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Targeting Healthcare in Syria: A Military Tactic or Collateral Damage?

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Abstract

Nine years of continuous conflict in Syria have borne witness to various atrocities against civilians, some of which amount to war crimes. Most of the involved parties have committed such atrocities, but the Government of Syria (GoS) and its allies remain at the top of the list of perpetrators. Out of a population of 21 million in 2010, more than half a million Syrians were killed as of January 2019 with more than 13 million displaced either inside the country, in neighbouring countries or elsewhere. Moreover, civilian infrastructures, including but not limited to health, have been severely affected, resulting in interrupted services and suffering. Looking at patterns of these atrocities, timing of occurrence, and consequences, could allow us to draw conclusions about motivations. While the GoS maintains these attacks were against combating civilians, we argue that civilians and civilian infrastructure were military and strategic targets, rather than collateral damage to the attacks committed by the GoS and its allies. The motives behind attacking civilians may be related to military gains in imposing submission and surrender; whereas others may be linked to long-term goals such as forced displacement and demographic engineering. This paper argues, supported by several examples throughout the course of the Syrian conflict, that GoS has used a five-point military tactic with targeting healthcare being at the heart of it. This military tactic has been extremely effective in regaining most opposition strongholds at the expense of civilian suffering and health catastrophe.

Keywords: Syria, war crimes, healthcare

Introduction

Generating knowledge and learning on atrocities and extreme violence is indispensable but precarious and troublesome to conduct. Conducting research in such settings is very challenging (Mfutso-Bengo *et al.*, 2008). Humanitarian actors, including local first responders, usually struggle to find a balance between collecting data and documenting lessons learnt on the one hand, and coping with rapidly changing environments and responding to acute needs on the other hand. Understandably, lifesaving pressing needs in the various forms of rapid humanitarian assistance and arbitrary response take precedence over research. Regardless of how many resources are being poured into such responses, it is relatively rare to find reliable information and data during the acute phase of such crisis (Checchi *et al.*, 2017). However, for the Syrian conflict, the scarcity of data has been rectified by the use of social media, which has provided an intensive documentation for this conflict. Syrian local activists played key roles in documenting and communicating realities on the ground. Some of these efforts have been institutionalised, forming many credible organisations such as the Violations Documentation Center, the Syrian Network for Human Rights, and Lawyers and Doctors for Human Rights (LDHR).

Collaboration between all actors in conflict settings is essential to document their lived experiences in light of these challenges in conducting research. Documenting experiences of humanitarian and public health practitioners is of special importance because, in these settings, they may be the only witnesses to crimes and atrocities. To draw lessons from these resource-limited and

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extreme settings, direct observations of humanitarian responders, public health practitioners, human rights defenders, and policy and academic researchers complement other sources of information. This can notably fill gaps resulting from shortages of data and lack of evidence.

A case in point is violations of international humanitarian law (IHL) protecting humanitarian health workers. Article 14 under the Geneva Convention guaranteed the protection of healthcare workers, transport, and facilities, and those injured during war. Since the start of the twentieth century the International Committee of the Red Cross (ICRC) was seen as responsible for safeguarding medical neutrality, which is the concept of non-interference in medical services in conflict situations, built around IHL, human rights law and medical ethics. This role was most apparent and effective post-Second World War and up to the late 1990s (Druce *et al.*, 2019). Over the past three decades, however, the increase in interstate and internationalised wars has led to longer, more complicated wars with more long-term effects and an erosion of the protection of healthcare that has challenged the international system (Spiegel, 2017; Madhiwalla and Roy, 2009).

