Physicians for Human Rights

Organization for Justice & Accountability in the Horn of Africa

Stolen, Broken, Destroyed

How Impunity Has Fueled Ongoing Attacks on Health Care in Ethiopia

August 2026 | Research Brief

Acknowledgments

Contents

This research brief was written and reviewed by researchers from the Organization for Justice and Accountability in the Horn of Africa (OJAH) and Physicians for Human Rights (PHR). The research team would like to recognize the strength of the health professionals whose experiences and resilience are reflected within this data.

About Physicians for Human Rights

Physicians for Human Rights (PHR) uses medicine and science to document and call attention to human rights violations. PHR was founded on the idea that physicians and other health professionals possess unique skills that lend significant credibility to the investigation and documentation of human rights abuses. In response to the scourge of sexual violence, PHR launched its Program on Sexual Violence in Conflict Zones in 2011 that has worked to confront impunity for sexual violence in the Central African Republic, the Democratic Republic of Congo, Ethiopia, Iraq, Kenya, Myanmar, and Ukraine. PHR has conducted research to understand the scale and scope of conflict-related sexual violence in a variety of conflicts and contexts including in Democratic Republic of the Congo, Kenya, Myanmar, and Sierra Leone.

About the Organization for Justice and Accountability in the Horn of Africa

The Organization for Justice and Accountability in the Horn of Africa (OJAH) is an independent and impartial organization dedicated to strengthening justice and accountability mechanisms in the Horn of Africa through evidence collection and preservation. The organization is on a mission to deter war crimes, crimes against humanity, conflict-related sexual violence and other severe human rights abuses across the Greater Horn of Africa. This is pursued through conducting documentation and investigations, advancing the environment for justice and accountability, preserving and analyzing materials, and supporting international justice and accountability actors and efforts.

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Cover: A nurse stands in a section of Wukro General Hospital allegedly looted by Eritrean soldiers, in Wukro, north of Mekele.
Photo: Eduardo Soteras/AFP/ Getty Images

Right: A health center located in Ademeyti Town, Tahtay Adyabo District, North Western Zone of Tigray on the border of Ethiopia and Eritrea. This health center was attacked in early in 2021 and was occupied by Eritrean Forces.
Photo: OJAH

Introduction & Executive Summary

Attacks on health care have become a major feature of armed conflict in Ethiopia. Attacks and threats to health care infrastructure, supply chains, and the health care workforce continue to be used as a tactic in conflict affected regions of Ethiopia, including Tigray, Amhara, and Afar.[1] Combatants are striking health facilities with aerial drones; health care workers are being interrogated and executed. The resources to sustain and rebuild conflict-affected health care systems are scarce, and have been further reduced due to cuts to critical health funding made by the United States and other international donors.[2] In recent months, the threat of escalating violence across Ethiopia driven by impunity for years of human rights violations and lack of atrocity prevention has further raised the alarm.[3] Further attacks against health care seem imminent, placing civilians at significant risk. The international community must act now to secure accountability for these violations of the norm protecting health care in conflict and to prevent even more harm to civilians.

Research conducted by Physicians for Human Rights (PHR) and the Organization for Justice and Accountability in the Horn of Africa (OJAH) has documented that attacks on health care have occurred since November 2020 in conflict-affected regions across Ethiopia, including Afar, Amhara, and Tigray regions. While the location of conflict has shifted along with political alliances, the playbook of targeting health care has persisted. Armed actors in Ethiopia have:

- Attacked, robbed, and occupied health facilities
- Stripped away medical supplies, equipment, and essential medications from communities
- Threatened, violently attacked, and even killed health care workers for providing care.

Above: Medical supplies are seen on the floor at the Zarima hospital, which villagers say was allegedly looted by Tigray People's Liberation Front (TPLF) fighters, in Zarima, 140 kilometers from Gondar, Ethiopia. Photo: Amanuel Sileshi/Getty Images

As a health officer from Tigray interviewed by PHR and OJAH shared:

> "Many health centers and hospitals were damaged. The attackers looted medical equipment and deliberately destroyed the facilities to prevent them from serving the community again. They demolished buildings, broke down doors, and engaged in various acts of vandalism."

There were 89 documented attacks on health care in Ethiopia from January 2025 to April 2026 alone, including strikes on health centers using aerial drones as well as targeting, intimidation, and killing of health care workers, according to Insecurity Insight.[4]

Despite the ongoing attacks and threats to health care in Ethiopia, documentation has been limited, for example the World Health Organization does not currently include Ethiopia in its surveillance system for attacks against health care due to a lack of resources to adequately support tracking and verifying.[5]

These attacks reflect a broader pattern in the conduct of conflict in Ethiopia. PHR and OJAH surveyed 602 health care workers across Afar, Amhara and Tigray regions from July to September 2024, most of whom reported experiencing various forms of direct physical attacks on facilities and health infrastructure. Select key findings from PHR and OJAH's survey of health care workers and additional sources include:

- 63.5 percent (382) of the 602 health care workers surveyed by PHR and OJAH reported experiencing attacks on ambulances between November 2020 and September 2024.
- 61.1 percent (368) of surveyed health care workers reported theft and looting at their health facilities between November 2020 and September 2024.
- 57 percent (343) of surveyed health care workers experienced armed takeover of their health facilities between November 2020 and September 2024.

Health care workers in Ethiopia also experienced direct violence coupled with indirect impacts, including mental health effects from providing care for conflict-affected communities and economic impacts through denial of salary and their means of survival.

- 28 percent (167) of health care workers indicated they had been targeted or experienced violence during the conflict in Ethiopia because of their role as a health care worker, while 45 percent (268) of health care workers reported that they had colleagues who had experienced violence or been targeted because of their role as a health care worker.

A health officer from Afar shared:

> "Some health workers were attacked. During the conflict, health centers lost property such as chairs and other medical supplies. There was a shortage of medical supplies such as medicines, and there were incidents where some people had a hard time accepting the lack of medicines and assumed that we were lying. Some people threatened health workers because they thought we were hiding medicine."

Every major armed party to the conflict – including the Ethiopian National Defense Forces (ENDF), Eritrean Defense Forces (EDF), the Tigray People's Liberation Front (TPLF), and Amhara Fano – has been implicated in these attacks, reflecting the normalization of health care as a target in conflict in Ethiopia.[6] With multiple drone strikes on facilities reported in the last six months, the violence is intensifying, raising fears of wider conflict, including increased attacks against health care.[7]

The Ethiopian health system has been devastated by years of conflict and is wholly unprepared for further escalation of fighting. The health care system in Tigray, which was once a model for the rest of Africa, has been severely damaged by conflict.[8] Despite numerous promises, the Ethiopian government has failed to provide justice to the victims and survivors of such attacks, and the international community (specifically, the African Union and the United Nations) has failed to pursue accountability for the human rights violations and atrocity crimes committed in Ethiopia, leaving the tensions underlying the conflict unaddressed and unmitigated.[9] While there is still a chance to end the repeating cycles of violence, early warning signs of increased conflict are already visible. Facilities are stockpiling resources, turning away non-emergency cases, and operating under chronic shortages of supplies and unpaid staff. With tensions rising, the window for meaningful intervention is narrowing rapidly.

International actors must treat the crisis that has emerged from half a decade of conflict in Ethiopia with the urgency it demands. The protections afforded to health care under international humanitarian law are unambiguous, yet they have been systematically violated with impunity across Ethiopia. Urgent investment is needed to support health infrastructure, supply chains, and health worker compensation in conflict-affected regions, and credible accountability mechanisms to investigate attacks and deter further violence must be urgently established.

Recommendations

To all Parties to the Conflict:

- Halt attacks on health as a tactic of war and respect the protection of health care in conflict.
- Ensure access to impartial, independent documentation and investigation of serious human rights violations and atrocity crimes that have occurred, including attacks on health care, by reestablishing international and regional investigative mandates to monitor and document human rights violations and other violations of international law.
- Allow and facilitate the unfettered delivery of impartial humanitarian relief for civilians in need of supplies essential to their survival; support the reconstruction and rehabilitation of health care infrastructure to strengthen the availability, accessibility, acceptability, and quality health services and other forms of rehabilitation, without discrimination, including for survivors of sexual and reproductive violence, across all conflict-affected areas.

To the Government of Ethiopia:

- Support Ethiopian health professionals by ensuring full payment of salaries, including owed back pay, and provide support for addressing secondary and vicarious trauma.
- Ensure prompt reparation, justice, and accountability measures that are credible and survivor-centered and engage those directly affected by conflict including implementing a transitional justice process aligned with international and regional standards.
- Conduct prompt, independent, and thorough investigations into all allegations of violations of IHL, as well as conduct that may constitute war crimes and crimes against humanity in Tigray, Amhara, and Afar, and ensure that perpetrators are brought to justice through transparent and credible processes.

