Still Under Attack

A Decade of Monitoring Attacks on Health Care after the Adoption of United Nations Security Council Resolution 2286

Executive Summary

Insecurity Insight

Foreword

In 2016, states reaffirmed the imperative to protect health care during conflict by adopting United Nations Security Council Resolution (UNSCR) 2286. Yet during the last decade, attacks on health care have increased. Delivering care in conflict-affected settings remains perilous in many countries and territories, with devastating consequences for health care workers, patients, their families, and communities.

Despite these challenges, protecting health care from violence remains essential – not only to prevent avoidable deaths and suffering, but to preserve dignity and humanity amid conflict.

This report reviews the available evidence on recorded attacks on health care during the decade following the adoption of UNSCR 2286. It draws on data systematically collected by Insecurity Insight and shared with the Safeguarding Health in Conflict Coalition (SHCC) for the purpose of its annual reporting.

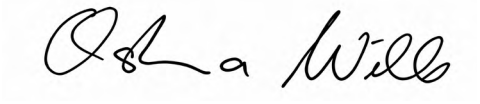
The report builds on the work of those who have long called for the stronger protection of health care, including Robin Coupland, Leonard Rubenstein, Rudi Coninx, Susannah Sirkin and many others. It also reflects the sustained commitment of members of Insecurity Insight's data team, who have compiled incident data month after month, year after year. This long-standing work and the current report were made possible through support from the Researching the Impact of Attacks on Healthcare (RIAH) project at the University of Manchester (funded by the United Kingdom's Foreign and Commonwealth Development Office) and collaboration with the SHCC (with funding from the Tides Foundation).

The report was written by Christina Wille and Ana Elisa Barbar, with chapter contributions from Clara de Solanges, Leonard Rubenstein, and Camille Delbourgo of Legal Action Worldwide (LAW). Helen Buck conducted the data analysis and Larissa Fast kindly reviewed the text, providing important comments before its final version.

In the chapters that follow, we provide an overview of the available data and the patterns of violence revealed by that data. While the findings are alarming, this report does not seek to deepen a sense of inevitability or despair. Instead, we aim to strengthen the evidence base needed to identify practical actions that will empower us to collectively act to better protect health workers during armed conflict, safeguard health care and health care systems during crises, and ensure continuity of care for all patients.

By examining the dynamics and interrelated drivers of attacks on health care, the analysis sheds light on why well-intentioned efforts have so often fallen short. It also highlights areas of progress, including practical measures to prevent and mitigate violence and efforts to uphold the rule of law, while pointing toward possible ways forward.

To this end, we hope that the evidence compiled here will inform concrete, actionable steps to better protect health workers, patients and access to care in conflict-affected settings.



Christina Wille

Director, Insecurity Insight

Executive Summary

On 3 May 2016, the United Nations Security Council adopted Resolution 2286, reaffirming the need to protect all aspects of health care during armed conflict. A decade on, health care remains highly vulnerable and is often the target of attacks during armed conflict, with devastating consequences for health care systems and patients' long-term health outcomes.

Over the past ten years, more than 17,000 attacks on health care have been recorded, including 4,327 attacks that damaged or destroyed health facilities and 3,000 instances of interference such as armed entries to facilities or their military occupation that disrupted care. More than 3,600 health workers were killed and a further 2,575 arrested, often in instances when providing care in line with medical ethics has been criminalised. These findings underscore the ongoing failure to safeguard medical personnel, while also illustrating the profound loss of medical expertise resulting from these attacks that can take generations to reverse.

International humanitarian law (IHL) has established clear obligations for all conflict parties to protect health care during conflict, yet these safeguards have repeatedly failed in practice. At the same time, the right to health is clear: individuals should have access to adequate, non-discriminatory health care at all times. Unfortunately, this entitlement remains out of reach in many conflict-affected settings.

The total of more than 17,000 incidents on which this report is based is undoubtedly an undercount. No dataset on violence against health care will ever be complete. Despite great progress in evidence gathering, a challenge remains in understanding patterns revealed by the best available data and acting on the evidence base that such an understanding would establish.

The spectrum of violent acts reported here directly reduces health care systems' ability to care for the wounded and sick, undermines disease treatment and control efforts, and restricts people's access to essential health services, thereby driving up preventable mortality.

Drawing from the incidents collected and collated by Insecurity Insight over a decade and released in various publications, including the SHCC annual reports, this report examines patterns and trends in attacks on health care. Using a framework that considers the vulnerability of health care systems in terms of the context in which they function and the means and intent of conflict actors, the report analyses the features that make health care uniquely vulnerable during conflict and identifies some of the leading drivers of violence. Data trends are discussed in the context of changing information environments and weapons use, and broader shifting attitudes towards compliance with the so-called rules of war.

This report, produced in collaboration with the Researching the Impact of Attacks on Healthcare (RIAH) project at the University of Manchester and the SHCC, aims to summarise the evidence base using data collected from January 2016 through December 2025 in order to identify clear recommendations to enhance the protection of health workers, safeguard health care systems during armed conflict, and ensure the continuity of care for patients during conflict. The analysis offers a focused assessment of the complex dynamics and interrelated factors driving attacks on health care in order to strengthen our understanding of the ways in which solutions have often failed despite good intentions. The report also highlights progress made on the prevention and mitigation of violence with the application of practical measures and efforts to uphold the rule of law.

Addressing these challenges requires coordinated action by governments, armed forces, legal experts, UN agencies, civil society, humanitarian organisations, and health care providers to safeguard health care and prevent further devastation in conflict-affected settings. Ultimately, the protection of health care during conflict depends on the behaviour of conflict parties and their willingness to respect humanitarian norms. When this protection fails, the consequences are severe: avoidable mortality, long-term harm to communities, and the increased risk of the spread of disease at both the local and global levels. Health care during conflict is not optional – it is essential!

