# C2 | HEALTH INFORMATION, CONFLICT, AND THE RIGHT TO HEALTH

Accurate and reliable health data and information are essential in conflict situations. Without information of a reasonable quality, it is impossible to plan the best or most appropriate response to increased needs, including communicable disease outbreaks and physical and mental trauma, and to evaluate the quality of health care and other assistance that is being provided. Health information can also be used to monitor the effects of certain weapons and the conduct of parties to the conflict. Aggregated data and information can provide an overall regional, national, or international picture, provide evidence of global trends, and be used for comparing different programmes and interventions.

For the people engaged in data collection and analysis, and for the families and communities of the dead, the recording of necessary data is crucial. For the sick and the injured, their diagnosis, treatment, follow-up, and eventual recovery is dependent on it. It can also be crucial when seeking justice or reparation for people who have been 'wrongly' attacked, shot, shelled, poisoned, or bombed. For the relatives and the communities of the dead, it is vital for achieving healing, reconciliation, and justice. It is also essential for providing evidence of the longer-term public health effects of conflict, because this proof can contribute to efforts aimed at mitigating the effects of future conflicts and to conflict prevention.

*Global Health Watch 2* emphasised the importance of all actors recognising the right to health, including in conflict situations when increased needs due to physical and mental trauma, overcrowding, and a breakdown of infrastructure and services are common. It is a well-established part of international humanitarian law that all civilians in conflict situations have a right to access health care and the essentials of life that are necessary for health. Combatants, as soon as they are wounded or captured, and are 'out of the conflict', have the same rights, including the right to medical treatment.[1]

This chapter considers access to health information and data from the point of view of the rights of those affected by conflict. Part of their right to health is their right to information and data on how they have suffered owing to conflict. The collection, analysis, and dissemination of this information and data need to be adequate and impartial.

Far too often, this is not the case. This chapter concentrates on four reasons why:

- Those who collect information and data are intimidated
- Health information and data are distorted or reported inaccurately for fulfilling political or military agendas
- Inconvenient health data and information are dismissed by making unrealistic demands for quality, including the lack of proof of a causal link
- A selective and inequitable use of the precautionary principle.

### Data during conflict: collection and use

Collecting health information in conflict situations or conflict areas presents particular challenges. It is frequently difficult to estimate the total population owing to population movements, insecurity, and out-of-date census data. Many of those affected may not be able to reach a health facility, and people may decide not to risk travelling in insecure situations unless it is for a dire emergency. Information may be collected intermittently because health services may have to be closed or suspended.

Various methodologies that take these challenges into account have been developed for collecting information in conflict zones. Some of the commonly used methods are rapid assessment techniques, surveys, and surveillance. These also take into account factors such as limited access due to reduced working time (curfew and insecurity) and factor in security considerations for both those conducting the survey and those from whom information is being sought (the respondents).[6] There is ongoing research into the development of these methodologies, with estimations of mortality receiving particular attention.[7]

An often undervalued source of information is the national health information system, which may be disrupted, but which in some cases can provide a geographical breadth of data that other instruments cannot. In periods of less intense conflict, other tools can be employed, ranging from community assessments to random cluster sample surveys. Sometimes the best that can be achieved is an estimation derived by triangulating all sources of information in a specific situation.

Health information, including information on mortality, morbidity, and disability, increasingly plays a significant role in estimating the damage caused by conflict and in assessing how a conflict has been conducted. This information carries the potential to contribute to future conflict resolution and can potentially provide evidence as to whether parties to a conflict have conformed to, or complied with, international humanitarian law. When these data are aggregated to gain a broader understanding of the larger picture, it should drive learning and should ensure that mistakes and injustices are not repeated. This is essential for ensuring that the right to health is respected, and without it claims that the right to health has been ignored can be more easily dismissed.

The challenges of collecting health information during conflict also make it easier to contest its accuracy. The information may be questioned to support

**Box C2 Death and injury in conflict: who, when, and where**

A woman is hit in the chest by shrapnel from an exploding shell in Mullaitivu, in northwest Sri Lanka. She thought she was safe as the area had been declared a no-fire zone. Her injury is recorded along with other deaths and injuries by a doctor working in a makeshift hospital. Her details are included in the total number of injured for that day. She is later evacuated by ship from the conflict area. Her name, address, age, sex, and receiving ward at destination are recorded. The receiving ward registers all the standard information on her for a hospital outside the conflict zone.

At this point, all official information about her as a victim of the shelling ceases. The doctors who recorded her initial injuries in the no-fire zone are arrested when the area is overrun and later appear at a press conference organised by the government, where they deny knowledge of the incident.