In the last decade especially, and since the start of the Syrian conflict in 2011, violence against healthcare has gained significant international attention. With mounting international pressure and in line with United Nations (UN) Sustainable Development Goals 3 – toward health for all, and 16 – toward justice and peace, the World Health Assembly (WHA) approved resolution 65.20 in 2012 tasking the World Health Organization (WHO) to lead efforts on documenting attacks against healthcare in conflict (AHCC). In 2014, the UN General Assembly approved draft resolution (A/69/L.35) on global health and foreign policy, with a focus on protection of health workers, and in 2016 the UN Security Council approved resolution 2286 on the protection of healthcare during conflict. Accordingly, various UN agencies and human rights and humanitarian local and international organisations have intensified efforts to document AHCC. The WHO established the Surveillance System for Attacks on Health Care (SSA) mechanism as a global surveillance system. Physicians for Human Rights (PHR), Médecins Sans Frontières (MSF), the ICRC's Health Care in Danger (HCiD), and the Safeguarding Health in Conflict coalition now also collect data on violence against healthcare.

Since 2014, more than 1,500 medical workers have been attacked and many more threatened, injured, kidnapped and tortured (Druce *et al.*, 2019). At one point, Syria accounted for up to 70 per cent of worldwide attacks against healthcare facilities documented by WHO (2018). According to PHR, 90 per cent of these attacks are carried out by the Government of Syria (GoS) and its allies. Recent research conducted by the Peace Research Institute Oslo and *The Lancet*–American University of Beirut (AUB) Commission on Syria suggests targeting of healthcare can now be considered an emerging tactic in conflict (Druce *et al.*, 2019), and that Syria is a prime example of what has been called the 'weaponisation of health care' (Fouad *et al.*, 2017).

While the GoS and Russia have maintained that all military efforts in the Syrian context were against combating parties (Hill and Triebert, 2019), there is a suggestion that the majority of military attacks target neighbourhoods and towns where the opposition has control rather than any specific military sites (Boxx, 2013). This is mentioned in literatures outside of health in the contexts of the weaponisation of water, electricity, urbanicide or the geospatial destruction of cities, 'razing', besiegement tactics and the use of chemical weapon attacks (Scheumann, 2014; Vignal, 2014; Al-Jablawi, 2017; Maitra, 2017; Todman, 2016; Ekzayez and Thompson, 2018).

We present here our observations that civilians and civilian infrastructure were strategic targets as part of a distinct military tactic that we, as humanitarian practitioners, have borne witness to. As an extension to the aforementioned concept of a 'weaponisation of healthcare' (Fouad *et al.*, 2017), we present four examples throughout the course of the Syrian conflict which evidence the direct application of a military tactic aimed at civilian infrastructure in addition to corresponding patterns in attacks on health facilities.

> Destruction of property, history, culture, and collective memory. Lost dignity of the population, broken families, livelihoods lost, economies destroyed. Loss, pain, fear and hate predominate and social exclusion, poverty and miscommunication reign over generations. (Physicians for Human Rights, 1998)

Objective and Methodology

The study aims to investigate scale and patterns of attacks on healthcare during the Syrian conflict as a form of extreme violence. It aims, also, to contextualise these attacks through investigating their time of occurrence, consequences and potential perpetrators. This is to allow us to draw conclusions on whether these attacks had military motivations behind them.

The study started with a literature review of available evidence on attacks on healthcare in Syria as well as on military and political events surrounding these attacks. Then, we conducted secondary analysis of available data sources on attacks on healthcare in Syria that are publicly accessible. These data sources are the Physicians for

Human Rights (PHR), the WHO Monitoring Violence against Healthcare (MVH), the WHO Surveillance System for Attacks on Health Care (SSA), and the Syrian Network for Human Rights (SNHR). We also recruited our direct observations, being involved in the humanitarian health response in Syria throughout the crisis, to analyse and interpret findings.