Despite the scale and complexity of the challenges ahead, this moment should not be read as a point of defeat, but as the appropriate time for an urgent call to recalibrate and act with greater clarity and determination. Setbacks of this magnitude expose weaknesses that have to be understood within the wider political context of the moment. However, they also offer the opportunity to learn, adapt, and rebuild stronger foundations that withstand violence, upheaval, and change.

The protection of health care during conflict is neither an abstract ideal nor a negotiable aspiration. It is a legal standard and a practical and moral necessity that demands renewed commitment from all actors. Progress will require persistence, courage and a willingness to confront uncomfortable realities, but inaction is not an option. At stake is more than compliance with legal norms – it is the preservation of humanity itself in the most fragile of circumstances.

By strengthening the protection of health care, we safeguard not only lives and dignity in times of crisis, but also the possibility of recovery, resilience, and hope for communities striving to rebuild in the aftermath of conflict, while upholding and renewing the foundations of the international system that generations have worked to build and sustain.

15 key findings at a glance

1. Reports of violence against health care increased over the decade since the adoption of UNSCR 2286, in a trend that is clear according to the available data presented in this report, despite limitations and the recognition of under-reporting.

2. On average, health care was attacked 917 times per year between 2016 and 2021. This had risen to 3,015 times per year between 2022 and the end of 2025.

3. Violence against health care causes harm beyond the war wounded – it profoundly disrupts an essential civilian service. For example, over 400 attacks on maternal health care services have harmed pregnant women and newborns, and have left families and communities devastated.

4. Attacks on health care are so frequent in many conflicts that they may only be interpreted as part of a wider strategy of disproportionate attacks. Some health care facilities are repeatedly affected – in some cases as many as 156 times over 27 months through a range of different acts, disrupting care through damage and intimidation, and limiting the ability to provide health care.

5. Local health workers experience most of the documented harm – 54% of health workers known to have been killed were working in their respective national health care systems. This highlights an issue that extends far beyond the protection of international health workers and is closely connected to the broader protection of civilians during conflict.

6. States – the primary IHL duty bearers – have driven the increase in violence against health care recorded in this report. In 2016, 55% of all reported incidents were attributed to state actors, but by 2024 this had risen to 72%. The absolute number of violent events attributed to non-state actors has also increased, from 154 recorded incidents in 2016 to 846 in 2024.

7. Developments in weapons systems deployed in conflict contribute to increasing risks to health care. The use of explosive weapons – an inherently indiscriminate weapon system – increased from 15% in 2020 to 47% by 2024. In particular, the growing use of drones has increased the risks faced by emergency health service providers.

8. Highly visible incidents – such as hospital bombings or attacks in widely reported conflicts – shape public perceptions of violence against health care, yet selective visibility does not accurately reflect the broad impact of this issue.

9. Seemingly “quiet”, intentional disruptions to the provision of health care like supply blockades often inflict significant and long-term harm. Under-reported violence affecting medical supplies, equipment, and laboratory capacity disguises the profound and multifaceted impact on health system functionality, with long-term consequences for entire populations.

10. The provision of health services is increasingly being criminalised, as evidenced by a growing number of health worker arrests and the denial of health care providers' access to people in need, which underpins the complex link between conflict and oppression in contested political spaces.

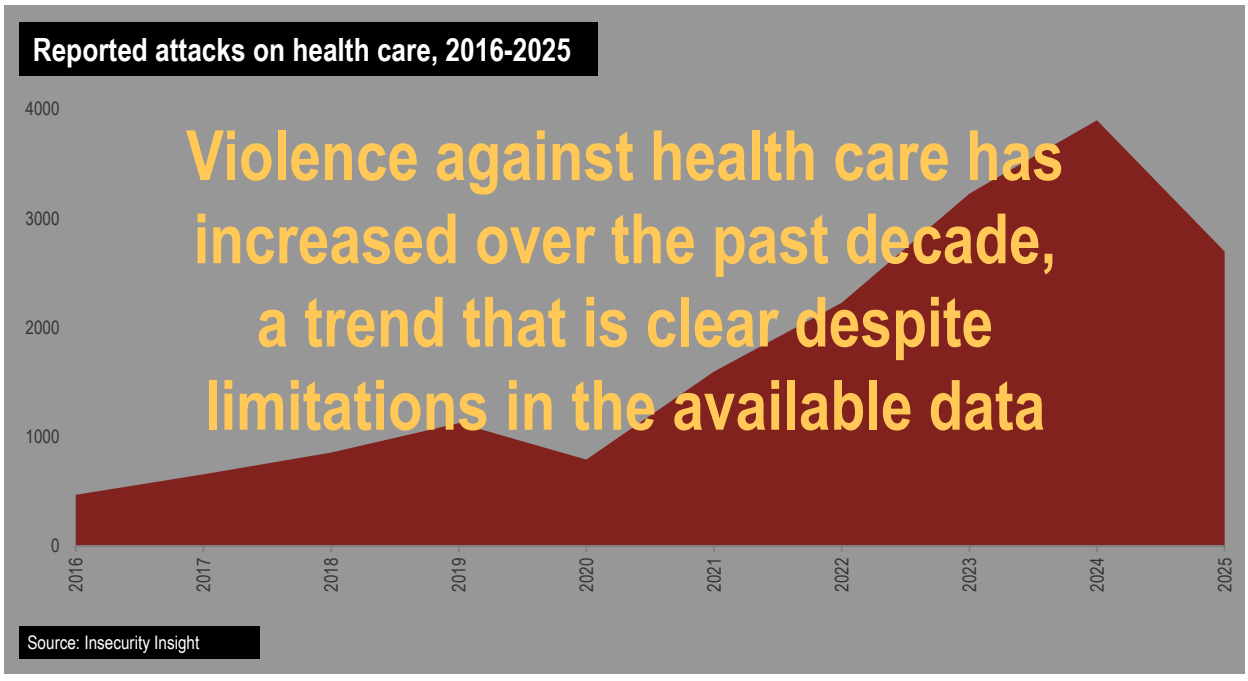
11. A shift in public narratives is reframing perceptions of attacks on health care. Rather than centring the unacceptable harm to health services that drove the adoption of UNSCR 2286 in 2016, the burden is increasingly placed on health workers to prove that medical facilities are not being misused.

