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SAFEGUARDING HEALTH IN CONFLICT

Insecurity Insight
Data on People in Danger

Violence Against or Obstruction of Health Care in the Democratic Republic of the Congo (DRC)

LETTER FROM THE CHAIR

The fifth anniversary of the United Nations (UN) Security Council's Resolution 2286 on the protection of health care comes at a time of unceasing violence inflicted on hospitals, clinics, ambulances and health workers. As this report shows, the number of health workers reported killed in conflict settings rose to 185 in 2020, up from 167 and 150 in 2018 and 2019, respectively. It was a rare conflict where escalation in fighting was not associated with a corresponding upsurge in violence against health care of some kind.

During the five years since the UN resolution was adopted, 14 conflicts have seen more than 50 reported incidents of violence against health care, eight conflicts have seen more than 100 such incidents, five more than 200, and four more than 300 incidents apiece. This is probably an undercount, and the real numbers are likely to be much higher. Violence against health care is continuing in 2021.

The reasons for the violence are variable and sometimes complex, but the explanation for continuing impunity is not: states have failed to fulfil their commitments to take action – individually or as part of an international effort – to prevent violence against health care or hold the perpetrators accountable. Consider these questions regarding implementation actions found in the resolution itself or the UN Secretary-General's recommendations for implementation:

Did member states ensure that their militaries 'integrate practical measures for the protection of the wounded and sick and medical services into the planning and conduct of their operations'? – *No.*

Did member states adopt domestic legal frameworks to ensure respect for health care, particularly excluding the act of providing impartial health care from punishment under national counter-terrorism laws? – *No.*

Did member states engage in the collection of data on the obstruction of, threats against and physical attacks on health care? – *No.*

Did member states undertake 'prompt, impartial and effective investigations within their jurisdictions of violations of international humanitarian law' in connection with health care and, 'where appropriate, take action against those responsible in accordance with domestic and international law?' – *No.*

Did the Security Council refer cases where there is evidence of war crimes in connection with violence against health care in Syria and elsewhere to the International Criminal Court? – *No.*

Were all states found by the Special Representative of the Secretary-General on Children in Armed Conflict to have engaged in violence against hospitals listed in the annex to the Secretary-General's annual report on children in armed conflict? – *No.*

Did member states that sell arms that have been used to inflict violence on health care cease those sales? – *No.*

LETTER FROM THE CHAIR

Non-state armed groups, many of which profess their commitment to abide by international law, have also abdicated their responsibilities. Only three have signed the Geneva Call's Deed of Commitment to Health Care. This compares to more than 50 non-state armed groups that have agreed to forgo the use of antipersonnel landmines and 25 that have agreed not to use child soldiers.

Why the inaction? Militaries do not change their operational procedures if there are few demands on them to do so. Laws are not reformed when counter-terrorism priorities pay little regard to international law. Arms sales are huge moneymakers and a valued way of achieving policy goals without direct military involvement. Investigations and accountability are inconvenient in a conflict. At the UN, the very structure of the Security Council – especially the veto power of its five permanent members – has become an excuse for failure.

If governments are to do what they have committed to – i.e. protect health workers, health facilities, and transport from being targeted and attacked – both pressure and accountability are urgently needed.

To that end, the UN Secretary-General has the power to and should report every year on what each UN member state has done and not done to carry out the purposes of Resolution 2286. This form of accountability can also be advanced by the appointment of a special rapporteur or special representative to submit reports thematically and on countries to assess their response to the requirements of Resolution 2286. Most of all, the public health, nursing, and medical communities must demand that political leaders move beyond declarations, meetings, and pallid measures and take concrete steps to ensure that health workers and the sick and wounded who need care are properly protected.

It is long overdue for the important commitments of UN Resolution 2286 to be more than hollow words. All those who care about protecting health care in situations of conflict must take meaningful and concrete steps to make real these essential promises to those who risk their lives to safeguard the health and well-being of populations in their care.

