Terrorist Attacks against Health Care Targets that Provide Abortion Services

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Abbreviations:
GTD: Global Terrorism Database
START: National Consortium for the Study of Terrorism and Responses to Terrorism

Abstract

Introduction: Terrorist attacks against hospitals and health care providers have disproportionally increased during the last decades. A significant proportion of these attacks targeted abortion clinics and abortion providers. In the light of the overturning of *Roe v. Wade* in 2022, an increase of anti-abortion terrorist attacks is anticipated. Therefore, it becomes imperative to gain further insight into the risk and characteristics of past terrorist attacks. This study aimed to review terrorist attacks against health care targets providing abortion services from 1970 through 2020.

Methods: Data collection was performed using a retrospective database search through the Global Terrorism Database (GTD). The GTD was searched using the internal database functions for all terrorist attacks against abortion health care providers from January 1, 1970 - December 31, 2020. Temporal factors, location, attack and weapon type, and number of casualties or hostages were analyzed using descriptive statistics.

Results: In total, 262 terrorist attacks were identified in five different countries. The majority (96.6%) occurred in the United States, with the highest counts during the last 20 years of the 20th century. Facility and infrastructure attacks were the most common attack types, followed by bombings and explosions. The attacks resulted in 34 injuries and nine fatalities. Kidnapping took place in three incidents. Of all successful attacks, 96.9% resulted in property damage.

Conclusion: Abortion-related health care facilities and providers have repeatedly been the target of terrorists over the past decades. Nearly all of these attacks took place in the United States, with the highest counts during the last 20 years of the 20th century.

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Introduction

Medical abortions are essential medical interventions which fulfill an indispensable role within health care.[1–5] In 1973, the United States Supreme Court made a landmark decision on abortion rights, often referred to as *Roe v. Wade*. The Court ruled that the United States conferred the right to have an abortion. The decision struck down many federal and state abortion laws, and caused an on-going abortion debate in the United States.[6] The recent overturning of *Roe v. Wade* by the Supreme Court on June 24, 2022 again fueled the discussion on abortion rights and woman rights in the United States, and resulted in the suspension of medical abortions in 16 states, with five more states having trigger laws which were blocked by courts.[7] Reduced access to essential reproductive health services as well as maternal and newborn health services are known to increase maternal and newborn deaths, unintended pregnancies, and unsafe abortions.[4,5,8–11] Women denied an abortion are also more likely to experience potentially life-threatening conditions associated with pregnancy

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and are at higher risk of reporting worsening long-term physical health.[2,4] Apart from physical health effects, being denied an abortion can have harmful short-term and long-term financial and mental health impacts, including higher rates of anxiety and stress, lower self-esteem, and lower life satisfaction.[2,5,11,12] Finally, enabling an abortion is associated with decreased numbers of physical violence from partners involved with the pregnancy.[2]

The abortion debate is extremely polarizing and has been associated with mass protests and violent extremism.[13–16] Unfortunately, harassment and violence targeting abortion health care has steadily increased over the last 45 years.[17] Compared to 2020, the year 2021 was associated with a strong increase in intimidation, vandalism, and other activities aimed at disrupting abortion services, harassing abortion providers, and blocking patients' access to abortion care. Increases were as high as 600% for stalking, 450% for blockades, 163% for hoax devices/suspicious packages, 129% for invasions, and 128% for assault and battery. Likewise, there was an increase in abortion-related demonstrations since the Supreme Court's opinion draft was made public.[18] Furthermore, it was observed that demonstrations increasingly turn violent and that it is more common to witness firearms at abortion-related demonstrations.[18] Following the overturning of *Roe v. Wade*, the United States Department of Homeland Security (Washington, DC USA) warned that there was an imminent risk for churches, judges, and abortion providers, with protesters predicting a "*summer of rage*."[19,20] Some of these violent acts may be characterized as terrorism. Of note, anti-abortion violence is considered to be one of the most concerning forms of domestic terrorism in the United States.[21]

Recently, specific health care facilities have been identified as potential targets of terrorism, including hospitals, ambulances, and primary care offices. During the last two decades, the risk of terrorist attacks against hospitals disproportionately increased compared to terrorist attacks in general.[22,23] Likewise, terrorist attacks against vaccinators, Emergency Medical Services, and primary care providers increased during the last decade.[24–26] A study focusing on anti-abortion violence from 1977 through 1988 found 110 incidents, including arsons and bombings aimed at abortion providers and organizations supportive of abortion rights.[27]

In the light of the recent developments, an increase of anti-abortion terrorist attacks is anticipated. Therefore, it becomes imperative to gain further insight into the risk and characteristics of past terrorist attacks against abortion-related health care targets. This study aimed to review all documented terrorist attacks against abortion-related health care targets from 1970 through 2020 as reported in the Global Terrorism Database (GTD).

