HUMANITARIAN ACTION AND ETHICS

With a Foreword by Hugo Slim
Edited by Ayesha Ahmad and James Smith

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‘Books change us. Books save us. I know this because it happened to me. Books saved me. So I do believe through stories we can learn to change, we can learn to emphasise, and be more connected with the universe, and with humanity.’

Elif Shafak

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8 | ETHICAL CHALLENGES AMONG HUMANITARIAN ORGANISATIONS: INSIGHTS FROM THE RESPONSE TO THE SYRIAN CONFLICT

Kory L Funk, Diana Rayes, Leonard S Rubenstein, Nermin R Diab, Namrita S Singh, Matthew DeCamp, Wasim Maziak, Lara S Ho and W Courtland Robinson

Background

Decision-making for humanitarian health organisations in armed conflict, where combatants often violently interfere with humanitarian operations, is fraught with ethical challenges. Health workers often find themselves confronted with dilemmas where answers consistent with humanitarian values and standards do not exist, requiring what Hunt et al. (2012) describe as the need to choose a 'least-worst option'. De Waal (2010) refers to these challenges as among humanitarianism's 'inescapable cruelties', and argues that they are an unavoidable consequence of working at odds with the interests of powerful forces of war.

Increasingly, the ethical challenges that humanitarian health workers face are the result of direct attacks on healthcare facilities and health workers themselves. In 2016, attacks against health workers were recorded in twenty-three countries (SHIC, 2017). Although determining recent trends in attacks against health workers is difficult, in part due to the lack of standardised reporting (ibid.), it is clear that such attacks are not a new phenomenon (Abu-Sa'Da et al., 2013; Pedersen, 2002).

During the ongoing Syrian Civil War, health workers have been systematically targeted. The war has decimated the Syrian health system, which had seen a steady improvement in health outcomes in the preceding decades (Kherallah et al., 2012; Save the Children, 2014). In April 2011, pro-government forces began arresting doctors, paramedics, and patients in protest areas (Fouad et al., 2017), and

in July 2012, the Syrian government passed 'anti-terrorism' laws that effectively criminalised the provision of medical aid to opposition groups (OHCHR, 2013). By September 2013, an estimated 15,000 doctors had fled Syria; by November 2016, that number had increased to 27,000 (Al Dardari, 2016; Iacopino, 2014). The World Health Organization estimated that more than half of Syria's hospitals were either closed or only partially functional by the end of 2016 (WHO, 2017). A review of data from multiple sources by Fouad et al. (2017) found that, as of March 2017, the number of health workers killed in targeted attacks had risen to 814, of which 723 were attributable to the Syrian Government and its allies. The same data also found that attacks on health facilities in Syria steadily increased between 2013 and 2016 (ibid.).

Few studies have been conducted on the impact of attacks against health workers. In Yemen, Neuman (2013) observed – even before the current conflict, in which hospitals have been bombed – that Yemeni doctors live in a constant state of fear due to threats of violence, and explored the impact of this on health outcomes and public perceptions of health workers. In eastern Burma, Footer et al. (2014) documented how fear and insecurity among health workers have made it difficult to fulfil the right to healthcare in minority communities. While these studies provide some insight into how attacks targeting health workers generate serious ethical challenges concerning obligations to act with neutrality and impartiality, to ensure quality of care, and to serve all in need and ensure the safety of staff, additional research is needed to better understand these issues and pathways to addressing them.

In light of this need, our study team, including members from the Johns Hopkins Bloomberg School of Public Health (JHSPH), the Syrian American Medical Society (SAMS), and the International Rescue Committee (IRC), sought to better understand the ethical challenges that humanitarian health organisations face in violent settings, and their implications for decision-making in such contexts. This chapter presents a preliminary analysis of themes and relationships from key informant interviews with managerial staff of humanitarian organisations operating in Syria. Interviews were conducted between January and March 2017 in Gaziantep, Turkey and Amman, Jordan, which serve as key hubs for organisations working in northern and southern Syria. The interviews formed part of the first phase of a

two-year study entitled, 'Ethical challenges in humanitarian health in situations of extreme violence'.[1]

