

Still Under Attack

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



Contents

Foreword	5
Executive Summary	6
15 key findings at a glance	8
Recommendations	15
Introduction	19
Structure of the report	21
Understanding and Addressing Violence Against Health Care	22
An analytical framework	22
Vulnerability of health services in conflict	23
Context, means, and intent of attacks	24
Impact of conflict on health services and outcomes	25
How Data Sources Shape Our Knowledge and Understanding of Attacks on Health Care	27
From newspaper cuttings to open-source information	29
Data management ethics	32
Understanding of violence against health care from institutional and open-source systems	33
The limitations and value of data presented in this report	34
Vulnerability of Health Systems in Conflict: Attacks on Health Workers, Health Facilities and Obstruction of Health Care	36
Attacks against health workers in conflict	36
The heightened vulnerability of local health workers	38
Attacks on health facilities in conflict	40
Damage and destruction of health facilities	40
Armed entry and occupation of health facilities	41
The impact of attacks on health facilities	42
Disruption and obstructions to health care in conflict	43
Maternal health disrupted by violence	45
When narratives become the risk: Protection of health care in the digital information environment	48
Social media monitoring, perception and risks to healthcare	48
Declining trust in health authorities and health messages	49
Social media, criminalisation of health care and undermining protection under IHL	51
Persistent risks to health care in the age of social media	52

Context, means and intent: how armed actors attack health care	53
Violence against health care in the context of public health responses in conflict affected countries	54
Vaccination efforts and violence	56
Violence against health care by state and non-state actors	58
Means and intent of armed actors in conflict: weapons used, tactics, and motives	56
Weapons used in violence against health care	61
Firearms	62
Explosive weapons	63
The criminalisation of health care in conflict settings	66
Justification of hospital attacks – growing, open lack of respect for international humanitarian law	69
The proliferation of claims of military use of hospitals	69
Legal safeguards for hospitals and ambulances when military use is alleged	71
The threat to hospitals and the wounded and sick everywhere	73
Measures to protect health care in conflict	74
Legal pathways to accountability	74
Voluntary accountability	74
Reporting and monitoring	75
IHL duty bearers and the protection of health care in conflict	76
Security risk management for health care	76
Security Risk Management For Health Care (SR4H) Handbook	77
Conclusions	80
What can be done?	81
Reclaiming the narrative	81
Strengthening law enforcement and legal accountability	81
Equipping armed forces with practical tools	81
Supporting health care workers	82
Strengthening the evidence base	82
Abbreviations and acronyms	83
Endnotes	84

The contents of this report, including the data presented, may be partially or fully cited if the following citation and reference standards are respected:

- Citing the text (partially or fully) or the numbers and data given in the report:

Insecurity Insight (2026) *Still Under Attack: A Decade of Monitoring Attacks on Health Care after the Adoption of United Nations Security Council Resolution 2286*. Geneva: Insecurity Insight.

- Citing the sections in this report or the 2024 handbook:

Leonard Rubenstein (2026) 'Justification of hospital attacks – growing, open lack of respect for international humanitarian law.' In: Insecurity Insight, *Still Under Attack: A Decade of Monitoring Attacks on Health Care after the Adoption of United Nations Security Council Resolution 2286*. Geneva: Insecurity Insight.

Insecurity Insight (2024) *Security Risk Management for Health Care Services*. Handbook. Geneva: Insecurity Insight.

Please note that we strongly discourage direct reproductions of graphs and other visual distributions of data from this report, because doing so may distort the meaning of the presented information. Contact [**info@insecurityinsight.org**](mailto:info@insecurityinsight.org) if you would like to obtain more information about the data.

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.

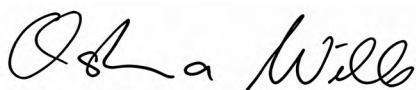
The report builds on the work of those who have long called for the stronger protection of health care, including Robin Coupland, Leonard Rubenstein, Rudi Coninx, Susannah Sirkin and many others. It also reflects the sustained commitment of members of Insecurity Insight's data team, who have compiled 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

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.

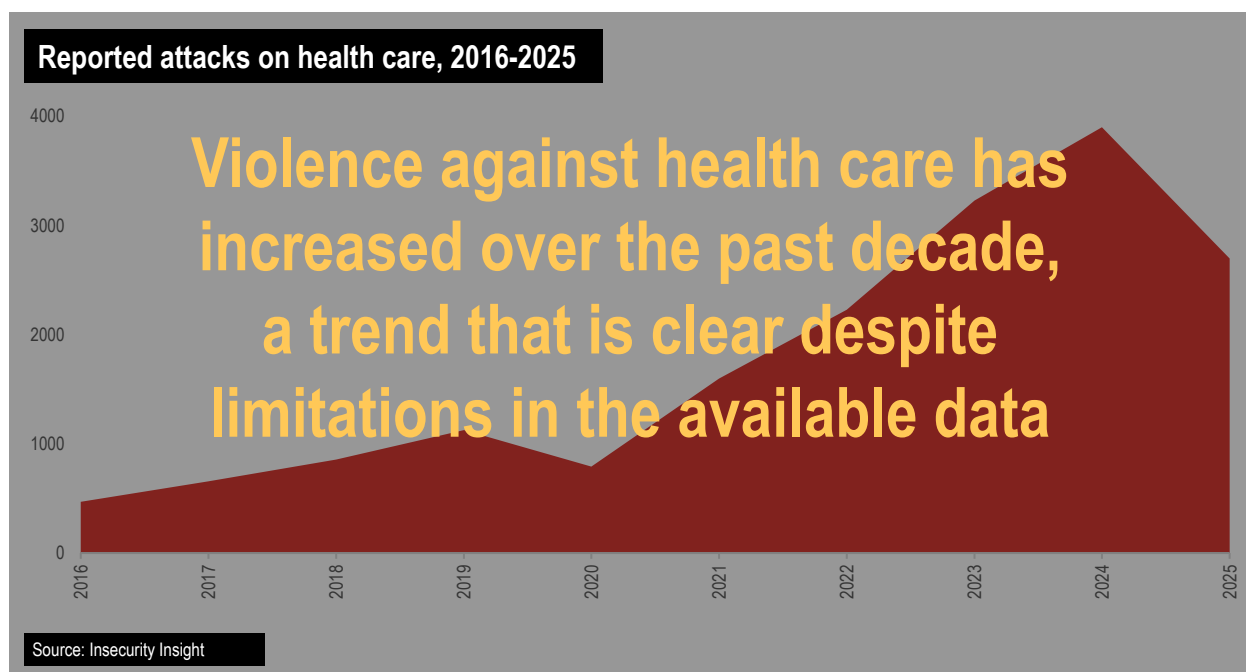
The protection of health care during conflict is neither an abstract ideal nor a negotiable aspiration. It is a legal standard and a practical and moral necessity that demands renewed commitment from all actors. Progress will require persistence, courage and a willingness to confront uncomfortable realities, 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

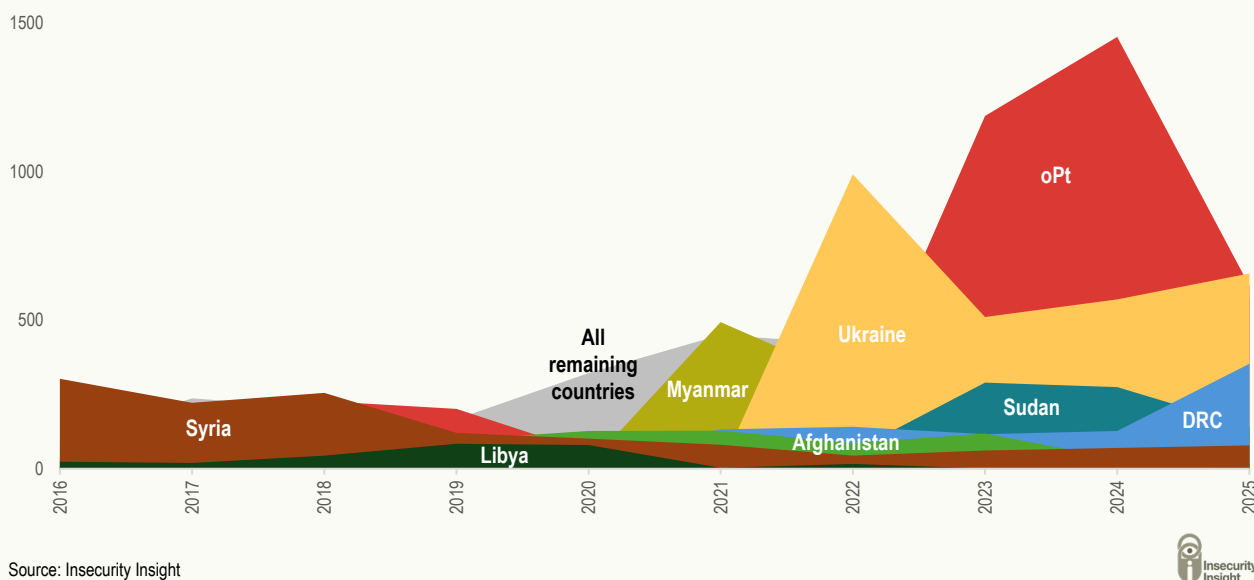
1. Reports of violence against health care increased over the decade since the adoption of UNSCR 2286, in a trend that is clear according to the available data presented in this report, despite limitations and the recognition of under-reporting.
2. On average, health care was attacked 917 times per year 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

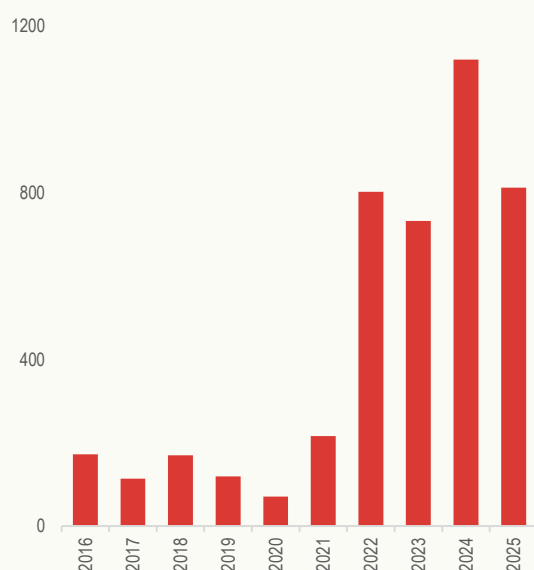
Reported incidents have risen since 2019 alongside major conflicts, with early peaks in Syria and Libya, later surges in Myanmar and Ukraine, and further escalations from 2023 in Afghanistan, Gaza (oPt), Sudan, and eastern DRC.



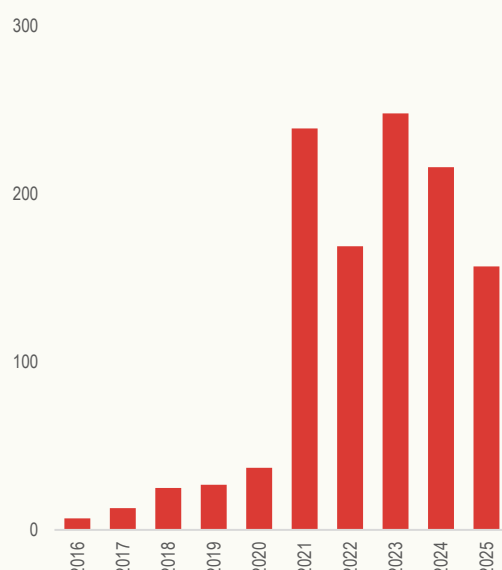
On average, health care was attacked 917 times per year between 2016 and 2021. This had risen to 3,015 times per year between 2022 and the end of 2025.

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.

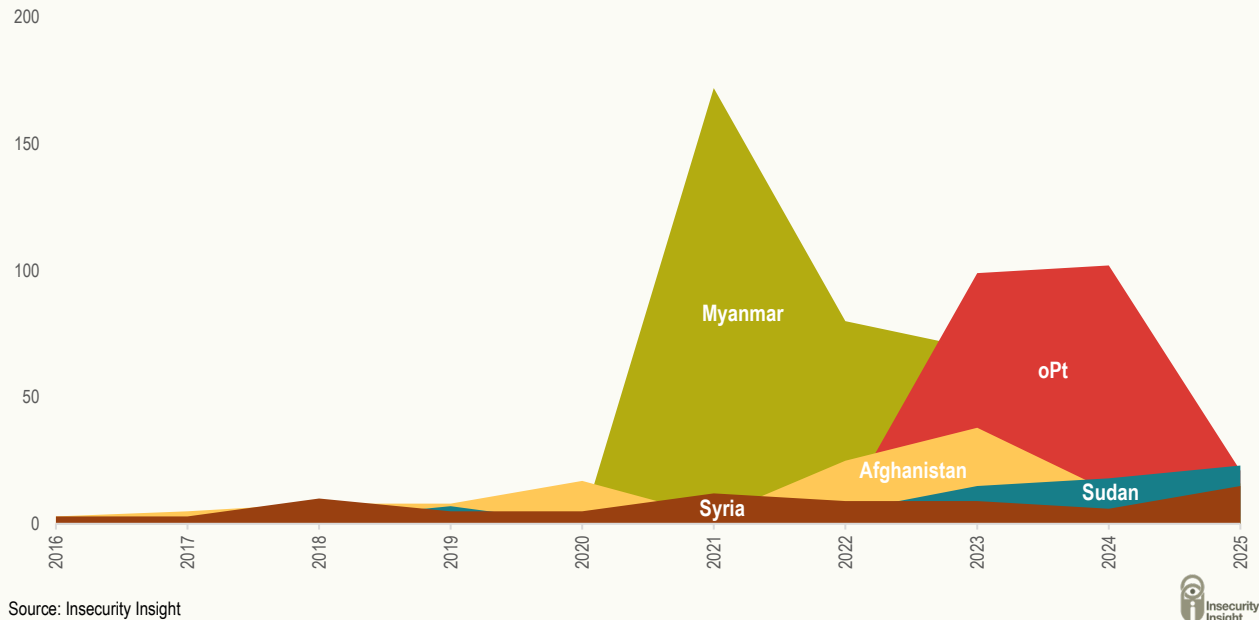
**Health worker arrests, 2016-2025**

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.



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

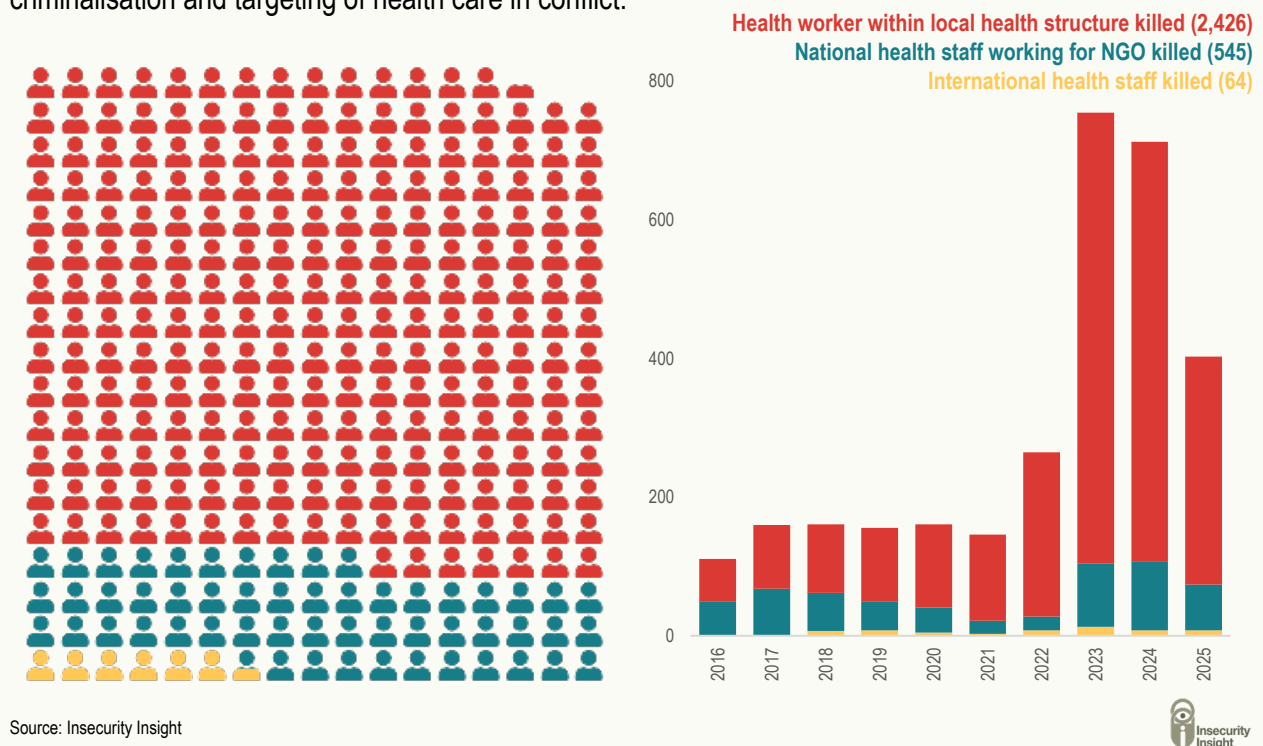
Global increases in health worker arrests have been driven by a small number of conflict-affected countries, with Myanmar recording the highest numbers over the past decade, followed by sharp rises in Afghanistan after 2021, the occupied Palestinian territory - particularly Gaza - in 2023–2024, and Sudan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



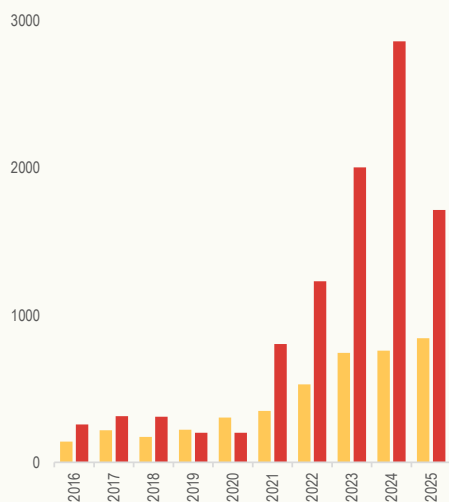
The reliance of humanitarian organisations on local staff for front-line health service delivery in conflict settings often places the greatest risks on those with the fewest protections, as local health workers typically have less access to evacuation, security guarantees and other safeguarding measures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



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.

External state forces



Domestic state forces



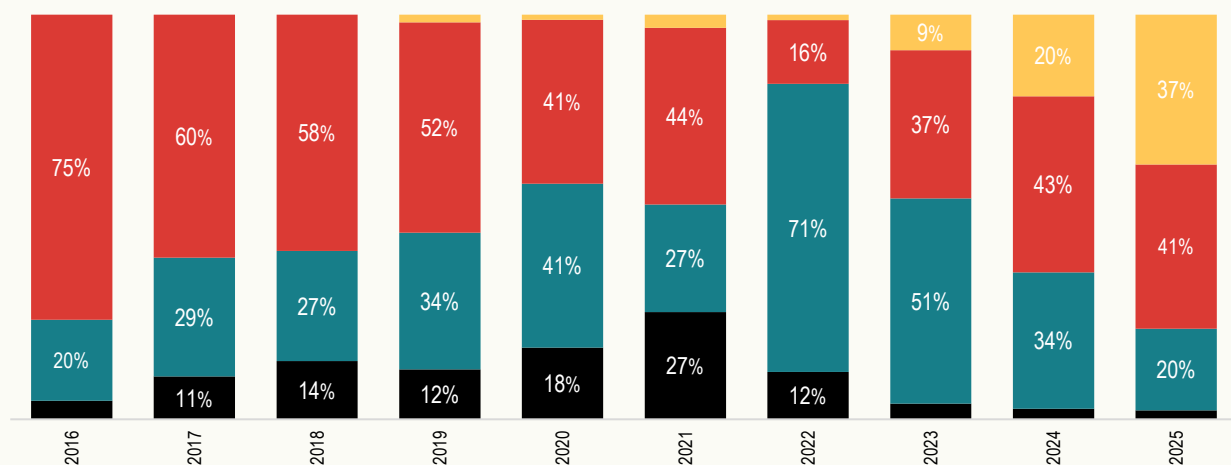
Note: State armed forces are identified using their official names, in accordance with Insecurity Insight's naming conventions.
Source: Insecurity Insight



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.



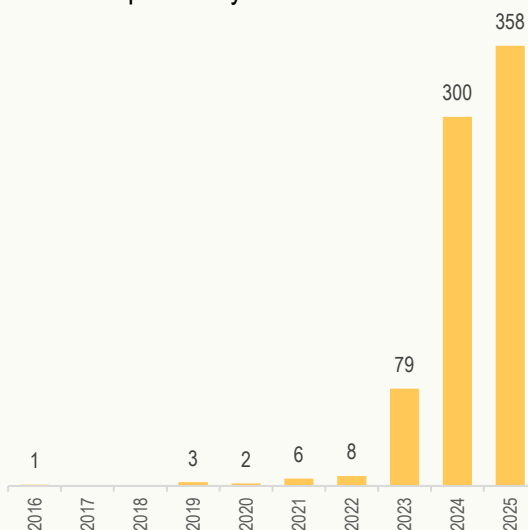
Incident where aircraft-delivered explosives were used (2,169) Incident where directly emplaced explosives were used (328)
Incident where drone-delivered explosives were used (758) Incident where ground-delivered explosives were used (1,912)

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.

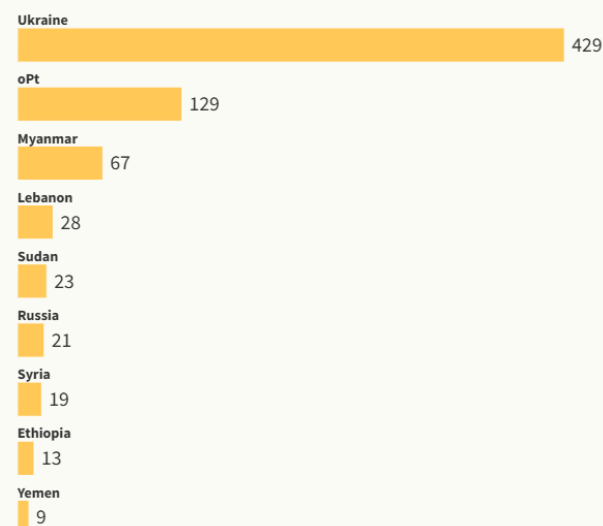


Source: Insecurity Insight



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.



On 3 May 2016, the 15 member states of the UN Security Council unanimously adopted Resolution 2286 (UNSCR 2286) aimed at “the protection of the wounded and sick, medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities”.¹ Galvanised into action by repeated air strikes on hospitals in Syria and following the 2015 attack on the Médecins Sans Frontières (MSF) hospital in Kunduz, Afghanistan, 84 UN member states co-sponsored the resolution, signalling a widespread commitment that reaffirmed states as the primary parties responsible for protecting their populations, and stressing the importance of ensuring accountability for violations of the laws, rules, and norms protecting health care.

However, a decade on, the provision of health care in conflict-affected settings remains as precarious as ever – if not more so. Insecurity Insight’s monitoring, which is shared with the Safeguarding Health in Conflict Coalition (SHCC), reveals that in the ten years following the adoption of UNSCR 2286, more than 3,600 health workers were violently killed, highlighting the failure to protect health workers during hostilities, while over 2,500 health workers were arrested, illustrating the extent to which health care has been criminalised during conflict. Over the same period, more than 4,000 attacks damaged or destroyed health facilities, while over 2,000 incidents affected health facilities as a result of armed entries, military occupations, and other adverse measures that interfered with or prevented the delivery of health care.

Such harms have not only persisted over the past decade, but have intensified. Between 2016 and 2021, an average of 2.5 conflict-related incidents affecting health care were recorded each day (approximately 918 annually). By the end of 2025, this had risen to eight incidents per day (around 2,922 annually). One of several explanations for this is the increase in the use of explosive weapons in populated areas, which, among other types of harm, has caused extensive damage to health infrastructure. A growing disregard for the protection of health care during conflict continues to erode established standards codified in IHL, while the impartial provision of medical care in line with the principles of medical ethics has frequently been deliberately recast as assistance to the enemy, and the work of health professionals framed as conduct that warrants force and criminal sanction.

Among these attacks, at least 447 maternal health services were damaged or disrupted by violence and coercive measures, affecting countless mothers, newborns, and their communities, and starkly illustrating the widespread and intergenerational impact of attacks on health care for conflict-affected communities. The cumulative impact of attacks on essential health infrastructure, compounded by insufficient funding for maintenance, reconstruction and recovery, has had a devastating effect across tens of countries affected by conflict, with widespread preventable loss of life.

Humanitarian organisations and many local health service providers have developed practices over time that help to protect health services and in some way mitigate the risk of attacks and their worst consequences through good communication strategies, practical measures that avoid drawing attention to health services, and support for traumatised and exhausted health workers.

Attacks on health facilities have surged since 2022, rising from an average of 1,032 incidents a year between 2016-2021 to 2,836 annually by 2025, almost 2.5 times higher.

Attacks on health care during conflict are not isolated incidents, but are embedded in broader patterns of violence, conflict dynamics, power relations and technological change. In the decade following the adoption of UNSCR 2286, advances in communication technologies, imagery from satellites and smartphones, and changing weapons systems have transformed the strategies and tactics used by conflict parties, reshaped battlefields and workplaces, altered the information environment, and challenged aspirations for a rules-based international order. Many of these developments have heightened the risks borne by health care providers in conflict settings, while also enhancing access to the documentation of attacks available in the public domain.

Attacks on health care also occur beyond conflict and have been documented amid several public health emergencies. The COVID-19 pandemic, along with other disease outbreaks such as Ebola, have placed an immense strain on health systems; contributed to shifting attitudes toward certain health care practices, such as vaccination, patient isolation, and the use of personal protective equipment; and altered working practices for health care and information professionals alike.

Based on the open-source data collected by Insecurity Insight, it has become clear that the last decade has also seen a shift in how and why attacks on health care occur. Beyond the documentation of incidents, the analysis highlights broader developments that shape the risks faced by health care providers during conflict. These developments include the growing role of social media platforms in undermining trust in and acceptance of health services, and in the erosion of respect for the norms that protect health care during conflict. For example, narratives that circulate online increasingly portray health care actors as partisan or engaged in hostile activities, contributing to the justification of using violence against them.