Methods

Data collection was performed using a retrospective database search through the GTD. The GTD is an open-source database containing over 200,000 global terrorism incidents that occurred in the period from January 1970 up to and including December 2020.[28] It contains both domestic and international terrorist attacks. It is maintained by the National Consortium for the Study of Terrorism and Responses to Terrorism (START) at the University of Maryland (College Park, Maryland USA) and is part of the United States Department of Homeland Security's Centers of Excellence.[29] The data for the database are collected from publicly available, unclassified source materials.

The GTD defines a terrorist attack as: "*The threatened or actual use of illegal force and violence by a non-state actor to attain a political, economic, religious, or social goal through fear, coercion, or intimidation.*" To be considered for inclusion in the GTD, the following three attributes must all be present:

1. The incident must be intentional;
2. The incident must entail some level of violence or immediate threat of violence; and
3. The perpetrators of the incidents must be sub-national actors (excluding state terrorism).

Additionally, at least two of the following criteria must be present in order to be included in the database:

1. The act must be aimed at attaining a political, economic, religious, or social goal;
2. There must be evidence of an intention to coerce, intimidate, or convey some other message to a larger audience than the immediate victims; and/or
3. The action must be outside the context of legitimate warfare activities. That is, the act must be outside the parameters permitted by international humanitarian law, insofar as it targets non-combatants.

An extensive description of the data collection methodology, criteria, and definitions can be found in the GTD codebook, which is available on the START website.[28,29] Due to data loss, incidents from 1993 are not present in the online database. The efforts made to recover these incidents represent only 15% of estimated attacks. A separate file with these recovered incidents has been made available by the GTD.

The general dataset and the 1993 recovery file were downloaded and searched for terrorist attacks against abortion-related health care providing targets. Abortion-related health care was defined as therapeutic surgical abortion and medical pharmacological abortion. The following search terms were applied in the database: "Abortion;" "Maternity," "Pregnancy," "Pregnancies," "Parenthood," and "Family Planning." All cells were eligible for a hit. Incidents were included if the aim of the attack was to target an abortion-providing health care facility or health care provider. All duplicate event IDs were removed. Subsequently, all remaining incidents were manually reviewed. All incidents that were not targeting abortion clinics or abortion providers were excluded, as well as the incidents for which this remained unclear. Also, all incidents labelled as "Doubt Terrorism Proper" were excluded. These are incidents for which there could be doubt on whether or not the incident is exclusively based on terrorism and no other act of violence. Exclusion was based on information provided in the database. Figure 1 shows the flowchart.

Data collected per incident included temporal factors, location (country, world region), attack and weapon type, the successfulness of the attack, the number of casualties and/or hostages, property damage, information about the perpetrators, and whether or not the attack was part of a multi-part terrorist attack. The success of the attack, as defined by the GTD codebook, is based on the tangible effects of the attack and whether or not it took place.[29] It is not defined by the (larger) goals of the perpetrators.

Data extraction was done by the lead researcher (BW). Each entry was then reviewed manually for inclusion or exclusion based on the incident description. The second author (DB) reviewed each entry, and in case of doubt or discrepancies, three other authors were advised on the final decision. All collected data were exported into Excel spreadsheets (Microsoft Professional Plus 2016,