Methods

Key informant interviews (KIIs) were conducted using a semi-structured interview guide with staff members of organisations who are currently providing (or have provided) medical services inside Syria. The guide asked respondents about their role within their organisation, the services provided by their organisation, and what ethical challenges their organisation has faced while providing or supporting the provision of health services in Syria. Eight interviews were conducted in Arabic, four were conducted in both Arabic and English, and the remaining twenty-two were conducted in English. Interviews in Arabic were conducted and later translated into English by members of the study team fluent in both Arabic and English. No audio-recording equipment was used, as the goal of the KIIs was to capture major themes and guide the development of subsequent study phases, which will include in-depth interviews with field staff working in Syria and stakeholder workshops, with the ultimate goal of developing an ethical framework, tool, and guidelines to enable humanitarian health organisations to respond to complex ethical challenges in violent settings. Interview notes were recorded by hand or typed by the interviewer, and later transcribed electronically in English. Interview participation was restricted to qualified managerial staff who: were responsible for the coordination or administration of humanitarian health relief efforts inside Syria; were at least eighteen years of age; spoke English or Arabic; were accessible in Jordan or Turkey during the interview period of January to March 2017; and were willing to provide verbal, informed consent.[2]

Forty-one respondents (thirty-two males, nine females) took part in thirty-four interviews (nineteen in Turkey, fifteen in Jordan), representing twenty-seven organisations (sixteen international, eleven local) who were recruited from the list of members of the World Health Organization's Health Clusters in Amman and Gaziantep, and with the aid of additional snowball sampling. The majority of interviews were completed by an individual respondent, although two interviews in Turkey and two interviews in Jordan were conducted with more than one respondent present. Representatives of one multi-government and one United Nations entity were interviewed in Jordan, while

the rest of the interviews were conducted with non-governmental organisations. Most of the organisations worked in opposition-controlled areas, although some worked in areas controlled by the Syrian government. Most of the organisations interviewed operate or support primary health centres inside Syria, with many supporting secondary healthcare services, outreach, logistics, and other health-related operations. Some of those interviewed were also responsible for health service provision to refugees or displaced persons in Jordan or Turkey, but it should be noted that these services were not the subject of the interviews.

Once all of the interviews were completed, a member of the study team analysed the interview transcripts using qualitative content analysis (Morse & Field, 1995) to identify challenges in general, and once this was completed, to focus more specifically on ethical challenges. 'Challenge' was defined as a difficulty encountered by an organisation during the course of their humanitarian health operations inside Syria, while 'ethical challenge' was defined more specifically as a challenge that made it difficult or impossible for an organisation to provide services consistent with humanitarian and bioethical principles. Descriptions of how organisations responded operationally to challenges were also analysed.

Once all of these challenges were identified, six themes were identified by a team member such that challenges could be grouped into thematic categories which described the context in which the ethical challenge arose, and which might be useful in the formulation of questions for the subsequent in-depth interviews that would hone in on ethical challenges faced by field staff inside Syria. These themes included: challenges related to targeted attacks; access restrictions; resource limitations; engagement with governing authorities and armed groups; cultural norms; and the demands of donors. Each challenge was matched to a single, most relevant theme, as determined by a team member. The ethical challenges described in this chapter were selected from this analytical process.

Results

Numerous ethical challenges were identified spanning a variety of themes. Challenges identified as stemming from physical attacks were most frequent, followed by those stemming from access restrictions, resource limitations, and the actions of governing authorities and armed

groups. Challenges identified as stemming from cultural issues and donor behaviour were also present, but were less frequently reported. The ethical challenges experienced and reported by humanitarian aid organisations were sorted into the following themes:

Attacks Targeting Healthcare

Many challenges originated from targeted attacks on healthcare, by far the most prevalent concern among respondents. Targeted attacks may create ethical challenges related to the need for health organisations to balance the safety of their staff and patients while under attack, with the obligation to provide care to the communities they serve. Respondents reported instances in which workers were injured, kidnapped, killed or threatened with violence, as well as situations where their organisation's facilities had been deliberately and systematically targeted, so much so that some could anticipate where and when the next attack would take place. Multiple respondents gave insight into their resulting dilemmas:

> The trend of attacking hospitals has led to the moving of hospitals underground … We know they are targeting health care centers. Now communities are refusing hospitals and health care centers because they believe it will be bombed.[3]

> How do you make it a safer environment? Do you decrease length of stay? Do you decrease the number of health care workers working there? Do you decentralise decision-making? Some communities have protested and even burned down health facilities because of fear that it will be targeted and increase risk.[4]

Another respondent described how the destruction of health facilities creates a burden on resources for other facilities in the area:

> There was a point where … a nearby maternal and child health hospital had sustained attacks over the course of three days. Two [hospitals] were destroyed completely … This was horrible for us because of the added stress on our facility … Think about 30,000 people living in [a] camp with one maternal and child health hospital to cater to them, then it goes out of service.[5]

Multiple respondents raised concerns about what they referred to as 'risk transfer', whereby larger organisations reserve more dangerous

tasks for smaller (usually Syrian) organisations in order to mitigate risks posed to their own staff. One respondent said:

> A lot of [international NGOs] don't have employees on the ground, but only work through partnerships with local people … this is all done so that they don't assume their responsibility if something happens to them … Staff are themselves being attacked and are traumatised, and these NGOs won't assume their responsibility.[6]

Restrictions on Access

Numerous challenges also arose from access restrictions. These included: the inability to physically transport materials or personnel into service areas due to the closure of the Jordanian and Turkish borders; denial of entry or passage by the Syrian government or other armed actors; and the inability to conduct in-person training or to monitor activities on the ground. These practices necessitated difficult choices about whose needs would be met, in what way, and how well, with constraints imposed by the combatants, rather than as determined by the needs of the communities.