To the International and Regional Community:

- Urgently reestablish impartial, independent investigative mechanisms to document violations and establish pathways for justice and accountability for affected communities.
- Mobilize, safeguard, and disburse funding to support realization of the right to health in Ethiopia including funding for essential supplies and commodities, rebuilding conflict-affected health systems and support for health professionals, through global health engagements and aid agreements that are grounded in human rights, equity, and mutual accountability, and must not condition, restrict, or leverage funding, data, or access to essential health services in ways that are coercive or extractive.
- Ensure meaningful access for conflict-affected populations, including survivor-centered, trauma-informed care and physical and psychological rehabilitation for survivors of conflict-related sexual violence in humanitarian support to Ethiopia, with specialized care for children and adolescents.
- Take measures to promote accountability and justice for attacks on health, including by supporting universal jurisdiction claims and other pathways for accountability through regional and international courts and commissions.

To the Office of the United Nations High Commissioner for Human Rights:

- Release public updates, including annual reporting, on the situation of human rights in Ethiopia, and strengthen international efforts to secure accountability and justice for past violations as well as to prevent further atrocities.
- Ensure the full-scale implementation of the national transitional justice mechanisms and monitor progress.
- Support independent, external investigations into human rights in Ethiopia.

To the World Health Organization:

- Document attacks on health care in Ethiopia and publicly share data on attacks on health care, including in the Surveillance System for Attacks on Health Care.

Methodology

Between July and October 2024, PHR and OJAH undertook a rigorous, mixed-methods research project to document attacks on health care, and the broader impact of conflict on Ethiopia's health system in the Tigray, Amhara, Afar, and Oromia regions. Quantitative and qualitative data were triangulated, including 602 structured surveys of health care workers, 40 key informant interviews, and four focus group discussions (see Annex 1 for full methodology). This provided insight into both scale and scope of attacks on health and in-depth exploration of the lived experiences of Ethiopian health workers. As part of its work to monitor ongoing human rights crimes among widespread conflict in Ethiopia, OJAH has continued to document incidents where health professionals and health facilities were directly attacked by different armed forces using reporting from its network of local human rights defenders and open source investigation.

A health center located in Ademeyti Town, Tahtay Adyabo District, North Western Zone of Tigray on the border of Ethiopia and Eritrea. This health center was attacked in early in 2021 and was occupied by Eritrean forces. Photo: OJAH

Findings

Health Care in Ethiopia Is Under Attack in 2025 and 2026

Since armed conflict in Ethiopia began in the Tigray region in November 2020 multiple regions of Ethiopia, including Amhara, Afar, and Oromia regions, have experienced conflict that has profoundly impacted civilians and communities. Humanitarian reports have documented grave violations of human rights and the laws of war, including extrajudicial killings, sexual violence, drone strikes, mass detention, targeting civilian sites such as hospitals and schools, attacks against health care, and blockades and shortages of humanitarian aid, transportation, access to banking services, and communications infrastructure.[10]

89 attacks on health care were perpetrated in Ethiopia between January 2025 and April 2026, according to monitoring by Insecurity Insight.[11] Documented attacks on health care included strikes on hospitals and clinics, forced entry and occupation of health facilities, destruction and damage to medical transports, and attacks affecting access to medication. Of the 89 documented incidents, 23 health care workers were reported killed, nine health care workers were reported to be injured, eight kidnapped, and 76 arrested. The majority of incidents were documented in Amhara region (64 cases).[a] The Ethiopian National Defense Forces (48) and Ethiopian police (11) were the most frequently identified perpetrators of attacks on health in this data set.[b]

In 2025 and 2026 OJAH documented numerous examples of attacks against health care that are emblematic of the patterns of ongoing violations seen across Ethiopia which include attacks on facilities, destruction of supplies, attacks against health care workers, humanitarian blockades, and withholding salary from health care workers.[12]

Attacks on Health Facilities, Increasingly Using Drone Technologies[13]

The increasing use of aerial drones to strike health care facilities has been a notable feature of the conflicts in Ethiopia. The Ethiopian National Defense Forces (ENDF) has been public about its use of drone technology in internal conflicts since 2021.[14] The ENDF has a track record of targeting civilians and civilian infrastructure with aerial drones despite prohibitions on attacks on health facilities and personnel in conflict.[15]

On September 27, 2025, a drone struck Sanka Primary Health Care Unit.[16] The health facility, which is in a town twenty kilometers from Woldia, the capital of the North Wollo Zone in Amhara region, was serving thousands of people with essential and emergency health services. Reports indicated that the drone struck the inpatient services of the health facility.[17] Residents suspected that the attack likely targeted wounded Fano fighters receiving treatment, but it resulted in the deaths of five civilians, including a pregnant mother who was at the facility to give birth.[18] Furthermore, it caused the injury of 10 individuals, including several health professionals. The strike not only claimed lives; it damaged health care infrastructure, rendering it unusable. OJAH has documented that medical staff have since abandoned the health facility, leaving thousands of residents without access to life-saving services. These attacks are likely to have been perpetrated by the ENDF, which is the only military force known to operate drones in Ethiopia.[19]

On February 11, 2026, after weeks of heavy fighting in South Gondar Zone, Amhara, the conflict escalated into a large-scale battle as Fano forces attempted to seize Debre Tabor City. The violence reportedly resulted in the deaths of four civilians and caused widespread destruction of property. Among the structures destroyed by Fano militias were 20 government institutions, including the local health department, medical supply warehouses, and two ambulances.[20] The destruction of health-related infrastructure and emergency transport severely disrupted access to essential health services and further endangered the rights and wellbeing of civilians.

Targeting, Intimidation, and Killing of Health Care Workers

On August 4, 2025, federal soldiers reportedly executed a civilian health professional in Merawi town, Amhara Region. The deceased was the head of the Rim Health Center, located in the Merawi neighborhood and was likely targeted because of allegations of working with the "enemy."[21]

On November 7, 2025, a health information technology professional was reportedly killed while on duty inside Angene Health Center in Dembecha town, Dembecha Zuria Woreda, West Gojjam Zone in Amhara region. Perpetrators were alleged to be members of Fano forces.[22]

a. While the majority of cases were documented in the Amhara region. Cases were also documented in Tigray (5), Gambela (3), Benishangul-Gumuz (3), Oromia (7), Addis Ababa (4), Sidama (1) and Southern Nations, Nationalities, and Peoples (SNNP)(1).

b. Other armed actors were also identified as perpetrating attacks on health, including the Fano (7), Tigray People's Liberation Front (3), Oromo Liberation Army (3) and militia/unidentified armed actor (7).

On February 3, 2026, a health professional at the Amhara Regional State Health Bureau was reportedly abducted and killed by local security forces in Bahir Dar. According to colleagues, who did not know why he was targeted, security personnel affiliated with the Amhara regional government arrived at his office under the guise of receiving guests from the Federal Ministry of Health, took the health professional into custody and transported him away from the Bezaweit area in Bahir Dar city for interrogation. Within four hours, he was reported dead. Following his detention, security forces searched his residence and confiscated his personal laptop and all mobile phones found at his home. His family was reportedly told to collect his body later that day.[23]

Lack of Rehabilitation and Justice Creates Ripe Conditions for Escalating Harm

In addition to ongoing attacks against health care, the health care system in Ethiopia has not been meaningfully rehabilitated in conflict-affected regions. In fact, steps are being taken to actively undermine health system's ability to rebound, prolonging the impact of attacks on health, through denial of health care workers' rights, reductions in international funding to support health system rehabilitation, and lack of support for regional health systems, particularly in Tigray. Additionally, the absence of credible transitional justice, including accountability for documented attacks on health care, has created ripe conditions for escalating threats to health care.[24]

May 2025 health care workers strike

In May 2025, health care workers across Ethiopia went on strike demanding better wages, working conditions, and payment of overdue salaries.[25] The walkout caused disruption to essential health care services across the country. Many health care providers cited conflict and attacks against health care, stress, lack of support, and unpaid wages as the reason for going on strike.[26] Health care workers expressed a clear link between, conflict, lack of investment in rebuilding damaged health care systems, health care workers not being able to provide basic services and the health care workers strike.[27] The government of Ethiopia did not engage in meaningful dialogue with striking health care workers, and harassed and arbitrarily detained at least 140 health care workers related to the strike and held at least 20 health care providers incommunicado for multiple weeks.[28] The crackdown on the strike is part of a wider pattern of restriction of civic space and intimidation by the government of Ethiopia seen in 2025 and 2026.[29]