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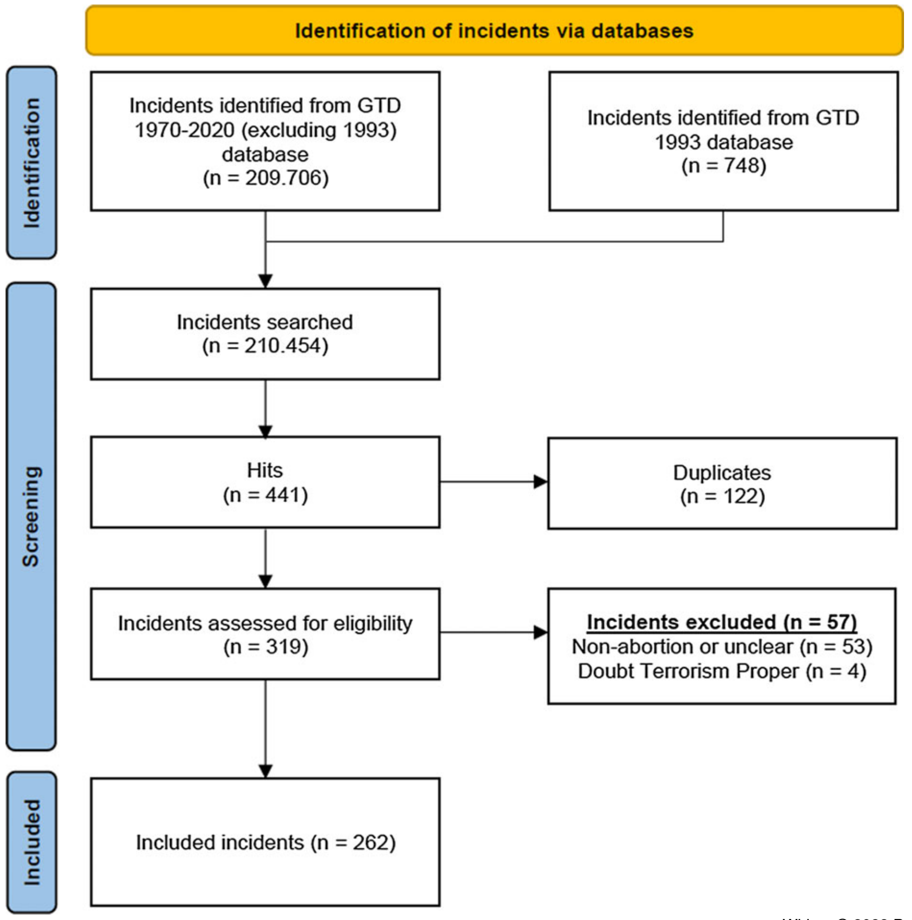

Figure 1. Flowchart of Database Search.
Abbreviation: GTD, Global Terrorism Database.

Microsoft Corporation; Redmond, Washington USA) and analyzed descriptively. This study was approved by the medical ethical review board of Maastricht University Medical Center (Maastricht, the Netherlands; no. 2021-2655).

Results

From 1970 through 2020, the GTD contained 262 incidents that fulfilled the inclusion criteria (Figure 1). Of these, 85% were deemed successful. Fifteen (15) out of the 51 years in the study period were without terrorist attacks against abortion-related health care targets. The years with the highest number of terrorist attacks were: 1984 (n = 25), 1995 (n = 18), 1992 (n = 17), and 1997 (n = 17). The number of attacks per year is shown in Figure 2.

Most of the incidents (n = 253; 96.6%) occurred in the United States. The remaining nine incidents occurred in Canada (n = 4; 1992, 1994, 1997, 2000), West Germany (n = 3; 1980), Argentina (n = 1; 1983), and Pakistan (n = 1; 2012). Within the United States, the states with the highest number of attacks were: California (n = 33), Florida (n = 22), and Ohio (n = 19), followed by Texas (n = 14) and Oregon (n = 13). In 13 states, no terrorist attacks were observed. Figure 3 shows a visual representation of the number of attacks in each state.[30]

Forty-four (44) of all attacks (16.8%) were part of coordinated, multi-part terrorist attacks, not limited to anti-abortion incidents. One incident, a kidnapping event, lasted for more than 24 hours.

In total, 199 incidents (76.0%) were labeled as facility/infrastructure attacks and 47 (17.9%) as bombings/explosions. The remaining attacks involved armed assaults (n = 8), assassinations (n = 5), hostage takings (n = 2; one barricade incident and one kidnapping), and an unarmed assault (n = 1). Five of the incidents had a second attack type. These concerned armed assaults in four incidents and a facility/infrastructure attack in one incident. The most frequently used weapon types were incendiary (n = 194; 74.0%) and explosives (n = 46; 17.6%), followed by firearms (n = 17) and chemical (n = 1). The chemical attack concerned a bomb laced with an unknown chemical warfare agent. The incendiary attacks involved gasoline in 64 events, arsons (n = 61), and Molotov or petrol bombs (n = 40). The explosive devices used were pipe bombs (n = 9), dynamite (n = 7), mail bombs (n = 6), and time fuses (n = 3). Of the known firearms, seven were non-automatic rifles, two were (semi-)automatic, and two were handguns. Six of the incidents had a second weapon type and one had a third weapon type involved. None of the incidents were labelled as suicide attack. Of all incidents, 86.6% (n = 227) resulted in property damage. This number is higher than the number of 223 successful incidents, because some attacks were unsuccessful but still managed to cause damage in the process. Of all 223 successful attacks, 216 (96.9%) resulted in property damage.

