Medical Care in the Crosshairs
The attack on humanity

MEDECINS SANS FRONTIERES

Photo frontcover: The severely destroyed Al shifa hospital in Gaza city. February, 2025. Photo: Nour Alsaqqa/MSF

Photo backcover: Burnt-out corridors, collapsed roofs, twisted metal and ash, is all that remains of many building at the MSF Trauma Centre in Kunduz, northern Afghanistan, following the 03 October US airstrike on the facility which killed more than 20 MSF staff members and patients. Afghanistan. October 2015. Photo: Andrew Quilty.

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Acronyms

ACLED	Armed Conflict Location & Event Data
AWSD	Aid Worker Security Database
CAR	Central African Republic
DRC	Democratic Republic of the Congo
HCiD	Health Care in Danger initiative
ICRC	International Committee of the Red Cross
ICU	Intensive care unit
IDF	Israel Defence Forces
IHFFC	International Humanitarian Fact-Finding Commission
IHL	International Humanitarian Law
INSO	International NGO Safety Organisation
GPS	Global Positioning System
JIAT	Joint Incident Assessment Team
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
RoE	Rules of engagement
SSA	WHO's Surveillance System for Attacks on Health Care
SHCC	Safeguarding Health in Conflict Coalition
UNGA	UN General Assembly
UNSC	United Nations Security Council
WHO	World Health Organization

↑ Security adviser Oleksandr Cherniavskyi surveys the extent of the destruction. MSF team examines the scale of the destruction after the recent attack. MSF office is completely destroyed. Ukraine, April 2024. Photo: Yuliia Trofimova/MSF.

Executive Summary

Ten years ago, on 3 October 2015, MSF experienced one of the deadliest attacks in its history. Forty-two people, including 14 MSF staff, were killed when a US AC-130 gunship attacked the MSF Trauma Centre in Kunduz, Afghanistan. This incident and others in Syria and Yemen, along with advocacy campaigns by the medical-humanitarian sector, put the protection of medical care in armed conflict on the agenda of governments, international organisations and NGOs. Seven months later, on 3 May 2016, the UN Security Council unanimously adopted Resolution 2286, condemning attacks against medical facilities and personnel in conflict, and demanding that parties to armed conflict comply with international law.

Since that resolution, there has been little evidence of progress. Drawing on extensive data, this report concludes that 10 years after the Kunduz attack, medical and humanitarian care in armed conflict is under fire more than ever. The report analyses underlying causes and impacts of recent attacks and provides practical recommendations for states to enhance respect for and protection of medical and humanitarian care in armed conflict.

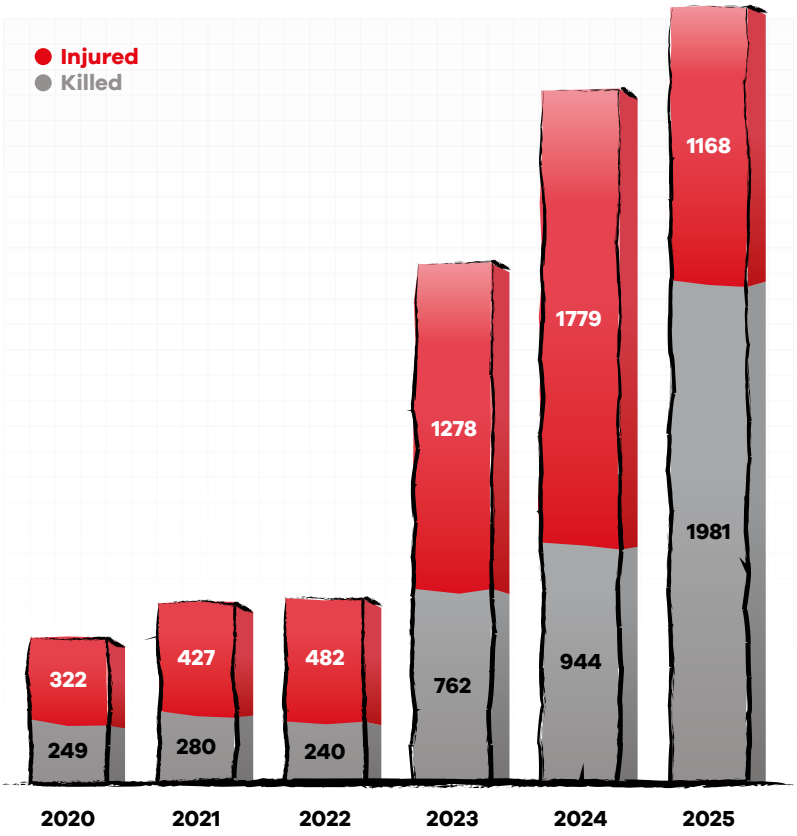
Data from UN and NGO sources demonstrates that since 2021, attacks against medical and humanitarian action in contexts of armed conflict have increased, with numbers reaching new highs every year. For example, the Safeguarding Health in Conflict Coalition (SHCC) recorded 3,623 incidents in 2024 against healthcare in armed conflict – a new high and an increase of 15 per cent from 2023 and of 62 per cent from 2022. Every database consulted shows that in 2024 the number of attacks as well as the number of medical and aid workers killed had doubled – at least – from 2021 figures.

Most of these attacks took place in a handful of situations: Lebanon, Myanmar, Palestine, South Sudan, Sudan and Ukraine. The full list of countries where health and aid have been under attack includes many more. The majority of incidents in 2024, as many as 80 per cent, were attributed to States. The Israel Defense Forces alone have been responsible for a staggering number of attacks against medical and humanitarian facilities and staff: at least 53 per cent of attacks against medical care and 67 per cent of killings of medical staff in 2023 and 2024 happened in contexts where Israeli forces conducted most of the attacks. Violence against medical and humanitarian care not only destroys facilities and kills staff and patients. It also has other far-reaching consequences: when health services stop functioning or medical-humanitarian actors withdraw because of attacks, people and communities are deprived of lifesaving medical care, making life even more unbearable in areas in armed conflict.

The motivations behind such attacks are often difficult to verify. However, the prevailing narrative has shifted in certain contexts from that of "mistaken attacks" to one of "loss of protection" of medical and humanitarian facilities and personnel, as afforded under international humanitarian law (IHL). This shift often reflects a subordination of mitigating civilian harm to claims of military necessity. In some cases, these attacks may stem from a misinterpretation of the relevant rules of IHL, which exploits ambiguities in both treaty and customary law. For instance, core requirements such as the obligation to provide timely, advance and feasible warnings – giving medical facilities the opportunity to address the circumstances argued for the loss of protection or to evacuate patients – are too frequently ignored. Warring parties also appear less willing to uphold the protection from attack of fighters who are hors de combat (out of action) and thus protected by IHL – in practice stripping such individuals as well as the facilities treating them of their legal safeguards.

The adoption of Resolution 2286 has often been referenced as a turning point in the effort to reduce attacks on medical humanitarian facilities and personnel in conflict and to hold perpetrators accountable. The reality on the ground shows otherwise: the situation has not improved and has arguably worsened. This report provides analysis, reflection and measures that parties to armed conflict ought to take to enhance the protection of and respect for medical care and humanitarian action in armed conflict. This commitment is more than a purely legal obligation. Attacks against medical and humanitarian care in armed conflict are attacks against humanity, and must be treated as such.

Attacks on healthcare worldwide



Source: World Health Organization

Violence against healthcare workers goes unpunished

Despite clear prohibitions under international law, no one has been held accountabile for the 7,500+ documented attacks.

Source: World Health Organization

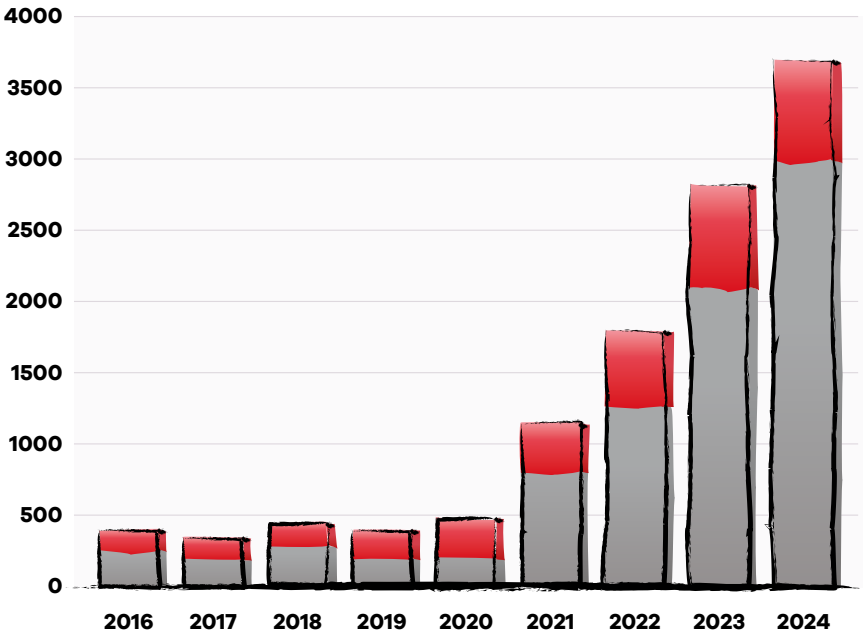
Destruction or damage to medical facilities

In 2024, more than 1,100 medical facilities were destroyed or damaged – more than double the previous year.

Source: Safeguarding Health in Conflict Coalition

Violent incidents and obstruction of aid

Since 2022, violent incidents against healthcare workers have increasingly been attributed to state actors (i.e., not gangs, but military combat operations).



81% of violent incidents in 2024 were committed by state actors, with the frontrunners since 2022 being Russia (in Ukraine) and Israel (in Gaza, Lebanon, and Syria).

3.231 Non-state armed gangs

8.250 State actors

Source: Safeguarding Health in Conflict Coalition

Conflict zones where healthcare was most frequently attacked in 2025

In 2025, violence against healthcare providers and medical facilities led to the destruction of vital health infrastructure and disruptions to medical care, leaving thousands of patients without access to care.

	Conflict areas	Attacks	Deaths	Injuries
1	Ukraine	577	19	204
2	Palestine / Gaza	449	125	357
3	Myanmar	70	148	186
4	Sudan	65	1620	276
5	Democratic Republic Congo	40	0	10
6	Syria	32	41	10
7	Mali	21	1	2
8	Russia	21	0	17
9	Cameroon	20	0	6

	Conflict areas	Attacks	Deaths	Injuries
10	Haiti	11	1	8
11	Israel	9	0	42
12	Burkina Faso	9	4	5
13	South Sudan	9	16	44
14	Thailand	5	0	0
15	Iran	3	6	0
16	Lebanon	3	0	1
17	Yemen	2	0	0
18	Libya	1	0	0
19	Cambodia	1	0	0

Source: World Health Organization

↑ Damaged OT room in Sheraro hospital. Ethiopia, March 2021. Photo: MSF.

Introduction

↑ Burnt-out corridors, collapsed roofs, twisted metal and ash, is all that remains of many building at the MSF Trauma Centre in Kunduz, northern Afghanistan, following the 03 October US airstrike on the facility which killed 42 people including 14 MSF staff members and patients. Afghanistan, 10 October, 2015. Photo: Andrew Quilty.

The Kunduz Trauma Centre in Afghanistan, which MSF opened in 2011, was regarded by medical and humanitarian workers as a safe place. It proved not to be. In the early hours of 3 October 2015, over the course of an hour, a US AC-130 gunship fired 211 shells at the main hospital building, despite repeated calls by Médecins Sans Frontières (MSF) staff urging that the attacks be halted.[1] As MSF's International President stated in her address to the UNSC on the day Resolution 2286 was passed: "I truly believed that the hospital was a safe place. I cannot say that any more about any medical facilities on the frontlines today."[2]

For MSF, this was one of the deadliest attacks in its history – a history defined by operations in many of the world's most insecure places, where extreme needs are often compounded by inadequate and insufficient humanitarian response. In Kunduz, 42 people were killed, including 14 MSF staff. It was a devastating loss for the organisation. In its acknowledgement of responsibility for the attack, the US attributed the incident to a tragic series of "mistakes".

Just seven months after the attack in Kunduz, on 3 May 2016, the UN Security Council unanimously adopted Resolution 2286 on the protection of medical missions. This initiative sparked hope. It was the first time a Security Council resolution directly addressed attacks on healthcare in armed conflict, and its content was robust. The resolution was passed just one week after MSF-supported Al Quds Hospital in Aleppo, Syria, was attacked, killing 55 people.[3] No one claimed responsibility for the attack, but it was clearly carried out by an actor with airstrike capabilities. Syria had such capabilities, as did its ally Russia, who supported Resolution 2286. Three months later, Saudi Arabia bombed another MSF-supported hospital, this

time in Abs, Yemen, killing 19 people, including one MSF staff member.[4] It was not the first such attack by the Saudi-led coalition. Riyadh was backed in its war by three other countries that had also voted in favour of Resolution 2286: the US, the UK and France.

Attacks on medical missions cause not only immediate and devastating harm but also have serious medium- and long-term consequences. They force the closure of essential medical services, cutting off access to healthcare for communities that often have no alternatives. These people live in areas already ravaged by violence, where the loss of medical care makes life even more unbearable. Worse still, in many areas, the presence of humanitarian organisations is either limited or entirely absent, due to actual or perceived insecurity. These are often the very areas where needs are most acute and the humanitarian response is weakest. One of the most frequently cited reasons for this gap is precisely the lack of security and the persistent threat of attacks.

Ten years after the Kunduz attack, assaults on medical and humanitarian missions – and the conditions that enable them – are widely perceived as even more prevalent than they were in October 2015. This concern is shared not only within the medical and humanitarian sectors, but probably also across civil society and political spheres. While comparing incidents across different times and contexts is inherently complex, the situation in countries such as Palestine, Sudan and Ukraine strongly suggests a deepening erosion of respect for medical and humanitarian action. As will be explored in this report, this trend is evident in both statistical data and the discourse of political leaders, military actors, and others engaged in armed conflict. The recent situation in Palestine illustrates a worrying shift in narrative – from framing attacks as "mistakes" to invoking a "loss of protection". While some attacks are still labelled as errors, in many cases the Israeli armed forces have justified direct attacks on medical facilities by claiming that these sites had forfeited their protected status under IHL. The burden of proof, in effect, has been inverted: instead of being presumed civilian and protected, "a population or a health facility has to prove that it is not of military character".[5]

This report reviews attacks on medical and humanitarian missions over the past decade and examines the various initiatives that have emerged in response. It also seeks to shed light on the current situation and the underlying factors that may explain it. The analysis draws on data from seven databases,[6] while acknowledging the limitations and challenges inherent to the available information. The report interrogates how such attacks continue to occur and what factors allow or facilitate them. Finally, it offers concrete, actionable recommendations aiming at reversing this trend and strengthening the protection of medical care and humanitarian action in armed conflict.

Medical and humanitarian organisations are fully aware that, while medical facilities are granted extensive protection under IHL, this protection may be lost under certain circumstances. However, such loss of protection is intended to be an absolute exception, and it is strictly conditioned on specific requirements. These include the provision of timely, advance and feasible warnings that give the facility an opportunity to address and resolve the situation that allegedly triggered the loss of protection – or to evacuate patients. Furthermore, even if an attack is carried out, the principle of proportionality must still be upheld. In practice, however, parties to armed conflict may interpret or apply IHL rules in ways that significantly undermine the protection of medical and humanitarian services. This report therefore analyses the current legal and operational frameworks.

The purpose of this report is not to discourage medical and humanitarian engagement in insecure areas – quite the opposite. In line with its medical and humanitarian mandate, MSF seeks to advocate for conditions that make such work possible. To that end, this report includes several recommendations that aim to facilitate the provision of impartial care in armed conflict.

The Kunduz attack and its aftermath

↑ Iron roofing and rubble litter a corridor in the MSF Kunduz Trauma Centre as the facility lies destroyed following the 03 October aerial attack which killed 42 people including 14 MSF staff members and patients in northern Afghanistan. Afghanistan. October 2015. Photo: Andrew Quilty.

2.1 Before Kunduz

There has never been a safe "golden age" for MSF and other humanitarian and medical organisations, which have come under attack throughout their existence. In this regard, Kunduz was not a first. The UNSC had already addressed concerns about attacks against humanitarian action in resolutions 1502/2003[7] and 2175/2014[8], and both the ICRC and MSF had initiated their campaigns: the ICRC's Health Care in Danger (HCiD) in 2011[9] and MSF's Medical Care Under Fire in 2013.[10] Selected examples prior to Kunduz include:

- The ICRC documented 2,400 attacks against health workers, patients, medical facilities, and medical transports in 11 countries between 2012 and 2014.[11]
- In South Sudan, in the six months between 15 December 2013 and 15 June 2014, 58 people were killed in four MSF hospitals, including 25 patients. There were 17 incidents in which medical vehicles were stolen or destroyed; seven incidents in which non-medical MSF premises were forcibly entered, ransacked, looted and/or occupied; and six incidents in which hospitals were ransacked, looted and/or burnt. All these incidents occurred in the towns of Bentiu, Bor, Leer, Malakal and Nasir.[12]
- In Syria in 2015, 94 aerial and shelling attacks hit 63 MSF-supported facilities, often by "double-tap" attacks, in which a second wave of strikes is launched to kill first responders. In these attacks, 81 MSF-supported medical staff were killed or wounded.[13]

In October 2015, the hospital in Kunduz was not the only health structure attacked. In Syria, MSF documented 12 hospitals in the north of the country bombed in that month, including six supported by MSF.[14] In Yemen, the Saudi-led military coalition destroyed an MSF-supported hospital that October,[15] and two other MSF-managed or -supported health facilities in December and January 2016.[16]

MSF first worked in Afghanistan in 1980, and attacks on MSF facilities, staff and transport shortly began. MSF teams documented attacks on healthcare in Afghanistan already during the Russian invasion. In the 2000s, one of the deadliest attacks, unprecedented in the history of MSF, occurred on 2 June 2004. Five members of its staff (two Afghans and Belgian, Dutch and Norwegian nationals) were deliberately attacked and killed when a clearly marked MSF vehicle was ambushed in the north-western province of Badghis.[17] Government officials presented MSF with credible evidence that local commanders conducted the attack, but they were not detained. A Taliban spokesperson also claimed responsibility for the killings (opportunistically, as they were probably not involved) and falsely stated later that organisations like MSF worked for US interests, and threatened with further attacks. MSF decided to pull out of Afghanistan, denouncing the lack of government response to the killings and the US-led coalition's attempts to co-opt humanitarian aid and use it to "win hearts and minds".[18] Between 2004 and 2009 the organisation did not work in Afghanistan.

