region of Afghanistan, and involved armed opposition groups that claimed allegiance to ISIL threatening clinics, resulting in their closure. ACBAR concluded the attackers perceived the clinics as an extension of government influence in the area. Additionally, it appears that armed opposition groups sought to acquire supplies.

Attacks on vaccination programs increased in 2015. ACBAR recorded 22 such incidents, most of which were targeted killings and abductions. Eight incidents involved armed opposition groups destroying or confiscating vaccination supplies and equipment. In one incident in Kunar Province, perpetrators abducted and later shot and killed three vaccinators.⁶ In December 2015, a gunman shot and killed a female polio worker on a motorcycle in Kandahar.⁷

While the exact number of abductions of medical workers varies according to source, ACBAR documented at least ten such incidents, including the abduction and killing of the three vaccinators in Kunar. The motive behind these tactics varied greatly, ranging from intimidation to mistaken identity, and the duration of the abductions also varied from approximately 30 minutes to several weeks.

Health professionals were stopped at illegal armed opposition group checkpoints at least four times, and were questioned about the nature of their work before being allowed to continue on their journeys. In addition, criminal activity affected health services, with 26 incidents during the reporting period, including personal, family, or tribal disputes; robbery of clinics for supplies; and violence.

The fighting also resulted in collateral damage to health workers, facilities, and supplies, with 13 such incidents recorded by ACBAR. On February 22, 2016, in the Sia Gird District of Parwan Province, a suicide attacker targeting Afghan security forces detonated an improvised explosive device near the entrance of a district health clinic, killing seven civilians and injuring seven others, including three children.⁸

According to the ACBAR data, the Afghan National Security Forces (ANSF) were involved in nine incidents affecting the health sector, four of which were positive developments, such as the rescue of abducted health personnel or the disposal of an improvised explosive device outside a clinic. The remaining incidents involved the ANSF taking over or affecting clinics during clashes. In one case, the ANSF entered a clinic in search of medical supplies; in another, in July 2015, police entered a clinic in search of wounded members or armed opposition groups. Health workers have conveyed that some government and ANSF officials believe that Taliban receiving care in clinics are legitimate targets and doctors should not be treating them.⁹

On February 18, 2016, the Afghan Ministry of Interior Special Forces and the international military conducted a joint operation in the Tangi Sayedan area of the Daimirdad District of Wardak Province and entered a government health clinic funded by the Swedish Committee for Afghanistan (SCA). Two patients and a young boy were taken away from the clinic and subsequently killed. Staff were arrested and beaten. The SCA is requesting that the Afghan government and the management of the foreign forces in the country provide a detailed explanation of the incident and conduct an independent investigation. The Swedish government has also been asked to follow up on the incident.¹⁰

Attack on Clinic of Swedish Committee for Afghanistan

In the early morning, around 2 a.m. on February 18, the Afghan armed forces entered a clinic run by the Swedish Committee for Afghanistan (SCA) in Tangi Saidan, in the Day Mirdad district of the Wardak province. The forces took two injured patients from the clinic, along with a young boy accompanying one of the patients. The three people were brought to a place nearby, where they were later killed.

During the operation, the head of the clinic and one other member of the staff were pushed and kicked by the soldiers; the head of the clinic was held by the military and forced to conduct a search of nearby buildings before being left behind with his hands tied together.

Table 2. Incidents by Perpetrator

Perpetrator	Number of Incidents
Armed Opposition Groups (AOG)	57
Afghan National Security Forces (ANSF)	9
Armed Criminal Groups	25
International Military Forces	1

Table 3. Armed Opposition Group Incidents by Type

Primary Tactic	Number of Incidents
Intimidation	17
Collateral Damage	13
Abductions	10
Destruction/Theft of Supplies	8
Targeted Killings	5
Illegal Checkpoints/ID Checks	4

Table 4. Distribution of Incidents

Region	Number of Incidents
Central	9
East	40
North	4
Northeast	7
South	10
West	22

Data collected March 1, 2015 – February 10, 2016, by the Agency Coordinating Body of Afghan Relief and Development

The United Nations Assistance Mission in Afghanistan has confirmed that foreign military forces participated in the operation in Tangi Saidan. Information received from staff at the SCA clinic indicates that foreign troops were present; foreign uniforms were observed on the scene. It is unclear whether the foreign troop members participated in the raid or arrived afterward.

This raid was a gross violation of international humanitarian law and the Geneva Conventions. Equally disturbing, Afghan local government officials defended the soldiers' conduct, claiming that as enemies they had no rights. A spokesperson for the provincial governor, Toryalay Hemat, said, "They were not patients, but Taliban," and "The main target of the Special Forces was the Taliban fighters, not the hospital." The spokesperson for Wardak's police chief, Abdul Wali Noorzai, said, "Those killed in the hospital were all terrorists," adding he was "happy that they were killed."¹¹

AN ENVIRONMENT OF INCREASING HARASSMENT AND INTERFERENCE

"We have seen the presence of armed men in medical facilities, turning them into targets. We have seen violations by the ANSF, damage done to health facilities that were taken over as bases to conceal themselves and fight [the insurgents] from. We have seen checkpoints located close to health centers. Why? So that, in case of hostilities, forces can take shelter in the concrete building. We have seen looting. We have seen the ANSF at checkpoints deliberately causing delays, especially in the south, including blocking patients desperately needing to get to a health facility. We can never be certain that [such a delay] was the cause of death, but we believe it has been."

—Head of a health agency

Attack on the Médecins Sans Frontières Kunduz Trauma Centre

Médecins Sans Frontières (MSF) began working in Kunduz in August 2011, when the Kunduz Trauma Centre (KTC) was first opened. The KTC was the only facility of its kind in northeastern Afghanistan. The center provided high-quality, free surgical care to victims of general trauma such as traffic accidents, as well as those presenting with conflict-related injuries such as from bomb blasts or gunshots. The hospital had 92 beds, which increased to 140 beds at the end of September 2015 to cope with the unprecedented number of admissions.

KTC was equipped with an emergency department, three operating theaters, and an intensive care unit, as well as x-ray, a pharmacy, and physiotherapy and laboratory facilities. The center employed a total of 460 staff. In 2014, more than 22,000 people received care at the hospital and in 2015 more than 3,000 surgeries were performed between January and August.¹²

MSF activities in Kunduz were based on a thorough process of negotiation to reach an agreement with all parties to the conflict to respect the neutrality of the medical facility. These agreements contained specific reference to the applicable sections of International Humanitarian Law, including: guaranteeing the right to treat all wounded and sick without discrimination; protection of patients and staff guaranteeing nonharassment while under medical care; immunity from prosecution for performing their medical duties for staff; respect for medical and patient confidentiality; and respect for a "no-weapon" policy within the hospital compound.¹³

These commitments were discussed and endorsed by the militaries involved in the conflict, including all international military forces such as the United States (both the regular and special forces branches), ISAF and later Resolute Support command structures, Afghan National Army, National Police, and National Security agencies, as well as the military command structures of armed opposition groups. The global positioning system coordinates of the hospital were furnished to US and Afghan authorities.

In the early hours of October 3, the MSF hospital in Kunduz came under aerial attack by US forces. Patients burned in their beds, medical staff were decapitated and lost limbs, and others were shot while fleeing the burning building by the circling AC-130 gunship. Fourteen MSF staff and 28 patients and caretakers were killed.

The MSF trauma center was fully functioning as a hospital with 119 patients admitted and surgeries ongoing at the time of the US airstrikes. The MSF rules in the hospital were implemented and respected, including the no-weapons policy. MSF was in full control of the hospital before and at the time of the airstrikes; there were no armed combatants within the hospital compound, and there was no fighting from or in the direct vicinity of the trauma center before the airstrikes. During the attack, MSF phoned and texted US and Afghan authorities more than a dozen times to seek its halt, to no avail.

US and Afghan officials made a series of inconsistent public statements in the immediate aftermath of the incident. On October 7, 2015, MSF launched a call for an independent investigation by the International Humanitarian Fact-Finding Commission. Although the commission has made itself available for an investigation, the US and Afghan governments did not respond to this investigation; their consent was needed to allow the investigation to continue. On April 29, 2016, the US military issued a redacted version of its internal investigation on the attack, which acknowledged that the hospital was a protected facility and that multiple human and procedural errors led to the attack. It disciplined 16 soldiers administratively but declined to seek criminal penalties against any of them.

CENTRAL AFRICAN REPUBLIC

The humanitarian crisis in Central African Republic (CAR) is the result of one of the world's most complex and protracted internal armed conflicts.¹⁴ CAR has experienced military coups, ethnoreligious rebellions, foreign intervention, spillover from conflicts in neighboring states, and internal strife resulting from pervasive poverty, disputes between pastoralists and farmers, banditry, and intercommunal criminal violence.

The current crisis began in 2012, when the Séléka coalition—a group formed when several rebel groups came together from CAR's Muslim minority¹⁵ and foreign groups¹⁶—took control of the northern and central regions of the country, burning houses, pillaging village institutions, and raping and killing civilians on their way to the country's capital in Bangui.¹⁷ In March 2013, the Séléka coalition captured Bangui, ousted President Francois Bozizé, and installed the Séléka leader, Michel Djotodia, as president. Djotodia suspended the constitution. The Anti-Balaka emerged in the middle of 2013 as local self-defense groups formed in the absence of any government protection for communities targeted by the Séléka.¹⁸ Since then, the influx of foreign fighters and shifting alliances have continued the conflict and victimized the civilian population, which has suffered large-scale displacement,¹⁹ widespread atrocities,²⁰ and little to no access to safe refuge or critically needed medical treatment.

The conflict forced many civilians to seek shelter in enclaves such as mosques, churches, and NGO hospitals. Most humanitarian organizations have left the country for security reasons.²¹ In December 2013, the UN Security Council authorized the deployment of an African Union peacekeeping force that was supported by the French military; the peacekeeping force was transformed into a UN peacekeeping mission in September 2014 (MINUSCA). In January 2014, under considerable international pressure, Djotodia stepped down and surrendered power to a transitional government. Elections for a new government were held in December 2015, February 2016, and March 2016. The violence nevertheless has continued and the country remains highly unstable. An outbreak of violence in Bangui on September 26, 2015, resulted in 90 deaths and displacement of more than 50,000 people, and was followed by waves of attacks against civilians and humanitarian organizations around the country.²²

As of February 2016, OCHA estimates that more than 430,000 people were displaced in CAR, and 470,000 people have sought refuge in neighboring countries.²³ More than 50% of the people remaining in CAR lack access to drinking water, hygiene, and sanitation, and are food insecure, and the level of chronic malnutrition among the country's children is the highest in the world.²⁴ At the end of 2015, while medical needs were immense, most health facilities were dysfunctional. Medical personnel who have been available are often ill-trained and supplies difficult to maintain. In the wake of the September violence, MSF medical teams ran hospitals and operated health facilities or mobile clinics in five sites for internally displaced persons but were unable to reach many people in urgent need of medical care because of threats of violence or blockades preventing access.²⁵ Demonstrations and clashes, along with roadblocks, impeded the passage of ambulances. As a consequence, many wounded people who needed to be transferred to Bangui General Hospital died while awaiting secondary medical care.²⁶ Outside the capital, transport of essential medical and food supplies often requires flights that are expensive and difficult, leaving many communities without critical resources.²⁷

Throughout the conflict, humanitarian agencies attempting to respond to health and other needs have been targeted and their compounds systematically looted of medical supplies,²⁸ including more than 200 attacks on compounds in 2015, which made access to health facilities dangerous for patients and health workers alike.²⁹ In March 2015, an MSF vehicle was attacked as it was returning from a visit to a health center; on April 1, an MSF compound was attacked and robbed of supplies, leading to reduction in some of its medical activities.³⁰

Many attacks occur on roads. In a single week, OCHA reported the following: On December 2, two staff members of a national humanitarian organization were held hostage by armed men in Bangui; on December 7, a cargo truck transporting humanitarian supplies, including food, to a school was stopped and raided by armed men; and armed men robbed international NGO staff members traveling on the road. One NGO temporarily suspended its activities in locations where many armed groups have been present.³¹ Attacks on food distribution trucks and convoys by armed groups are common,³² leaving a quarter of CAR's children with malnutrition and half the population unable to find and secure food.³³

Health centers have also been attacked. In 2013, the Séléka attacked the main hospital in Bangui and executed 10 patients; in 2014, the same group killed 19 civilians and three humanitarian workers at a village health center. In both instances the facilities suspended operations.³⁴ Attacks on health facilities, health workers, and vehicles continued in 2015 with the carjacking of a national blood bank vehicle by Anti-Balaka forces on February 27, and the abduction and killing of a nurse working in a village dispensary on March 15.³⁵

COLOMBIA

The Colombian conflict began in the mid-1960s and has involved the Colombian government; paramilitary groups; several groups that emerged after an official paramilitary demobilization process a decade ago; and guerrillas, including the Revolutionary Armed Forces of Colombia (FARC) and the National Liberation Army. Millions of people have been displaced by violence associated with the conflict.