One respondent described how restrictions on access contributed to a supply shortage, and how that may prevent the delivery of supplies to certain areas:

> In 2015, in Wa'er, I was buying from the black market. Where else can I get supplies? There were some big issues regarding malnutrition. We were only able to guarantee entrance of supplies after three months. Hard to reach areas are difficult.[7]

Restrictions on access also posed difficult questions about maintaining standards of care and accountability for these standards:

> We can follow up on medical procedures in Jordan, but who will assess that inside Syria? There is not any kind of accountability of those staff inside. We have stories about a nurse who is doing a laparotomy[8] – who will judge her at the end of the day? This is a huge problem in Syria.[9]

A respondent from a major donor expressed concern about dilemmas that arise when access limitations result in an inability to verify information germane to operations and to meeting responsibilities to communities:

> As an organisation that is accountable to the public, we cannot just 'trust' people with funds. But we cannot verify needs assessments; we have to rely on third parties. Who is controlling distribution? Who decides who gets treated? Most of the doctors running these clinics say that they're open to all, but without access, it is difficult to verify that.[10]

Limitations on Resources

Other ethical challenges related to a lack of adequate resources and the implications this had on the ability to meet community needs. These challenges included those related to staff shortages, which resulted in the overworking of staff, or practices that were beyond an individual's scope of training and knowledge; hospitals operating over capacity; and gaps in service provision, such as a lack of gender-based violence interventions or psychosocial support for children. These challenges all raised concerns about adherence to obligations to provide quality care and deliver humanitarian aid.

Multiple respondents described scenarios in which a lack of specialists led to physicians operating beyond their scope of practice. One respondent gave the following example:

> Staff availability is the biggest concern. Most of the staff have left Syria or fled inside the country. At the end of the day, that person needs money to support his family. At the same time, they cannot protect their family. Staff availability is very, very low. You will find a general surgeon doing a C-section or a general practitioner doing a normal vaginal delivery. You cannot abide by WHO or other standard guidelines.[11]

In addition to a lack of staff, hospitals operating beyond their capacity was also a common concern. The following respondent described difficulties with overcrowding after attacks on nearby facilities resulted in theirs being the only maternal and child health facility in the area:

> We had a flu outbreak – eighty-five kids to twenty cribs. The corridors [of the hospital] were filled with people sitting on mattresses, waiting. We had to place two babies per incubator … As a doctor, I know – I mean, I was trained that it is wrong for a hospital room to be crowded or to place two infants in one incubator. I have to make a decision based on the reality of the situation.[12]

A resource-limited environment also creates challenges for organisations that must set priorities and make decisions related to the equitable allocation and distribution of resources. One respondent described trying to work with beneficiaries in such situations:

> Our needs assessment might say 10,000 kits are needed, but only 5,000 are available. This can create a situation of people hating each other – 'Why did you get it and not me?' [or] 'Only IDPs, but not local residents?' … Go and distribute something, and then come back and ask if [they] got something the first time, they will say no. But if you say, 'if you got something the first time, I will give you something else', they will say yes … Even the medical facilities will lie about actual needs. You might train someone to do a facility assessment, and they go to the facility during the day and it is empty of equipment, but if they go back at night, it is full.[13]

Demands of Governing Authorities or Combatants

Additional challenges related to the actions of local or national governing authorities or fighters that could compromise organisational independence, neutrality and impartiality as well as medical confidentiality. Challenges falling under this theme included those related to: registration with the Syrian government; armed groups making demands about whom to hire or to whom to provide services, including the physical removal of trauma patients from facilities; armed groups asking for beneficiary information; or other challenges resulting from the influence of groups exercising authority that interfered with the ability to uphold the humanitarian principles and adhere to medical ethics.