Len Rubenstein
Chair, Safeguarding Health in Conflict Coalition

DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

At 2:30 AM on February 1, 2021 armed men broke into a hospital providing Ebola treatment in Mambasa territory, Ituri province. Soldiers of the Armed Forces of the DRC (FARDC) guarding the health facility were unable to prevent militants from entering the hospital. The armed men looted four vehicles from the hospital courtyard before trying to break into the wards by breaking the windows. The intervention of UN peacekeepers forced them to flee before they could enter the patients' area.[1]

REPORTED INCIDENTS AND MOST COMMONLY REPORTED CONCERNS

81	27	24	22	19
REPORTED INCIDENTS	HEALTH WORKERS INJURED	HEALTH WORKERS KILLED	INCIDENTS WHERE HEALTH FACILITIES WERE DESTROYED OR DAMAGED	HEALTH WORKERS THREATENED

Source: 2020 SHCC Health Care DRC Data

OVERVIEW

The Safeguarding Health in Conflict Coalition (SHCC) identified 81 incidents of violence against or obstruction of health care in the DRC in 2020, compared to 434 such incidents in 2019. In these incidents, health facilities were damaged and destroyed, and health workers were killed and injured. The decrease from 2019 was likely attributable to the end of the tenth Ebola outbreak in eastern DRC, which had been marred by extensive violence against responders. Violence by conflict parties continued at high levels, however.

This factsheet is based on the dataset 2020 SHCC Health Care DRC Data, which is available on the Humanitarian Data Exchange (HDX).

THE CONTEXT

Ongoing armed conflict between government forces and armed groups in the DRC's north-eastern Kivu and Ituri provinces continued to cause insecurity for health workers and organizations operating in the region.

DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Ebola-related mistrust among local communities, based on misinformation and rumours spread person-to-person and online, affected both the safety of health workers and the progress of Ebola treatment and prevention in north-eastern DRC in 2020.

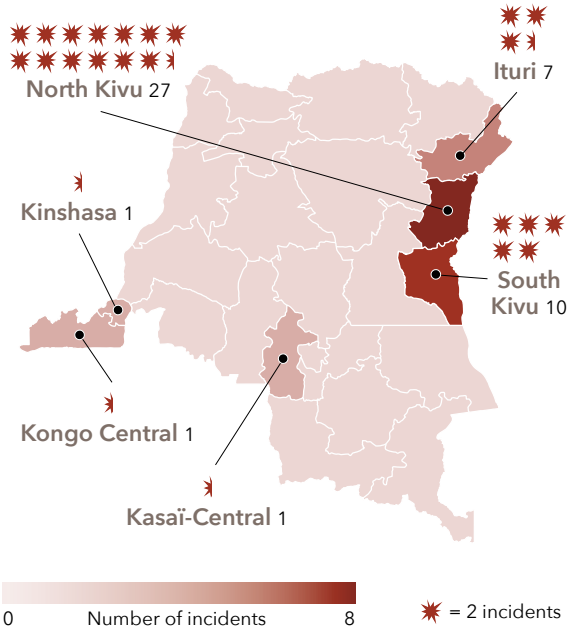
VIOLENCE AGAINST OR OBSTRUCTION OF HEALTH CARE IN 2020

As the tenth Ebola outbreak was gradually brought under control and declared over by June 2020, the number of reported acts of violence against health providers fell to levels similar to those observed before the outbreak.

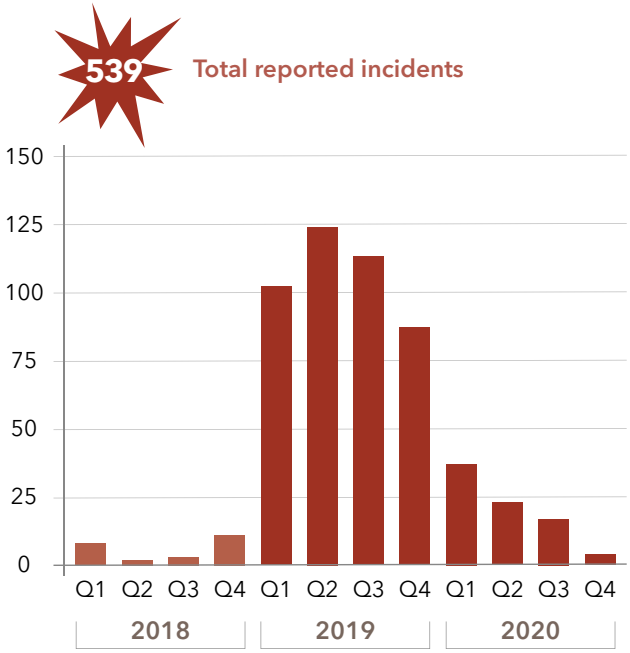
In 2020, incidents were documented in six of the DRC's 25 provinces. The highest numbers were recorded in North and South Kivu and Ituri provinces, all of which are plagued by protracted conflicts. Congolese health workers, hospitals, and clinics were frequently targeted in these areas. INGOs were also targeted, but less often. While much less frequent, acts of violence against health providers were also reported in Kinshasa, Kongo Central, and Kasaï-Central provinces.