Peace negotiations with guerrillas have been underway and, at the joint request of President Santos and FARC, the UN Security Council adopted a resolution to establish a political mission in Colombia after the signing of a final peace accord with FARC. The mission would last for a minimum of 12 months and would consist of unarmed international observers that would be part of a mechanism in charge of monitoring and verifying a bilateral ceasefire and cessation of hostilities.³⁶ The goal for reaching an agreement with FARC was March 23, 2016, but as of the writing of this report, one had not yet been reached.

Attacks on and interference with health services had been an ongoing feature of the conflict for many years. Although attacks on health care in Colombia have decreased, in April 2015, members of FARC reportedly attacked a Colombian Navy hospital boat that was travelling along the Putumayo River in the municipality of Leguizamo.³⁷

DEMOCRATIC REPUBLIC OF THE CONGO

Attacks on civilians and health care services by both armed groups and government forces have continued in the long-standing conflict in eastern Democratic Republic of the Congo.

On November 29, 2015, a group of approximately 40 attackers entered the North Kivu town of Eringeti and began killing and looting, including inside the Eringeti health clinic.³⁸ A regional official said he witnessed “seven patients and a nurse cut up by machete at the hospital.”³⁹ The International Committee of the Red Cross (ICRC) said the killings were committed in cold blood and that damage to the clinic has deprived an estimated 35,000 people of access to health care.⁴⁰ UN General Jean Baillaud said the attack was likely carried out by a Ugandan Islamist group, the Allied Democratic Forces, which is now based in northeastern Democratic Republic of the Congo.⁴¹ Local sources said the attack was a result of ongoing clashes between the Congolese army and UN forces against the Allied Democratic Forces.⁴²

In December 2015, two MSF staff were robbed and abducted in North Kivu Province. As a result, MSF temporarily suspended its operations in Mweso, which had included more than 185,000 outpatient visits and 6,000 hospitalizations in the prior ten months. MSF described the need to suspend operations as a catastrophe for the population.⁴³

There were several reports of denial of access to humanitarian services in North and South Kivu by armed groups.⁴⁴

IRAQ

Iraq has been engaged in armed conflict since the US invasion in 2003. The wars have had a disastrous effect on the country's health infrastructure and access to health care.⁴⁵

Parties to the conflict have carried out indiscriminate bombings, killings, abductions, looting, and expulsions.⁴⁶ From January 2014 to early 2016, 3.4 million people were forced to flee their homes.⁴⁷ At the end of 2015, 3 million people were living under the control of ISIL,⁴⁸ which has carried out mass executions, systematic rape, and torture.⁴⁹ It has enslaved women and girls, which has contributed to rising incidence of depression and suicides among them.⁵⁰

According to the WHO, in early 2015, 6.7 million people needed access to essential health services, and a year later the number rose to 8.5 million.⁵¹ In four of the most severely conflict-affected provinces—Anbar, Ninewa, Salah al-Din, and Kirkuk—14 hospitals and more than 160 other health facilities have been damaged or destroyed. In some areas more than 45% of health professionals have fled since 2014.⁵² Medicine and medical equipment deliveries have been irregular because of insecurity as well as electricity and fuel shortages, rupture of the cold chain, and the cut-off of supply routes by the Iraqi government to areas controlled by ISIL, including Mosul, Fallujah, and other parts of Anbar.

The health system is severely compromised, and crowded conditions and compromised water and sanitation have led to disease outbreaks, including cholera, in 2015.⁵³

The UN Special Representative on Children in Armed Conflict reported that from the beginning of 2014 through mid-2015 the UN received 61 reports of attacks on hospitals and their protected personnel. It received a total of 134 reports since 2011.⁵⁴ No breakdown by year or type of incident has been reported. Several airstrikes hitting hospitals occurred in 2015.⁵⁵ On August 13, 2015, Iraqi Security Forces reportedly hit a maternity and children's hospital in Nassaf village, south of Fallujah, killing 31 people—including at least eight children—and wounding 39 others.⁵⁶

Doctors have been targeted, especially by ISIL, for providing care to individuals who are considered enemies, for seeking to treat wounded civilians ahead of fighters under accepted principles of medical triage, and for refusing to go to an ISIL-controlled hospital and treat its fighters.⁵⁷ An unknown number of doctors have also been abducted by ISIL. In December 2014, ISIL executed four doctors in Mosul, two apparently for refusing to work in hospitals to treat ISIL fighters.⁵⁸ In January 2015, in Miqdadiya district (Diyala), an improvised explosive device targeted the house of a person known for providing medical services.⁵⁹ The same month, ISIL executed four doctors in Mosul, although the reasons are not known.⁶⁰ On April 7, 2015, the body of a doctor abducted from a hospital in Mosul on January 17 by ISIL was found with three bullet wounds to the chest.⁶¹ On March 16, 2015, ISIL executed another two doctors in the Ghabat area of northern Mosul for refusing to go to Tikrit to treat ISIL fighters.⁶²

ISIL has also taken over civilian hospitals for treating wounded fighters. At least seven hospitals in Salah al Din, Ninawa, and Kirkuk were used by ISIL and pro-government militias to treat their injured members,⁶³ and in some cases the groups vacated the hospitals of all other patients.⁶⁴ Other armed groups have engaged in the same practice. In November 2014, in the Miqdadiya district (Diyala), members of Asaeb al Haq, a Shia paramilitary group, forcibly vacated Al Miqdadiya General Hospital except for medical staff to treat the group's injured fighters.⁶⁵ In some cases, ISIL closed health facilities and forced doctors to go elsewhere to treat ISIL fighters. In March 2015 ISIL forcibly closed nine private clinics in Mosul while demanding that doctors go to public hospitals to treat ISIL fighters.⁶⁶

Hospitals also were taken over for military purposes and became scenes of fighting, with little effort to minimize harm to patients. On April 22, 2015, during fighting between ISIL and Iraqi security forces, Iraqi security forces were situated on the roof of one of Ramadi's two main hospitals while ISIL shelled it.⁶⁷ On November 12, 2015, a day-long gun battle between Shia Turkmen forces and Kurdish forces erupted around Tuz Khurmatu's general hospital, followed by the burning of dozens of shops and

homes and abductions on both sides.⁶⁸ After hospital staff treated a wounded fighter from the government-affiliated Popular Mobilization Forces (PMF) for gunshot wounds, they put him in an ambulance for additional treatment in Kirkuk. PMF forces, however, fired at the hospital, apparently believing he had been refused treatment. Meanwhile, forces of the Badr Brigades, also associated with PMF, that were several hundred meters away, fired at the ambulance. A nurse and driver came back to the hospital, but the patient died. Later, PMF forces entered the hospital to lead patients and staff out, but one current medical staff member, a Kurdish former hospital director, was killed.⁶⁹

On January 6, 2016, ISIL detonated some parts of Ramadi General Hospital before the arrival of the Iraqi security forces. According to reports, ISIL had evacuated the civilians, detaining them in areas outside the hospital before the arrival of Iraqi security forces.⁷⁰

"We cannot say no to any of these cases. [ISIL] threatens us with death if we refuse to treat its wounded."

**—Doctor at Mosul General Hospital, Iraq
via Al Monitor⁷¹**

LIBYA

Libya has experienced armed conflict since 2011, when armed groups rose up against Muammar Gaddafi, the longtime dictator. A breakdown in government and proliferation of armed groups, including the entry of ISIL in 2014, exacerbated the conflict.⁷² Two rival governments, one based in the cities of al-Bayda and Tobruk and the other in Tripoli, coexisted until the UN-brokered Government of National Accord entered Tripoli in March 2014. The city of Derna is controlled by the Derna Mujahideen Shura Council (DMSC), a militant alliance aligned with al-Qaeda. The DMSC ousted ISIL militants and pushed them to a surrounding mountainous region, but hostilities continue with ISIL frequently initiating attacks.⁷³

Since 2014, fighting and instability have affected more than 3 million people, nearly half the population of Libya. Almost 2.5 million people are in need of urgent humanitarian assistance, and 1.9 million people have serious unmet health needs.⁷⁴ More than 400,000 people have been displaced.⁷⁵

“Can we afford to wait for the political decision-making to materialize and then we embark on humanitarian response? Can a patient with insulin-dependent diabetes wait for a new prime minister to come and reform the health system so that she can receive insulin? Can we wait for that? Absolutely not. Because there may be people dying on a daily basis because they do not have access to lifesaving medicine and health care.”

–Dr. Syed Jaffar Hussain,
WHO Representative for Libya⁹²

“The health situation in Libya is rapidly deteriorating, with extensive displacement, damage, and closure of health facilities in conflict areas. Repeated rounds of violence have not allowed for a proper recovery of the health system, which even prior to the crisis was struggling to meet the basic needs of the Libyan population.”