Trends in violence against health care are evidence of a growing lack of respect for IHL. Challenges affecting legal and political multilateral systems have weakened the application of established norms and mechanisms, calling into question the assumptions that supposedly underpinned a shared understanding of international responsibilities at the time that UNSCR 2286 was adopted. As a result, existing approaches that rely on states as the driving force behind the protection of health care must be reconsidered.

In particular, the increase in violence against health care reflects the failure of state forces to uphold their obligations to respect and protect health care during conflict. Strategic and tactical decisions (often taken by states) have directly undermined these protections, which have been further compounded by persistent failures to ensure accountability. Since 2021, 48% of all recorded and attributed incidents affecting health care were linked to three state actors: the Israel Defense Forces (IDF), the Myanmar Armed Forces, and the Armed Forces of the Russian Federation. While state-perpetrated acts of violence have grown in recent years, non-state actors are believed to have been responsible for more than 5,000 incidents between 2016 and 2025, with the annual average rising from 313 between 2016 and 2021 to 821 between 2022 and 2025.

States' and their international allies' widespread disregard for the so-called rules of war has emboldened both non-state armed groups and a growing number of states. Their attacks have continued and intensified amid persistent lack of accountability and the normalisation of large-scale violations of IHL, despite clear protections under IHL and international human rights law.

This report, produced in collaboration with RIAH and the SHCC, begins by outlining a framework to support the analysis and understanding of attacks on health care. This framework establishes a three-dimensional overview of key considerations that include (1) the vulnerability of health care systems; (2) the context, means, and intent surrounding attacks on health care; and (3) the impact of attacks on health care.

Before exploring these considerations in more detail, the chapter immediately following this introduction outlines how evidence is gathered to inform and strengthen protective policies in conflict settings. We emphasise that data gathering remains complex, is subject to many sensitivities and is continually evolving. This chapter describes the changes in the information environment as of the end of 2025, as well as the limitations and opportunities affecting contemporary data collection practices. Emphasis is placed on the need to recognise that our understanding of complex social and political phenomena is deeply shaped by the sources through which data is gathered. Data is not a neutral reflection of reality: it is produced, filtered, and interpreted through specific methodological, technological, and institutional lenses.

Thereafter the report is structured in terms of the dimensions of the previously mentioned analytical framework.

The section on the *vulnerability of health care systems* presents available data on the scale of damage to and the destruction of health facilities, the impact of armed entries and occupations, the loss of supplies and disruption of supply chains, and the harm suffered by health workers during conflict.

Health care is not only vulnerable to direct attacks, but also to perceptions about its legitimacy and impartiality. A special section in this report explores how social media narratives shape public perceptions of health services, often reducing acceptance and undermining protection.

The subsequent section on *context, means, and intent* examines patterns of violence affecting public health care and emergency responses, highlighting the multitude of challenges faced by health services operating in conflict-affected settings.

Two additional contributions authored by Len Rubenstein examine the criminalisation of health care and the more frequent accusations that attacks on health care are a consequence of the misuse of facilities to hide weapons or harbour combatants. While such claims are increasingly commonplace, investigations reveal that many of them are unfounded, highlighting the need to protect health services from both physical attacks and false allegations.

A final section, prepared by LAW, outlines legal avenues for protecting health care personnel and services during conflict, alongside other protective measures, followed by recommendations for five priority areas for action.

Violence against health care in conflict settings is widespread, but does not take a single form. Monitoring and analysis therefore rely on a range of methods depending on the context, typology of incidents, and respective effects and impacts. An attack on health care – also referred to as an event or incident – describes an act by a conflict party, occurring at a specific time and place, that affects the delivery of health care services. Such violence may affect health facilities, threaten or harm health workers, or disrupt supply chains and access routes on which people needing care depend. A single act may affect one or multiple components of the health care system.

Regardless of its form, violence against health care undermines access to essential services and puts lives at risk. However, the pathways linking violence to poorer health outcomes are rarely straightforward. They are shaped by complex structural and contextual factors and – importantly – their consequences are not inevitable.

An analytical framework

Understanding and addressing violence against health care during conflict is complex. This report uses a framework for understanding violence against health care that reflects pathways to address it in practice. Violence against health care is analysed by examining it from four different perspectives: (1) health care vulnerability; (2) the context, means, and intent of conflict parties; (3) the impact of violence on health services; and (4) health outcomes across time and space. This framework is designed to balance analytical ambition with the practical constraints of data availability, focusing on what can be meaningfully assessed and what can be used to generate actionable insights for policy and practice.² Its aim is to inform policy efforts to encourage perpetrator accountability, identify opportunities among both armed actors and health care providers for steps to prevent or mitigate the violence that far too frequently affects the delivery of health care in conflict-affected contexts, and support measures to mitigate the effects of violence on health systems and access to care.

Key concepts used in this report:

Vulnerability refers to the intersectional factors that explain how health services are exposed to harm during conflict. Related discussion focuses on the characteristics of health systems, facilities, and operations that increase risk, and on elements that can be strengthened to reduce their vulnerability.

Context, means, and intent describe how the tactics, strategies, and weapons systems used by conflict parties contribute to harming health care in a range of contexts. These concepts also cover the possible motives behind attacks on or interference with health services, which are central to legal and accountability assessments.

Impact refers to the processes through which violence progressively weakens health care systems and restricts access to care. These processes diminish the quality, availability, and accessibility of services and often unfold in complex, cumulative ways rather than as immediate or isolated events. Over time, they contribute to poorer health outcomes, increased mortality, and wide-ranging local and global consequences.

Norms: The protection of health care is included under the obligations defined by IHL and international human rights law. States are responsible for ensuring respect for these obligations.

Understanding vulnerability and impact can help to ensure the practical application of the principles contained in IHL and strengthen protection frameworks, while the analysis of means, intent, and motive can support accountability efforts, including investigations and the pursuit of prosecutions against the perpetrators of violence.

The primary responsibility for designing and implementing adequate security risk management (SRM) measures lies with health care providers and health institutions, and these measures require adequate resources and sustained support to be effective. At the same time, health care providers and their supporters can take practical steps to reduce risks and mitigate the impact of attacks. Based on an understanding of vulnerabilities, risks and impact pathways, providers can implement tailored SRM measures.

Vulnerability of health services during conflict

Health care is inherently vulnerable during conflict because it must remain accessible to patients. Accessibility is central to its function, yet this openness limits the use of certain risk mitigation measures, which makes health services less easily shielded from violence.

Health care is particularly vulnerable to be adversely affected during conflict because it is not a single activity. Health care systems are based on complex interdependent processes that depend on skilled personnel, functioning logistical systems – including the availability of medicines, equipment, laboratories, data, and referral pathways – as well as public health measures and patients' corresponding access to health services. Disruption at any point in this process, whether through attacks on facilities; threats to health workers; supply interruptions; or interference with information flows, energy and water supplies, or access routes to health facilities, can have cascading effects with severe and often fatal consequences for patients.

Health care is vulnerable because armed conflict undermines the health system beyond direct attacks on health care. The reduced availability of training for health workers, suspended public health planning and implementation, and lack of investment in essential infrastructure can have equally profound and long-lasting impacts on health services. Vulnerability is also conferred by the nature of the services provided by a health system and public perceptions of its role. As a system that should treat anyone in need of care – from civilians to injured combatants – it is exposed to competing claims about its role. The special protected status of medical units can generate risk, because armed actors may exploit health infrastructure to provide cover for their activities, while disinformation campaigns may be used to allege such misuse in order to justify attacks.

Researching the Impact of Attacks on Healthcare (RIAH)

Much of this section on impact draws heavily on the work of the **RIAH** Consortium (in particular its two reports on methodologies of assessing impact from **2020** and **2026**), of which Insecurity Insight was a member. The RIAH (2019-2026) project was a multi-institution and interdisciplinary research programme aimed at improving our understanding of the immediate, long-term, and broader impacts of attacks on healthcare on populations in contexts affected by armed conflict. It published dozens of academic and policy publications and other tools on the issue of attacks on health care and their impact.



Adopting a nuanced approach to vulnerability can reveal that some health services are more vulnerable to attack than others. Public health responses in conflict-affected communities may trigger hostility from within the community – as has happened during pandemics and epidemics – while emergency medical responses in active conflict settings, including by military medics, face higher risks than routine health care delivery. Certain outreach services, such as vaccination campaigns, are susceptible to broader criticism of public health measures if community scepticism regarding these services is high, making public health measures particularly vulnerable.

Health care is also increasingly vulnerable during conflict because patients are often unable to seek health care when they need it, such as when routes are unsafe or curfews or fuel shortages prevent travel. This causes health conditions to worsen or forces patients to decide to live with an untreated condition instead of making the risky decision to seek health care.

Context, means and intent of attacks

A wide range of complex context-related factors – including the nature of the conflict and the characteristics of the armed actors involved – shape why and how health care is vulnerable during conflict. These factors interact in highly specific and often only partially known circumstances, creating a complex and dynamic threat environment. Crucially, they also define the scope for possible interventions to strengthen the protection of health care in diverse risk and threat contexts.

The specific features of conflict settings (the context) affect legal interpretations about the use of force, violence against health care and possible interventions. Violence against health care occurs in international armed conflicts between two or more states; in non-international armed conflicts between state forces and non-state armed groups; and in situations of political unrest in which security forces seek to suppress demonstrations or civilian political movements. It may also arise in fighting among multiple non-state armed actors or in contexts driven by mixed motivations – political, economic, or criminal – such as competition over drugs or other resources. Although these categories are clearly defined in law, in practice they are often fluid and lack clear-cut boundaries. Possibilities for interventions are often influenced by such higher-level contextual classifications, thereby profoundly influencing opportunities for action. In addition to the principles of IHL that are valid in times of conflict, the right to health is a fundamental right that applies in all contexts.

Each weapon system and its delivery methods – referred to as the means of perpetrating violence – carry distinct risks that may affect health care. Many explosive weapons have wide-area effects, causing damage well beyond the point of impact; for example, shattering hospital windows or damaging walls even if the building is not directly hit. The risk to medical units also varies depending on whether explosive munitions are delivered from the air by aircraft or drones, are launched from the ground as artillery shells, or emplaced directly as landmines or improvised explosive devices (IEDs). Some weapons systems are inherently imprecise and cause extensive destruction over a broad area, while others enable highly accurate and precise targeting.

State military or non-state armed group command and decision-making structures also vary widely, exposing health services to diverse risks. In terms of the broadly defined notion of intent, decisions that fall on a spectrum from deliberate targeting to the precautionary avoidance of harm, as well as broader choices made during armed conflict, have a major impact on health services' determination of risk. The nature and organisation of armed units also affects the threat environment in which these services function. For example, health services may face risks from individual armed actors who act autonomously, or from large, organised units that are supported by complex technological and command structures, each of which creates different patterns of interaction, harm, and possible entry points to enhance efforts to protect health care.

The ways in which armed actors interact with health services further shapes the threat environment these services face. Risks differ markedly, ranging from direct, face-to-face interactions – such as armed units stopping ambulances or medical supplies at checkpoints, or entering health facilities to conduct searches – and remote forms of attack initiated from a distance, whether from the ground, air, or sea. In remote attacks, there is rarely any direct contact with health personnel and little or no opportunity for communication with the attacking force.

Context, means and intent are closely interlinked. While it is rare that details of all three factors will be known, the triangulation of available information across these factors can support broader threat assessments. Given the diversity of strategies and capabilities, one-size-fits-all recommendations are insufficient. Instead, protecting health care requires nuanced, context-specific approaches and targeted entry points to improve the conduct of armed actors during hostilities.

Violence against health care can occur during the conduct of hostilities when conflict parties carry out military operations, but equally during demonstrations in times of political upheaval and in response to opposition to public health measures during a disease outbreak. The right to health applies in all situations, and therefore violence against health care also includes those acts that intentionally disrupt or deny individuals' right to access health care.

A full list of what is considered an attack on health care, as documented by Insecurity Insight, can be found at: **Definitions and Methodologies**.

Impact of conflict on health services and outcomes

Violence against health care during armed conflict undermines the functioning of health systems, restricts access to essential services and leads to poorer health outcomes for patients. Attacks on health facilities, ambulances, and medical personnel increase morbidity and mortality as a result of untreated injuries and diseases, preventable medical and surgical emergencies, and disruptions to the treatment of chronic conditions. The fear of attack can deter people from seeking timely care, compounding avoidable harm and placing additional strain on already fragile health systems.

The impact of violence on health systems does not follow a single, inevitable chain of events. Instead, it varies depending on where within a tightly interdependent health system the shock occurs. The pathways of impact differ depending on whether violence affects health workers (leading to the loss of skilled personnel); medicines or equipment (limiting the ability to provide appropriate diagnosis and care); physical infrastructure (leading to damage to or the destruction of buildings, vehicles, and water or energy supplies); or patients (by preventing or discouraging them from seeking care).

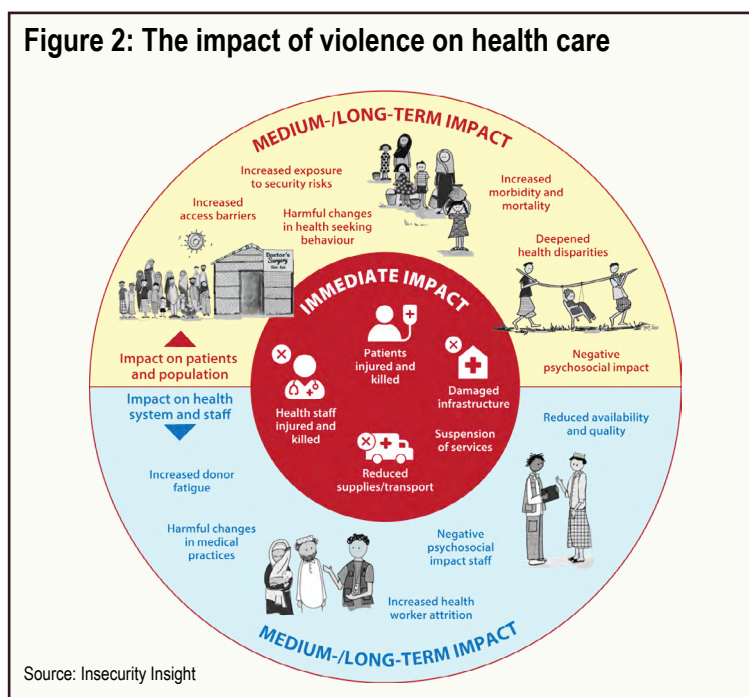
The link between violence and its impact is most visible when care delivery is directly disrupted, such as during an attack on a hospital or ambulance. These interruptions are often acute, but time bound, with services frequently resuming if immediate damage can be addressed. Less visible – and often far more difficult to mitigate – are the impacts on health care support systems, including medicine production and supply chains, cold-chain infrastructure, laboratory capacity, and the training and retention of the health care workforce. Such incidents are often overlooked, particularly when they cause no casualties at the time of an attack. Yet their consequences for health system functioning can be profound; for example, when the only laboratory capable of testing for certain bacterial infections and corresponding antibiotic sensitivities is put out of action, countless patients suffer preventable complications due to the protracted consequences of untreated or drug-resistant infections.

The impact of attacks on patients can be especially life altering when violence shapes the perception of risk associated with seeking care or creates financial and other barriers to accessing care. These indirect effects are frequently severe, because they directly influence health-care-seeking behaviour and long-term health outcomes.

Impacts on the health workforce vary by role and function within the system, but also by gender. However, many nuances remain underexplored due to the lack of sufficiently disaggregated data. Gender data remains incomplete, but where reported, men are more frequently affected by violence targeting health workers. However, significant reporting gaps limit the ability to draw firm conclusions regarding gender-specific impacts beyond the anecdotal.

The consequences of violence may be immediate or cumulative, resulting from repeated incidents over time. Impacts may remain localised or spread across regions, and may either intensify or be diminished depending on whether persistent risks are mitigated. As a result, it is very difficult to determine the impact of violence on health care, because multiple interacting factors determine the scale, duration, and severity of harm to health systems, populations, and individual patients caused by a complex range of interacting violent actions. Nevertheless, it is vital to predict the foreseeable harm that results from specific incidents of violence against health care.

Figure 2: The impact of violence on health care



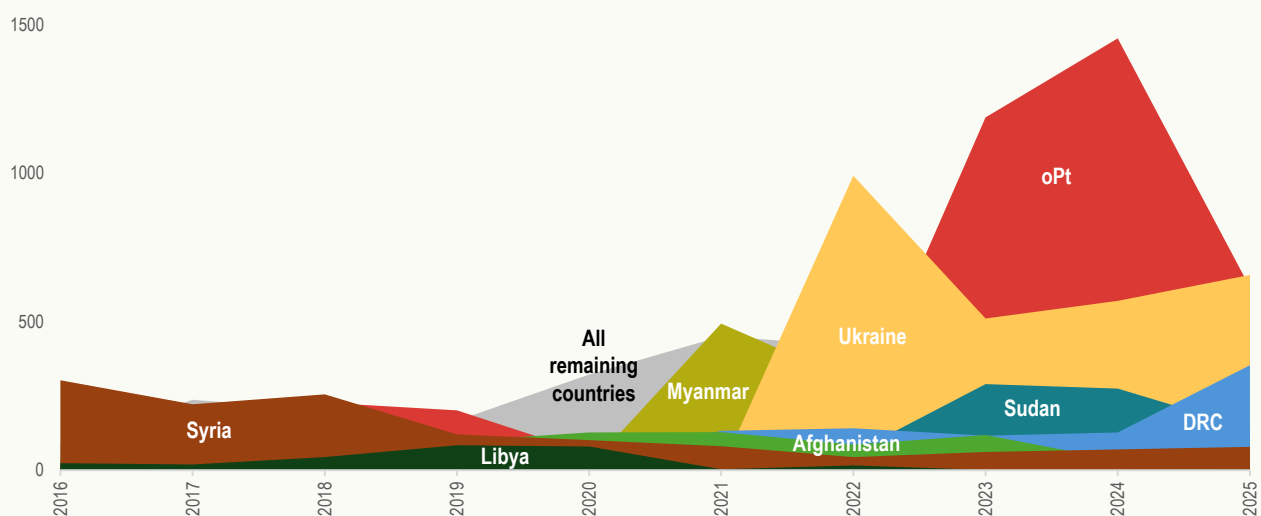
Insecurity Insight's monitoring has recorded 17,565 reported attacks on health care between January 2016 and December 2025. As defined by the World Health Organization (WHO), attacks on health care include “any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access and delivery of curative and/or preventive health services during emergencies”.³ Since 2019, reports of violence affecting health care have surged, peaking during major armed conflicts. While the Democratic Republic of the Congo (DRC), Myanmar, the occupied Palestinian territory (oPt), Syria and Ukraine stand out due to exceptionally high levels of violence, 18 countries have seen an overall increase in attacks. This trend reflects both an increase in the number of conflicts and in the way in which hostilities are conducted.⁴

The Insecurity Insight dataset captures broad trends in violence against health care, but does not reflect every nuance. Despite these limitations, a critical examination of the evidence outlined in this chapter suggests that this dataset is sufficiently robust to support policy-relevant analysis of the drivers of violence and to inform meaningful action to reduce the vulnerability of health care during conflict.

No dataset on violence against health care is ever complete – but it does not need to be. It is not the numbers that matter most, but the patterns they expose, and how they are interpreted and ultimately acted on.

Figure 3: Reported incidents of violence against and obstruction of health care during conflict, 2016-2025

Reported incidents have increased since 2019, closely tracking major conflicts. Early peaks occurred in Syria and Libya, followed by spikes in Myanmar (2021) and Ukraine (2022). From 2023 onward, Afghanistan, Gaza (part of the oPt) and Sudan saw dramatic escalations in violence against health care, with further increases in eastern DRC in 2025. These trends highlight how large-scale violence directly heightens risks to health care systems across conflict-affected regions.



Source: Insecurity Insight

During armed conflict, comprehensive data collection and ideal research designs are rarely feasible and are often ethically problematic. Health workers in such contexts are expected to deliver care in severely under-resourced and understaffed conditions. Some health workers may feel a sense of agency and purpose when documenting attacks on health care that they have witnessed. But requests from research organisations to compile broader geographic datasets risk diverting time and critical resources away from life-saving activities, and may expose staff to retaliation if such activities become known. At the same time, deploying researchers to conflict-affected settings can be dangerous, inconsistent with good-practice guidance and costly. As such, the data presented in this report has been generated using the most practical and ethical approach under such circumstances: continuous, daily remote monitoring with the collation, cross-checking, and verification of available information from multiple sources and networks, all coded and entered into a structured database.

Insecurity Insight data is collected using an incident-based approach in which details for each event are systematically recorded and stored in the database. Information on violence against health care has become more readily available due to witness-generated reporting shared openly and through private networks. Incident data necessarily focuses on what can be credibly observed and verified, including what occurred, the harm or damage caused, and the weapons systems used. Witness accounts can often reliably describe the means of attack – for example, whether health services were affected by aerial bombardment, ground fire, or armed entry into facilities – and whether impacts involved direct strikes on or disruptions to supply systems. By contrast, other dimensions, particularly intent or motive, are generally not observable or discernible. Conflict parties are under no obligation to disclose the intent behind their military operations affecting health care, and as a result, incident data provides limited insight into intent that can only be inferred from the broader context.

Documentation can constitute a form of resistance against violence: combining otherwise disparate information into a single dataset can demonstrate powerful evidence of harm. However, such a process must not inadvertently also cause harm. Large datasets can offer protection through aggregation, but risks remain for individuals, particularly in cases such as abductions or arrests, where public reporting may increase their exposure and danger.

Concerns are also frequently raised about reporting attacks on health care facilities,⁵ yet there is limited evidence that documentation increases risk. Many incidents are already widely known, and locations and structures are visible in satellite imagery and shared photographs. The locations of health facilities are generally accessible on maps or other public forms of information. By contrast, clandestine facilities need to preserve their low-visibility status. However, in most cases, an attack indicates that the location was already known to the attacking party.

Data collection for which there is not a clear, corresponding purpose may also be unethical. Responsible documentation requires balancing protection from harm with the obligation to ensure that data is ethically used to inform action.

Finally, incident-based monitoring rarely produces a complete record of incidents, and reporting practices vary widely across incident types and contexts. The wider information environment profoundly shapes how violence against health care is documented, transmitted, interpreted and contested. As a result, incident data must be interpreted critically – not only in terms of what is included, but also what is missing, and what those gaps may reveal.

From newspaper cuttings to open-source information

Insecurity Insight began developing approaches to documenting attacks on health care in 2008, contributing to work conducted by the International Committee of the Red Cross (ICRC) to develop the evidence base for what later informed the establishment of the Health Care in Danger initiative,⁶ and advising the WHO on the establishment of the Surveillance System for Attacks on Health Care (SSA), which was implemented in 2019 after the World Health Assembly instructed the WHO in 2012 to initiate such a data-collection system.⁷

Following the adoption of UNSCR 2286 in 2016, Insecurity Insight began to systematically collect incident-based data, which has since been shared with the SHCC for use in its annual reports since 2014.

The decade that followed the adoption of UNSCR 2286 saw profound changes in the information ecosystems that shape access to information. The past decade has seen a revolution in open-source methodologies, with the rapid expansion of social media use, which has increased from approximately 31% of the global population in 2016 to 69% by 2026.⁸ This process has transformed how trust, legitimacy, and power are constructed and negotiated in conflict settings. These changes affect not only our understanding of violence against health care, but also the vulnerabilities faced by health workers and facilities, and the means of conducting conflict and their impact on health care.

Over the past 15 years, Insecurity Insight has developed data responsibility and quality policies⁹ and practices related to open-source methods for monitoring reported violence against health care, with the aim of ethically obtaining the best possible data in a rapidly and profoundly changing information ecosystem. These changes have shaped both data-collection practices and the evidence presented in this report.

Since 2019, the WHO SSA has reported on violence against health care using its own institutional incident-reporting mechanism, which has also been influenced by changes in institutional architectures, processes and mandates. Medical organisations have developed processes for their own evidence gathering on this issue, albeit at a smaller scale and with different mandates and methods, and usually not for public consumption. Open-source and institutional data-collection efforts should be seen as complementary rather than duplicative: they reflect different information ecosystems, and it is in their overlap and divergence that some of the most important insights into missing information emerge.

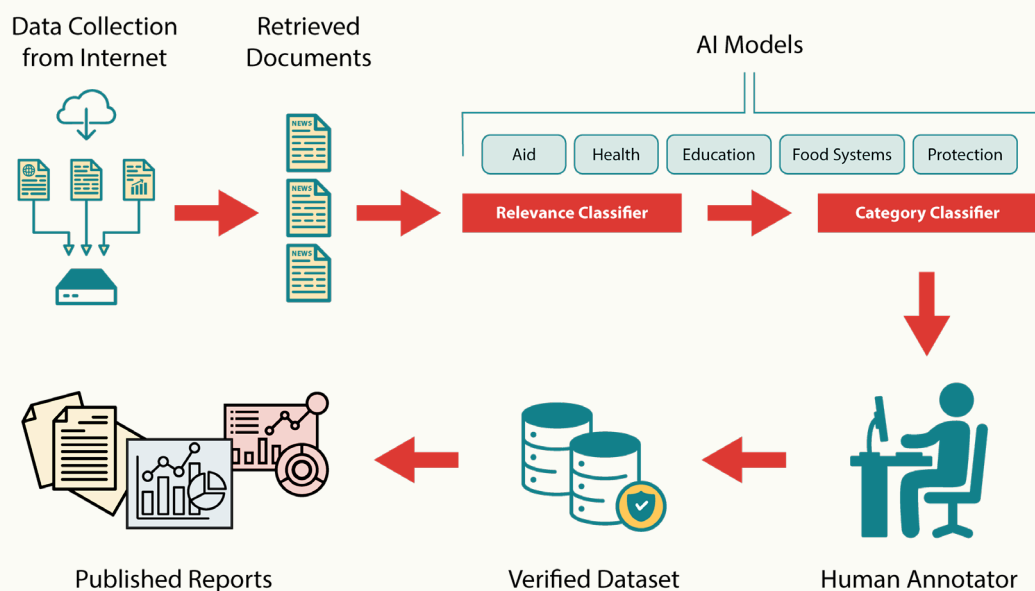
When Insecurity Insight first began testing methods to collect information on individual incidents of attacks on health care in 2008, data collection relied on print media, including physical newspaper cuttings or media reports from a limited range of internet sources that were printed and stored for analysis. Newspapers were purchased in affected countries, manually cut, and sent via diplomatic pouch for manual processing and cataloguing.

