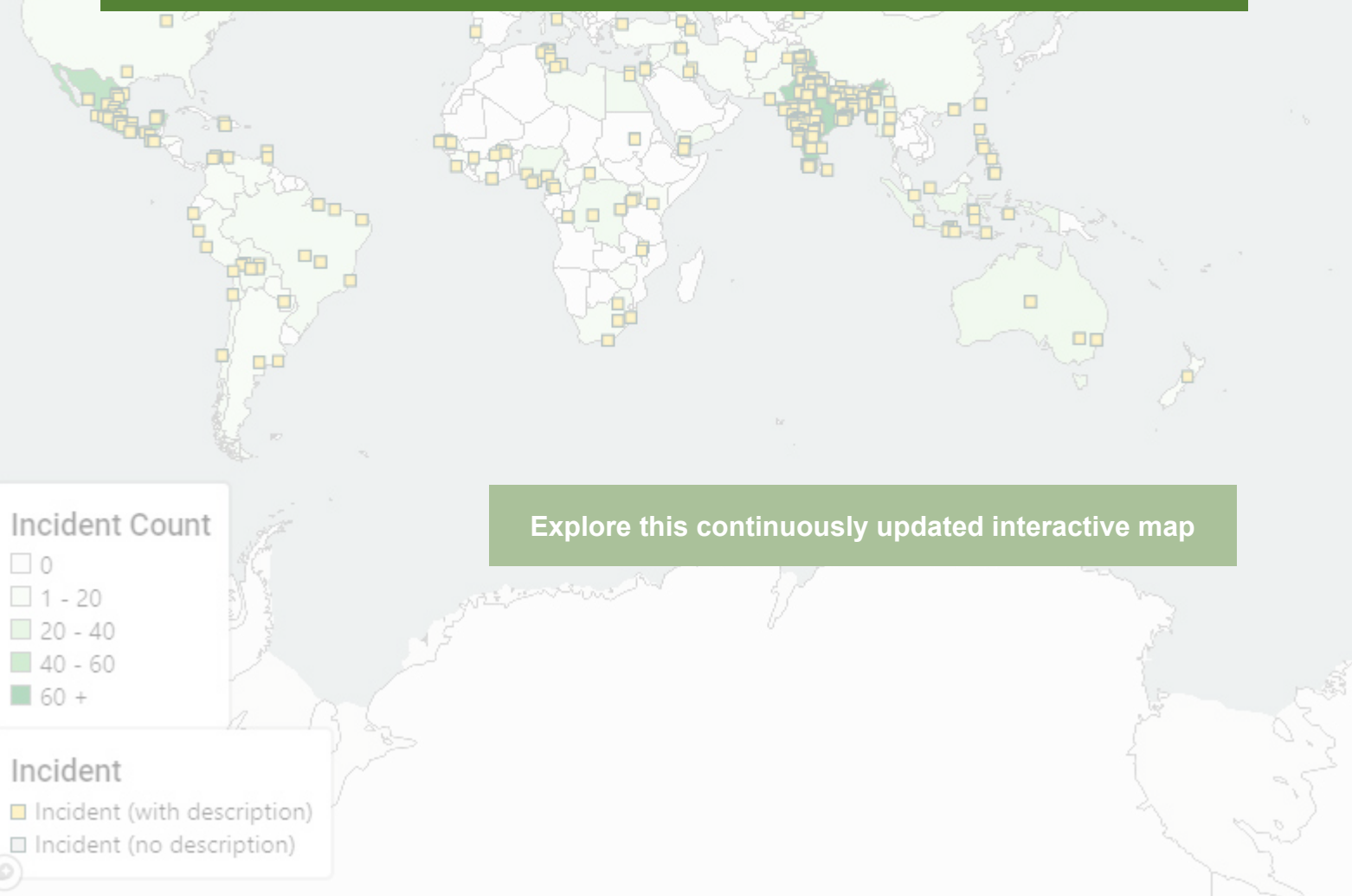


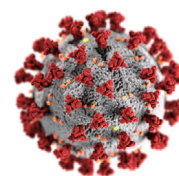


412 reported incidents globally
01/01/2020 - 31/12/2020

Threats and Violence against Health Care during the COVID-19 Pandemic in 2020



By Insecurity Insight, the Researching the Impact of Attacks on Healthcare project (RIAH)
and the Safeguarding Health in Conflict Coalition (SHCC)