–H.E. Dr. Reida Oakely, Libya’s Minister of Health⁹³

The health system in Libya has all but collapsed. Primary health care facilities have been closed because of armed clashes, insecurity, or the inability of staff to reach them.⁷⁶ Many health facilities were staffed by foreign workers, who left during the conflict. More than 80% of nursing staff were evacuated in 2014.⁷⁷ In the Tripoli Medical Center, the city’s main hospital, only 250 nurses remained of the 1,200 who had been working there in 2012.⁷⁸ Few specialists such as surgeons and obstetricians remain. Security constraints limit access to health facilities in Benghazi and other areas, thus putting pressure on facilities elsewhere.⁷⁹ In the east, warehouses storing medical supplies were destroyed in 2014 and transport of supplies in the west and south is fraught by danger from armed threats.⁸⁰ Clinics and hospitals in safer parts of Benghazi, Misrata, Tripoli, and Sabha have been overburdened with demands for care of displaced persons.⁸¹

In 2015, fighting resulted in the destruction and/or looting of remaining warehouses in both the east and west.⁸² Shortages of surgical and obstetric supplies and medicines for chronic diseases remain pervasive.⁸³

The conflict was marked by attacks on hospitals in 2014 and 2015, including the Tripoli Medical Center and the Al-Zahraa hospital.⁸⁴ Further attacks against ambulances marked with Red Crescent symbols took place.⁸⁵ By December 2015, 40% of health facilities were closed because they were in a conflict zone or lacked staff or electricity.⁸⁶ From June 2014 to December 2015, five health workers were killed and 20 were injured as a result of attacks.⁸⁷ The WHO maintained minimal coverage of mobile health teams and clinics, reaching only 250,000 people.⁸⁸ On March 16, 2015, approximately 30 ISIL fighters attacked Ibn Sina Hospital in Sirte and kidnapped 20 foreign health professionals working at the hospital. ISIL later released the health workers, ordering them to remain in the town.⁸⁹

In early 2016, the minister of health stated that the health situation continued to deteriorate because of extensive damage to and closure of health facilities.⁹⁰ At the same time, attacks on hospitals and health workers further escalated. On February 7, 2016, unidentified aircraft attacked the Al-Wahda Hospital compound in the Bab Tobruk area of Derna. Two bombs hit the kidney and internal medicine wards as well as the staff dormitory, causing extensive damage. The strikes killed a pharmacy staff member, Mastura Ali Mohamed al-Drissi, and her 10-year-old son, Mohamed Jomaa Abdelazziz al-Ghwari, who were both asleep in the staff residence.⁹¹

MALI

The humanitarian crisis in Mali dates to 2012, when a Tuareg separatist group, the National Movement for the Liberation of Azawad (MNLA), routed the Malian army from the north of the country (a region sometimes referred to as Azawad by the Tuareg people). The MNLA and several Islamist armed groups moved quickly to occupy the territory. The rebellion led to a 2012 coup by the Malian army, shifting coalitions of Islamist and separatist groups, a 2013 French-led intervention to restore the country's territorial integrity and civilian democracy, and the creation of the UN Multidimensional Stabilization Mission (MINUSMA).⁹⁴

The 2012-2013 armed conflict displaced hundreds of thousands of Malians. Although most have since returned home, nearly 140,000 Malians are still living in asylum countries, and more than 60,000 Malian citizens remain internally displaced.⁹⁵ During the conflict, all armed groups perpetrated human rights abuses against civilians such as indiscriminate and targeted killings, mutilation, rape and other forms of gender-based violence, and the use and recruitment of children for fighting.⁹⁶

Since the conflict began in 2012, health services have been seriously impaired by attacks on aid workers, transport convoys, civil servants, hospitals, and patients. Health services have also been impeded because many civil servants have fled and continued attacks and insecurity in the region have precluded the use of roads.

Despite ceasefires and a 2015 peace agreement intended to end the military and political crisis in the north, insecurity, rampant banditry, criminal activity, and clashes among armed groups persist and have spread into southern regions.

In 2015, armed groups continued to launch attacks on Malian soldiers, neutral peacekeepers, aid workers, and other civilians. Many civilians were also wounded or killed on major roads by landmines and improvised explosive devices. The ongoing violence continues to undermine the delivery of health services and humanitarian aid.

As of December 2015, at least 45 UN peacekeepers had been killed and 200 wounded from deliberate attacks since the start of MINUSMA in July 2013, making it one of the most dangerous UN peacekeeping missions on record.⁹⁷ Several Islamist groups have claimed responsibility for the majority of these attacks.⁹⁸ With continued attacks on UN personnel, government agencies, and aid groups, MINUSMA's mandate was extended through June 2016.⁹⁹

Government forces have continued to respond to the attacks with military operations that on several occasions have resulted in arbitrary arrests, executions, torture, and other mistreatment.¹⁰⁰

The Islamist groups turned their military efforts toward the south in 2015, targeting Malian civilians, civilian foreign nationals, humanitarian workers and their NGOs, and UN mission personnel.¹⁰¹ Fighters associated with the Macina Liberation Front, a Fulani Islamist armed group, attacked towns in the Mopti and Segou regions, targeting and executing civilians whom the group believed had worked for either government agencies or Malian/French forces.¹⁰²

During 2015, armed Islamist groups launched more than 30 attacks against the humanitarian NGO community.¹⁰³ In February 2015, members of the Movement for Unity and Jihad in West Africa (MUJAO), an Islamist group, kidnapped five ICRC aid workers, whom were later freed by the French military. Between November 2014 and April 2015, humanitarian vehicles were robbed, stolen, or burned in 13 separate attacks.¹⁰⁴

On March 30, 2015, an ICRC driver was killed and his colleague wounded when they were ambushed while driving a truck clearly marked with the Red Cross emblem on their way to Niger to collect critically needed medical equipment for Gao Hospital, the main medical facility in the north of the country. The armed men shot into the truck and then burned it.¹⁰⁵ MUJAO claimed responsibility.¹⁰⁶ After the attack, the ICRC and more than a dozen other humanitarian organizations temporarily relocated staff and suspended operations.¹⁰⁷

During May and June, despite a peace agreement between the government in Bamako and several armed groups in the north, including the MNLA, fighting in the northern and central regions of Mali increased the vulnerability of humanitarian operations in those regions.¹⁰⁸

From August through September 2015, security incidents—including attacks by rocket launchers and landmines that killed peacekeepers and humanitarian personnel—limited humanitarian access to the Mopti, Timbuktu, Kidal, and Gao regions of the country and discontinued access to health care.¹⁰⁹ In November, there were additional attacks on aid workers and peacekeepers. An attack on the Radisson Hotel in Bamako killed 19 people, and took more than 150 people hostage.¹¹⁰ The hostages were later rescued. In December, two unidentified armed men stole a United Nations Refugee Agency vehicle that had been borrowed by the humanitarian group Mercy Corps in Timbuktu.¹¹¹

MYANMAR

Fighting between armed groups has persisted for decades in Myanmar. In November 2015, the National League for Democracy, with an overwhelming majority, achieved victory in Myanmar's national election, beating the military-aligned Union Solidarity and Development Party in the polls.¹¹²

In December 2014, the government permitted MSF to resume its health program in Rakhine State after a ten-month ban so that it could serve the Muslim Rohingya population there.¹¹³

There has been a decline in recent months in reported incidents of attacks on health care in Myanmar, after three well-documented accounts in 2015. In February 2015, two volunteers from the Myanmar Red Cross Society were injured when their marked convoy was attacked on the road from Laukkai. The convoy was evacuating civilians displaced by fighting in the northern Shan state.¹¹⁴ Four days later a Myanmar Red Cross Society volunteer was injured in an attack on another Red Cross convoy traveling from Laukkai.¹¹⁵ During a political demonstration in March 2015, police officers dragged a sick protester out of an ambulance, beat him, and destroyed the ambulance.¹¹⁶ Physicians for Human Rights (PHR) reports the Myanmar government said that it will investigate the police's use of force in breaking up the protest.¹¹⁷

NIGERIA

Over the past six years, the government of Nigeria has been in conflict with the militant Islamist group Boko Haram in the northeastern part of the country.¹¹⁸ The insurgents have engaged in abductions, rapes, forced recruitment, and killings of the local population and abducted and threatened health workers, attacked health facilities, and disrupted medical supply delivery.¹¹⁹ The government declared a state of emergency, which has since expired in affected states. Since 2012, the government reports that Boko Haram is responsible for the destruction of 445 health facilities. In that time, four doctors have died in Yobe State and two in Maiduguri, Borno State, and 152 have been severely injured.¹²⁰

Most health facilities in the area have shut down due to the conflict, severely disrupting access to health services.¹²¹ Access is also hindered by the counter-insurgency response, including the banning of motorcycles and the interruption of mobile phone service.¹²² Many health workers have fled the region in fear for their lives.¹²³ The Nigerian government announced in March 2016 that it was making an effort to address the health worker shortages due to the presence of insurgents.¹²⁴

Although there were fewer attacks on health workers and facilities reported in 2015 than in previous years, assaults continue. In May 2015, a senior nurse with the Federal Medical Centre, Ido Ekiti, Margaret Aladeneka, was abducted by unknown attackers. Five days later the former chief medical director of Ekiti State University Teaching Hospital and his wife were also kidnapped.¹²⁵ The chairman of the Nigerian Medical Association in Ekiti State, Dr. John Akinbote, reported that seven doctors in Ado-Ekiti received threats from kidnappers.¹²⁶ According to MSF, as a result of destruction in prior years, none of the hospitals outside of Maiduguri and Biu in Borno State were functioning in July 2015, as many of them were destroyed with bombs and those that weren't destroyed were looted.¹²⁷

Health workers are vulnerable to violence and extortion from individuals not necessarily affiliated or suspected of affiliation with Boko Haram and in parts of the country where the group does not operate. In February 2016, health workers fled towns in the Delta State, as their health facilities were forced to shut down following the more-than-two-week siege on the riverine communities by soldiers hunting for pipeline bombers.¹²⁸ In February 2016, an armed policeman shot a doctor during a peaceful protest by members of the Nigerian Medical Association in Owerri, Imo State. The president of the Nigeria Labour Congress, Ayuba Wabba, alleged it wasn't uncommon for health workers to be the victims of these sorts of assaults.¹²⁹ In March 2016, four health workers administering polio vaccines in Gazamari village in Kaduna State were kidnapped.¹³⁰ A resident said the kidnappers demanded 10 million naira (about \$50,000) for the release of the local government area polio facilitator, and 2 million naira (about \$10,000) for the release of other two health workers and a field volunteer.¹³¹

OCCUPIED PALESTINIAN TERRITORIES

In September 2015, acts of violence between Palestinians and Israelis escalated, with individual Palestinians committing multiple attacks that killed Israelis, and Israeli security forces killing Palestinians. The UN Office for the Coordination of Humanitarian Affairs reported that, in 2015, 170 Palestinians and 26 Israelis were killed and 15,377 Palestinians and 370 Israelis were injured.¹³² In addition to the violence and increasing tension in the Occupied Palestinian Territories and East Jerusalem, Israeli security forces have obstructed and attacked Palestinian ambulances and medical teams and interfered with patient care.

Between October 2015 and January 2016, the Palestine Red Crescent Society (PRCS) reported 335 attacks on its teams and ambulances by Israel Defense Forces and settlers. It further reported that 147 paramedics and volunteers were wounded, 94 ambulances were damaged, and that there were 94 instances where its ambulances were denied access.¹³³ Physicians for Human Rights – Israel (PHR-I) investigated and documented 28 cases of attacks on medical teams and inhibition of medical work during October-December 2015, 14 of which were attacks on PRCS teams.

On October 10, 2015, in Al-Bireh near Jerusalem, an ambulance from PCRS attempted to aid a wounded individual at a protest. As the ambulance drove toward the wounded person, border police fired bullets at the vehicle. A border policeman then pointed his gun at the ambulance driver and ordered him to stop. An ambulance crew-volunteer tried to explain that there was a wounded man in need of medical treatment, but the border policeman responded by kicking the volunteer. The police then forcibly removed the injured man from the care of the medical workers and arrested him. The policeman also fired into the air and threw stun grenades at the ambulance. After the incident, the volunteer-driver was treated in a hospital in the West Bank.

Violent incidents include shots fired at medical teams in the field, physical attacks on ambulance teams, physical attacks on the injured during the provision of care, and shots fired at ambulances.