Global health funding cuts exacerbating harm in 2025 and 2026

The sudden cessation in 2025 of over $380 million of health funding provided through foreign assistance has had a profound impact on a health system in Ethiopia and has exacerbated the harms caused by attacks against health care.[30] Global health aid cuts have disrupted the supply of essential HIV commodities, limited access to maternal and child health services, services for survivors of violence, and critical nutrition interventions with severe impacts, including preventable maternal deaths.[31] For example the Center for Victims of Torture (CVT), which operated five service sites in Ethiopia, was forced to halt counseling and physiotherapy sessions for women who were raped during the conflict as well as the provision of training to health care workers on conflict-related sexual violence care.[32] Global health funding cuts have directly impacted sexual violence survivors, whose recovery, safety, and dignity were supported by services that were eliminated. All indications are that the constraints caused by the sudden suspension of funding persist a year later in 2026.[33] There is a continued risk that remaining food and cash transfer assistance programs may run out of funding and shutter by June 2026 in light of shrinking foreign assistance, raising concerns about future malnutrition and food insecurity in communities that continue to be affected by conflict.[34]

Tigray health system on the brink of collapse in 2026

In March 2026, the Tigray Regional Health Bureau issued an urgent appeal stating that the health system in Tigray faced potentially imminent operational collapse due to severe shortages in fuel, medicine, and supplies, and financial restrictions.[35] Officials in Tigray have reported a ban on fuel delivery to Tigray since January 2026, which has impacted health care delivery through difficulty with medical transports, ambulances, and ability to maintain cold-chain for vaccines.[36] Additionally, the Tigray health bureau and humanitarian organizations report a severe shortage of medicines and medical supplies, resulting in rationing supplies, delaying necessary procedures and stockpiling.[37] Finally, health care workers have worked without salary since January 2026.[38]

Across these incidents, attacks on health workers, health care facilities, medical supplies, and broader systems of support reflect a pattern of continuing violence and threats against health care in Ethiopia with no justice or accountability for these crimes. Furthermore, attacks against health care continue to be notably lacking in documentation of violence in Ethiopia; the World Health Organization does not currently include Ethiopia in its surveillance system for attacks against health care.[39]

Current Context Mirrors Patterns of Attacks on Health Documented from November 2020 to October 2024[c]

Attacks on health care are an ongoing and widespread conflict tactic being deployed across multiple regions of Ethiopia, with the clear aim of destabilizing communities and amplifying harm to civilians. The current patterns of attacks on health care mirror patterns of attacks that have been documented extensively throughout the Tigray war, starting in November 2020, and increasingly reported as violence escalated in other regions, starting in 2021 and 2022, specifically Amhara region, as well as Afar region.

While conflict has affected different regions of Ethiopia during different periods of time, there is consistency in the patterns of attacks and the impact is similar and persistent. Health care systems were targeted and damaged or destroyed, health care workers were injured and intimidated, and the essential inputs for functional health care, including medications, supplies, equipment and technologies, were stripped away – ultimately making it impossible for affected individuals and communities to receive necessary health care both during the conflict and in the post-conflict period.

Direct attacks on health care facilities and infrastructure

Health care workers from all regions described health care facilities and systems as direct targets of violence, with attacks occurring in ways that went beyond incidental damage to cause cascading harm to health for civilians. Health care workers described violence and threats that seemed intentional and strategic. Attackers did not merely occupy or pass through health compounds but actively dismantled their ability to provide care through multiple fronts – thereby eliminating the facility's ability to serve communities rather than merely cause temporary disruption.

In Tigray, health care workers who were interviewed described the damage as both widespread and consequential. The physical infrastructure of health care facilities, such as buildings and utilities, suffered extensive damage, further weakening service delivery and in some cases making facilities inoperable. The result was that communities were left without functional points of care. As one health officer described:

> "Many health centers and hospitals were damaged. The attackers looted medical equipment and deliberately destroyed the facilities to prevent them from serving the community again. They demolished buildings, broke down doors, and engaged in various acts of vandalism."
> Tigray, Health Officer

> "Occupied hospitals were attacked multiple times. Even operation theaters were demolished, and medical records were burned."
> Tigray, Physician

In Amhara, health care workers described how infrastructure loss led to health care facilities improvising modes of service delivery, creating a situation where facilities could not reliably conduct clinical care. In one focus group discussion, health care workers described moving service delivery outdoors using temporary materials because of damage:

> "Due to the war, most of the materials used in medical facilities were destroyed. We didn't even have a medical unit. We provided medical services outside using the tents donated by the government because many houses were burnt down."
> Amhara, Physician

Presence of armed actors transforms care environments

Health care workers shared that armed combatants were routinely present in hospital settings. The presence of armed forces, either while occupying the health facility for military purposes or while seeking care for wounded fighters, changed health facilities into spaces of surveillance, intimidation, and heightened threat.[40] Facilities were not seen as neutral zones which contributed to making them targets and diminished both staff's willingness to come to work and patients' ability to access services.

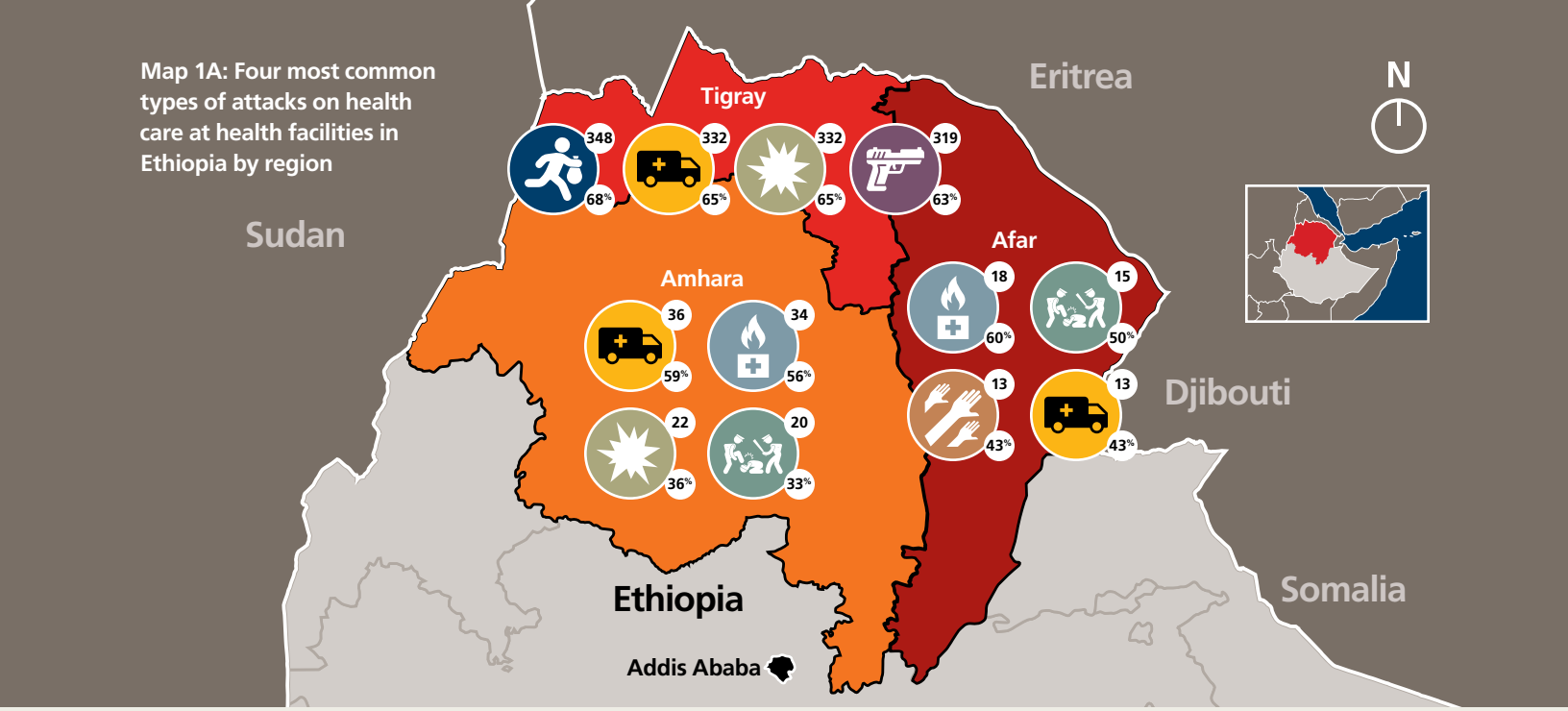
In Tigray, health care workers described constant armed presence at their facility and its direct effect on staff as a barrier to access care; patients feared exposure, surveillance, or retaliation for seeking care. This barrier remained even after forces had left communities and health facilities.