Abdulkarim Ekzayez was trained as a neurosurgeon in Aleppo before his training programme was interrupted by the conflict. In 2012, when opposition armed groups took over the eastern part of Aleppo city, many people lost access to healthcare in these areas and some were not allowed to access the governmental hospitals in the western part of the city. As a result, he decided to move to the eastern part and establish field hospitals there. Consequently, he was under a high risk of being detained and he had to give up his medical training. Between 2013 and 2016, Dr Ekzayez worked for Save the Children, leading their health response in north-west Syria. In the same period, he was heavily involved in the polio vaccination and in strengthening the health system in the region through supporting the establishment of Idleb Health Directorate. Late in 2016, he moved to the UK to do a master's in Epidemiology at the London School of Hygiene and Tropical Medicine (LSHTM). Between 2017 and 2020 he was involved in various research related to health in conflict settings with LSHTM, Chatham House and *The Lancet*–AUB Commission on Syria. He is now a research associate with the Research for Health in Conflict in the Middle East and North Africa (R4HC-MENA) project at King's College London. He is still a regular contributor to many medical and civil society entities in Syria and in the Middle East. Ammar Sabouni is also a Syrian physician who started his medical training in Damascus, Syria (2011–13). During those years, and at the start of the conflict, he worked as an emergency responder and coordinated local medical and humanitarian aid in Damascus and its suburbs. As a result of these activities he was persecuted and forced to leave Syria. Since 2013, he has been active in designing and implementing Medical Education and Training of Health Professionals within Syria through tele-training and with the Syrian American Medical Society Education Committee. He is now a practising academic physician on placement at Chatham House's Centre on Global Health Security and a Research Affiliate for *The Lancet*–AUB Commission on Syria and health.

Context

The Syrian conflict provides a vital context in which we can explore issues related to extreme violence and mass atrocities. As the conflict enters its ninth year, out of a population of 17.5 million in 2020, 13.2 million Syrians are in need of health assistance. Displacement continues to be a major challenge for the country with 5.6 million refugees and 6.6 million internally displaced persons (IDPs) according to UNHCR as of April 2019 (Humanitarian Needs Overview, 2019). The conflict has caused a severe disruption in health services leading to a collapse of the health system in the most conflict-affected areas. Attacks on healthcare have been a major threat in Syria, in what has been described as a 'weaponisation of health care' (Fouad *et al.*, 2017). The UN estimates that half of the health facilities in Syria are either only partially functional or destroyed. Physicians for Human Rights have documented 588 attacks on health facilities and 914 medical personnel killed between March 2011 and November 2019 (Physicians for Human Rights, 2019). Essential health services have been further disrupted by the increasing number of health professionals fleeing the country. This has left populations with limited access to healthcare leading to increased vulnerability to communicable and non-communicable diseases.

Since the defeat of the Islamic State in 2018, there have been three distinctive territories in Syria corresponding to the different areas of control. About 60 per cent of the Syrian territories, including the capital Damascus and most central and southern areas, are controlled by the Assad regime. Kurdish armed groups, supported by the United States, control around 25 per cent of north-east Syria, with a population of approximately 4 million. The remainder of opposition armed groups, supported by Turkey, control around 15 per cent in the north-west with a population of approximately 3.5 million (Humanitarian Needs Overview, 2019). Health services in each territory have been provided using different adaptation mechanisms to the conflict. In the opposition-controlled areas, with the collapse of the health system and the withdrawal by the Damascus Ministry of Health, local medical networks – relying on limited local resources, the remanent health infrastructure and equipment and the humanitarian health resources – adopted a new bottom-up approach to build a hybrid and kinetic health system that is currently functioning as an autonomous local health authority in the region. For example, Idleb Health Directorate was able to maintain its role as the main health authority in Idleb governorate without being affiliated with the Interim Syrian government that operate from Turkey, nor with the Salvation Government that is affiliated with Hayat Tahrir Al Sham. The military actors have been avoiding major interference with this health system as it is a functioning system that they cannot replace. This health system was able to maintain the functionality of health services in these areas with the support of international and local non-governmental organisations (NGOs).

Healthcare Workers Experience during the Syrian Conflict

Local Syrian healthcare workers have played a unique humanitarian role throughout the nine years of the Syrian conflict. In addition to their professional medical roles, they have participated in coordination of medical aid, humanitarian aid, advocacy and grass-roots health governance. Suffering under the severe resource constraints of war and a stunted international response, they have adapted through innovation, role shifting and resilience.