12. There is a growing body of best-practice measures to enhance protection – including in Insecurity Insight's *Security Risk Management for Health Care Services* handbook – that are aimed at reducing specific security risks for health care providers. However, major barriers still prevent sector-wide implementation.

13. Violence against health care prevents many people from accessing care, demonstrating that hindering access to care is not only a concern over denied humanitarian access harming individuals in need of health care, but a fundamental denial of the right to health, with long-term consequences.

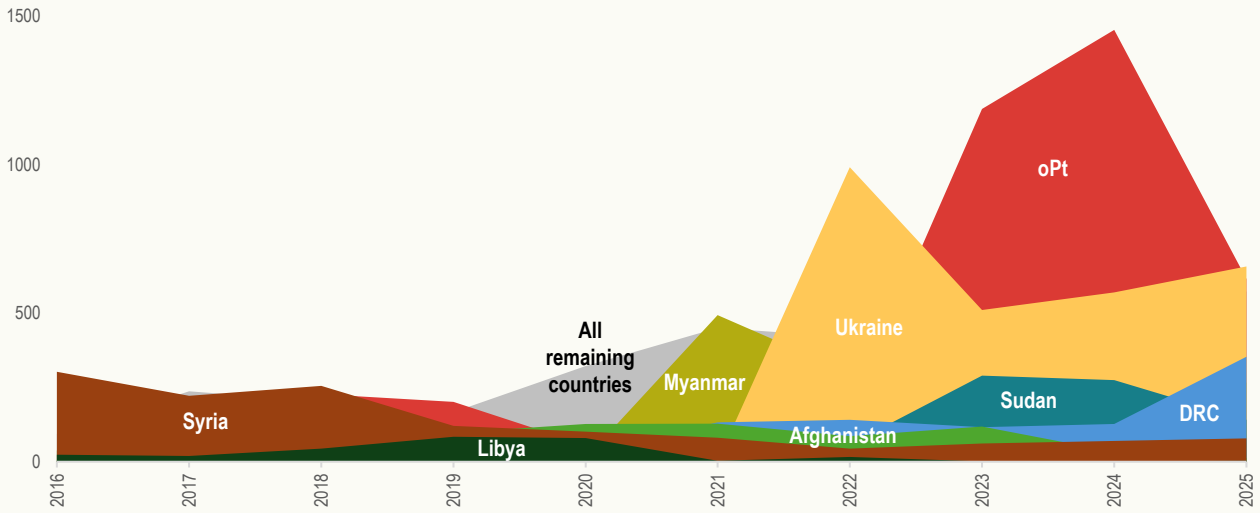
14. The scale of increased attacks on health care during conflict is largely a product of open disregard for the law by conflict parties seeking to prevail militarily.

15. Meaningful accountability for attacks on health care remains exceedingly rare. Despite the existence of pathways to accountability, there have been only two convictions for crimes involving direct attacks on health care.



Reported incidents of violence against and obstruction of health care during conflict, 2016-2025

Reported incidents have risen since 2019 alongside major conflicts, with early peaks in Syria and Libya, later surges in Myanmar and Ukraine, and further escalations from 2023 in Afghanistan, Gaza (oPt), Sudan, and eastern DRC.

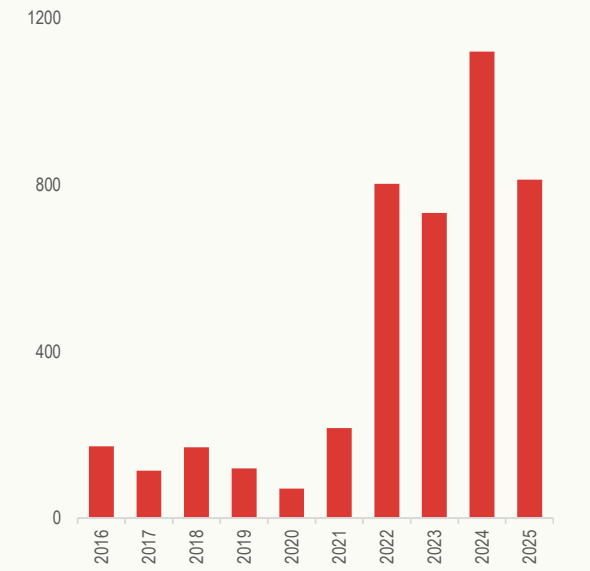


Source: Insecurity Insight

On average, health care was attacked 917 times per year between 2016 and 2021. This had risen to 3,015 times per year between 2022 and the end of 2025.

Number of reported attacks damaging or destroying health facilities, 2016-2025

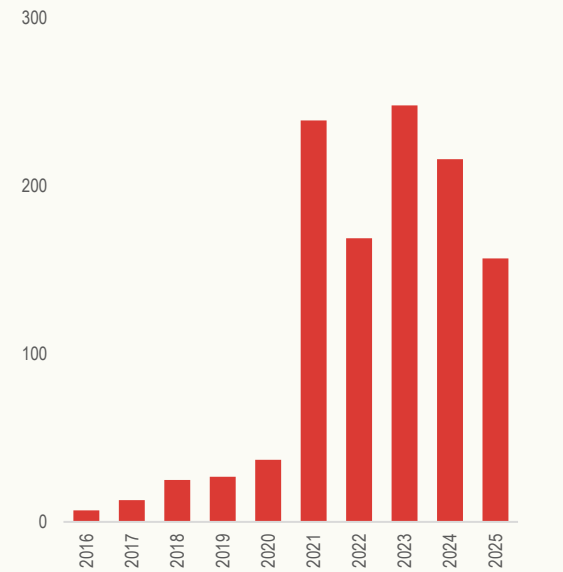
Over the past decade, more than 4,300 attacks have damaged or destroyed health facilities, with a sharp increase since 2022.