Introduction

When the World Health Organisation (WHO) declared COVID-19 to be a pandemic on 11 March 2020, only just over 100,000 cases of the new respiratory disease had been confirmed. Less than a year later there are over **109 million confirmed cases** of COVID-19, and over **two-and-a-half million people have died** from the viral disease.

The global and rapidly spreading virus has placed unprecedented demands on health systems in most countries around the world. Health providers have struggled to keep pace with the rising care needs, and many health structures have experienced massive disruptions to their provision of health care services.

As a public health control measure many governments imposed lockdowns on their populations that were maintained, lifted, and reimposed as infection rates surged and ebbed across the world's regions and countries.

On the front lines of the fight against the pandemic, health workers faced and continue to face **difficult working conditions**, including insufficient and inadequate personal protective equipment (PPE), increased working hours, psychological distress, burnout, and mass traumatisation. At the same time the world is experiencing an infodemic resulting in mis- and disinformation undermining the public health response, fuelling stigma, increasing conflict and violence, and threatening people's physical and mental health.

In most cases, communities have applauded en masse to recognise and thank health workers for their efforts. However, there have also been numerous reports of health workers being threatened and assaulted.

Violence against health workers is not a new concern. Emergency services in particular regularly report **threats or violence** against health workers. For example, in the United Kingdom, the annual health staff survey for 2019 showed that over 14% of health workers said they had experienced physical violence from patients, their relatives or the **public**. Rising rates of violence against health services have been previously **reported** in India, and health workers in South Africa have spoken up about the unacceptable levels of **violence** they face.

Violence against health services in conflict settings has also been a considerable concern for many years. While international humanitarian law demands that health care staff and facilities should be protected, the reality is different. The Safeguarding Health in Conflict Coalition documented **1,203 incidents** affecting health care in 20 countries and territories in conflict in 2019. Among these, **434 incidents** occurred during the tenth outbreak of the Ebola epidemic in eastern Democratic Republic of the Congo (DRC), which has long been plagued by **protracted conflict**.

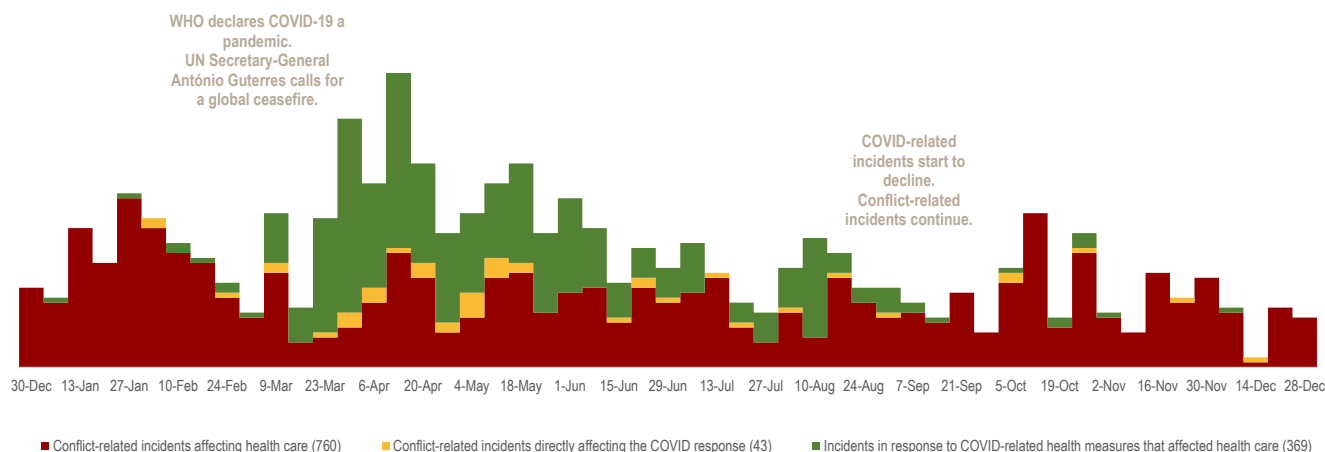
This report presents the documented threats and violence against health workers and facilities in the context of the COVID-19 pandemic. It discusses the perpetrators of this violence and the contexts that triggered it.