> "The presence of armed soldiers in hospitals 24 hours a day with weapons in four directions made it impossible to work. The hospital became a target, and staff were too afraid to come to work."
> Tigray, Psychiatry Professional

> "There were so many armed men here, the survivors were afraid of them. They didn't come fearing the one who attacked them would find them again."
> Tigray, Case Manager

c. Between July and October 2024 PHR and OJAH undertook a rigorous-mixed method approach to document attacks on health care, and the broader impact of conflict on Ethiopia's health system in the Tigray, Amhara, Afar and Oromia regions. Quantitative and qualitative data were triangulated, including 602 structured surveys of health care workers, 40 key informant interviews, and four focus group discussions. (See Annex 1 for full methodology)

Map 1A: Four most common types of attacks on health care at health facilities in Ethiopia by region



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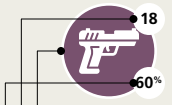
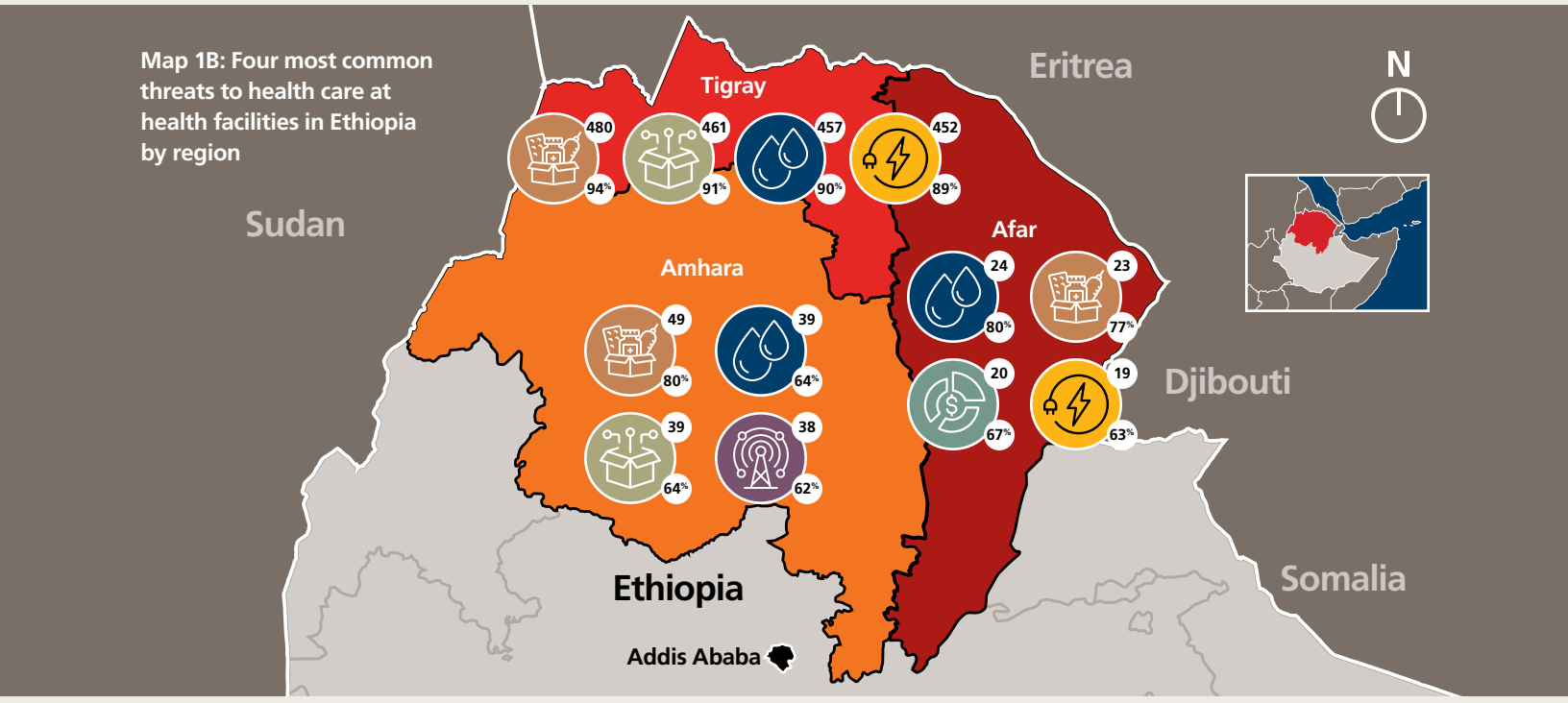


Incident Report Type

- Armed takeover of health facility
- Attacks against health workers providing outreach services in the community
- Attacks against health workers working in the health facility
- Attacks on or destruction of ambulances
- Attacks on or destruction of immediate surface roads outside of health facility
- Physical attack on health facility infrastructure (drone strikes, bombing, shelling, arson, and other)
- Theft or looting of health facility

Map 1B: Four most common threats to health care at health facilities in Ethiopia by region



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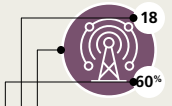


Incident Report Type

- Loss of communication infrastructure (phone or internet)
- Loss of electricity
- Shortage in medical supplies
- Shortage of capital budget (for payment of salary etc.)
- Shortage or loss of clean water
- Supply chain interruptions

Health care workers survey, 2024

> "Initially, survivors were hesitant to seek care due to the presence of enemy forces in health care facilities. Many feared that these facilities were being used as military camps. Even after the departure of enemy forces, survivors were reluctant to come forward due to the ongoing conflict and safety concerns."
> Tigray, Reproductive Health Professional

During the conflict in Tigray, there were numerous attacks on ambulances and medical convoys, creating additional fear around accessing health care using transport systems.[41]

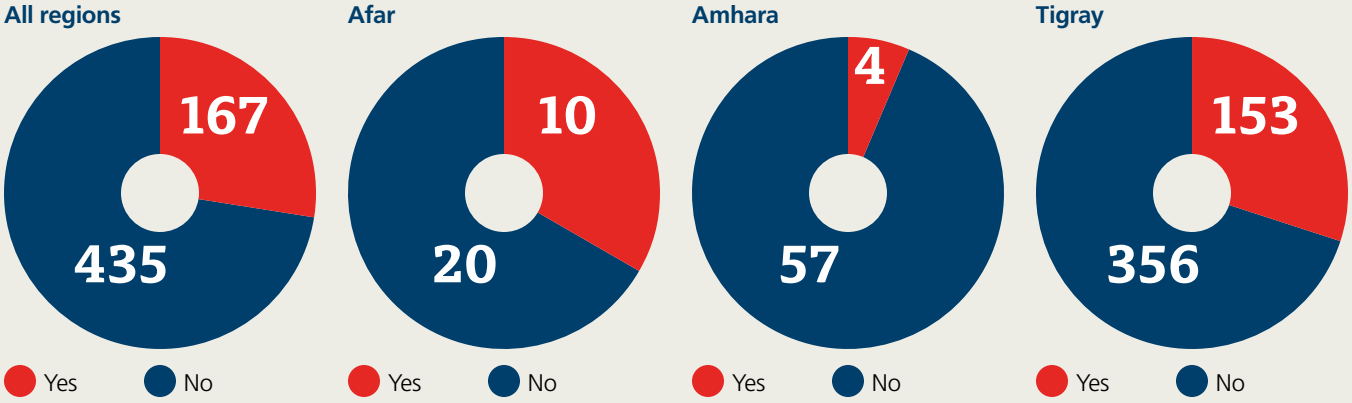
In Amhara, a health care worker shared a similar experience.

> "We can't even go to bring a patient by ambulance because they [the perpetrators/TPLF forces] were saying 'I will kill you if you come back for a second time' So the ambulance drivers were scared."
> Amhara, Health Officer

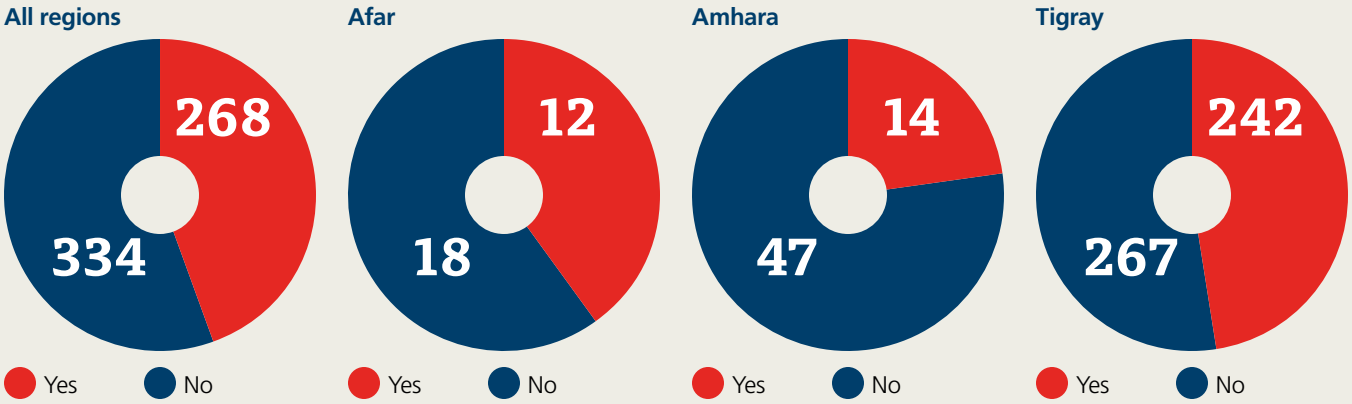
Attacks and threats against health care workers

Health care workers across all regions were victims and witnesses of violence, threats, and intimidation, with experiences ranging from coercion in the workplace to lethal attacks. Health care workers from Afar, Amhara, and Tigray shared that they still grappled with the aftermath of direct violence, the mental health and secondary traumatic impact of witnessing violence, and the tangible economic impacts of lost wages and other resources.