PHR-I documented eight raids on Palestinian hospitals and collected hospital staff and patient testimony. The apparent purpose of the raids was either to make an arrest or collect medical files and patient information. PHR-I's findings suggest that Israeli security forces interfered with patient care and medical teams' work during the raids.¹³⁴ Staff and patients reported incidents lasting up to an hour and 45 minutes. Further, the prolonged presence of security forces delayed the provision of care. For example, after breaking into al-Makassed Hospital in East Jerusalem on October 28, 2015, Israeli security forces prevented medical staff from accessing a pediatric ward housing 28 children for approximately 30 minutes. During the same raid, security forces withheld access to the alert room where emergency alerts are received.

PHR-I's investigations also indicate that some of the hospital entries involved excessive force against medical teams, hospital staff, and wounded persons. In particular, staff and patients reported assaults by Israeli security forces even though they did not mount any resistance.¹³⁵ During one incident in a Nablus hospital, security forces struck the head nurse as well as patient Karam Razek. In the above-mentioned raid into al-Makassed hospital, while PHR-I personnel were present, tear gas, rubber bullets, and stun grenades were fired into the hospital square as nonviolent protesters were on site speaking out against the raids.

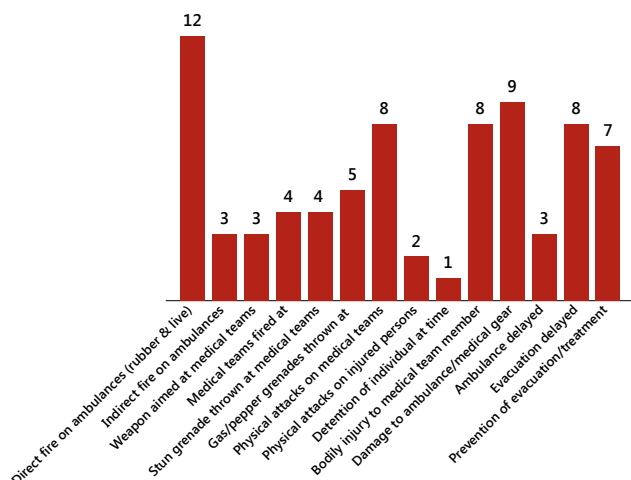
In October 2015, Israeli security forces introduced barriers throughout East Jerusalem, especially at entrances to Palestinian neighborhoods, many of which functioned as new checkpoints. According to the WHO, 29 cement barriers were erected in eight East Jerusalem neighborhoods, three of them at hospital entrances. The new barriers affected the movement of 150,000 people, creating severe traffic jams and limiting access to medical care and disrupting access to six hospitals, and particularly affecting dialysis and cancer patients.¹³⁶ Most of the hospital barricades remained until December 2015.

According to information collected by PHR-I, Israeli security forces installed 14 military checkpoints. Between October and December 2015, according to the Palestine Red Crescent Society/Jerusalem, it took between 30 and 60 minutes longer to evacuate patients from the field.¹³⁷ These delays occurred because ambulances are prohibited from overtaking other vehicles at a checkpoint prior to receiving authorization.¹³⁸ After authorization is received,

security forces conduct a search, adding minutes more to an already lengthened journey. Such delays severely inhibit these teams from providing medical treatment.

Furthermore, restrictions on the freedom of movement of East Jerusalem Palestinians impairs their ability to access health care and takes a heavy toll on the work of medical teams.

Figure 1. 28 Attacks on Medical Teams in the West Bank, October–December 2015



Note: the total sum exceeds 28 because multiple acts took place during many incidents.

Figure 2. Sites of Attacks on Medical Teams

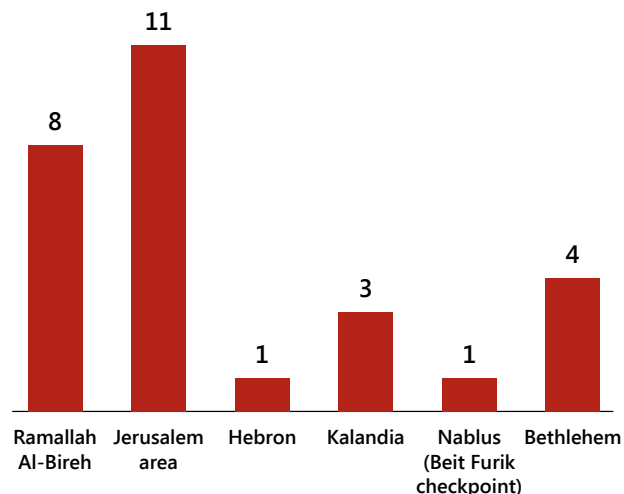


Figure 3. Perpetrators of Attacks

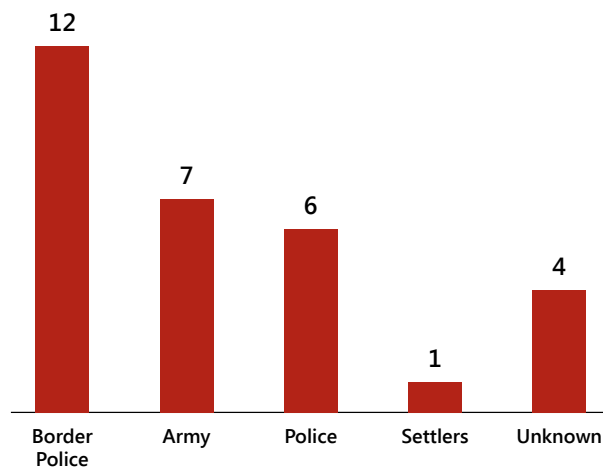
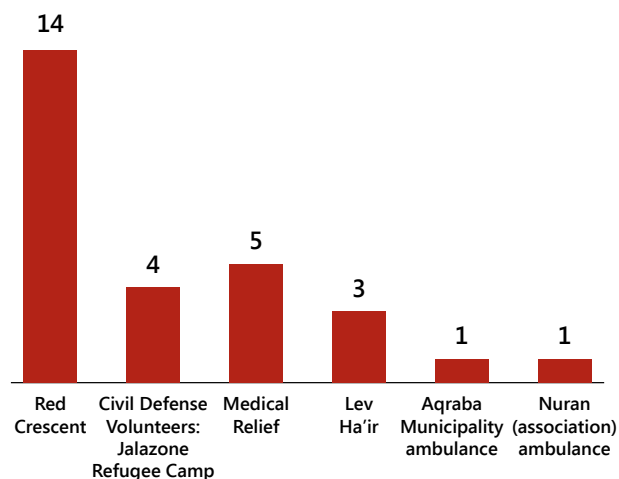


Figure 4. Affected Medical Organization



Source: Physicians for Human Rights – Israel

INTERFERENCE WITH MEDICAL ETHICS IN NATIONAL SECURITY DETENTION

In situations of conflict, interference with ethically appropriate medical care is often violent. But interference can take other forms as well, including government demands that health professionals forgo adherence to their ethical obligations to individuals detained during the conflict. One such example is the coercion of physicians and nurses to help break hunger strikes, which are forms of political protest. While hunger strikes take place in detention settings, the stakes are particularly high when national security concerns are invoked. Individuals in such cases are often imprisoned indefinitely, without due process or judicial review. Hunger strikes are often the only recourse to protest such detention, yet some governments have responded by ordering medical professionals to force-feed detainees.

The international medical and nursing communities consider force-feeding to be unethical, and the World Medical Association has found it to be a form of inhuman and degrading treatment.¹⁵¹ Under internationally agreed ethical standards, doctors and nurses must counsel hunger strikers on the health consequences of refusing food and provide appropriate medical care for them, including respecting the autonomous decisions of competent individuals. In recent years, numerous medical and nursing groups have opposed the force-feeding of national security detainees as a violation of clinician independence and patient rights, including the World Medical Association, the International Council of Nurses,¹⁵² the Israel Medical Association,¹⁵³ the American Medical Association, and the American Nurses Association.

In Israel, a new law authorizes a district court to order force-feeding or forced medical care of a detainee on a hunger strike. Several Palestinians held under administrative detention orders for alleged connections to terrorist activities have launched lengthy hunger strikes; the Israeli medical community has stood up to the law. In the case of Mohammad Allan, who was detained for alleged affiliation with Islamic Jihad (he was not charged with a crime), doctors consistently refused to administer force-feeding on ethical grounds. When Allan came dangerously close to death or risk of permanent injury, authorities struck a release deal with him that ended the strike.

Mohammad Al-Qeeq, a Palestinian journalist alleged to have been engaged in terrorist activities linked to Hamas, went on a 95-day hunger strike. Doctors were pressured to force-treat him by a hospital's medical ethics committee, which appears to have been pressured by Israel's security authorities. Although doctors at first agreed to comply with the committee's force-treatment orders, the doctors later refused.¹⁵⁴

In the United States, the military maintains a policy of force-feeding Guantánamo Bay detainees on hunger strike who protest their prolonged, arbitrary, and unlawful detention. In 2014, a Navy nurse became the first known medical officer to refuse to participate in force-feeding at Guantánamo and was threatened with disciplinary action and discharge. In 2015, the Department of Defense initiated proceedings to revoke the nurse's security clearance, even though the Navy cleared him of misconduct and the American Nurses Association honored him for his commitment to ethics.¹⁵⁵

"Feeding induced by threats, coercion, force, or use of physical restraints of individuals who have opted for the extreme recourse of a hunger strike to protest against their detention, are, even if intended for their benefit, tantamount to cruel, inhuman, and degrading treatment."¹⁵⁶

–Juan Méndez, UN Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment

The World Medical Association, addressing the Prime Minister of Israel, stated the following: "Force-feeding is violent, very painful, and absolutely in opposition to the principle of individual autonomy. It is a degrading, inhumane treatment, amounting to torture. But worse, it can be dangerous and is the most unsuitable approach to save lives."¹⁵⁷

–Dr. Xavier Deau, WMA President and Dr. Ardis Hoven, WMA Chair

The American Nurses Association presented its first-ever Year of Ethics Award to the US Navy nurse who refused to force feed prison detainees at Guantanamo Bay Detention Camp. It stated the following:

"The registered nurse's first duty is to the patient, regardless of the setting of care or the employment situation."

–Pamela Cipriano, ANA president¹⁵⁸

PAKISTAN

Pakistan is one of two remaining countries where polio is endemic.¹³⁹ The disease is concentrated in the insecure Federally Administered Tribal Areas,¹⁴⁰ where Pakistani armed groups affiliated with the Taliban are in conflict with government forces. Nevertheless, progress has been made in reducing the incidence of polio, and the number of new polio cases fell to 54 in 2015, an 80% decrease from 2014.¹⁴¹

In 2015, OCHA reported 37 incidents of threats against or attacks on polio vaccination teams: 11 people were killed, including four police escorts, and five were injured. In 2014, there were 79 attacks on and threats against vaccination teams, resulting in 45 deaths (21 polio workers) and 18 people wounded (five polio workers).¹⁴² One factor in the relative decline of attacks and deaths was the government's more intensive police protection for vaccination teams after having been criticized for exposing vaccinators to great danger without sufficient security. A vaccination drive in Karachi in December 2015 was postponed due to the unavailability of security officers to protect the vaccination teams.