The report is based on **Insecurity Insight's** monitoring of incidents affecting health care carried out throughout 2020 for the **Safeguarding Health in Conflict Coalition**.

Violence against health care in the context of the COVID-19 pandemic in 2020

Monitoring by **Insecurity Insight** has identified 412 attacks on health care related to the COVID-19 pandemic between January and December 2020. Health workers were abused, injured, threatened and harassed, and health facilities were attacked, damaged and/or set on fire in these incidents. The incidents referred to in this report are unlikely to be a complete record of all incidents that affected health care in 2020.

Attacks on health care (January-December 2020): reported attacks on health care in the context of conflict or COVID-19

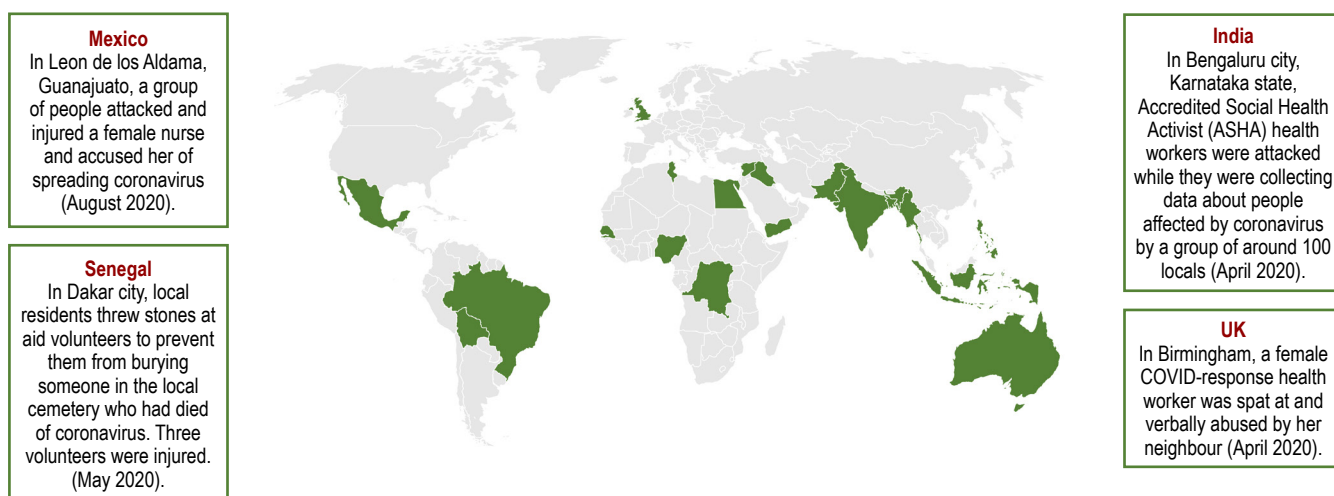


The graph shows (in red) the conflict-related violence against health care, highlighting the permanent undercurrent of violence perpetrated by conflict parties. Reported COVID-19-related violence (in green) peaked in the early weeks of the pandemic and has since fallen. It is unfortunately not possible to compare the number of reported cases of violence against health workers and facilities in non-conflict settings because no systematic global data on reported incidents of this kind is available.

COVID-19-related violence against health care was reported in many countries. Violent incidents and threats have been frequently reported in India and Mexico. Facilities that were essential for the COVID-19 response were also affected (events shown in yellow in the graph) when conflict-related violence damaged and destroyed health facilities or killed or injured health workers.