Health care workers who report being targeted or attacked because of their work during the conflict in Ethiopia



Health care workers who indicated that they have colleagues who have been targeted or experienced violence during the conflict in Ethiopia because of their role as a health care worker



Health care workers survey, 2024

In Tigray, health care workers described shooting, and intimidation in hospital compounds and surrounding communities as well as killings at or near facilities or while providing care.

> "There was one Pharmacist who was shot, he was shot at the door of the hospital…we couldn't stop the bleeding because he was shot multiple times."
> Tigray, Health Officer

In Amhara, health care workers reported that providing care triggered violence, suspicion, and punishment. Being questioned, beaten, arrested, or accused of aiding one side created a climate of fear and reshaped the environment where they were providing clinical practice.

> "We were often questioned about our activities when we provided care, and there were some incidents of violence like getting beaten that we faced. When we attempted to assist, we faced further questioning like why we would help this side but not help the other side and even arrested in some cases."
> Amhara, Nurse

> "Our colleagues were arrested at the hospital and nearly sentenced to death, suspected of being military collaborators. They were released only because of friends they knew. Some of our close friends were also arrested, and even our superiors were detained. They were questioned and arrested simply for being outside."
> Amhara, Midwife

> "Some health workers were attacked and threatened, especially when they couldn't provide medicines."
> Amhara, Health Officer

In Afar, a health care worker spoke about how threats caused health care workers to leave clinical practice, resulting in work force challenges.

> "Some of the health care professionals were displaced in fear of being attacked or victimized, which resulted in a shortage of manpower during the conflict."
> Afar, Health Officer

Across all regions, health care workers described deterioration of their mental health following exposure to war-related violence and suffering, attacks against health care, and threats and violence against health care workers. Trauma was ongoing, health care workers described depression, heightened sensitivity, intrusive memories, and impaired concentration.

> "I have been psychologically affected since I was imprisoned when the war first erupted. The most severe impact is that I have developed mental health problems because I still do not know whether he [my husband] is alive or dead. My mental state is not normal; it is not the same as before."
> Tigray, Case Manager

Above: A baby incubator lays among the debris of a ward of the Shiraro Health Centre in Shiraro that collapsed because of artillery shelling.
Photo: Michele Spatari/AFP/Getty Images

Professional Quality of Life (ProQol) Measure

The Professional Quality of Life (ProQol)[42] tool was administered to 593 health care professionals in Tigray, Amhara and Afar regions to assess their current levels of compassion satisfaction[d], burnout[e], and secondary trauma[f] within the last 30 days, on a scale of low, moderate or high.[g] The ProQOL allowed for a deeper understanding of the impact of conflict and violence against health care on health professionals in Ethiopia.

Overall, health care workers reported a moderate level of burnout, with 571 (96 percent) scoring between 23 and 41.

Health care workers showed a high level of compassion satisfaction, with 404 (68 percent) reporting moderate satisfaction and 185 (31 percent) reporting high satisfaction; indicating generally moderate-to-high fulfillment derived from doing their work.

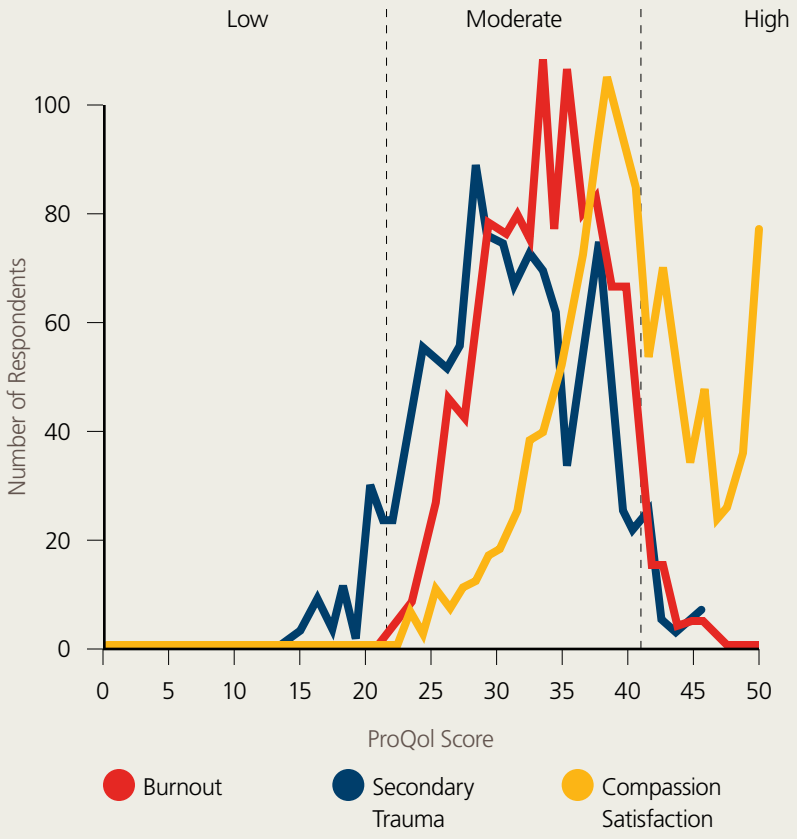
Moderate secondary trauma stress levels were reported by 523 (88 percent) of health care workers.

Comparing scores across region we see that health care workers in Tigray have higher odds of having high secondary traumatic stress levels compared to those in Amhara and Afar.[h]

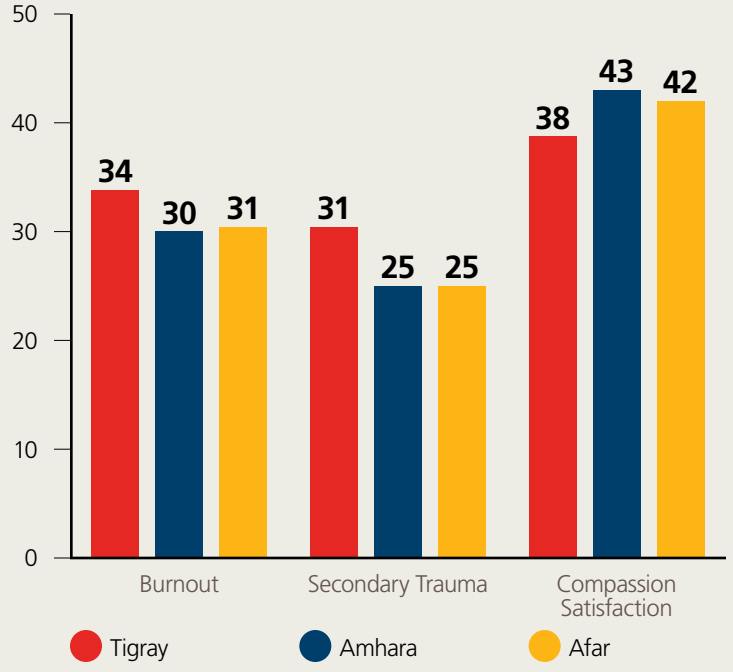
Compassion satisfaction varied significantly by region. Compared to Tigray, participants in Amhara and Afar had significantly higher odds of reporting higher compassion satisfaction.[i]

This regional analysis shows that health care workers in the Tigray region were more likely to have higher secondary traumatic stress and lower compassion satisfaction relative to other regions. When considering the measure was administered to health care workers in Tigray almost two years after the formal cessation of hostilities these results help to demonstrate the long-term impact of the conflict in Tigray on health care workers there and the impact of ongoing threats to health care, even if direct attacks have ceased.

Distribution of ProQoL Scores



Mean ProQol Scores by Region



d Compassion satisfaction in the ProQOL measure is defined as the pleasure derived from being able to do work well. For example, a respondent may feel like it is a pleasure to help others through their work. (From: https://proqol.org/proqol-measure)

e Burnout is one of the elements of Compassion Fatigue (CF), it is associated with feelings of hopelessness and difficulties in dealing with work or in doing a job effectively. (From: https://proqol.org/proqol-measure)

f Secondary trauma is the second component of Compassion Fatigue (CF) and is the work related, secondary exposure to extremely or traumatically stressful events. (From: https://proqol.org/proqol-measure)

g Scoring for all ProQol scales are as follows: Low (22 or less); Moderate (23 to 41); High (42 or higher) out of a total potential score of 150.

h Odds Ratio ≈ 0.11, $p < 0.001$

i Odds Ratio = 4.93 and 3.76, respectively, $p < 0.01$

Theft and shortages of medical supplies

The vast majority of health workers across all regions indicated that they experienced theft, looting, destruction, and shortage in medical supplies and critical supply chain interruptions, which diminished operational capacity over the long-term, making health care facilities unable to meet even basic needs. Across all regions, even if buildings remained standing, service provision became impossible due to lack of basic tools and supplies.