The type of role local healthcare workers have played has been dictated largely by geopolitical changes over the course of the conflict (Bdaiwi, forthcoming). In government-controlled Syria, at the start of the conflict, healthcare workers attended to wounded protestors and helped torture victims. With the militarisation of the conflict and the development of non-government-controlled Syria, makeshift field hospitals developed into organised secondary and tertiary care centres and then grass-roots health governance structures. Changes in the political landscape, demonstrated by the appearance of ISIS, meant that Kurdish-controlled Syria and Turkish-controlled Syria introduced independent and unique healthcare systems, regulations and structures which added to the mosaic of roles healthcare workers had to take during the conflict (Bdaiwi, forthcoming).

Loose networks of local healthcare workers developed into local health directorates to fill the gap left by the withdrawal of the government's Ministry of Health from non-government-controlled Syria (Ekzayez, 2018). Concomitant with the formation of these governance structures locally, diaspora Syrian healthcare workers developed Syrian NGOs in response to the Syrian conflict. The Syrian American Medical Society (SAMS), Syrian Expatriate Medical Society (SEMA) and the Union of Medical Care and Relief Organizations (UOSSM), among other NGOs, shaped a substantial part of the international response to the Syrian conflict. International NGOs were able to operate in non-government-controlled Syria through these local NGOs and local Syrian healthcare workers. For local healthcare workers, though this improved resources substantially, it limited the power of local governance structures, excluded many local actors who did not have the capacity to acquire the necessary licensing (Ekzayez, 2018) and produced challenges of accountability to external parties with cultural differences, and differing funding goals (Bdaiwi *et al.*, 2020).

Throughout the Syrian conflict and across all roles healthcare workers have played, they have been under constant and targeted attack as part of the weaponisation strategy of the GoS (Fouad *et al.*, 2017). During the peaceful uprising, anyone found to be assisting wounded demonstrators or activists was prosecuted, tortured and sometimes killed. In 2012 the GoS effectively criminalised medical neutrality through anti-terrorism legislation that allowed prosecution of those treating demonstrators injured by government forces (Fouad *et al.*, 2017). Doctors working in government hospitals were forced to misfile the cause of death of bodies of detainees killed under torture (Human Rights Council, 2013) and student healthcare workers studying or training in opposition institutions were persecuted (Bdaiwi, forthcoming).

After the militarisation of the conflict, it quickly became apparent that the GoS was targeting healthcare facilities and supressing humanitarian aid to non-government-controlled areas (Sibbald, 2013). Consequently, healthcare workers removed markings from ambulances, paramedics stopped wearing uniforms and civilians in non-government-controlled areas chose to live far from field hospitals for fear of being bombed. Besiegement tactics, chemical weapon attacks and withholding international aid, in addition to the documented bombardment of civilian infrastructure, meant healthcare workers were unable to perform their roles effectively without medical supplies, water or electricity (Meininghaus, 2016). In addition, there were dire consequences of these attacks for the health and wellbeing of the civilian populations and their social determinants of health.

With the internationalisation of the conflict in Syria, Russian military strategy echoed that of the GoS with attacks against healthcare almost doubling in 2016, the year after the Russian military joined in air offensives. Even healthcare institutions with coordinates shared with Russia by the UN as part of a 'deconfliction' were targeted (Ensor, 2019).

Reporting Attacks on Healthcare in the Syrian Conflict

With the start of violence in March 2011, only a few organisations, such as PHR, started to systematically report attacks on healthcare (Physicians for Human Rights, 2019). However, their reporting mechanisms and methodologies were restricted considering the limited sources of information and the limited access under the GoS control. The first report by the UN Human Rights Council devoted to investigating assaults on medical care in Syria was issued in September 2013. As per this report, the first attack on hospitals was committed by the GoS when they broke into Daraa national hospital and

positioned snipers on its roof, using it as a military object (Human Rights Council, 2020).