Nearly two decades later, Insecurity Insight primarily collects information from a vast range of online sources. This shift reflects broader changes in the media landscape, as local and international news providers have increasingly shifted their reporting online. As a result, the structure and accessibility of media and information environments profoundly shape the process of information collection. These developments have occurred at different speeds across countries, reshaping access to information, multiplying the range of voices, and increasing the agency of local actors in the international arena through the ways in which data is collected and used.

In 2017, following an analysis of the patterns of data collection (eventually reported by Parada et al. in 2023¹⁰), Insecurity Insight made a strategic decision to prioritise and strengthen the development of open-source information collection, with the intention of complementing institutional data sources that were rarely available outside the institution in question. This dual-track approach was intended to strengthen overall coverage by capturing incidents occurring both in and outside official reporting structures. Since then, data-collection methods have continued to evolve in response to profound changes in the global information environment that were not foreseen at the time.

In some contexts, the internet revolution has fundamentally changed who tells the world about the impact of conflict and how its consequences have to be understood. Whereas reporting was once dominated by foreign war correspondents (often white men from Western countries) observing affected communities from the outside and filtering stories through their own worldviews, today local health workers and affected communities increasingly tell their own stories, including on social media, about how they experience attacks and how this changes access to health care. The changed information environment gives access to lived experience in ways that external conflict observers rarely had access to in the past. As voices have become more local and much closer to the point of impact, monitoring efforts have been able to better reflect these realities and incorporate perspectives that were previously marginalised. In short, the global view of violence against health care has become more personal.

Figure 4: Insecurity Insight's open-source data-collection process



Source: Insecurity Insight

At the same time, growing restrictions on freedom of expression have constrained journalists' work in many contexts. Reporters face increasing barriers to investigation, and in such settings the information space has narrowed.¹¹ Where external investigation teams and foreign correspondents once played a central role in documenting gross violations of human rights, their access is now frequently denied, which has been most starkly illustrated in recent years by Israel's refusal to allow foreign journalists to enter Gaza. In some contexts, journalists resort to self-censorship to minimise the risks local reporters face.

Local first responders – especially health workers – have become key witnesses to violence and are central to the documentation of incidents, yet inequalities in information systems persist: while many communities now have access to advanced communication tools, this access remains uneven between and within countries. Health workers (who are often relatively privileged members of their communities) tend to have greater access to these tools than the general population. From Myanmar to Sudan and Gaza, health workers' first-hand experiences have become one of the most noticed voices in open-source reporting. Synthesising these accounts into a broader analysis across contexts requires researchers with the expertise to apply systematic classification and interpretation procedures.

Technologies are influencing how observers can find these testimonies. When Insecurity Insight first began systematic open-source online data collection in 2016, it relied primarily on keyword searches using general search engines such as Google. These methods performed poorly. A comparison of results produced by Insecurity Insight and the WHO SSA (both based on online search approaches) found only a 12.9% overlap of their respective results, suggesting substantial under-reporting.¹² Today, Insecurity Insight uses tailored algorithms trained on more than a decade of data to identify relevant information through automated classification and categorisation processes, supported by artificial intelligence (AI) that make use of natural language processing (NLP) and large language models (LLMs).¹³ These tools help human analysts locate relevant material, which staff members then review, verify and code. These systems require continuous adjustment and investment to respond to evolving contexts, language, and reporting practices. When calibrated to clearly defined information criteria, these tools improve the precision and relevance of searches, enabling data collection to focus on specific analytical needs at a fraction of the cost of field-based data-collection processes and without exposing researchers to heightened physical risk. However, mental health risks among researchers are real, stemming from the vicarious trauma caused by continuous exposure to documenting violence and its tragic impacts on health workers and patients.



Data management ethics

Insecurity Insight applies strict principles to ensure responsible, safe, ethical and effective data management. These principles are based on the Inter-Agency Standing Committee publication *Operational Guidance: Data Responsibility in Humanitarian Action*¹⁴ and the work of the Data Responsibility Working Group,¹⁵ and centre around the principles of data security, data privacy, and data use, taking into account that Insecurity Insight's work has a responsibility to health workers, health care systems, and humanitarian health care providers.

The key objectives are that:

- data is used to make more informed decisions to protect health workers and the health care system;
- the privacy and security of the information related to people at risk are protected;
- data is shared and disseminated to improve stakeholders' understanding of how conflict affects the delivery of health care; and
- transparency regarding data sources contributes to the collective improvement of data and information.

Insecurity Insight applies strict data ethics to identify solutions to data-related dilemmas when competing principles require it to take priority decisions guided by the principle of doing no harm. Based on these considerations, we report the available information on the perpetrator(s) of violence. Information on the perpetrator(s) is not only important methodologically to determine if an incident is conflict-related, but, most significantly, it provides the key information required to develop preventive strategies and mitigation measures that reduce the incidence and impact of attacks and to support accountability processes. Because we believe that the key objective of all data work has to be that it can be used to address harm, Insecurity Insight considers the information related to perpetrators and the locations of incidents in countries to be of primary importance. Strict data security principles are applied to personally identifiable information and to any information that links to people or organisations at risk from any potential repercussions from conflict parties.

Understanding violence against health care from institutional and open-source reporting systems

Open-source information on attacks on health care has developed in parallel to institutional reporting systems, most notably the WHO SSA, which captures incidents through official reporting channels and partner organisations.¹⁶ Institutional reporting systems have the potential to record incidents that do not reach public attention, providing insight into more commonplace or less visible forms of violence such as arrests, threats, intimidation, restricted access, or kidnappings. At the same time, such data may carry additional sensitivities and be constrained by the need to protect individual privacy. When such systems function effectively, they generate structured, standardised and internally validated data grounded in established reporting protocols. The official nature of this data can carry greater political weight and prove to be persuasive in informing policy and advocating for action.

The effectiveness of institutional reporting is shaped by the external environment and depends on multiple organisational factors, including strategic intent, operational access, and the availability of sufficient personnel and resources. In recent years, these factors have been significantly affected by profound global and local changes. The COVID-19 pandemic, for example, disrupted data collection due to lockdowns and access restrictions, while ongoing conflict has increasingly restricted the ability of international organisations to operate in contested areas where many attacks on health care occur. A growing voluntary sector has also developed in parallel to formal Health Cluster-led structures, adding challenges to coordination and information-sharing processes.

Furthermore, institutional reporting systems operate within politically sanctioned frameworks, making them vulnerable to political shocks. Shifts in authority can lead to the abrupt loss of access, disrupted reporting flows or the exclusion of entire geographic areas from monitoring. Concerns over public criticism – whether for being perceived as overly transparent or insufficiently comprehensive – can result in institutional data being restricted to internal use, with external stakeholders receiving only partial and filtered subsets of larger datasets. Funding constraints, including recent reductions in aid affecting the WHO and other health care providers, have further weakened monitoring capacity by limiting staffing and field presence.



A comparison of data trends from open sources collected by Insecurity Insight with WHO SSA institutional reporting highlights the influence of structural, technological, and political changes on information collection, and how access, governance, and information flows shape what is ultimately documented.¹⁷ These shifts help to explain why trends characterising the same phenomenon diverge considerably between Insecurity Insight and the WHO SSA. Notably, restrictions during the COVID-19 pandemic affected institutional reporting far more than open-source monitoring. In contexts where conflict has intensified, many areas highly impacted by violence became inaccessible to international actors due to security concerns or deliberately imposed government restrictions, reducing reporting through formal WHO-supported mechanisms. Meanwhile, the growing reach of alternative communication channels has enabled more reports to emerge via open sources, driven by community and individual reporting.

The limitations and value of data presented in this report

The data presented in this report is primarily derived from open sources, which carry biases and limitations. As an H2H Network organisation,¹⁸ Insecurity Insight is committed to transparent methodologies and open access to information that is compiled with a data-responsibility approach that respects the agency of individual data providers and encourages data use in support of action to protect health care.

Open-source data typically underestimates the total burden of attacks on health care, and is more likely to capture large-scale, publicly visible events than incidents or access constraints affecting health workers, supplies, or patients. As a consequence, some types and locations of violence against health care, as well as those who are affected, are better covered by open-source data than others. An appreciation of these limitations informs the interpretation of the data presented throughout this report.

Data on attacks against health care provides clear insights into the vulnerability of health systems during conflict. Visible incidents – such as damage to facilities or attacks on health workers – highlight both structural and human risks, while first-hand accounts document impacts on the quality of care and the psychological well-being of health workers and patients. Although not all attacks are reported and some types of attacks are more frequently under-represented than others, the data is generally reliable. Health workers have little incentive to misreport incidents, and visible damage can often be independently verified. As such, their reports offer a robust indication of some of the structural risks facing health services in conflict settings. That said, the available data is far less effective at capturing how conflict affects the supply of medicines and medical equipment, while many instances of the denial of access to health facilities or of health workers being prevented from reaching the injured and sick go unreported. As a result, the scale and impact of this widespread and often systematic form of violence remain poorly documented and inadequately understood.

Data on attacks against health care also provides insights into the capabilities and methods of perpetrators of violence against health care. Reports typically describe the means used – such as air strikes, armed entries, or individual assaults – and indicate whether the perpetrator was an individual, an armed group, or state forces. Systematically classified information on weapons types, delivery methods, and actor characteristics offer a meaningful indication of the nature and intensity of the violence being reported. Although some details may be missing or inaccurate, the longitudinal analysis of the same datasets over the past decade provides a broadly reliable illustration of the ways in which conflict parties and the weapons systems they use have evolved.

Data remains weak on the issue of intent. Most reports come from those who experience attacks and can therefore describe what happened, but cannot definitively explain why an attack occurred or what the attacker intended. Intent can only be derived directly from the perpetrators, who rarely disclose such information and often prevent investigations or the publication of findings. Systematic analyses can present plausible scenarios, such as by distinguishing among direct hits, collateral damage or wide-area effects. A direct hit may indicate intent to strike a specific location, but, once again, intent differs from motive: a military actor may aim to target an adversary rather than to deliberately harm health care. Determining the underlying motive is rarely possible with a high degree of certainty, and fuller insights often emerge decades later when internal records are declassified. This difficulty in establishing intent and motive contributes to low levels of accountability, because those responsible can avoid scrutiny by remaining silent as to their intentions.

Beyond intent, most incident descriptions of violence against health care contain little information on the impact following an attack. Attack data in this report is used to discern overall impacts by distinguishing among attacks that affect points of delivery, the supply chain and access to health care. Attacks on health care delivery points – such as hospitals and ambulances – are often the most visible and frequently reported forms of violence against health care, usually because they cause the most immediate disruption to services. Armed entries, illegal searches, disruptive or violent raids, or occupations of health facilities impact the point of delivery, but they are less frequently reported. Attacks on supplies, whether in warehouses, pharmacies, in transit, or at points of entry, are much less systematically reported, yet their impact can be far reaching. Finally, violence that impedes patients' access to health care is the least systematically reported, and because of this, much wider gaps in our knowledge of patterns and trends persist.

The data used to describe patterns of violence against health care in the decade following the adoption of UNSCR 2286 is uneven. Even so, it offers deeper insight into some incidents and contexts – and any limitations must be transparently acknowledged and interpreted. Nevertheless, evidence does not need to be perfect or complete to inform policies and corresponding actions. Given budgetary constraints, deteriorating access conditions, and the risks of relying solely on internal reporting processes, the available information that is presented constitutes the most robust, “good enough” evidence base at present. Despite the previously mentioned limitations, the evidence reveals consistent and deeply concerning patterns that demand attention. Information-gathering processes and practical responses must continue to adapt to shifting contexts as violence against health care continues to affect millions of people in conflict settings.



Vulnerability of Health Systems iDuring Conflict: Attacks on Health Workers, Health Facilities, and the Obstruction of Health Care

Attacks on health workers during conflict, 2016-2025

Number of health workers affected	Number of health workers killed	Number of health workers kidnapped	Number of health workers arrested
14,869	3,618	1,558	2,575
Source: Insecurity Insight			

Over the period 2016-2025, more than 3,600 health workers have been reported killed, 1,558 kidnapped and 2,575 arrested amid armed conflict. In total, more than 14,800 incidents have directly affected health workers in addition to the deaths, arrests, and kidnappings, including a wider range of injuries from assaults, sexual violence, and threats. Health workers are highly vulnerable in situations of armed conflict: they are unarmed and dedicated to humanitarian activities, not military ones. Their safety depends largely on conflict parties' respect for their medical mission and on health workers' ability to manage risks associated with their work in areas affected by hostilities.

Health workers typically live and work in the communities they serve, which heightens their vulnerability during conflict. A majority of attacks affecting health workers occur outside the medical workplace, with 66% of reported killings, 73% of reported kidnappings and 68% of reported arrests taking place away from hospitals or ambulances. Around 30% of incidents in which health workers were killed, kidnapped, or arrested occurred while they were on duty in medical facilities or ambulances. Vulnerability is particularly high during commutes, while at home, or engaging in private activities such as shopping or picking up children. In contrast, medical workplaces often provide a level of protection that is absent in community settings.

Two doctors arrested by the Myanmar military in Mandalay

On 26 April 2022, the Myanmar military arrested two doctors who were in a personal relationship in Mandalay. One of the doctors, who owned three private clinics providing outpatient care and laboratory services, was detained together with his father and elder sister. The family's ordeal quickly escalated. After 18 days in detention, the father was released. However, on 14 December 2022, the doctor's sister was sentenced by a junta-controlled court to 20 years in prison. The following year, the doctor himself received a 21-year prison sentence. In addition to these harsh penalties, the military authorities shut down, sealed and confiscated all three clinics, cutting off vital health care services previously provided to the local community. The charges against the victims stemmed from their alleged employment of health workers affiliated with the Civil Disobedience Movement. They were prosecuted under counterterrorism laws and were accused of supporting and financing a terrorist group.¹⁹

These arrests are two of 2,575 health worker arrests recorded since the adoption of UNSCR 2286.

Two health workers ambushed and killed in Burkina Faso

In February 2023, two male national health workers were killed by armed men during an ambush of an international non-governmental organisation (INGO) health vehicle with four staff members onboard. The other two staff members escaped without injuries. Following the attack, the INGO suspended activities in Boucle du Mouhoun region.²⁰

This attack resulted in two of 3,618 health worker killings recorded since the adoption of UNSCR 2286.

While some health workers are harmed as civilians, in many cases there is evidence that they are specifically targeted because they are health workers. Targeted attacks are often carried out when no other health workers can witness the act or when facility leaders are unable to intervene. This is especially true of arrests, which frequently occur in private homes. It should be emphasised that it is likely that the number of health workers harmed outside the workplace is under-reported and that the true scale of their community-based vulnerability is even higher.

All attacks – whether in or outside the medical workplace – contribute to the loss of a skilled health workforce, reducing the availability and quality of care over time. Regardless of the type of attack, the resulting trauma and negative effects are not confined to individuals, but accumulate and can affect the whole health care system. Psychological injury among health workers affects staff retention, performance and willingness to operate in high-risk environments. It is therefore essential to understand differentiated trauma pathways to anticipate foreseeable harm, and then design mitigation measures that support health workers both at home and in transit to work in contexts where heightened risks are present.

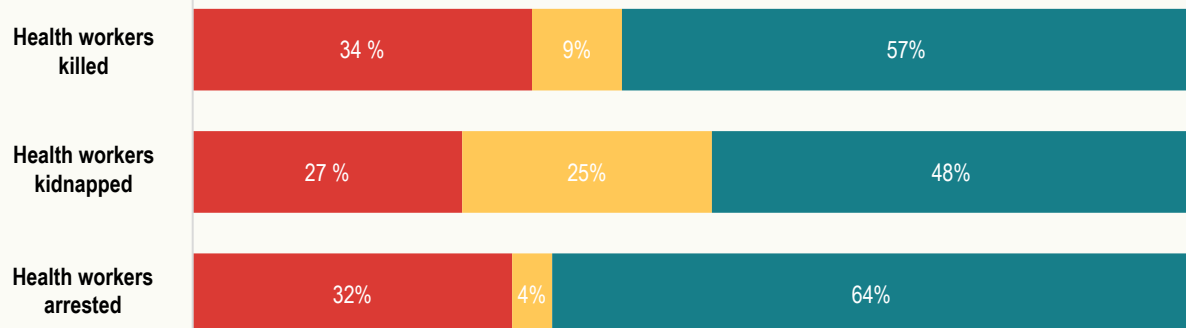
Health workers harmed at the point of service deliverable and elsewhere, 2016-2025

Health workers face high on- and off-duty risks, particularly the latter, with lasting impacts on health systems.

At home or pursuing a private activity (4,424 incidents)

Inside health facilities or while working in an ambulance (2,432 incidents)

On their way to or from work (827 incidents)

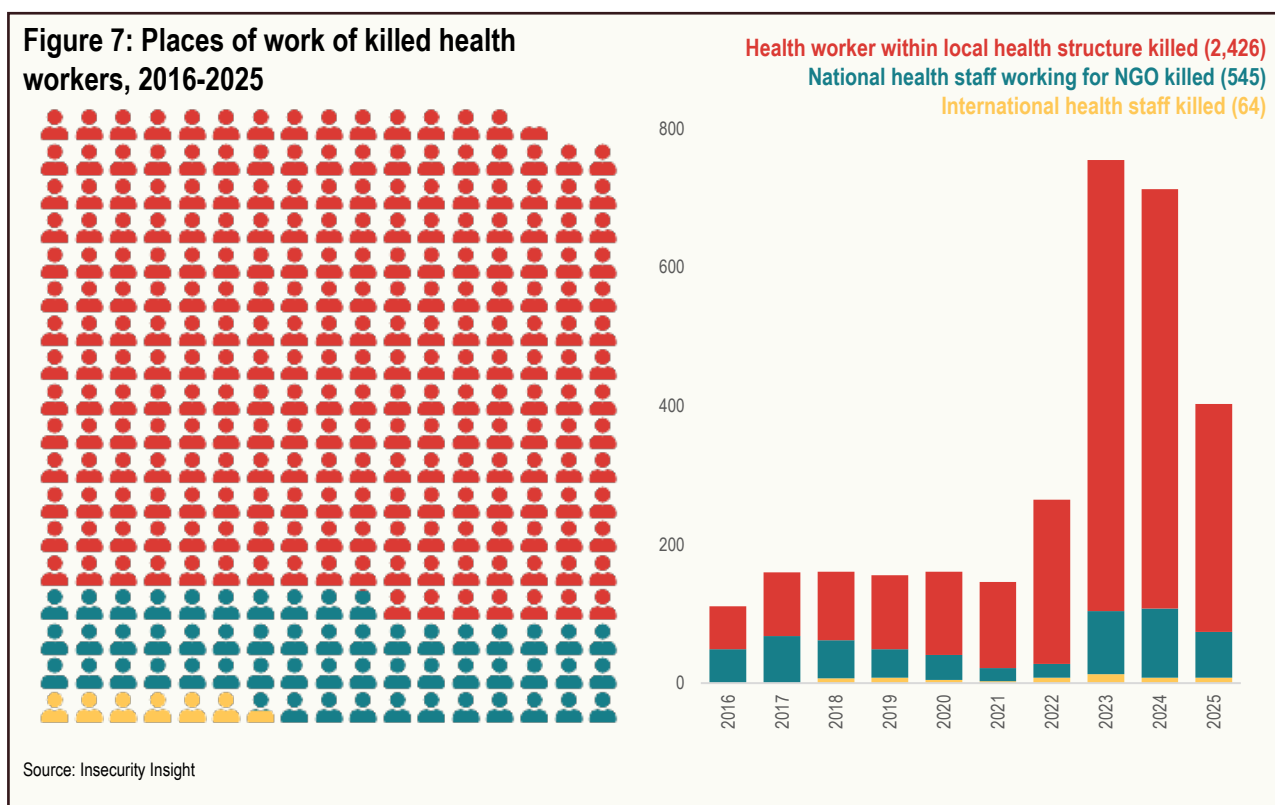


Source: Insecurity Insight

The heightened vulnerability of local health workers

The largest group of health workers killed during conflict are health workers who come from the communities they serve. Of the 3,618 health workers killed between 2016 and 2025, approximately 68% – over 2,400 people – worked in a local health structure. More than 500 killed health workers were national staff working for INGOs that were running health programmes, accounting for a further 18% of those killed. The 67 international health workers killed during conflict over the past decade account for 2% of the total recorded killings.²¹ These figures indicate not only the enhanced vulnerability of local health workers, but also a clear concentration of lethal risk affecting them.

This pattern reflects the structural features of how health care is delivered in conflict-affected contexts. Local health workers provide the majority of day-to-day care through services embedded within communities. Because of this, they are more likely to be perceived as affiliated with one side involved in the conflict, regardless of their status or impartiality in the provision of care. Ethnicity, language, residence, or prior interactions with armed actors can lead to assumptions about political or military alignment. More broadly, in contexts where health care is criminalised, instrumentalised, or deliberately targeted, providing care to civilians or wounded combatants can be interpreted as a hostile act. These dynamics undermine respect for the medical mission and can increase the risk of attacks.



Seven health workers kidnapped by masked perpetrators in Somalia

On 27 May 2020, seven national health workers and a civilian were kidnapped by masked perpetrators from a health facility run by a local NGO in Somalia's Middle Shabelle region, and later executed.²² Their bodies were found the next day.

This attack is one of 1,558 health worker abduction incidents recorded since the adoption of UNSCR 2286, and led to seven of 3,618 reported health worker killings in the same period.

Employment structures can contribute to a disproportionate burden of vulnerability. International humanitarian organisations provide support to health service delivery during conflict through funding, supplies, training and advocacy, but their risk-management practices often limit the deployment of international staff. As a result, front-line service delivery increasingly relies on local employees and partners who face the same threats, but with fewer protective measures, less access to evacuation, and limited leverage to negotiate security guarantees. This effectively transfers the most dangerous aspects of health service delivery to those who are least protected.

Local health workers fulfil a wide range of roles, from curative to preventive health care, from specialist services focused on specific civilian groups (such as children or those needing maternal health care of some kind) to the treatment of the wounded during crises. When they are attacked, specific skills can be lost, influencing which patient group will be most affected. At a time when the WHO is highlighting a projected shortage of over 11 million health workers by 2030, mostly in low- and middle-income countries,²³ every health worker lost means a huge systemic gap.

Colombian testimonies highlighting health workers' profound sense of vulnerability

"Many times when you go out on the street, there is a fear that you will be attacked just for the act of working in health."

"Always at night between 7PM and 6AM, you cannot go out because the [armed] group plants landmines in the highway."

Excerpts taken from: K. Crawford et al. (2023) "There is a fear that you will be attacked just for the act of working in health": a survey of experiences of violence against healthcare in Colombia.' *Conflict and Health*, Vol. 17(1). doi: 10.1186/s13031-023-00548-3.



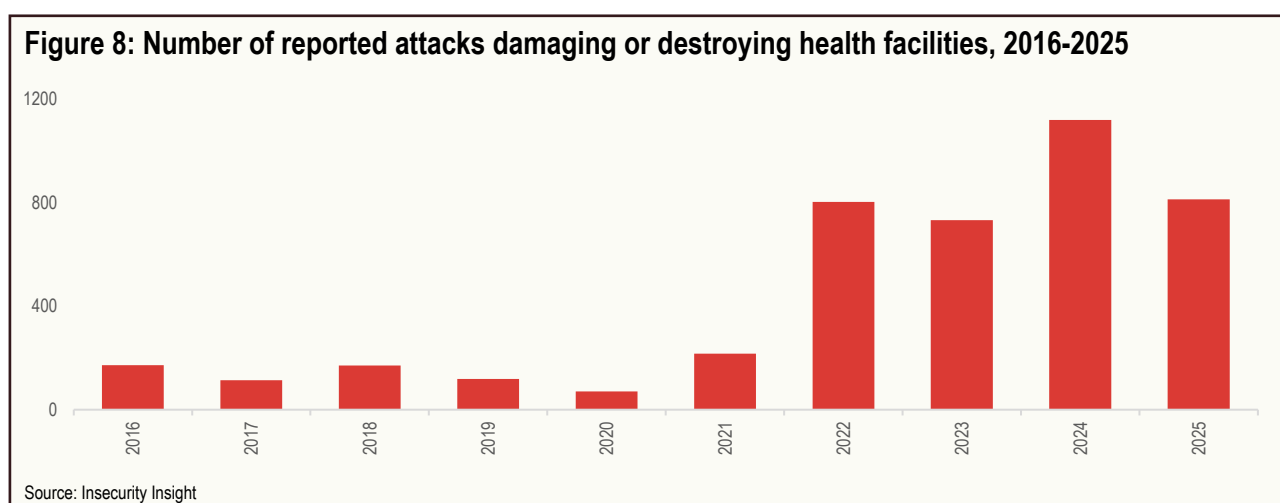
Attacks on health facilities during conflict

Number of incidents where health facilities were affected	Number of incidents where health facilities were damaged/destroyed	Number of incidents where health facilities were forcefully entered	Number of incidents where health facilities were occupied
9,025	4,327	1,449	502
Source: Insecurity Insight			

Damage to and the destruction of hospitals and other health facilities are increasingly reported, and often have an immediate impact on the delivery of health care. Over the past ten years, over 4,300 attacks have been recorded that caused damage to or the destruction of health facilities, involving the use of a range of military methods. These include 1,870 reported air strikes that damaged or destroyed hospitals, and 1,108 ground-based artillery strikes. Health facilities were also vulnerable to other forms of interference, including 1,449 armed entries and 502 instances in which health care buildings were occupied. In total, over 9,000 incidents that affected health facilities were recorded.

Damage to and destruction of health facilities

The number of reported attacks on health facilities that caused damage or resulted in their destruction has risen sharply since 2022. From 2016 to 2021, on average 140 incidents were reported per year in which health facilities were damaged or destroyed. Since 2022, that figure has jumped to an average of 828 attacks annually, nearly six times the previous rate. The number of reported incidents fell slightly in 2025, driven by a reduction in incidents in Gaza, where most health facilities had been rendered no longer functional due to repeated bombings and the decimation of health care services. In other contexts, such as eastern DRC, incidents increased in 2025.



Armed entry and occupation of health facilities

During the last decade, 1,449 incidents of armed entry into health facilities were recorded, some of which resulted in the arrest of health workers (at least 138 incidents). In other cases, patients and health workers were killed (at least 104 incidents). During 1,213 incidents, violent searches that did not result in the arrest or killing of health workers or patients were documented.

In addition, conflict parties occupied health facilities for non-medical purposes, at times denying patients access to treatment. A total of 502 incidents involved the military occupation of health facilities.