In Tigray, a health officer described how looting, combined with attacks on physical infrastructure, had an immediate operational effect due to the breadth of equipment and supply loss.

> "The attackers looted medical equipment and deliberately destroyed the facilities to prevent them from serving the community again…. I have even heard firsthand accounts from doctors who had to bring chairs from their homes to sit on while treating patients."
> Tigray, Health Officer

In Tigray, looting and destruction of equipment occurred alongside a blockade of humanitarian aid, including medical supplies, that was reported to be in place starting in October 2021 until April 2022, after which humanitarian aid was still limited.[43] This blockade, imposed by the Ethiopian national government, impacted transportation, communication, banking, and humanitarian supplies, and made it difficult, if not impossible, to replace supplies that were looted or destroyed through attacks on health care.

> "Even HIV drug supplies and basic medicines were looted, leaving patients without necessary treatments …. Especially in the last war [2022], the medicine that was there was stolen, broken, destroyed. And the hospital was destroyed again. Even when the NGOs were trying to provide supplies, it was blocked on the road…. There were many women with STIs at the time. Let alone other medications, even for HIV drug users, the medications were missing until recently."
> Tigray, Case Manager

In Afar, a health care worker described how equipment and supplies were both taken. In some instances, they shared that the shortage of medicine put health professionals at risk of violence from patients.

> "Some health workers were attacked. During the conflict, health centers lost property such as chairs and other medical supplies. There was a shortage of medical supplies such as medicines, and there were incidents where some people had a hard time accepting the lack of medicines and assumed that we were lying. Some people threatened health workers because they thought we were hiding medicine."
> Afar, Health Officer

Supplies Commonly Reported as Missing by Health Care Workers in Survey

Medication

Sexual and Reproductive-Health Commodities

Supplies for management of chronic diseases and mental health conditions

Laboratory Materials

Sanitation and Protective Supplies

Imaging and Clinical Assessment Tools

Equipment

Furniture

IT Equipment

Transport, Electricity, Food, Water

Prolonged economic deprivation of health care workers
Beyond critical supply shortages, health care workers also experienced personal economic deprivation. 81 percent (487) of the 602 health care workers surveyed reported that their facilities experienced a shortage of capital budget which impacted payment of salaries.

In Tigray, health care workers experienced prolonged periods where they were unpaid, which made it difficult to sustain their livelihoods, provide for their families, and reduced the ability of health care workers to continue service provision. Ultimately, the economic deprivation caused some health care workers to migrate and leave the sector completely.

> "Even beyond the occupation, during the siege there was a lack of salary for the health professionals. So, the health professionals in Tigray worked for 20 months without salary, literally with no salary….a lot of them migrated even though it was not occupied, we were not providing service."
> Tigray, Physician

> "We did not interrupt our services; we were simply staying at work. With nowhere else to go, we kept working, even when we were hungry and struggling with many problems. During the war, it was not a good place to be, but we stayed because we had to—not because we were satisfied or because we were being paid."
> Tigray, Psychologist

> "…many of us are struggling to make ends meet. Personally, as a public servant, I am currently working without receiving a salary. …Our financial challenges mean we have little to provide for our families. If our children get sick, we often cannot afford the medical care they need."
> Tigray, Psychiatry Nurse

Respondents in Amhara and Tigray also reported experiencing food insecurity while continuing work.

> "During the war, they [health care professionals] were starving and begging for leftover food using plastic bags [to beg for and collect leftover food]. You would be surprised, everyone was struggling, and even now many are not satisfied."
> Amhara, Midwife

Analysis & Conclusion

The Time to Act is Now

The documented patterns of attacks and threats to health care across Ethiopia's conflict-affected regions reflects a deeply alarming trend. The experiences of health care workers from November 2020 to October 2024 mirror patterns documented in 2025 and 2026. Even though the types of violence, and most impacted regions vary over time, there is a consistency in the pattern of attacks on health care. As conflict has continued, so too has the destruction of health infrastructure, supply chains, and services, and targeting, intimidation and threats to health care professionals. These attacks and threats do not occur in isolation; they are part of a broader continuation of violence that shows little sign of abating and in fact appears to be intensifying.

By dismantling every element of the health care system in conflict-affected regions across Ethiopia, perpetrators of attacks and threats to health care limit survivors' ability to access critical care in the immediate aftermath of violence, while simultaneously deepening the long-term consequences of violations by delaying or removing access to care. (See Figure 1).

In Tigray, respondents described an intensifying crisis in which direct attacks on health care facilities, combined with widespread looting of equipment and medicines, and supply chain blockades stripped the health system of both infrastructure and essential inputs. Facilities were damaged or destroyed, and the systematic removal of medical tools, furniture, and critical commodities, including HIV and sexual and reproductive health medications, produced acute shortages that made routine service delivery impossible even where buildings remained standing.[44] Armed actors were present in hospitals and health centers, seeking care and occupying health centers as military bases, turning care sites into unsafe spaces thus limiting their accessibility and, in some cases, making them targets of further attack.[45] In parallel, health care workers experienced threats, violence, and deadly attacks, while extended periods of unpaid work further weakened their ability and willingness to remain in service.[46] It is reported that over 70 percent of health facilities were looted and at least 86 percent of health facilities endured structural damage during the war.[47] Six months into the war, none of the 712 local health posts in Tigray were functional and only 27.5 percent of hospitals were able to offer services.[48] The result was severe health impacts on civilian populations. One study that examined maternal morbidity and mortality before and during the conflict at Ayder Comprehensive Specialized Hospital in Tigray found that only 9 percent of patients with potentially life-threatening obstetric conditions were referred during the conflict period –a significant reduction from 55 percent of patients pre-war.[49]

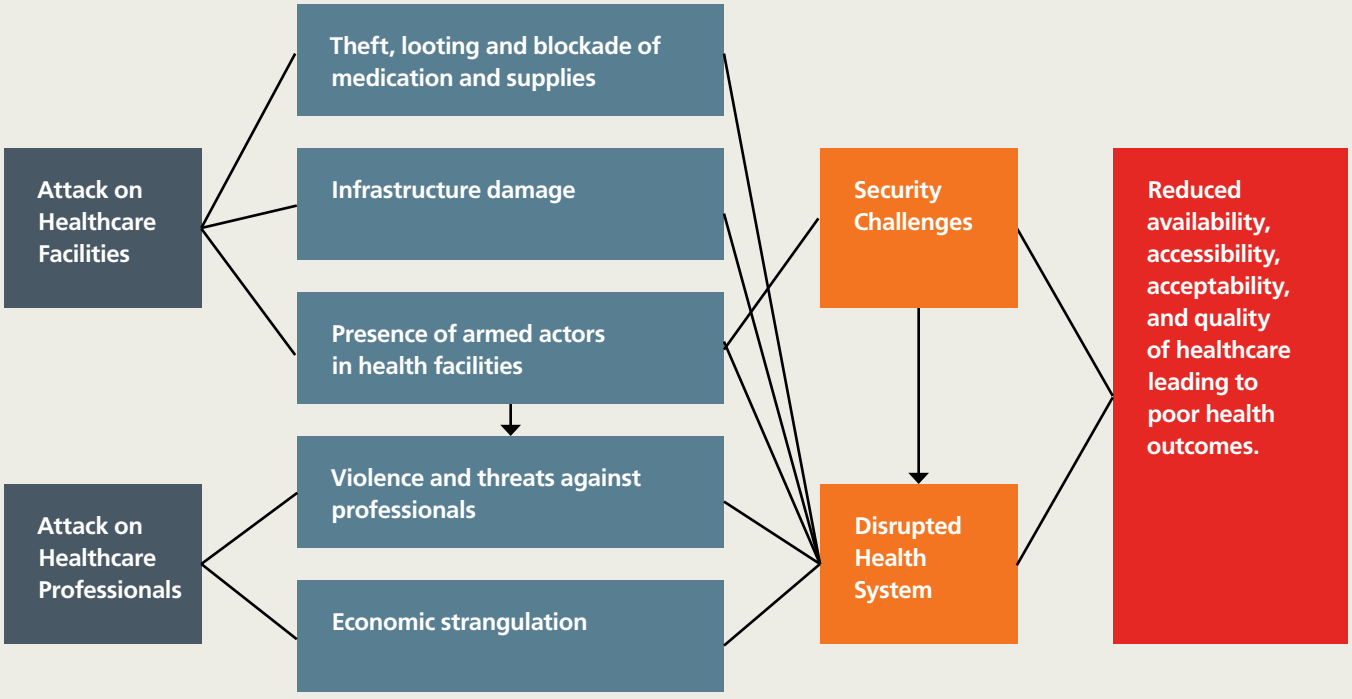
In Amhara, respondents also described how the health care system has increasingly been targeted, particularly with strikes using drone technology reported in 2025 and 2026.[50] Alongside this, key health care inputs such as equipment and supplies have been stripped away due to looting, seizure, and shortages.[51] Health care workers in Amhara have been particularly and persistently targeted in recent years – with providers experiencing violence, including execution, and threats of violence for providing care, particularly due to perceived allegiance with militia groups due to provision of care.[52] As a result, both providers and patients avoided facilities due to fear related to the presence of armed groups and ongoing threats of violence and retaliation. An analysis of 12 studies found that conflict in the Amhara region rendered 60 percent of health facilities nonfunctional, disrupted access to medical supplies for 70 percent of the population, and reduced service availability by 80 percent.[53]

Although PHR and OJAH collected less data from the Afar region, survey responses and qualitative interviews there show patterns largely similar to those seen in Tigray and Amhara. This suggests that health care facilities and health care workers across Ethiopia are experiencing violence and threats as part of the conflict.