Many respondent organisations were unregistered with the Syrian government and expressed concern about continuing to operate while not complying with the legal requirements to do so. They reported that the registration process can take years and involves providing the government with information about beneficiaries and staff that can compromise their security. One respondent described the risk this poses to their perception as a neutral and impartial organisation:

> You have to understand that even though we declare ourselves as a non-biased health organisation with no political standing, the mere fact that we are not 'pro-government' makes us [perceived as] 'the enemy' and 'anti-government'.[14]

Another respondent noted that registration might affect their organisation's standing with the local community as an impartial and neutral actor:

> Our credibility in Syria with beneficiaries and staff is that we are unaffiliated with the government. If we register, how does how our beneficiaries view us change? Working with the government is inherently political. They are trying to manipulate the humanitarian effort in their favour.[15]

Additional ethical issues arose as a consequence of interference with the obligation to provide impartial care. One respondent recounted the organisation's inability to follow through with needed treatment after an armed group removed a pro-government fighter who was receiving treatment from their facility:

> We couldn't do anything about it; we obviously couldn't refuse although [the fighter's] situation was critical … We never knew what happened to him; we obviously were scared for our own safety. Who do we report to? The government? We are not registered: of course we can't do such a thing![16]

Another common concern was that demands from combatants not to treat certain individuals led to decisions about whether to comply or to shut down a facility due to an inability to provide impartial care. A respondent noted that this was a concern for both health workers and patients:

> Sometimes we have to shut down treatment facilities and hospitals because groups ask, 'who are you treating?' We are a humanitarian organisation, we do not say 'no' just because someone is a fighter on one side or the other. We do not ask their background … We are not for one side or the other. Sometimes women will lie because their husbands are fighters. What do you do?[17]

Two respondents also noted the need to decide whether to adhere to the Syrian government's demand that organisations fabricate or censor information, rendering it difficult to assess actual needs on the ground. One respondent described the government's use of coercion to influence reporting, and the ethical dilemma this generated:

> We have to go back and forth on humanitarian needs documents because the [Syrian] government asked us to change them. The government wants no mention of serious violations or ethical challenges. For example, [a major international organisation to which the respondent reports] has come back to us and said, 'the government is threatening our staff, we need you to change this'.[18]

Cultural Norms

Challenges arose from conflicts between the responsibility to meet women's needs equally and local cultural practices and attitudes towards women and women's health. Organisations reported that services oriented towards women, especially reproductive health and gender-based violence services, are often difficult to implement; male gynaecologists often face harassment and family planning interventions must be implemented in secret. On gender-related issues, one respondent said the following:

> In women's hospitals, we need female doctors. For gender-based violence, we need female doctors … Female staff have their own issues – rape issues and risks at night when their work requires day and night shifts. Or a husband doesn't let his wife work, [or] a brother doesn't let his sister work.[19]

Donor Demands

Challenges also arose from donor demands that impeded independent decision-making and the use of judgement to meet the needs of beneficiaries. These demands included accountability standards and restrictions on how funding could be used that were not consistent with the reality of humanitarian aid delivery and cross-border access into Syria. These rules led to service gaps and a need to seek alternative funding to meet obligations to certain populations, and in some cases resulted in the denial of services to people. One respondent described the dilemma of deciding whether to work with external funders:

> Documentation and transparency … it is hard to put up signs and be noticed. But donor[s] ask … for example, the donor wants invoices for purchased projects, such as buying diesel … we don't buy diesel at a shop; we get it from a barrel.[20]

Conclusion

The responses of those interviewed for this study provide a valuable insight into the circumstances in which ethical decision-making challenges arise, based on the perspectives of members of humanitarian health organisations operating inside Syria. While those circumstances are varied and complex, our analysis suggests that health organisations are most commonly confronted with ethical challenges that make it difficult to fulfil their obligations to act with neutrality and impartiality, practise independent decision-making, ensure the equal treatment of women, and deliver an acceptable quality of care.

We intend to conduct further research, including interviews with field staff, to understand the nature and impact of ethical decision-making challenges on healthcare delivery in the context of violence, and to explore ways in which humanitarian health organisations can mitigate these impacts.

Limitations

It should be noted that this study has certain limitations. The findings here represent only a preliminary analysis of key informant interviews from the first phase of a two-year study. In this phase, interview notes were recorded by hand, which could have affected clarity and completeness of the recorded content. The second phase of the study, which will include in-depth interviews, may provide additional insight into these challenges, how they come about, and what organisations can do to mitigate their impact or prevent such challenges altogether. In the second phase, interviews will be recorded, and member-checking will be carried out to improve the credibility of results. In addition, most of the respondents that participated in this first phase work with organisations that operate in opposition-controlled areas of Syria. Ethical challenges faced by organisations operating in government-controlled areas might differ from those detailed here. Finally, study findings pertain to the conflict in Syria; while this context offers an ideal case study for the investigation of ethical challenges associated with violence against humanitarian health workers, appropriate caution should be taken before generalising our findings to other contexts.