Source: Insecurity Insight

Health worker arrests, 2016-2025

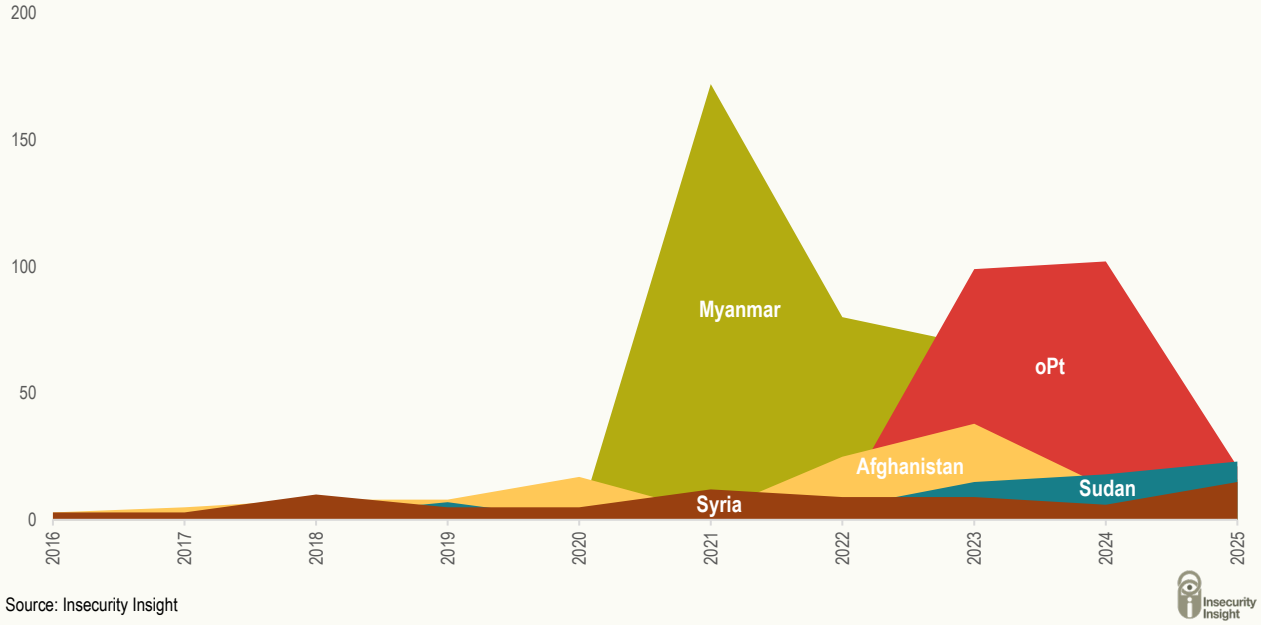
Reported incidents remained relatively low between 2016 and 2020 but increased sharply in 2021 and remained persistently high through 2023 and 2024, indicating the emergence of a sustained pattern of criminalisation rather than a temporary spike.



Source: Insecurity Insight

Five contexts where high numbers of health worker arrests were reported, 2016-2025

Global increases in health worker arrests have been driven by a small number of conflict-affected countries, with Myanmar recording the highest numbers over the past decade, followed by sharp rises in Afghanistan after 2021, the occupied Palestinian territory - particularly Gaza - in 2023–2024, and Sudan in 2025.