Countries with high numbers* of reported incidents directly related to the COVID-19 pandemic between January-December 2020 (see incidents coded in green on the [interactive map](#))

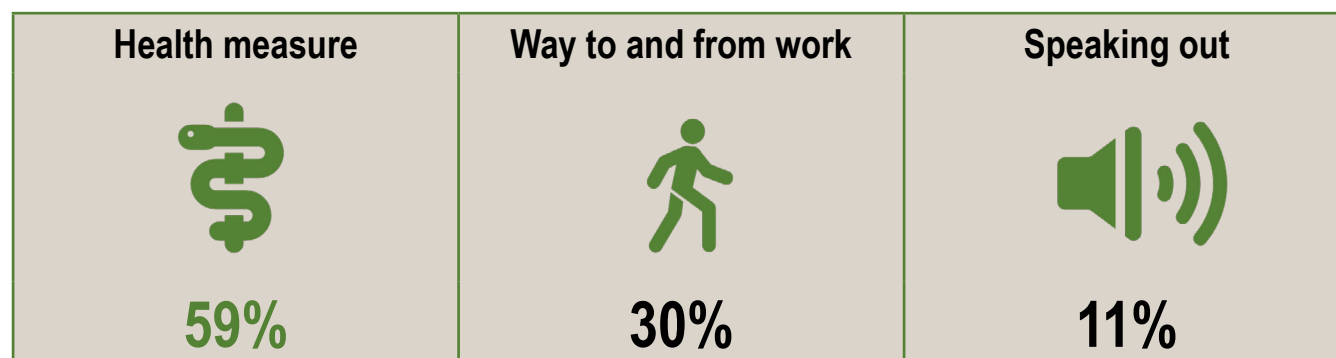
* Countries where five or more incidents were reported between January and December 2020.



[Explore this continuously updated interactive map](#)

Triggers for abuse and violence directed at health workers during the COVID-19 pandemic

In most COVID-19-related incidents abuse or violence was triggered by people opposing health measures intended to contain the spread of the virus. Health workers also faced abuse or violence while travelling to and from work, and for speaking out against difficulties they experienced in their work, including the lack of PPE.

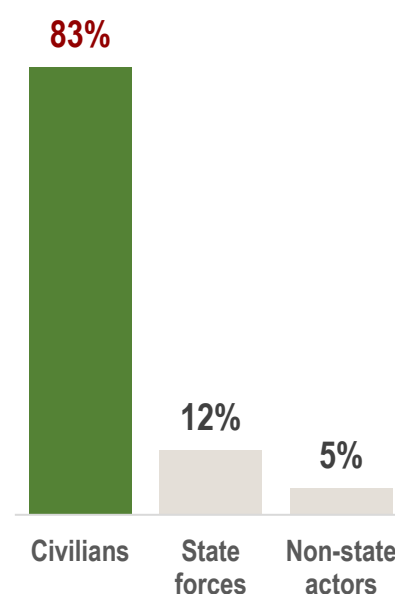


Threats and violence triggered by opposition to health measures

- Threats or violence directed at health workers was frequently triggered by opposition to medical tests for COVID-19 diagnosis or by decisions to hospitalise an individual. In the images shown on this [story map](#) a health worker in India is chased out of the neighbourhood in Indore, Madhya Pradesh state.
- These types of incidents usually took place at hospitals and/or while health workers were on duty, and were most frequently reported in India, Indonesia and Mexico. During one incident in [Mexico](#) a health worker carrying out COVID-19 contact tracing was physically abused by a family member of an infected person who accused the health worker of being the source of the infection. In another incident – shown in detail on this [story map](#) – a health worker is accused of claiming to have a COVID-19 infection for personal gain.
- Another trigger was opposition to hospitals being used to treat COVID-19 patients, which occurred in India, Hong Kong and Mexico. In Hong Kong, petrol bombs were thrown at at least four health centres after the government had listed them as designated clinics for COVID-19 treatment, which had caused dissatisfaction due to authorities' failure to consult the public. Two clinics were targeted more than once. In Mexico, at least three health clinics under construction for use in the COVID-19 response were threatened with or targeted in arson attacks.
- Changes to burial practices requested by authorities to prevent the spread of the virus also triggered violence and affected health workers when they attended such events. Opposition to changes to burial practices were common in India and Indonesia. During these incidents health workers were threatened, sometimes by family members of the deceased person armed with knives; assaulted; and injured by stones thrown at them. In one incident in Tunisia, family members and relatives of a deceased COVID-19 patient violently attacked health workers and destroyed health equipment at the Ibn Al Jazzar Hospital in Kairouan city in their attempt to remove the body of the deceased from the hospital.