By 2009 the humanitarian situation in the country became too dire to be absent for MSF, an organisation with a self-proclaimed objective of providing healthcare in situations of armed conflict. MSF negotiated the return with the Afghan government and other armed actors. This resulted in an agreement, based on IHL, which included respect for the facilities, transport and staff; all wounded people to be treated within MSF facilities and no weapons allowed. In June 2015, MSF opened a clinic in Chardara district, 15 km from Kunduz, largely under the control of the armed opposition, where nurses provide immediate care to trauma patients before being transported to Kunduz city. MSF worked in both sides of the frontlines, in areas under the control of both parties to the armed conflict.

On 1 July 2015 – three months before the US attack – heavily armed Afghan Special Forces entered in the hospital in Kunduz, cordoned off the hospital, began shooting in the air and physically assaulted three MSF staff members (one was threatened at gunpoint by two armed men) and arrested three patients. One hour later, they released the patients and left the hospital. MSF temporarily suspended activities at the hospital.[19] When the Taliban forces took Kunduz in late September, they visited the hospital and committed to respect what was previously agreed with them and the former authorities, and "they did not enter the hospital to search for wounded enemy forces, nor did they try to enter with weapons when bringing or visiting patients."[20]

2.2 3 October 2015[21]

In October 2015, the Taliban and other armed opposition groups were combated by the Afghan armed forces and two US-led military coalitions: NATO's Resolute Support and US Operation Freedom's Sentinel. Those coalitions were made by soldiers or dozens of countries, and there was also unilateral presence of armies of other countries and a significant number of private military contractors.

On 28 September 2015, the Taliban captured Kunduz City, the sixth largest city in Afghanistan, with a population around a quarter of a million people. It was the first time that they had seized a provincial capital since they were ousted from power in 2001. Heavy fighting in Kunduz in the early morning forced MSF to activate its mass casualty plan to receive an expected large number of wounded patients. By 10pm, MSF medical teams had treated 137 wounded including 26 children. Since the opening of the trauma centre in 2011, the vast majority of the wounded combatants were government forces and police, but the week starting that 28 September this shifted to primarily wounded Taliban combatants as the frontline shifted. On 30 September, 65 out of the 130 patients were wounded Taliban combatants, but a large number of patients self-discharged from the hospital since that day, some against medical advice.

Between 28 September and 2 October, MSF shared its GPS coordinates with different US, NATO and Afghan military interlocutors, who confirmed receipt. MSF also increased the number of MSF flags on the roof of the hospital, and it was one of

the only buildings in the city with full electricity from generator power on the night of the attack. In that period, MSF treated 376 patients in the emergency room (between one quarter and half, depending on the day, were severe cases requiring immediate care) and performed 138 surgeries.

On 3 October an AC-130 aircraft from the US Air Force struck the hospital's central building, which included the emergency and X-ray rooms and the operating theatres where MSF staff were performing surgeries. The GPS coordinates of this building were precisely the ones shared by MSF with the military forces. Strikes started between 2 am and 2:08 am and lasted about one hour. They were precise and sustained and only targeted the main hospital building – the first room hit was the intensive care unit (ICU), where staff were caring for immobile patients, some on ventilators. The rest of the buildings in the MSF compound were comparatively untouched. MSF made multiple calls and SMS contacts to US, NATO and Afghan authorities in Afghanistan and the US to try to stop the airstrikes, but did not succeed.

There were 140 locally hired MSF staff and nine international colleagues in the hospital area, as well as one ICRC delegate. As the strikes started, three international staff and 23 national staff were performing surgeries or caring for patients in the main building; eight patients were in the ICU and six were in operating theatres. People were shot from the air as they tried to flee the main building. MSF medical staff were shot while running to reach safety in different parts of the compound.

The MSF-run Kunduz Trauma Centre was a functioning hospital. A very relevant one that provided high-quality, free surgical care to victims of trauma, from traffic accidents to weapons-related injuries. It was the only health facility of its kind in the entire North-eastern region of Afghanistan. [22] At the time of the attack, the hospital was in full operation, with two of the three operating theatres busy. 105 patients were at that moment in the hospital, of which between 3 and 4 of the patients were wounded government combatants, and approximately 20 patients were wounded Taliban.

Since the opening of the hospital in 2011, MSF had performed more than 15,000 surgeries and more than 68,000 emergency patients had been treated. In 2014, the complete year before the attack, MSF teams treated more than 22,000 patients and performed more than 4,241 surgeries. Between January and August 2015, 3,262 surgeries were performed. [23] The hospital had an emergency department, three operating theatres, an ICU, X-ray, pharmacy, physiotherapy and laboratory facilities. It was a 92-bed hospital, but the number of beds increased to more than 140 at the end of September, just a few days before of the attack, to cope with the unprecedented number of admissions. By 2015, the hospital employed 460 staff. Services were complemented in June 2015 with an MSF-supported clinic in Chardara district, 15km from Kunduz, for immediate care to patients before being referred.

The MSF review of the attack confirmed MSF's initial observations: "the MSF rules in the hospital were implemented and respected, including the 'no weapons' policy; MSF was in full control of the hospital before and at the time of the airstrikes; there were no armed combatants within the hospital compound and there was no fighting from or in the direct vicinity of the trauma centre before the airstrikes".[24]

There were four investigations on the attack in Kunduz: (1) by MSF; [25] (2) by the US: 721 of a total of more than 3,000 pages made partially public, much of it redacted; [26] (3) by Afghanistan, which was never made public;[27] and (4) by NATO (Resolute Support Combined Assessment Team), not made public but with a press release.[28]

After the attack, MSF engaged in discussions with all parties to the conflict over an 18-month period, finalising formal commitments that allowed the MSF teams to gradually resume providing medical care in Kunduz. In July 2017, MSF opened a new outpatient clinic in Kunduz for people with minor trauma-related wounds and injuries, the first return to the area. In August 2021, MSF opened a new trauma centre.

2.3 10 lessons (not only) from Kunduz

The US attack against the hospital in Kunduz represented a turning point for MSF and globally. It was one of the most devastating events in MSF's history, and it triggered significant action in MSF to learn what happened and why such a tragedy took place. The official version provided was that a series of mistakes made it possible, but beyond the direct cause of the attack, MSF has learnt many lessons, including the following:

1 **Humanitarian actors may interpret IHL differently than state military forces or the parties to an armed conflict.** In the heavily redacted 721 pages made public, the US investigation report identified a series of human and technical "errors". However, an analysis of the contents reveals that many of those errors were in fact "incorrect understanding and implementation of IHL and the military doctrine", and that "rules and procedures were not at all clear enough amongst the military forces".[29] Humanitarian and medical organisations and armed actors, operating in the same geographical space, need to have a shared understanding of their practical protections, as we shall see later in this report.

2 **The treatment of wounded combatants, while fully legal and a pillar of IHL, may not be accepted and respected by the parties to the armed conflict.** Bound by medical ethics, MSF regards everybody as entitled to healthcare. MSF and other medical organisations treat patients only based on their needs, not on who they are, and regardless of whether they might be labelled belligerents, terrorists or criminals. This is MSF's ethical responsibility. And it is this impartiality that underpins MSF's ability to operate in contexts of armed conflict. According to IHL, a hospital in which all patients are wounded fighters is still a protected site. The caring for war wounded was not the reason for the attack on the hospital in Kunduz, but several facts suggested that treating such patients may be unwelcome or could raise suspicions among the parties to the conflict: for example, the incursion conducted without a warrant by Afghan special forces on 1 July 2015 to arrest patients; the question from a US Government official in Washington about whether the hospital or any other MSF locations had a large number of Taliban "holed up";[30] the notion raised during trilateral discussions among MSF and the US and Afghan armies that a hospital could be held "hostage" by the Taliban;[31] media reports in the US suggesting that the attack took place because US forces believed the hospital was taken by the Taliban;[32] and public declarations by top Afghan authorities that the hospital had been "occupied by Taliban".[33] In Syria, it had become clear that treating wounded combatants was not permitted: laws issued on 2 July 2012 criminalised medical aid "to anyone injured by pro-government forces in protest marches against the government".[34]

3 **Armies and parties to the armed conflict may have flawed and opportunistic interpretations of IHL and the loss of protection of medical facilities.** The statements made by US and Afghan officials mentioned above suggest an association of the presence of wounded Taliban fighters with purposes other than medical assistance. This can be inferred from the words used: "hostage", "taken", "holed up", "hiding", "occupied" or "shelter". The US report said that "the hospital was reportedly held by the Taliban" and made several references to a hospital and to a "Taliban command and control node".[35] The claim is both untrue and, in the view of MSF, not the reason for the attack on the hospital.[36] But these statements raised concerns: if those words had reflected reality, the Taliban presence could be interpreted as a hostile act harmful to a party to the conflict and outside a humanitarian function, potentially amounting to loss of protection.[37] IHL makes no distinction regarding the loss of protection in civil and military hospitals. However, military doctrines may make such a distinction. According to US military doctrine, incidental harm to military medical facilities is not prohibited. In this regard, Françoise Bouchet-Saulnier and Jonathan Whittall wondered if, "under the US LoWM [Law of War Manual], the presence of the wounded Taliban in the Kunduz Trauma Centre on the night of the attack may have adversely affected its civilian status under US military doctrine and thereby deprived it of the highest level of protection."[38]

4 **The concept of self-defence can be misused and abused.** According to the US investigation, both air and ground

forces justified the operation as "self-defence" via pre-emptive attack. The US forces invoked their rules of engagement (RoE[39]) regarding self-defence, but they were followed in a manner inconsistent with the IHL obligations of precaution, distinction and proportionality, which still apply in cases of self-defence. US doctrine prioritises the security of its own forces and invoking self-defence was understood as an authorisation to eliminate the supposed threat at any cost, even if the threat was not in the hospital, but in an unspecified area including it. For the ground commander, what mattered was not the absence of hostility from the MSF hospital, but the possibility of hostility arising in an environment that had been in its entirely as hostile.[40]

5 **Contexts with multiple military actors and overlapping legal and operational frameworks can be conducive to "mistakes".** In certain situations of armed conflict where humanitarian organisations are operating, the legal and operational frameworks of the various actors may overlap, which presents at least three problems. Firstly, when counter-terrorism laws are applicable, they are meant to work in parallel with other legal frameworks, which means that States cannot use counter-terrorism as an excuse to disregard IHL. In practice, however, States may give preference to counter-terrorism legal and political frameworks, thereby side-lining IHL. Politically, counter-terrorism frameworks are often more permissive regarding the acceptability of harm to civilians and targeted killing, and at the same time less tolerant towards medical and humanitarian action that doesn't obey the logic of "with us or against us". Secondly, IHL is founded on publicly available and widely accessible texts, whereas rules of engagement, domestic military manuals and military doctrines are often confidential. It is crucial to strike a balance between maintaining the necessary level of confidentiality and ensuring that rules are understood consistently both by military forces and by civilian healthcare providers and humanitarians.[41] This balance is essential to enable the latter to take the necessary measures to enhance their safety while operating in contexts of armed conflict. Thirdly, military coalitions involving many nations raise the problem of participants with diverse military doctrines and practices engaging in the same military campaigns. In such instances, the safety of medical humanitarian action does not depend on the best performance in the entire chain of those coalitions, but in ensuring respect and good practices in their weakest links. As stated by the MSF International President to the UNSC during the debate on Resolution 2286: "You are charged with protecting peace and security. Yet four of the five permanent members of this council have, to varying degrees, been associated with coalitions responsible for attacks on health structures over the last year."[42]

6 **If truth is the first casualty of war, accountability is often the second.** Everywhere MSF has been attacked, MSF has demanded explanations and accountability. On 7 October 2015, just four days after the US attack on the Kunduz hospital, MSF requested an impartial and independent investigation by the International Humanitarian Fact-Finding Commission (IHFFC), an investigative body established under the First Additional Protocol to the Geneva Conventions. It was the first time MSF had turned to this Commission. The IHFFC agreed to investigate, but the US and Afghan governments, both non-State parties to the Commission, refused consent. MSF requested clarity on the facts, appropriate measures, and commitments that would allow MSF to continue providing care to people in Afghanistan and beyond. MSF managed to engage in useful dialogue with the US and gain a better understanding of the way military operations are often conducted. This kind of post-attack dialogue with those responsible has been rare in MSF's experience in armed conflict settings, limiting a better understanding of events. The sharing of independent and rigorous investigations with MSF, leading to clarification of facts and a degree of accountability, has also not been the norm. In fact, many attacks have not been acknowledged at all, as has often happened in Syria.[43]

7 **Engagement with special forces has its limits.** Humanitarian actors need to communicate with military forces and non-state armed actors, as a prerequisite to enable medical-humanitarian operations. However, direct engagement with special forces is rare. The disconnect between national security laws and IHL is often mirrored in the separation between "special" and "regular" forces. By definition,

"special" forces play a role in specific operations outside normal procedures, and they are granted broad powers. According to NATO, they use "unconventional techniques and modes of employment".[44] Conditions may include making difficult decisions without requiring authorisation by higher ranks; operating at a level of secrecy not subject to parliamentary control; having immunity from foreign legal prosecution for military action carried out abroad, as well as some degree of de facto domestic immunity, under the provision of secrecy; and extreme pressure to fulfil the mission entrusted to them.[45] A decision may emerge in reaction to a specific situation, and might be at the discretion of a pilot, for example, allowing little time for deliberation or verifying coordinates of protected sites. Moreover, special operations are increasingly conducted by autonomous or remote-controlled mobile robots, such as unmanned aerial vehicles or drones, which may entail technical and communication failures, reduced empathy for populations and a vacuum of legal responsibility. When special forces are in play, the chain of command is often unclear to outside actors (the structure remains secretive). In Kunduz, the airstrikes lasted approximately one hour, with some accounts saying the strikes continued for one hour and fifteen minutes, despite multiple calls and SMS contacts from MSF to their US and NATO interlocutors in Afghanistan and the US.

8 **With the risk of targeted killings, the admission of certain patients may be problematic.** Targeted killings[46] have been tolerated within legal, political and public-opinion perspectives in certain counter-terrorism and other national security frameworks, in spite of violating several human rights principles, including judicial guarantees and due process, as well as the right to life. The practice becomes a major concern when medical-humanitarian actors receive a high-ranking patient in a medical facility. IHL grants protected status to both fighters hors de combat and the medical facilities that receive them. Attacking a medical facility for one "high-value target" stretches the concept of proportionality almost to non-existence. In the episode of Afghan special forces storming the hospital in Kunduz on 1 July 2015, the attack was based on false information that a military commander was being treated in the hospital.[47] In August 2016, Saudi Arabia destroyed a vehicle transporting a targeted wounded person while it was inside the MSF-supported hospital in Yemen.[48] The parties to the conflict may in such instances argue that they are not targeting the medical-humanitarian facilities or transports themselves, only pursuing what they consider a strategic, even legitimate, objective. However, from an IHL and medical ethics standpoint, a patient is a patient, regardless of their military rank or relevance. In practice, cases have been reported of armed groups refraining from taking their leaders to MSF hospitals because they were afraid this could invite an attack against the facility, resulting in the killing of the leader and the closure of the facility serving many more.[49]

9 **Humanitarian aid can be politically instrumentalised.** Obviously, this is not a lesson from Kunduz, given the long history of such instrumentalisation. However, during the first two decades of the 2000s in Afghanistan, military humanitarianism and synergies between military and humanitarian actors were commonplace, although not without controversy. In post-2001 Afghanistan, humanitarian organisations were being systematically incorporated into military stabilisation strategies by the US, Afghanistan and their allies in three ways: "first, the provision of public services enhances government legitimacy; secondly, carefully targeted services help to reduce grievances; and thirdly, encouraging cooperation in healthcare can make it possible to also encourage cooperation on other issues."[50] What enables such a scenario is that humanitarian principles are not conceived and implemented consistently across the humanitarian sector. However, MSF categorically rejects the use of humanitarian aid as a stabilisation and state-building tool in contexts of armed conflict. This rejection can be met with hostility from government and military authorities that expect such collaboration. This disagreement doesn't explain the attack on the hospital in Kunduz, but it does shed light on some of the statements and arguments used by political and military authorities.

10 **IHL is not enough – effective protection requires active engagement.** Since the attack on the hospital in Kunduz, MSF has strengthened measures regarding identification of health facilities; systematised notification and deconfliction

procedures with parties to the conflict; analysed and improved understanding of acceptance and perception of MSF action; imposed restrictions and internal rules in medical facilities and transport, such as the banning of weapons (including knives traditional in certain cultures), the presence of mobile phones or the wearing of military uniforms; ensured that no gathering of armed groups takes place in the immediate vicinity of MSF health centres and offices; prevented fighters from using medical facilities as refuges for temporary rest; and has taken many other locally adapted measures intended to reduce any potential perception of a use other than purely medical-humanitarian. These measures go well beyond what IHL imposes. The effective protection of medical facilities requires explicit and contextualised negotiations. This is what MSF does in many places, in regular dialogue with all actors over the rationale behind respecting not only hospitals, but medical services as a whole. In Afghanistan, MSF renegotiated the humanitarian space with the Afghan and US governments.[51] Since Kunduz, MSF considers sharing GPS coordinates indicating the whole perimeter of the protected site, not just one central coordinate.[52] This may help the parties identify the right boundaries.

2.4 UNSC Resolution 2286 and follow-up initiatives

Adopted partly as a response to the attack against the MSF trauma centre in Kunduz,[53] UNSC Resolution 2286 was the first-ever resolution on attacks on healthcare in contexts of armed conflict. The members of the Security Council unanimously expressed their "deep concern" about increasing numbers of "acts of violence, attacks and threats against medical personnel and humanitarian personnel exclusively engaged in medical duties [...] as well as hospitals and other medical facilities".[54] The Resolution was not designed to declare additional obligations but to "demand" that all parties to armed conflicts comply with existing obligations under international law, those of IHL in particular; take proactive measures to prevent attacks and promote accountability; increase data collection on attacks and obstruction of medical care in armed conflict; implement practical measures for the protection of medical care into the planning and conduct of military operations; and investigate and hold accountable those responsible for serious violations.[55]

MSF strongly supported the resolution and significantly contributed to its development,[56] knowing that it would only be effective if member states enacted it and followed through. For MSF, the ability to protect the wounded and sick and those who care for them was the last front line for humanity in the otherwise inhumane and brutal reality of war.