Casualties were reported in 20 events. There were 19 events with reported injuries and six fatal incidents, which in total resulted in

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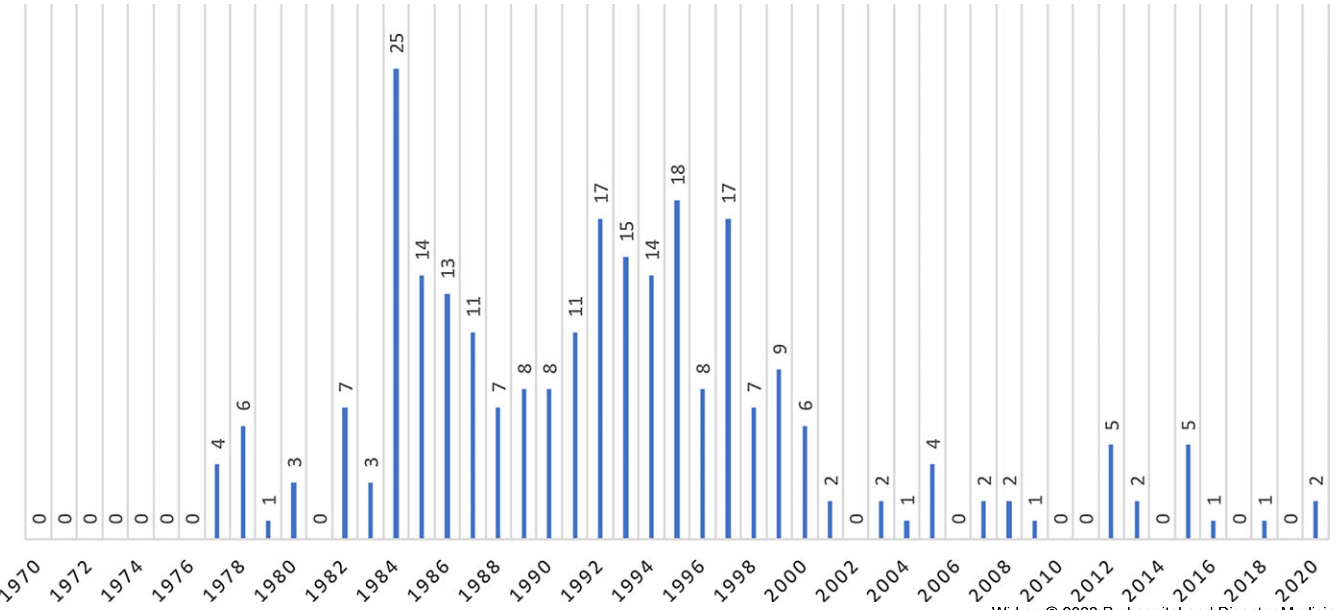

Figure 2. Number of Terrorist Attacks against Abortion Clinics per Year.

