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Documenting Attacks on Health Care Facilities, Case Study: Syria

Since the inception of modern warfare, attacks on health-care facilities and personnel have been used as a weapon of war. The deliberate targeting of health-care infrastructure in Afghanistan, Libya, Syria, Iraq, Somalia, South Sudan, Ukraine, and Yemen, and failure of the international community to act have normalized these violations of international humanitarian law. According to the International Committee of the Red Cross, there have been 2,400 attacks on medical services across 11 countries in the past three years.

Syria is among the worst examples of armed forces targeting medical care as a weapon of war. Patterns of attacks on health-care in Syria have included the bombing of field hospitals, the looting of ambulances, the torturing of patients, and execution of doctors. Although attacks on health-care have occurred in other conflicts, Syria's civil war is the first conflict where health-care facilities and personnel have been attacked as part of a systematic strategy. From the time of this writing, there has been a total of 378 aerial attacks on 265 health-care facilities, which have resulted in 750 medical personnel death. For the aforementioned reasons, Syria is used as my case study.

Data collection of attacks on health-care is very important. The data is predominantly used to increase awareness, accountability and advocacy. Data on the attacks on health-care can be used in the field of conflict prevention and response, by being adopted as an indicator in early warning systems. It also has the potential to show patterns of violence that are able to reveal the intent, extent, and at times, the nature of violence by armed forces.

In terms of the collection processes, health professionals, by their professions, are naturally situated to collect medical documentation that provides concrete evidence of human rights violations. The data collected by them on health-care attacks include the work from a wide range of professionals: including those of toxicologists, burn specialists, orthopedic surgeons, psychologists, and forensic scientists, to name a few. Physicians for Human Rights explains "such medical documentation is far more difficult to refute than oral or written testimonies of abuse, no matter how well corroborated by witnesses." As a result, there is an added value to the data collected on health-care attacks.

International humanitarian law (IHL) has provided a framework for assuring protection and respect for medical personnel, medical facilities, and ambulances, in international and non-international armed conflicts. During armed conflict, medical personnel and aid workers are protected under the principle of medical neutrality, which has a strong foundation in medical ethics and international law. Medical neutrality requires: 1. The protection of medical personnel, patients, facilities, and transport from attack or interference, 2. Unhindered access to medical care and treatment, 3. The humane treatment of all civilians, 4. The nondiscriminatory treatment of the sick and injured. The protections of these elements are stipulated in International Humanitarian Law (IHL) for state and non-state parties. The Geneva Conventions of 1864 have multiple articles ensuring the right to health in international armed conflicts and non-international armed conflicts. The Commentary to Additional Protocol II explains "it should be recalled that respect and protection imply not only the obligation to spare

the people and objects concerned, but also to actively take measures to ensure that medical units and transports are able to perform their functions and to give them assistance where necessary.”

Therefore, my research question is: 1. Who is documenting the attacks on health-care facilities in Syria? and 2. Are their methodologies effective? I have chosen health-care facilities as the object to document since they have endured the highest number of attacks as opposed to ambulances, health personnel, or health entities. Effectiveness in my research question is defined as the ability for the data to show the pattern and nature of attacks being committed by a party to a conflict.

At the beginning of my research project, my methodology comprised of aggregating the quantitative data from all the different organizations documenting attacks on health-care facilities. Through aggregating the data, I would be able to determine which datasets had advantages over others. For example, which gave more qualitative information on how the attack occurred, which gave a more accurate account for the number of casualties, which described the damage to the facility itself? Through analyzing the data, I would be able to look at each organization's methodologies to determine how they produced this data, and what recommendations I would pose to ameliorate the data collection processes. Unfortunately, half-way through my SURF project, it became clear that I would not have access to the data collected by these NGOs. Since a lot of this data is privy and contains sensitive identifiers, organizations were very reluctant to disclose this and I was compounded with more recommendations than ability to data collect during my interviews. Therefore early on, it became clear that I would have to use different sources to retrieve the data. This included the use of interviews by all five organizations documenting attacks, and official UN reports that mention attacks on health-care to determine which sources they used.

What I had found early on in my interviews was that although they were all collecting the same broad type of data, each organization had different purposes for collecting the data on attacks on health-care. For example, PHR wants to use their data for accountability purposes in the International Criminal Court. The WHO is interested in looking at the scale of effects of health of these attacks on conflict zones. Johns Hopkins is filling an information gap on the qualitative data of these attacks from local practitioners on the ground. Since all of them were fulfilling different criteria with their data, they had different methodologies and definitions on the data they captured. This produced seemingly variable datasets that were very hard to compare. For example, their definitions of health-care facilities, health-care personnel and attacks were different in every methodology. This already stood as a barrier for further assessment of effectiveness of a methodology.

To satisfy my definition of effectiveness, I determined three criteria that were of paramount importance to each methodology. This included: time-effectiveness (producing data 1-2 days after an attack occurred), accuracy (by a two-tier verification method where more than two sources corroborate an attack), and accessibility (an open-source database for non-affiliated parties to use). Unfortunately, none of the organizations satisfied these three criteria. What I found is that, contrary to what I had thought, efficiency and accuracy are not mutually exclusive events. Johns Hopkins has been able to perfect the data collection of attacks in an emergency response by creating a health-cluster of hospitals to respond immediately when an attack occurs.

Secondly, making accuracy and accessibility compatible was a difficult feat. With an increased and accurate methodology, the type of data collected became increasingly sensitive which decreased the organizations incentive to share the data. I rationalized that if this data was very sensitive, organizations documenting attacks would only be sharing their data to highly established organizations such as the United Nations Office of the Security General or Human Rights Commission for Syria or the World Health Organization. However, none of their reports produced data collected from any other organization than Physicians for Human Rights, whose purpose is providing open-source data for future accountability measures. Therefore, human rights organizations as a whole must be more open with their data.

Therefore, my findings from my research project are: 1. that there should be a standardized definition across methodologies and datasets, 2. organizations should increase co-operation within their field and 3. methodologies should aim to produce open-source datasets for the public to access.