Known information on perpetrators

- Civilians, including local community members, protesters, patients, and their families, are named as perpetrators in over 80% of reported incidents related to COVID health measures.
- During one incident dozens of family members and members of the local community, some armed with sharp weapons, stopped an ambulance carrying a recently deceased COVID-19 patient while it was on the way to a cemetery in East Java province, Indonesia. The group threatened the health workers before removing the body with the intention of burying it without implementing the COVID-19 burial protocol.
- State forces or non-state actors are less often opposed to COVID-19-related health measures. However, there are incidents where members of the security forces seem to act in response to their personal opposition to what health workers had asked them to do. For example, in one incident in Erbil city in the Kurdistan region of Iraq, a police officer attacked and injured a health worker who, days earlier, had transferred the officer to hospital for a COVID-19 test after he had shown signs of having a fever. The police officer was later arrested.
- There are also some instances where conflict actors have confiscated or stolen COVID-19-related health equipment. For example, in Yemen, armed men in two military vehicles stormed a health facility in Aden city and stole 12 sprinkler devices used for COVID-19 disinfection.



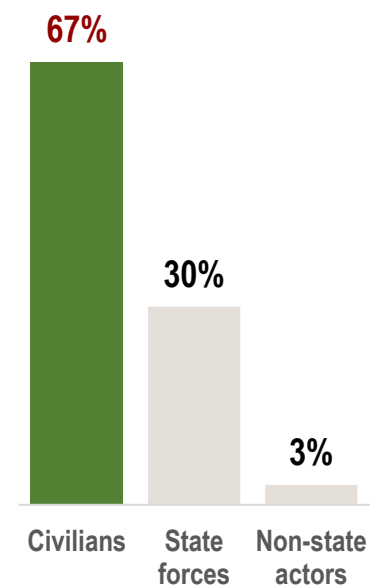
Health workers abused and harmed on their way to and from work

- At least 100 reported incidents occurred while health workers were on their way to or from work and account for a quarter of all reported attacks on health care related to the COVID-19 pandemic.
- Health workers, often while wearing official uniforms and/or ID badges, have been reportedly assaulted, threatened, called “disease spreaders” and spat on by individuals in the community.
- Fear, misinformation, and distrust are the main triggers for violence or abuse and have prompted accusations of health workers being responsible for spreading the virus.
- Police or other state security forces have threatened, assaulted or arrested health workers whom they had accused of breaking lockdown measures.

Known information on perpetrators

- Civilians, including local community members and protesters, are frequently named as perpetrators of attacks on health workers. In Australia, an intensive-care nurse wearing scrubs who was boarding a train was assaulted on suspicion of spreading COVID-19. As a result of increasing hostility health workers in Australia are being encouraged not to wear work clothing in public. In the Philippines, an ambulance driver was shot and wounded by a neighbour who objected to the driver parking the ambulance in a residential district in the belief that it could carry the COVID-19 virus. The driver was hospitalised and the neighbour was taken into police custody.

- Security forces' policing of lockdown measures has also led to violence against health workers on their way to work who were inappropriately accused of ignoring stay-at-home measures. In Burkina Faso, gendarmes assaulted an ambulance driver for not complying with a COVID-19 curfew. In Kathmandu city, Nepal, three doctors returning home after work were assaulted by police officers, who accused them of violating the lockdown enforced to minimise the spread of COVID-19.
- Two-thirds of attacks on off-duty health workers were reported in India and Mexico. In India, police officers are frequently named as perpetrators. In one incident police officers accused two junior doctors on their way home after going off duty at a hospital of spreading COVID-19 and beat them with sticks. In Mexico, protesters are frequently named as perpetrators of violence against health workers. During one incident an individual accused a nurse of spreading COVID-19 and doused her with scalding coffee.