In the first three years of the conflict, assaults on health were being reported as part of reporting violations against human rights. Few local human rights organisations, such as the Violations Documentation Center (VDC, 2020) and the Syrian Network for Human Rights (Syrian Network for Human Rights, 2020a), and international organisations, such as Human Rights Watch (Human Rights Watch, 2020), were reporting these incidents as part of other human rights violations.

In this period, health humanitarian actors had a very primitive approach to reporting violence on healthcare merely for communication and advocacy purposes. For example, in November 2012 when the seven-storey 'Al Shifa'a hospital' in eastern Aleppo city was bombed to the ground (*Telegraph*, 2020), it was covered extensively in the media, but no health actor produced any incident report about it (Ekzayez, forthcoming). Local health actors did not pick up the issue of reporting attacks on health until 2014 when such attacks intensified. These actors were inspired by the reporting of PHR which played a key role in training actors on how to report this type of attacks. Among the actors that have been documenting violence on health systematically since 2014 are SAMS and UOSSM. In the same period, various human rights organisations started to have special reporting systems on attacks on healthcare. For example, the SNHR has been reporting such attacks since 2015 (Syrian Network for Human Rights, 2020b).

In early 2016, the WHO-led Health Cluster in southern Turkey (Gaziantep) started a new reporting mechanism called 'Monitoring Violence against Healthcare (MVH)' relying on the cluster's members who have field presence to report incidents of violence on healthcare, mainly in opposition-controlled areas. The MVH reporting used innovative techniques and tools, such as WhatsApp groups, to collect, verify and disseminate information (Elamein *et al.*, 2017). However, this reporting mechanism, which was widely welcomed by local and international humanitarian actors in Syria, was replaced by the new SSA of WHO (WHO, 2018). While the SSA provides a promising step toward a systematic documentation of violence on healthcare internationally, it might fall short in capturing data related to context, consequences and potential perpetrators. This makes it especially challenging to use the findings of the SSA in accountability mechanisms, which is essential to engage with local actors in reporting (Ekzayez, forthcoming).

For the purpose of this paper, we analysed data of attacks on healthcare in Syria from three publicly accessible data sources: PHR, SNHR, and SSA. Information related to the timeline of the political and military developments in the Syrian conflict were sourced from a special publication by the United States Institute of Peace (United States Institute of Peace, 2020).

Patterns of Attacks on Healthcare in Syria

Between March 2011 and November 2019, PHR reported 588 attacks on 350 health facilities, out of which 530 attacks were committed by the GoS and its allies, including the killing of 914 personnel (Physicians for Human Rights, 2019). The WHO's SSA, since it was established in January 2018 until January 2020, has reported 228 attacks on healthcare in Syria (WHO, 2018). The WHO, ICRC and international NGOs, on several occasions, have raised the alarm after spikes in attacks against healthcare in the Syrian conflict in the last few years, calling on all parties to the conflict to adhere to the international warfare norms (WHO, 2018; ICRC, 2017). Moreover, some researchers consider Syria to be the most dangerous place on earth for medical workers in what has been termed to be a 'weaponisation of health care' (Fouad *et al.*, 2017).

In 2011, violence against healthcare was taking forms of attacks on health personnel, such as kidnapping, torture and detention, and blocking access to healthcare through deprivation of medical supplies and detention of patients seeking healthcare. Health personnel subjected to this violence were mostly those who were involved in treating protesters or providing health services in homes and secret field hospitals.

Incidents of violence against health peaked throughout the Syrian conflict, corresponded to military campaigns and offensives. In the summer of 2012, there was a peak of attacks on health facilities, with fourteen monthly incidents in August and September, most of which took place in the eastern part of Aleppo city after it was captured by opposition factions in July 2012. Another peak was reached in July 2014, with many of these incidents taking place in Al Ghouta with the intensification of the armed conflict in rural Damascus. In 2015 and 2016 there was a constant occurrence of incidents, with an unprecedented peak in the fourth quarter of 2016 concurrent with the Aleppo battle when the Syrian government forces had sieged and then took over the eastern part of the city. In November 2016 alone, 56 and 30 attacks were reported respectively by the SNHR and the MVH of the Turkey Health Cluster.