The resolution provided some improvements on existing IHL rules, but it was mainly seen as a reassurance that impartial medical action would be protected in contexts of armed conflict. The improvements included the broadening of the terminology of IHL protection to medical and humanitarian personnel exclusively engaged in medical duties, without requiring the State to assign this status (a designation required under IHL); it did not mention State consent as a requirement for medical and humanitarian assistance (IHL requires such consent) and obliged all parties to the armed conflict (State and non-state) to facilitate safe and unimpeded passage; stated that the protection offered by the IHL does not depend on the proper identification of the protected assets; listed follow-up mechanisms such as the UN Secretary-General to report violence against or obstruction of medical care in his annual report on protection of civilians in armed conflict; requested States to amend domestic legal frameworks to comply with international obligations and prevent impunity; promoted data collection on attacks on medical missions; and requested the UN Secretary-General to provide further recommendations to operationalise the content of Resolution 2286.[57]

Recommendations of the Secretary-General after UNSC Res. 2286

A.	Establishing or reinforcing a framework of respect for, and 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 in armed conflict
1.	Adhering to relevant international treaties
2.	Reinforcing national legislative frameworks
3.	Guaranteeing the ability of personnel exclusively engaged in medical duties to act in line with medical ethics, without incurring sanctions or punishment for doing so
4.	Promoting regular cooperation, including exchanges of information, analysis and best practices, among all stakeholders
5.	Enhancing the role of United Nations peace operations
6.	Using available means of influence vis-à-vis parties to a conflict in order to ensure respect for, and prevent violations of, international law relating to the protection of medical care in armed conflict
7.	Promoting awareness and compliance
8.	Reporting on the implementation of Security Council resolution 2286 (2016)
B.	Enhancing the protection of medical care in armed conflict
9.	Adopting, reviewing, revising and implementing operational precautionary measures
C.	Enhancing the documentation of, and accountability for, acts of violence against medical care in armed conflict and providing redress and assistance
10.	Contributing to regular data collection, analysis and reporting on incidents
11.	Ensuring full, prompt, impartial, independent and effective investigations into serious violations of international law relating to the protection of medical care in armed conflict
12.	Ensuring that individuals suspected of perpetrating serious violations of international law relating to the protection of medical care in armed conflict are prosecuted
13.	Providing reparations and assistance to victims and restoring essential services

↑ Source: UNSC, "Letter dated 18 August 2016 from the Secretary-General addressed to the President of the Security Council", ref. S/2016/722, 18 August 2016, https://digitallibrary.un.org/record/839216

However, for the most part, the resolution and the recommendations by the Secretary-General have not been implemented comprehensively by States and have failed to meaningfully reduce attacks against medical facilities or to clearly establish inquiry mechanisms to document and investigate relevant situations, to adopt targeted sanctions, and to establish or refer accountability mechanisms.[58] Also, domestic prosecutions have remained rare, and no meaningful investigative and accountability mechanisms have been set up or operationalised. To date, no successful international prosecutions for attacks on medical care have taken place. Although the UN Secretary-General provided recommendations aimed at enhancing the practical application of protections,[59] these efforts did not create meaningful follow-up. As Bagshaw and Scott report, "in 2018, the UN Secretariat canvassed the members of the informal 'Group of Friends' of Resolution 2286 on steps they had taken to implement the resolution. Only one state responded. A similar survey of all 193 UN member states in advance of the 2021 report focusing on implementing Resolution 2286 received only fourteen responses."[60]

In 2021, the SHCC concluded that States had not lived up to any of their obligations under Resolution 2286.[61] Based upon that conclusion, Physicians for Human Rights called it an "abject failure of the UN Security Council and UN Member States to take any meaningful measures to prevent attacks or hold those responsible to account".[62] Indeed, neither MSF nor any other medical or humanitarian organisation can operate more safely today than before the adoption of Resolution 2286.

While Resolution 2286 is the only resolution dealing specifically with the protection of medical care in armed conflict, other relevant resolutions

deserve mention. In Resolution 1894 (2009) on the protection of humanitarian personnel, the Security Council stressed the importance of respecting and protecting humanitarian personnel in situations of armed conflict.[63] In its Resolution 79/138 (2024) on the safety and security of humanitarian personnel and protection of United Nations personnel, the UN General Assembly also emphasised the importance of the protection of such personnel.[64]

Group of Friends of Resolution 2286

In 2016, Canada and Switzerland established this informal group. Meeting periodically in Geneva, it now includes Australia, Austria, Belgium, Brazil, France, Germany, Italy, Japan, Liechtenstein, Luxembourg, the Netherlands, Norway, Portugal, the United Kingdom, and Uruguay.[65] It represented one of the only state-led follow up initiatives of Resolution 2286,[66] but is no longer active.[67] The group's main objective was the swift and consistent implementation of Resolution 2286 through diplomacy and advocacy. Working primarily at UN level, the informal multilateral group engaged and informed UN debates and UN initiatives, supported national policy and legislation, and advocated for better protection of medical care in armed conflict more generally.[68] Given that only few states, even amongst its members, had implemented its recommendations consistently, little had been operationalised.[69]

Political declaration on the protection of medical care in armed conflict

In 2017, France launched a political declaration which was endorsed by 48 States.[70] The Declaration represents a non-binding instrument under which States commit "to take practical measures to enhance the protection of, and prevent acts of violence against, the medical and humanitarian personnel, and to better ensure accountability for violations, in accordance with [...] international humanitarian law".[71] The declaration identifies several areas of action, including: acceding to and ratifying relevant treaties; reviewing relevant national legislation and policies, including military doctrine and operational practice; ensuring protection to the wounded and sick, medical and humanitarian personnel exclusively dedicated to medical care; ensuring that legislation and policies permit impartial and unimpeded provision of medical care in armed conflict in line with medical ethics; refusing arms transfers if they risk being used to commit serious violations of IHL; calling upon the UN Security Council to adopt measures in response to violence against health care in conflict; calling upon States to use means of influence to ensure respect for IHL protecting health care in conflict; emphasising the importance of advance warnings providing a reasonable time limit to evacuate personnel and staff; establishing oversight, fact-finding and investigative, and accountability mechanisms; providing assistance to victims allowing for the restoration of critical services. However, as a non-binding declaration without central follow-up mechanisms or enforcement abilities, the declaration essentially repeats existing obligations under international law.

Deed of commitment for the protection of health care in armed conflict

In 2018, Geneva Call launched a so-called Deed of commitment to engage non-state armed groups with IHL norms.[72] Under this initiative, non-state armed groups formally, though voluntarily, would commit to rules protecting healthcare facilities and personnel in armed conflict, mirroring those under IHL. Undersigning groups also consent to Geneva Call publicising compliance or non-compliance and to monitoring and verification procedures.[73] In addition, Geneva Call also developed a series of training materials to engage non-state armed groups on the issue of protecting health care in armed conflict.[74] To date, five non-state armed groups have signed the Deed of commitment.[75] Although ratification has remained limited compared to other Geneva Call's deeds of commitment, it represents one of the only initiatives engaging directly with non-State armed groups and offering them the possibility to positively commit to respecting and protecting medical care in armed conflict.

Ministerial group for the protection of humanitarian personnel

In September 2024, a group of nine countries (Australia, Brazil, Colombia, Indonesia, Japan, Jordan, Sierra Leone, Switzerland and the United Kingdom) announced this group "dedicated to upholding and championing international humanitarian law and driving action to protect humanitarian personnel in conflict zones."[76] On 22 September 2025, it released the Declaration for the Protection of Humanitarian Personnel, that at the time of writing has been signed by 105 States,[77] with a wide geographical representation. The Declaration deplores the "growing numbers of attacks, acts of violence, arbitrary arrest and detention, and threats by State and non-State actors" on humanitarian staff (paras 2 and 4). While acknowledging that the legal framework of IHL is clear and comprehensive, it concludes that "meaningful accountability and justice is lacking", requiring practical action to enhance the respect for and protection of humanitarian

missions (paras 7 and 9). Noteworthy, thereby, is the call to cooperate directly with humanitarian organisations, to provide adequate financial support for the security and protection of humanitarian personnel (paras 17–20), and to "ensure that humanitarian activities carried out by humanitarian organisations are not criminalised" (para 21.2). The declaration identifies four areas of action: respect for and adherence to IHL; "allowing and facilitating full, safe, rapid and unhindered humanitarian access"; "alignment of actions to strengthen protection for" humanitarian personnel; and "commitment to pursuing greater accountability and justice in response to incidents" (para 21).[78] The Declaration has the potential to meaningfully enhance the practical security of humanitarian and medical missions in armed conflict. However, much depends on the actual willingness of States to take appropriate domestic action and keep the momentum internationally.

Global initiative to galvanise political commitment on IHL

In 2019, Germany and France presented the Call for Humanitarian Action, aimed to "mobilise the international community to effectively implement and strengthen international humanitarian law, particularly as regards the protection of humanitarian workers and healthcare personnel".[79] It called for an implementation of Resolution 2286, including by incorporating the protection of medical care in the planning of military operations, conducting legal trainings for state and non-state military actors, taking into account concerns of humanitarian actors in regard to counter-terrorism measures and legislation, and enhancing the documentation of relevant rules of IHL and preventing a culture of impunity. The Call has been endorsed by 51 States.[80]

In September 2024, Brazil, China, France, Jordan, Kazakhstan and South Africa, along with the ICRC, launched a global initiative with the objective to produce concrete and practical recommendations and good practices on challenges and violations of IHL by the end of 2026.[81] As of September 2025, the initiatives included 89 states and set up a dedicated working group on the protection of hospitals, co-chaired by Nigeria, Pakistan, Spain and Uruguay.[82] Although the results of the current round of consultations and the initiative had yet to be seen, the broad coalition of States and the ICRC promised a serious endeavour to identify current challenges to IHL as well as practically relevant responses that go beyond recommitting to existing norms. It is particularly laudable that this initiative includes a dedicated working group on the protection of hospitals. However, the implementation of any recommendations and good practices will require long-term efforts and commitments beyond 2026.

Civil society initiatives and research projects

The protection of medical and humanitarian personnel has also been addressed by several civil society initiatives.[83] Similar to MSF, several NGOs that have experienced attacks against their personnel have called for independent and transparent inquiries and investigations, mostly without success. In addition to data-collection and reporting initiatives, several NGOs, including MSF, have also been engaged in advocacy campaigns on the protection of medical care in armed conflict.[84] In 2017, on the occasion of World Humanitarian Day (19 August), the UN Office for the Coordination of Humanitarian Affairs (OCHA) launched its global #NotATarget campaign to reemphasise the protection of civilians, including medical and humanitarian workers, in armed conflict.[85] It served as a global call to raise public awareness and advocate for protection and accountability. The campaign was supported and continues to be amplified by a variety of organisations, including WHO, the ICRC and MSF.[86] The #NotATarget hashtag was originally coined by MSF in 2015.[87]

Several academic research projects have also taken up the issue of the protection of medical and humanitarian missions in armed conflict. The Researching the Impact of Attacks on Healthcare consortium, led by the Humanitarian and Conflict Response Institute at the University of Manchester, "aims to improve the understanding of the nature, frequency, scale, and impact of attacks on healthcare in conflict through enhanced data collection and analysis" to support global policy and advocacy efforts.[88] It continues to produce a high number of academic analyses as well as policy reports relevant for the protection of healthcare in armed conflict.[89] Similarly, the Humanitarian Research Lab at the Yale School of Public Health addresses the issue of protecting the health of populations affected by crises, including armed conflict, by analysing and preserving evidence that can be used for ongoing and future accountability mechanisms.[90] Finally, Forensic Architecture, a research agency based at Goldsmiths University of London, through an interdisciplinary approach investigates and reconstruct incidents of state violence and human rights violations.[91] Although not concerned specifically with the protection of medical care in armed conflict, it has released several highly relevant reports on attacks against or affecting medical missions and hospitals.[92]

2.5 Fact-finding and accountability instruments

In the past ten years, several fact-finding and investigative mechanisms have been created. UN bodies have established fact-finding missions and independent investigative mechanisms to conduct investigations into violations of IHL and human rights for specific contexts (e.g., Libya, Myanmar, Palestine, Sudan). NGOs and independent lawyers have also conducted their own investigations.

The International Humanitarian Fact-Finding Commission (IHFFC)

Immediately after the attack on the hospital in Kunduz, MSF turned to the IHFFC.[93] Although established in 1991, this mechanism had never been activated before MSF's request. Two requests listed on the IHFFC website were also related to attacks against MSF: one in Yemen (Shiara hospital, Razeh district in Sa'ada governorate, attack of 10 January 2016) and one in Syria (Ma'arat Al-Numan, Idlib province, attack of 15 February 2016). While the cases on Kunduz and Yemen were requested by MSF, the third, concerning Syria, was proposed by the IHFFC itself.

The IHFFC can only conduct investigations in two circumstances: a) into State parties, as membership implies consent for such investigations; and b) into non-state parties when they expressly approve. Only States parties can request a formal investigation. Furthermore, the IHFFC only applies to Additional Protocol I to the Geneva Conventions relating to the protection of victims of international armed conflicts, although it may apply to non-international armed conflict when it is authorised by the affected State (a very unlikely scenario). The reluctance of governments to submit the conduct of their armies to external investigations is widely evident. Neither Afghanistan, the US, Syria, Russia nor Saudi Arabia are States parties to the IHFFC and, unsurprisingly, none consented an independent investigation.

In fact, the IHFFC has never succeeded in conducting a formal investigation. By requiring the express approval of the investigated parties, it is fundamentally flawed. Yet this instrument would likely never have been allowed to exist had it not included this provision. The IHFFC stated that the best thing that humanitarian organisations could do would be to continue to record incidents and request IHFFC investigations, and that the lack of investigations did not mean the IHFFC had not contacted the parties to the conflict and conveyed their concerns.[94]

The IHFFC can also offer its "good offices". In this case, the consent from States is not required (what happens when a non-state party objects is not regulated), and the outcome is similar to that of the formal procedure. Good offices can be requested by State parties or an "interstate organisation" (but not NGOs). The offer of good offices has successfully happened twice: a) in relation to an attack in Ukraine at the request of the OSCE in 2017 (Russia, then a State party, did not object, but withdrew from the IHFFC in 2019 because of this case and is no longer a State party); and b) Poland in relation to the Polish worker of World Central Kitchen killed in Gaza. In the case of the OSCE (an interstate organisation), the investigation team included members of the IHFFC and external experts, including forensic specialists. When a "good office" is agreed upon, the MoU specifies what information may be made public and how. In terms of transparency, this seems an advantage over the formal procedure, wherein both State parties involved (the requesting party and the party under investigation) must expressly authorise any publication (by default, all communication is confidential).

The IHFFC relies on the trust of states. The IHFFC is not an accountability instrument, but rather one at the service of states willing to improve their compliance with IHL.

On accountability

Deliberately attacking medical facilities and medical personnel is a serious violation of IHL and a war crime. The Rome Statute unambiguously criminalises intentional attacks against "hospitals and places where the sick and wounded are collected, provided they are not military objectives" in both international and non-international armed conflicts.[95] It is equally prohibited to attack civilian medical personnel as well as persons seeking medical care, including combatants and fighters hors de combat.[96] However, it bears notice that, to date, no person has been convicted under the Rome Statute specifically for attacks against medical facilities. As Leonard Rubenstein observes:

> There has been only one prosecution in an international tribunal for a war crime against a hospital, and the last trial for crimes against humanity concerning

> health was the case against Nazi doctors after World War II for brutal human experimentation in its concentration camps. For violence inflicted on health care, justice hasn't just been delayed; it has not even been attempted.[97]

Following the attack on the hospital in Kunduz, the US, NATO and Afghanistan conducted their own investigations. The attacks in Yemen were investigated by the Joint Incident Assessment Team (JIAT), an internal mechanism of the Saudi Arabia-led coalition. However, these investigations have been the exception, rather than the norm, with regard to attacks on humanitarian and medical facilities.

Independent, effective and prompt accountability mechanisms are needed. What is clear is that for anything to have a real impact, strong political commitment is necessary. However, even if independent investigations were possible, humanitarian needs and accountability mechanisms do not work at the same tempo. When MSF asks for clarification of the facts, it does not necessarily only seek justice, but also concrete improvements from an operational standpoint. Medical and humanitarian organisations need to understand the dysfunctions that caused an attack and what commitments the warring parties will make to correct them. Even if governments and armies do consent to independent investigations, the international mechanisms are largely designed to obtain results that, at best, will lead to a change in military behaviour in the long term. This might be useful for future wars, but humanitarian organisations need reactive investigations that produce results quickly, and that allow the continuation of medical and humanitarian activities. In this regard, investigations carried out by the parties to the conflict, even if not independent, can be of great help.

MSF has valued the publication of internal investigations and has also conducted its own inquiries. In some cases, rigorous investigations conducted by the parties to the conflict may be more valuable than ones outsourced internationally, especially when a non-independent investigation facilitates dialogue, accountability, avoidance of further attacks and increased trust, enabling the continuation of medical-humanitarian operations. However, it appears increasingly unlikely for the parties to the armed conflict to conduct such investigations.

Attacks against medical facilities, personnel and patients must be investigated – and, if appropriate, prosecuted – by States if committed by its own nationals (including by members of its armed forces) or on its territory.[98] However, domestic investigations, in particular concerning acts of a State's own armed forces, have oftentimes proved to be futile. States also have a right, although no legal obligation, to investigate, and where appropriate prosecute crimes committed by anyone under the principle of jurisdiction.[99] Although national criminal investigation and prosecution under universal jurisdiction could fill important gaps in penalising attacks against medical care, the concept of universal jurisdiction has not been utilised in a meaningful way:

> Despite clear prohibitions under international law, not one person has been held accountable for any of the over 7400 attacks documented by WHO [since 2018]. Historically, only a handful of cases have led to charges and prosecution.[100]

10 years after Kunduz: humanitarian action and medical care (still) under fire

↑ Palestine, Khan Younis, south Gaza, April 23, 2024. Photograph taken inside Nasser Hospital, after a siege by the Israeli forces. At the end of January, the Israeli forces issued evacuation orders for the entire area and surrounded the hospital, which found itself at the centre of intense fighting for several weeks, April, 2024. Photo: Ben Milpas/MSF

A decade has passed, but violence against medical and humanitarian action in situations of armed conflict remains. Indeed, in his report of 15 May 2025, the UN Secretary-General, using figures provided by Insecurity Insight, presented the situation as follows:[101]

> In 2024, violence against medical personnel and facilities caused the destruction of vital health infrastructure and the disruption of medical care, leaving thousands without access to necessary treatment. In 20 conflict-affected countries, more than 870 healthcare workers were killed, more than 770 were injured, more than 100 were kidnapped, and around 300 were threatened or assaulted. The highest numbers of medical workers killed and injured were in Lebanon, the Occupied Palestinian Territory, followed by Ukraine and Sudan. Kidnappings of medical personnel were most prevalent in the Democratic Republic of Congo, Mali, Myanmar and Nigeria, while Ethiopia reported the largest number of health workers displaced by violence. Attacks on medical personnel were also

reported in Mozambique, Niger, the Syrian Arab Republic, Yemen and elsewhere, exacerbating the challenges faced by healthcare workers and patients.