Implications

We hope that the information and insights drawn from our study may be of use to humanitarian health practitioners, policy-makers, and researchers alike, who seek to gain a better understanding of the types of ethical challenges that humanitarian health organisations face, along with how these challenges are contextualised. This analysis underscores the need for continued research in this area, and for the development of guidance to support humanitarian health organisations operating in violent contexts.

Notes

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2 The study protocol was approved by the Institutional Review Board (IRB) at the Johns Hopkins Bloomberg School of Public Health, as well as the IRB at the Jordan University of Science and Technology, and the Ethical Research Committee at Gaziantep University.

3 Interview in Amman, January 2017.

4 Interview in Amman, January 2017.

5 Interview in Gaziantep, February 2017.

6 Interview in January 2017.

7 Interview in Gaziantep, February 2017.

8 A surgical incision into the abdominal cavity, which is beyond a nurse's scope of practice.

9 Interview in Amman, January 2017.

10 Interview in Amman, January 2017.

11 Interview in Amman, January 2017.

12 Interview in Gaziantep, February 2017.

13 Interview in Amman, January 2017.

14 Interview in Amman, January 2017.

15 Interview in Amman, January 2017.

16 Interview in Amman, January 2017.

17 Interview in Amman, January 2017.

18 Interview in Amman, January 2017.

19 Interview in Gaziantep, February 2017.

20 Interview in Gaziantep, March 2017.

References

Abu-Sa'Da, C, Duroch, A & Taithe, B (2013), Attacks on medical missions: overview of a polymorphous reality: the case of Médecins Sans Frontières. *International Review of the Red Cross*. Vol. 95 (890): 309–30.

al Dardari, A (2016), Syria's long-term humanitarian and development challenges [video]. Middle East Institute's 70th Annual Conference. Available from: www.youtube.com/watch?v=68GBLTM4KNQ&feature=youtu.be&t=42m21s (accessed 6 July 2017).

De Waal, A (2010), The humanitarians' tragedy: escapable and inescapable cruelties. *Disasters*. Vol. 34 (S2): S130–7.

ELRHA (2017), Research for health in humanitarian crises [online]. Available from: www.elrha.org/work/r2hc (accessed 21 August 2017).

Footer, KH, Meyer, S, Sherman, SG & Rubenstein, L (2014), On the frontline of eastern Burma's chronic conflict—listening to the voices of local health workers. *Social Science & Medicine*. Vol. 120: 378–86.

Fouad, FM, Sparrow, A, Tarakji, A, Alameddine, M, El-Jardali, F, Coutts, A, … Jabbour, S (2017), Health workers and the weaponization of health care in Syria: a preliminary inquiry for the Lancet—American University of Beirut Commission on Syria. *The Lancet*. Published online 14 March 2017.

Hunt, MR, Sinding, C & Schwartz, L (2012), Tragic choices in humanitarian health work. *Journal of Clinical Ethics*. Vol. 23 (4): 338–44.

Iacopino, V (2014), Attacks on medical care in Syria [online]. The Lancet Global Health blog. Available from: http://globalhealth.thelancet.com/2014/02/28/attacks-medical-care-syria (accessed 7 July 2017).

Kherallah, M, Alahfez, T, Sahloul, Z, Eddin, KD & Jamil, G (2012), Health care in Syria before and during the crisis. *Avicenna Journal of Medicine*. Vol. 2(3): 51–3.

Morse, JM & Field, PA (1995), *Qualitative research methods for health professionals*. Thousand Oaks, CA: Sage Publications.

Neuman, M (2014), No patients, no problems: exposure to risk of medical personnel working in MSF projects in Yemen's governorate of Amran [online]. *Journal of Humanitarian Assistance*. Available from: https://sites.tufts.edu/jha/archives/2040 (accessed 29 July 2017).

OHCHR (2013), *Assault on medical care in Syria*. Human Rights Council: 24 Session. Agenda item 4. A-HRC-24-CRP-2. Geneva: Office of the United Nations High Commissioner for Human Rights.

Pedersen, D (2002), Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being. *Social Science & Medicine*. Vol. 55: 175–90.

Save the Children (2014), *A devastating toll: the impact of three years of war on the health of Syria's children*. London: Save the Children.

SHIC (2017), *Impunity must end: attacks on health in 23 countries in conflict in 2016*. Safeguarding Health in Crisis Coalition, May 2017.

WHO (2017), *Syrian Arab Republic: annual report 2016*. Geneva: World Health Organization.

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