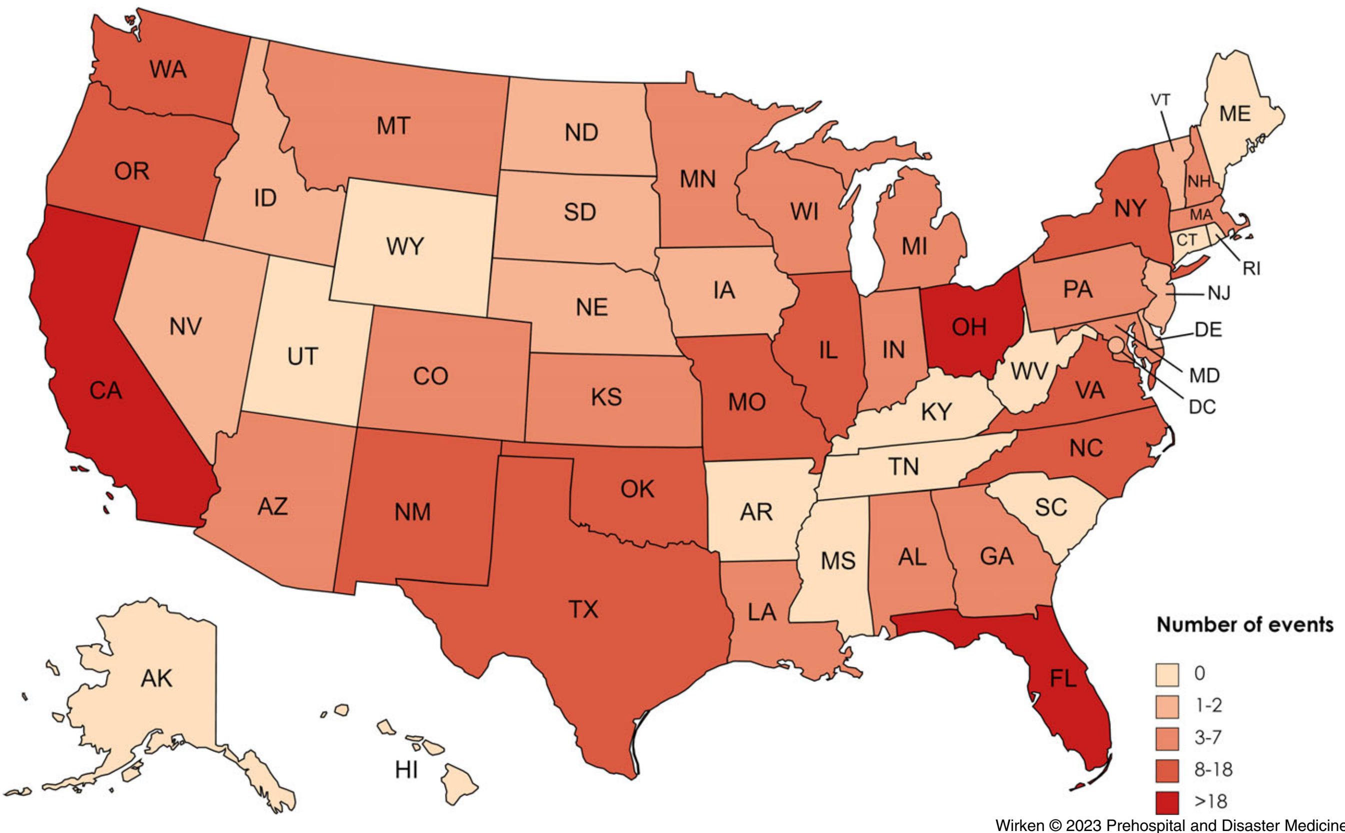

Figure 3. Number of Terrorist Attacks per US-State.
Note: Image derived from Mapchart.[30]

34 injuries and nine fatalities. None of the casualties were terrorist actors. Furthermore, kidnapping occurred in three incidents. The total number of people kidnapped was unknown.

The perpetrators were found to be members of the Army of God (n = 18), Christian Liberation Army (n = 2), Baby Liberation Army (n = 1), and White supremacists/nationalists (n = 1).

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The remaining perpetrators were other anti-abortion extremists (n = 237) or labelled as unknown (n = 3). The number of perpetrators was known in 123 attacks and concerned one (n = 95), two (n = 9), three (n = 10), or four (n = 9) perpetrators/assailants.

Discussion

Abortion-related health care facilities and providers have repeatedly been the target of terrorist attacks over the past decades. Nearly all of these attacks took place in the United States, with the highest numbers during the last 20 years of the 20th century. Incendiary weapons and explosives were most commonly used, and most attacks were perpetrated by "lone wolves."

Although the number of terrorist attacks against abortion-related health care targets is lower than the number of attacks against hospitals in previous studies, abortion clinics and their providers remain a prominent target for terrorists.[22,23] As described, the attacks were mainly observed in North America, the United States in particular. In this world region, the pro-con abortion debate is heavily polarized and an important, recurrent theme in politics, which may be an explanation for this worrisome dynamic. The overturning of *Roe v. Wade* in 2022 and the subsequent abortion ban decisions in several states may create a renewed impetus for anti-abortion violence.