A hospital under repeated attack in Sudan

On 3 and 7 October 2025, the Saudi Maternity Hospital in El Fasher, North Darfur was hit twice by artillery during clashes linked to the ongoing armed conflict in Sudan. The 7 October shelling of the maternity ward killed at least 13 people, including children, and injured at least 16 others, including a female doctor and a nurse. The hospital and its equipment were severely damaged, destroying what was the last fully functioning major medical facility in El Fasher.

These attacks were part of four assaults on the hospital in October 2025 during a prolonged siege of the city. On 26 October, Rapid Support Forces (RSF) fighters attacked the facility, killing a nurse, injuring three health workers and forcibly abducting the minister of health.²⁴ Two days later, RSF fighters raided the hospital again, resulting in the deaths of more than 460 patients and a nurse, and the abduction of six health workers, including four doctors, a nurse, and a pharmacist.

These attacks form part of a wider pattern of violence affecting health care in Sudan since the outbreak of the civil war in April 2023, with hospitals, clinics, medical transport and health workers repeatedly impacted, severely constraining access to life-saving health services for civilian populations.

A total of 88 attacks on health facilities were recorded in the Darfur region between April 2023 and December 2025 amid fighting between the Sudan Armed Forces (SAF) and RSF. These attacks reflect a wider trend of 487 documented attacks on health facilities across Sudan since 2016, underscoring the sustained and widespread impact of hostilities on medical services.

These four attacks were part of the over 9,025 attacks on health facilities recorded since the adoption of UNSCR 2286.

A hospital under attack in the DRC

On Friday, 14 November 2025, Byambwe Reference Health Centre in Lubero territory, North Kivu province was attacked overnight by the Allied Democratic Forces (ADF).²⁵ Armed assailants systematically forcefully took medicines and medical equipment before setting the facility on fire, rendering it inoperable. Two health workers were reportedly abducted. The hospital's maternity ward, supported and run by the Little Sisters of the Presentation, was deliberately set ablaze, and women receiving postnatal care were killed in their beds. Some were found with their throats slit, while other women and newborns died in the fire. At least 15 people were killed inside the hospital, with five more killed nearby.

This attack is one of over 9,025 attacks on health facilities recorded since the adoption of UNSCR 2286.

A hospital occupied in Myanmar

On Wednesday, 6 November 2023, a public hospital in Indaw town, Sagaing region was seized by the Myanmar military following the capture of surrounding towns by local resistance forces.²⁶ The hospital, along with other civilian buildings, was converted into a military bunker, with mortars positioned nearby, effectively denying patients access to essential medical care.

This incident is one of over 500 recorded incidents where health facilities were occupied and used for non-medical purposes since the adoption of UNSCR 2286.

The impact of attacks on health facilities

Attacks affecting health facilities disrupt the delivery of health services. The duration of a disruption to the availability of health services depends on the severity of the damage, the availability of alternative services (including resupply options), and available funding and other resources for recovery. Depending on their conduct and duration, violent raids, disruptive searches, and the occupation of health facilities have a variable impact on health services. Limited disruption may occur when the ongoing provision of medical activities is respected, but intimidation, arrests, or the removal of patients and staff directly interfere with care and violate medical ethics. The patient groups most affected vary according to the services disrupted. Repeated attacks compound these effects, prolonging disruption and delaying the recovery of health facilities and their return to service.

Impacts can be long term and cumulative. The health workforce can be particularly shaken by the experience of attacks. As a result, attacks can lead to staff flight, and the long-term loss of human resources and the capacity to provide health care. Severe impacts occur when war crimes are committed that result in the immediate loss of life and collapse of services. These are among the most visible forms of violence against health care, which are typically witnessed by large numbers of people, including health workers, patients and their families.

The impact of violence against health care on the health of children and mothers

A multidisciplinary team comprising researchers from the Ecole Régionale de Santé Publique de l'Université Catholique de Bukavu, the International Rescue Committee, the RIAH project and Insecurity Insight published the following findings from a 2023 case study of attacks on health care in three health zones in eastern DRC.

Impact on access to and use of health services: Following armed attacks, health centres either reduced service provision or ceased operations altogether for one to four weeks. This disruption was primarily driven by challenges in staffing on call and night shifts, the lack of resources to replace taken or damaged infrastructure and equipment, and widespread fear among both health workers and the community, which reduced their attendance at facilities. Services gradually resumed, initially limited to daytime hours due to continued concerns about further attacks.

Impact on women's health services: The attacks sharply reduced women's use of maternal health services. Childbirth was the most affected service, given its high likelihood of occurring at night. As a result, the number of deliveries fell dramatically across all the health centres studied, even after they reopened. Many women chose to travel long distances to other facilities or to give birth at home rather than risk attending recently attacked centres, increasing the likelihood of complications and adverse outcomes.

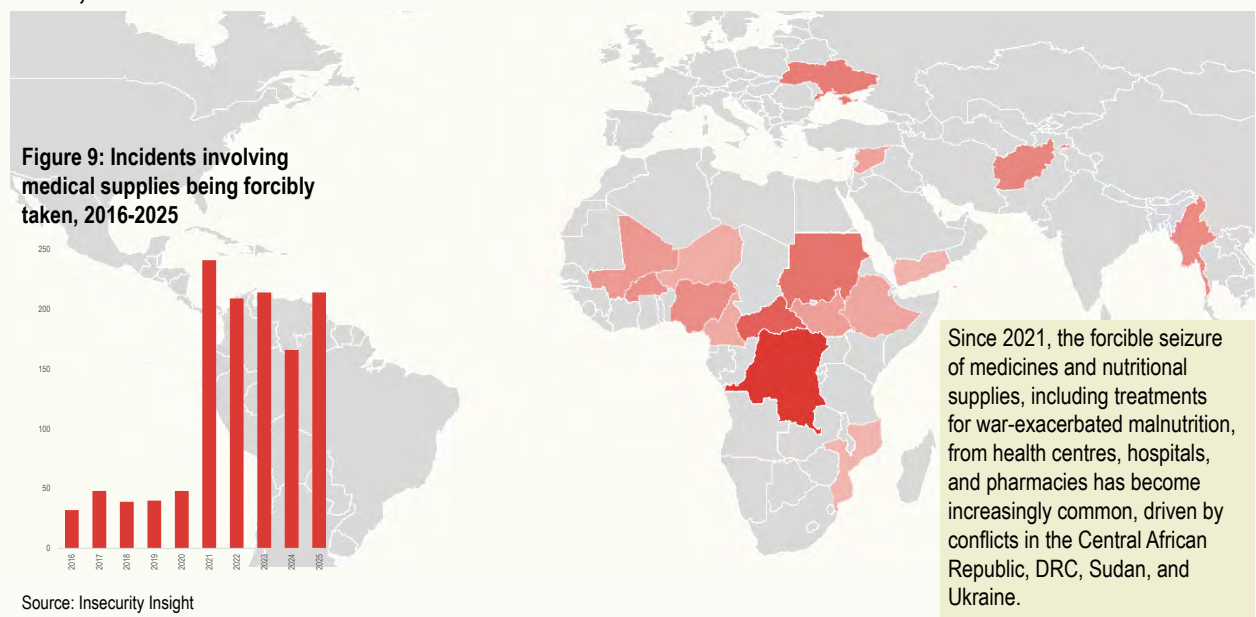
The study is available in [English](#) and [French](#).

Disruption of and obstructions to health care during conflict

Number of incidents where medicines, vaccines and other health products were impacted	Number of incidents where medical supplies were forcibly taken	Number of incidents where health transportation was forcibly taken	Number of incidents where access was denied
1,824	951	679	634
Source: Insecurity Insight			

The many facets of health systems are highly vulnerable to disruption during conflict. Violence can destroy stocks of medical supplies, disrupt medical transport and supply chains, cause fuel shortages, and interrupt water and energy supplies. The full scale of this impact remains hidden, because attacks that affect the overall functioning of the health system are less often reported than the high visibility attacks that have an immediate and direct impact on patients, health workers or facilities. In fact, most attacks that have an impact on medical supply chains are rarely associated with direct, lethal violence against health workers, which likely contributes to under-reporting and reduced public attention. Only 5.9% of all recorded health worker killings occurred in the context of supply-chain- or access-related incidents. Witnesses to conflict events often fail to recognise the wider impact on health care of an incident that, for example, destroys a laboratory when there were no associated civilian casualties, and as a consequence these incidents remain under-reported.

Map 1: Conflict-affected countries recording 20 or more incidents of medical supplies being forcibly taken, 2016-2025



Yet reports about conflict-related disruptions to the distribution of medical supplies and access to health care have been more frequently noted, particularly from 2021 onward. The most frequently reported incidents involve the forceful taking and theft of medical supplies, with more than 950 incidents recorded since the adoption of UNSCR 2286. Non-state armed groups have repeatedly attacked hospitals and medical warehouses, often seizing medicines, equipment, and fuel to support their own operations or to exert control over affected populations. Some of these incidents were also associated with violence against health workers, with 12.5% of all recorded kidnappings occurring during incidents involving the forceful taking of supplies or ambulance-related incidents. This suggests that while supply-related violence may not often result in immediate fatalities, it frequently involves intimidation and coercion directed at health care personnel.

Health transportation has been persistently affected throughout the last decade, and ambulances have been stopped, seized or repurposed for military use. Hijackings and thefts of health transports are most commonly associated with armed group strategies for territorial control and the restriction of mobility, particularly in Sahelian countries, the DRC, and Sudan, where control of movement routes is central to conflict dynamics.

Reported cases of the obstruction of and denial of access to health care rose sharply between 2022 and 2024. These incidents include the confiscation of medicines or fuel, the blocking or delaying of supply convoys, and restrictions imposed through bureaucratic procedures or the imposition of checkpoints. Taken together, the data suggests a shift from more sporadic supply disruptions before 2020 to more systematic and large-scale interference with health care access and supply chains in the post-2021 period. In several contexts, these patterns are closely linked to high-intensity conflict and large-scale military operations, as well as to the criminalisation of health care.

Conflict-related violence affecting health care supplies and access has some of the most profound consequences for the functioning of health systems and for health outcomes in conflict settings. Disruptions to medicines, fuel, transport, and the immediate provision of health services can undermine entire care pathways, even when facilities remain physically intact. These forms of violence are therefore central to understanding why health outcomes deteriorate during conflict. Documenting the full impact of such violence is inherently complex. The consequences depend on which supplies are disrupted, which services are interrupted, and how long these disruptions persist, as well as the investment that was made in the health system before the conflict. The effects are often indirect and cumulative rather than immediately visible.

Health supplies and vaccinations disrupted in Syria

On Thursday, 8 February 2018, at around 14:30, Syrian regime warplanes struck the Syrian Arab Red Crescent centre in Irbeen city, Rif Dimashq governorate, which provided nutritional support and routine immunisation services.²⁸ The centre was hit by four air strikes over the course of an hour, partially destroying the facility, damaging critical equipment, and forcing its closure at a time when humanitarian access was already severely constrained by siege conditions and ongoing bombardment across eastern Ghouta.

The attack further undermined the delivery of vaccines and essential care to children and other vulnerable populations in an area already struggling with shortages of medical supplies and limited access to basic health services. By late March 2018, the WHO reported that routine vaccination activities in parts of eastern Ghouta had been halted as the conflict intensified, leaving children unable to access lifesaving immunisations. While mobile outreach vaccinations continued in shelters and newly reached areas, the inability to reach front-line towns starkly illustrated how insecurity and attacks on health infrastructure directly curtailed immunisation efforts and jeopardised the health of children and vulnerable communities.

This attack is one of over 1,800 that affected medicines, vaccines and other health products recorded since the adoption of UNSCR 2286.

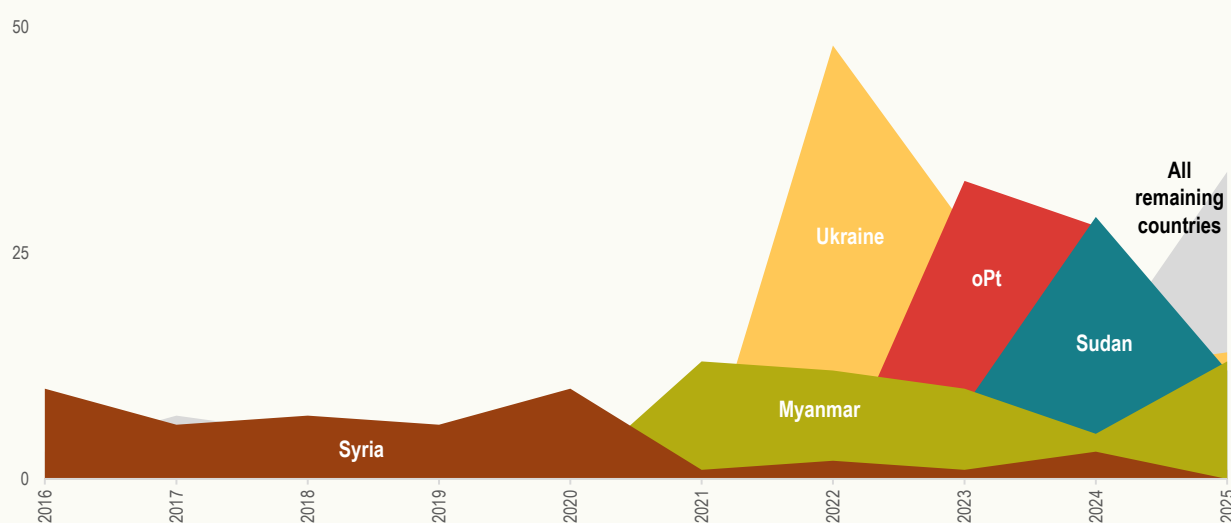
Maternal health disrupted by violence

Number of incidents affecting maternal health services	Number of incidents where explosive weapons damaged maternal health facilities	Number of forcible entries into maternal health facilities	Number of health workers killed who provided maternal care
447	148	48	93
Source: Insecurity Insight			

In the early years after the adoption of UNSCR 2286, reported violence against maternal health services remained relatively limited in scale, although persistent incidents were recorded, particularly in Syria (47 incidents over the ten-year period). From 2022 onwards, however, violence escalated sharply. The post-2022 rise is driven primarily by remote attacks on maternal health facilities, including air strikes, shelling, and the use of other forms of explosive weaponry, particularly in Ukraine (103 incidents, concentrated between 2022 and 2025), the oPt (64 incidents concentrated between 2023 and 2025), and sustained high levels in Myanmar (53 incidents) and Sudan (47 incidents). Facility-linked harm – damage, destruction and service disruption – represents the dominant pattern, accounting for approximately 37% of all reported incidents (175 of 447). Such attacks cause both immediate casualties and the longer-term degradation of essential maternal services.

Figure 10: Violence against maternal health care services in conflict settings since 2016

Reported violence against maternal health services was relatively limited in the years immediately following the adoption of UNSCR 2286, although persistent incidents occurred in Syria. From 2022 onward, attacks escalated sharply, driven by air strikes, shelling, and other explosive weapons use in Ukraine, the oPt, Myanmar, and Sudan.



Source: Insecurity Insight

An INGO-run maternity unit attacked in Afghanistan

At around 10:00 on Sunday, 12 May 2020, three attackers armed with AK-47s and hand grenades attacked Dasht-e-Barchi Hospital in Kabul.²⁹ The attackers shot and killed a security guard, then walked straight past a number of other wards closer to the hospital's entrance and made straight for the 55-bed maternity unit run by MSF, systematically shooting dead 16 mothers, an MSF midwife, two children, and six other people. A total of 26 mothers and mothers-to-be were in the unit at the time of the attack, ten of whom managed to flee to safe rooms. The gun battle between the attackers and Afghan security forces went on for four hours as many of the maternity unit's patients and staff took cover. One mother sheltering in the safe room gave birth while trying not to make a sound. A midwife severed the umbilical cord using her bare hands. By the time the attack was over, the walls and floors were sprayed with spent bullets and blood.

MSF, which had run the maternity unit since 2014, announced its decision to end its activities and withdraw from the facility in mid-June, citing as reasons the insecure context and the likelihood of repeated attacks in the future.

This attack is one of over 447 that affected maternal health services recorded since the adoption of UNSCR 2286.

Armed entries and direct violence in maternity hospitals occur less frequently. Such incidents were most frequently reported in Myanmar, while some of the most brutal cases were documented in Afghanistan and Sudan, where pregnant women, postpartum mothers, newborns, and health staff were harmed inside facilities. In other contexts, maternal health personnel – including midwives – were targeted with assaults, threats, intimidation, and arrests, undermining the front-line delivery of care and the provision of specialist obstetric care through direct attacks on personnel rather than on other elements of health care delivery.

Maternal services are also affected by the denial or obstruction of access, including blocked movement due to checkpoints, curfews and insecurity. Such restrictions prevent women from reaching facilities in time for delivery or emergency obstetric care and impede the movement of health workers, equipment, and supplies. Where the medical capacity is available, some women and doctors described scheduling deliveries, including C-sections, in order to avoid the dangers associated with travelling during active bombardment and general insecurity.³⁰

Incident descriptions most frequently reference maternity wards and labour and delivery services (225 incidents), obstetrics and gynaecology services (117 incidents), and midwives (70 incidents), indicating that both routine and emergency maternal care are repeatedly affected. Family planning or abortion services did not prominently feature in the dataset; however, services provided to survivors of conflict-related violence were reported to have been affected in some contexts.

A maternity hospital bombed in Ukraine

On Wednesday, 23 November 2022, Russian armed forces launched a rocket attack using S-300 missiles on the maternity ward of the central district hospital in Vilniansk city, Zaporizhzhia oblast.³¹ The strike killed a newborn boy who was only two days old. His mother survived, while two doctors were injured, one of whom sustained burns to 37% of his body.

This attack is one of over 447 that affected maternal health services recorded since adoption of UNSCR 2286

Attacks and obstructions affecting maternal services amplify risk in both immediate and cumulative ways. Damage to facilities and disrupted access delay treatment for obstetric emergencies – such as haemorrhage, eclampsia, sepsis, and obstructed labour – increasing the likelihood of maternal death, stillbirth, and newborn mortality. This is particularly the case when referral pathways, blood supplies, surgical capacity (including for C-sections), and skilled birth attendance are compromised. Beyond direct injury, repeated disruptions erode the continuity of care, reduce antenatal attendance, increase stress and malnutrition during pregnancy, and contribute to adverse outcomes, including low birthweight and pre-term birth. At the community level, sustained attacks on maternity care can alter reproductive patterns by negatively affecting facility-based birth rates, increasing neonatal complications, and deepening inequities when specific populations face systematic barriers to safe delivery care. Over time, these patterns risk reshaping demographic outcomes and reinforcing cycles of vulnerability in conflict-affected settings.



When UNSCR 2286 was adopted in 2016, Facebook reported approximately 1.6 billion monthly active users. Ten years later, social media platforms counted well over 5.6 billion users worldwide.³² In the decade following the resolution's adoption, the percentage of the world's population using social media rose from 31% to 68%, contributing to a transformation with profound consequences for health care system vulnerability in certain contexts.³³ Social media – digital platforms where users create, share, and respond to content in public or semi-public spaces – has increasingly supplemented traditional media and face-to-face communication. Online spaces have become a central arena in which social trust, humanitarian and public health legitimacy, and political authority are constructed and contested.

Health workers' ability to deliver care during conflict not only depends on legal frameworks, operational measures, and political commitments, but also on social perception and acceptance, that is whether communities, armed actors, and authorities recognise health care workers as neutral, impartial, and trustworthy. Many of the narratives spreading today on social media platforms are profoundly harmful and undermine trust in health services, thereby amplifying risks and potentially legitimising attacks on health care.

Social media monitoring, perceptions and risks to health care

Regarding perceptions of and sentiment towards the health sector, a single post will not change public perceptions, but rather what happens in its wake. Posts set the frame for a report on a disease outbreak, an air strike on a hospital or a vaccine rollout announcement. For those who read this information, meaning is shared and created in the comments, where users reinterpret events, question motives, and spread often-harmful narratives. Because many comments appear to come from users' peers rather than authorities, they are often persuasive. A small number of highly active users can dominate the discussion and influence the far larger silent majority who read posts and comments without actively responding in some way. Some of this activity reflects genuine opinion, while some is driven by inauthentic behaviour, including coordinated accounts, so-called "trolls", or the automated amplification of views, which distorts the perceived consensus on a particular issue. Over time, repeated exposure to these narratives reshapes perceptions of health care, health workers and health facilities.

The term "harmful information" is used as an umbrella term encompassing misinformation, disinformation and other content that undermines trust, acceptance or safety. It not only includes false claims and selective or misleading information about health advice, but increasingly also gives interpretations and makes insinuations that cast doubt on the legitimacy, medical neutrality, or civilian nature of health services and those who provide them.

Following violence against the health sector that erupted during the tenth Ebola response in eastern DRC in 2018, violence-monitoring efforts highlighted the central role of social media messaging in a context in which 87 health workers were killed in violent attacks and arson destroyed health centres on 50 occasions.

In 2020, Insecurity Insight began targeted social media monitoring, and has since expanded this work into systematic, long-term monitoring across multiple conflict-affected settings, including the Sahel region, Myanmar, Syria, the DRC, and Sudan.

This monitoring focuses on publicly accessible content and examines how the aid and health care sectors are discussed. It does not aim to measure public opinion or to fact-check, but to understand how visible digital narratives shape risk and national and community acceptance of health care services or contribute to undermining the protected status of these services.

Across contexts, this work has consistently highlighted four interlinked concerns directly relevant to the protection of health care:

- Social media conversations undermine trust in public health measures by questioning the intentions and credibility of health authorities and health care actors.
- Social media conversations contribute to the criminalisation of health care, particularly when services are provided to people perceived to be associated with a particular social group that is publicly defined as “the enemy” or “terrorists”.
- Social media narratives undermine respect for IHL and the special protection afforded to health care by introducing doubt that an attack affected a functioning health service, or by questioning the civilian character of health facilities and personnel by alleging the presence of weapons or fighters.
- Social media exchanges reflect growing frustration among affected communities over the international community’s failure to meet community members’ protection expectations, contributing to falling levels of trust and growing cynicism.

Social media undermines trust and the perceived protection of health care primarily by introducing doubt through questions that are gradually repeated and reframed as facts, rather than by directly articulating false claims.

The loudest voices on social media are not representative, but they set a direction and influence the silent majority who read social media posts and comments without actively responding, which over time shapes broader perceptions of what health care is and whether it deserves protection. As such, social media platforms can be used to incite violence against the health sector during periods of heightened crisis.

Declining trust in health authorities and health-related messages

Over the past decade, trust in health-related messaging has declined globally, a trend made highly visible during the COVID-19 pandemic. Social media polarised responses to public health measures, framing vaccination, movement restrictions, and outbreak control as political acts, tools of control, and symbols of inequality. In such an environment, trust in health expertise can be lost.

The COVID-19 pandemic placed an unprecedented demand on health care systems worldwide, with rising care needs stretching facilities and staff to their limits. Amid this crisis, Insecurity Insight’s monitoring of violence against the health sector recorded hundreds of incidents across 24 countries, with health workers being abused, injured, threatened, or harassed, and health facilities being attacked, damaged, or set on fire.

Front-line staff faced difficult conditions, including insufficient personal protective equipment, long working hours, psychological distress, burnout and mass traumatising. While many communities applauded and recognised their efforts, at least for a time, violence, hostility and obstruction in numerous cases further compounded the challenges associated with delivering essential health services during the pandemic.

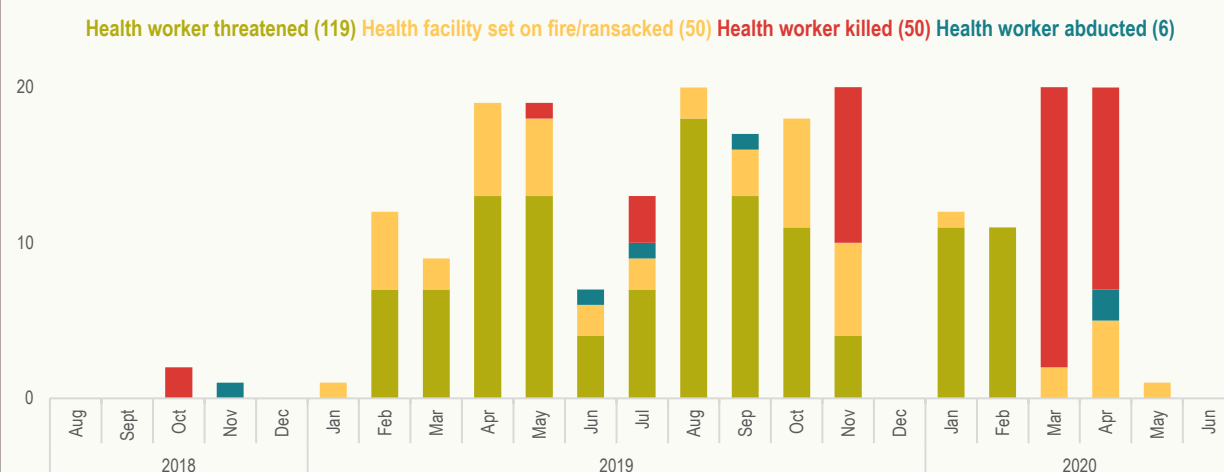
Insecurity Insight has observed similar processes in relation to disease outbreaks in conflict-affected settings. As described below, across contexts, social media conversations repeatedly question why health interventions have been introduced, who benefits from them and what hidden agendas they may serve.

Common elements include claims that outbreaks are fabricated or exaggerated, accusations that health workers are experimenting on populations, and assertions that disease control measures are designed to further some other political or commercial interests.

- **Ebola outbreak in Uganda (2022):** Social media users claimed the Ebola outbreak was fabricated or exaggerated by authorities to embezzle international funds or displace communities from gold-rich areas. The messages reframed public health measures as a form of corruption, and implemented for the purpose of land grabbing rather than disease control.³⁴
- **Mpox outbreak in the DRC and neighbouring countries (2024):** Social media conversations accused governments and international actors of using mpox vaccines for profit, experimentation or population control, with widespread vaccine mistrust and anti-foreign narratives undermining confidence in the public health response.³⁵

Figure 11: Threats and violence against Ebola response measures during the tenth Ebola outbreak, August 2018-June 2020

When severe health emergencies combine with insecurity and poorly understood narratives around real grievances, health workers can become extremely vulnerable, as occurred during the tenth Ebola outbreak in eastern DRC between 1 August 2018 and 25 June 2020.