Health facilities were frequently struck and at times misused for military purposes, exposing patients and medical staff to harm. This conduct resulted in death and injury and severely weakened healthcare systems, leaving hospitals inoperable and populations without medical services. More than 900 healthcare facilities were damaged or destroyed in the same 20 countries, with WHO documenting incidents affecting patients, transport and medical supplies. In Gaza, WHO reported more than 300 reported attacks that damaged or destroyed health facilities, with 19 of 36 hospitals and 86 healthcare centres out of service in December 2024. Destruction or damage to health facilities was also observed in Ethiopia, Myanmar, the Sudan, the Syrian Arab Republic and Ukraine. In the Central African Republic, mobile clinics and primary healthcare centres came under attack and, in the Democratic Republic of the Congo, the bombing of hospitals resulted in the death of patients, including children. In parts of Myanmar, humanitarian organisations had to suspend medical activities due to hostilities and severe restrictions on their access, leaving communities without healthcare. In Lebanon, dozens of health workers and patients were killed and health facilities damaged. Attacks on healthcare personnel of facilities also affected populations in Burkina Faso, Cameroon, Mozambique and elsewhere. Ambulances and other means of medical transport were damaged in Lebanon, Ukraine, the Occupied Palestinian Territory and elsewhere. In Colombia and Ethiopia, parties to conflict used ambulances as a cover, exposing them to attack.

3.1 Has humanitarian and medical care become more dangerous?

The attack in Kunduz heightened global awareness of the need to protect medical and humanitarian care in armed conflict. However, this has not resulted in a noteworthy decline of attacks and hostilities. On the contrary, all datasets point to a sharp increase in recent years.

The narrative of deteriorating security conditions for medical and humanitarian action in contexts of armed conflict is not new. Similar concerns were raised around armed conflicts in the Northern Caucasus and Somalia in the 1990s and 2000s as well as in Afghanistan and Sudan in the 2000s and Syria in the 2010s, among others. These narratives were sustained with data and the shared perceptions of a significant part of the humanitarian sector.

A comparative analysis of trends of attacks between different decades and circumstances is complex, if not impossible, and requires cautious interpretation. Every incident is context specific, and figures and criteria vary significantly across different databases. Reporting is constantly improving how incidents are tracked and recorded, but underreporting is still a serious limitation, either due to the normalisation of insecurity, the downplaying of violence affecting national staff, the reluctance to openly report an incident given the potential sensitivity of victims involved,[102] or to retain "the image of success that is so essential to their fundraising efforts."[103] Statistics such as the number of aid workers for relative analyses (there has been a dramatic growth in recent decades) and data regarding intentionality are generally not available; and the perceived risks for humanitarian actors have caused projects to shift, operations to downsize and risk aversion to increase, leading to potentially false interpretations regarding insecurity.

3.1.1 The data and its limits

States and organisations invest in reporting tools because statistics are useful. However, there are limitations that need to be considered, despite all databases having significantly evolved and improved the registration of incidents. These limitations include the following:

- **Quantity and quality of information:** Reporting of incidents by medical and humanitarian staff, as well as analysis, has become more extensive and reliable in the last decade, benefiting from more stable, robust and effective information networks, including diaspora populations. This limits a comparison to past periods, in which incidents may have been significantly underreported and uncertain, especially regarding locally hired staff. However, underreporting may also still occur today, as publicly reporting events might jeopardise the safety of staff and others; access may be restricted for staff, journalists and researchers; internet blackouts or poor connectivity may limit communications; and fear of reprisals may affect reporting activity.

- **Statistics do not properly reflect impact:** The attack on Kunduz counts as a single incident. A robbery or a two-day arrest also counts as a single incident, but these things are not the same. Some datasets only focus on the most severe incidents, while some include other types of violence. Today's humanitarian operations are generally far bigger than in the past, and suspending activity because of an attack may have a far bigger impact. The type of attack and weaponry used today must also be considered, as well as the media exposure and pressure derived from today's global visibility.

- **High numbers in specific contexts alter global statistics:** Not all armed conflicts are equally unsafe for medical and humanitarian action. During the 2010s, Syria was singled out as a particularly dangerous context, while in recent years the numbers of attacks and deaths have significantly increased with the escalation of violence in Myanmar (2021), Ukraine (2022), Sudan and Palestine (2023) and Lebanon (2024), where most attacks have occurred.

- **It is unclear what exactly has increased:** Risks depends not only on threats, but also on exposure. Risk aversion in the humanitarian sector has increased with the greater perception of threat, leading projects to downsize operations and/or reduce exposure. Visibility is higher and reporting is more widespread, affecting perception.

- **Lack of denominators:** These figures are needed to enable conclusions and comparative analysis. The presence of humanitarian organisations and workers in contexts of armed conflict has multiplied in comparison to the 1990s or the 2000s, with their number currently estimated at over 4,000.[104] This means that an increase in the number of incidents in absolute terms could actually correlate with a relative reduction in incidents, proportionally.

- **Humanitarian and medical staff are difficult to define:** Some databases measure attacks on "medical" staff, while others do so for "humanitarian" or "aid" workers. In the case of MSF, those categories overlap but, in general, most medical staff are not humanitarians and most humanitarian workers are not medical staff. The concept of "humanitarian" staff may not be fully interchangeable with that of "aid" workers, and it may be debatable to what extent members of certain organisations, agencies and public and private enterprises may be included in such categories. There is an inherent complexity in classifying a person as a "humanitarian worker".[105] For example, roles such as a truck driver contracted from a private company, community volunteers, or daily workers can blur the boundaries of "humanitarian" status. Moreover, local staff of humanitarian organisations are primarily members of the local community, and many do the same work in and out of the humanitarian environment. It is often hard to determine whether hostility toward a local worker stems from their humanitarian affiliation or from other factors such as family ties, community disputes or broader political and social dynamics – especially in contexts where armed conflict permeates everyday life.

- **Intention, logic of the attack and type of incident are difficult to determine:** The perpetrator of an aggression against a health or humanitarian worker can include a licensed staff angry because a perceived unjust firing, a patients' relative who believes the doctor did wrong or not enough to save his/her life or an armed actor that associates the worker with the enemy. Similarly, economically motivated attacks may occur in contexts where the

acceptance of humanitarians is low, while politically motivated attacks may also involve robbery. It can be very difficult to determine motivations and classify hostility. Moreover, certain acts of violence are more likely to be reported, such as killings or kidnappings, because of their severity and visibility, whereas episodes of harassment, threats or looting of supplies are less likely to be reported or even detected.

This report has examined seven datasets on violence against medical and humanitarian workers and organisations, six of them public and one internal to MSF:

- **The WHO Surveillance System for Attacks on Health Care (SSA).** Established in 2017, SSA is aimed at improving data collection of violence against healthcare in armed conflict and other emergencies and providing reliable evidence for advocacy, accountability, and improved protection of health care. It systematically collects, verifies and analyses data on attacks – defined broadly to include direct violence but also obstruction, looting, intimidation or other acts that impair or obstruct health service delivery – that is gathered from WHO country offices, humanitarian partners, NGOs, media and other sources. It has been the first central, UN-backed monitoring platform dedicated exclusively to attacks on healthcare. Although it has provided valuable data, incidents remain underreported, and the dataset does not identify the perpetrators of attacks.

- **The Safeguarding Health in Conflict Coalition (SHCC).** Established in 2012 as a global coalition of NGOs, academic institutions and relevant professional associations, SHCC similarly aims at gathering and verifying information on violence against healthcare in armed conflict, and engaging in advocacy at the level of governments and the UN. The SHCC produces annual global reports that provide general and country-specific data and analysis. As a non-governmental coalition, the SHCC is able to name perpetrators of attacks. However, it is also affected by underreporting and diverging quality and quantity of data.

- **Aid Worker Security Database (AWSD).** Data is collected both from public sources (through systematic media monitoring) and directly from aid organisations, operational security entities and regional and field-level security consortiums. Incident reports are crosschecked and verified annually (i.e., the latest, unverified incidents provided on the online database are provisional and may change). Aid workers are defined as employees and associated personnel of not-for-profit aid groups that provide material and/or technical assistance. This includes emergency relief, multi-mandated and development organisations, but excludes UN peacekeeping personnel, human rights workers, election monitors or purely political, religious or advocacy organisations.

- **Insecurity Insight.** It uses public sources and verified submissions from partner agencies. Data is not confined to armed conflict situations and is crosschecked with AWSD. Events include verbal or physical violence, obstruction or threat of violence. Aid workers are defined as individuals employed by or attached to a humanitarian, UN, international, national or government aid agency.[106]

- **International NGO Safety Organisation (INSO).** Data collected by INSO only covers countries and areas where it operates (currently 21). Primary incident data is collected and verified by field teams and undergoes several layers of review. It considers security incidents as acts that directly or indirectly, intended or unintended, negatively affect NGOs. This includes physical impact such as loss of life or damage to property, but also threats. It considers NGOs as legally established non-profit entities working in relief and development. It includes the Red Cross and Red Crescent movement but excludes UN agencies which are treated separately. "NGO staff" excludes daily labourers, contracted trucking and embeds.[107]

- **Armed Conflict Location & Event Data (ACLED).** This database provides data on political violence targeting health workers and demonstrations involving health staff. It is derived from a wide range of local, national and international sources in over 75 languages, collected by trained researchers. The data is coded in real time and published on a weekly basis following a multi-stage internal review process. It defines "health worker" as any civilian who engages in actions with the primary goal of providing health services to a community. Health workers are coded as an associate actor when they are involved in an event, regardless of whether they were specifically targeted or not. Only political violence is included – criminal violence is excluded.[108]

	Health-related missions	Humanitarian missions	Coverage	UN included	Government included	Coverage starts	Records on perpetrator/ responsibility	Records motive/ intent
WHO/ SSA	X	If also health workers	SSA reporting system (includes indication of certainty level)	If health-related	If health-related	2018	No	No
SHCC	X	If also health workers	Reliable sources and partner submissions (no independent verification)	If health-related	If health-related	2016	Yes	Partly[109]
Insecurity Insight	If also aid workers	X	Reliable sources and partner submissions (no independent verification)	If aid-related	If aid-related	2020	No	Partly
AWSD	If also aid workers	X	Reliable sources and partner submissions (annual verification through confirmation with partner or other means)	If aid-related	No	1997	Yes	Yes
INSO	If also humanitarian	X	Incidents reported by INSO field teams (prior verification through several layers of review)	Treated separately	No	2019	Yes	Yes
ACLED	X (only events)	No specific category	Reliable sources (no independent verification)	If health-related	If health-related	1997 (Africa) 2010 (Asia) 2016 (M. East) 2019 (rest)	Yes	No

3.1.2 What the statistics reveal

Despite data limitations, a number of conclusions can be drawn from the consulted datasets, as follows:

- **The number of attacks has increased significantly since 2021.** All datasets point to a sharp increase in attacks in recent years:[110] the SHCC recorded 3,623 incidents against healthcare in 2024 – a new high and an increase of 15 per cent from 2023 and 62 per cent from 2022.[111] Of these, over 1,100 incidents involved violence against health facilities causing damage or destruction thereof, which is more than double the number of incidents recorded in 2023.[112] The WHO's SSA database reported 1,647 attacks on healthcare in 2024 and 1,348 attacks in 2025, after reaching a high of 1,788 in 2022 – more than double the numbers of the 802 attacks recorded in 2018. The WHO SSA database shows an increase of killings from 249 in 2020 to 1,981 killings in 2025. When looking at injuries, the numbers have increased from 322 injuries in 2020 to 1,168 in 2025. According to AWSD, 385 aid workers were killed in 2024 (329 in 2025), more than double the average in the years 2018–2022. And the Insecurity Insight database shows an increase of violence (or threats) against aid workers of around 70 per cent in 2023 and 50 per cent in 2024 when compared to the years 2020 and 2021. More than one third of events involving national staff since 1997 occurred since 2021, according to AWSD, the dataset with the longest period of analysis:

	1997 – 2025		2021 – 2025		Percentage of the last term in the entire period	
Staff	**International**	**National**	**International**	**National**	**International**	**National**
Killed	243	3,124	29	1,241	11.9%	39.7%
Kidnapped	368	1,879	38	604	10.3%	32.1%
Wounded	288	2,942	42	1,006	14.6%	34.2%
Detained	22	474	22	430	100%	90.7%
Total	921	8,419	131	3,281	14.2%	39%

An analysis of the above-mentioned public datasets shows that since 2021 significant increases have been reported due to the escalation of violence in contexts that proved particularly dangerous for humanitarian and medical action, including in Myanmar (2021), Ukraine (2022), Sudan and Palestine (2023) and Lebanon (2024). Other contexts where humanitarian and medical missions have frequently been attacked have continued with ups and downs, but with no clearly identified trends, such as in Central African Republic (CAR), DRC, Mali, Nigeria, Somalia, South Sudan and Yemen, while the numbers in Afghanistan and Syria have fallen.

- **Attacks are significantly concentrated in a few countries.** According to AWSD, 52 per cent of attacks between 2014 and 2020 occurred in just three countries: Afghanistan, South Sudan and Syria, while 84 per cent occurred in the top 10 countries. In the period between 2021 and June 2025, the said three countries only totalled 22 per cent of attacks, but the top three (Palestine, South Sudan and Sudan) accounted for 51 per cent, and the top 10, 79 per cent. The Security Insight dataset showed similar figures in the period between 2021 and June 2025, also with 45 per cent for the top three (but in Myanmar, Palestine and South Sudan) and 80 per cent for the top 10. Datasets focusing on attacks on medical missions showed higher concentration: according to WHO's SSA, 83 per cent of attacks between 2021 and mid 2025 occurred in the top three (Myanmar, Palestine and Ukraine) and 98 per cent in the top 10; according to the SHCC dataset, around two thirds of attacks in the period 2021-2024 happened in the top three (Palestine, Ukraine and Myanmar) and 90 per cent in the top 10.

- **Most attacks are attributable to State actors.** According to SHCC, "approximately 81 per cent of incidents of violence against health care in 2024 were attributed to state actors, a percentage that has risen over time together with the more widespread use of explosive weapons systems in urban areas."[113] This source attributed the vast majority of the attacks since 2022 to Russian forces (for attacks in the North Caucasus, Syria and Ukraine) and the IDF (for attacks in Palestine, Lebanon and Syria), but it also attributed many attacks to other national state forces or foreign forces.[114]

- **Israel has been the main perpetrator in 2023 and 2024.** According to WHO-SSA data, 623 out of the total 762 killings (or 82 per cent) and 824 out of 1,556 attacks (53 per cent) in 2023, and 288 out of the 944 killings (31 per cent) and 729 out of 1,647 attacks (44 per cent) in 2024 happened in Palestine; and 238 additional killings (other 25 per cent) and 149 additional attacks (9 per cent) took place in 2024 in Lebanon (11 attacks and 3 killings in 2023). This means that at least 53 per cent of the attacks and 67 per cent of the total killings of medical staff in those two years happened in contexts where Israeli forces were responsible for the vast majority of the killings.[115]

- **Palestine has been the context with most affected medical and humanitarian staff.** According to WHO's SSA, 47 per cent of the attacks, 34 per cent of killings and 49 per cent of injured in the 2023–June 2025 period took place in Palestine. According to Insecurity Insight, 32 per cent of the attacks, 45 per cent of aid workers killed, 33 per cent of injured and 24 per cent of arrested or kidnapped in that period happened in Palestine; and according to SHCC, 35 per cent of the attacks in 2023 and 2024 occurred in the same territory. Finally, 22 per cent of all violence registered in 2023–2025 by the AWSD dataset affected locally hired staff in Palestine, as well as the 45 per cent of aid workers killed in the 2021–2025 period, followed by Sudan (11 per cent). According to AWSD, the number of aid workers killed in Palestine between 2023 and 2025 (572) was higher than the aggregated number in any other country since 1997, considering the entire period with data in the AWSD dataset (since 1997). Afghanistan (490), Syria (310), South Sudan (282), Sudan (274), Somalia (261), DRC (110) and Pakistan (105) were the only contexts registering more than a hundred aid workers killed from 1997 to 2025. Palestine is for all datasets the setting with the most recorded

attacks since 2023, while the WHO's SSA identifies more deaths (50 per cent, 87 per cent of these in 2025) in fewer number of attacks (4 per cent) in Sudan.

- **Hostility against humanitarians and against health staff is not coincidental.** The higher the presence of humanitarian actors within health structures, the higher the correlation between attacks on humanitarians and attacks on health workers. But in situations where the health system is not sustained by humanitarians, the discrepancies may be very high. According to SHCC, "more than 900 health workers" were killed in 2024, "a rise of 21 per cent from 2023", mainly in armed conflict settings; however, of these, only "34 worked as local employees of the internationally supported humanitarian system, but the vast majority provided care under a national ministry of health or de facto authorities", including eight foreigners.[116] This means that most health workers killed were not staff of humanitarian organisations. In some contexts, the opposite applied: most humanitarian workers killed were not conducting health-related activities. Comparing between countries and public datasets:

    - In South Sudan, attacks on humanitarian workers far exceed attacks on health workers, suggesting specific hostility against humanitarians, respect for health staff in certain areas, very few health staff or likely underreporting.
    - In Lebanon and Ukraine, attacks on health workers far exceed attacks on humanitarian workers, suggesting indiscriminate attacks or specific attacks on the health system.
    - In Afghanistan, CAR, DRC, Myanmar, Palestine and Sudan, there are generally high numbers of attacks both on humanitarian staff and on health workers, suggesting high presence of humanitarian organisations within the health system, or indiscriminate violence affecting both.