Ebola operations in the Kivus and Ituri were affected by violence, but not to the same extent as in 2019 during the height of the disease outbreak and response. Ebola-related violence briefly spiked again in April after new Ebola cases were identified a few days before the pandemic was expected to be declared over. Few incidents of threats and violence were reported during the 11th Ebola outbreak, which lasted from June to November 2020 in Equateur province.

Known locations of reported incidents affecting health care in the DRC in 2020, by province[2]



Reported incidents affecting health care in the DRC in 2018, 2019 and 2020, by quarter



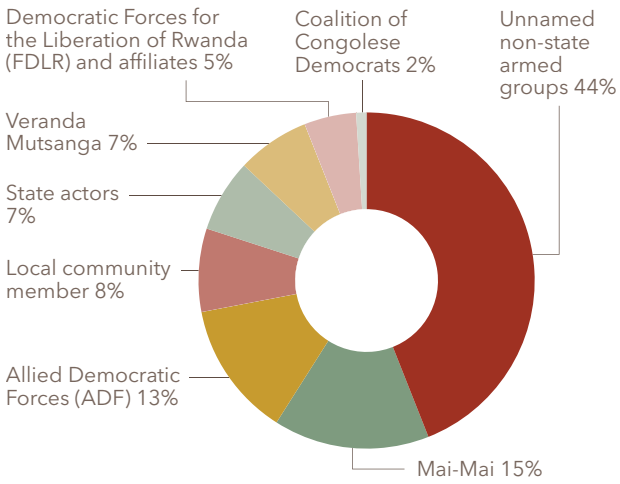
Source: 2020 SHCC Health Care DRC Data

DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

PERPETRATORS

Unnamed and named non-state armed groups were the most frequent perpetrators of violence against health care in the DRC. Identified groups included Mai-Mai militias, the Allied Democratic Forces, and local vigilante groups.

Reported perpetrators[3]



Source: 2020 SHCC Health Care DRC Data

Unnamed non-state armed groups kidnapped and killed health workers in North Kivu, South Kivu, and Ituri provinces. These armed groups also forcefully entered primary health centers, damaging equipment and infrastructure, and looting medical supplies.[4,5,6]

Fourteen men armed with bladed weapons broke into the Revolution Health and Maternity Center in Kinshasa and raped at least two nurses and an unknown number of patients. The group also stole money and blood supplies, and robbed several patients.[7]

In Kasaï-Central province, a group of at least 11 COVID-19 responders were attacked and wounded by armed men.[8]

Mai-Mai militia reportedly carried out a number of violent acts on health infrastructure across north-eastern DRC. In Ituri, Mai-Mai gunmen broke into a local hospital and ransacked a number of Ebola response vehicles.[9] In North Kivu, Mai-Mai militants attacked two health clinics and damaged and destroyed equipment.[10] In South Kivu, Mai-Mai Reunion militants robbed an INGO vehicle and destroyed equipment.[11]

Allied Democratic Forces (ADF) militia, sometimes armed with machetes, killed four INGO health workers in Ituri province and set fire to health centers and a pharmacy in North Kivu province. Some attacks were carried out against civilians and villages in the context of an escalating conflict between the Congolese army – the FARDC – and the armed group.[12]