Source: Insecurity Insight

While these narratives have in common that they assume hidden agendas, the alleged driving forces behind public health interventions often take highly context-specific forms reflecting local histories of abuse, patterns of marginalisation, conflict dynamics and political economies. With each new public health challenge, similar underlying grievances resurface and narratives are recycled in ways that build on what has become the familiar narrative. As such they offer a persuasive interpretation of a new threat. This contextualisation of narratives makes them more believable to local communities and more complex and difficult to address with standardised international approaches based on strict medical principles and protocols.

For health care providers intervening in public health responses, understanding these local variants in attitudes and grievances is essential, because they shape how health messages are received and whether health workers are trusted or resisted. Entering a particular context with health care expertise, but without an understanding of the cultural and sociopolitical environment, can be challenging, because health care responders often fail to recognise the ways in which repeated narratives have made communities hesitant, suspicious or less willing to engage with health services over time. The result can be heightened risk for health workers, who are perceived as agents of harm rather than providers of care.

Social media, the criminalisation of health care and undermining IHL protection

“Don’t support those terrorists.”

In many conflicts, health care is now treated as a political act. Health workers who treat demonstrators, conflict-injured people or stigmatised populations are portrayed as taking sides. Social media reinforces this framing, recasting humanitarian activities as political loyalty tests and labelling the provision of care as complicity and betrayal.

Insecurity Insight has examined multiple cases where violence against health care was preceded or accompanied by hostile social media commentary. Social media comment sections reveal how users interpret the available information to conclude that health workers or facilities support terrorists. Once this interpretation is established, violence is framed as justified – or even necessary.

- **Burkina Faso, Djibo (2023):**³⁶ Following jihadist attacks in Djibo, social media users accused humanitarian organisations, including MSF and the Red Cross, of colluding with terrorists after rumours claimed these organisations had prior knowledge of the attack. Comment sections framed medical and humanitarian organisations as complicit in the attacks, with calls for them to be investigated or expelled, and violence against aid actors portrayed as justified.

“But was this really a hospital?”

Over the last decade, there have been at least 9,025 attacks on health facilities worldwide. Social media has become a key space in which these attacks are retrospectively debated, reframed and justified.

The monitoring of social media reactions to hospital bombings reveals two dominant interpretations:³⁷ the first questions whether the facility was truly a hospital, suggesting it was used by armed groups, served combatants or functioned as a military base. The second expresses frustration with the international system's failure to prevent attacks, leading to cynicism about the relevance or effectiveness of IHL itself.

- **Questioning hospitals' protected status:** Following attacks on hospitals in Myanmar and Ukraine, social media users questioned whether the facilities were "real" or functional hospitals, claiming they were empty, makeshift ("fake") or being used by armed groups and therefore legitimate military targets, despite independent reporting confirming they were operational at the time of the attacks.
- **Disillusionment over lack of IHL enforcement:** Following air strikes on hospitals in Gaza and Sudan, social media comment sections expressed outrage at repeated violations and framed IHL and international institutions as ineffective or meaningless, with users arguing that condemnation and legal norms had failed to prevent attacks and therefore offered no protection.

Both interpretations undermine health care protections: the first by eroding the presumption of civilian status, the second by normalising the inevitability of violations and diminishing expectations of restraint. While the latter is an expression of disillusionment, it is also problematic if it remains unaddressed by authorities and other stakeholders who are responsible for ensuring respect for IHL and the need for accountability.

Persistent risks to health care in the age of social media

Social media has exposed health services to new risks by amplifying negative perceptions through the spread of harmful information. These dynamics are not new, but their scale, speed and reach are. While previously contained, local rumours now circulate widely, persist over time and shape perceptions far beyond their point of origin. In turn, the health and aid systems have struggled to respond. Silence, delayed clarification and institutional language leave space for hostile interpretations to take hold. Once established, these narratives are difficult to reverse.

The social media of the future is only going to expand in sophistication, reach and numbers of users. Protecting health care now requires active social media monitoring to allow for the proactive management of public perceptions and organisational reputation. Understanding how narratives form, adapting communication to contested digital spaces, and anticipating how messages will be reinterpreted are essential to health worker safety, community access to health care, and respect for IHL. Over the course of the next decade, the protection of health care will depend as much on navigating a changing information environment as it will on identifying and mitigating physical threats.

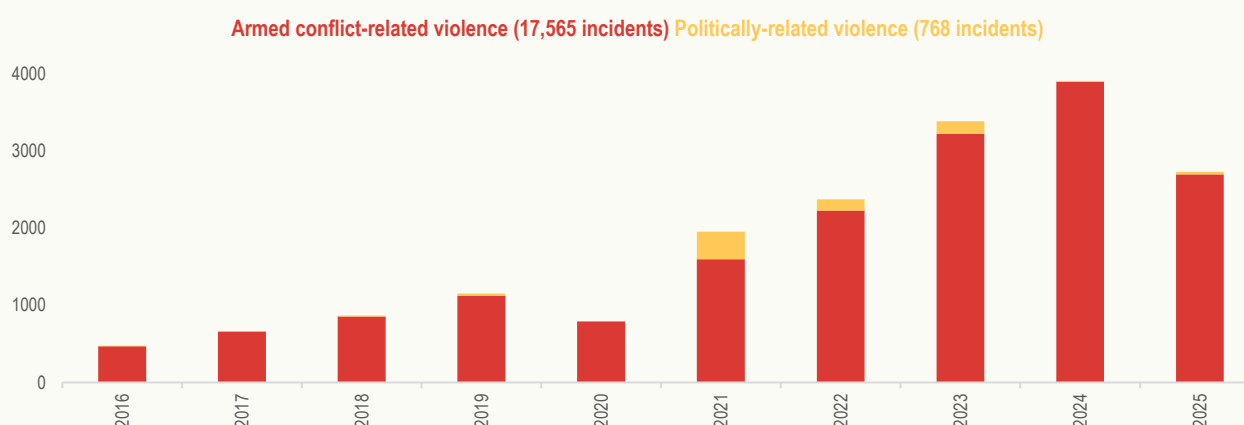
Context, means and intent: how armed actors attack health care

Number of conflict-related incidents	Number of politically-related incidents	Number of incidents affecting public health emergencies in conflict
17,565	768	997
Source: Insecurity Insight		

Violence against health care occurs not only during active armed hostilities, but also in periods of heightened political tension, instability and uncertainty, including during public health emergencies. Although the legal frameworks governing violence differ depending on whether a situation qualifies as an international armed conflict, a non-international armed conflict or another form of organised violence, the practical impact on health systems is similar. Health facilities may be damaged, access restricted, personnel threatened and services disrupted regardless of the formal legal classification of the overarching context. Moreover, all forms of violence that undermine the realisation of the right to health are in breach of human rights legal frameworks that apply in times of both peace and conflict.

The boundaries between generalised political violence and armed conflict are often fluid rather than clearly defined, and this type of violence can occur in the period preceding non-international internal armed conflict and in post-war periods. Recognising this, a pragmatic approach that classifies incidents as conflict-related when the perpetrator is part of an organised armed unit and as politically related when the perpetrator is part of state security forces such as a police unit (irrespective of the unit's legal status in a conflict) reveals important trends. Together, this analysis highlights the growing role of state actors as perpetrators of violence, underscoring the expanding involvement of state security forces in incidents that disrupt or damage health services. Armed forces and police units often work together as part of a concerted strategy where armed forces affect or target health services during battles for control of territory and police forces follow in their wake, carrying out checks and arrests at checkpoints and in health facilities after territorial control has changed hands.

Figure 12: Conflict-related violence against health care in the context of armed conflict and political violence, 2016-2025



Source: Insecurity Insight

Violence against health care in the context of public health responses in conflict-affected countries

Number of incidents affecting public health emergencies	Number of incidents affecting Ebola responses'	Number of incidents affecting COVID response	Number of incidents affecting polio vaccination campaigns
997	462	439	179
Source: Insecurity Insight			

In conflict-affected settings, public health programmes targeting specific diseases can inadvertently trigger violence against health care providers. Although such incidents are usually not directly linked to active hostilities, they are often closely connected to the broader conflict environment. High levels of distrust toward authorities, widespread insecurity and the arrival of external actors in already traumatised communities can heighten tensions.

The rollout of health interventions designed from a purely biomedical perspective and without adequate consideration of conflict-related sensitivities can generate misperceptions and suspicion. In fragile contexts, communities may interpret targeted disease responses as politically motivated, discriminatory or extractive. These perceptions can escalate into hostility toward health care workers, facilities and outreach teams.

Language and framing also matter. Terminology such as “combating diseases” may unintentionally evoke militarised narratives that resonate negatively with people already traumatised by violence. In settings where social cohesion has been eroded, even routine operational decisions such as the allocation of medical supplies, staffing or geographic targeting can become sources of contention. The distribution of resources may be viewed through the lens of conflict dynamics, especially in communities facing acute economic hardship.

Outsiders are rarely trusted in such environments. Mobile technical teams deployed to address a specific disease may be viewed with suspicion, particularly if community engagement and transparent communication are limited. In the absence of clear and consistent messaging, rumours can spread quickly and may incite threats or attacks against health services.

An Ebola treatment centre attacked in North Kivu

On Saturday, 9 March 2019, Mai-Mai militiamen attacked a recently reopened Ebola treatment centre in Butembo city, North Kivu province at around 06:00 in an apparent attempt to spread fear and chaos among local communities.³⁸ During the attack, a police officer was killed and at least one health worker was wounded. The facility had only just resumed operations after being forced to close following a previous attack the week before.

Since the adoption of UNSCR 2286, this attack is one of 458 recorded attacks or acts of violence against or threats towards Ebola response efforts during the tenth Ebola outbreak in eastern DRC between 1 August 2018 and 25 June 2020.

Violence towards COVID-19 response measures in the Philippines

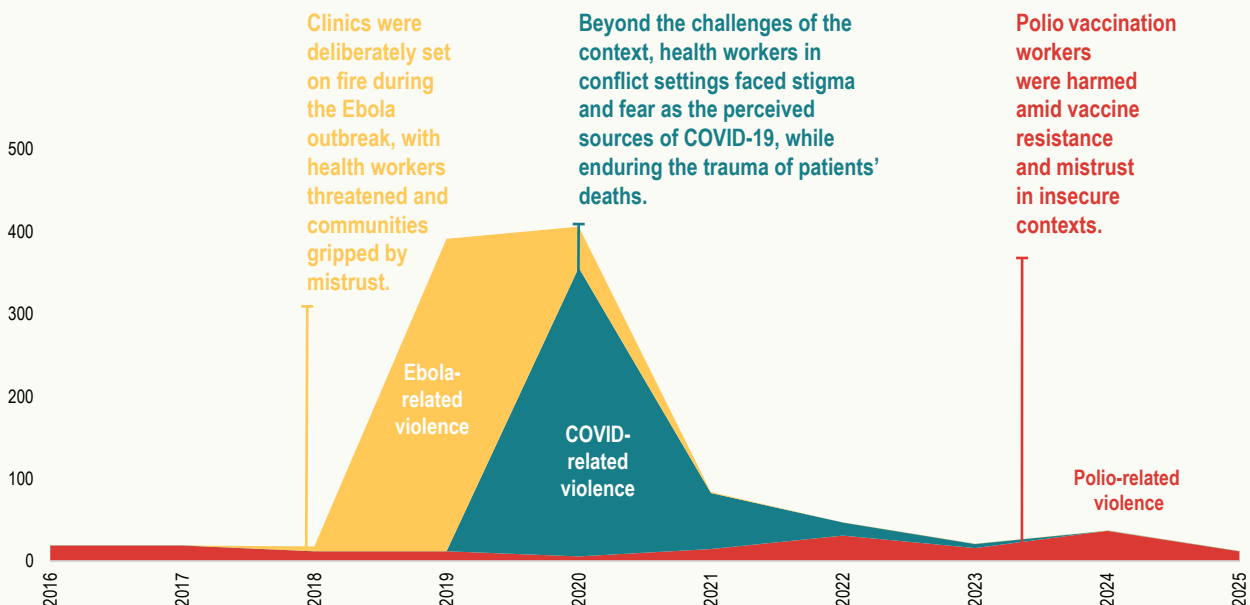
On Sunday, 22 May 2020, members of the West Papua National Liberation Army shot two health workers in Intan Jaya Regency, Papua province as they were delivering medicine for COVID-19 patients.³⁹ One of the health workers died at the scene, while the other sustained critical injuries.

Since the adoption of UNSCR 2286, this attack is one of 439 recorded attacks on or acts of violence against or threats towards COVID-19 response efforts in conflict-affected countries during the global pandemic.

For these reasons, public health responses in conflict-affected settings must be sensitive to and aware of conflict dynamics. Integrating contextual analysis, community engagement, careful communication strategies, and an awareness of local power dynamics is essential, not only to ensure programme effectiveness, but also to protect health workers and safeguard access to care.

In recent years, particularly high numbers of incidents affecting health care were recorded during the Ebola response in the DRC (2018-2020). Amid a protracted conflict, the response to a highly fatal disease unfolded in a context characterised by deep insecurity and distrust. The outbreak claimed the lives of more than 2,000 patients, and attacks during that period killed 87 health workers, while health facilities were deliberately set on fire on 50 occasions. The combination of a health emergency response and an environment shaped by ongoing violence significantly heightened risks for health personnel and infrastructure.

Figure 13: Violence against health care during public health emergencies in active conflict environments since 2016



Source: Insecurity Insight

Vaccination efforts and violence

Vaccination efforts have emerged as one of the specific, health-driven flashpoints amid wider insecurity, mistrust and the contestation of public authority. In the decade since the adoption of UNSCR 2286, 240 incidents of violence directly affecting vaccination programmes were recorded.

The impact of conflict violence on vaccination efforts (campaigns and local programmes) is a key example of how the consequences of violence against health care in conflict can trigger consequences for public health outcomes that will persist for many years, because immunity gaps are created that can fuel future outbreaks. When campaigns are suspended or access is restricted due to insecurity, children miss doses and susceptibility to vaccine-preventable diseases increases. Epidemiological evidence shows that even modest declines in vaccination coverage increase the risk of outbreaks for certain diseases. For example, measles requires around 95% immunisation coverage to maintain herd immunity, and coverage gaps have been directly linked to major outbreaks. The 2019 measles epidemic in the DRC (over 340,000 cases and more than 6,000 deaths)⁴⁰ and the 2019 Madagascar outbreak (over 100,000 cases and more than 1,200 deaths) were preceded by insufficient immunisation coverage.⁴¹ Similarly, in polio-endemic settings, insecurity-driven interruptions to the provision of vaccinations have delayed eradication efforts and increased the risk of transmission.⁴²

A large share of recorded incidents of violence affecting vaccination campaigns involved direct attacks on vaccinators, their security escorts, and health workers during door-to-door or other campaign activities, and included shootings, ambushes, and the killing of police officers assigned to protect teams; the harassment of and physical assaults on vaccinators; and occasional abductions while teams were travelling to remote areas.

A second common theme is community resistance that escalates to violence, including large groups of people damaging vaccine supplies, confronting vaccination teams at schools or community sites, or forcing programme suspensions, often driven by rumours about or accusations against health workers.

A third theme is that violence occurs at or near vaccination sites, with staff being assaulted over disputes about eligibility, paperwork, vaccine side effects, or vaccine handling, and cases where wider political violence spilled into health spaces.

Polio vaccinators attacked by community members in Pakistan

On Monday, 3 November 2025, a polio vaccination team in the Misri Shah area of Lahore, Punjab province was attacked by a group of 20-25 people at a local school.⁴³ The assault injured a health worker and destroyed vaccine doses. The incident reportedly began as a dispute between the team and children's mothers, escalating when others joined, and highlighting how health workers are increasingly exposed to threats while carrying out essential immunisation activities. Police arrested seven individuals in connection with the attack. The Pakistani minister for health and population condemned the assault, emphasising that health workers continue to perform their duties despite extreme weather and challenging conditions.

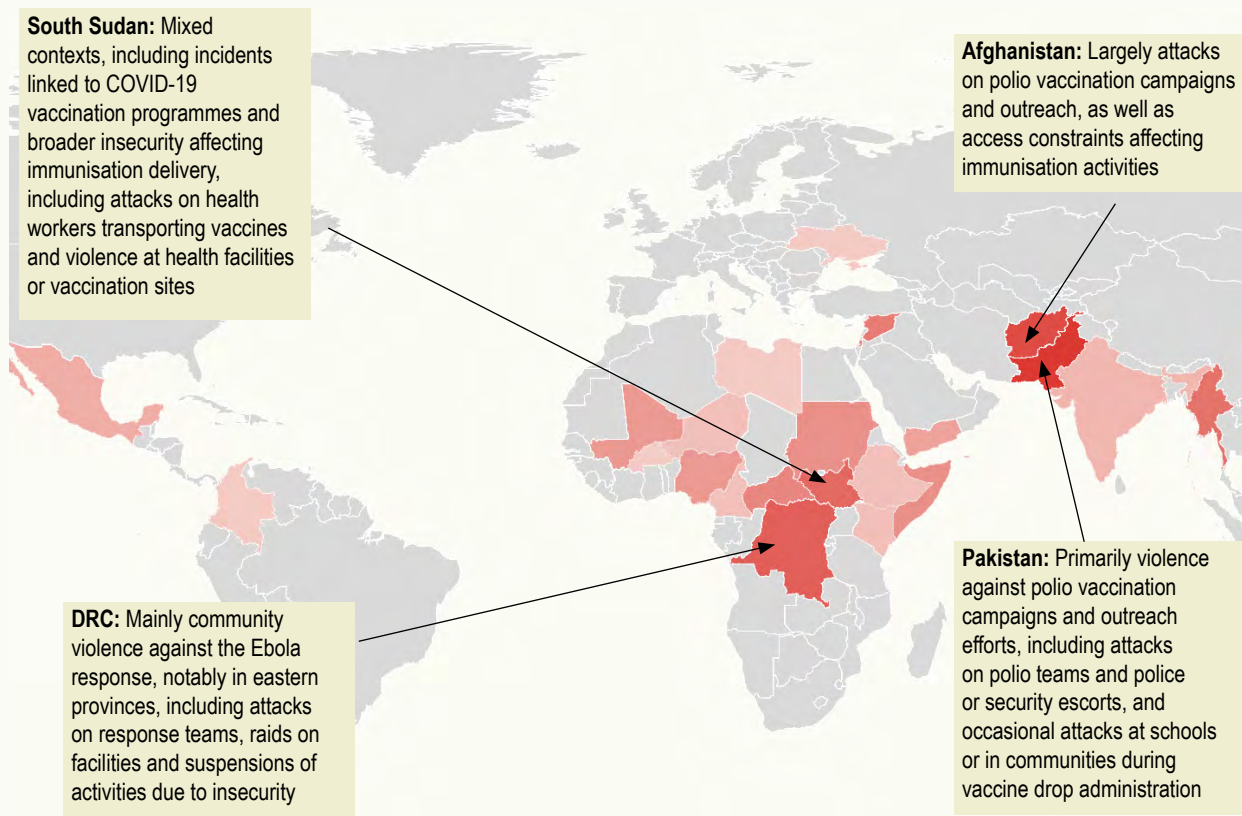
This attack is one of 179 attacks or acts of violence or threats affecting vaccination campaigns recorded since the adoption of UNSCR 2286.

Reported vaccination-related violence has been concentrated in a small number of settings and is closely tied to how vaccines are delivered. Incidents of violence against vaccination efforts rose in the first years after the adoption of UNSCR 2286; decreased in 2020, when COVID-19 disrupted routine health programmes; and increased in 2021 and 2022, as opposition to COVID-19 vaccinations triggered many incidents. Throughout the ten-year period covered in this report, polio campaigns – particularly in Afghanistan and Pakistan – were the most commonly affected type of vaccination campaign.

As mentioned, more than half of all reported violence occurred during vaccination programmes and outreach campaign activities, highlighting the heightened vulnerability of mobile teams and temporary sites, and the risks teams face during road travel. Around a quarter of violent incidents were reported to have occurred in health centres, while another quarter covered a range of threats, disruptions and other impacts. Attacks on fixed vaccination sites rather than mobile teams were particularly common during the COVID-19 vaccination drive.

Map 2: Attacks against vaccination response efforts, 2016-2025

Vaccinators face high risks, particularly during campaign and outreach activities, with the greatest concentration in Afghanistan and Pakistan, where most incidents were linked to polio vaccination campaigns. In the DRC, India, and South Sudan, violence and disruptions affected polio, Ebola, and COVID-19 vaccination programmes through site-based attacks, community tensions, and broader insecurity.



Source: Insecurity Insight

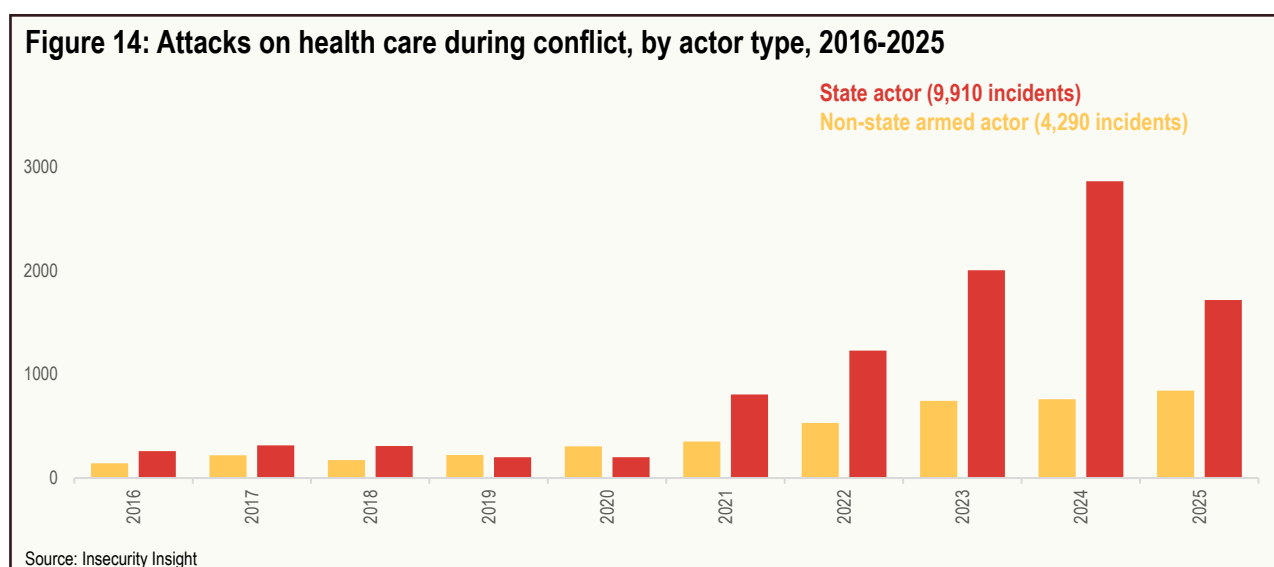
Violence against health care by state and non-state actors

Number of incidents attributed to state actors	Number of incidents attributed to non-state actors	Number of incidents where the perpetrator was unidentified
9,910	4,290	3,365
Source: Insecurity Insight		

At the time of the adoption of UNSCR 2286 and in the years immediately following (2016-2018), state actors were the primary identified perpetrators of conflict-related incidents adversely affecting health care, accounting for approximately 60-70% of attributed incidents annually.

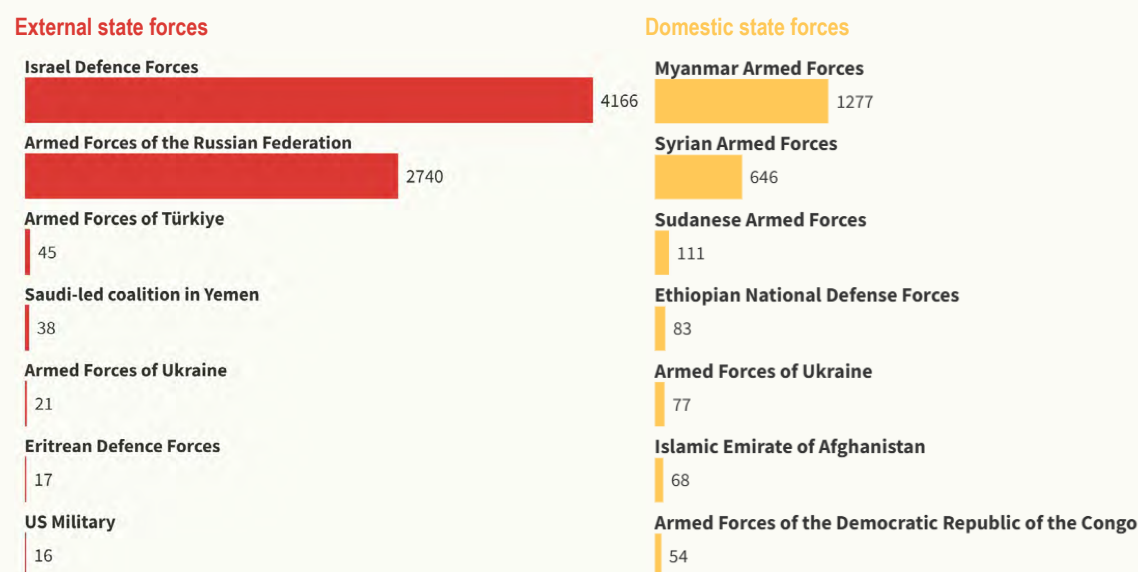
Between 2019 and 2020, this pattern shifted, with non-state actors representing the greatest proportion of primary perpetrators. During this period, more than 60% of incidents with identified perpetrators were attributed to non-state armed groups, marking a temporary shift in the threat landscape affecting health service providers.

However, from 2021 onwards, this trend reversed sharply. The period 2021-2025 saw a clear resurgence of state-driven violence, with a substantial increase in incidents attributed to state actors. These incidents peaked in 2024 (when they accounted for roughly 70-79% of identified incidents) and remained high in 2025. As such, 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 forces have adversely affected health care both within their own territory and through military operations beyond their national borders. Violence by state actors against health care inside their own countries rose sharply in 2021, marking a significant escalation in internal-conflict-related incidents that has been sustained as a result of the actions of armed forces in Myanmar, Syria and Sudan, which account for the highest number of reported incidents. This violence was enacted through a combination of air strikes, arrests and hospital raids.