These attacks reflect a pattern of conduct across all perpetrator groups. The Ethiopian National Defense Forces (ENDF), Eritrean Defense Forces (EDF), the Tigray People's Liberation Front (TPLF), and Amhara Fano, are all reported to have committed attacks against health care, suggesting normalization of attacks on health as a conflict tactic rather than isolated incidents or patterns specific to one perpetrator group.[54]

Despite robust legal protections of health care under international humanitarian law (IHL) and international human rights law (IHRL)[55], attacks and threats to health care in Ethiopia have served to harm, intimidate, and weaken communities. Attacks on hospitals may violate international humanitarian law because IHL prohibits attacks on civilians and civilian objects, protects the wounded and sick, and gives special protection to medical units, medical personnel and medical transports, including ambulances.[56] A hospital or ambulance may lose its special protection only if it is used, outside its humanitarian function, to commit acts harmful to the enemy, and even then, protection ceases only after an appropriate warning has gone unheeded, where such a warning is required.[57] Parties to the conflict must allow and facilitate impartial humanitarian relief for civilians in need, including medical and other supplies essential to survival, subject to their right of control.[58] Thus, deliberate attacks on functioning hospitals, shelling or looting health facilities, occupying them in ways that obstruct care, threatening medical workers, or blocking ambulances could amount to IHL violations and, depending on intent and circumstances, war crimes.

Figure 1: Impact of Conflict on Health Care



Even where a party claims to be attacking a military objective, IHL requires compliance with distinction, proportionality, and precautions: attacks expected to cause excessive incidental civilian harm are prohibited, and parties must take all feasible precautions to avoid or minimize harm to civilians and civilian objects.[59] In the health context, that analysis should include reasonably foreseeable reverberating effects, such as deaths or untreated injuries caused by the loss of emergency care, disruption of ambulance services, destruction of medical supplies, fear among patients and staff, and reduced access to health care in surrounding communities. Ethiopia is bound by the relevant treaty framework, including the Geneva Conventions and Additional Protocol II, and the core protections for civilians, the wounded and sick, medical care and humanitarian relief also reflect customary IHL applicable in non-international armed conflicts.[60]

Attacks on health facilities and health service delivery may also violate international human rights law (IHRL), which continues to apply during armed conflict alongside IHL. Hospital attacks can interfere with the rights to life, health, security of person, and non-discrimination, especially where they deprive civilians, detainees, wounded fighters, pregnant people, children, or persons with disabilities of essential medical care. The UN High Commissioner for Human Rights has warned that ongoing violations and abuses in Ethiopia continue to endanger civilians and reconciliation, and has called on parties to halt hostilities and protect rights.[61] Under IHRL, the Ethiopian state has duties not only to refrain from unlawful attacks and arbitrary deprivation of life, but also to investigate, prosecute, and provide remedies for serious abuses.[62] Where attacks on hospitals are widespread, repeated, or tolerated with impunity, they may therefore indicate both direct violations by state forces and failures of due diligence to protect civilians from abuses by non-state armed actors.

Since attacks on health care began to escalate in November 2020, there has been a sustained failure to document, investigate, and ensure accountability for violence against health care in Ethiopia.[63] No credible on-the-ground investigations or prosecutions have been publicly reported, and the government of Ethiopia successfully advocated for the closure of regional and international investigation bodies in favor of a transitional justice policy that has fallen short of international and regional standards and has not to date meaningfully addressed violence experienced by impacted communities.[64] In the face of a failed transitional justice process independent documentation from organizations like WHO and OHCHR has been non-existent or inconsistent leaving attacks too often unrecorded and unaddressed.[65] The data that is available about attacks on health care is likely a vast undercount of the full scale and scope of violence. Our evidence makes clear that this is not a closed chapter or a set of isolated cases but a playbook of attacks that is ongoing. The consequence is predictable and devastating – survivors and affected communities face substantial barriers to care as services are disrupted, facilities become nonfunctional, health care workers leave their posts, and access to essential health care is systematically undermined.

Escalating violence in Ethiopia today creates an even greater imperative to act. There are already reports of shortages of supplies and prolonged gaps in pay, and facilities have begun stockpiling resources and turning away non-emergent cases, rationing in anticipation of increased violence.[66] These threats make it critically important that stakeholders act now to support health care systems in Ethiopia with needed investment and inputs, while seeking accountability for attacks against health care, deterring a culture of impunity.

The Ethiopian health system is still in recovery following over half a decade of conflict and is wholly unprepared to meet the surge in need that further escalation of violence would inevitably bring.[67] When violence intensifies, civilians bear the heaviest burden – through direct physical harm, displacement, and the collapse of essential services. Without a functioning health system capable of meaningfully responding to survivors' needs, harm is compounded: injuries go untreated, mortality rises, disease spreads, and psychological wounds deepen without support.

Attacks on health care in Ethiopia have inflicted profound and enduring harm on communities, patients, survivors, and health workers. These violations must be urgently halted and immediate protection and support restored for those affected.

Recommendations

To all Parties to the Conflict:

- Halt attacks on health as a tactic of war and respect the protection of health care in conflict.
- Ensure access to impartial, independent documentation and investigation of serious human rights violations and atrocity crimes that have occurred, including attacks on health care, by reestablishing international and regional investigative mandates to monitor and document human rights violations and other violations of international law.
- Allow and facilitate the unfettered delivery of impartial humanitarian relief for civilians in need of supplies essential to their survival; support the reconstruction and rehabilitation of health care facilities to strengthen the availability, accessibility, acceptability, and quality health services and other forms of rehabilitation, without discrimination, including for survivors of sexual and reproductive violence, across all conflict-affected areas.

To the Government of Ethiopia:

- Support Ethiopian health professionals by ensuring full payment of salaries, including owed back pay, and provide support for addressing secondary and vicarious trauma.
- Ensure prompt reparation, justice, and accountability measures that are credible and survivor-centered and engage those directly affected by conflict including implementing a transitional justice process aligned with international and regional standards.
- Conduct prompt, independent, and thorough investigations into all allegations of violations of IHL, as well as conduct that may constitute war crimes and crimes against humanity in Tigray, Amhara, and Afar, and ensure that perpetrators are brought to justice through transparent and credible processes.

To the International and Regional Community:

- Prioritize and engage in de-escalation measures and facilitate peaceful political dialogue between the government of Ethiopia and the Fano, TPLF, OLA and other armed groups.
- Support regular monitoring and transparent reporting of the implementation of the Cessation of Hostilities Agreement (COHA) including but not limited to cessation of hostilities, transitional justice mechanisms and protection of human rights and humanitarian law as stipulated in the agreement.
- Urgently reestablish impartial, independent investigative mechanisms to document violations and establish pathways for justice and accountability for affected communities.
- Mobilize, safeguard, and disburse funding to support realization of the right to health in Ethiopia including funding for essential supplies and commodities, rebuilding conflict-affected health systems and support for health professionals, through global health engagements and aid agreements that are grounded in human rights, equity, and mutual accountability, and must not condition, restrict, or leverage funding, data, or access to essential health services in ways that are coercive or extractive.
- Ensure meaningful access for conflict-affected populations, including survivor-centered, trauma-informed care and physical and psychological rehabilitation for survivors of conflict-related sexual violence in humanitarian support to Ethiopia, with specialized care for children and adolescents.
- Take measures to promote accountability and justice for attacks on health, including by supporting universal jurisdiction claims and other pathways for accountability through regional and international courts and commissions.

To the Office of the United Nations High Commissioner for Human Rights:

- Release public updates, including annual reporting, on the situation of human rights in Ethiopia, and strengthen international efforts to secure accountability and justice for past violations as well as to prevent further atrocities.
- Ensure the full-scale implementation of the national transitional justice mechanisms and monitor progress.
- Support independent, external investigations into human rights in Ethiopia.

To the World Health Organization:

- Document attacks on health care in Ethiopia and publicly share data on attacks on health care, including in the Surveillance System for Attacks on Health Care.