Arrested and threatened for speaking out

- Health workers were threatened, suspended, fired, and arrested for speaking out against difficulties they had experienced in their work. In Egypt, state forces arrested health workers after they criticised the country's handling of the COVID-19 response. By speaking out, health workers have been accused of spreading fake news, misusing social media and joining a terrorist organisation. In one case three doctors were arrested after they criticised the export of medical equipment despite local shortages. State media accused them of having links to the Muslim Brotherhood, a banned political group.
- In India, police officers arrested a doctor in West Bengal state for sharing images of doctors wearing raincoats as a form of PPE in the COVID-19 ward of a government hospital when the correct PPE was unavailable. He was released the following day, but only after posting on social media that the state government was working hard to help doctors.
- In Venezuela, an unknown number of health workers continue to be arrested, often for reporting COVID-19 cases. In one case a doctor in Lara state was accused of carrying out a hate crime after having criticised the national government via WhatsApp messaging for its handling of the COVID-19 pandemic and was arrested by DGCIM officers, but later released. (DGCIM is the country's military counter-intelligence agency.)

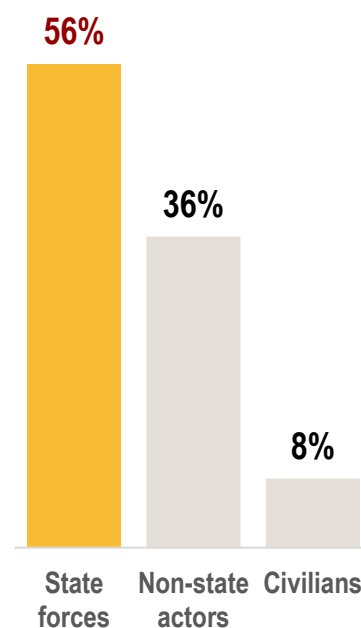
In some countries governments are responding to attacks on health care and taking action by introducing new policies to protect health care staff and facilities.

- The Indian government has amended the Epidemic Diseases Act to make it protect all health workers, including ASHA workers at the community level. Perpetrators of attacks on health workers are now punishable with prison terms of up to seven years.
- In Australia, the New South Wales government has extended a ministerial direction under the Public Health Act to make it a criminal offence to spit at or cough on health workers at work or travelling to and from their workplaces during the COVID-19 epidemic. Police now have the power to issue an AU\$5,000 on-the-spot fine to anyone who coughs or spits at health workers.
- In Mexico, some cities have implemented dedicated transport services for health workers after many were refused entry to public buses.