Whilst explosives were the most prevalent weapon type in the attacks against hospitals, Emergency Medical Services, and primary health care practices, abortion-related health care targets were most commonly attacked by arson. This is in line with an earlier study on anti-abortion violence from 1977 through 1988.[27] However, explosives still ranked second. The casualty tolls and numbers of hostages were considerably lower than those of terrorist attacks against other health care targets.[23–25] It is common for specific-issue terrorism to inflict a relatively low number of casualties.[31] The perpetrators generally undertake symbolic attacks in order to create wide-spread attention, and seldom cause mass-casualty attacks.

Besides the direct consequences of the attacks, anti-abortion terrorism may also have indirect effects, including psychological symptoms in workers at abortion facilities and in women seeking abortion services.[21,32,33] Furthermore, abortion violence has the potential to reduce the availability of abortion providers due to the temporary or permanent closure of clinics that provide abortion services. There may also be a behavioral response to the terror. Women seeking abortion health care may feel forced to travel further to reach less abortion restrictive areas, or they may be discouraged to seek an abortion. The post-attack reduction in abortion providers may impair abortion services for several years.

The recent flare-up in the discussion on abortion rights may likely result in further extremist actions and terrorist acts and constitutes a potential threat for abortion health clinics and their providers, both in the United States and abroad. Abortion clinics should consider further hardening themselves as a target, especially during times of political and societal turmoil. Target hardening can be achieved by several measures, many of which are already common practice in United States abortion clinics. These include entrance guarding and screening, video surveillance, working with so-called volunteer escorts, and limiting access through the use of identification badges or biometrics.[34,35] Unfortunately, despite these measures, threats, harassments, and attacks occur. Although not universally implemented, buffer zones help to reduce harassment of patients and staff who attend abortion clinics and may also have a role in the prevention and mitigation of terrorist attacks.[36,37] Additional measures may include (armed) security, the utilization of metal detectors, and agreements with the local police department.[38] Particular focus should be placed on the prevention and mitigation of incendiary attacks. Although building codes dictate some minimal requirements with regards to fire safety, such as the presence of fire alarm and sprinkler systems and the use of fire-resistant or fire-retardant materials, the structural standards for facilities providing abortion services differ between states.[39] In only 17 states, abortion providers have to meet the structural standards comparable to ambulatory surgical centers. Organizing regular bomb threat and fire drills for staff and fire brigades may further improve awareness and preparedness. Furthermore, the polarization in the abortion debate should be given priority. Here especially lies a role for national governments and subnational governing bodies. The United States national strategy for countering domestic terrorism now focuses on reducing the supply and demand of recruitment materials by limiting the availability online and bolstering resilience of those who encounter it, which may be achieved by enhancing media literacy and critical thinking skills.[40] It also entails keeping dangerous weapons out of dangerous hands and equipping local communities, families, and individuals with the necessary resources to prevent potential violence. Such measures should also be applied to abortion-related extremism as a means of further mitigation.

Limitations

This study used the most recent GTD data, which also include data for 2020. Although the GTD is the most up-to-date, comprehensive, and reliable database, it does have its limitations and therefore so does this study. Using pre-existing databases such as the GTD as a data source inherently introduces potential challenges such as changing coding methodologies, miscoding errors, or data entry errors. Furthermore, the lack of a universally agreed-upon definition of the term terrorism can create inconsistencies between databases in the labelling of such events. Interpretations of trends using the GTD needs to also be done with caution. Furthermore, the GTD dataset is exclusive to terrorism-related events and many attacks on abortion clinics will therefore not be recorded if they do not meet terrorism criteria. Finally, the database used for the study is based upon convenience sampling and not validated by the original data collection organization, limiting the ability to determine sampling error and selection bias.

Conclusion

Abortion-related health care facilities and providers have repeatedly been the target of terrorists over the past decades. Nearly all of these attacks took place in the United States, with the highest counts during the last 20 years of the 20th century.

Author Contributions

Bart Wirken: Conceived and designed the analysis, collected the data, performed analysis, wrote the paper, draft manuscript preparation.
Dennis G. Barten: Conceived and designed the analysis, performed analysis draft manuscript preparation.
Harald de Cauwer: Draft manuscript preparation.
Luc Mortelmans: Draft manuscript preparation.
Derrick Tin: Draft manuscript preparation.
Gregory Ciottone: Draft manuscript preparation, supervision.

All authors reviewed the results and approved the final version of the manuscript.

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