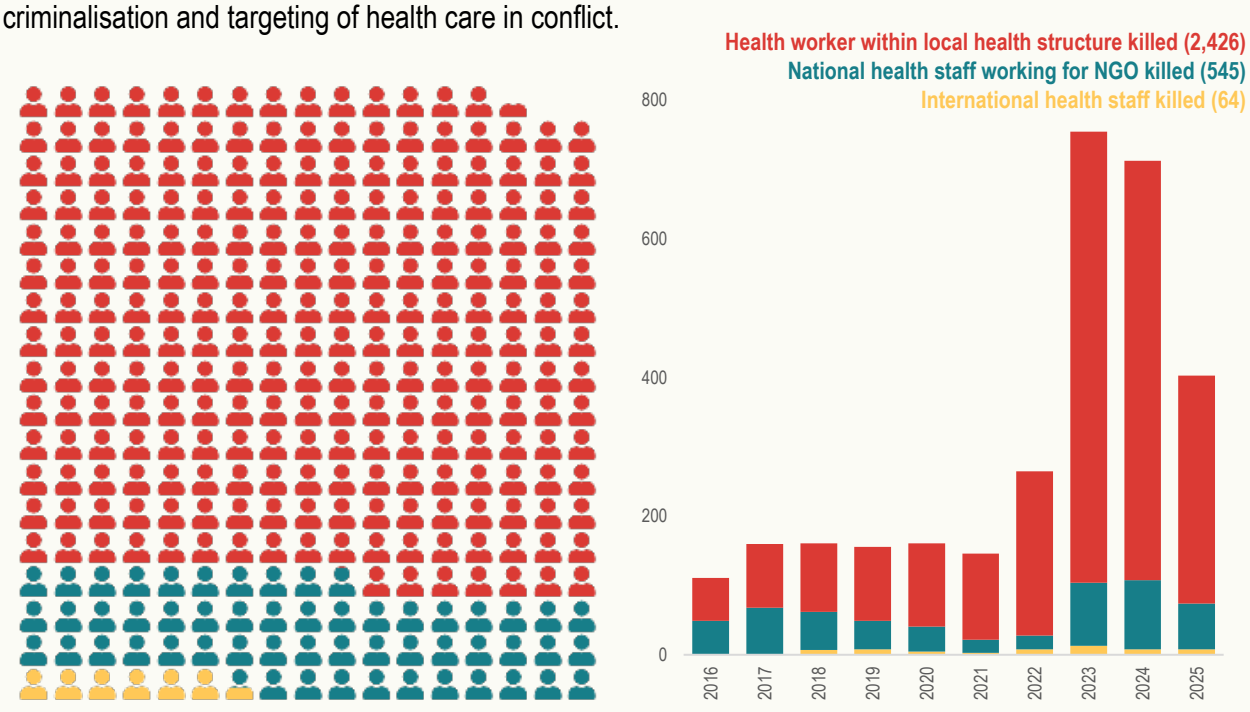


Source: Insecurity Insight

The reliance of humanitarian organisations on local staff for front-line health service delivery in conflict settings often places the greatest risks on those with the fewest protections, as local health workers typically have less access to evacuation, security guarantees and other safeguarding measures than international personnel.

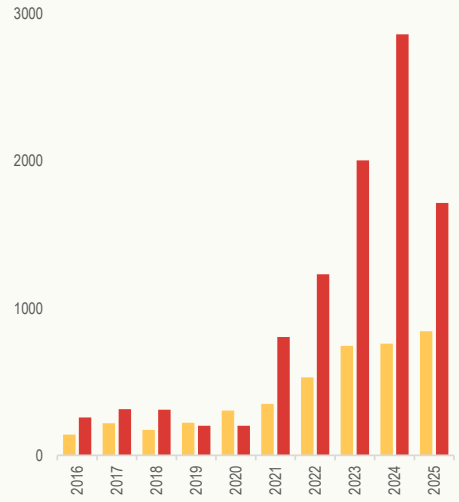
Places of work of killed health workers, 2016-2025

Since 2016, local health workers bore the overwhelming burden of lethal violence in conflict settings, accounting for more than two-thirds of the 3,618 health worker killungs recorded, highlighting their heightened vulnerability due to their close ties to the communities they serve and the increasing criminalisation and targeting of health care in conflict.



Source: Insecurity Insight

Attacks on health care during conflict, by actor type, 2016-2025



Since 2016, state actors have been the main perpetrators of attacks on health care, except in 2019-2020 when non-state armed groups predominated.

The spike in recorded attacks on health care after 2021 can be primarily attributed to state actors.

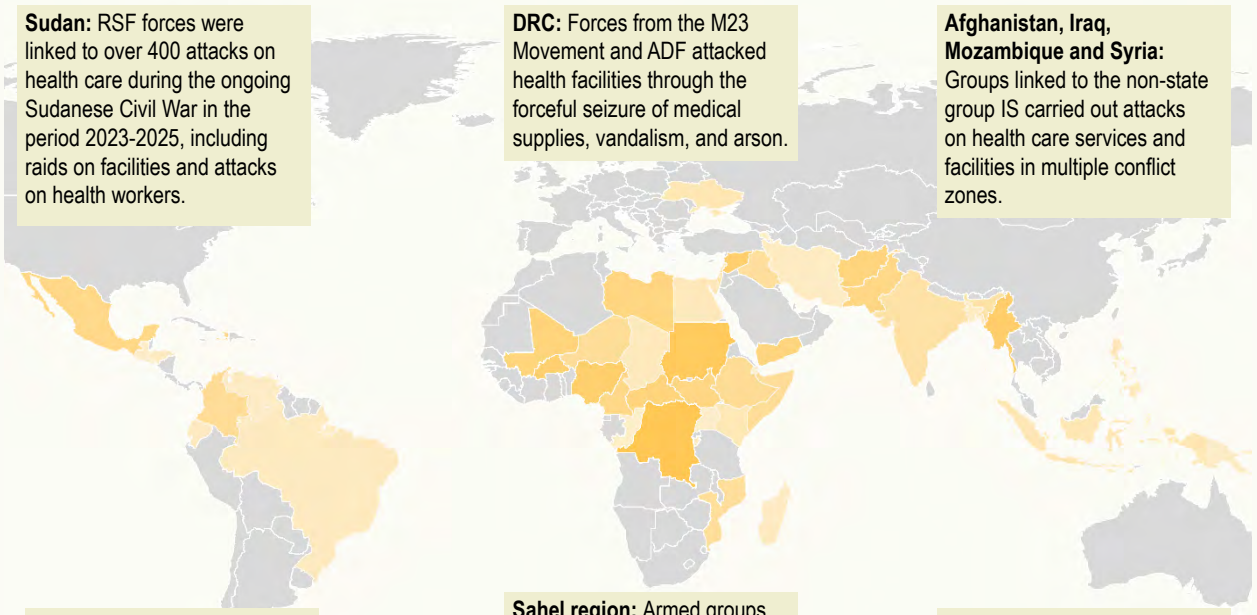
At the same time, violence by non-state armed groups continued to rise steadily, contributing to an increasingly complex and multi-actor threat environment for health service providers.

State actor (9,910 incidents) Non-state armed actor (4,290 incidents)

Source: Insecurity Insight

Attacks on health care by non-state armed actors, 2016-2025

Non-state armed groups in Afghanistan, Burkina Faso, the Democratic Republic of the Congo, Iraq, Mali, Mozambique, Niger, Somalia, Syria, and Yemen have attacked health care through killings, kidnappings, forceful seizure of medical supplies, and the destruction or occupation of medical facilities, severely disrupting access to care.