Figure 15: External and domestic attacks on health care by state armed forces, 2016-2025



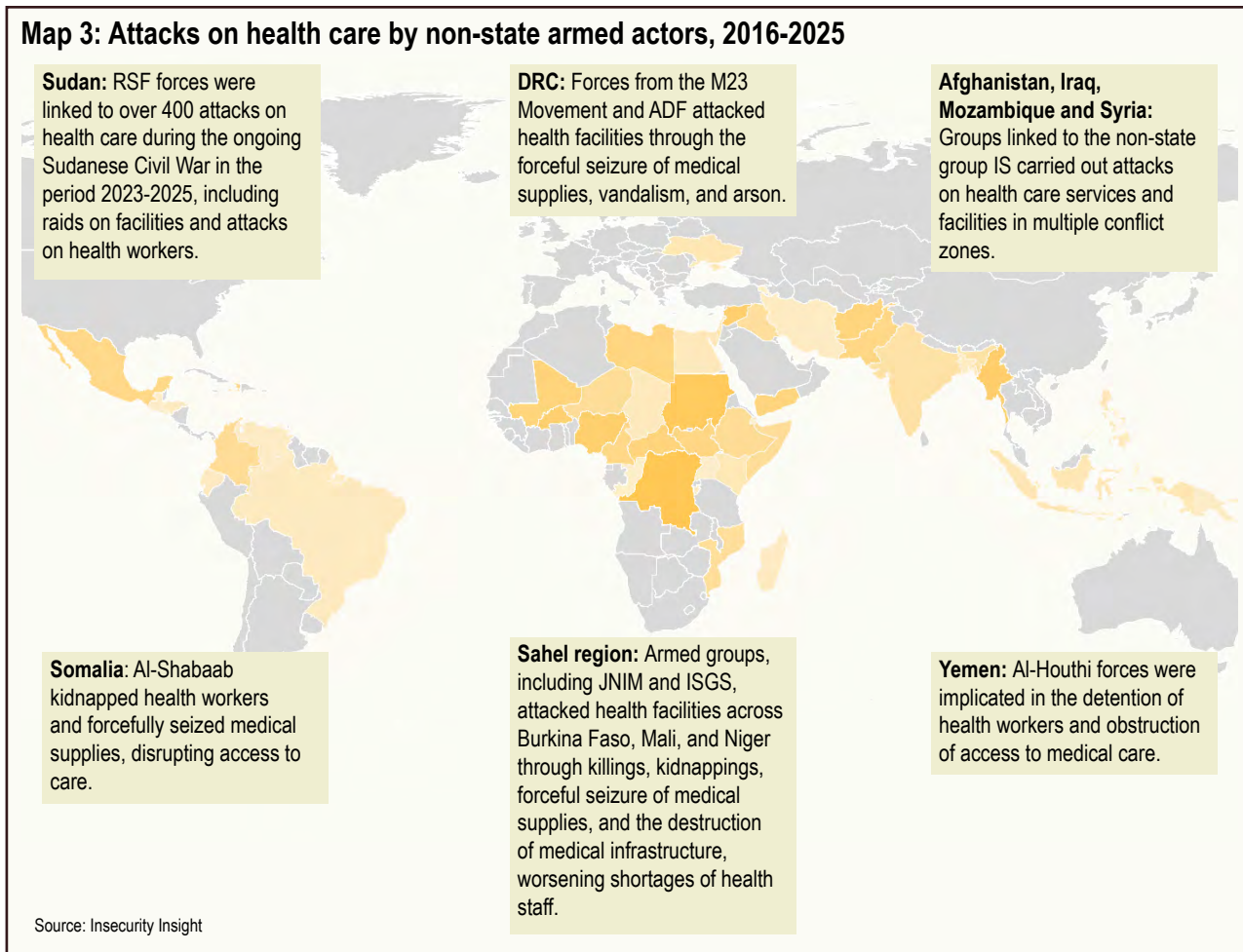
Note: State armed forces are identified using their official names, in accordance with Insecurity Insight's naming conventions.
Source: Insecurity Insight

Since 2022, the number of attacks on health care attributed to state forces intervening outside their own territory increased, with remote air strikes implicated in the greatest proportion of attacks (40% of all incidents attributed to states forces between 2022 and 2025). While the highest overall number of attacks were attributed to the IDF and the Armed Forces of the Russian Federation, seven state armed forces carried out air strikes on health facilities outside their territory: alongside the two states just mentioned, the Armed Forces of Türkiye (45 incidents, primarily in Syria, and in Libya and Iraq), the Saudi-led coalition in Yemen (38 incidents), the Armed Forces of Ukraine (21 incidents), the Eritrean Defence Forces, and the US military.

Since the adoption of the resolution, violence by non-state armed actors against health care has increased steadily, rising from approximately 142 reported incidents in 2016 to more than 800 in 2025. Most incidents occurred in protracted conflicts in fragile states, contributing to the systematic erosion of already-fragile health systems and restricting civilians' access to life-saving care.

In Sudan, RSF fighters were responsible for the highest number of reported attacks by a non-state armed actor on health care, with over 400 recorded cases linked to the group following the April 2023 outbreak of the civil war between the RSF and SAF. Health facilities were repeatedly raided and occupied, and health workers killed, injured or forcibly detained.

Various armed groups have carried out raids on health centres and abductions of health workers, and have forcibly taken medical supplies and facilities, often to care for their own members. Other non-state armed groups, notably Jama'at Nasr al-Islam wal-Muslimin (JNIM) and Islamic State of the Greater Sahara (ISGS), repeatedly attacked health care across Burkina Faso, Mali, and Niger, including through the killing and kidnapping of health workers and the destruction and forceful taking of health infrastructure. This contributed to severe shortages of medical personnel in affected areas. Groups linked to the non-state group Islamic State attacked health care in Afghanistan, Iraq, Mozambique and Syria. In Yemen, Shia al-Houthi rebels were implicated in attacks involving the detention of health workers and interference with access to care, while in the DRC, the March 23 Movement and ADF carried out attacks that included forceful taking of medical supplies, vandalism, and the setting on fire of health facilities. In Somalia, al-Shabaab kidnapped health workers and forceful taking of medical supplies.



Means and intent of armed actors during conflict: weapons, tactics, and motives

	State actors	Non-state armed actors
Incidents where air-delivered explosives were used	2,619	93
Incidents where ground-delivered explosives were used	1,346	207
Incidents where directly-placed explosives were used	40	121
Incidents where firearms were used to kill/injure	587	874
Incidents where arson was used	88	304

Source: Insecurity Insight

Both state and non-state armed actors are linked to lethal and life-altering attacks on health care, including the killing and injury of health workers and the severe disruption of health care delivery. However, the modalities of violence differ. A detailed examination of the weapons types used in violence against health care provides important insights into the wider context and enabling environments that contribute to such violence. State actors frequently combine kinetic military force with bureaucratic and security-service measures, such as raids, arrests, detentions, and access restrictions, reflecting both their coercive authority and institutional reach. Non-state actors, by contrast, more commonly employ armed group tactics, including abductions, intimidation, targeted attacks linked to territorial control, and predatory or criminal violence. These differences are also reflected in their respective access to and deployment of weapons systems, with state actors generally possessing heavier weapons and those with more technologically advanced capabilities.

Weapons used in violence against health care

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. State actors generally have access to more complex weapons systems, integrated targeting infrastructure and better logistics. These systems should increase their capacity to target, and thus minimise, collateral harm, if they are employed in accordance with IHL.⁴⁴

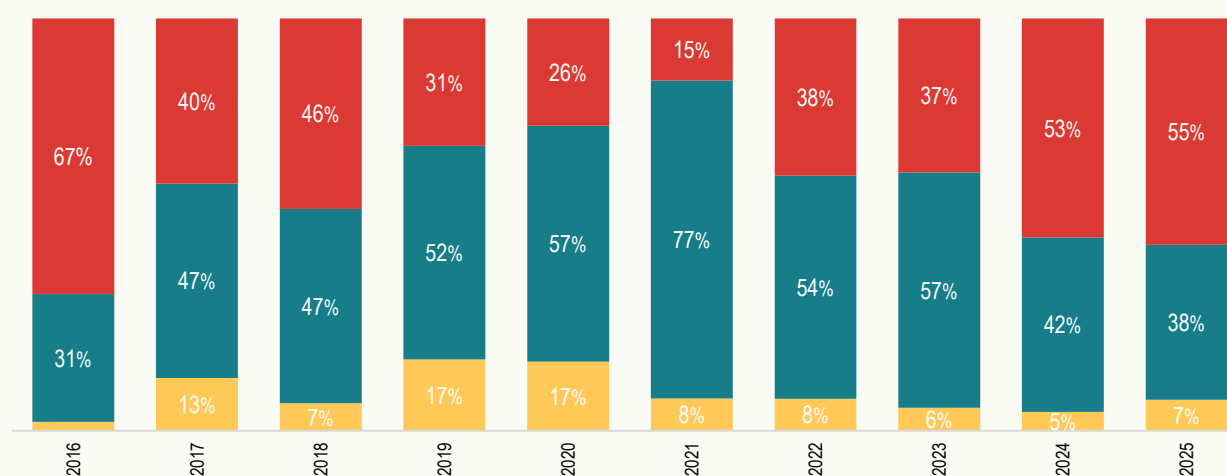
Different weapons systems and the logistical infrastructure that supports them provide actors with varying capacities to either cause or prevent harm. Explosive weapons in particular are often considered inherently indiscriminate (particularly when used in populated areas) due to their wide-area effects, which cannot reliably distinguish between military targets and civilians or civilian objects. These effects can cause extensive damage to health infrastructure that is typically not possible with firearms.

Figure 16: Attacks on health care, by weapon type, 2016-2025

Incident where explosive weapons were used (6,374)

Incident where firearms were used (7,639)

Incident where other weapon types were used (1,098)



Source: Insecurity Insight

Firearms

Overall, firearms are the most commonly used weapon type in violent incidents that affect health care. Their use was highest in 2021, reflecting the high proportion of political violence at the time. Firearms are used during arrests, kidnappings, at checkpoints and in armed entries. They affect health care in the way in which they represent and enable force, even when they are not directly implicated in lethal violence.

The use of firearms places a high degree of responsibility for compliance with IHL on the individual user or the commander of a unit, because their effects are more directly controllable and their lawful use depends heavily on real-time decisions regarding target selection, the principles of proportionality and precautions that should govern military attacks,⁴⁵ or compliance with internal policy guidance.

A shoot-out at a hospital in Yemen

On Friday, 7 July 2023, the emergency department of Sayun General Hospital in the 22 May neighbourhood, Sayun district, Hadramout governorate, was attacked by an armed group of approximately five individuals from the 1st Military Region at around 17:00. Dressed in civilian clothes and carrying Kalashnikov rifles and pistols, the group verbally assaulted medical staff, brandished weapons, and threatened civilians inside and around the emergency department while attempting to remove one of their injured members from the hospital, who was accused of shooting civilians earlier that day.

Around 18:00, a second attack was carried out by approximately 15 soldiers from the Military Police Brigade of the 1st Military Region. Armed and riding in two military vehicles, they forcibly entered the hospital's emergency department and removed the same injured individual and members of the armed group involved in the first attack. The incidents caused panic among medical staff, patients, patient escorts, and visitors, severely disrupting hospital operations and threatening the safety of health care personnel and civilians.

This attack is one of 7,639 attacks where firearms affected health care recorded since the adoption of UNSCR 2286.

Notably, firearms – most often pistols rather than machine guns – are the principal means by which police apply force or compel compliance through the threat of force.

Explosive weapons

In percentage terms, explosive weapons account for a growing share of the impact of violence on health care systems since 2022, overtaking firearms as the most frequently used weapon type. However, their use is not new. In 2016, the 303 reported incidents involving explosive weapons already accounted for over 60% of all reported incidents. In 2024, over 1,900 incidents involving explosive weapons represented 49% of total recorded incidents for that year, highlighting both an increase in the proportion of explosive weapons attacks and an increase in the absolute number of attacks. Arson and similar attacks continue to be used, but they are proportionately rare in relation to the scale of the use of military weapons systems.

The increasing use of explosive weapons to cause the large-scale destruction of physical health infrastructure such as hospitals offers a partial explanation for the growing public awareness of attacks on health care. The large-scale damage to infrastructure, affecting laboratories, pharmacies, and access routes, has also contributed to the growing impact of conflict violence on access to quality health care.

The availability and choice of weapons systems also reflect operational contexts, tactics, means, and intentions, and can provide broad indications – particularly in the absence of explicit statements of intent – regarding the nature of military objectives and patterns of conduct. For instance, armed forces and state actors attacking health care outside their own territory or in opposition-held areas increasingly used explosive weapons delivered by air strikes or long-range ground-launched munitions, whereas police forces tended to rely primarily on firearms.

Non-state actors' use of explosive weapons also increased year on year from 2016 to 2025, with reported incidents nearly doubling between 2022 and 2023. While many non-state actors continued to rely primarily on directly placed explosives, such as IEDs, a growing number have acquired and used more advanced systems, including ground-launched weapons and drones.

A hospital damaged in a car bombing attack in Syria

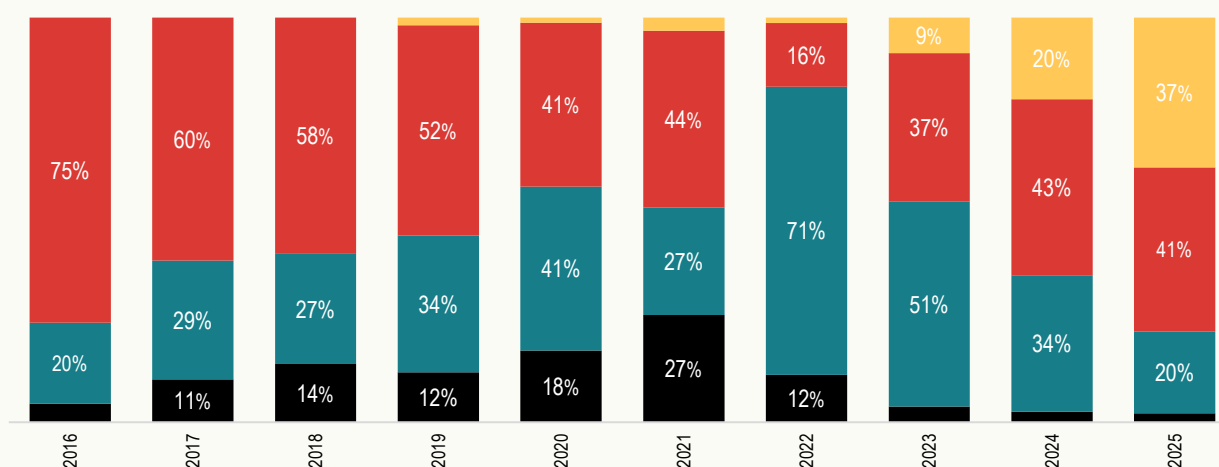
On Saturday, 24 March 2018, the specialised clinic wing of Idlib Central Hospital in Idlib city, Idlib governorate, a facility supported by an INGO, was destroyed by a car bomb of unidentified origin.⁴⁷ The blast heavily damaged the building and medical equipment, temporarily putting the clinic out of commission. The vehicle was parked in front of a military centre of the non-state group Hay'at Tahrir al-Sham, which controlled the city at the time.

This attack is one of 328 recorded attacks where directly emplaced explosive weapons affected health care since the adoption of UNSCR 2286.

Explosive weapons include a range of munitions of large to small payloads that can be delivered from the air or ground, or directly emplaced. Some explosive devices are closely associated with certain actors. For example, non-state actors tend to use IEDs, while state actors with large defence budgets can afford expensive munitions that need costly delivery systems, such as aircraft and even aircraft carriers, to be deployed. Purchasing power and sources of international financial support influence the systems that states can access. Ground-launched munitions can also be used by non-state actors, particularly when they have been taken from state arsenals during raids.

Figure 17: Attacks on health care where explosives were used, by delivery type, 2016-2025

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

A mortar attack on a hospital in Iraq

In April 2017, a row of ambulances parked in front of a health centre in Mosul district, Nineveh governorate was damaged when mortars fired by International Coalition Forces in Syria struck the facility, shattering its windows.⁴⁸ A guard at the front gate was critically injured and transported to hospital, where he survived. Following the attack, nurses evacuated the centre, disrupting medical operations and emergency responses.

This attack is one of 1,912 recorded attacks where ground-launched explosives affected health care since the adoption of UNSCR 2286.

A drone strike on a health centre in Ethiopia

Around midday on Friday, 11 October 2024, a drone strike carried out by the Ethiopian National Defense Force struck the Mehal Genet Health Centre in South Mecha woreda, North Gojjam Zone, Amhara.⁴⁹ The attack destroyed the health centre's pharmacy and killed eight people, including a pharmacist and a nine-year-old child, and injured at least 12 others.

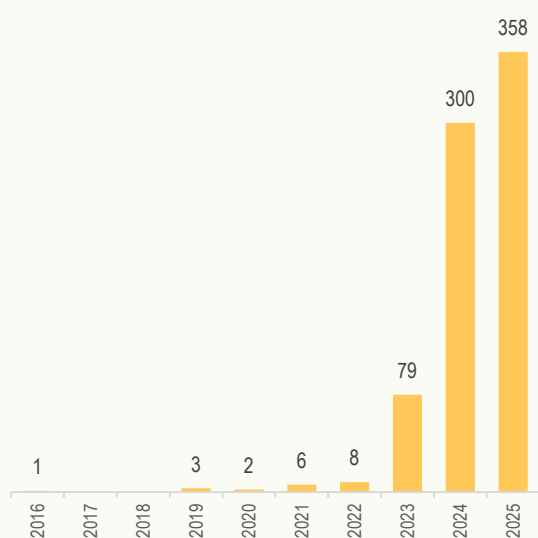
This attack is one of 757 armed drone strikes affecting health care recorded since the adoption of UNSCR 2286.

Over time, the proportion of directly emplaced explosives has fallen, along with a decrease in the proportion (but not the total number) of incidents attributed to non-state actors. Proportionally, the use of ground-launched explosives was highest during the ongoing Russian invasion of Ukraine, during which ground-launched weapons systems were widely used.

Throughout the last decade, air strikes were traditionally delivered almost exclusively by manned aircraft and were almost exclusively associated with state forces. However, since 2019, the growing use of drones to deliver explosive munitions has reduced the operational costs of conducting air strikes for state actors and has also enabled a growing number of non-state actors to expand their means of attack to include aerial forms of delivery, owing to the significantly lower cost and accessibility of these systems.

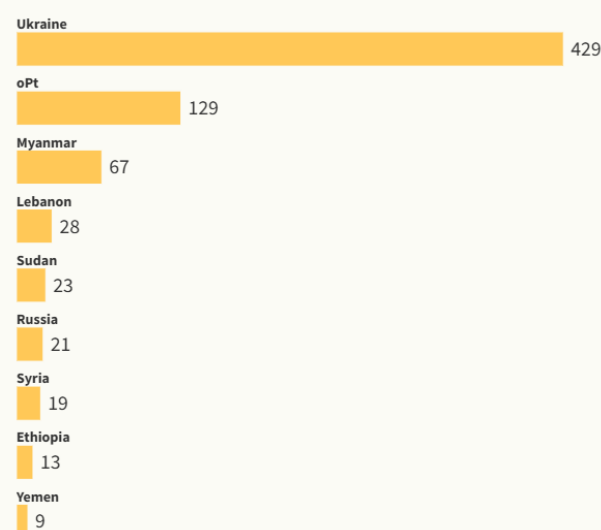
The use of remotely delivered explosive weapons engages command-and-control responsibilities under IHL at an earlier and more systemic stage, because compliance with the principles of distinction, proportionality, and precautions is largely determined through planning, authorisation, and targeting processes within the military chain of command.

Figure 18: Attacks on health care in which drone-delivered explosives were used, 2016-2025



Source: Insecurity Insight

Figure 19: Countries/territories where a high number of reported incidents involved drone-delivered explosives impacting health care, 2016-2025



Source: Insecurity Insight

As with firearms, directly emplaced explosives, including IEDs, concentrate responsibility under IHL on the individual users or small-unit commanders, because their deployment, concealment, and detonation are typically decided and executed at the point of use, with limited separation between planning and action.

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. While rules of engagement (RoE) should explicitly incorporate the objective of protecting health care, the practical means of achieving this in combat situations must be embedded in armed forces' standard operating procedures (SOPs). These procedures will necessarily vary depending on whether the weapons involved are firearms or remotely delivered munitions, and must be adapted to the specific decision-making structures and operational constraints associated with each system.

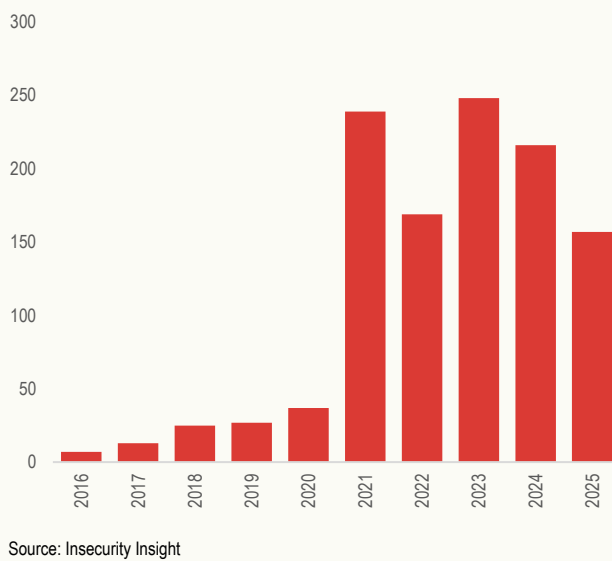
In this context, generic or simplistic calls for “respect for IHL” are insufficient, because they do not adequately equip individual weapons bearers or commanders with the practical tools required to ensure compliance. Effective implementation depends not only on the moment that a weapon is deployed, but also on how targeting decisions, authorisation processes, and contextual judgements are distributed across the various levels of military and organisational hierarchies.

The criminalisation of health care in conflict settings⁵⁰

The decade since the adoption of UNSCR 2286 has not only been marked by continued physical attacks on health care, but also by a growing trend towards the criminalisation of the provision of health services in some conflict settings. Criminalisation refers to the use of laws, regulations, and security measures to penalise, restrict, or prosecute cases involving the delivery of impartial medical care in line with medical ethics, or cases involving people seeking health care (for example, people in conflict with the law). It reflects a shift in tactics: rather than solely attacking health facilities or personnel through violence, conflict parties increasingly use legal and administrative tools – including arrests and detentions – to suppress health care delivery.

Legal and administrative measures are often under-reported, and arrests themselves are likely significantly undercounted. Nonetheless, the available data shows a clear and concerning pattern.

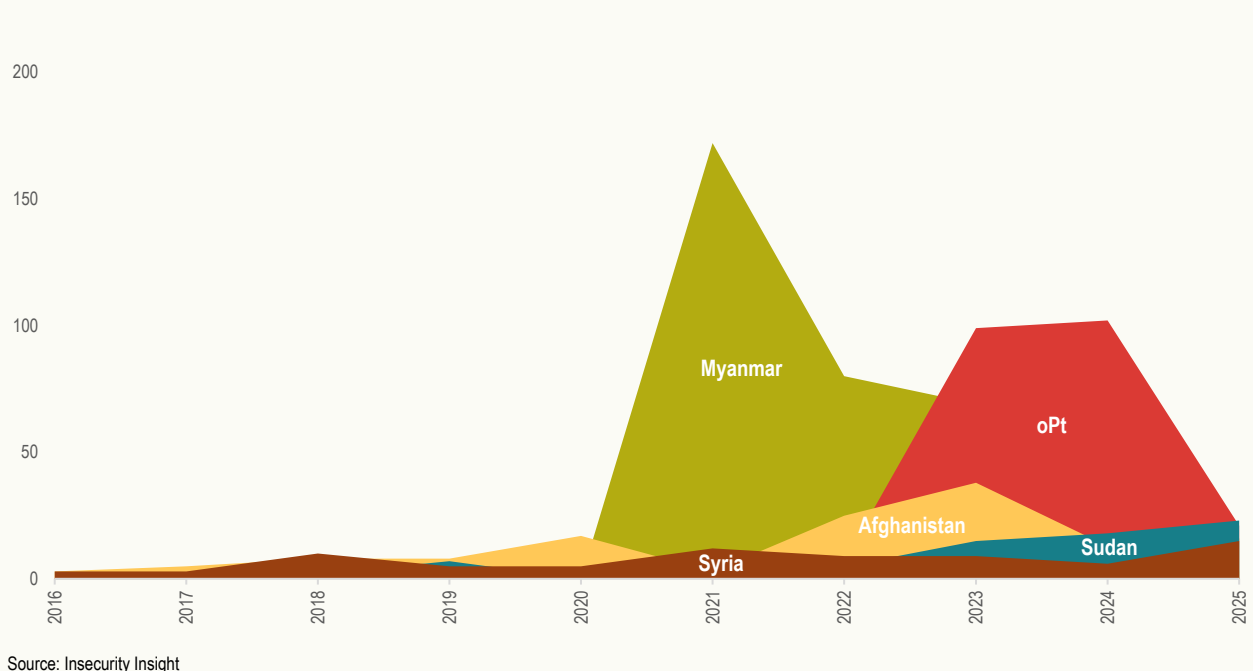
Most health worker arrests are reported to have been carried out by state security actors, inclusive of the military, intelligence and police forces. Arrests of health workers increased sharply after 2020, marking a fundamental shift in the risk environment. Between 2016 and 2020, reported incidents remained comparatively low (between seven and 34 reported incidents per year). From 2021 onwards, annual incidents rose dramatically (239 reported incidents in 2021; 247 in 2023), with 2021 representing a peak both in the number of incidents and in the total number of health workers detained. Importantly, elevated levels persisted through 2023 and 2024, indicating that the 2021 increase was not a temporary spike, but the emergence of a sustained pattern of criminalisation.

Figure 20: Health worker arrests, 2016-2025

The increase in health worker arrests parallels an increase in arrests of aid workers during the same period,⁵¹ suggesting that the targeting of health care forms part of a wider crackdown on the delivery of impartial assistance in conflict settings. In this sense, criminalisation is not an isolated phenomenon affecting individual professionals, but reflects broader efforts to restrict access to services and limit the support available to conflict-affected populations.

Globally, the upward trend is driven primarily by a small number of highly affected contexts. Myanmar accounts for the largest number of recorded incidents and arrests over the course of the last

decade, particularly following the February 2021 military coup, when health workers were detained in connection with protests, civil disobedience activities, and broader security crackdowns. One mass series of arrests in Yangon in February 2021 alone involved more than 200 health workers. In 2023 and 2024, the oPt (and particularly Gaza) became the primary location of high arrest figures, including several large-scale detentions by the IDF. In 2021, health worker arrests increased in Afghanistan following the Taliban takeover. In 2025, Sudan emerged as a country in which health worker arrests were occurring, reflecting shifting conflict dynamics and demonstrating how national crises can shape global trends in available data.