In 2017, with the de-escalation zones agreement between Russia and Turkey, there was a decrease in incidents – apart from the first quarter of the year, preceding the Khan Shaykhun chemical attack in April 2017. A similar peak to the one that was noticed when the GoS took control over eastern Aleppo, was observed

again when the GoS took over eastern Ghouta in the first quarter of 2018. According to the UN's Regional Humanitarian Coordinator for Syria, Panos Moumtzis, the first four months of 2018 witnessed more Syrian health facilities attacked than in all of 2017 combined (France24, 2018).

Starting from April 2019, there was an increase in attacks on health in north-west Syria in line with the military offensive by the GoS and its allies on northern Hama and southern Idleb. At the time of writing (2020), attacks on healthcare in north-west Syria are still on the rise as part of the military campaign on Idleb governorate.

Figure 1 illustrates the timeline of the frequency of attacks on healthcare throughout the Syrian conflict as reported by the PHR and the WHO reporting mechanisms.[1]

Examples of the Use of Attacks on Healthcare as a Military Tactic

Looking at patterns of attacks on health, timing of occurrence, and its consequences could allow us to draw some conclusions about the motivations behind these atrocities. As argued by Fouad *et al.* (2017), we believe that healthcare was instrumentalised by the GoS and its allies in their warfare. Moreover, we argue that these attacks were strategically used as part of a larger military tactic to weaken the resilience of communities under opposition control. We will demonstrate this use in the following examples of military offensives by the GoS and its allies.

The Baba Amr Offensive, Homs, 2012

The Baba Amr neighbourhood, whose residents protested against the GoS and became a stronghold for opposition fighters, was sieged by the GoS forces in January 2012. The neighbourhood was then heavily bombarded throughout February 2012, with about 200 civilians killed on 4 February alone. The field hospital in the area was hit, killing 19 people (*Guardian*, 2012a). Access to health was also denied, with reports talking about premature born babies and the lack of incubators. Most of the civilian infrastructure in the neighbourhood was attacked. In less than a month, the neighbourhood was declared to fall under GoS control by 1 March 2012 and most of its residents were evacuated to other opposition-held areas (*Guardian*, 2012a, 2012b; Al Jazeera, 2012).

The Madaya Town Offensive, Western Ghouta, 2013–16

In 2013, the 40,000 people in Madaya were considered as opposing the GoS and hosting opposition factions. Accordingly, the GoS put the town under siege by the end of 2013. The siege was tightened in July 2015, not allowing even food and medical supplies to enter the city (Syrian Network for Human Rights, 2020b; Médecins Sans Frontières, 2016d).

As a result, the health of Madaya's residents deteriorated with the emergence of communicable diseases, mental health issues and malnutrition. In December 2016, SNHR reported that the GoS targeted the last medical point in the town (Syrian Network for Human Rights, 2016). MSF reported on 7 January 2016 that 23 people, including 6 babies under one year old, had died of starvation with an estimated 320 cases of malnutrition (Médecins Sans Frontières, 2016d). The city was also subjected to bombardments and airstrikes, causing severe damage to the civilian infrastructure.