Sudan: RSF forces were linked to over 400 attacks on health care during the ongoing Sudanese Civil War in the period 2023-2025, including raids on facilities and attacks on health workers.

DRC: Forces from the M23 Movement and ADF attacked health facilities through the forceful seizure of medical supplies, vandalism, and arson.

Afghanistan, Iraq, Mozambique and Syria: Groups linked to the non-state group IS carried out attacks on health care services and facilities in multiple conflict zones.

Somalia: Al-Shabaab kidnapped health workers and forcefully seized medical supplies, disrupting access to care.

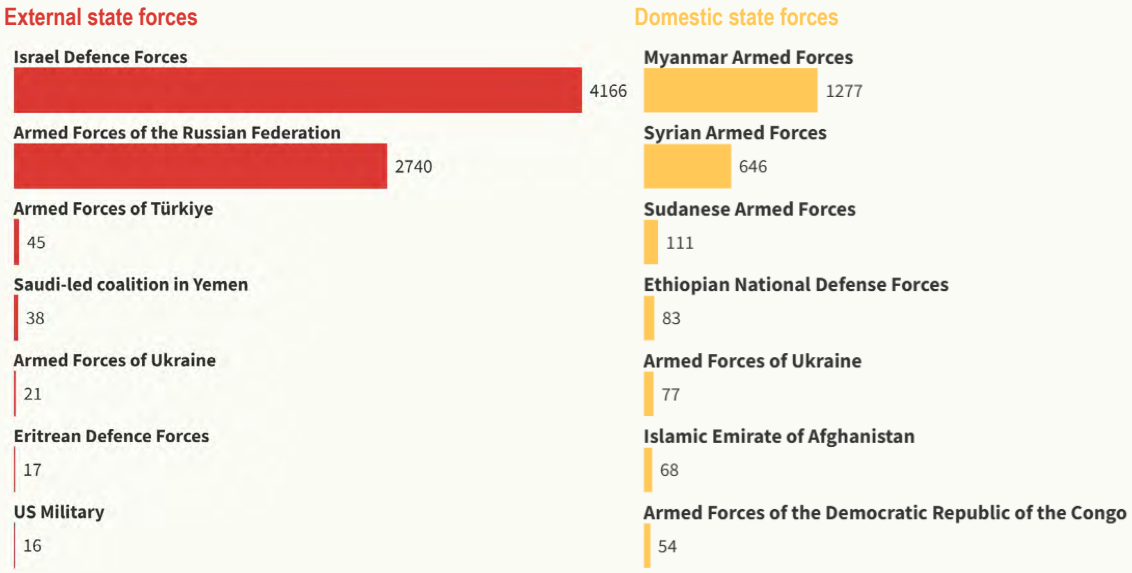
Sahel region: Armed groups, including JNIM and ISGS, attacked health facilities across Burkina Faso, Mali, and Niger through killings, kidnappings, forceful seizure of medical supplies, and the destruction of medical infrastructure, worsening shortages of health staff.

Yemen: Al-Houthi forces were implicated in the detention of health workers and obstruction of access to medical care.

Source: Insecurity Insight

External and domestic attacks on health care by state armed forces, 2016-2025

Since 2021, state forces have sharply increased attacks on health care within their own countries - particularly in Myanmar, Syria, and Sudan - through air strikes, arrests, and hospital raids. From 2022 onwards, attacks by state forces operating outside their own borders have also increased, with airstrikes accounting for 40% of incidents and the highest numbers attributed to the Israel Defense Forces and the Armed Forces of the Russian Federation.

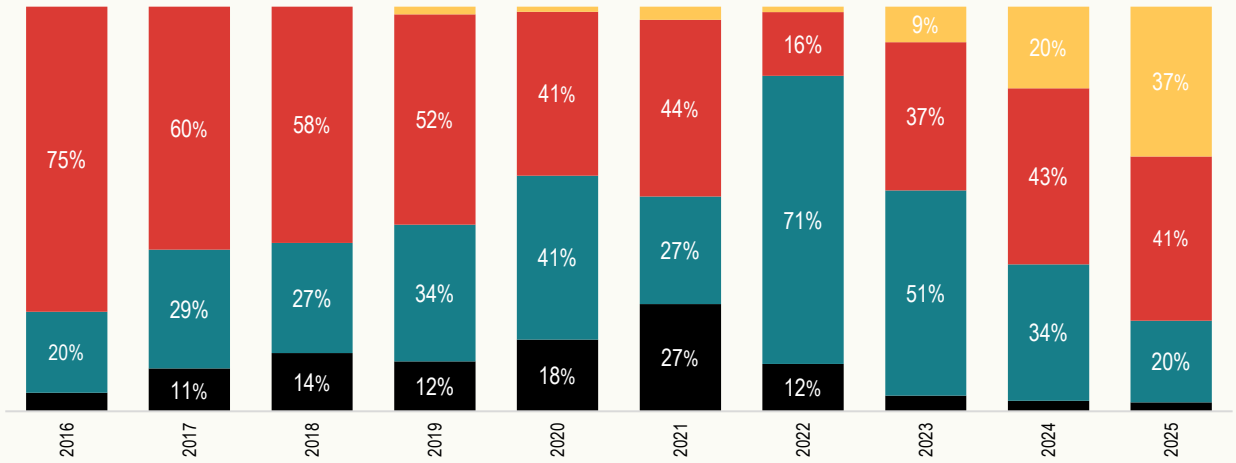


Note: State armed forces are identified using their official names, in accordance with Insecurity Insight's naming conventions.
Source: Insecurity Insight

The types of weapons used in armed conflict and the impact they cause provide important contextual information about the threat posed to health care and the identification of intervention needs.

Attacks on health care where explosives were used, by delivery type, 2016-2025

Over the past decade, airstrikes have evolved from being conducted almost exclusively by state forces using manned aircraft to increasingly involving drones used by both state and non-state actors, raising important IHL responsibilities related to planning, authorisation, and targeting decisions.