Local community members attacked Ebola response teams with machetes on at least two occasions in Ituri and North Kivu provinces, seriously injuring two health workers.[13] A former Ebola treatment center in North Kivu was set on fire by local community members in protest at plans to use it for COVID-19 patients.[14]

State actors, including **FARDC soldiers**, stormed a local health center in North Kivu province looking for injured rebels, and attacked a nurse and a patient.[15]

Congolese National Police dispersed protests by health workers, using tear gas in Kongo Central and rubber bullets in South Kivu, injuring a doctor.[16]

Veranda Mutsanga, a vigilante group based around Beni, North Kivu, vandalised and ransacked Ebola treatment centers in Beni. The incidents were sparked by a resurgence in Ebola cases in the region.[17]

Members of the **Democratic Forces for the Liberation of Rwanda (FDLR) and affiliates** kidnapped nurses in North Kivu.[18] In one incident, a USD 1,200 ransom was demanded for the release of a male nurse.[19]

Insecurity in Djugu town, Ituri province, linked to Coalition of Congolese Democrats activities, forced the Jiba Hospital to temporarily shut its doors.[20]

TENTH EBOLA RESPONSE IN THE DRC

Between August 2018 and June 2020 Insecurity Insight monitored reported attacks on health care throughout the response. Take a look at this overview analysis of these attacks and the recommendations that were developed following this analysis.

1 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 82.
2 This chart only shows the locations mentioned in the original source. Information on the location of 34 incidents is not available and therefore not included in the chart.
3 This chart only shows the perpetrators who are named in the original source. Information on the perpetrators in 41 incidents is not available and therefore not included in the chart.
4 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 304.
5 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 338.
6 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 469.
7 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 843.
8 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 1359.
9 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 82.
10 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 17
11 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 855.
12 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 719.
13 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 28.
14 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 469.
15 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 549.
16 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 735.
17 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 335.
18 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 67.
19 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 1374.
20 Insecurity Insight. Safeguarding Health in Conflict Coalition 2021 Report Dataset: 2020 SHCC Health Care DRC Data. Incident number 490.

METHODOLOGY

This eighth report of the Safeguarding Health in Conflict Coalition (SHCC) covers 43 countries and territories and provides details on incidents of threats and violence against health care in 17 countries and territories experiencing conflict in 2020. We referred to the Uppsala Conflict Data Program (UCDP)[21] to determine if a country is considered to have experienced conflict in 2020, and of these countries, we included those that had experienced at least one incident of violence against or obstruction of health care in 2020. We discuss the 14 countries with more than 15 reported incidents in separate chapters, and the other three countries with less than 15 reported incidents in paragraphs. Twenty-six other countries are included in the total counts, but are not discussed in detail. Fourteen of the countries and territories covered in factsheets in 2020 were included in factsheets in 2019. For the 2020 report, Azerbaijan, Mexico and Mozambique were added, while Egypt, Ethiopia, Iraq, Pakistan, Sudan and Ukraine do not have country chapters in 2020.

The report uses an event-based approach to documenting attacks on health care, referred to as 'incidents' throughout the report. To prepare this report, event-based information from multiple sources was cross-checked and consolidated into a single dataset of recorded incidents that were coded using standard definitions. The full 2020 data cited in this report can be accessed via Attacks on Health Care in Countries in Conflict on Insecurity Insight's page on the Humanitarian Data Exchange (HDX). The data for the 17 countries is made available as individual datasets. The links are provided in the individual country profiles.

DEFINITION OF ATTACKS ON HEALTH CARE

The report follows the WHO's definition of an attack on health care: 'any act of verbal or physical violence, threat of violence or other psychological violence, or obstruction that interferes with the availability, access and delivery of curative and/or preventive health services'. In this report, however, we do not use the word 'attack', but rather 'incident' or 'incident of violence', because the word 'attack' is often interpreted to convey intent, whereas many reported incidents result from indiscriminate or reckless behaviour/actions, but otherwise meet the WHO definition.