*Source*: Constructed from various sources and personal communications

A woman is kidnapped while returning from a trip carrying out development work in Afghanistan. She is killed during an attempt by the US military to rescue her. There is worldwide news coverage of the kidnapping and the subsequent rescue attempt, and then an investigation is launched to find out how she died. When it is revealed that she died from an exploding grenade thrown by a member of the team sent to rescue her, a 10-man joint US–UK investigation team is sent to Afghanistan for two and a half weeks. They conduct interviews and assess 'hours of video evidence and hundreds of pages of documentary evidence'.[2] As a result, members of the rescue team are disciplined for 'failing to provide a complete and full account of their actions in accordance with US military procedure'.[3] This is following initial reports that the woman was killed as the result of the explosion of a suicide vest worn by one of her captors.

In November 2009, residents of Korkhashien village drove dead bodies, including the bodies of two children, in a convoy of vans and station wagons to the governor's office in the provincial capital, Lashkar Gah. The residents claimed that a NATO rocket attack had killed nine people, including the children. They wanted the governor to see the bodies as evidence of this claim. NATO said the rocket was fired because they believed people were planting a bomb.[4]

A week later, a letter from the Permanent Joint Headquarters in the UK said that one of the reasons it was difficult for NATO to estimate civilian casualties was because of the local custom of burying the dead within 24 hours.[5]

political and military agendas regardless of the efforts made to produce the best available estimation in a conflict situation.

The difficulties of collecting accurate data in conflict should not be underestimated. However, the 'best possible' data and information are essential, and infinitely better than the chaos caused by having no information at all.

### Shooting the messenger

Health information can be disputed because of the perceived partiality of those who have collected or analysed it, and claims can be made that figures are exaggerated or downplayed. Those whose responsibility it is to collect the information may come under pressure not to disseminate it, or may not have been able to collect it in the first place. This can complicate the work of health workers and potentially put them – and in some cases their patients – at risk.

As the conflict between the Sri Lankan government and the Liberation Tigers of Tamil Eelam (LTTE) reached its final stages in early 2009, five Sri Lankan doctors stayed in the ever-shrinking 'safe zone' to care for the sick and the wounded. Other actors such as NGOs and the media had been informed that it was not safe for them to stay in the area, so the doctors were the sole source of mortality and morbidity information, which they transmitted using their mobile phones and which they collected as part of their duty of care. When the conflict zone was finally overrun, they were arrested and held in detention on the charge of 'spreading false information'.[8] Some months later, they appeared at a government-organised press conference and stated that they had exaggerated the figures.[9]

This case illustrates clearly the dangers faced by health workers in the line of duty. This was information they needed to collect as a regular part of their work, so that those outside the area could understood the health needs of the people caught in the conflict and could respond effectively. Information about the dead and the wounded – particularly those from a 'safe zone' – also raised questions about how the conflict was being conducted and whether international humanitarian law was being respected. As all other actors who could have reported this information, including the media and NGOs, had been told that the area was too unsafe for them to be in, there were no other sources to corroborate the information. This left the doctors particularly vulnerable.

### Manipulating data for military or political purposes

Health information that emerges from different conflict situations is disseminated, examined, and followed up to varying levels. During the interval, often far too brief, when media attention is focused on an incident, those who have access to the media may use the opportunity to present information in a way that matches their military and political interests. This may involve presenting themselves in a positive light in relation to international

**25** Tamil protestors in Geneva demonstrating against military operations in Sri Lanka, February 2009 (© Shuttlecock | Dreamstime.com)

humanitarian law, even when this is at the expense of those who are actually affected on the ground.

In the present conflict in Afghanistan, it is very unclear how many civilians are being killed or what efforts are being made to prevent civilian deaths – despite public pronouncements. In July 2009, it was announced that three civilians had died in Operation Panther's Claw. This was an operation with an element of surprise in an area with an estimated population density of 200 people per square kilometre. In all, 350 soldiers transported in Chinook helicopters were backed up by Apache and Black Hawk helicopter gunships, a Spectre gunship, Harrier jets, and unmanned drones.[10] When requests were made for information as to how the figure of three dead civilians had been arrived at, there was no clear response. Instead, the replies drew attention to the practical difficulties of estimating mortality figures and the local custom of burying the dead within 24 hours. However, this incident occurred at a time when there were instances of civilians driving dead bodies to the offices of local governors in order to provide evidence of attacks. How the figure of three dead civilians was arrived at was not explained.[11]

The Senior Civilian Representative in Afghanistan stated in October 2010

on prime-time radio that 90 per cent of civilian casualties in Afghanistan were now deliberately caused by the Taliban.[12] This figure was higher than the figures given in the UNAMA (United Nations Assistance Mission in Afghanistan) mid-year report a few months previously. The UNAMA reports also include clear qualifications regarding the completeness and accuracy of the information they collect and present.[13] A request for clarification as to how the Senior Civilian Representative knew this figure at the time of making this statement did not receive a reply.

These are just two examples of statements whose accuracy can go relatively unnoticed, but that have the potential to gradually build up a picture in the public mind that favours one side against the other. The general public may then more readily accept the claim about the necessity for the conflict, as well as its more indiscriminate strategies, such as bombing of residential areas.