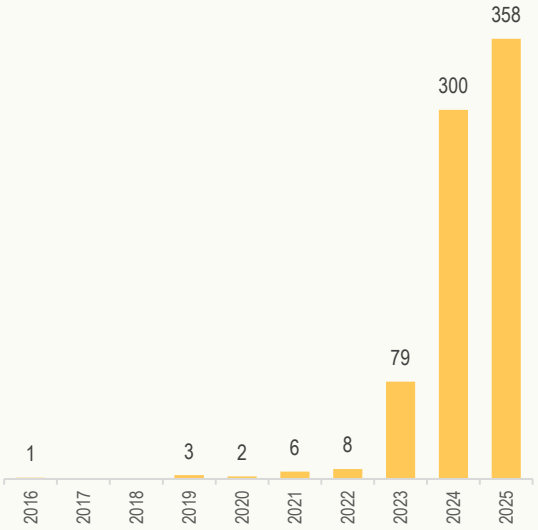


Incident where aircraft-delivered explosives were used (2,169) Incident where directly emplaced explosives were used (328)
Incident where drone-delivered explosives were used (758) Incident where ground-delivered explosives were used (1,912)

Source: Insecurity Insight

Attacks on health care in which drone-delivered explosives were used, 2016-2025

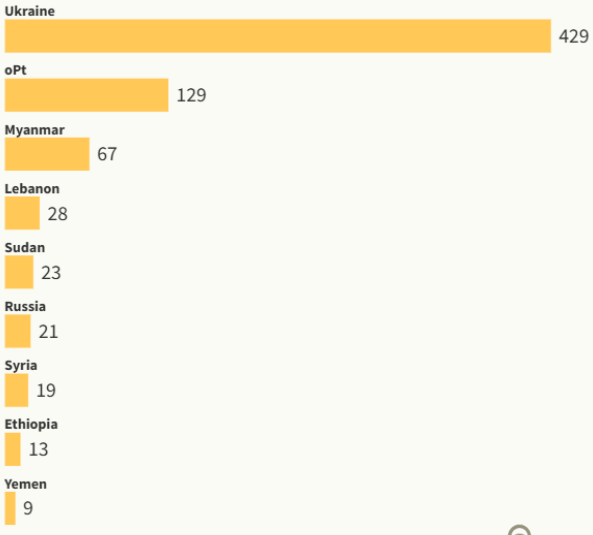
Since 2019, the increasing use of drones has expanded aerial attacks by both state and non-state actors, heightening the importance of command responsibility under IHL.



Source: Insecurity Insight

Countries/territories where a high number of reported incidents involved drone-delivered explosives impacting health care, 2016-2025

The vast majority of drone strikes impacting health care have been recorded in Ukraine, followed by the occupied Palestinian territory.



Source: Insecurity Insight

A close examination of the various weapons systems used to attack health care is essential, because compliance with IHL cannot be understood in isolation from the technical and operational characteristics of these types of weaponry.

Recommendations

I - For States

A. Reinforce protection principles:

a) Uphold international humanitarian law (IHL) through domestic implementation and within the diplomatic arena; and by the use of unambiguous language and clear statements, reject reinterpretations of IHL that weaken the protection of health care.

b) Communicate the basic objectives of efforts to protect health care in understandable language, aiming at clear, less complex, less legal messaging aimed at the general public, and via modern communication platforms.

c) Use diplomatic, political, and economic tools to deter perpetrators of attacks on health care, including through targeted sanctions, travel bans, and arms export controls linked to obligations in the UN Arms Trade Treaty.

B. Strengthen the enforcement of norms and accountability:

a) Include attacking hospitals and medical units as war crimes under domestic law, incorporating the language of Rome Statute Articles 8(2)(b)(ix) and 8(2)(e)(iv).

b) Create national war crimes units and strengthen and use universal jurisdiction and applicable domestic laws permitting prosecutions.

c) Support evidence gathering and systems for storing and sharing evidence.

C. Strengthen and renew investigative mandates:

a) Support UN investigative bodies, including commissions of inquiry and fact-finding missions, with explicit commitments and processes to address the protection of medical services during conflict.

b) Support the publication of related findings to encourage transparency and accountability.

D. Support the health care sector during conflict:

a) Support reparation pathways for health workers and health care facilities, including administrative schemes that allow the acknowledgment of and compensation and medical rehabilitation for both physical and mental health challenges.

b) Invest in pragmatic measures to reduce the security risks faced by health care providers during conflict.

c) Support the implementation of deconfliction mechanisms, hospital geolocation systems, secure medical supply chains, and training on medical neutrality and harm-reduction measures.

d) Support health care providers to ensure they are prepared and able to implement practical, context-sensitive risk mitigation and community-based protection strategies.

E. Strengthen data collection to support evidence-based policies:

a) Support transparent data gathering on attacks on health care by supporting open information systems (particularly where internet connectivity is compromised), innovative data-collating processes and responsible data-sharing networks.

b) Support evidence-based user-focused information products that are tailored to support context analysis, advocacy, training, security risk management, and public understanding of the need for a rules-based order that protects health care facilities and providers and civilians during conflict.

c) Support the understanding of trends and communication engagement to counter harmful narratives, including by adapting protective pre- and post-incident communication and risk assessments, and developing social narratives by using modern communication tools.

II. For armed forces:

A. Translate safeguards for the protection of health care into practical standard operating procedures for a range of different situations and command structures.

B. Operationalise principles through adapted personnel training for a range of functions and levels of education to reinforce the basic objective of avoiding harm to civilians and non-combatants:

a) Include assessments of impacts on health care into post-battle assessments and after-action reviews, and investigate reasons for possible failures to protect health care personnel and facilities, translating learning into improved practice.

b) Develop a culture of internal accountability for investigations and prosecutions in all cases of suspected and confirmed breaches of IHL.