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

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

These categories have been included insofar as they were reported in sources. However, some forms of violence, such as psychological violence, blockages of access or threats of violence, are rarely reported. We also record incidents of violence against patients in health facilities when references to the effects of violence on patients are included in descriptions of incidents. However, the impact of incidents of violence against patients is much broader and complex than individual incidents and cannot be accurately documented through event-based monitoring.

DEFINITION OF CONFLICT

The SHCC report covers three types of conflict as defined by the UCDP:[22]

- **State-based armed conflict** is defined as 'a contested incompatibility that concerns government and/or territory where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths in one calendar year year'.
- **Non-state conflict** is defined as '[t]he use of armed force between two organized armed groups, neither of which is the government of a state, which results in at least 25 battle-related deaths in a year'.
- **One-sided violence** is defined as '[t]he deliberate use of armed force by the government of a state or by a formally organized group against civilians which results in at least 25 deaths in a year'.

A country is included in the SHCC report if it is included on the UCDP list of one of the three types of conflict[23] and if we identified at least one attack on health care perpetrated by a conflict actor, which for the purposes of this report is defined as a person affiliated with organized actors in conflict, which can be armed conflict, non-state conflict or one-sided violence as defined by the UCDP.

Interpersonal violence and violence by patients against health care providers are not included in this report, even when they occurred in conflict-affected countries. In 2020 violence against specific public health programmes, such as polio vaccinations campaigns or the Ebola and COVID-19 responses, were only included when (a) the perpetrator was a member of a party to a conflict, and (b) available evidence suggested that the incident occurred either in the context of a contested incompatibility of territory or as one-sided act of violence by security forces included on the UCDP list of countries with more than 25 reported deaths from one-sided violence attributed to security forces. This is an important difference to the inclusion criteria used in the 2019 report, where all incidents that occurred in the conflict-affected eastern Democratic Republic of the Congo (DRC) in the context of the tenth Ebola response were included, even when there was not enough detail to determine whether the perpetrators were linked to a recognized conflict party or may have originated from local communities.

Throughout 2020 the SHCC also monitored violence triggered by the COVID-19 pandemic. COVID-19-related threats and violence against health care are only included in the 2020 SHCC report when the incidents met the strict conflict-related inclusion criteria in relation to the country being included in one of the three UCDP lists, and the perpetrator and context of the incident were directly related to conflict, as outlined above.

METHODOLOGY

INCLUSION OF INCIDENTS

We included only the incidents that met the inclusion criteria for types of conflicts and perpetrators, and for these we included the following types of incidents and details in the report dataset:

- incidents affecting health facilities, recording whether they were destroyed, damaged, looted or occupied by armed individuals/groups;
- incidents affecting health workers, recording whether they were killed, kidnapped, injured, assaulted, arrested, threatened or experienced sexual violence (when available, we recorded the number of affected patients, although we acknowledge the likely serious underreporting of these figures);
- incidents affecting health care transport, recording whether ambulances or other official health care transport were destroyed, damaged, hijacked/stolen or stopped/delayed; and
- incidents recorded by the WHO Surveillance System of Attacks on Healthcare (SSA) for the ten countries included in the system if the WHO confirmed the incidents.

KEY DEFINITIONS

Health worker: Refers to any person working in a professional or voluntary capacity in the provision of health services or who provides direct support to patients, including administrators, ambulance personnel, community health workers, dentists, doctors, government health officials, hospital staff, medical education staff, nurses, midwives, paramedics, physiotherapists, surgeons, vaccination workers, volunteers or any other health personnel not named here.

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

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

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

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

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

METHODOLOGY

SOURCES

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

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

1. information included in Insecurity Insight's Attacks on Health Care Monthly News Briefs,[24] which provide a combination of media sources and publicly shared information from partner networks, such as the Aid Worker Security Database (AWSD)[25] for global data from international aid agencies coordinating health programmes; Airwars[26] and the Syrian Network for Human Rights (SNHR)[27] for data on Syria; the Civilian Impact Monitoring Project (CIMP)[28] for data on Yemen; and databases such as that of the Armed Conflict Location & Event Data Project (ACLED);[29]
2. information provided by Medical Aid for Palestinians (MAP)[30] for incidents in the occupied Palestinian territories (oPt);
3. information provided by SHCC member Syrian American Medical Society (SAMS) Foundation[31] for incidents in Syria;
4. information from the WHO SSA on 11 countries: Afghanistan, Burkina Faso, the DRC, Libya, Mali, Myanmar, Nigeria, the oPt, Somalia, South Sudan and Yemen (information from the SSA represents approximately one-third of the data gathered for this report); and
5. information on Afghanistan from 74 WHO SSA reported incidents (but we were not able to compare the individual reports to meaningfully combine the data).