- **The risk of killing, kidnapping and injury remains highly context-specific for international humanitarian staff.** According to AWSD, 29 international humanitarian staff have been killed in 11 contexts between 2021 and 2025. 21 of them (72 per cent) occurred in just three contexts: Palestine (8), South Sudan (7) and Ukraine (6). Other eight countries registered only one killing. The same source reports in the same period 38 kidnappings and 42 injuries of international staff. Twenty-six of the kidnappings (68 per cent) happened in three contexts: Haiti (14), Mali (7) and Yemen (5), with one to three cases in five other countries. Twenty-eight of the wounded staff (67 per cent) occurred in four contexts: Ukraine (10), South Sudan (9), Palestine (5) and Sudan (4), with one or two cases in 11 other countries.

- **Most humanitarians affected by attacks are locally hired staff.** According to AWSD, between 2014 and 2020 814 national staff were killed, 914 wounded and 681 kidnapped. In the same period, 49 international staff were killed, 110 wounded and 56 kidnapped. This means that 94 per cent killed, 89 per cent wounded and 92 per cent kidnapped were national staff. Between 2021 and 2025, 1,241 national staff were killed, 1,006 wounded and 604 kidnapped, while 29 international staff were killed, 42 wounded and 38 kidnapped. The percentages for the national staff were 98 per cent, 96 per cent and 94 per cent, respectively. Considering that national staff often account for 90 per cent of the total staff (with significant differences in proportion among humanitarian organisations), the number of incidents affecting national staff seem to be higher. However, there are at least two issues to consider: first, 45 per cent of killings of national staff in the 2021–2025 period occurred in only one context: Palestine; second, incidents involving national staff are often significantly underreported, meaning that the true percentage could be higher still.

  In MSF, 107 staff have been killed in the organisation's history (believed to be related to their work with MSF), 91 of which had a national contract.[117] Divided by decade, the numbers are as follows: 27 (1989–2000), 24 (2001–2010), 28 (2011-2020, including 14 in Kunduz) and 12 (2021-2025).[118] This does not show a significant rise or fall in the number of killings, although the number of locally hired staff has increased a lot. Regarding kidnappings, international staff have suffered 23 incidents, with 61 kidnappings between 1980 and 1999 (three per year, 2.7 people per event) compared to 25 incidents with 46 kidnappings between 2000 and mid-2025 (1.8 per year, with 1.8 people per event). On the contrary, the increase in the number of locally hired staff kidnapped has been significant: 10 (0.5 per year) and 82 (3.1 per year), respectively.

- **Attacks on national humanitarian staff are also concentrated in certain countries.** According to the AWSD, in the period 2014–2020, 54 per cent of incidents, 61 per cent of killings and 57 per cent of wounded affecting national staff took place in only three countries: Afghanistan, South Sudan and

Syria; while 66 per cent of kidnapped/detained national staff occurred in four: Afghanistan, DRC, Mali and South Sudan. In the following period, 2021-2025, 40 per cent of killings affecting national staff took place in only two countries (Palestine and South Sudan), while 47 per cent of wounded occurred in three countries (South Sudan, Palestine and Syria). In the entire period 2014–2025, 52 per cent of killed and 42 per cent of wounded national staff took place in only three countries (Palestine, Syria and South Sudan), while 55 per cent of kidnappings occurred in only four countries (Afghanistan, DRC, Mali and South Sudan). In MSF, most of the 107 staff killed related to their work with MSF and around half of incidents involving killings between 1989 and 2025 occurred in only three contexts: Afghanistan, Somalia and Sudan.

- **Movements are increasingly dangerous.** There are indications that frontline medical and humanitarian responders are at increased risk. According to AWSD, in the seven years from 2014 to 2020, 967 humanitarian staff were affected (killings, wounded and kidnapped) on the "road", including 246 people killed, 306 wounded and 411 kidnapped. In the subsequent period, 2021–2025 (in five years), 1,057 humanitarian staff were affected, including 260 killed, 385 wounded and 363 kidnapped. South Sudan was by far the most affected country in both periods, with 210 in 2014–2020 and 182 in 2021–2025. In this most recent period, the main countries affected were Palestine (100), Mali (99), Ukraine (79), DRC (62), Sudan (62), Ethiopia (58), CAR (51) and Somalia (43). Some countries have had a significant reduction in attacks on the road during these two time periods, including Afghanistan (from 132 to 17), DRC (from 114 to 62) and Syria (from 76 to 35). However, the situation dramatically increased in places such as Ukraine (from 0 to 79), Palestine (from 2 to 100) and Ethiopia (from 9 to 58). As we shall see later, risks associated with staff movements are a major source of concern.

3.2 Why are we attacked?

Due to data limitations and the complexity in the interpretation of attacks, absolute conclusions about the reasons for attacks remain challenging. However, it is relatively clear that the total number of incidents affecting health care in armed conflicts remained relatively stable between 2016 and 2020,[119] but there has been a sharp increase since 2021, mainly because of the escalation in hostile incidents in Lebanon, Myanmar, Palestine, Sudan and Ukraine, which have notably involved military actors. An explanation of the recent peaks in attacks seems to be the escalation in major armed conflicts involving at least one State,[120] with fighting occurring close to medical and humanitarian actors and using wide-impact explosive weapons.[121] According to SHCC, "in 2023, 36 per cent of all incidents affecting health services involved explosive weapons use, rising to 48 per cent in 2024. The number of incidents in which aircraft delivered explosive weapons that impacted health care doubled in 2024. [...] The use of drone-delivered explosives that impacted health care services nearly quadrupled in 2024, and occurred in some countries where aircraft strikes were not reported, including Colombia, Niger, and Russia."[122]

The participation of States in armed conflicts results in specific challenges for the protection of medical care. States are more likely to use air-launched attacks than non-state armed groups. The use of explosives – especially in highly populated areas – constitutes a particular risk for facilities, movements and personnel.[123] As mentioned above, more than 80 per cent of all attacks against healthcare involving state actors in 2024 took place on foreign territory, in particular Russia in Ukraine and Israel in Palestine and Lebanon.[124]

3.2.1 Are the attacks deliberate?

Only some of the six datasets considered in this report register the motivations for the attack.

- According to AWSD, 25 per cent of all registered incidents between 2014 and 2020 had a political motive (i.e., based on the victim's affiliation with aid provision and perpetrated to divert, punish or obstruct the provision of aid due to political or military aims), and 12 per cent were incidental (with 25 per cent having economic, disputed or other motives, and a huge share, 38 per cent, having unknown motives); between 2021 and 2025, political motives decreased to 12 per cent, while incidental incidents had risen to 30 per cent (unknown motives still applied in 38 per cent).
- In the period 2019–2024, NGO Safety notes a "profile-related" motive (i.e., incident intended to target the NGO specifically due to some characteristics of their work, such as the type of programming) in 40–60 per cent of all incidents (with Ukraine, at 15 per cent, as outlier), and "collateral" reasoning (i.e., incidents in which involvement of NGO or NGO workers was entirely incidental/accidental and not related to either their professional or personal characteristics) in 8–25 per cent of all incidents (with Palestine, at 37 per cent, and Ukraine, at 71 per cent, as outliers). This could be explained by the increased use of air-launched attacks, which may cause more harm.

In certain contexts, the number of attacks is so high that intentionality is hard not to see. MSF's Secretary General stated that the pattern of attacks by Israeli forces against humanitarian workers, facilities and transport was "either intentional or indicative of reckless incompetence."[125] Indeed, within the first seven months of Israel's military campaign in the Gaza Strip, 32 of the 36 hospitals in Gaza were damaged directly or indirectly, raided by the IDF, or put out of service.[126] MSF's Secretary General concluded that this "not only shows the failure of deconfliction measures; it shows the futility of these measures in a war fought with no rules. That these attacks on humanitarian workers are allowed to happen is a political choice. Israel faces no political cost."[127]

In many contexts, intentionality seems less the explanation than putting military objectives over the protection of despised people considered an obstacle to those objectives. IHL has cynically and mistakenly been used for the calculation of risk-benefit ratios to assess acceptable levels of so-called collateral damage.[128] Collateral damage refers to people or civilian assets harmed in the immediate vicinity of a military target that may be a legitimate target under IHL. But warring parties are obligated to minimise the harm caused to civilians and civilian infrastructure and abide by the principles of proportionality and precaution. In theory, if precautions are taken, civilian lives can be spared. The problem is that the criteria for evaluating proportionality and precaution falls on military strategists often acting under pressure to meet military objectives.

One justification for collateral damage would hold that making living conditions unbearable for people will reduce popular support for the enemy being targeted. This practice is not new.[129] Indiscriminate attacks fit in this logic. In Syria, Physicians for Human Rights counted up to 601 attacks on 400 different health centres in a decade of war, which killed 942 health professionals.[130] But Islamic Relief also pointed out that the number of bombed schools was counted in "thousands".[131] Patients were terrified to stay overnight in a hospital, but students and teachers probably had similar feelings. The same could be said for farmland or other civil facilities.[132]

Box 1 lists several overlapping motivations, based on MSF's experience, for deliberate attacks on healthcare. Box 2 lists causes for unintentional attacks. Both lists result in similarly harmful consequences.

Box 1 Overlapping motivations that may apply in deliberate attacks on health care

Source: Alejandro Pozo, Helen Richards and Natasha Sax, "Medical Care Under Fire; The New Normal? MSF's experience in Gaza, Sudan & Ukraine", MSF-Iecah, October 2024, https://arhp.msf.es/wp-content/uploads/2024/12/Medical-Care-Under-Fire.pdf

- Use lethal force to directly target an individual or object within a health facility to achieve a military advantage; this has included the targeting of wounded fighters, despite their protected status under IHL.
- Conduct law enforcement operations inside health facilities, including raids, searches and arrests.
- Loot/rob resources from the facility, particularly as means to provide financial benefits to fighters.
- Inflict collective punishment on a population, including by discouraging humanitarian and medical actors from providing services to communities perceived as associated with 'the enemy'.
- Force the displacement of the population by making healthcare unavailable in the area.
- Avoid the scrutiny of international organisations by utilizing tactics discouraging their presence.
- Directly attack local healthcare providers who are viewed as "not neutral" or as part of the "resistance" or "opposition", and thus labelled as a legitimate target (in violation of IHL).

Box 2 Overlapping reasoning potentially explaining unintended attacks against health care

Source: Alejandro Pozo, Helen Richards and Natasha Sax, "Medical Care Under Fire; The New Normal? MSF's experience in Gaza, Sudan & Ukraine", MSF-Iecah, October 2024, https://arhp.msf.es/wp-content/uploads/2024/12/Medical-Care-Under-Fire.pdf

- Lack of awareness that a person or site is entitled to protection from direct attack.
- A mistake of fact, such as confusing a protected object or person, like a health facility or medical worker, with a legitimate military target.
- The erroneous belief that a protected site has lost its protected status.
- An incorrect assessment of the reasonably foreseeable harm to a medical facility, transport or patient during an attack on a legitimate military objective in the immediate vicinity.
- A misinterpretation of the principle of "proportionality" under IHL, resulting in excessive harm to the civilian population and civilian infrastructure.

As a medical-humanitarian organisation, MSF is not positioned to make legal determinations as to the intentionality of attacks. However, intentionality matters, and identifying motivation is crucial to continue providing assistance:

- Attacks against medical or humanitarian facilities, staff or transportation may entail significant legal implications, regardless of whether they are deemed "deliberate", "negligent" or "disproportionate". They may amount to flagrant violations of IHL.
- Risks assessments are a prerequisite for operations, and understanding intentionality is crucial for decision-making, including the possibility of withdrawal due to the safety risks posed to both staff and patients.
- In case of deliberate attacks, notification and deconfliction measures[133] may be irrelevant or even be perceived as counterproductive. Humanitarian notifications only work if armed actors respect the protected nature of humanitarian facilities. In certain locations, including Syria, medical and humanitarian staff have had the impression that notifying armed actors of the location of health care facilities increased the risk of attack.[134]

The above-mentioned motivations and intentionality apply both to State and non-state armed actors. Many of the attacks against medical and humanitarian action have been attributed to non-State armed groups. In some contexts, most security incidents experienced by MSF have been perpetrated by these groups. The killing of 24 people in the Dasht-e-Barchi

maternity in Kabul, Afghanistan, in May 2020 (see details below), a baby shot dead in her mother's arms in front of MSF staff while they sought shelter in the MSF hospital in Zemio (CAR) in July 2017,[135] and the violent incidents against MSF teams in DRC that led to the end of MSF activities in Fizi territory in late 2020[136] are only a few very different examples of attacks against MSF's medical-humanitarian action conducted by non-State armed groups.

3.2.2 A shifting narrative: from "mistake" to "loss of protection"

The US justification for the attack in Kunduz was "a series of mistakes". In Yemen, this rhetoric has also been used by the Saudi- and Emirati-led coalition regarding the attacks on hospitals in both Haydan (26 October 2015)[137] and Abs (15 August 2016)[138]. In Nigeria, the government claimed a "mistake" in the airstrike on a refugee camp in Rann in January 2017.[139] From a humanitarian perspective, "mistakes" which result in the bombing of healthcare facilities are hardly reassuring. Mistakes can be human, technical, procedural or legal, and MSF has insisted that every feasible step be taken to ensure that such errors do not reoccur.

The recent examples in Gaza are indicative of a shift in narratives, from one of "mistakes" to "loss of protection". Medical and humanitarian facilities, vehicles and staff have been attacked or rendered inoperable on a scale never seen before.[140] Some attacks have still been justified as "mistakes", but in many cases the armed forces claimed that the medical facilities had "lost their protection", so as to make them the legitimate objects of attacks. MSF teams have been forced to evacuate the hospitals they were supporting on many occasions, and MSF staff have been killed by the IDF while performing medical activities.[141] The Israeli army has alleged a "systematic use of hospitals" by Hamas – yet those claims have not been independently verified – and concluded that "when medical facilities are used for terror purposes, they are liable to lose the protection from attack in accordance with international law."[142]

But even if such military activity was demonstrated, the Israeli forces failed to fulfil the legal obligations stated by IHL. When a hospital loses protection under IHL, the belligerent actors are still obliged to issue warnings and ensure that any attack complies with the principles of proportionality and precaution, which also consider the "reverberating impacts" of attacks on health care – the effects on the wider health system. The attacking force always bears the obligation to refrain from launching attacks that would cause disproportionate harm to civilians and/or civilian infrastructure. As the ICRC has rightly pointed out, "the basic principle that a health facility is of civilian character today is questioned." Rather than a default protected status, "a population or a health facility has to prove that it is not of military character."[143] Interpreted in this way, rules are deliberately distorted to justify attacks against medical facilities that the rules were designed to protect.[144]

On certain occasions, armies have affirmed that they did not want to attack a hospital, but rather a high-value person inside that facility. In an armed conflict, the parties must distance themselves from medical infrastructures and staff.[145] However, military doctrines may hold just the opposite: for example, the US *Law of War Manual* says that medical infrastructures and staff must be distanced from military locations or face the consequences.[146] This inconsistency may de facto transfer the responsibility for protection from the military to humanitarian-medical actors. For instance, the JIAT justified the bombing against an MSF mobile clinic in Taiz, Yemen, on 2 December 2015 by arguing that MSF should have kept "the mobile clinic away from military targets so as to not be subjected to any incidental effects" and defended the legitimacy of the attack as a "high-value military target".[147]

The rhetoric of loss of protection, sometimes in direct contradiction to IHL, represents a dangerous shift from the narrative of the mistake. It openly challenges the basic principles of IHL concerning proportionality and discriminating between people directly taking part in the hostilities and protected assets and people. In December 2023, 11 UN Special Rapporteurs[148] and an expert stated that "rather than abide by these rules, Israel has openly defied international law time and again, inflicting maximum suffering on civilians in the occupied Palestinian territory and beyond", and included in the suffering the targeting of health facilities and medical and

humanitarian staff, and the arbitrary restrictions on access to humanitarian aid. They argued that "Israel's continued impunity sends a dangerous message suggesting that parties to other [armed] conflicts around the world need not comply with their obligations under international humanitarian law".[149]

As stated by the UN Secretary-General:

> "Parties have also distorted the rules of war to the point of justifying immense civilian harm instead of minimizing it. With permissive interpretations or weak assessments of who is a lawful target, what is a military objective, what is proportional incidental civilian harm, what are feasible precautions, or who poses a threat for detention purposes, parties to [armed] conflict have undercut the humanity principle at the heart of international humanitarian law. This conduct risks lowering standards well below the balance between military necessity and humanity, thoughtfully achieved through decades of international humanitarian law development."[150]

3.2.3 Is caring for "the other" still accepted?

Patients should not be pursued, questioned or arrested while they are under care. This experience was not new before the attack in Kunduz. For instance, in 2011 in Bahrain, many people including injured protestors who were too afraid to seek treatment in public health facilities came to MSF health centres. Armed security forces stormed into the MSF facilities, confiscated medical equipment and supplies and arrested MSF staff.[151]

Health staff have taken an oath to treat every person, no matter who they are. Medical and humanitarian medical staff should never give up in their commitment to medical ethics. They have always argued their right to treat everyone, as stated in IHL and a guiding principle for many organisations, including MSF. Health workers must be respected in all circumstances and not punished for providing healthcare to whoever is in need, regardless its identity or affiliation. Assisting combatants has always been questioned, but it is no longer only treating a member of an armed group that is reviled, but also assisting a relative, a neighbour or anyone who inhabits the same space as the enemy. In some contexts, governments restrict assistance to people "associated" with terrorism or with weapons injuries.[152]

Assisting wounded fighters, especially if they are designated terrorists, is not universally accepted. According to a 2016 perception research by WIN/Gallup International, commissioned by the ICRC, among the general public in 16 countries, 89 per cent of respondents agreed with the statement: "everyone wounded or sick during an armed conflict has the right to health care", while seven per cent disagreed. However, the percentage of those who agreed varied significantly among contexts: from 98 per cent or more in Yemen, Ukraine, Afghanistan and Colombia to 84 per cent in the US, 75 per cent in Israel and 73 per cent in Palestine and South Sudan. 94 per cent in countries affected by armed conflict agreed (compared to 99 per cent surveyed in 2009). Additionally, 30 per cent of those interviewed in Israel, 23 per cent in the US and 16 per cent in Palestine and Iraq found "circumstances" in which they thought it was "acceptable for combatants to target health care workers". In the case of the US – the country with the highest number of respondents – out of the 23 per cent who agreed, such "circumstances" were, for 64 per cent, "when health workers are treating the enemy combatants who are wounded and sick" and for 63 per cent, "when health workers are treating the wounded and sick civilians who side with the enemy".[153] While people who thought that it was acceptable to target health workers in certain situations was a "small minority", it increased in comparison to 2009.