Figure 21: Five contexts where high numbers of health worker arrests were reported, 2016-2025

Arrests often occur during raids on health facilities, at checkpoints or as part of broader security operations. Detentions at health workers' homes are also common, particularly in contexts characterised by political repression or counterinsurgency campaigns. Health facilities remain one of the most frequently recorded locations of arrests, underscoring the erosion of their protected status.

The people detained are overwhelmingly national health workers, and international health workers account for a comparatively small share (1% of 2,575 recorded arrests). Gender data remains incomplete, but where reported, men are more frequently recorded among those arrested. However, significant reporting gaps limit the ability to draw firm conclusions regarding the gender-specific dimensions of health worker arrests.

Overall, the data indicates that since 2021, arrests have become an increasingly normalised feature in conflict settings. The criminalisation of health care represents a profound challenge to the principles of medical neutrality and impartiality. By treating the provision of care – or the act of seeking care – as grounds for detention, authorities transform health care from a protected function into a perceived security threat. The growing changes in narratives discussed earlier harden perceptions and justifications for criminalisation. This trend places individual health workers at risk and undermines access to life-saving services for entire communities. If sustained, the criminalisation of health care risks entrenching a new and dangerous precedent in conflict settings – one in which providing medical care is no longer protected, but perceived as punishable.



The decade since the adoption of UNSCR 2286 has been marked not only by a growing trend of criminalisation of the provision of health services, but also by an increasingly open disregard for the laws of war that were designed to protect health care during armed conflict. This overt disdain for legal norms by parties seeking to prevail militarily has contributed to a significant rise in attacks on health care. Russia, for example, no longer attempts to conceal its targeting of hospitals (as well as Ukraine's power grid, residential buildings, schools, and shopping centres) through sustained missile, artillery, and drone strikes. In Sudan, the parties to the conflict – the RSF and SAF – operate as though they are unconstrained by law, collectively carrying out an average of two to three attacks on health care each day. Similar patterns are particularly evident in Myanmar and the DRC, but can be seen in conflicts worldwide.

UNSCR 2286 admonishes states to comply with the requirements of international law, incorporate these requirements into domestic law, and hold their own armed forces to account. They have largely not done so. A more insidious trend has also emerged: some states that purport to embrace and abide by IHL have instead read it selectively or twisted it to allow assaults on civilians and health care. As the ICRC puts it, “overly permissive interpretations of the law” are “thwarting its purpose”.⁵² These states have reinterpreted the law to expand the definition of military objects subject to attack while seeking to narrow the meaning and scope of key IHL obligations, including the implementation of the principles of precautions and proportionality during attacks, a stance that gives them more “leeway to kill”.

This trend has been especially evident in Gaza, where Israel has sought to limit the scope of the obligations of proportionality and precautions during attacks.⁵³ Equally disturbing, it has justified hundreds of attacks on health care facilities and transports on the grounds that, under IHL, they lose their protection and immunity from attack when, outside their humanitarian function, they have allegedly committed “acts harmful to the enemy”.⁵⁴ Israel's approach threatens the protection of hospitals and the wounded in armed conflicts everywhere, because it interprets this rule to suit its own intentions and uses this entirely self-serving interpretation of IHL to justify attacks on health care.

The proliferation of claims of the military use of hospitals

In past wars this century, only occasional reports appeared that parties to conflicts took over a hospital or clinic to house fighters or fire at an enemy from it. Of the over 18,000 recorded incidents, 493 contained credible information of military occupation and 112 included information that a hospital or ambulance was used to launch an attack. Yet in recent years, public claims have proliferated, although most were correctly dismissed as disinformation. For example, in 2019 the Assad regime in Syria told the UN Security Council⁵⁵ that terrorist groups had turned five hospitals and 114 health care centres in the city of Idlib into military posts, arms depots, and launching pads for rockets, and had converted 33 ambulances into car bombs. These claims were thoroughly debunked by Mark Lowcock,⁵⁶ the UN's Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator at the Security Council. Similarly, during the siege of the Ukrainian city of Mariupol in 2022, Russia told the UN that it attacked a maternity hospital because it was being used as a Ukrainian military base. An independent investigation, including the use of satellite imagery, found no evidence of this.⁵⁷

In a series of short wars in Gaza between Israel and Hamas starting in 2009, Israel made numerous assertions that Hamas used hospitals and ambulances for military purposes. Most of these claims were not independently confirmed, but in one case human rights investigators found that a hospital was used as an interrogation centre.⁵⁸ However, during the Gaza war that began in October 2023, Israel repeatedly made such claims and launched a public-facing website⁵⁹ purporting to show evidence supporting them. It cited these uses to justify launching hundreds of attacks on hospitals,⁶⁰ with the result that all but two of Gaza's 36 hospitals were damaged in the fighting.⁶¹

There is evidence that parts of Hamas's tunnel network in Gaza were under or near hospitals, although their existence is not necessarily evidence of the hospitals' use as command centres or for other military purposes. Moreover, Israel's claims of Hamas's military use of hospitals were often based on scant evidence. In December 2024, a lead ICC investigator said it was difficult to assess the truth of claims that Hamas used hospitals for military purposes, but noted that reports alleging this appeared to be exaggerated.⁶² In response to a 2024 draft report by the UN Office of the High Commissioner for Human Rights (OHCHR), Israel cited the military use of six hospitals, but the OHCHR found the allegations to be insufficient and that they were sometimes contradicted by other evidence,⁶³ including by other IDF statements. Foreign medical volunteers interviewed by the media said they saw no evidence of military use in the clinical areas where they worked.

The OHCHR report examined one of the most prominent claims, involving the al-Shifa medical complex, in detail. Israel alleged that Hamas operated a command centre and held hostages in the complex, and used its ambulances to transport weapons. The horrors of the IDF assault on the hospital gained widespread international attention and was the subject of 27 Israeli media releases, including animations, infographics, and information the IDF said it obtained from interrogations and other intelligence sources. However, the OHCHR review noted that the evidence released was not sufficient to permit the independent verification of the IDF claims and in some respects was inconsistent with its claims. A Washington Post investigation also concluded that Israel failed to show evidence of Hamas's use of al-Shifa Hospital as a command centre or that its tunnels were connected to the hospital's five buildings.⁶⁴

In some other cases, Israel's claims were easily disproven. In one case, the IDF alleged that Hamas was using a camera on a fourth-floor balcony of Nasser Hospital to observe Israeli troops. An independent investigation⁶⁵ showed that in fact the camera was used by journalists, but an Israeli tank fired high explosive shells at it, killing a Reuters journalist. After this initial strike, medical and emergency workers came to the scene to treat the injured. Israeli tanks fired again, this time at the rescuers, killing another 21 people, including health workers and other journalists. In another case, Israel attacked a hospital, alleging that a Hamas leader conducted terrorist operations from it. In fact, the Hamas official was admitted just a few hours before for medical treatment,⁶⁶ and because he was not involved in combat, under IHL was both entitled to care and immune from attack.

Legal safeguards for hospitals and ambulances when military use is alleged

The laws of war clearly stipulate that hospitals and ambulances may be used to transport or treat wounded combatants, but should never be used to conduct military activities. However, even if we assume that Hamas did use hospitals in Gaza for military purposes, IHL imposes obligations on conflict parties to respect and protect patients and clinicians in these hospitals, because they retain their immunity from attack. Similarly, legal safeguards exist to preserve hospital functioning. Firstly, the attacker must issue a warning⁶⁷ uniquely applicable to health facilities demanding that the military use of a hospital ceases, and must provide a reasonable time for a response in appropriate cases. The warning can also enable hospital administrators to reply to the accusation and plan for the safe evacuation of the wounded and sick. Only if the alleged misuser does not respond and discontinue military activities can an attack be launched.

Secondly, the attacker must also determine that the hospital has become a military object, defined as one that, by its “nature, location, purpose or use make[s] an effective contribution to military action and whose partial or total destruction, capture or neutralization, in the circumstances ruling at the time, offers a definite military advantage”.⁶⁸ Thus, military uses of health care facilities that are too minor or temporary to create such an advantage cannot justify a violent response.

Thirdly, as in any attack in war affecting civilians, “constant care” must be taken to spare them and civilian objects during an attack.⁶⁹ The attacking forces must take “all feasible precautions in the choice of means and methods of attack, with a view to avoiding, and in any event, minimizing incidental loss of civilian life, injury to civilians and damage to civilian objects”. The ICRC has issued practical guidance to enable military forces to abide by this requirement where the use of force is contemplated against health care facilities.⁷⁰ It includes coordinating with administrators and clinicians to minimise disruption; setting specific rules for the use of force; requiring high-level authorisation for an attack; limiting the kinds of weapons employed; and establishing rules and protocols for ensuring continuity of care for and the safety of the wounded and sick, and, if necessary, safely evacuating them.

The other precaution is to refrain from an attack (and if launched, suspend it) if it is disproportionate; that is, if it may be expected to “cause incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated”. Under IHL, an attack must be cancelled or suspended if it becomes apparent before or during an assault that the expected civilian harm outweighs the anticipated military advantage.⁷¹

In making a determination whether harm could be excessive, the commander must take account of the special protection afforded to the wounded and sick and the great risks to them in an attack on a health facility from likely loss of life support, water, food, medicine, and continuity of care. These considerations can tilt the balance toward not attacking the hospital at all or limiting the attack’s lethality and scope,⁷² for example, by forgoing the use of highly explosive weapons such as bombs and missiles in attacks on a hospital and avoiding patient care areas.⁷³

Similarly, the commander must assess the foreseeable decline in the ability of the hospital to function, such as providing surgery, safe childbirth care or intensive care, as a result of an attack. The determination of excessive harm must also account for the diminution of health services over the course of the conflict, as services become increasingly stressed.⁷⁴

As the commentaries to the Geneva Conventions explain,⁷⁵ the proportionality calculus also imposes limits to attacking parts of a hospital that are not used to commit harmful acts or where a military advantage gained by eliminating the use of part of the hospital for military purposes is marginal. For example, attacking a room where some weapons are stored in a closet will often likely lead only to a slight military advantage, but can be expected to cause great harm to patients, staff and the facility. To avoid excessive harm, the assessment should also rule out certain military actions in favour of less lethal and damaging ones. For example, it is difficult to envision circumstances where the advantage gained from shelling, bombing, or carrying out missile attacks on a hospital could ever outweigh the likely catastrophic harms these weapons are known to inflict on patients, staff and a facility.

Adherence to these protective rules could have saved many lives and preserved hospitals' ability to continue to provide critical functions such as surgery, intensive care, and safe childbirth.

Dispensing with safeguards - a case study from Gaza

There is abundant evidence that Israel has not followed the rules governing the protection of health care in its military actions in Gaza since October 2023. In its public statements, Israel has only rarely cited warnings of attacks it has given to health care facilities, while in some cases it is clear from other evidence that it did not issue such warnings. In the relatively few cases where it has cited the precautions it used in hospital attacks, they mostly involved arranging the evacuation of patients or limiting the types of explosive weapons used. In the former, evidence has revealed that it did not make proper and safe arrangements for patients, which in some cases led to their deaths.⁷⁶ And the IDF has rarely claimed to have undertaken any proportionality assessments prior to attacks.

Indeed, Israel has almost never purported to show compliance with the safeguards required by IHL, even in post-attack investigations. In a case where the IDF killed 14 emergency responders in ambulances, an investigation justified the attack based on an "operational misunderstanding" and that the troops acted based on claims of Hamas's alleged past use of ambulances for military purposes.⁷⁷ The report makes no mention of a warning, whether the ambulances had become military objects, precautions taken (such as stopping the ambulances) or a judgement on proportionality.

In the case of the attack on Nasser Hospital mentioned in the analysis above, Israel alleged only that a camera on a balcony on the building was used to view Israeli troop movements. A statement released after the preliminary IDF investigation had been undertaken did not cite a warning, precautions taken or a proportionality assessment. Instead, it stated that IDF troops "operated to remove the threat by striking and dismantling the camera".⁷⁸ It further stated that "The Chief of the General Staff emphasized that the IDF directs its activities solely toward military targets", as though the requirements of warnings, precautions and proportionality did not exist. The statement did not address the fact that a warning might have allowed hospital administrators to show that the camera was being used by journalists, not Hamas fighters, or to remove it from the balcony. Nor did it address the decision to repeatedly fire high explosive tank shells at the hospital, or whether there was an alternative to firing shells at the balcony.

These are two examples of incidents documented by Insecurity Insight in which the conflict party justified an attack as being lawful, but without evidence to support the claim.

The threat to hospitals and the wounded and sick everywhere

The obstacles to compliance with the law protecting health care during armed conflict are severe and long-standing. Israel's repeated invocation of what is a very narrow exception to the immunity of health facilities from attack, which has been extended beyond Gaza to Lebanon and Iran, further threatens such compliance. Although the justification for attacking hospitals based on their military use is severely limited and subject to extensive safeguards to ensure that patients can receive the care that is their right, that clinicians remain safe when providing it, and that the facility can function, it is being eviscerated by conflict parties' increasing willingness to ignore or dilute these safeguards. The health care community and governments committed to the implementation of IHL must forcefully and vigorously respond to the new rationalisations for attacking health care during conflict and ensure accountability for parties responsible for invoking them.



Legal pathways to accountability

Attacks on health care during armed conflict can lead to catastrophic harms, including the deaths and injuries of patients and medical staff and the undermining of the delivery of medical services to patients and their communities. IHL is designed to protect health care against such harms, while UNSCR 2286 reaffirms that, with very limited and rigorously defined exceptions, attacks on medical facilities and personnel during armed conflict constitute violations of IHL. UNSCR 2286 clearly calls for compliance with the law, and urges investigations into and accountability for attacks.

Ten years on from the resolution's adoption, meaningful accountability remains exceedingly rare. There are legal pathways to accountability (see the following box), but as of 2026, there have been only two convictions in international courts for crimes involving direct attacks on health care: one in the International Criminal Tribunal for the former Yugoslavia⁸⁰ and the other in the ICC.⁸¹

Domestic war crimes units in several European states have opened investigations into attacks on health care documented in Syria and Ukraine. Domestic criminal jurisdiction often exists for attacks on health care that violate codes of military justice, even when they are not specified as war crimes. Universal jurisdiction allows for the pursuit of prosecutions against perpetrators of international crimes regardless of where the attacks occurred or who the perpetrators are; for example, universal jurisdiction complaints have been filed in Germany concerning aerial attacks on hospitals in Idlib and Aleppo in Syria. Domestic courts can prosecute crimes committed by foreigners that were perpetrated in their territory, as has been the case in Ukraine.

Voluntary accountability

Some states have established mechanisms to make ex gratia payments to the victims of wrongful targeting and mistaken air strikes, or instituted broader national reparations programmes following conflict. However, these efforts are quite rare.

Legal pathways for accountability

- Intentional attacks on health care facilities and personnel are war crimes. In cases where it has jurisdiction, the ICC can prosecute the perpetrators of these crimes, as well crimes against humanity and genocide.
- The International Court of Justice (ICJ) adjudicates disputes between states and determines state responsibility in cases where a jurisdictional basis exists (usually some form of consent). It does not hold individuals to account.
- UN commissions of inquiry and fact-finding missions are investigative bodies created by the UN Human Rights Council or the General Assembly to document violations of protected rights, attribute responsibility, and preserve evidence; they do not adjudicate, but can be a source of information for courts and can stimulate diplomatic, political, and economic action.
- Regional human rights commissions courts can determine state responsibility for violations of protected rights and can require just satisfaction or reparations.

In appropriate cases, domestic courts can adjudicate violations in various ways, such as through the military justice system; under domestic law in civil courts; and, for international crimes, under the principles of universal jurisdiction.

Civil accountability

Civil accountability concerns either the establishment of state responsibility for certain crimes, such as through the ICJ, or domestic civil cases for wrongful acts such as causing death or personal injuries that can result in the payment of damages to the victim or victims. In the latter cases, however, sovereign immunity can create a barrier to justice.

Regional human rights courts may address related violations of the right to life or health (e.g. European Convention on Human Rights, arts. 2 and 8; American Convention on Human Rights, arts. 4 and 26), which can produce findings and recommendations (orders or awards) for reparations, but do not constitute criminal accountability.

International criminal accountability

IHL protects the provision of medical care in two related ways. Firstly, it protects medical units, transports, supplies and personnel that perform medical functions. Secondly, it protects the wounded and sick, who are entitled to care. These protections apply in international and non-international armed conflicts under the four Geneva Conventions of 1949 and their Additional Protocols of 1977. Even states that have not ratified the Conventions and Protocols and non-state armed groups are bound by most of the provisions relating to the protection of health care under customary IHL.

Under these laws, parties to conflicts must respect the wounded and sick, health facilities, and medical personnel. Notably, the display of an emblem to signify a hospital's or medical unit's protected status is not required in conflicts where hospitals are deliberately targeted, and therefore the emblem is not a compulsory condition for the right to protection. In addition, protections for civilians, including through the principles of distinction, precautions and proportionality, also apply.⁸²

Hospitals can lose protection if they are used to commit acts harmful to the enemy. However, this loss of protection only exists for as long as the harmful acts continue, a warning to cease harmful acts has been issued and it is unheeded, the hospital or parts of it have become military objects, and the principles of precautions and proportionality have been respected. The Progress Report of the Global Initiative to Galvanize Political Commitment to International Humanitarian Law discusses this issue in detail.⁸³ See also the chapter in the present report on 'Justification of hospital attacks – growing, open lack of respect for IHL'.

Reporting and monitoring

UN entities have extensively documented attacks on health care. The Human Rights Council's Commissions of Inquiry in Syria, Yemen, Ethiopia, Sudan, and Palestine have written special reports on the subject or have included details in broader reports. In addition, the Special Representative of Children in Armed Conflict has documented attacks on hospitals as part of their mandate to identify and investigate attacks on schools and hospitals. The OHCHR has issued reports on attacks on health care, while the Special Rapporteur on the Right to the Highest Attainable Standard of Health published an important report in 2013 on the applicability of international human rights law during armed conflict.⁸⁴

Incident monitoring is also extensive. The SHCC issues a global annual report on attacks on health care during conflict, based primarily on data collected and processed by Insecurity Insight. The WHO SSA seeks to provide standardised, publicly accessible data recording attacks on health facilities, health personnel and medical transports in emergencies. Several other humanitarian organisations and investigative non-profit agencies have initiated or continued their own efforts to broaden the evidence base available to identify, understand, and investigate attacks on health care.

IHL duty bearers and the protection of health care during conflict

IHL establishes universal requirements that afford special legal protection to all aspects of health care. Conflict parties are required to distinguish medical services from military targets, to take all feasible precautions to avoid harm to health care, and – in situations where harm cannot be avoided – to ensure that any incidental impact of such harm is proportionate to the anticipated military advantage, inclusive of all foreseeable immediate and longer-term consequences.

However, the practical implementation of these obligations varies depending on the weapons systems employed and the command structures that guide armed units. Close analysis of the patterns of effects on health care associated with different weapons systems and operational contexts, combined with insights into health system vulnerabilities and foreseeable consequences, provides rich contextual information. This information can support the development of practical guidance for the application of IHL in diverse settings.

Many governments and armed forces have already invested in training and guidance to strengthen compliance with their IHL obligations. Such efforts can be further informed and refined by drawing from the evidence that details how military practices affect health care during conflict.

Both the rules of engagement and standard operating procedures need to specifically mention the protection of health care during conflict.

Rules of engagement (RoE): RoE are directives specific to military operations that govern the use of force in combat situations. They are derived from international law, mission objectives, and operational directives, and serve as both a legal and procedural framework for determining when and how force may be used. RoE are crucial for maintaining operational integrity and ensuring compliance with applicable legal standards during military engagements.

Standard operating procedures (SOPs): SOPs provide a clear and consistent framework to guide routine military operations, ensuring the efficiency and uniformity of performance. They are not intended to restrict the decision-making capacity of personnel, but rather to guide and support them in the execution of assigned tasks.

Security risk management for health care

Health care providers are not responsible for the actions of conflict parties. However, depending on the context, a range of strategies can help to minimise the impacts of these parties' actions on health care systems and mitigate against the consequences of conflict-related violence on health care service delivery. Security risk management (SRM) for health care providers encompasses operational and pragmatic measures designed to promote safe working environments for health workers and to support continuity of care during conflict, while balancing the rights and responsibilities of health workers and patients, and the communities that health care providers serve.

Information on common patterns of violence against health care can help providers to select the most effective protective strategies. These may range from ensuring a shared awareness of the risks and preparedness involved in responding to violent incidents, to implementing longer-term, sustainable changes that enhance protection for health care personnel, health services, and associated infrastructure.

SRM for health care providers:

Appropriately adapted SRM practices can prevent and mitigate the worst consequences of violence against health care. This involves the following factors:

- **Acceptance (by communities, states, non-state groups, etc.):** This can be achieved by emphasising the neutral role and humanitarian function of health care during conflict.
- **Protection:** This involves implementing practical measures, such as applying plastic film to windows to prevent injuries from shattered glass or relocating health facilities underground.
- **Approach:** Any approach to SRM should be grounded in *awareness, preparedness and response*, with a focus on sustaining health services through continuous adaptation (see the SR4H cycle in the next section for a more detailed discussion of these factors).

SRM for states, donors and supporters:

States, donors and supporters of health services during conflict can fund or in other ways support mitigation measures that help to minimise the impacts of violence through a range of adaptations that allow the continuation of health services. The focus should be on the following factors:

- **Well-being:** Promote the mental health of health workers through clearly articulated support programmes.
- **Utilities:** Provide generators or solar panels to ensure that health facilities can operate as autonomously as possible.
- **Protection:** Supply sandbags and plastic sheeting, or modify the distribution of services in health care facilities to enhance safety.
- **Replacement:** Replace lost vehicles, equipment, supplies and essential drugs as soon as possible.
- **Capacity-building:** Support continuous education and training for health care personnel.

In particular, understanding whether health care is likely to be deliberately targeted or incidentally affected by conflict-related violence is crucial when determining appropriate risk management strategies. In some contexts, strategies may prioritise engagement and communication with conflict parties, including the use of visible signs to indicate a health care unit's medical status, and thus reinforce the protection it should receive. In other contexts, adaptation may require the reduced visibility and concealment of health care activities to minimise exposure and better protect health services.

Security Risk Management For Health Care (SR4H) Handbook

Insecurity Insight developed the Security Risk Management for Health Care Services Handbook (also called the SR4H Handbook – see the box below),⁸⁵ which is available in **Arabic, English, French, and Spanish**. It was developed to provide a framework for practical measures that health care services can put in place to improve the safety and security of their personnel and facilities while focusing on the continued provision of health care. It builds on practices developed by aid agencies and emphasises awareness-raising, preparedness, response, and continuous learning. At its core is an acceptance-based approach, in terms of which the purpose of and services offered by health care providers are clearly communicated in order to secure the consent of conflict parties and local communities to their provision of services, while simultaneously implementing practical measures to enhance the safety and continued functioning of the health care system. The evacuation of staff, while sometimes necessary, risks depriving patients of essential services and therefore cannot be deployed as the default response.

The SRM for health care (SR4H) cycle, which is central to the *Security Risk Management for Health Care Services Handbook*, is constituted by four key factors:

Awareness: This includes generating awareness among staff about possible threats, and communicating ways of managing these threats to ensure as far as possible a violence-free environment in which health care services can function properly.

Preparedness: This includes assessing the risks of violence affecting health care and putting systems and procedures in place to better prevent and cope with such violence before it occurs.

Response: This includes ways of responding if a violent incident occurs.

Sustainability: This includes dealing with the aftermath of violent incidents and working towards sustainable health care provision and access to health care for all those in need.



The SR4H Handbook provides practical tools to strengthen SRM within the health sector and suggests tools that can enhance partnership agreements between external partners and front-line health care providers so as to better incorporate security-related activities. The Handbook also seeks to empower local partners and serves as a foundational resource for the effective and ethical implementation of appropriate SRM measures, with the aim of making health care delivery safer and more sustainable for all actors involved.

The SR4H Handbook approaches SRM for health care with a focus on balancing the rights and responsibilities of patients and health workers, recognising at its core that patients have a right to care and that health workers have a right to work in a violence-free environment. At the same time, health workers have a responsibility towards their patients to deliver the best possible care, and patients have a responsibility to treat health care personnel and services with respect. Finally, security forces have the responsibility to respect health services and patients and protect them from violence, and all conflict parties have the responsibility to respect health care and protect it from the impact of conflict.

Figure 22: Health-care-related rights and responsibilities



The SR4H Handbook's approach to SRM is designed for health facility and programme managers, as well as NGOs working with front-line health care providers working in conflict-affected settings. It is not directed at individual health workers, because the responsibility for ensuring that appropriate protection measures are put in place that enable health workers to safely provide care rests with employers and managers. While building on tested aid agency approaches, the SR4H Handbook's strategies recognise the important differences between international and local health actors. Effective localisation clearly requires more than the transfer of guidelines originally developed for international organisations. Instead, it demands tools and guidance specifically designed to address the distinct and often continual risks that local health providers face in specific conflict settings.

Unfortunately, health care will remain vulnerable in situations of armed conflict. Awareness, preparedness, and strengthening the capacity to respond can make a difference for patients, providers, and affected communities. **But ultimately, the responsibility to protect health care remains with conflict parties.** However, the pragmatic reality remains that health care providers cannot wait for conflict parties to change their behaviours before adopting measures that will increase the safety and security of health care personnel and systems.



The adoption of UNSCR 2286 in 2016 reflected a clear reiteration of the need to strengthen the protection of health care during conflict. Ten years later, however, the results have been deeply disturbing. The resolution has not lived up to its stated ambitions. Rather than a reduction in violence against health care, attacks have increased.

A substantial share of this increase is attributed to state actors, while non-state armed groups are responsible for a much larger number of recorded attacks. This trend has unfolded against the backdrop of profound structural changes to both the information environment and the ways in which hostilities are conducted. The rapid expansion of the internet and social media in conflict-affected settings has transformed the information environment, while technological innovation – particularly the growth in the use of remotely delivered and precision-guided weapons – has altered the conduct of hostilities. Together, these developments have both complicated the protection of health care and improved the visibility of and ability to document attacks, especially where attacks are publicly observable and affect people with internet access.