Annex

Methodology

This study employed a rigorous-mixed method approach to document conflict, attacks on health care, and the broader impact of conflict on Ethiopia's health system. Quantitative and qualitative were triangulated, including 602 structured surveys of health care workers, 40 key informant interviews, and four focus group discussions. This design strengthened the reliability of findings across multiple data sources and provided insight into both scale and scope of attacks on health and in-depth exploration of lived experiences.

Health care workers working in a health care setting in Ethiopia including doctors, nurses, midwives, medics, hospital/health center administrators, community health workers, and other health workers who worked in in hospitals, health centers, mobile emergency clinics, refugee camps, safehouses, and one-stop centers who treated patients in or from Ethiopia after November 2020 were eligible for inclusion in this study. (See table below for respondent demographics).

All participants were engaged in an informed consent process prior to data collection. The study received ethical approval from three institutional review boards.

Data were collected between July and October 2024, with supplementary data collected in 2025 and 2026, by a multidisciplinary research team based in Ethiopia and the United States. The study period covered the start of hostilities in Tigray in November 2020 to August 2024, with supplemental data examining 2025 and early 2026.

The survey of health care workers experiences of sexual and reproductive violence, attacks on health care, and the impact of conflict on the health system and health care workers was administered to selected health care workers, using Open Data Kit (ODK). Participants also completed the ProQoL scale to assess the health care worker's current mental health status.

The survey used a multistage sampling procedure drawing from 40 functional health facilities that treat survivors of conflict-related sexual violence in the three conflict-affected regions, two from Afar, four from Amhara, and 34 from Tigray. Individual participants from those facilities were selected based on professional duties. Due to security considerations, identifying information about the names of facilities, their exact locations, number of facilities sampled, and types of facilities that were included in the sample are not presented in this report. Due to ongoing occupation, blockade, and safety concerns, health facilities in Western Tigray and some areas of Amhara were inaccessible at the time of data collection and were excluded from the study. The calculated sample size was proportionally distributed across the remaining accessible facilities, based on the number of health professionals at each site.

Focus group discussions and semi-structured interviews on the nature of attacks on health care and their impacts on service delivery and health workers were conducted with health workers, humanitarian actors, and community leaders with experience providing care to conflict-affected Ethiopian populations, in Ethiopia and refugee settings in Kenya and Sudan.

Participants were eligible if they were health care workers of any discipline, humanitarian actors, or community leaders aged 18 years or older with experience working with Ethiopian populations affected by conflict after November 2020. A demographic questionnaire was administered prior to interviews. Purposive sampling was used to ensure representation across health facility types, professional roles, and lived experiences.

The semi-structured interview guide explored challenges in delivering trauma-informed care, including experiences of attacks on health care and their effects on providers. Interviews were conducted in Tigrigna, Amharic, Oromo, or English by trained, language-concordant data collectors. All interviews were audio-recorded, transcribed verbatim in the original language, translated into English, and independently verified for accuracy by bilingual members of the research team.

Right Page: A health center located in Ademeyti Town, Tahtay Adyabo District, North Western Zone of Tigray on the border of Ethiopia and Eritrea. This health center was attacked in early in 2021 and was occupied by Eritrean Forces. Photo: OJAH

Data Analysis

All data were deidentified. A research team made up of medical, public health, human rights, and legal professionals conducted data analysis collaboratively.

Qualitative semi-structured interviews and focus group discussions were reviewed and analyzed using Dedoose, a qualitative data management and analysis software. All interviews were independently coded using a coding dictionary. The coding dictionary was based on the research objectives as well as emergent themes from the data review. The study team used an iterative and collaborative effort three-step analysis process that included 1) open coding categorized data within and across interviews into common areas of interest, 2) theme tables to capture key themes that emerged from the data and discussed in debrief meetings, and 3) summaries to describe and integrate the key elements within each theme.

Quantitative data from the health care workers survey and ProQol were cleaned by a multidisciplinary team using agreed upon parameters and analyzed using descriptive statistics to summarize attacks against health care and provider experiences.

Limitations

These data provide important insights into attacks on health care across selected facilities in conflict-affected areas of Tigray, Amhara, and Afar, but they do not permit definitive estimates of prevalence across all regions of Ethiopia and are limited to the study period from November 2020 to August 2024. Sampling constraints resulted in overrepresentation of Tigray, while security, ethical, and administrative barriers restricted access to certain populations and geographic areas, particularly in Amhara and, to a lesser extent, Afar, contributing to underrepresentation and potentially obscuring variation in conflict dynamics across regions and over time. Qualitative findings reflect the perspectives of participating health professionals and are subject to recall bias, as respondents reported on events dating back to 2020. In addition, the qualitative sample was small and non-random, limiting generalizability to the broader population of health care workers in Ethiopia. To mitigate these limitations, data collectors were trained on standardized protocols, multiple data sources were triangulated across surveys and interviews, and translations and coding were cross-checked by a multidisciplinary research team to enhance consistency and reduce interpretation bias. Nonetheless, these constraints underscore the need for further research to address gaps in geographic coverage, representativeness, and temporal scope.

Respondent Demographics

Table 1: Demographic characteristics of surveyed health care workers

Category	Total	Tigray	Afar	Amhara	Others
# of Surveys N (%)	602 (100)	509 (84.6)	30 (5)	61 (10.1)	2 (0.4)
Age, y, Median, Interquartile Range (IQR)	32 (28 – 40)	32 (29 – 41.5)	31 (27 – 39.25)	29 (27 – 32)	29 (26 - _)
Male N (%)	237 (39.4)	172 (33.8)	19 (63.3)	45 (73.8)	1 (50)
Female N (%)	365 (60.6)	337 (66.2)	11 (36.7)	16 (26.2)	1 (50)

Respondents Professional Background

Category	Total	Tigray	Afar	Amhara	Others
Community Health Worker	15 (2.5)	8 (1.6)	4 (13.3)	3 (4.9)	0 (0)
Public Health/ Health Officers	69 (11.5)	59 (11.6)	5 (16.7)	4 (6.6)	1 (50)
Paramedics	16 (2.7)	13 (2.6)	2 (6.7)	1 (1.6)	0 (0)
Nurses	223 (37)	187 (36.7)	8 (26.7)	27 (44.3)	1 (50)
Midwives	182 (30.2)	162 (31.8)	7 (23.3)	13 (21.3)	0 (0)
Physicians	36 (6)	34 (6.7)	0 (0)	2 (3.3)	0 (0)
Mental Health Care Workers	22 (3.7)	18 (3.5)	1 (3.3)	3 (4.9)	0 (0)
Case Manager/ Social Workers	10 (1.7)	9 (1.8)	1 (3.3)	0 (0)	0 (0)
Administrative and Support Staff	6 (1)	4 (0.8)	2 (6.7)	0 (0)	0 (0)
Other	23 (3.8)	15 (2.9)	0 (0)	8 (13.1)	0 (0)

Table 2: Demographic characteristics of interviewed health care workers

Category	Total	Afar	Amhara	Kenya/Sudan	Oromia	Tigray
# of Interviews N (%)	40 (100%)	1 (3%)	3 (8%)	12 (30%)	7 (18%)	17 (43%)
Age, y, Median (IQR)	32 (9)	28 (0)	28 (2)	37 (11)	31 (5)	30 (9.5)
Male N (%)	17 (43%)	0 (0%)	3 (100%)	5 (42%)	6 (86%)	2 (12%)
Female N (%)	23 (58%)	1 (100%)	0 (0%)	7 (58%)	1 (14%)	15 (88%)
Period of time working with people affected by the conflict in Ethiopia, y, Median (IQR)	4 years (1.5)	5 years (0)	4 years (2)	4 years (2)	3 years (3)	3 years (2)
Community Health Worker	3 (8%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (18%)
Public Health/Health Officers	9 (22%)	1 (100%)	0 (0%)	3 (25%)	1 (14%)	4 (24%)
Paramedics	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Nurses	13 (33%)	0 (0%)	3 (100%)	5 (42%)	3 (43%)	2 (12%)
Midwives	2 (5%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (12%)
Physicians	5 (13%)	0 (0%)	0 (0%)	1 (8%)	3 (43%)	1 (6%)
Mental Health Care Professionals	2 (5%)	0 (0%)	0 (0%)	1 (8%)	0 (0%)	1 (6%)
Case Manager/Social Workers	3 (8%)	0 (0%)	0 (0%)	1 (8%)	0 (0%)	2 (12%)
Administrative and Support Staff	1 (3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (6%)
Other	2 (5%)	0 (0%)	0 (0%)	1 (8%)	0 (0%)	1 (6%)

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Endnotes

continued

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Stolen, Broken, Destroyed

A health care worker walks through debris that litters the floor of the medical lab at the Mersa Health Center in North Wollo on January 12, 2022. Photo: E. Countess/Getty Images

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