In April 2016, and as a result of negotiations between the Iranian government and opposition factions controlling two besieged Shia towns in Idleb governorate, the

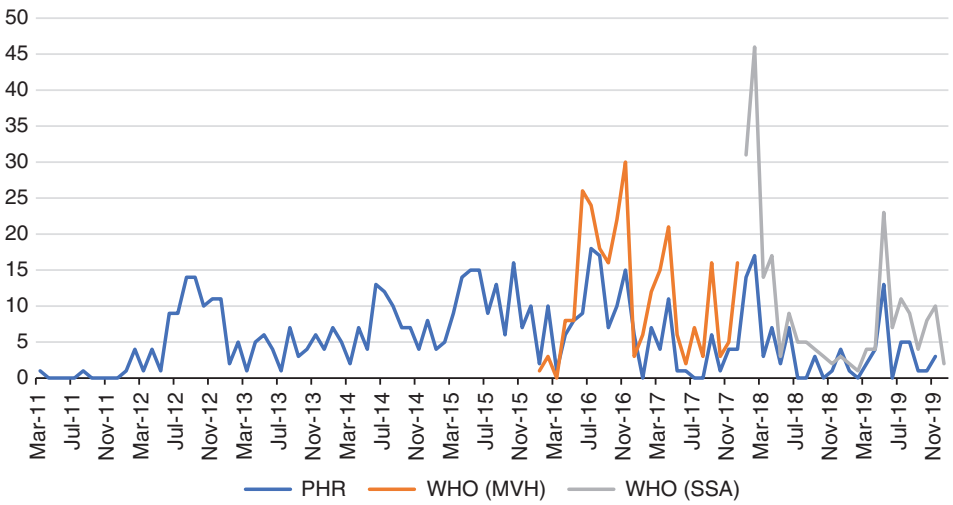

Figure 1: A timeline for the frequency of attacks on health throughout the Syrian conflict

GoS allowed some medical cases to be evacuated from Madaya (Human Rights Watch, 2016). A year later, all of the anti-GoS population were evacuated from the town in what was called 'the four besieged towns agreement'. The deal led to the evacuation of both Madaya and Zabadani towns in western Ghouta to other opposition-held areas in return for the evacuation of Al Foua and Kfarya, two Shia towns in Idleb governorate, to GoS-held areas (Reuters, 2017).

The East Aleppo Offensive, Aleppo City, 2016

In July 2012, the opposition factions entered the eastern part of Aleppo city, where an estimated 300,000 people resided, and took it as a stronghold for the opposition. Investing in the good infrastructure in Aleppo city, residents of east Aleppo, supported by NGOs and grass-roots organisations, were able to maintain and develop the city's various sectors and functions, including health (Wahba, 2017). There were at least ten hospitals with a number of medical points providing a comprehensive package of health services in this part of the city (OCHA, 2017).

Despite the daily shelling and airstrikes by the GoS, opposition groups were able to make east Aleppo one of their fortified strongholds. However, the involvement of Russia in October 2015 put the opposition on the back foot (Reuters, 2016).

In July 2016, the GoS started a decisive offensive to take over the city. The offensive started with tightening the besiegement of the opposition areas in the city, which were completely encircled (Reuters, 2016). Over the following months, bloody battles happened on different fronts of the city with heavy airstrikes by the GoS and its allies targeting the civilian infrastructure. Bakeries, schools and residential areas were bombarded on an almost daily basis (Wahba, 2017). All health facilities in eastern Aleppo were hit by airstrikes and many doctors and medical staff were killed by these attacks, including the last paediatrician in the city (Médecins Sans Frontières, 2016a, 2016b, 2016c; Siva, 2016; Li, 2018).

In late October, the GoS and its allies proposed a pause in their campaign, and they set up what were called 'humanitarian corridors', urging the population to evacuate eastern Aleppo. However, opposition groups and civilians refused to surrender. The military campaign resumed with heavy aerial bombardment to force residents to flee the city. In November 2016, the GoS used chlorine gas in targeting residential areas and civilian infrastructure in eastern Aleppo (*Guardian*, 2016). Consequently, the opposition, alongside the remaining civilians, were trapped in a small area and were forced to surrender. In December, they had to accept a forced displacement agreement to evacuate the city and move to other opposition-held areas in north-west Syria (Wahba, 2017; Reuters, 2017).