CODING PRINCIPLES

The general theory and principles of event-based coding were followed, and care was taken not to enter the same incident more than once. The standard coding principles are set out in the *SHCC Overview Data Codebook*. Please see www.insecurityinsight.org/projects/healthcare/shcc for full details of SHCC coding and annexes.

Coding the perpetrator and context of attacks on health care can inform the development of preventive strategies and mitigation measures that reduce the incidence and impact of attacks and support accountability processes. Because it is rarely possible to know a perpetrator's motive(s), we relied on the context identified in the incident descriptions and coded the intentionality of the attacks from these descriptions to the extent possible.

METHODOLOGY

INCLUSION AND CODING OF SSA-REPORTED INCIDENTS

Information from the WHO SSA was included for 11 countries and territories: Afghanistan, Burkina Faso, the DRC, Libya, Mali, Myanmar, Nigeria, the oPt, Somalia, South Sudan and Yemen. We accessed the SSA on 7 April 2021 for Afghanistan, 24 March for Nigeria and 18 March for the oPt, and included the information for incidents in these countries reported in 2020 that were available on these dates. For all other countries, the SSA was accessed on 15 January 2021. Any changes to the SSA system after that date are not reflected in the SHCC dataset, but may be noted in the country profiles.

We coded 229 SSA-reported incidents from the 11 countries and territories based on the information included on the online SSA dashboard. Since the SSA does not provide information on perpetrators, we assumed that all of the SSA incidents we included involved conflict actors (rather than private individuals) and therefore fulfilled the SHCC inclusion criteria. The SSA also does not provide any information on location, except for the country where the incident occurred. The SSA-reported incidents could therefore not be included in the maps showing the affected regions or provinces in the individual country profiles.

The lack of detail in the 28 SSA-reported incidents from Syria made it too difficult to determine which of these incidents overlapped with the 121 Syrian incidents collected by SHCC members. Thus, the 28 SSA-reported incidents from Syria were not incorporated into the report.

The SSA includes the fields of 'Affected Health Resource', 'Type of Attack', and 'Affected Personnel', with standard categories for each incident. However, these fields were not consistently filled in, and for 35 of the 229 incidents only one or two of the fields provided information. When one or more fields were left empty, it was usually not possible to fully understand the nature of the incident from the information reported. Therefore, 35 SSA-reported incidents appear in the SHCC dataset as recorded incidents without much further detail, and 194 incidents reported by the SSA are included with more details.[32]

LIMITATIONS OF THE RESEARCH

This report is based on a dataset of incidents of violence against health care that has been systemically compiled from a range of trusted sources and carefully coded. The figures presented in the report can be cited as the total number of incidents of attacks on health care in 2020 reported or identified by the SHCC. These numbers provide a minimum estimate of the damage to health care from violence and threats of violence that occurred in 2020. However, the severity of the problem is likely much greater, because many incidents probably go unreported and are thus not counted here. Moreover, differences in definitions and biases within individual sources suggest that the contexts that are identified are also not representative of the contexts of all incidents.

METHODOLOGY

The SHCC dataset aims to bring together available information from different sources on violence and threats of violence against health care. As a consequence, it suffers from limitations inherent in the information provided by contributors to the SHCC. For some countries, combining available information is challenging when various data collection efforts do not share data in a way that allows information to be cross-checked. Moreover, not all contributors provided access to their original sources and many details were lost in the process, affecting our ability to provide more accurate and consistent classification. This results in two important warnings:

The reported numbers of incidents by country should not be compared to those of other countries without considering the factors that affect the flows of information. For example, the information flows from Syria and the oPt are well established. As a result, a relatively high proportion of incidents are generally reported. For a number of countries that emerged as new concerns in 2020, the SHCC made special efforts to improve related data flows, among them Azerbaijan, Burkina Faso, Cameroon, Mozambique, Myanmar and Somalia, but these information flows need further attention. For some other countries, in particular the Central African Republic (CAR), the flow of information remains very challenging.