On January 13, 2016, a suicide bombing at a polio vaccination center in Quetta, the capital of Balochistan Province, killed 15 members of Pakistan's security forces and wounded 23 other people as they gathered for a planned three-day vaccination campaign.¹⁴³ Two militant groups, Tehreek-e-Taliban and Jundullah, or Army of God, claimed responsibility.¹⁴⁴

The January attack came just ahead of a three-day nationwide vaccination drive. Aiming to eliminate the virus this year, 100,000 health workers fanned out across the country in teams to vaccinate every child.¹⁴⁵ On February 17, two gunmen on a motorcycle shot and injured a polio worker in Lahore, where approximately 4,000 vaccinators were dispatched along with police officers for security. The polio worker was treated for a bullet wound to the leg.¹⁴⁶

Aside from attacks on vaccinators, Pakistan has a history of attacks on physicians by armed groups and criminals. Reports going back more than two decades indicate a steady increase in physician deaths throughout the country, with a large spike in such incidents in recent years, including at least 11 killed in 2014.¹⁴⁷ According to the Pakistan Medical Association, in the city of Quetta, at least 16 doctors were killed and another 27 were abducted from 2012 through 2014; in Karachi, at least 47 doctors were killed from 2010 through 2015.¹⁴⁸ In poverty-stricken tribal areas of the northwest, physicians have been kidnapped for ransom, seized and forced to provide medical treatment to members of radical groups, and targeted for killing as part of armed groups' efforts to intimidate the wider population.¹⁴⁹ Not all attacks, however, are conflict-related. An in-depth study in Karachi revealed that a third of respondents have experienced some physical or verbal violence and another third have witnessed violent incidents.¹⁵⁰

SOMALIA

Somalia has been in conflict for nearly three decades. The civil war began as resistance to the Siad Barre regime during the 1980s. By 1991, armed opposition groups overthrew the Barre government. In the years that followed, armed factions competed for influence in the power vacuum and turmoil, particularly in the south. Since 2006, the Islamist armed group Al-Shabaab has been in conflict with the central government.

In January 2007, the UN Security Council created the African Union Mission in Somalia (AMISOM), a peace support operation for Somalia's institutions, which has been fighting Al-Shabaab alongside the Somalia National Army. In October 2011, Kenyan troops entered southern Somalia to fight al-Shabaab and to establish a buffer zone inside Somalia.¹⁵⁹ A year later, Kenyan troops were formally integrated into a multinational force.¹⁶⁰ Ethiopia, long involved in Somalia, is also part of the multinational force. In 2012, the Federal Government of Somalia was established, constituting the first permanent central government in the country since the start of the civil war.¹⁶¹ But Somalia remains an unstable, conflict-affected fragile state.

Although numbers are uncertain, an estimated 350,000 to 1,000,000 Somalis have died in the conflict since 1991.¹⁶² A decades-long humanitarian crisis continues, exacerbated by flooding, drought, and an influx of refugees from Yemen. At the start of 2016, 1.1 million people were internally displaced and about 4.7 million people—40% of the population—were in need of humanitarian assistance.¹⁶³ One in eight children under the age of five are suffering from acute malnutrition and more than 50,000 of them are severely malnourished and at risk of death.¹⁶⁴ Health conditions in Somalia remain severely compromised, with some 3.2 million people in need of improved access to emergency health services.¹⁶⁵

During the conflict, Al-Shabaab has engaged in repeated attacks on health facilities and health workers. In 2013, MSF left Somalia after threats against, abductions of, and the killing of 16 of its staff and the failure of the parties with whom it negotiated access to abide their agreements on security.¹⁶⁶ Other humanitarian groups remained, but in 2015, according to the WHO Regional Director for the Eastern Mediterranean, Dr. Ala Alwan, attacks on health workers and facilities have forced the suspension of medical activities and have delayed critical health and nutrition programs.¹⁶⁷ In recent years, vaccination programs have been disrupted by abductions. In April 2015, an attack on a UN vehicle in Garowe, Puntland, Somalia, killed seven people, two of them polio workers with the Global Polio Eradication Initiative that brought polio vaccines and routine immunizations to the area.¹⁶⁸ In December 2015, in Tubako area, members of Al-Shabaab abducted a driver and three national staff of a vaccination program during a vaccination campaign in the rural areas of Gedo Region. They were freed after intervention by local elders.¹⁶⁹ A Somali media outlet reported that on December 30, 2015, two health workers were abducted in central Somalia, and released after the intervention of local elders, though the ambulance that they were traveling in at the time of abduction was not returned.¹⁷⁰ Another local media source reported that on December 31, 2015, in Dhusamareb in the Galgadud region, a gunman linked to al-Shabaab abducted two health workers.¹⁷¹

SOUTH SUDAN

South Sudan achieved independence from Sudan in 2011, but in December 2013, fighting broke out between forces loyal to President Salva Kiir, the Sudan People's Liberation Army (SPLA), and those loyal to Vice President Riek Machar,¹⁷² the SPLA in Opposition (IO). During more than two years of fighting, both sides have enlisted ad hoc groups and militias, organized largely along ethnic lines,¹⁷³ in the conduct of hostilities.¹⁷⁴ By the beginning of 2016, nearly 800,000 people had fled, seeking refuge in neighboring countries, 263,000 individuals had moved to UN Mission in South Sudan (UNMISS) Protection of Civilians (POC) sites for protection, and nearly 1.7 million persons had been displaced within the country.¹⁷⁵ Many of those displaced are not in formal camps but in isolated areas of the bush with little to no access to food or medical care.¹⁷⁶ The UN has estimated that at least 50,000 people have died in the conflict,¹⁷⁷ though observers think it could be substantially greater. Nearly 4 million people are now at serious risk of starvation.¹⁷⁸

Attacks on civilians and civilian institutions, including health facilities, have been a central part of each side's conduct in the conflict. The African Union Commission of Inquiry on South Sudan, which was established to investigate alleged human rights abuses, and UNMISS human rights division reports documented indiscriminate killings, torture, sexual abuse, rape, and other gender-based crimes, abductions and disappearances, the forcible conscription of children, the deliberate burning of people alive while they were imprisoned in their homes.¹⁷⁹ In December 2015, OHCHR and UNMISS released a comprehensive reporting detailing abuses since 2013, stating that the parties' actions "revealed a shocking disregard for civilian life."¹⁸⁰

The parties have repeatedly obstructed civilian access to medical facilities, stolen medical supplies, attacked and burned clinics, abducted health and other aid workers, intercepted lifesaving treatment kits intended for displaced persons hiding deep in the swamplands, and attacked people seeking shelter and treatment in clinics and hospitals.¹⁸¹ OCHA reported that at least 52 humanitarian workers, and likely many more, were killed from December 2013 through the first quarter of 2016.¹⁸² By the end of September 2015, 55% of the health facilities in the Greater Upper Nile region were no longer functioning and in Unity State, only a single state hospital remained standing to serve more than 1 million people.¹⁸³ The delivery of humanitarian medical assistance has also been hampered

as key hospitals have been rendered nonfunctional due to their proximity to fighting or their abandonment after the evacuation of local health agency and international NGO medical staff.¹⁸⁴ According to a spokesperson for the UN Food and Agricultural Organization in South Sudan, as a result of forced displacements and population movements to remote areas of Unity State, the only option for the physical delivery of aid in some places has been by helicopter, but aid drops have been frequently lost in the water or seized by soldiers before civilians could reach the lifesaving aid.¹⁸⁵

In April 2015, SPLA forces¹⁸⁶ sought to reassert authority over opposition-controlled territory in the three states of the Greater Upper Nile region, especially Unity State, in part by attacking and forcing the civilian population out of all opposition-controlled areas.¹⁸⁷ SPLA forces razed villages; destroyed crops; raided livestock; looted humanitarian agencies, health clinics, and hospitals; and destroyed medicine, food, and seed stocks—depriving people of their livelihoods and basic health services,¹⁸⁸ and forcing people into hiding in swamplands or remaining on the move.¹⁸⁹

From May through June, 2015, health programs in the Greater Upper Nile region as well as other areas suffered intense attacks and extensive disruptions of essential primary and secondary health services.¹⁹⁰ Vaccination, malnutrition screening and antenatal care programs were disrupted; surgery and referral services as well as programs for HIV, tuberculosis, and mental health were limited or nonexistent.¹⁹¹ In some places, there were no remaining stocks of essential medicines.¹⁹² In April 2015, three World Food Program (WFP) staff members were abducted in Upper Nile State and never found, leading to a temporary suspension of operations in the counties surrounding the incident.¹⁹³ In May, MSF evacuated its staff from its Leer County compound in Unity State, and the ICRC and other aid agencies followed. Two months later, two MSF staff members who had returned to the agency's Leer compound were killed in separate attacks.¹⁹⁴ Soon after ICRC staff members returned to the ICRC compound in Leer, they were forced to withdraw after dozens of armed men entered the compound, threatened ten ICRC workers, and stole two of the agency's vehicles and filled them with equipment, medical supplies, and money.¹⁹⁵ In June 2015, a health mission delivering medical supplies to a primary health care unit in Tonj South County, Warrap State, was ambushed, resulting in the death of the driver and severe

injuries to three humanitarian workers,¹⁹⁶ leading to relocation that reduced the delivery of health services in the area.¹⁹⁷

In Unity State, starting in May 2015 and continuing through September, staff members from at least six humanitarian agencies were killed and nearly every humanitarian compound in the three conflict-affected counties was looted and destroyed.¹⁹⁸ The South Sudan Protection Cluster estimated that during the period from the spring of 2015, more than 300,000 people were prevented from accessing humanitarian assistance in Unity State alone.¹⁹⁹ In Upper Nile State, humanitarian aid workers were evacuated when intense fighting moved close to the Melut POC compound. Due to the lack of critical resources, a significant portion of the Melut POC camp's population could not access needed medical assistance or food aid and left Melut for other POC compounds.²⁰⁰ At the same time, extensive violence in the Greater Upper Nile states caused a dramatic influx of civilians into the POC compounds in those states, leading to many facilities stretched far beyond their planned capacities with insufficient resources for the internally displaced population.²⁰¹ The combatants' use of landmines and other explosive ordnance has also impeded aid delivery and health care.²⁰²

At the same time, during the spring and summer of 2015, the SPLA imposed restrictions on the movement of UNMISS and other aid agencies.²⁰³ Civilians sought help in the Malakal POC, which became overcrowded, and brought risks of water contamination and dysentery, diarrhea, hepatitis E, and cholera.²⁰⁴ Insecurity, poor roads, and bureaucratic obstacles limited humanitarian access. After a brief return in August, humanitarian agencies withdrew from southern and central Unity State because of insecurity.²⁰⁵ According to MSF, the Malakal Hospital quickly filled beyond capacity with children suffering from "life-threatening cases of pneumonia, malaria, and other illnesses,"²⁰⁶ but it lacked critical medicines and medical supplies due to looting and thefts. At the time, South Sudan was experiencing an "unprecedented malaria outbreak, with nearly 2.28 million cases,"²⁰⁷ that was taking a harsh toll on children under 5, who accounted for nearly one-third of reported cases and 75% of the deaths.²⁰⁸ The SPLA also restricted access to the town of Wau Shilluk, near Malakal, until early August.²⁰⁹

Criminal violence was also inflicted against NGOs. From July through September, there were 49 NGO compound robberies in the capital city of Juba alone, and the combination of crime and political violence resulted in the deaths of nine humanitarian workers.²¹⁰

In July, in Upper Nile State, fighting forced the ICRC to evacuate staff after an attack on the Kodok Hospital, which provided medical services including advanced surgeries²¹¹ to a population of 40,000.²¹² Two people died, 11 people were injured, and the hospital sustained significant damage.²¹³ A few days later, without the expertise of the surgical team, 11 patients died.²¹⁴ On February 17 and 18, 2016, at the Malakal POC compound, clinics were looted and burned, along with shelters, nutrition centers, and schools, by armed men wearing SPLA uniforms. At least 25 people, including at least three aid workers, were killed and more than 120 were wounded.²¹⁵ On February 21, violence and looting forced MSF health workers and civilians to move its health care facility in Pibor, where it had been providing laboratory services, inpatient care, and lifesaving blood transfusions to the UNMISS base.²¹⁶ As a result, 170,000 people lost access to secondary healthcare.²¹⁷

Apart from deaths from lack of access to emergency health care, the cumulative result of the attacks and displacement has led to the spread of communicable diseases due to poor sanitation, lack of access to safe water, and overcrowded living conditions in POC camps and in other places where IDPs were hiding. According to the ICRC, in Unity State tens of thousands of people are "hiding in swamps, surviving on water lilies and fruit,"²¹⁸ forced to drink unsafe water, with no access to clinics for the treatment of malnutrition from cholera, acute watery diarrhea, and other waterborne illnesses. Young children and pregnant women are particularly vulnerable to these illnesses.