III. For legal experts:

A. Strengthen advisories for early evidence collection and preservation.

B. Improve legal qualification and case building, including expertise on medical and contextual analysis such as the interpretation of medical records, patient demographics, and patterns of injuries, and the use and understanding of open-source intelligence.

C. Enable better evidence collection by supporting enhanced standards and training on documentation for intermediaries, and ensure the secure storage of evidence that allows its effective use in accountability processes.

D. Ensure that legal debates advance on less consensual areas of the law by promoting legal examples and policy and operational practices that sustain the most protective interpretations of the law for civilians and health care personnel during conflict.

E. Strengthen cooperation frameworks with international investigative bodies and with civil society and other actors.

F. Advance accountability pathways across jurisdictions.

G. Focus legal assessments and prosecutions on command responsibility and intent in terms of both state and non-state actors, as well as the foreseeable consequences that follow the failure to implement precautionary measures during attacks, in order to mitigate the possible killing or injuring of health care personnel and patients and the damaging or destruction of health facilities.

IV. For accountability mechanisms:

A. The International Criminal Court (ICC) should, as a matter of priority, investigate and prosecute cases of attacks on health care.

V. For the UN and UN agencies:

A. The UN Secretary-General should regularly report to the Security Council on attacks on health care during conflict beyond merely referencing them in the annual report on the Protection of Civilians. In particularly egregious cases, dedicated reports should be published.

B. UN agencies should collaborate to ensure a coherent approach to attacks on health care, recognising the importance of humanitarian coordination, the role of the Health and Protection Clusters and human rights mechanisms, and the role of humanitarian agencies and civil society.

C. The UN and its agencies should strengthen cross-purpose data sharing and use, not only about incidents, but also about good practices to enhance protection.

VI. For civil society:

A. Continue to document, analyse, and raise the issue of attacks on health care with national governments and in international forums.

B. Invest in the identification and dissemination of trends in attacks, and support the development of effective policy responses to hold actors accountable for their respective IHL responsibilities.

C. Engage in the public defence of the protected status of health care during conflict.

VII. For health care providers:

A. Strengthen duty-of-care approaches towards staff to improve the continuity of care and safety during its provision, and to better support staff exposed to risks and violence.

B. Develop and share best practice on how to safeguard operations during conflict.

C. Advocate nationally and internationally to defend the central role of health care workers in the delivery of essential health services and their associated right to work free from violence.

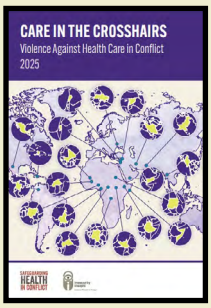
VIII. For humanitarian agencies:

A. Support local health care providers as needed, including with training and the implementation of risk management measures and policies to address staff well-being (including physical and mental health needs) in high-risk areas.

B. Support health care providers to advocate for their needs, including the safer reporting of incidents and the implementation of dedicated support for staff who have been exposed to violence, and resist the criminalisation of health care.

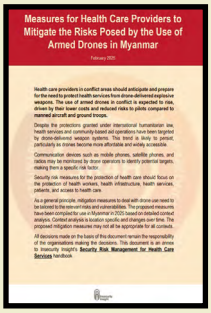
Other resources

Attacks on health care were relentless in 2025, ten years after the unanimous adoption of United Nations Security Council Resolution 2286, which reaffirmed the protection of the wounded and sick, medical personnel, and humanitarian workers during armed conflict. Using data collected by Insecurity Insight, the Safeguarding Health in Conflict Coalition (SHCC) recorded 2,546 incidents in 33 countries in which damage to or the destruction of health care facilities was reported on at least 790 occasions, while 455 health workers were killed, 218 kidnapped and 263 arrested. Read the full **report**



Health care provision has unique characteristics that shape its specific exposure to security risks in conflict zones. The Security Risk Management for Health Care (SR4H) Handbook – available in **Arabic**, **English**, **French** and **Spanish** – provides guidance on how to implement a range of actions intended to promote respectful and violence-free environments and prepare individuals or organisations to face and respond appropriately to violent incidents, also dealing with the aftermath of such events.

Health workers in Myanmar face an urgent and growing threat—armed drones targeting hospitals, mobile clinics, and aid operations. These attacks endanger lives and access to critical care. This guidance document - in **Burmese** and **English** - provides practical measures to help health care providers mitigate these risks. From early warning systems to protective strategies for staff, infrastructure, and mobile teams, this guide is essential for anyone working to safeguard medical services in Myanmar.



Available as individual guidance on:

Outside When a Drone is Spotted: **Burmese** | **English**

Inside a Building During a Drone Attack: **Burmese** | **English**

Response During a Drone Attack: **Burmese** | **English**

This document is published by Insecurity Insight

This document is funded and supported by the Foreign, Commonwealth and Development Office (FCDO) of the UK government through the RIAH project at the Humanitarian and Conflict Response Institute at the University of Manchester, and by the Tides Foundation.

As an H2H (humanitarian-to-humanitarian) association, Insecurity Insight supports the work of aid agencies; the providers of health care, education, and protection services; and other civil society organisations by providing publicly available information that humanitarian organisations can use to design evidence-based policies to guide their activities and operations. We collect and analyse data about violence against civilians and the damaging and destruction of vital civilian infrastructure in order to strengthen civilian protection and the delivery of aid in contexts affected by armed conflict.

Suggested citation: Insecurity Insight. 2026. Still Under Attack: A Decade of Monitoring Attacks on Health Care after United Nations Security Council Resolution 2286, Executive Summary, May 2026. Switzerland: Insecurity Insight. https://bit.ly/10YearHealthReport2026ExSum

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