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

REPORTING AND SELECTION BIAS

The SHCC dataset suffers from 'reporting bias', which is the technical term for selective reporting. While the process of data cleaning carried out by the SHCC focuses exclusively on selecting incidents based on the inclusion criteria, the pool of information accessible for this process depends on the work done by those who first reported the incidents. Events may be selected or ignored for a range of reasons, including editorial choices, when the source is a media outlet; lack of knowledge, because the affected communities had no connection to the body compiling the information in the first place; or simple errors of omission. These biases mean that the SHCC's collection of incidents may not be complete or representative, and that only a selection of incidents is included in the first lists that are used to compile the final SHCC dataset. This dataset therefore only covers a fraction of the relevant evidence and covers incidents in certain countries and certain types of incidents more widely than others.

KNOWN REPORTING AND SELECTION BIASES IN SHCC SOURCES

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

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

ACCURACY OF INFORMATION AND DIFFERING DEFINITIONS

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

robberies and abductions, it is often difficult to ascertain from available information whether the act was committed by a party to the conflict or by criminals. We based our inclusion decisions on judgements about the most likely motivations.

The nature of the WHO SSA dataset and the extent to which the SHCC relies on contributions from this dataset for specific countries influence the overall SHCC dataset. Because the SSA does not report information on perpetrators, the SHCC dataset could not provide information on the perpetrators in 229 incidents. As a consequence, the coding is much more limited for those countries for which a significant proportion of incidents came from the SSA. In addition, the SSA reported 35 incidents that did not contain enough precise information to include the events in the SHCC dataset beyond the incident count.

The SHCC dataset therefore contains limitations associated with using preprocessed data without access to the original sources or additional detail, which would have allowed for potentially more comprehensive and consistent classification.

The standard coding principles are set out in the *SHCC Overview Data Codebook*. Please see www.insecurityinsight.org/projects/healthcare/shcc for full details regarding SHCC coding and annexes.

21 Department of Peace and Conflict Research, Uppsala University. Uppsala Conflict Data Program. https://ucdp.uu.se/ (accessed 6 April 2021).
22 Department of Peace and Conflict Research, Uppsala University. UCDP Definitions. https://www.pcr.uu.se/research/ucdp/definitions/.
23 https://ucdp.uu.se/. Because the 2020 UDCP country conflict list was not publicly available when this report was being written, we consulted UCDP staff via email to obtain information on the changes related to countries included in the UCDP list for 2020.
24 http://insecurityinsight.org/projects/health care/monthlynewsbrief.
25 https://aidworkersecurity.org/.
26 https://airwars.org/.
27 http://sn4hr.org/.
28 https://civilianimpactmonitoring.org/.
29 https://www.acleddata.com/.
30 https://www.map.org.uk/.
31 https://www.sams-usa.net/.
32 Please contact Insecurity Insight if you would like more details on the process of including SSA-reported incidents in the SHCC dataset.

SAFEGUARDING HEALTH IN CONFLICT

The Safeguarding Health in Conflict Coalition is a group of more than 40 organizations working to protect health workers and services threatened by war or civil unrest. We have raised awareness of global attacks on health and pressed United Nations agencies for greater global action to protect the security of health care. We monitor attacks, strengthen universal norms of respect for the right to health, and demand accountability for perpetrators. www.safeguardinghealth.org.

Safeguarding Health in Conflict Coalition
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PHR Physicians for Human Rights
Johns Hopkins Bloomberg School of Public Health — Center for Public Health and Human Rights
Human Rights Center, UC Berkeley School of Law
Drexel University Dornsife School of Public Health — Office of Global Health
IntraHealth International — Because Health Workers Save Lives.
MAP Medical Aid for Palestinians
IFMSA International Federation of Medical Students' Associations
SAMS
MedGlobal