While preventive care and vaccination campaigns have been in place and working in most POC sites, care to address water-borne diseases, malaria, measles, and polio is urgently needed.²¹⁹ Only six of South Sudan's 79 counties have had the requisite minimum 80% measles vaccination coverage; an estimated 400,000 children in the Greater Upper Nile region under age 5 remain at risk of contracting the disease.²²⁰

SUDAN

Renewed conflict and internal displacement has resulted in acute humanitarian needs in the Darfur region and in the South Kordofan and Blue Nile states. More than 300,000 people have died in Darfur since the conflict began in 2003. In December 2015, there were 3.2 million displaced persons in the country, nearly 2.7 million of them in Darfur.²²¹

During the course of the conflict, the Sudanese government has restricted civilian access to humanitarian assistance, including health services, and periodically expelled humanitarian aid groups as well as UN human rights monitors. Civilians displaced by violence have often fled to areas where there is no humanitarian access. Without food, water, shelter, or medical care, they are at risk of death from dehydration, starvation, illness, or exposure.²²² Attacks on peacekeepers who protect civilians have made access to humanitarian assistance and medical care even more difficult.

Government forces, including its Rapid Support Forces (RSF), have carried out atrocities against civilians including killings, mass rapes, destruction of wells, and plunder of goods and means of livelihood. The overall climate of fear created by attacks on civilians has in some cases led people to distrust medical facilities. In late 2014, after mass rapes in the town of Tabit, in North Darfur, many women and girls shunned what little medical care was available. Victims expressed fear of visiting medical clinics and hospitals, some believing that doctors would report their abuse to authorities and suffer reprisals, including further sexual assault or arrest. Local authorities in some instances have refused to help victims of rape access medical help. Traditional leaders and doctors expressed fear that helping women at risk would jeopardize their own safety.²²³

Sudanese military forces have attacked hospitals. Since 2011, they have bombed 26 health facilities in South Kordofan State, leaving only two hospitals operating to serve a population of more than one million people.²²⁴ Government attacks continued in 2015, and a new offensive began in Jebel Marra, Darfur, in January 2016. In January 2015, military forces destroyed a health center in Golo vicinity, in Central Darfur.²²⁵ Hospitals also became the site of atrocities. In late January 2015, RSF forces attacked the town of Golo, engaging in looting, raping, and executions. Military and civilian authorities told civilians to remain in the town's hospital for safety. Many people obeyed, but the hospital instead became a de facto detention center where people were held for weeks and the soldiers raped more than 60 women.²²⁶

The government's restrictions on aid and attacks on civilians have had severe health consequences, including in South Kordofan. People hiding in mountains, caves, and enclaves suffer from respiratory infections, skin diseases, eye infections, and diarrhea.²²⁷ Immunizations for children have decreased.²²⁸ The UN has reported abnormally high numbers of measles and dengue fever cases since the most recent uptick in violence in the country.²²⁹

SYRIA

The Syrian crisis is the worst humanitarian disaster of our time. Fighting over the past five years has killed an estimated 400,000 people, according to the Syrian Center for Policy Research,²³⁰ displaced over half of the country's 22 million people, and left 13.5 million people in need of humanitarian assistance.²³¹ More than 4 million Syrians have fled to neighboring Jordan, Lebanon, and Turkey, and in 2015 hundreds of thousands of people chose to risk their lives at sea in the hope of reaching safety in Europe. Millions of Syrians remain in their country, their lives at stake every day, with little hope for an end to the violence. According to OCHA, 11.5 million Syrians require health care, 12.1 million need water and sanitation, and almost 2.5 million are food insecure.²³² Siege Watch has estimated that over 1 million people are living under siege in Syria.²³³

The conflict, which began with peaceful protests for human rights and democracy in 2011, has spiraled into a brutal conflagration involving numerous parties. The Syrian government and allied Hezbollah and Iranian militias on the ground were for a period in late 2015 and early 2016 backed by Russian air support in their fight against hundreds of opposition groups and ISIL, which the US-led international coalition is also targeting with airstrikes.

While many parties in the conflict have carried out attacks on health care facilities and personnel, reporting by numerous NGOs and UN bodies indicates that the Syrian government and its allies are responsible for the vast majority of attacks on medical facilities and ambulances, killings of medical personnel, and obstruction of medical aid. According to the Independent International Commission of Inquiry on the Syrian Arab Republic, established by the Human Rights Council to investigate violations of human rights law in Syria since March 2011, the targeting of hospitals, medical personnel, and transport and the denial of access to medical care remain an "ingrained feature" of the Syrian conflict.²³⁴ The WHO reported that, as of December 2015, only 43% of Syria's public hospitals were fully functioning, while 31% were partially functioning, and 26% were nonfunctioning.²³⁵

According to data collected and verified by PHR, 2015 was the worst year on record for attacks on medical facilities in Syria, with 122 attacks documented on 93 facilities (PHR has documented more than 350 attacks from 2011 to February 2016).²³⁶ This represents a 37% increase from the previous high of 89 attacks in 2012.²³⁷ Syrian government and Russian forces were responsible for more than 95% of these assaults, with all but three of their 116 attacks via

On November 28, 2015, Médecins Sans Frontières reported a double-tap strike on a facility it supports in the besieged town of Zafranah in Homs governorate. Around 9:40 a.m., a barrel bomb was dropped from a helicopter on a populated part of the town, killing a man and a young girl and wounding 16 others. Shortly afterward, a barrel bomb was dropped next to the town's hospital, damaging the dialysis unit. Approximately 40 minutes later, when wounded people from the first attack had been transferred to the hospital and were receiving treatment, two additional barrel bombs were dropped at the entrance to the hospital. One bystander was killed and 31 patients and staff were injured in the second attack, which also partially destroyed the hospital.²⁵⁵

"When I am in the hospital, I feel like I am sitting on a bomb. It is only a matter of time until it explodes. It is wrong—a hospital should not be the most dangerous place."

—Dr. Tennari, director of the hospital in Sarmin, which was damaged by Russian airstrikes on October 20, 2015

"You must be safe to save others...If you kill the physician or destroy the hospital, the medicine doesn't benefit any people."

—Dr. D., a urologist working in a trauma hospital in Aleppo

airstrikes. Thirty-seven attacks were with indiscriminate barrel bombs—barrels filled with shrapnel, nails, and explosives that are dropped from helicopters and break into thousands of pieces upon impact, devastating anything and anyone in their enormous blast radius.²³⁸ MSF reported 94 aerial or shelling attacks on 63 MSF-supported facilities in opposition-controlled areas in 2015, 12 of which were completely destroyed.²³⁹

MSF noted a significant increase in casualties from aerial attacks starting in October 2015, including a sharp increase in “mass casualty events,” or events with ten or more wounded.²⁴⁰ PHR similarly reported an increase in attacks on medical facilities that month, immediately after Russia became militarily involved in Syria on September 30. PHR documented 16 such attacks in October—the highest monthly tally since the start of the conflict—of which at least ten attacks were by Russian forces.²⁴¹ One attack occurred on October 20 in Sarmin, in the Idlib countryside. According to the Syrian American Medical Society (SAMS), at about 1 p.m. a Russian warplane launched an air-to-surface missile on the town’s hospital. Ten minutes later, after medical personnel and civil defense had rushed to the scene to rescue the wounded and provide first aid, Russian forces launched a second attack. The strike killed a physiotherapist, a hospital guard, and ten other civilians, injured dozens more, and severely damaged the hospital.²⁴² This attack follows the pattern of double-tap strikes that the Syrian government has employed throughout the conflict to target rescue and medical workers.

PHR documented the killings of 107 Syrian medical personnel in 2015 (and more than 725 killed between 2011 and February 2016). This represents a more than 40% decrease in health worker deaths from the levels documented in each of the three prior years. In 2015, 72% of health worker deaths were from bombings and shellings, 11% were from shooting, 11% from torture, and 5% from execution.²⁴³ The decrease could be due to the precipitous drop in the number of health workers remaining in Syria and the local development of techniques to better protect health facilities and personnel during attacks, such as deploying early warning systems and fortifying health facilities or moving them underground. The Syrian government and allied forces were responsible for 83 deaths, ISIL for nine, opposition groups for six, Kurdish forces for one, and unknown forces for eight. This marks an increase in attacks on health workers by opposition groups and ISIL, which, in the four years prior to 2015, were responsible for a total of four and five deaths of health workers, respectively.²⁴⁴ In addition to those killed, many more Syrian medical personnel are injured in attacks. MSF reported that 81 of its staff members were wounded or killed in attacks in 2015.²⁴⁵ Faced with these relentless assaults on their lives, half of Syria’s health professionals have fled the country, according to the WHO.²⁴⁶

The killing and wounding of Syria’s remaining health workers further reduces the capacity of Syria’s critically understaffed health care system at a time when these services are most needed. For example, SAMS reported that Dr. Mohamad Taha Allamadani died in an airstrike on a primary health care center in the besieged area of Eastern Ghouta, east of Damascus, on November 19, 2015. He was the only forensic doctor left serving a population of more than 400,000.²⁴⁷ In the northern city of Aleppo, PHR reported that only 5% of the pre-war physician population remains, leaving Aleppo’s 300,000 residents vastly underserved. Today, there is only one doctor for every 7,000 Aleppo residents, compared to one doctor for every 800 residents in 2010.²⁴⁸

Compounding the disastrous effects of a destroyed health care system on civilians are deliberate obstructions to humanitarian aid and medical supplies. OCHA reported in December that 4.5 million Syrians live in hard-to-reach areas, including 393,700 living in besieged and difficult-to-reach sectors. Aid deliveries to these locations are extremely challenging, due to the active conflict and imposition of “deliberate restrictions” by parties to the conflict.²⁴⁹ During the few times Syrian government security forces approved aid convoys to opposition-controlled areas, they often prohibit the inclusion of medical aid. In April, OCHA reported that local security forces did not approve the inclusion of surgical kits and intravenous fluids on a convoy to eastern Aleppo city, depriving 33,115 people of these vital medical treatments.²⁵⁰ Even when OCHA obtains prior approval from the Syrian government for delivery of medical supplies, security forces often strip humanitarian convoys of lifesaving aid. In May, OCHA reported that medical and surgical supplies were removed from four aid convoys to Homs, Aleppo, and Rif Dimashq governorates, depriving 78,902 people of critical medical treatment.²⁵¹