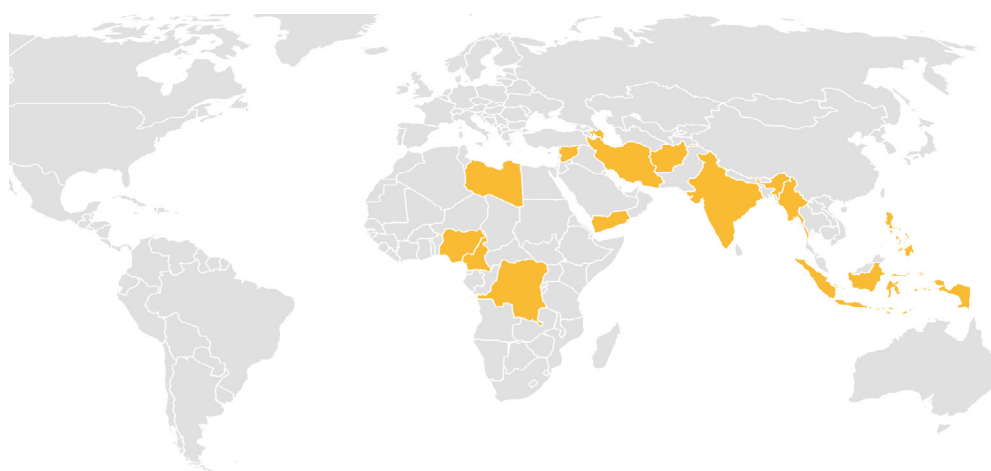


Conflict-related violence affecting the COVID-19 response

- Insecurity Insight's monitoring of attacks on health workers and facilities during the pandemic has identified 43 conflict-related events affecting the COVID-19 response in 12 countries between January and December 2020.
- These incidents took place after UN Secretary-General António Guterres had called for a global ceasefire amid the COVID-19 pandemic on 23 March 2020. Reminding the world that in war-ravaged countries health care systems have often collapsed and that health professionals have been targeted, he called on warring parties to cease hostilities, silence the guns and end air strikes on civilians.
- Health providers supporting COVID-19 response efforts came under attack in what appear to be targeted violence by conflict actors. In Myanmar, a marked WHO vehicle transporting COVID-19 testing samples came under gunfire, resulting in the death of the driver; a health worker was also injured in the incident. In Cameroon, suspected Ambazonian separatists destroyed hand sanitisers; in Libya, a plane reportedly carrying COVID-related equipment was shot down; and in Yemen, armed men in military vehicles stormed a health facility and stole 12 disinfectant sprinklers.
- Violence by conflict parties damaged hospitals treating COVID-19 patients in Libya and quarantine centres in Yemen. Air strikes and shelling in both countries hit at least 11 hospitals and COVID-19-related facilities between March and May 2020. This includes air strikes on 6 and 7 May on the Al Khadra Hospital in Tripoli, Libya, which was treating COVID-19 patients, and on three COVID-19 quarantine centres in Al Hudaydah Al Bayda, Ma'rib and Taiz city governorates, Yemen. For images of health centres hit by air strikes in Libya, see the [story map](#).
- The violent actions of conflict parties that do not respect the work of health workers and health facilities will make it harder to control the pandemic in conflict-affected countries. Such violence also undermines primary health care and preventive health policies.

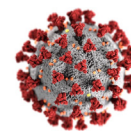


Countries experiencing conflict-related incidents directly related to the COVID-19 pandemic between January-December 2020 (see incidents coded in yellow on the chart on page one)



* Occupied Palestinian Territory

	Number of incidents
Myanmar	12
Yemen	8
Cameroon	4
Libya	4
Syria	3
DRC	2
Nigeria	2
oPt*	2
Afghanistan	1
Azerbaijan	1
India	1
Indonesia	1
Iran	1
The Philippines	1



Recommendations

STATES SHOULD:

- Work with health workers to develop detailed measures for their protection and include these measures in national pandemic response plans;
- Develop and implement strategies to effectively communicate reliable, evidence-based, and timely information on COVID-19 and related violence against health care to all populations, with a particular focus on high-risk groups;
- Ensure that perpetrators of violence are held accountable through strong and responsible law enforcement actions;
- Invest in and improve systematic data collection programmes on the incidence of violence against health workers, disaggregated by types of attacks and the gender and profession of both victims and perpetrators;
- Invest in training and procedures that protect health workers as part of COVID-19 emergency budgets;
- Actively support global efforts to ensure all countries' equitable access to COVID-19 vaccines, prioritising the vaccination of health workers; and
- Take all actions mandated by UN Security Council Resolution 2286 and the Secretary-General's implementation recommendations.

CIVIL SOCIETY ORGANISATIONS AND HEALTH-WORKER ASSOCIATIONS SHOULD:

- Strongly condemn acts of violence perpetrated against anyone by any person and express solidarity with and support for health workers who have been targeted by or are at risk of violence;
- Advocate for law reforms to better protect health workers;
- Collaborate with governments to take meaningful action to support the protection of health workers and the prevention of violence against them;
- Develop or strengthen mechanisms to collect, report, and disseminate data on violence against health care during public health emergencies and humanitarian crises;
- Raise public awareness of the incidence and health, social, and economic consequences of violence against health care;
- Develop coordinated strategies to support the communication of accurate and timely information on COVID-19, including transmission and vaccination;
- Work with and empower communities to manage mis- and disinformation and increase their resilience against it; and
- Ensure health workers' access to confidential, free mental health and social support services (including legal services).