Targeted killings have been made acceptable under certain states' security and political frameworks. This acceptance often depends on the military value attributed to the target and the public perception of how admissible harm to civilians may be. A problem is that high-value targets also become ill or get wounded, and their mere presence in a health structure may justify, in the eyes of some and even if contrary to IHL, putting the entire facility in jeopardy. No State will admit in advance that it may attack a health facility, but it can happen – at least this is what can be inferred from what States and armies publicly and privately declare. For instance, they may argue that they would never knowingly attack

a protected facility. But one wonders whether there may be a limit: what about if there were a designated terrorist being treated in the hospital? And if s/he were accused of killing national citizens? What if the patient were the main leader of the designated terrorist organisation? The way some governments have justified certain attacks suggests that there may be a limit to respecting the legal constraints of IHL. And humanitarians need to know where that limit is. Because IHL clearly states that even the most vilified person would be a protected patient, should s/he be hors de combat and receiving medical treatment.

3.2.4 The danger on the road

Attacks on medical personnel and aid workers "on the move" in the course of their duties represent a particularly concerning yet relatively underexamined phenomenon. These movements happen between facilities, along supply routes or on field visits, as well as during ambulance services, medical evacuations or patients' referrals. These attacks can affect patients, their caretakers, and medical and humanitarian staff. A fundamental principle of IHL is that the wounded and sick must be protected and cared for, thus special protection is provided to medical transports to ensure such access to medical care. However, when ambulances or vehicles are stopped, soldiers or members of armed groups may associate the occupants with their "enemies" or their perceived bases of support. In either case, harassments, threats at gunpoint, arrests and even killings may occur. This has happened to MSF in Sudan,[154] Haiti[155] and many other countries. For instance, in central Mali, an ambulance clearly identified as MSF that was transferring patients between Douentza and Sévaré was violently stopped by armed men in January 2021. The patients, driver and medical staff were detained for several hours, and one patient died.[156]

Palestine has been particularly dangerous for movements, even if practices of humanitarian notification have been widely used to enable deconfliction. On 23 March 2025, the Israeli military attacked ambulances being driven by the Palestinian Red Crescent Society, killing 15 first responders. The Israeli military blamed "professional failures", but its statement repeated accusations that ambulances were routinely used by Hamas to "transport terrorists and weapons", while providing no independently verifiable evidence to support such claims.[157] "Evacuation orders" have also been problematic for movements. On 3 June 2025 MSF teams were informed that any movement to Nasser hospital would require prior authorisation from the Israeli authorities, which would need to be requested 24 hours in advance.[158] For the period during which this directive was in place, ambulances carrying emergency cases accessed the hospital under the risk they would be shot at for lack of authorisation.

Cameroon has been a context of special concern regarding attacks on medical-humanitarian movements. Between 1 April 2018 and mid-March 2019, MSF teams documented 76 events resulting in 129 allegations of violations of IHL specific to the medical mission, including 61 attacks on healthcare facilities and 39 against professionals, including six killings and seven abductions of healthcare workers.[159] They were committed by both non-state armed groups and the Cameroonian armed forces. In the year that followed, until March 2020, eleven MSF ambulances were stopped at military checkpoints. In several cases, MSF staff and patients were intimidated during long interrogations. Soldiers were very aggressive, mistreated and threatened patients, seized phones and took photos and videos of staff and patients, who were even detained for alleged complicity with separatists, hampering their access to health care and putting patients' lives in danger. Some staff and patients had to receive psychological support following these incidents. Soldiers delayed emergency transfers to hospitals and even forced some ambulances to return.

Under IHL, medical transports must be respected and protected by parties to armed conflict.[160] This includes any vehicle exclusively assigned to transport the sick and wounded. Like in the case of medical facilities, those transports only lose their protection if they commit "acts harmful to the enemy" outside of their humanitarian function. Further attention is required to safeguard medical and humanitarian movements to allow medical and humanitarian professionals to perform their life-saving function.

3.3 The impact of attacks

3.3.1 End or reduction of quantity or quality of services

Apart from condemning the acts of violence against medical patients, staff, transports and facilities, Resolution 2286 deplored "the long-term consequences of such attacks for the civilian population and the health-care systems of the countries concerned".[161]

When health services stop functioning because of attacks, people are deprived of lifesaving medical care, making life even more unbearable in contexts of armed conflict. For instance, only considering Kunduz and the first two examples of attacks shown below, a total of 116 people were killed. However, an indeterminate but much larger number of people were deprived of access to health services in contexts where the medical needs were massive and urgent. The reduction or closure of services – or the lower quality provided as a result of attacks – probably cost the lives of many more people.[162]

- Yemen, 2016.[163] On 15 August, the MSF-supported Abs rural hospital in Hajjah governorate in northwestern Yemen was hit by a Saudi Arabian airstrike killing 19 people, including one MSF staff member, and injuring 24 others. As of that date, MSF had a 205-strong staff (over 160 national staff, some 30 Ministry of Health employees on incentives paid by MSF, and a permanent presence of around eight international staff). Between July 2015 and July 2016, the Abs hospital staff had attended 1,631 deliveries, including over 160 caesarean sections in the previous 7 months. The emergency room had treated over 12,000 patients, the vast majority of whom were acute internal medical cases. In the month before the airstrike on the hospital, 22 per cent of all emergency room patients were under five years of age, which means a total of 1,540 admissions. After the attack, the hospital was inactive for 11 days and then partially reopened while destroyed parts of the hospital were being rebuilt. Nine months earlier, on 26 October 2015, Saudi Arabia had struck and destroyed an MSF hospital in Haydan, in northern Yemen. The attack left at least 200,000 people without access to healthcare.[164]

- Syria, 2016.[165] MSF-supported Al Quds hospital in Aleppo was bombed from the air on 27 April by unknown military forces. No one took responsibility for the attack. Since 2013, this 34-bed hospital had been East Aleppo's only cardiology, neurology and paediatric ICU provider, as well as a main referral hospital for paediatrics, internal medicine, ICU and gynaecology/obstetrics. It had a full-service diabetes and dialysis centre, which generally saw 25–30 chronic disease patients daily. The hospital performed an estimated 10 surgeries and five deliveries a day, and the ICU was always at 100 per cent occupancy. On average, Al Quds saw 5,000 patients monthly and provided services free of charge. Most patients were poor and could not receive treatment if Al Quds charged for its services. 55 people were killed in the attack, including six staff, and eight of the hospital staff were also seriously injured. A paediatrician and a dentist killed were said to be among the last medical specialists left in East Aleppo after five years of war. The attack had a heavy emotional impact on East Aleppo's population. Al Quds re-opened 20 days after the attack, but not all services were activated, and capacities were greatly limited. Paediatric, cardiology and neurology services were suspended, as the hospital's paediatrician was killed and essential medical equipment was destroyed. Also, the emergency room and lab, along with their vital supplies, were lost.

- Afghanistan, 2020. On 12 May, armed men brutally and despicably attacked the Dasht-e-Barchi maternity in Kabul, killing 24 people, including 16 mothers, an MSF midwife, and two children aged 7 and 8, and injuring six MSF staff, one newborn and one caretaker. The attackers deliberately and methodically killed mothers and pregnant women in their beds. This attack on a maternity ward had no precedent in MSF's 50-year history. No one claimed responsibility, and MSF's fact-finding exercise could not reach a solid conclusion regarding the identity of the perpetrators. The most likely hypothesis pointed to at least two members of the Islamic State–Khorasan Province armed group. The fact-finding exercise could also not identify their

motivations. No indication was found that MSF, as an institution, was directly targeted, but this possibility could not be ruled out. Other hypothesis suggested the attack was a form of retaliation vis-à-vis Afghan authorities or a deliberate targeting of the women as members of the Hazara community.[166] On 15 June, MSF announced its decision to withdraw from the hospital, fearing that MSF patients and staff would be targeted again. In 2019 alone, MSF teams had assisted 16,000 births in Dasht-e-Barchi.[167]

- Ethiopia, 2021.[168] On 24 June, three MSF staff were brutally killed in an intentional and targeted attack. Their vehicle, clearly identified as MSF, was intercepted as they raced to medically evacuate wounded individuals in Tigray region. Immediately following the killings, MSF and other humanitarian agencies based in Abi Adi evacuated their staff and suspended operations, severely reducing the local population's access to healthcare and lifesaving assistance. In the days and months following the incident, MSF suspended operations in several towns of central and eastern Tigray region and in other parts of the country due to insecurity and the lack of progress on MSF's request for clarification of the circumstances surrounding the killings. In Tigray region alone, in the six months prior to June 2021, MSF's teams provided more than 30,000 outpatient consultations, delivered more than 3,600 babies, provided more than 20,000 routine vaccinations, conducted more than 900 surgeries, and treated more

than 750 people wounded by intentional violence. In August 2022, the lack of response and accountability forced a section of MSF to take the painful decision to permanently close its operations in Ethiopia, representing a significant part of MSF's overall work in the country, where MSF has worked for over 40 years. In 2020–21, MSF teams assisted communities in nine out of 10 regions in Ethiopia.

- South Sudan, 2025.[169] On 14 April, dozens of armed men stormed the MSF hospital and office in Ulang, Upper Nile state, threatened staff, and looted vital medical supplies and equipment. The previous day, as violence drew closer to Ulang town, patients began fleeing the hospital in fear – despite being under medical care. At the time, more than 100 patients were admitted and receiving critical treatment, including trauma care, maternity services and paediatric care. All were forced to flee when armed men entered the facility and began looting room by room. In 2024 alone, in this 60-bed hospital alongside a network of decentralised healthcare services, MSF teams provided over 10,000 outpatient consultations, admitted 3,284 patients and assisted 650 maternal deliveries. The incident forced MSF to suspend services, leaving the area without a functioning health facility, halting vital efforts to treat cholera patients and control the ongoing outbreak. Furthermore, more than 800 patients living with HIV, tuberculosis and chronic diseases lost access to their treatment, putting their lives at significant risk. In January 2025, MSF had already been forced to suspend all outreach activities in the region as two clearly identified MSF boats carrying six staff were attacked by armed men.[170] Weeks later, the MSF hospital in Old Fangak – the only one in Fangak county, Jonglei State, serving a population of over 110,000 people – was deliberately attacked on 3 May by two helicopter gunships that dropped a bomb on the MSF pharmacy, where all medical supplies for the hospital and outreach activities were stored. One patient and two caregivers, including one MSF staff, were injured, and patients who were not in critical condition ran from the facility.[171]

3.3.2 Reduction of medical-humanitarian coverage

In November 2016, a project by Humanitarian Outcomes and the Global Public Policy Institute concluded, regarding the effects of insecurity on humanitarian coverage, that humanitarian presence in high-risk areas was declining, clustered in safer areas, and aid was not enough to attend the rising humanitarian needs; that "as access becomes more difficult, aid becomes more basic and less responsive to the most critical needs and the most vulnerable people;" and that donor policies and agency incentives could "work against humanitarian access and coverage" by discouraging aid programming in opposition-held areas and "making the aid presence seem more robust than it actually is."[172]

In 2014, MSF had already raised concerns regarding humanitarian coverage. The report *Where is Everyone?*[173] found that, while the humanitarian aid system had greater means, resources and know-how than ever before, MSF teams repeatedly saw that UN agencies and INGOs concentrated on the easiest-to reach populations, ignoring the more difficult high-risk field locations. The report stated that many humanitarian actors were working at arm's length through local NGOs or government authorities, acting more as technical experts, intermediaries or donors than as field actors; that they often lacked the skills and experience required to conduct technically difficult interventions, in particular in contested areas; and that technical capacity in sectors such as water and sanitation or health also seemed to be declining in emergency settings. Risk aversion in contexts of perceived insecurity against the medical and humanitarian missions was one of the main factors explaining the weak response.

Later, the two-year MSF Emergency Gap Project concluded that "the humanitarian sector, as a whole, is failing to mount timely and adequate responses in the acute phase of [armed] conflict-related emergencies".[174] The project identified many causes explaining the "emergency gap", both external and internal to the humanitarian sector. Internally, the report highlighted the existing flaws in the conceptual drive of the sector, its structural setup and the predominant mindset that shapes the sector's response. Externally, the politicisation, instrumentalisation and obstruction of humanitarian action remained key factors in the shrinking of humanitarian space. MSF stated that insecurity was less an insurmountable

obstacle than what was perceived. However, it is obvious that the continued disrespect and violence towards medical and humanitarian action have had a significant impact on humanitarian response.

3.4 The protection of medical facilities and personnel under IHL

In situations of armed conflict, IHL remains the principal and universally accepted framework governing armed conflict.[175] The rules pertaining to the protection of medical care as well as the wounded and sick are well-enshrined in treaty and customary law. However, the treaty provisions formally bind only those States that have ratified them, leaving gaps in universal applicability, particularly with respect to the Additional Protocols, which have not been universally accepted. Customary international law may close some of these gaps, but it remains more ambiguous in scope and content. As such, it is important to promote protections for medical care that currently exist under IHL while addressing ambiguities that can impair their full effectiveness.

Medical facilities and personnel are protected in international and non-international armed conflicts as a matter of treaty[176] as well as customary IHL.[177] Thus, they must never – that is, under no circumstances and for whatever purpose – be directly and deliberately attacked. However, the obligation "to respect and protect in all circumstances" is not only concerned with protection against attack – it is wider in scope. As such, it requires parties to armed conflicts to refrain from impairing the provision of medical care and to do everything feasible to spare medical facilities from the consequences of armed conflict, as well as to actively protect and facilitate their activities.[178] Hence, IHL prohibits direct attacks against medical facilities and personnel, but also prohibits other military operations that interfere with or impair their proper functioning, such as search or seizure operations.[179]

Medical facilities and staff are civilian in nature, and are protected by the general prohibitions of indiscriminate and disproportionate attacks.[180] These prohibitions also apply to persons who seek medical care within medical units – including combatants and fighters hors de combat – who may never be attacked as long as they abstain from any hostile act.[181] The prohibition of disproportionate attacks in particular plays a critical role: it prohibits an otherwise lawful attack when it is done in the expectation that it would cause excessive immediate injury or death to medical personnel or patients and/or damage and destruction to medical facilities (all this may happen as a result of an attack against a military objective in the proximity of a hospital); in addition, and in view of the fundamental importance of medical facilities and staff in situations of armed conflict, an attacking party must always take into account the indirect and cumulative incidental harm that results from the incidental obstruction of health care.[182] The rule against indiscriminate and disproportionate also restrict the use of certain weapons – and in particular high-impact explosives – in the proximity of medical facilities.

Although situating civilian hospitals in proximity to military objectives ought to be avoided, this would not result in an end of their protection or in not having to consider them in proportionality.[183] However, using medical facilities to deliberately shield military objectives from attacks is prohibited.[184] The classification of persons within medical facilities as "terrorist", "enemy", or "unlawful combatant" does not change the fundamental protection against attacks of anyone who does not, or not anymore, take part in hostilities and their right to receive medical treatment. This also protects medical personnel who provide medical care to such persons: treaty and customary IHL categorically prohibit punishments for or prohibitions of medical activities compatible with medical ethics, regardless of the receiver of aid.[185] As such, would it be allowed neither to attack any person inside a medical unit who has been incapacitated by wounds or sickness and is incapable of defending him- or herself nor to assume a loss of protection of the unit for treating such person. However, the protection of a combatant or fighter presupposes that he or she is not engaging in any hostile act. Although the notion remains open to interpretation, it is generally understood to apply to persons capable of "resuming combat if the opportunity arises, attempting to communicate with one's own party and destroying installations of the enemy or one's own military equipment."[186] In this regard, measures such as prohibiting the use of mobile phones and similar communication

tools, as MSF has done in some of its facilities, can enhance protection, since it reduces the possibility for parties to claim that patients or staff are communicating or coordinating military operations.

IHL requires military commanders to constantly take all "feasible precautions [...] to avoid, and in any event to minimise, incidental loss of civilian life, injury to civilians and damage to civilian objects".[187] This obligation requires parties to armed conflicts to always verify whether buildings of persons are dedicated exclusively to medical activities and, hence, enjoy special protection under IHL. This is the case in particular if they wear visible symbols indicating their medical mission, such as the protected emblems of the Geneva Conventions – Red Cross, Crescent, and Crystal[188] – but may also use other logos, such as those of their respective organisation. When provided, parties to an armed conflict must also implement and crosscheck up-to-date non-strike lists that include coordinates of (mobile) medical units and facilities. Importantly, while the provision of coordinates to the belligerent parties as well as the wearing of emblems and logos is an effective way to enhance the protection of medical facilities and personnel on the ground, the non-use or provision thereof does not deprive them of the protection provided by IHL. Belligerent parties' failure to take these precautions, therefore, constitutes an independent violation of IHL and does not excuse perceived mistakes in attack.

MSF's default policy and practice have been to increase visibility and identification as MSF as much as possible,[189] especially in contexts with records of aerial bombing or where attacks have happened. MSF medical facilities are fully identified (including on roofs and terraces) as are MSF vehicles (on the bonnet, on the sides and on the roof), and MSF standards include nighttime-specific illumination of the identification signs. However, the risk of attacks is demonstrated in practice. In certain contexts, such as Ukraine, the location of hospitals is well known, and their exact coordinates are public knowledge, yet they are still attacked. Ambulances clearly marked are also hit. In other locations, identification is not possible or advisable, because locals perceive the probability of an attack may increase with the identification, because MSF has not been allowed to be registered in the country or because an MSF partner decided not to identify. In contexts of high insecurity, such as Palestine, along with the GPS coordinates MSF also provides to the armies a kind of dossier of each MSF vehicle, including pictures (all sides) and information on registration, plates and other details.