### Health information, cause and effect, and the precautionary principle

The farther in time from the actual conflict, the harder it is to establish a causal relationship, and the greater the number of potential confounders. This is another area where evidence is accumulated, methodologies are developed, and the 'best possible' data agreed upon. However, instead of supporting this process, these confounders and the difficulty of establishing a causal link can be used as sufficient grounds to dismiss the problem, often in support of a political or military agenda. A lack of scientifically conclusive evidence can be used to dismiss indicative evidence that the conflict could have been the cause of specific sickness, disability, and death. It can also result in the delay of further examination, investigation, and research that might both clarify the specific situation and contribute to learning and conflict mitigation in the future.

In 2005, health professionals in Fallujah first started raising concerns about the number of babies with birth defects they were delivering. It was suggested that this development was linked to the highly polluted environment that the mothers had had to endure following two attacks on Fallujah, one in 2004 and one in 2006. These attacks had included the use of depleted uranium shells and other toxic agents and had produced high levels of stress among the population of Fallujah.[14] In the six years since these attacks, civil society had attempted to study the pattern of these deformities. However, these studies have been relatively small, and none has been supported by the coalition forces that carried out the attacks or by the Iraqi government. Reports indicate that the complaints have not been responded to[15] and that the Iraqi government does not want to embarrass the United States over the issue.[16]

In 2010, the concerns continue to remain unanswered. At the time of writing, it is still civil society that is trying to investigate the situation, although a major study by the World Health Organisation is anticipated in 2011. In December 2010, a study reported that 15 per cent of all deliveries in the Fallujah General Hospital during May 2010 had birth defects. The study

also examined in detail the family history of a group of families to whom babies with birth defects had been born in the previous two years. The study concluded: 'These defects could be due to environmental contaminants which are known components of modern weaponry.' It also said, 'While the causes of [the] increased prevalence of birth defects are under investigation, we opted to release this communication to contribute to [an] exploration of these issues.'[17]

There are numerous instances when the cause of death, illness, or disability during or following situations of violent conflict is disputed, and in many instances considerable time and effort will be required to investigate the matter and reach a conclusion. But this is no reason to dismiss legitimate concerns, and the lack of a proven causal relationship should never be a reason to dismiss such concerns.

### The precautionary principle

According to this precautionary principle, the responsibility for showing that certain actions were the cause of death, sickness or disability shifts to showing that these actions were not the cause. It also means that the suspected action should be stopped until it has been proved that it was not harmful. Deciding when the precautionary principle comes into play is also influenced by the severity of what is being investigated; viz. babies born with birth defects in Fallujah.

In March 2010, a spokesman for the US military responded to questions about the level of heart defects among the babies being delivered in Fallujah. He said that the US military always took public health concerns '*very seriously*'. He added, 'No studies to date have indicated environmental issues resulting in specific health issues.'[18] This is just one example of how both health information and professional opinion can be dismissed. While the statement is accurate in itself, it totally ignores the weight of information and professional opinion that should trigger the application of the precautionary principle. If applied, this principle should result in those who used the suspect weapons and materials taking responsibility for ensuring more and better-funded research into the cause of the heart defects among the babies, and a moratorium on the use of the suspected weapons.

There is also a gross inequality as to when, where, and in which situations the precautionary principle is applied. If the concerns expressed by the health professionals at the Fallujah General Hospital had been raised by health professionals in the countries of the coalition forces that had mounted the attacks on Fallujah, it would have led immediately to major investigations being launched.

### Recommendations

Based on the above, the major recommendation is that health data and information should not be interfered with in the pursuit of military and political ends.

Health workers are already protected under international humanitarian law. However, it would be useful if this fact were made clearer in relation to their safety while they are collecting and disseminating health data.

It is important to create greater awareness of the way in which health information is manipulated, leading to increased and more probing questioning of public statements and holding to account those who make these statements. Military health professionals and political advisers need to play a more active role in advising their colleagues about the accuracy of data, epidemiological estimations, and the precautionary principle.

The precautionary principle needs to be applied in a more equitable way in conflict situations. While the links between depleted uranium and birth defects continue to be denied by the UK and the US military, in both countries their own soldiers receive health and safety advice about depleted uranium before deployment.

At the present time, it is often left to civil society to support the collection of data, to question how it is used, and to demand accountability when powerful actors use (or abuse) it for meeting their own agendas. While civil society needs to continue playing this role, all actors have a responsibility to ensure that health information and data are as accurate as possible and that they accurately represent all those affected by violent conflict equally.

## Notes

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16 'Fallujah doctors report rise in birth defects'. John Simpson, BBC World Affairs Editor, BBC News. news.bbc.co.uk/1/hi/world/middle_east/8548707.stm (accessed 15 February 2011).

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