The Eastern Ghouta Offensive, Rural Damascus, 2013–18

With the start of the uprising in March 2011, residents of most towns in eastern Ghouta took part in demonstrations. In 2012, the newly established opposition armed factions expelled GoS forces from the region, making eastern Ghouta one of their most significant strongholds (Atlantic Council, 2018).

In 2013, the enclave was put under siege by the GoS closing all surrounding roads and preventing civilians from entering or leaving the area (Al-Om, 2018). In August of the same year, the GoS attacked the area with chemical weapons using sarin gas and killing at least 837 civilians in one attack (Patočka, 2016). Despite siege and the daily airstrikes and bombardments, residents of eastern Ghouta established many civil society organisations and developed advanced governance structures in the area (Angelova, 2014). The siege was partially overcome through numerous tunnels that were dug around eastern Ghouta, linking it with surrounding areas.

The siege on the area, with a population of nearly 400,000, was tightened throughout 2017. In February 2018, the GoS and its allies commenced a military offensive to recapture eastern Ghouta. The military campaign started with heavy aerial bombardment, targeting all of the civilian infrastructure in the area (Jabbour *et al.*, 2018). In the same time, airstrikes systematically targeted all health facilities in the area leading to the destruction of twenty-two hospitals in just one week in February (Rayes *et al.*, 2018). MSF reported that nineteen of their twenty supported hospitals were evacuated as a result of this military campaign (Médecins Sans Frontières, 2018).

In March, the GoS allowed limited aid delivery to the area and set up humanitarian corridors inviting people to evacuate eastern Ghouta. Displacement deals were agreed with the various towns in the region, resulting in more than 90,000 civilians leaving eastern Ghouta for GoS-held areas. However, the negotiations in Douma town were broken off resulting in a resumption of the military campaign on Douma. Shortly after, the town was attacked by chemical weapons killing about forty people and causing extreme panic among the remaining civilians (OPCW, 2019; BBC, 2018). As a result, the opposition groups in the city surrendered and the remaining people were displaced to the opposition-held areas in north-west Syria.

Conclusion

Based on analysing the patterns of attacks on healthcare in Syria, and by linking these attacks with the surrounding military developments, we argue that violence against healthcare was used as a military tactic by the GoS to weaken the resilience of communities in opposition-held

areas and induce submission. Furthermore, we also argue that this use was part of a wider military strategy that employed five tactics to push these communities to surrender. Throughout the Syrian conflict, these tactics were used either sequentially or in parallel in the various opposition-held areas that were recaptured by the GoS one after the other. This military strategy includes: (1) besiegement and deprivation of populations to drain out local resources, (2) targeting of civilians and civilian infrastructure to put more pressure on communities and to spread panic and apprehension, (3) targeting healthcare professionals and facilities to deprive civilians of access to healthcare, which is perceived by Syrian communities as a vital service for survival and resilience, (4) encouraging people to flee their homes through offering evacuation deals under labels of humanitarian corridors paving the way for forced displacement agreements, and, if all else fails, (5) the use of chemical weapons, which are usually very effective in pushing people out of their homes, especially in densely built-up areas.

This military strategy has been extremely effective in regaining most opposition strongholds at the expense of civilian suffering and humanitarian catastrophe. Moreover, this strategy, especially the forced displacement part, could have serious long-term consequences, such as forced displacement and demographic engineering, that could be almost impossible to reverse in post-conflict Syria.

Declarations

All data used in this paper are publicly accessible. The authors declare that they have no competing interests. The salary of the first author is covered partially by UK Research and Innovation (UKRI) as part of the Global Challenges Research Fund (GCRF); Research for Health in Conflict in the Middle East and North Africa (R4HC-MENA) project, grant number ES/P010962/1.

Authors' Contributions

Abdulkarim Ekzayez carried out the study design, conceptual framework, data analysis, literature search, first draft of the paper, multiple rounds of edits and produced the final manuscript. Ammar Sabouni contributed a substantial amount of content, added further literature, reviewed and approved the final manuscript.

Note

1 SNHR data is not included in this figure due to issues with data consistency.

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