Civilians living in opposition-controlled areas suffer deeply from this prohibition of medical aid. According to Amnesty International, doctors in besieged Eastern Ghouta lack antibiotics, anesthetics, painkillers, and other surgical supplies to treat the wounded, and dialysis medicine and equipment to treat those with kidney disease. Doctors also report a lack of medication to treat communicable diseases, which have become more prevalent under the siege. Some medication can be smuggled in through underground tunnels, but smugglers charge high prices for these medicines, making them unaffordable for

many people suffering from chronic illnesses.²⁵² In some locations such as Madaya, a town northwest of Damascus that has been besieged by Syrian government forces and Hezbollah since July 2015, local medical staff reported deaths due to starvation and lack of medical care. SAMS reported 31 such civilian deaths in Madaya in the month of December alone.²⁵³

The impact of the crisis on the health of people in Syria has been devastating. Lack of safe drinking water, sanitation, electricity, and fuel has led to increased vulnerability to outbreaks of diarrheal diseases, typhoid, hepatitis A, and other vaccine-preventable diseases. Inadequate or nonexistent treatment of chronic diseases, including diabetes, asthma, kidney disease, and cardiovascular disease, has increased the risk of death from these diseases. Shortages of skilled birth attendants and obstetricians have increased the dangers of childbirth.²⁵⁴

Figure 5. 2015 Medical Facility Attacks by Perpetrator

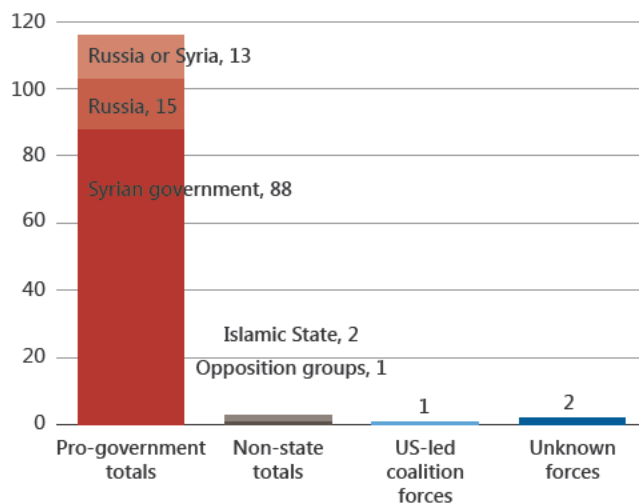


Figure 6. 2015 Medical Facility Attacks by Weaponry

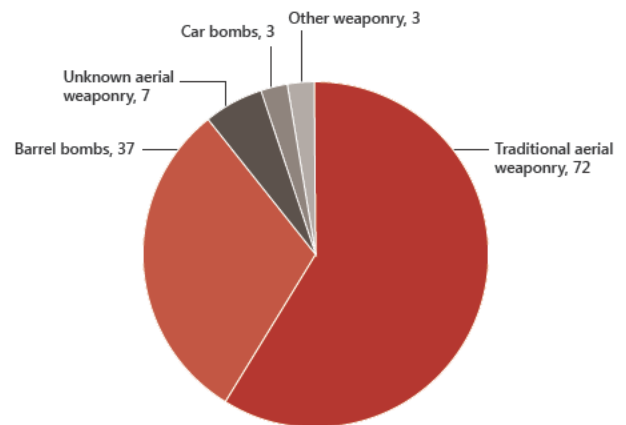


Figure 7. 2015 Medical Personnel Deaths by Perpetrator

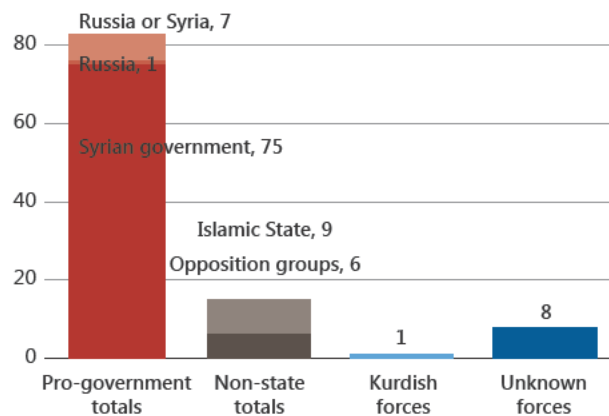
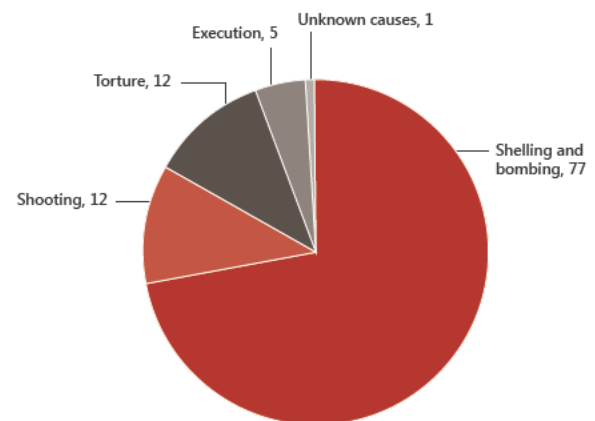


Figure 8. 2015 Medical Personnel Causes of Death



Source: Physicians for Human Rights

THAILAND

Since the outbreak of an armed insurgency in January 2004 in the south of Thailand, insurgent atrocities and retaliatory government abuses have been widespread.²⁵⁶ Human Rights Watch found that in the southern border province, where the number of doctors and nurses per capita is among the lowest in Thailand, public health services have been seriously affected by the violence.²⁵⁷ According to the Ministry of Public Health, over the past 12 years at least 112 public health volunteers and hospital staff have been killed or injured, and 28 community health centers burned or bombed.²⁵⁸ Some community health centers have reduced operating hours to avoid attacks by insurgents in the evening. Fear also prevents some doctors from treating patients outside health facilities, leaving frontline medical care to paramedics and public health volunteers.²⁵⁹

On March 13, 2016, Human Rights Watch reported that at least ten insurgents stormed Joh Airong Hospital in Narathiwat province and used it as a stronghold to attack a nearby Thai government security post, wounding seven members of a Taharnpran paramilitary unit. Before retreating, the insurgents tied up a pregnant nurse and destroyed hospital computers, telephones, and other equipment.²⁶⁰ The attack on Joh Airong Hospital was one of 17 attacks against military targets and civilians that insurgents conducted to mark the 56th anniversary of the National Revolution Front (Barisan Revolusi Nasional, BRN) separatist group.²⁶¹

In an incident of civil unrest unrelated to the insurgency in southern Thailand, in October 2015, media in Thailand reported that dozens of rioters blocked the road in Phuket province's Thalang district and attacked an ambulance carrying an elderly patient to have coronary surgery. The attack lasted for about 20 minutes, during which the critically ill patient's condition worsened. The patient later died at the hospital.²⁶²

TURKEY

Fighting between Turkish government forces and a branch of the Kurdistan Workers' Party (PKK) broke out again in mid-2015 in southeastern Turkey. As groups affiliated with the PKK sought to control and cut off access to neighborhoods, Turkish authorities launched security operations and imposed around-the-clock curfews in eight towns and city districts that prevented civilians from leaving. About 300 civilians have reportedly been killed in the fighting since July 2015, and more than 350,000 people have fled the region. A 78-day curfew ended in Cizre in early March 2016 but remained in Diyarbakır and Idil.

The curfews and lack of movement severely limited the ability of wounded and sick people to gain access to medical care. In addition to restrictions on their freedom of movement, the government has severely restricted the passage of ambulances in the city of Cizre and elsewhere. In September 2015, and again later, reports indicated that ambulances could not access wounded people shot during the curfew in Cizre, leading to the deaths of several people, including children.²⁶³

In September and December-March curfews in Cizre, emergency services personnel told individuals seeking ambulances that they could not respond; at the same time, there are numerous reports that police prevented people from being taken to hospitals in private cars and in some cases shot at those who tried.²⁶⁴ On January 20, 2016 in Cizre, the security forces reportedly shot a TV cameraman and a member of the local municipal council after they went with a large group into a neighborhood carrying a white flag to recover the bodies of the dead and injured. The council member later died of his injuries.²⁶⁵

Authorities in the province where Cizre is located denied that they had blocked the passage of ambulances, asserting rather that wounded people can be brought to a certain point in town and then transported.²⁶⁶ However, the European Court of Human Rights determined otherwise. For the first time in its history it issued an emergency order to enable an injured 16-year-old boy to get to a hospital. The order came too late, however, as the boy, who had been shot, had to wait four days before evacuation and died. The order, moreover, did not apply to other cases, and the court required new cases of lack of access to health care to be first brought before courts in Turkey.

One of the consequences of the curfews has been the flight of health workers, which has left emergency rooms to treat wounded people understaffed. In the town of Varto, with a population of 30,000 including surrounding villages, 17 doctors left.²⁶⁷

There have also been reports that unidentified armed groups have attacked ambulances, in one case leading to the deaths of at least two health workers. The government has introduced the use of an armored ambulance in Diyarbakır.²⁶⁸

Health workers have also been the subject of repression. In 2015, two doctors who provided aid to injured protestors during the Gezi Park protests of 2013 were convicted and imprisoned of denigrating a mosque for allegedly not taking off their shoes while providing treatment to the protestors.²⁶⁹ The doctors were among 250 people convicted of offenses in connection with those protests.

Human Rights Watch conducted detailed interviews with people in Cizre and Nusaybin about the curfews. The following testimonies are excerpted with permission from the organization's report, Turkey: Mounting Security Operation Deaths, on December 22, 2015.²⁷⁰

"On September 8, I was sitting inside and at 9 p.m. My wife, Meryem, went outside to do her abdest [ritual ablutions before prayer]. As she was closing the outer door to the yard she collapsed. We carried her in. First we thought it was just pellets [from a hunting rifle] but it wasn't. She had internal bleeding from a bullet. She was alive but we phoned for an ambulance and they told us they couldn't send one. We said we have Republic of Turkish IDs, that we're not the PKK. I believe she would have lived had we been able to get her to hospital. She died at around 12."

–Fevzi Süne

"On the second night of the curfew we ran from our house because armored vehicles were shooting into our street. My son was shot on his left side in the chest and in the throat right at the door of the house. A neighbor managed to phone the emergency services but no ambulance could get here. The police didn't allow it into the neighborhood."

–Gurbet Çağdavul

"For three days we just heard gunfire. My father went up the roof to see about the water tank because the water supply had been cut.... He was gone for some time and didn't come down. My stepmother went up to see what he was doing and discovered him face down in a pool of blood as if he were praying. He had been shot in the back but wasn't dead. We called an ambulance on 112. We cannot come, they told us or we will be killed. We called emergency services on 155 and gave the license plate number of my father's car so that they would know it was us coming. We put the body in the car and drove out of the yard and as we turned the corner the police shot directly at us. We know it was the police because the firing came from where they were positioned. We had to reverse or we would have been shot. My father died."

–Rahmet Erdin Agar

UKRAINE

As a result of the protracted conflict in eastern Ukraine, 1.3 million people have been internally displaced and 5 million people lack adequate access to health services.²⁷¹ More than 200,000 children have been displaced from their homes, and UNICEF estimates that a half million children have been traumatized by the violence.²⁷²

Although active fighting diminished in 2015 compared to the prior year, violence continued, and the situation remains tense. In May 2015, pro-Russian separatists attacked a military ambulance near Luhansk in eastern Ukraine, killing one Ukrainian serviceman and wounding another.²⁷³ But restrictions on travel and humanitarian relief implemented by the parties to the conflict were the more pervasive barrier to health care access in 2015.