Although each of the recorded incidents analysed in this study is unique and context-specific, the overall pattern points to a more fundamental concern: a gradual erosion of respect for IHL. What was once broadly accepted – that health care must be protected during conflict – has increasingly been challenged. In some instances, this shift has been openly articulated in political and military discourse, reflecting not merely non-compliance with IHL, but the apparent outright rejection of the legal frameworks protecting health care. This finding is not unique to this report, but has been articulated in the annual reports of the SHCC,⁸⁶ the Qatar-based World Innovation Summit for Health, MSF, the *British Medical Journal* and findings from the RIAH project.⁸⁷ Public narratives have evolved, with a growing emphasis on the alleged misuse of health facilities for military purposes, effectively shifting the burden of proof that they are not being used for these purposes onto health care providers, rather than requiring those who perpetrate attacks on health care to justify their actions. This development is compounded by a persistent lack of legal accountability, which reinforces a permissive environment.

Efforts to strengthen protection through traditional mechanisms of self-regulation by conflict parties have proven insufficient, and in the current context may be inherently limited.

At the operational level, health care providers have developed important coping mechanisms that enable continued service delivery under extremely challenging conditions. These measures are indispensable, but they are not enough. Health care needs inevitably increase during conflict, and services must remain accessible and available to deliver trauma care, maternal and newborn health interventions, and a wide range of other essential services. Unlike other civilian infrastructure, health care services cannot simply be suspended. The essential nature of such services requires that they remain open and able to deliver a comprehensive package of health care services, which in turn renders them inherently vulnerable.

Ultimately, the protection of health care during conflict depends on the behaviour of conflict parties and their willingness to respect legal obligations and humanitarian norms. When this protection falters, the consequences are severe: avoidable mortality and morbidity, injury and disablement, long-term harm to communities, and the increased risk of the spread of diseases.

What can be done?

The challenges health services face during conflict are significant, and there are no simple or universal solutions to resolve them. Prescriptive approaches are unlikely to succeed in a rapidly evolving global environment. Instead, efforts should focus on reinforcing core principles while adapting implementation measures to specific contexts.

Five priority areas have emerged: reclaiming the narrative; strengthening law enforcement and legal accountability; equipping armed forces with practical tools; supporting health care providers; and strengthening the evidence base available to identify, understand, and investigate attacks on health care.

Reclaiming the narrative

Protecting health care requires re-establishing and implementing the fundamental norm⁸⁸ that it must not be targeted during conflict.⁸⁹ As debates surrounding the supposed legitimacy of attacks increasingly play out in public and digital spaces, communication must extend beyond diplomatic forums and engage broader audiences. Messages need to be clear, direct, and accessible – emphasising the unconditional importance of protecting health care without resorting to overly legalistic language and explanations, while firmly challenging assumptions that health care facilities are inherently suspect or subject to misuse.

Strengthening law enforcement and legal accountability

Statements alone are no longer sufficient. The protection of health care must be reinforced using credible and effective forms of legal accountability. Reliance on self-investigation by states has contributed to the current permissive environment. Strengthening judicial pathways – both national and international – is essential to restoring standards, deterring violations, and reducing impunity. This requires closer collaboration among states, legal institutions and civil society actors.

Equipping armed forces with practical tools

Calls to “respect IHL” are insufficient without concrete guidance as to how to do so. Armed forces require detailed operational instructions to ensure that they integrate measures for the protection of health care into both their RoE and SOPs. These instructions must be tailored to specific weapons systems, command structures and operational realities. As new technologies are introduced, corresponding safeguards must be developed and institutionalised, and armed forces trained to respect them.

Supporting health care providers

Health care providers must be supported to operate safely and effectively in active conflict-affected settings. This includes ensuring reliable access to supplies; maintaining infrastructure; supporting personnel; and providing training, mental health and other support services. Practical and material measures – ranging from salary support to alternative energy solutions and secure supply chains – are essential. Ministries of health also require strengthened guidance and the capacity to address security and service continuity challenges in context-specific ways.

Strengthening the evidence base available to identify, understand and investigate attacks on health care

Violence against health care is complex and demands nuanced, context-sensitive responses. Reliable data and insightful analysis are therefore critical to the development of appropriate responses. Improved incident reporting, a better understanding of the impact of violence on health care, and stronger linkages between evidence and policy are all needed. At the same time, data systems must balance transparency with confidentiality and be designed to serve multiple purposes. No single method will be suitable across all contexts. Progress in this priority area depends on collaboration, complementarity and sustained investment in information systems.

Despite the scale and complexity of the challenges ahead, this moment should not be seen as a point of defeat, but as the appropriate time for an urgent call to recalibrate work to protect health care and act with greater clarity and determination. Setbacks of the magnitude that this report has explored expose weaknesses that have to be understood within the wider context in which they appear, but they also offer the opportunity to learn, to adapt, and to rebuild stronger foundations that withstand upheaval and change.

The protection of health care during conflict is neither an abstract ideal nor a negotiable aspiration: it is a practical and moral necessity that demands renewed commitment from all responsible actors. Progress will require persistence, courage and a willingness to confront uncomfortable realities. Yet inaction is not an option. At stake is much more than compliance with legal norms, but rather the preservation of humanity itself in the most fragile of circumstances. By strengthening the protection of health care, we safeguard not only human lives and dignity in moments of crisis, but also the possibility of recovery and hope for communities striving to rebuild in the aftermath of conflict, while upholding and renewing the foundations of the international system that several generations of health care and human rights advocates have worked to build and sustain.

ACLED	Armed Conflict Location & Event Data
ADF	Allied Democratic Forces
AI	artificial intelligence
AWSD	Aid Worker Security Database
CIMP	Civilian Impact Monitoring Project
DRC	Democratic Republic of the Congo
HDX	Humanitarian Data Exchange
ICC	International Criminal Court
ICJ	International Court of Justice
ICRC	International Committee of the Red Cross
IED	improvised explosive device
IHL	international humanitarian law
INGO	international non-governmental organisation
INSO	International NGO Safety Organisation
IS	Islamic State
ISGS	Islamic State of the Greater Sahara
JNIM	Jama'at Nasr al-Islam wal-Muslimin
LAW	Legal Action Worldwide
LLM	large language model
MSF	Médecins Sans Frontières
NGO	non-governmental organisation
NLP	natural language processing
OHCHR	Office of the High Commissioner for Human Rights
oPt	occupied Palestinian territory
RIAH	Researching the Impact of Attacks on Healthcare
RoE	rules of engagement
RSF	Rapid Support Forces
SAF	Sudan Armed Forces
SHCC	Safeguarding Health in Conflict Coalition
SNHR	Syrian Network for Human Rights
SOHR	Syrian Observatory for Human Rights
SOP	standard operating procedure
SRM	security risk management
SSA	Surveillance System for Attacks on Health Care
UCDP	Uppsala Conflict Data Program
UN	United Nations
UNSCR	United Nations Security Council Resolution
WHO	World Health Organization

- 1 UNSC (United Nations Security Council) (2016) Resolution 2286 (2016). S/RES/2286 (2016) of 3 May. [https://undocs.org/S/RES/2286\(2016\)](https://undocs.org/S/RES/2286(2016)).
- 2 In addition to the conceptual underpinnings of Insecurity Insight's Security in Numbers Database (SiND), the framework draws on the research of the RIAH Consortium, the life-long work of Leonard Rubenstein (particularly his book *Perilous Medicine: The Struggle to Protect Health Care from the Violence of War*, published in 2023) and the work of Robin Coupland (see his article 'The role of health-related data in promoting the security of health care in armed conflict and other emergencies', published in the *International Review of the Red Cross* in 2013).
- 3 WHO (World Health Organization) (2020) 'Attacks on health care initiative: documenting the problem.' 22 July. <https://www.who.int/news-room/questions-and-answers/item/attacks-on-healthcare-initiative-documenting-the-problem>.
- 4 Uppsala University (2025) 'UCDP: sharp increase in conflicts and wars.' Press release, 11 June. <https://www.uu.se/en/press/press-releases/2025/2025-06-11-ucdp-sharp-increase-in-conflicts-and-wars>.
- 5 A.E. Barbar & C. Wille (2026) 'Navigating risks in data collection on attacks against healthcare: new technologies and ethical considerations stemming from the Insecurity Insight's practical experience.' In: B. Koch & D. Winkler (eds), *Artificial Intelligence Ethics in Military Medicine and Humanitarian Healthcare*. Cham: Springer. doi: 10.1007/978-3-032-11331-3_12.
- 6 ICRC (International Committee of the Red Cross) (n.d.a) Health Care in Danger website. <https://healthcareindanger.org/>.
- 7 World Health Assembly (2012) 'WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies.' Sixty-fifth World Health Assembly. WHA65.20 of 26 May. https://apps.who.int/gb/ebwha/pdf_files/wha65/a65_r20-en.pdf.
- 8 See WFA (World Federation of Advertisers) (2016) *We Are Social Reports on the State of Digital in 2016*. <https://wfanet.org/knowledge/item/2016/02/17/We-Are-Social-reports-on-the-state-of-digital-in-2016>; DataReportal (2025) *Digital 2025: State of Social Media in 2025*. <https://datareportal.com/reports/digital-2025-sub-section-state-of-social>.
- 9 Cf. footnote 5 and Data Responsibility Working Group (2023) *Operational Guidance: Data Responsibility in Humanitarian Action*. Endorsed by the IASC Operational Policy and Advocacy Group. <https://interagencystandingcommittee.org/system/files/2023-04/IASC%20Operational%20Guidance%20on%20Data%20Responsibility%20in%20Humanitarian%20Ac>.
- 10 V. Parada et al. (2023) 'Underestimating attacks: comparing two sources of publicly-available data about attacks on health care in 2017.' *Conflict and Health*, Vol. 17(3). doi: 10.1186/s13031-023-00498-w.
- 11 A.R. Gohdes & S.C. Carey (2017) 'Canaries in a coal-mine? What the killings of journalists tell us about future repression.' *Journal of Peace Research*, Vol. 54(2), pp. 157-174.
- 12 Parada et al., 2023.
- 13 H. Lamba et al. (2024) 'HumVI: a multilingual dataset for detecting violent incidents impacting humanitarian aid.' arXiv preprint. arXiv:2410.06370. <https://arxiv.org/abs/2410.06370>.
- 14 IASC (Inter-Agency Standing Committee) (2023) *Operational Guidance: Data Responsibility in Humanitarian Action*. Data Responsibility Working Group. <https://interagencystandingcommittee.org/sites/default/files/migrated/2023-04/IASC%20Operational%20Guidance%20on%20Data%20Responsibility%20in%20Humanitarian%20Action%2C%202023.pdf>.
- 15 ReliefWeb (2026) 'Data Responsibility Working Group (DRWG).' OCHA Services. <https://reliefweb.int/topics/data-responsibility-working-group-drwg?>.
- 16 Other organisations, such as the ICRC and various international NGOs, have their own institutional reporting systems on this matter, although in a less systematised way and without any foreseen process for the public display of information. These are essentially confidential internal systems, and information is only disclosed to support decisions to either advocate against attacks on health care in general or denounce specific attacks.
- 17 WHO SSA, accessed 15 January 2026. The SSA yearly incident totals were compared with Insecurity Insight's Attacks on Health Care Data, which can be publicly accessed on the Humanitarian Data Exchange.
- 18 The H2H Network brings together high-quality, independent humanitarian service providers.
- 19 Insecurity Insight, event report number 32472.
- 20 Insecurity Insight, event report number 33978.
- 21 Insecurity Insight, event report number 37270.
- 22 The type of health care provider and/or national status of the remaining incidents (12%) are unclear.

- 23 WHO (World Health Organization) (2026) 'Health workforce.' https://www.who.int/health-topics/health-workforce#tab=tab_1.
- 24 The RSF was classified as a non-state armed actor during its early formation and operational period from 2013 to 2017, when it functioned as a state-aligned militia with formal links to Sudan's security apparatus, but without full integration into the country's armed forces. From January 2017 to 14 April 2023, the RSF was legally recognised as an autonomous security force under the authority of the president of Sudan, operating alongside, but institutionally distinct from, the SAF. During this period, violence attributed to the RSF is generally classified as state or state-affiliated actor violence. From 15 April 2023 onward, following the outbreak of armed conflict between the RSF and SAF, the RSF is more appropriately classified as a non-state armed actor engaged in an intra-state armed conflict.
- 25 Insecurity Insight, event report number 120812.
- 26 Insecurity Insight, event report number 122615.
- 27 N. Kostandova et al. (2025) 'Healthcare under fire: quantifying the impact of violence on medical services in facilities supported by International Medical Corps in three prefectures of Central African Republic, 2016-2020.' *Conflict and Health*, Vol. 19(1). doi: 10.1186/s13031-025-00686-w.
- 28 Insecurity Insight, event report number 51481.
- 29 Insecurity Insight, event report number 25182.
- 30 H. Bashour et al. (2021) 'Childbirth experiences and delivery care during times of war: testimonies of Syrian women and doctors.' *Frontiers in Global Women's Health*, Vol. 30. doi: 10.3389/fgwh.2021.605634.
- 31 Insecurity Insight, event report number 35785.
- 32 DataReportal (2026) 'Global social media statistics.' April. <https://datareportal.com/social-media-users>.
- 33 Cf. footnote 8.
- 34 Insecurity Insight (2022) 'Uganda Ebola outbreak.' Social Media Monitoring brief, 4 November. <https://insecurityinsight.org/wp-content/uploads/2022/11/Uganda-Ebola-Outbreak-Social-Media-Monitoring-04-November-2022.pdf>.
- 35 Insecurity Insight (2024) 'Vaccines, conspiracies and distrust: social media's take on the mpox crisis in Burundi, Cameroon, CAR, DRC, Nigeria and Uganda.' Social Media Watch brief, September-October. <https://insecurityinsight.org/wp-content/uploads/2024/12/Protecting-the-Humanitarian-Space-to-Deliver-Health-Care-during-the-Mpox-Public.pdf>.
- 36 Insecurity Insight (2024) 'Viral allegations that an aid organisation had prior knowledge of the Djibo jihadist attack in November 2023 underline aid agencies' vulnerability to disinformation in Burkina Faso.' Sahel Social Media Monitoring brief, February. <https://insecurityinsight.org/wp-content/uploads/2024/02/Sahel-Social-Media-Monitoring-Burkina-Faso-February-2024.pdf>.
- 37 Insecurity Insight (2026) Social Media Reactions to Hospital Bombings: Lessons from Incidents in Four Conflict-affected Contexts for Safeguarding the Humanitarian Space and Medical Protection. <https://insecurityinsight.org/wp-content/uploads/2025/12/Social-media-and-protection-of-hospitals-from-the-harmful-use-of-explosive-weapons-in-conflict.pdf>.
- 38 Insecurity Insight, event report number 37587.
- 39 Insecurity Insight, event report number 28581.
- 40 L. Murray (2020) 'Measles: in Ebola's shadow, a quiet killer is on a rampage in DRC.' Al Jazeera, 7 April. Archived 10 May 2020.
- 41 V.D. Sodjinou et al. (2020) 'Madagascar 2018-2019 measles outbreak response: main strategic areas.' *Pan African Medical Journal*, Vol. 37. doi: 10.11604/pamj.2020.37.20.24530.
- 42 G. Chowell et al. (2019) 'Vaccination strategies to control Ebola epidemics in the context of variable household inaccessibility levels.' arXiv preprint. arXiv:1906.04590. <https://arxiv.org/abs/1906.04590>; Kostandova et al., 2025.
- 43 Insecurity Insight, event report number 120417.
- 44 M. Zehfuss (2011) 'Targeting: precision and the production of ethics.' *European Journal of International Relations*, Vol. 17(3), pp. 543-566. <https://journals.sagepub.com/doi/10.1177/1354066110373559>; ICRC (International Committee of the Red Cross) (2025) 'Autonomous weapon systems and international humanitarian law: selected issues.' Position paper. <https://www.icrc.org/en/document/icrc-position-autonomous-weapon-systems>.
- 45 For a detailed discussion of the principles of proportionality and precautions in military attacks, see the section on 'Legal safeguards for hospitals and ambulances when military use is alleged',
- 46 Insecurity Insight, event report number 46138.

- 47 Insecurity Insight, incident report number 21911.
- 48 Insecurity Insight, event report number 119642.
- 49 Insecurity Insight, event report number 85502.
- 50 This and the following subsection were authored by Leonard Rubenstein.
- 51 Insecurity Insight (2025) 'Arrests and detentions of aid workers: key trends and implications, 1997-2025.' Policy note. Switzerland: Insecurity Insight. <https://bit.ly/AidKIKATrends1997-2025>.
- 52 ICRC (International Committee of the Red Cross) (2024) International Humanitarian Law and the Challenges of Contemporary Armed Conflicts: Building a Culture of Compliance for IHL to Protect Humanity in Today's and Future Conflicts. Report. https://www.icrc.org/sites/default/files/media_file/2024-10/4810_002_CH%203.pdf.
- 53 L. Rubenstein (2023) 'Israel's rewriting of the law of war.' Just Security, 21 December. <https://www.justsecurity.org/>.
- 54 ICRC (International Committee of the Red Cross) (n.d.b) 'Rule 28. Medical units.' ICRC Customary IHL Databases. <https://ihl-databases.icrc.org/en/customary-ihl/v1/rule28>.
- 55 UN (United Nations) (2019a) 'Identical letters dated 16 July 2018 from the Permanent Representative of the Syrian Arab Republic to the United Nations addressed to the Secretary-General and President of the Security Council.' S/2019/572 of 17 July. https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_2019_572.pdf.
- 56 UN (United Nations) (2019b) 'Security Council backsliding on duty to protect Syria's civilians, rights advocate stresses, amid calls to protect hospitals, review deconfliction accords.' Press release, 13 July. <https://press.un.org/en/2019/sc13903.doc.htm>.
- 57 B. Bostock (2022) 'Russia claims without evidence that the maternity hospital it bombed – which killed a child – was a Ukrainian militia base.' Business Insider, 10 March. <https://www.businessinsider.com/russia-says-mariupol-maternity-hospital-militia-base-no-evidence-2022-3>.
- 58 Amnesty International (2015) 'Strangling Necks': Abductions, Torture and Summary Killings of Palestinians by Hamas Forces during the 2014 Gaza/Israel Conflict. Report. London: Amnesty International. <https://www.amnesty.org/en/documents/mde21/1643/2015/en/>.
- 59 IDF (Israel Defense Forces) (n.d.) 'Hamas' operations in hospitals.' <https://www.idf.il/en/mini-sites/hamas-operations-in-hospitals/>.
- 60 Insecurity Insight (2026) 'Attacks on health care in the oPt, 07-20 January 2026.' <https://insecurityinsight.org/wp-content/uploads/2026/01/73.-07-20-January-2026-Attacks-on-Health-Care-in-the-oPt.pdf>.
- 61 WHO (World Health Organization) (2025) 'oPt Emergency Situation Update.' Issue 66, 7 Oct 2023-31 Oct 2025. <https://www.emro.who.int/images/stories/palestine/sitrep66.pdf>.
- 62 The Guardian (2024) 'Claims of Hamas fighters in Gaza hospitals may have been exaggerated, says senior ICC prosecutor.' 11 December. <https://www.theguardian.com/law/2024/dec/11/claims-of-hamas-fighters-in-gaza-hospitals-may-have-been-exaggerated-says-senior-icc-prosecutor>.
- 63 OHCHR (Office of the United Nations High Commissioner for Human Rights) (2024) Attacks on Hospitals during the Escalation of Hostilities in Gaza (7 October 2023-30 June 2024). Thematic report, 31 December. <https://www.ohchr.org/sites/default/files/documents/countries/opt/20241231-attacks-hospitals-gaza-en.pdf>.
- 64 L. Loveluck et al. (2023) 'The case of al-Shifa: investigating the assault on Gaza's largest hospital.' Washington Post, 21 December. <https://www.washingtonpost.com/world/2023/12/21/al-shifa-hospital-gaza-hamas-israel/>.
- 65 S. Mednick & S. Magdy (2025) 'AP reporting calls into question why and how Israel attacked a Gaza hospital.' AP, 5 September. <https://apnews.com/article/israel-palestinians-hamas-war-strikes-hospital-journalists-75e79272f3acc37fa8acb653e45d564c>.
- 66 L. Rubenstein and J.S. Morrison (2024) 'Facts and falsehoods: Israel's attacks against Gaza's hospitals.' Think Global Health, 15 March. <https://www.thinkglobalhealth.org/article/facts-and-falsehoods-israels-attacks-against-gazas-hospitals>.
- 67 ICRC (International Committee of the Red Cross) (n.d.c) 'Article 13: Discontinuance of protection of civilian medical units.' <https://ihl-databases.icrc.org/en/ihl-treaties/api-1977/article-13?>

68 ICRC, n.d.b.

69 ICRC (International Committee of the Red Cross) (1977) 'Article 57: Precautions in attack.' <https://ihl-databases.icrc.org/en/ihl-treaties/api-1977/article-57>.

70 ICRC (International Committee of the Red Cross) (2020) *Protecting Healthcare: Guidance for the Armed Forces*. Geneva: ICRC. <https://www.icrc.org/en/publication/4504-protecting-healthcare-guidance-armed-forces>.

71 Cf. ICRC, 1977.

72 See key considerations in J. van den Boogaard (2023) *Proportionality in International Humanitarian Law: Principle, Rule and Practice*. Thesis, University of Amsterdam. https://pure.uva.nl/ws/files/39875294/Thesis_complete_.pdf.

73 L. Rubenstein (2026) 'Reinvigorating proportionality to protect hospitals during war.' *LAWFARE*, 17 February. <https://www.lawfaremedia.org/article/reinvigorating-proportionality-to-protect-hospitals-during-war>.

74 M.N. Schmitt (2024) 'Israel-Hamas 2024 Symposium – Israel's jus ad bellum and LOAC obligations and the evolving nature of the conflict.' Lieber Institute, West Point, 19 August. <https://lieber.westpoint.edu/israels-jus-ad-bellum-loac-obligations-evolving-nature-conflict/>.

75 ICRC (International Committee of the Red Cross) (2025) 'Article 19 – Discontinuance of protection of civilian hospitals.' *Commentary of 2025*. <https://ihl-databases.icrc.org/en/ihl-treaties/gciv-1949/article-19/commentary/2025?>.

76 Rubenstein & Morrison, 2024.

77 See full statement at idfanc.activetrail.biz/ANC20042593285053852.

78 See full statement at Israel Defense Forces @IDF, X, 25 August 2025. <https://x.com/IDF/status/1960364428786057545>.

79 This section was authored by LAW.

80 ICTY (International Criminal Tribunal for the former Yugoslavia) (2006) 'Prosecutor v. Stanislav Galić.' Case No. IT-98-29-A. 30 November. The Hague: ICTY. <https://www.icty.org/x/cases/galic/acjug/en/gal-acjud061130.pdf>.

81 ICC (International Criminal Court) (2019) 'Situation in the Democratic Republic of the Congo in the Case of The Prosecutor v. Bosco Ntaganda.' Case No. ICC-01/04-02/06. Trial judgment, 8 July. The Hague: ICC. <https://www.icc-cpi.int/case/icc-01-04-02-06>.

82 Under the Rome Statute, intentionally directing attacks against hospitals and other medical units is a war crime (arts. 8(2)(b)(ix) (IAC); 8(2)(e)(iv)). The Rome Statute does not cover negligence, incidental damage, or disproportionate attacks unless the conduct also meets the definition of another war crime such as intentionally directing attacks against civilians or civilian objects (Rome Statute, art. 8(2)(b)(i)-(ii); art. 8(2)(e)(i)). In addition, international crimes include intentionally attacking civilians (Rome Statute, art. 8(2)(b)(i); art. 8(2)(e)(i)); attacking civilian objects (art. 8(2)(b)(ii)); murder (art. 8(2)(c)(i)); cruel treatment (art. 8(2)(c)(i)); starvation of civilians as a method of warfare when focused on objects indispensable to their survival (art. 8(2)(b)(xxv); Additional Protocol (AP) I, art. 54; AP II, art. 14); and the destruction or seizure of property not justified by military necessity (Hague Regulations, art. 23(g); Rome Statute, art. 8(2)(a)(iv)).

83 Global Initiative to Galvanize Political Commitment to International Humanitarian Law (2025) *Progress Report*. Global IHL Initiative Progress Report October 2025 ENGLISH.pdf.

84 UNGA (United Nations General Assembly) (2013) *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*. Note by the Secretary-General. A/68/297 of 9 August. <https://docs.un.org/en/A/68/297>.

85 Insecurity Insight (2024) *Security Risk Management for Health Care Services*. Handbook. Geneva: Insecurity Insight. <https://insecurityinsight.org/wp-content/uploads/2024/08/Handbook-Security-Risk-Management-for-Health-Care-Services-EN.pdf>.

86 All reports are publicly available on the SHCC website: *Safeguarding Health in Conflict Coalition – Protecting Health Workers, Services, and Infrastructure*.

87 Many of these reports are cited in this comprehensive mapping study: RIAH (Researching the Impact of Attacks on Healthcare) (2026) *Mapping Report on Actions and Plans by States and Civil Society to Protect Health in Conflict*. Manchester: RIAH Consortium, University of Manchester. <https://riah.manchester.ac.uk/wp-content/uploads/2026/03/RIAH-MappingReport-Mar2026.pdf>.

88 RIAH (Researching the Impact of Attacks on Healthcare) (2025) *Normative States: Successes, Failures, and Lessons for Protection of Healthcare*. Manchester: RIAH Consortium, University of Manchester. <https://riah.manchester.ac.uk/wp-content/uploads/2026/02/RIAH-Normative-States-FINAL-photo-credit-amended-4.pdf>.

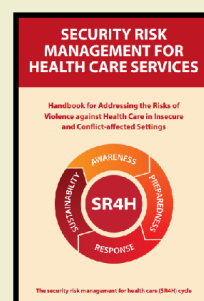
89 This request was also made in a joint statement by the ICRC, WHO and MSF on 3 May 2026: <https://www.icrc.org/en/statement/icrc-who-msf-health-care-must-never-be-casualty-war-resolution-2286>.

Other resources

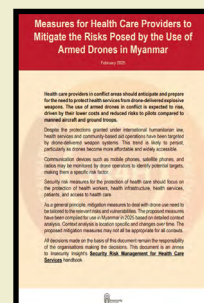
Attacks on health care were relentless in 2025, ten years after the unanimous adoption of United Nations Security Council Resolution 2286, which reaffirmed the protection of the wounded and sick, medical personnel, and humanitarian workers during armed conflict. Using data collected by Insecurity Insight, 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.

The opinions expressed in the report do not in any way reflect the position of the UK government, FCDO, or Tides Foundation, which are not responsible for the content expressed in this document.

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 May 2026. Switzerland: Insecurity Insight. <https://bit.ly/10YearHealthReport2026>