HEALTH CARE ORGANISATIONS SHOULD:

- Use the available data to develop policies and practices that help to protect health workers.
- Ensure appropriate and effective risk analysis and management systems, policies and procedures are developed and implemented, and workplace safety plans are in place that include violence prevention and response measures;
- Invest in training and procedures that protect health workers as part of COVID-19 emergency budgets; and
- Create or facilitate user-friendly, confidential and effective reporting mechanisms to record cases of abuse of and violence against health workers.

DONORS SHOULD:

- Invest in data collection on and analysis and dissemination of reports on violence against health care during pandemics; and
- Invest in research on the impact of violence against health care on health systems during a pandemic.

THE WORLD HEALTH ORGANISATION SHOULD:

- Improve its Surveillance System of Attacks on Health Care (SSA) to include data disaggregated by conflict- and pandemic-related violence.

You may be interested in:

- Download the data cited in this report on the **Humanitarian Data Exchange (HDX)**
- Visit our **website** or **follow** us on Twitter
- Join our **mailing list**



Definitions

Attack on health care

Any act of verbal or physical violence, obstruction, or threat of violence that interferes with the availability of, access to, and delivery of curative and/or preventive health services perpetrated by state and non-state actors, patients or relatives of patients, private individuals, and criminals.

Attack on health care during the COVID-19 pandemic

Any act of verbal or physical violence, obstruction, or threat of violence that interferes with the availability of, access to, and delivery of health services in the context of the COVID-19 pandemic.

Conflict-related attack on health care

Any act of verbal or physical violence, obstruction, or threat of violence against health providers perpetrated by conflict actors.

Resistance to COVID-19-related health measures

Includes resistance to medical tests to check for COVID-19 infections or antibodies; opposition to changes in local burial or cremation customs and practices, such as prohibiting relatives from attending funeral ceremonies or from viewing the deceased before burial/cremation; and protests against the use of specific burial locations for COVID-19 victims.

Attack on or opposition to hospitals or buildings being used to treat COVID-19 patients

Includes resistance to hospitalisation to treat COVID-19 in a hospital ward; opposition to the use of hospitals to treat COVID-19 patients; damage to and destruction of hospitals treating COVID-19 patients; resistance to quarantine measures or opposition to the presence of quarantine centres; and damage to or destruction of quarantine centres.

Resistance to public health measures

Includes resistance to disinfection; attacks on workers carrying out disinfection activities; resistance to COVID-19 sensitisation campaigns; attacks on individuals engaged in sensitisation campaigns; opposition to social-distancing measures that takes the form of protests or violence against health providers; or resistance to contact-tracing activities.

Speaking out

Includes health workers speaking out against difficulties in their work, such as the lack of personal protective equipment or being criticised/disciplined for reporting higher infection rates than those reported by the government.

Way to and from work

The health worker was en route to or from work when the incident happened.

Data and limitations

The dataset is based on identified reported incidents of violence against health care systematically compiled from two categories of sources: (1) open-source information, as published in the **'Attacks on Health Care Monthly News Brief'** and information alerts by Insecurity Insight, the **Armed Conflict Location and Event Data Project (ACLED)**, and other sources; and (2) information on verified security incidents submitted to Insecurity Insight by **Aid in Danger** partner agencies and confirmed incidents published on the publicly available **WHO SSA** dashboard. This data can be viewed by country on the global map **'Attacked and Threatened: Health Care Targeted in Conflict and COVID-19'** and downloaded on the **Humanitarian Data Exchange (HDX)**. Additional data and photographic evidence can be viewed on the story map **'Violence against Health Care: Attacks during a Pandemic'** produced in collaboration with the **Human Rights Center at the University of California, Berkeley**.

The data presented is neither complete nor comprehensive and may differ from that given in other sources. The incidents documented suggest a minimum estimate of the number of violent incidents adversely affecting the provision of health care. The severity of the problem is likely much greater because many incidents are not reported.

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