In July, rebel authorities in Donetsk and Luhansk suspended humanitarian programs. By September, OCHA reported that hospitals in those areas lacked essential medicines such as insulin and tuberculosis vaccines and could not perform surgery because they had no anesthesia. The suspensions remained in effect through October.²⁷⁴

In September and October 2015, authorities from the self-proclaimed Luhansk People's Republic and Donetsk People's Republic respectively ordered MSF to stop operations. At the time, MSF was providing 77% of insulin treatment for adults with diabetes and 90% of hemodialysis for kidney disease in territory controlled by the Donetsk People's Republic. Treatment for tuberculosis was also disrupted in the Donetsk region, which had one of the highest prevalence rates of tuberculosis in Ukraine before the conflict.²⁷⁵

Hospitals in rebel-held areas were also short on medications for mental illness and epilepsy.²⁷⁶ HIV medications were more available than in 2014, but the uncertainty of deliveries made the risk of interruption high. Ukraine has one of the highest rates of HIV infection in Europe, and it now appears to be on the rise.²⁷⁷ Prevalence of addiction in the region is also very high, but as of January 2016, only one methadone distribution center remained in rebel-controlled territory.²⁷⁸

In January 2015, the government imposed restrictions on civilians seeking to cross rebel-controlled territory into areas under government control, impeding their access to health care and medications. In November, OHCHR reported that only four transport corridors were operational in the Donetsk region and one checkpoint for pedestrians remained open in the Luhansk region. The difficulty of travel and transport across checkpoints is exacerbated by their limited capacity and the high demand for crossing with lines reaching up to 3 kilometers long.²⁷⁹

In addition to shortages of supplies, health care is impeded by harassment of and threats to medical staff by fighters from the Donetsk People's Republic and Luhansk People's Republic. Investigators from the OHCHR "witnessed a car with four armed group members at the hospital entrance, heavily armed, harassing female medical staff. Such conduct endangers medical personnel and patients."²⁸⁰

YEMEN

Yemen's political turmoil began in 2011 with the Yemeni Revolution, which grew out of the Arab Spring, and efforts to dislodge former President Ali Abdullah Saleh who had been in power since 1978. An internationally brokered agreement placed the former Vice President Abd Rabbuh Mansur Hadi in power, but the political environment was unstable. The Houthis, a Shia group, took over the capital in late 2014 and allied with supporters of former President Saleh. An attempted peace agreement established later in 2014 did not hold, and in January 2015 violence broke out and the Hadi-led government resigned. In March, Saudi Arabia, viewing the Houthis as an instrument of Iranian threat in the region, created a coalition that intervened militarily, including aerial strikes and a naval blockade. The United States, the United Kingdom, and France provided support to the effort.²⁸¹

Since then, the civilian population has endured a sustained campaign of aerial bombardment and heavy shelling from the ground.²⁸² By the first quarter of 2016, more than 6,400 people had been killed and more than 30,000 injured (as reported by health facilities).²⁸³ The number of deaths is believed to be much higher.²⁸⁴ A UN panel determined that all parties have violated international humanitarian law.²⁸⁵

Many children and other civilians have lost their lives as a result of coalition airstrikes.²⁸⁶ In 2015, UNICEF reported an average of eight children were being killed or maimed every day as a direct result of the conflict.²⁸⁷ UNICEF also reported that as of late 2015, at least 18 governorate hospitals were closed or operating at severely limited capacity, leaving 14.1 million people without access to health care.²⁸⁸

Yemen's health system was already weak before the conflict began. As of December 2015, the conflict had resulted in damage to more than 100 health facilities, including 38 hospitals and 11 polyclinics, and 28 ambulances. At least 12 health workers had been killed and 18 injured.²⁸⁹ According to the ICRC, between March and November 2015, bombs were dropped on or near medical facilities nearly 100 times,²⁹⁰ and UNICEF reported that 600 hospitals had been shut down.²⁹¹ The impact of these attacks is magnified by the need for surgeries to treat traumatic injuries from explosive devices.²⁹² According to MSF, the Saudi-led coalition has treated civilians and civilian structures as legitimate military

targets, and the Houthi forces have also repeatedly shelled civilian areas and medical facilities and blocked shipments of medical supplies.²⁹³

At the beginning of the conflict in March 2015, eight hospitals were hit within the space of a few days in Sana'a, Saada, Dhale, and Aden by the Saudi-led coalition.²⁹⁴ In April 2015, the Sana'a Science and Technology Hospital was hit by shrapnel resulting in injuries to three hospital employees.²⁹⁵ Six International Medical Corps staff members were injured in the same district when its humanitarian supply warehouses were damaged.²⁹⁶ The health center of Al-Mazraq camp for internally displaced persons in Haradh, Hajja governorate, was also bombed by the Saudi-led coalition in April, injuring two nurses.²⁹⁷ During the same month, MSF reported large pieces of shrapnel landed 30 meters away from a public hospital in Haradh where MSF staffers were treating wounded people. The attacks forced a large portion of the population, including several health workers, to flee.²⁹⁸

On April 19, 2015, at a time when Houthi fighters were in control of much of the southern port city of Aden, about 300 anti-Houthi forces stationed themselves inside a hospital in the city, and Houthi fighters, including snipers, stationed themselves on neighboring rooftops. Between March and April, Houthi forces opened fire on the hospital on multiple occasions, killing at least two civilians and wounding a nurse. In one instance in April, the anti-Houthi forces forced staff to reveal the location of two Houthi fighters who had been brought into the hospital for treatment, and shot both men dead in the hospital yard. Eventually the staff and patients evacuated the hospital on April 29.²⁹⁹

On May 9, 2015, airstrikes hit a military field hospital in Damnat Khadeer District, 40 kilometers north of Taiz. UN human rights field monitors were denied access to the site, and could not verify the death toll.³⁰⁰ In early September, Al Sabeen Hospital, the main pediatric hospital in Sana'a, sustained damage after a nearby building was hit in an airstrike, resulting in several infant deaths when their ventilators cut out.³⁰¹ On October 27, coalition airstrikes in the Haydan District in Saada in northern Yemen destroyed a hospital supported by MSF. Hospital staff and patients managed to escape before subsequent airstrikes occurred. According to MSF, with the hospital destroyed, at least 200,000 people now have no access to lifesaving medical care in the region.³⁰²

Ongoing conflict has also affected the major city of Taiz in southern Yemen. On November 11, 2015, the Al-Thawra hospital, one of the main health care facilities in Taiz was shelled.³⁰³ On December 3, a coalition airstrike hit another MSF facility, the Al Houban clinic in Taiz, wounding nine people. It was one of the few health facilities in Taiz offering medical care for displaced people.³⁰⁴

A third MSF hospital was hit by the coalition on January 10, 2016, in the Razeh district, killing six people and wounding ten.³⁰⁵ Also in January, a coalition airstrike hit the al-Noor Center for the Care and Rehabilitation of the Blind in Sana'a, but the bomb did not go off, thus minimizing damage and only wounded four civilians.³⁰⁶ On March 3, 2016, the only medical facility run by MSF in the northern city of Saada was closed following Saudi airstrikes.³⁰⁷

In addition to facilities, health workers have also been targeted by airstrikes and fighting on the ground. A volunteer ambulance driver with the Yemen Red Crescent Society was killed in Dhale'e in southern Yemen after his vehicle was hit by gunfire.³⁰⁸ In March 2015, in the Al-Sulaf area of Zubaid in the southern district of Al-Dhale, a Yemen Red Crescent Society health worker was shot and killed while coming to the aid of people who had been wounded in fighting.³⁰⁹ A few days later there were conflicting reports of a clinic damaged in the area of Sana'a, allegedly resulting in a doctor being killed.³¹⁰ On March 30, 2015, in Al Dhale'e in southern Yemen, a volunteer ambulance driver with the Yemen Red Crescent Society was killed after his vehicle was hit by gunfire.³¹¹ On April 4, 2015, two brothers and volunteer paramedics with the Yemen Red Crescent Society were shot when their ambulance was hit by gunfire in Aden.³¹² In July 2015, a clearly marked Yemeni Red Crescent Society ambulance came under fire in the city of Taiz when it was transporting an injured patient and two volunteers. As a direct result, the patient and his friend were killed.³¹³ Ten days after the Shiara Hospital bombing in January 2016, the ambulance service of the MSF-supported Al Gomhoury Hospital in the same Saada governorate was hit by an airstrike by the Saudi-led coalition as it arrived at the site of an earlier bombing. When people gathered to assist the victims, the same site was hit again. The driver and the ambulance were hit in a third strike.³¹⁴ In March 2016, four Red Crescent volunteers were wounded in Ma'rib governorate while retrieving the bodies of people killed during fighting.³¹⁵

Aid workers transporting medical supplies are at constant risk of kidnapping. In March 2015, Houthi fighters abducted three volunteers for Inqath, an aid group that provides medical supplies to hospitals in Aden, as they took boxes of medicine by taxi to al-Jumhuri Hospital, releasing them a week later.³¹⁶ The next month, three ambulances operated by the Ministry of Public Health and Population were taken by armed forces and used for nonmedical purposes. In May, aid workers in a convoy of five vehicles delivering medical supplies to a medical compound in the Mualla district of Aden were stopped at a checkpoint and held until two of their families each paid US\$1,000.³¹⁷

The attacks have prompted many health workers to flee the country and have disrupted the delivery of medical supplies.³¹⁸ Fuel and medical supply shipments from abroad have slowed down due to a rigorous inspection regimen imposed by the Saudis on all incoming cargo vessels, or in some cases halted entirely.³¹⁹ As a result of fuel shortages as well as widespread lack of electricity, many health facilities cannot run generators to provide power, leading to partial or complete closures of public and private hospitals.³²⁰

MSF reported in April 2015 that ambulance attacks, snipers, and road blocks in Aden were making it difficult for patients to go to the hospital.³²¹ That month, many private hospitals in Sana'a shut down due to a lack of fuel.³²² In November 2015, the ICRC also experienced difficulty accessing Taiz, a city in the south, reporting they were unable to deliver medical supplies from September through November. According to the ICRC, by the end of 2015, fewer than half of the previously functioning health facilities in Taiz remained to cope with the large number of wounded people amidst a severe shortage of supplies.³²³ MSF continued to experience difficulties delivering essential medical supplies to the hospital in Taiz, despite ongoing negotiations with the Houthis.³²⁴ In January 2016, Houthi guards confiscated oxygen cylinders from suppliers at checkpoints, causing some hospitals to run out of them. The head of the neonatal unit at al-Jumhuri Hospital told Human Rights Watch that since December 2015, six premature infants died because the hospital did not have the oxygen or the fuel to run the generator to power the incubators.³²⁵ Heavy fighting in Marib, Al-Jawf, and Taiz governorates, despite the declaration of the ceasefire from December 15–21, 2015, prevented many civilians from accessing health care.³²⁶

The impact on the civilian population has been devastating and the fighting continues. About 14.1 million people lack food security and health care. In addition to deaths directly related to the fighting, according to UNICEF, the lack of health care and immunizations has resulted in the preventable deaths of nearly 10,000 children under the age of five. UNICEF also estimates that 2.5 million children are now at high risk of diarrheal diseases, 1.3 million are at risk of acute respiratory tract infections, 2.6 million at risk of measles, and more than 320,000 are at risk of severe acute malnutrition.³²⁷

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**SAFEGUARDING
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The **Safeguarding Health in Conflict Coalition** promotes the security of health workers and services threatened by war or civil unrest. We monitor attacks on and threats to civilian health; strengthen universal norms of respect for the right to health; demand accountability for perpetrators; and empower providers and civil society groups to be champions for their right to health.

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