Medical facilities can lose their protection against attack when they are used to commit, outside their humanitarian function, hostile acts harmful to a party to the conflict.[190] This includes all acts that are not the accidental or unintended result of the facility's regular operations and that directly cause harm to one party to a conflict or otherwise deliberately obstruct a party's military efforts.[191] This has been accepted for instances in which such facilities have been used as a base from which to launch attacks, as military observation or command posts, as arms and ammunition depots for a party to the conflict, and as a shelter for combatants and fighters for purposes other than medical treatment.[192] However, particular acts are, thereby, explicitly listed as not being considered acts harmful to one party to a conflict: the carrying of light weapons of medical personnel for self-defence, the employment of armed guards; the temporary storage of arms and ammunitions to be handed over to the proper service; and, most importantly, the hosting of combatants or fighters for purely medical reasons.[193]

Medical units and personnel can, hence, lose their special protection under IHL. But they may only be attacked after a warning that includes a reasonable time limit, and that time limit has expired without compliance.[194] The giving of such warning is not optional and must be given when feasible,[195] although IHL does not as such prescribe a particular form.[196] The specific warning requirement for medical facilities serves three distinct functions: to enable clarifying the situation and responding to unfounded allegations, to enable the termination of acts causing loss of protection, and, where necessary, to evacuate.[197] In view thereof, warnings must, at a minimum, indicate clearly the activities that give rise to a loss of protection, and include a time limit that takes into account the reduced mobility of staff, patients and caretakers.[198] A warning is redundant only if immediate action is required or if a warning would be manifestly futile.[199]

A particular ambiguity to the obligation to provide warnings containing reasonable time limits is added through military or counterterrorism doctrines that deem the elimination of a high-value target an operational priority. If such a target is deemed to be present in a medical facility, such doctrines may deem it acceptable to execute attacks without providing advance warnings and/or time limits, despite IHL giving priority to the issuance warnings. This can lead to significant uncertainties in the field. In fact, on 4 August 2016, the Saudi-led Coalition acknowledged that they should have warned MSF before they attacked Haydan hospital in northern Yemen, as they deemed protection was

lost: "It was imperative to notify the MSF about withdrawing the international protection from this building before carrying out the bombing," the Coalition argued.[200] However, less than two weeks later, Saudi Arabia attacked the hospital in Abs, where a targeted killing of a wounded combatant deemed high-value was carried out.[201] Despite the obligation to issue warnings, the occasions on which MSF have received a warning have been extremely rare. One exception happened precisely in Yemen, where the Saudi-led coalition issued a warning against MSF, and this warning gave MSF the opportunity to identify military activity in the vicinity of the hospital, request them to move away and remedy the situation, and restore the protected status of the hospital,[202] without causing destruction to the hospital and death and injury to staff and patients.

↑ After Israeli forces issued evacuation orders and surrounded the area, Nasser Hospital, where our teams work, found itself at the centre of intense fighting for weeks. Gaza, January 2024. Photo: Ben Milpas/MSF

↑ First of July, Russian forces shelled a hospital in Kherson. A few days later, when we arrived, medical personnel had already begun to clean and repair the damaged parts of the building. But the consequences of the attack were brutal and clearly visible. We found glass from the broken window in a pot nearby. What was striking for me is that the hospital continues to operate, providing help for patients. Ukraine, July 2025. Photo: Yuliia Trofimova/MSF.

Turning the tide: enhancing respect for medical and humanitarian action in armed conflict

↑ The MSF team prepare medical supplies to transport by motor boat to isolated communities in Delta Amacuro state, northeastern Venezuela. Venezuela. May 2023. Photo: Matias Delacroix.

The adoption of UNSC Resolution 2286 and several international initiatives following upon the resolution have not succeeded in meaningfully enhancing the protection of medical and humanitarian care in armed conflict, despite high hopes. In fact, little has changed since 2017, when then-ICRC Vice President Christine Beerli said, "What is needed now is action that will turn these words into reality."[203] MSF had also asked the UNSC members the previous year "to translate this resolution into action" and "re-commit – unambiguously – to the norms that govern the conduct of war".[204]

This section does not aim to provide a "solutionist" approach.[205] The factors leading to attacks against medical and humanitarian action are generally multifaceted. For example, it is quite possible that many of the attacks – including some allegedly resulting from errors or from loss of protection – would have had better guarantees of precaution, distinction and proportionality, or perhaps would never have taken place, in an environment of greater acceptance and trust between medical and humanitarian actors and the warring parties. Also, acceptance and trust are directly dependent on the specific circumstances

of each context, in which the perception of who is carrying out the assistance, what exactly they are doing, how they are doing it and why, and who benefits matters greatly. In this sense, practical measures tailored to each actor and context are often more effective than global solutions, and focusing only on the latter may obscure the specific, tangible local logics that may explain violence against medical and humanitarian action in each location.

However, structural improvements are also important and easier to generalise as proposals. Therefore – recognising that the key factors explaining violence against medical and humanitarian assistance are contextual, local and concrete – structural measures that could foster a safer environment will be addressed here.

Respect for the relevant rules — and the necessary action to ensure such respect — lies first and foremost with parties to armed conflicts. It is the responsibility of States and non-state armed groups to ensure that their forces respect and protect medical facilities and personnel.[206] However, States have a clear moral obligation, flowing from their universal acceptance of IHL's basic principles, to enhance the protection of medical care in armed conflict.[207] This principle is also enshrined in Common Article 1 of the Geneva Conventions which, according to the prevailing interpretation, incorporates a legal obligation under which States are required to take proactive steps to prevent and stop serious violations of IHL by third States and non-state armed groups.[208]

Governments must adopt further legal-political, operational, fact-finding and accountability, and diplomatic actions to turn the tide and to create a safer environment for medical care and humanitarian assistance in contexts of armed conflict.

4.1 Legal-political

For the law to protect, it must first be acknowledged. This obvious truth points to a principal issue in regard to protection: although Geneva Convention IV has been universally ratified,[209] Additional Protocol I and Additional Protocol II, which lay down essential rules on the protection of medical care in armed conflicts, do not enjoy universal ratification.[210] Hence, basic legal instruments entailing fundamental rules on protection have not been ratified by a number of States – including those advocating for respect for those very rules: for example, only six of the 15 UNSC members who unanimously approved Resolution 2286 in 2016 had ratified all Protocols Additional to the Geneva Conventions; only nine were parties to the Rome Statute; only seven to the Arms Trade Treaty; and only six were members of the IHFFC.[211]

Although customary IHL is deemed to mirror most of the fundamental rules and close gaps resulting from lack of ratification of treaty instruments, its content remains ambiguous compared to treaty law.[212] Therefore, respect for the rules begins with States urging non-signatory states to ratify and unambiguously commit to the relevant rules enshrined in Additional Protocols I and II, as well other relevant frameworks.

Effective legal protection of medical and humanitarian care in armed conflict requires a coherent implementation of international legal principles and rules in the domestic legal order. As noted above, national legislation can interfere in practice with the obligations under IHL, especially regarding the right to access to medical care for everyone, including persons considered "enemies" or "terrorists". This right constitutes one of the raisons d'être of IHL, but it has been opposed and questioned along its 150 years of existence. While national laws rarely explicitly make impartial care illegal – Syria being an extreme case in 2012[213] – in many countries, health and humanitarian workers may be threatened with prosecution for doing their job in accordance with medical ethics. In this regard, IHL is clear: all individuals can receive treatment.[214] It is therefore of utmost importance to unambiguously commit to recognising and respecting principled and impartial medical and humanitarian action, with the explicit acceptance by all warring actors for treating wounded combatants and fighters. Respect for the rules and principles of IHL regarding the protection of medical and humanitarian care in armed conflict must be effectively translated into rules of engagement and military manuals.

States, as well as other armed parties to armed conflicts, must consider the special protection and function of medical missions in their military doctrines and practices.[215] They should include special provisions that spell out and clarify the protection of medical mission in the "fog of war". Military doctrines and manuals should

clearly include the effects on medical missions (through deprivation of health services for the population) into the assessment of precaution and proportionality of any attack (duty of commander). Medical and humanitarian organisations provide medical data on such reverberating impacts on health, making this impact "foreseeable" for military commanders and therefore steering their responsibility in decision of attack.

Rules of engagement must not reduce protection against incidental damage to medical and humanitarian facilities due to their proximity to military objectives or their operation in an area considered "hostile",[216] and must make it clear that the responsibility in terms of removing civilian objects from the vicinity of military objectives rests with the parties to the armed conflict. In proximity to medical and humanitarian facilities and teams, States should consider means and methods of warfare that minimise the risk of harm (e.g. avoiding high-impact explosives) and must prescribe precautions to ensure that they are protected to the maximum extent feasible.

Additionally, rules of engagement must never permit attacks against individuals hors de combat seeking medical treatment. In situations in which medical and humanitarian facilities are considered to have lost protection, rules of engagement must oblige military commanders to always issue advance and effective warnings that allow enough time to resolve the problem or evacuate staff and patients. Such warnings should at least be given to the medical civilian authorities in charge of the hospital and given with detailed information about the reason for the loss of protection. Parties to the armed conflict should refrain from opportunistically using the loss of protection for political and military ends and provide impartial and independent assessment of such potential loss of protection.

States have an obligation not only to respect IHL, but also to enforce it. They must use all political, diplomatic and economic measures available to them to increase the protection of medical and humanitarian action and improve accountability by other States.

4.2 Operational

Legal protection must be translated into operational reality. However, humanitarian actors and armed actors operating in the same geographical space too often lack a shared view of the practical protection of medical missions and the correct procedures to follow. As stated above, while the relevant rules of IHL are available to all actors, rules of engagement, domestic military manuals and military doctrines often remain confidential. However, medical and humanitarian organisations know from experience that practical protection primarily depends on armed actors' rules, procedures and doctrines. Hence, it is crucial to strike a balance between maintaining confidentiality and ensuring that these important rules are understood consistently both by military forces and by civilian healthcare providers and humanitarians.[217] In addition, States should inform themselves of the specific protective measures and assurances medical and humanitarian missions require for safe operations, and should take into consideration their critical function and vulnerabilities and educate and train their forces in this regard.[218]

Rules should be clear regarding identification of medical and humanitarian facilities and personnel, including mobile units. States must also ensure that, in contexts where coordinates of medical facilities are shared, they are recorded properly and available to all relevant commanders and personnel. Medical facilities and staff can only lose their protection after a warning has been issued. To deliver such warnings, states must take note of the competent person to whom the warning should be delivered, the most effective way to deliver it, and the timeframe required for evacuation – all of which may be different in different theatres of armed conflict. Oftentimes warnings should be provided not only to the health providers (e.g. a hospital director) but also to whomever needs the information to take necessary steps, including international actors supporting the health facilities (such as MSF).

It is of outmost importance that armed actors unambiguously commit not to use those facilities for military purposes, take active precautions not to locate military objectives in their vicinity, provide separate evacuation routes and safe evacuation areas for medical and humanitarian actors, and prohibit and prevent military presence and activity and stockpiling of military material in such facilities.[219] They should also commit to fully respecting any "no-weapons policies" that are the standard in medical facilities of MSF and other organisations.

Specific operational challenges and risks stem from military coalitions or partnerships. When States and/or non-state armed groups engage in partnered warfare, rules of engagement, military doctrines and means, and previous agreements with medical and humanitarian actors are not necessarily identical for each actor. In such situations, all parties to a coalition or partnership must require that every partner commits at a minimum to the relevant IHL rules and agreements with medical and humanitarian missions, has the relevant information regarding their identification, and shares the understanding of protocols pertaining to the loss of protection.[220] They must use their influence on their partners to ensure respect for relevant rules and procedures and opt out of operations in which they expect they might violate IHL.[221]

4.3 Investigations, fact finding, data collection and accountability

Effective protection of medical and humanitarian action in armed conflict requires credible mechanisms that can establish facts, investigate potential violations of IHL, enable effective prosecutions where appropriate, prevent further episodes and generate reliable data. Fact-finding and investigations are indispensable tools for clarifying facts of contested incidents, attributing responsibility for unlawful attacks, creating the conditions for accountability, and decreasing the current culture of impunity.[222] Clear identification and prosecution can have a deterrent effect that enhances respect for relevant rules, and allow for reparation, correction, improvement and, ultimately, the continuation of medical and humanitarian operations. At the same time, systematic and complete data collection, including the motivation and intent of perpetrators, is essential to understand the scope of the problem and trends and to identify patterns that can inform immediate and long-term operational protection measures and policy responses. To ensure reliable long-term data collection and reporting, relevant organisations and agencies must receive sufficient funding.

Fact-finding and effective investigations have been identified as a critical pillar by the UN Secretary-General calling for "full, prompt, impartial, independent and effective investigations into serious violations of international law relating to the protection of medical care in armed conflict".[223] This was stated by MSF's International President at the time UNSC Resolution 2286 was adopted: "Accountability begins with independent and impartial fact finding. Perpetrators cannot be investigators, judges and juries."[224]

On many occasions, attacks have not been acknowledged, but sometimes investigations following incidents have been conducted by the same States allegedly responsible for the attacks. The publication or the sharing of State-led investigations – whether internal or independent of the line of command – if reasonable, may be of help if they facilitate dialogue, accountability, avoidance of further attacks and increased trust, enabling the continuation of medical-humanitarian operations. However, this seems to be increasingly unlikely. Lack of effective accountability mechanisms is one of the foremost reasons for the current climate of impunity.[225] States as well as regional and international bodies and organisations must, therefore, assess how they can conduct and/or contribute to more effective automatic, independent, impartial and effective investigations into alleged violations of IHL protecting medical and humanitarian missions in armed conflict.

This also requires strengthening existing international fact-finding, investigation and accountability mechanisms,[226] including commissions of inquiry and other initiatives, either ad hoc or as standing bodies. The IHFFC remains the only standing international body specifically mandated to conduct fact-finding missions into alleged violations, and consenting to the IHFFC demonstrates a commitment to IHL. However, only 78 States have made a comprehensive declaration under Article 90 of Additional Protocol I accepting the competence of the Commission.[227] As the IHFFC depends on the consent of States parties to the respective armed conflict – including the potential perpetrator of unlawful attacks – it is unlikely that affected States will readily accept ad hoc the competence of the IHFFC or other fact-finding missions.[228]

Successful international and domestic prosecutions for attacks against medical and humanitarian missions have been rare. Third States can play a critical role in addressing

the current climate of impunity and enabling accountability for attacks against medical care in conflict.[229] International accountability measures regarding such attacks can be supported through a variety of measures: setting the issue as a priority; identifying gaps in the collection and use of evidence impairing effective prosecutions and providing assistance to close those gaps; and defending accountability initiatives against political interference.

States have the responsibility to investigate, and the independent investigation capacity should be strengthened. First, setting international standards of independence and due process for these investigations (e.g. outside the military chain of command); second, monitoring the respect of these standards of investigation; third, making available the results of investigations for review to international independent investigation body or investigators; and fourth, confronting these results with elements gathered from the victim and others.

4.4 Diplomatic

Effective diplomatic advocacy requires States to publicly commit to protection rules and principles and to demand all parties to armed conflicts – including their allies – to protect medical and humanitarian action. This also necessitates publicly condemning unlawful attacks by any party.[230]

The lack of a dedicated international body or representative tasked with the issue of protecting medical and humanitarian care in armed conflict remains a significant omission. The establishment of a permanent framework and procedure fully dedicated to the topic would help to observe and describe relevant developments, monitor compliance with relevant rules, and serve as focal point for international cooperation and advocacy.

- States may consider creating a UN Special Rapporteur on the Protection of Medical and Humanitarian Missions in Armed Conflict in the UN Human Rights Council, to deal exclusively with the issue of medical care and humanitarian action in situations of armed conflict.
- States may also consider creating a Special Representative of the UN Secretary-General for the Protection of Medical and Humanitarian Missions in Armed Conflict, an office that could be mandated to produce a regular report on medical and humanitarian care in armed conflict that identifies State and non-state perpetrators and recommends international responses.
- The Secretary-General could be mandated to produce a recurring publication that focuses on attacks against healthcare and humanitarian action, permitting the naming of perpetrators, where appropriate, and systematically calling on Member States to contribute to prevention and accountability. Regular and formal reporting at this level would ensure continued visibility and sustained attention within key international fora.

In parallel, States must engage in global diplomatic initiatives to enhance protection of medical and humanitarian care in armed conflict, either through existing fora or new global alliances.[231] Rather than splitting up resources and expertise, such fora can serve as spaces for governments to facilitate data sharing (for example by regularly reviewing data collection methods), coordinate diplomatic and political responses to attacks, and advocate for greater accountability.[232] Rather than simply reaffirming already binding norms or even attempt to conclude new treaties, such a forum could also be utilised for the long-overdue task of operationalising UNSC Resolution 2286 and closing ambiguities in the interpretation, application and implementation of existing rules of IHL.[233] Together with medical and humanitarian organisations and other relevant stakeholders, States should develop and share good practices among States, armed forces, and humanitarian actors[234] as well as practical guidelines on military doctrine and operational protocols that can function as norms filling existing ambiguities in IHL.[235]

↑ MSF transferred four patients in critical condition from Kostiantynivka hospital to medical facilities in Dnipro to receive specialised treatment. The patients were injured when a missle hit a marketplace in Kostiantynivka, in the Donetsk region of Ukraine. Ukraine, September 2023. Photo: Yuliia Trofimova/MSF.

Conclusions

↑ The main entrance of the MSF Kunduz Trauma Centre. Six years after the deadly attack, MSF opened this facility located around 1km from the previous one, and today mostly treats road traffic related trauma injuries. Although the conflict has ended and the security situation has improved, patients with injuries from sporadic fighting, gunshots, unexploded ordinance and other violent trauma still come for treatment. Between January and July 2025, there were 12,431 emergency admissions.. Afghanistan, August 2025. Photo: Alexandre Marcou/MSF.

For MSF, the attack on its hospital in Kunduz on 3 October 2015 was one of the deadliest incidents in the organisation's history. This assault – along with others in different countries around the same time, and the pressure of concerted advocacy campaigns – led to a series of global initiatives aimed at preventing such attacks from becoming an acceptable reality. Among these initiatives, UN Security Council Resolution 2286 offered a glimmer of hope, because it marked the first time these concerns were directly addressed in a binding resolution.

Since 2015, MSF has gained considerable experience and insight – much of it rooted in earlier operations and long-standing concerns – into how to navigate the complexities of conducting humanitarian-medical operations in armed conflict situations. The impartial treatment of wounded combatants, although fully legal and a fundamental precept of IHL, is not always accepted or respected by parties to armed conflicts. Moreover, warring parties often adopt contentious or self-serving interpretations of IHL, undermining the protection afforded to medical and humanitarian facilities. In contexts where targeted killings occur, admitting certain patients to a medical facility can carry significant risks.

Other lessons learned include that, in practice, States may invoke counter-terrorism and national security frameworks as a way to disregard or circumvent IHL; that military doctrines and rules of engagement may be unknown (and unknowable) to civilian healthcare providers and humanitarians; that the safety of medical-humanitarian operations may depend less on the best performers within military coalitions and

more on ensuring respect and good practices in their weakest links; that operational engagement with military special forces has inherent and significant limitations; that political and military actors may expect collaboration or alignment from the humanitarian sector with state-building agendas (and may resist objections grounded in humanitarian or medical principles); and that, if truth is the first casualty of war, accountability is often the second. MSF has also reaffirmed its long-held belief that the safety of its teams depends primarily on how they are perceived and accepted by armed actors – and on those actors' respect for the rules of war.

Ten years after the attack in Kunduz and the adoption of Resolution 2286, some improvements have been achieved. These include numerous political initiatives, frequent political statements unequivocally condemning such assaults, and the establishment of increasingly robust and diverse data collection systems on attacks. The issue is now regularly addressed by the UN Secretary-General, who routinely includes several paragraphs in his annual report on protection of civilians in armed conflict to examine attacks on healthcare, and who has also issued recommendations for operationalising Resolution 2286. Moreover, attacks against medical and humanitarian operations have perhaps never received as much media coverage and public attention as they do today.

However, the reality remains devastating: medical care and humanitarian action in armed conflict settings continue to come under fire – arguably more than ever. While data collection has certain limitations, as analysed in this report, all databases consistently confirm an increase in attacks since 2021. This trend is largely due to the concentration of attacks across an expanding number of contexts: Myanmar (since 2021), Ukraine (since 2022), Palestine and Sudan (since 2023) and Lebanon (in 2024) have all witnessed record levels of violence against medical and humanitarian workers. According to available data, most attacks in recent years have been carried out by States. Among them, Israel was by far the State responsible for the highest number of attacks in 2023 and 2024, while Palestine has been – again by a wide margin – the context most affected by assaults on medical and humanitarian activities. The majority of affected personnel continue to be locally recruited staff.

Qualitative analysis shows that, despite the growing attention and international engagement surrounding violence against medical and humanitarian missions, such attacks continue to occur – and with greater impunity than ever. Israel stands out as the most extreme case in this regard.

Fundamental questions remain: Why do attacks against medical and humanitarian care occur? Are they intentional? While the true intentions behind attacks are known only to those who carry them out, certain conclusions can be drawn from available data and observed patterns. The subordination of protection obligations to political or military interests may help explain some incidents.

Some strategists appear to have made decisions that resulted in disproportionate harm to civilian populations. The level of harm tolerated often depends not only on the military advantage sought, but also on the degree of respect – or contempt – shown by the attacker towards the civilians likely to be affected. An assault on a hospital, therefore, cannot always be understood through a simple mistaken-versus-deliberate framework. Other possible explanations include disregard for a facility's protected status when it is perceived as an obstacle to military objectives; its presence within a broader area targeted for indiscriminate or collective punishment operations; or the opportunistic killing of a person deemed to hold high military value, exploiting their vulnerability. In some cases, belligerents have claimed that their objective was not to strike a hospital per se, but rather to kill, interrogate or capture a high-value individual within the premises – even if that person was hors de combat. The intentions may differ in each of these scenarios, and while some may constitute flagrant violations of IHL, all have similar devastating consequences for access to medical and humanitarian care.

Following the attack on the Kunduz hospital, the US argued it was "caused by a combination of human errors, compounded by process and equipment failures."[236] The same rhetoric has been invoked to justify similar incidents in other contexts. However, the actions by the Israeli army in Palestine in recent years suggest a shift in the narrative – from "mistakes" to one of "loss of protection". Under IHL, medical facilities are presumed to be civilian in nature, and any loss of their protected status must be clearly demonstrated by the party conducting the attack and communicated in advance of any military action. Today, however, medical and humanitarian organisations are often forced to prove that their activities remain entirely unrelated to the surrounding violence. Interpreted in this way, the norms are deliberately distorted to justify attacks against the very facilities they are meant to safeguard.

The rhetoric of "loss of protection" based on a one-sided determination not only contradicts IHL but also represents a dangerous departure from the "mistake" narrative. It directly undermines core principles of IHL – proportionality and distinction between those taking a direct part in hostilities and those protected. Regardless of whether the alleged loss of protection is justified, any deliberate attack on a medical facility must, under IHL, be preceded by timely, advance and feasible warnings, allowing medical personnel the opportunity to address the cited concerns or to evacuate patients. In MSF's experience, however, such warnings have been extraordinarily rare – especially when compared with the high number of attacks sustained.

The UN Secretary-General observed: "With permissive interpretations or weak assessments of who is a lawful target, what is a military objective, what is proportional incidental civilian harm, what are feasible precautions, or who poses a threat for detention purposes, parties to conflict have undercut the humanity principle at the heart of international humanitarian law."[237] The protection of medical and humanitarian missions – along with notification and deconfliction mechanisms, internal regulations to minimise risks of conflict-related activity within medical facilities or transport, and the improvement of military practices – can only be effective if armed actors genuinely intend to respect the protected nature of medical and humanitarian action. This requires acknowledging and accepting the right of individuals hors de combat to receive assistance; refraining from opportunistic killing of high-value targets in protected environments; and tolerating the "limitations" that medical and humanitarian actors may pose to military objectives. If States are truly committed to IHL, they must adhere to international legal instruments that oblige them to respect civilians and be held accountable – politically, militarily and judicially – when they fail to do so. They must accept independent fact-finding missions and investigations, conduct their own inquiries, and share their findings transparently. These mechanisms are essential for clarifying the facts of disputed incidents, attributing responsibility for unlawful attacks, fostering accountability and countering the prevailing culture of impunity. When discrepancies with established standards arise, warring parties should communicate them clearly to medical and humanitarian actors so that these organisations can accurately assess their presence and operations in affected areas.

The insecurity brought about by attacks on humanitarian missions has long had a detrimental impact on humanitarian coverage, reducing the presence of aid organisations in high-risk zones and concentrating their efforts in safer areas – where needs are often less acute. This occurs despite the humanitarian system having greater capacity and expertise than ever before. Donors, averse to risk and reputational scandals, tend to discourage aid delivery in areas controlled by the opposition forces or groups designated as "terrorist". As a result, humanitarian actors have disinvested from high-risk regions, leading to a decline in operational capacity and effectiveness. This weakens the conceptual foundations, structural dynamics and prevailing mindset that shape the sector's response in insecure contexts, particularly during emergencies. Insecurity itself is not always the insurmountable barrier it is often perceived to be. However, the persistent targeting of medical and humanitarian missions – and the rhetoric and conduct of warring parties – continues to heighten both the perception and the reality of risk.

The situation is deeply concerning, but the solution cannot be to abandon populations in need to their fate. MSF and other organisations have demonstrated that it is possible to operate in highly insecure environments. Nevertheless, attacks come at great personal and institutional cost, and in certain circumstances, it is reasonable for medical and humanitarian organisations to refrain from working in areas of greatest need if they believe their integrity or safety is at risk.

Health professionals have sworn to treat all individuals, regardless of who they are. Health workers and patients should not be harassed, interrogated, punished or detained for providing or receiving medical care in accordance with medical ethics and IHL, regardless of their identity or affiliation. Beyond the physical, material, psychological, emotional, economic, social, environmental, ethical and reputational harm they cause, attacks on medical and humanitarian missions have severe short-, medium- and long-term consequences for both the general population and the healthcare systems that serve them. When healthcare services are disrupted or shut down as a result of attacks – or even the threat of them – people are deprived of essential medical care, making life in armed conflict zones even more unbearable.

Footnotes

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94 As explained by the then IHFCC's first vice-president at the Humanitarian Congress Berlin in October 2016. Interview with an MSF staff member who attended the event.

95 Articles 8(2)(b)(ix), 8(2)(e)(iv) Rome Statute. The Rome Statute is the international treaty that established the International Criminal Court.

96 Articles 8(2)(b)(i) and 8(2)(e)(i) Rome Statute; Articles 8(2)(b)(vi), 8(2)(c)(i) Rome Statute. A particular criminalisation exists in regard to attacks against persons and units using the distinctive emblems of the Geneva Conventions (Articles 8(2)(b)(xxiv) and 8(2)(e)(ii) Rome Statute).

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111 SHCC, Epidemic of Violence: Violence Against Health Care in Conflict 2024, p. 7, https://insecurityinsight.org/wp-content/uploads/2025/04/2024-SHCC-Annual-Report.pdf

112 SHCC, Epidemic of Violence: Violence Against Health Care in Conflict 2024, op. cit., p. 8.

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188 See also Article 18 Geneva Convention IV: "States which are Parties to a conflict shall provide all civilian hospitals with certificates showing that they are civilian hospitals and that the buildings which they occupy are not used for any purpose which would deprive these hospitals of protection in accordance with Article 19. Civilian hospitals shall be marked by means of the emblem provided for in Article 38 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949, but only if so authorized by the State."

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196 See Jean S. Pictet, Commentary, IV Geneva Convention..., op. cit., Article 19; Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds), Commentary on the Additional Protocols..., op. cit., Additional Protocol I, Article 13, para 555. See also ICRC, International Humanitarian Law and the Challenges of Contemporary Armed Conflicts..., op. cit., p. 43.

197 See Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds), Commentary on the Additional Protocols..., op. cit., Additional Protocol I, Article 13, paras 555-556 and Additional Protocol II, Article 11, paras 4725-4727; ICRC, International Humanitarian Law and the Challenges of Contemporary Armed Conflicts..., op. cit., p. 44.

198 Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds), Commentary on the Additional Protocols..., op. cit., Additional Protocol I, Article 13, paras 555-556; Additional Protocol II, Article 11, para 4726-4727.

199 See Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds), Commentary on the Additional Protocols..., op. cit., Additional Protocol II, Article 11, referring to a situation in which troops approach a hospital and "being met by heavy fire from every window."

200 Saudi Press Agency, "Joint Incidents Assessment Team (JIAT) on Yemen Responds to Claims on Coalition Forces' Violations in Decisive Storm Operations", 5 August 2016, https://www.spa.gov.sa/1524799

201 "MSF internal investigation of the 15 August attack on Abs hospital, Yemen. Summary of findings", MSF, September 2016, https://www.msf.org/sites/default/files/2018-05/yemen_abs_investigation.pdf

202 Françoise Bouchet-Saulnier and Jonathan Whittall, "An environment conducive to mistakes?...", op. cit., p. 360.

203 Christine Beerli, Vice-President of the ICRC in Un Security Council, 7951st meeting, 25 May 2017, UN Doc S/PV.7951, p. 3.

204 MSF, "MSF President to UN Security Council: "Stop these attacks", 3 May 2016, https://www.msf.org/msf-president-un-security-council-stop-these-attacks

205 "Solutionism takes problems for granted, without reflecting on their background, and focuses only on developing appropriate means and tools. It believes that problems can in principle be eliminated and seeks 'final solutions'". Jan Cornelius Schmidt, Philosophy of Interdisciplinarity: Studies in Science, Society and Sustainability, Routledge, London, 2021, https://link.springer.com/article/10.1007/s11569-024-00458-5

206 Common Articles 1 and 3 Geneva Conventions. See also Jean-Marie Henckaerts and Louise Doswald-

Beck, Customary International Humanitarian Law..., op. cit., Rule 139.

207 Frits Kalshoven, "The undertaking to respect and ensure respect in all circumstances: From tiny seed to ripening fruit", in Yearbook of International Humanitarian Law, Vol. 2, December 1999, p. 60, https://doi.org/10.1017/S1389135900000362

208 See ICRC, Commentary on the Third Geneva Convention: Convention (III) relative to the Treatment of Prisoners of War (ICRC, 2021), Article 1, paras 191-206. Jean-Marie Henckaerts and Louise Doswald-Beck, Customary International Humanitarian Law..., op. cit., Rule 144.

209 Geneva Convention IV has 196 State Parties.

210 Additional Protocol I has 175 State Parties, while Additional Protocol II has 170. States Signatories, but not State Parties, to either Additional Protocols I or II: Iran, Pakistan and United States. States Parties to neither Additional Protocols I nor II: Azerbaijan, Bhutan, Eritrea, India, Indonesia, Israel, Kiribati, Malaysia, Marshall Islands, Myanmar, Nepal, Niue, Papua New Guinea, Singapore, Somalia, Sri Lanka, Thailand, Türkiye and Tuvalu. States Parties to Additional Protocol I but not II: Iraq, Mexico, North Korea, Syria and Vietnam. See ICRC, "States Party to the Following International Humanitarian Law and Other Related Treaties as of 09-September-2025", 9 September 2025, https://ihl-databases.icrc.org/public/refdocs/IHL_and_other_related_Treaties.pdf

211 Many of the States part of the "Political declaration on the protection of medical care in armed conflict" and the "Ministerial group for the protection of humanitarian personnel" have not ratified the said instruments.

212 This is the case, for example, regarding the obligation to issue advance warnings before attacking medical facilities and personnel that have lost their protection against attacks. See Françoise Bouchet-Saulnier and Jonathan Whittall, "An environment conducive to mistakes?...", op. cit., p. 357, note 76.

213 As mentioned before, laws issued on 2 July 2012 criminalised medical aid "to anyone injured by pro-government forces in protest marches against the government." Fouad M. Fouad et al., "Health workers and the weaponisation of health care in Syria: a preliminary inquiry for The Lancet–American University of Beirut Commission on Syria", The Lancet, Vol. 390, 2 December 2017, pp. 2517–18. A broad practice of criminalising humanitarian and medical assistance was applied to populations in areas no longer controlled by the government. Bashar al-Jaafari, the Syrian ambassador to the UN, referred to MSF in this way at the UNSC on 17 April 2018: "(...) Similar to ISIS, they entered the country without our approval (...) Doctors Without Borders are similar to smugglers without borders, criminals without borders, opposers without borders, agents without borders, aggression without borders, and terrorists without borders". "H.E. Dr. Bashar Jaafari at the Security Council- Humanitarian Situation in Raqqa and Rukhban", 17 April 2018, minute 4:46-5:24, https://www.youtube.com/watch?v=LguhM-kF4jw&t=307s

214 See also ICRC, Protecting Health Care from Violence: Legislative Checklist (ICRC) p. 8; See also UN Security Council, Recommendations of the Secretary-General, submitted pursuant to paragraph 13 of Security Council Resolution 2286 (2016), UN Doc S/2016/722, Recommendation 2, para 9(a).

215 UN Security Council, Recommendations of the Secretary-General, submitted pursuant to paragraph 13 of Security Council Resolution 2286 (2016), UN Doc S/2016/722, Recommendation 69, para 19.

216 In Kunduz, as quoted in page 256 of the US investigation report, US ground troops assumed in their interlocution with the air force that "all civilians have fled and only Taliban remain in the city" and that "everything is a threat".

217 Françoise Bouchet-Saulnier and Jonathan Whittall, "An environment conducive to mistakes?...", op. cit., pp. 337-372.

218 Un Security Council, "Report of the Secretary General: Protection of civilians in armed conflict" UN Doc. S/2025/271, 15 May 2025, para 67(b). Also see ICRC, Protecting healthcare: Guidance for the Armed Forces.

219 See also UN Security Council, Recommendations of the Secretary-General, submitted pursuant to paragraph 13 of Security Council Resolution 2286 (2016), UN Doc S/2016/722, Recommendation 9, para 19(a).

220 Christine Beerli, Vice-President of the ICRC in UN Security Council, 7951st meeting, 25 May 2017, UN Doc. S/PV.7951, p. 5. See UN Security Council, Recommendations of the Secretary-General, submitted pursuant to paragraph 13 of Security Council Resolution 2286 (2016), UN Doc S/2016/722, Recommendation 7.

221 ICRC, Commentary on the Third Geneva Convention: Convention (III) relative to the Treatment of Prisoners of War (ICRC, 2021), Article 1, para 194.

222 On the critical importance of accountability mechanisms, see also Susannah Sirkin et al., "Normative States: Successes, Failures, and Lessons...", op. cit., pp. 20-21.

223 Recommendation 11 at UNSC, "Letter dated 18 August 2016 from the Secretary-General addressed to the President of the Security Council", ref. S/2016/722, 18 August 2016, https://digitallibrary.un.org/record/839216

224 MSF, "MSF President to UN Security Council: "Stop these attacks", 3 May 2016, https://www.msf.org/msf-president-un-security-council-stop-these-attacks

225 Susannah Sirkin et al., "Normative States: Successes, Failures, and Lessons...", op. cit., p. 23.

226 See also UN Security Council, Recommendations of the Secretary-General, submitted pursuant to paragraph 13 of Security Council Resolution 2286 (2016), UN Doc S/2016/722, Recommendation 11, paras

29-30; Susannah Sirkin et al., "Normative States: Successes, Failures, and Lessons…", op. cit., p. 27.

227 Most countries that have been accused of attacking medical missions, including Sudan, Israel, Russia, South Sudan, Myanmar, Syria, Yemen, Saudi Arabia, Ethiopia, Somalia, Afghanistan, the US, CAR, Haiti and Nigeria, have not accepted the competence of the Commission.

228 To note that, rather than an instrument for accountability, the aim of the IHFFC is to serve the States willing to improve their compliance with IHL.

229 Susannah Sirkin et al., "Normative States: Successes, Failures, and Lessons…", op. cit., p. 27.

230 Susannah Sirkin et al., "Normative States: Successes, Failures, and Lessons…", op. cit., p. 27.

231 Susannah Sirkin et al., "Normative States: Successes, Failures, and Lessons…", op. cit., p. 22.

232 Richard Brennan et al., In the Line of Fire…, op. cit., p. 25.

233 Susannah Sirkin et al., "Normative States: Successes, Failures, and Lessons…", op. cit., pp. 15-16.

234 Christine Beerli, Vice-President of the ICRC in UN Security Council, 7951st meeting, 25 May 2017, UN Doc S/PV.7951, p. 5. On the importance of a broad engagement and multi-sector alliances including States, international organisations, NGOs, and civil society actors, see also Susannah Sirkin, "Normative States: Successes, Failures, and Lessons…", op. cit., p. 16.

235 This would be similar to the Political Declaration on Explosive Weapons in Populated Areas (for this, see Susannah Sirkin, "Normative States: Successes, Failures, and Lessons…", op. cit., p. 12). Such initiatives should consider existing initiatives and good practices, such as ICRC, Protecting healthcare from violence: Legislative checklist.

236 US Central Command, "Summary of the Airstrike on the MSF Trauma Center in Kunduz, Afghanistan on October 3, 2015; Investigation and Follow-on Actions", 29 April 2016, p. 1. The text is available here: https://casebook.icrc.org/case-study/afghanistan-attack-kunduz-trauma-centre

237 UN Security Council, "Protection of civilians in armed conflict. Report of the Secretary-General", ref. S/2025/271, 15 May 2025, p. 12, para 52, https://docs.un.org/en/S/2025/271

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