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IN THE LINE OF FIRE

PROTECTING HEALTH IN ARMED CONFLICT

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CONTENTS

FOREWORD

The past three years have borne witness to an alarming increase in the frequency, scale and impact of attacks on healthcare. In Sudan, Gaza and Lebanon, the intensifying conflicts have been associated with increased assaults on healthcare, while ongoing violence in Myanmar, Ukraine and Haiti further jeopardized access to medical services. The Sahel also saw critical risks to health facilities, transport and patient access to healthcare.

It is the most vulnerable in our communities who have the greatest reliance on health services and programs – children, pregnant women, those with chronic diseases, the elderly and the disabled. Attacks on healthcare are truly attacks on the most vulnerable. In conflict, when health needs often soar, attacks on health deny communities access to essential and life-saving services precisely when they need them most.

It is of grave concern that the systems designed to protect healthcare in armed conflict are not working as illustrated by the thousands of documented attacks on healthcare. The principles of proportionality, precaution and distinction appear challenged, reinterpreted, or ignored. And the mechanisms put in place by local health workers to protect health facilities, ambulances, and other assets are often no match for the firepower of warring parties. The right to health – one of the most fundamental of human rights – is too often denied.

Addressing these realities requires a bold, unified response. It is imperative that United Nations agencies, governments and civil society, in collaboration with the healthcare community, adopt a more assertive stance against attacks that directly target or otherwise impact health services. Robust steps are required to promote and respect international humanitarian law, to end widespread impunity, and to mainstream protection of healthcare into health and humanitarian programs.

This report presents actionable policy and operational recommendations to protect health in the context of armed conflict. Addressing violence against health workers, patients and infrastructure urgently requires a new global approach and a redefined collective mindset.

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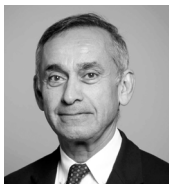

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EXECUTIVE SUMMARY

The imperative to protect healthcare in conflict settings is enshrined in international humanitarian law, enacted through humanitarian principles such as the distinction between civilians and combatants, the concept of necessity, the proportionality of harm to civilians in relation to military advantage, impartiality and humanity. These principles ensure that medical personnel, facilities and transports are safeguarded, and provide care without discrimination.

Despite these legal protections, there has been an alarming rise in attacks against healthcare, representing grave violations of human rights and international humanitarian law. Hospitals, clinics and ambulances are frequently bombed, looted or significantly hampered from the delivery of essential medical services. Healthcare workers have been assaulted, blocked from administering care and sometimes killed. These assaults severely disrupt vital health services, leaving vulnerable populations without essential care, with catastrophic effects on public health, health workers and healthcare facilities.

The central question this report seeks to address is how do we reset the balance and reaffirm the way forward to uphold the fundamental tenets of IHL, press for greater action to end impunity and foster greater political support to create structures that will ensure the protection of health systems and civilians during war.

Key challenges discussed include:

1. Trends in global conflict that highlight the scale and nature of attacks and its effect on population health.
2. Protective mechanisms for the delivery of healthcare in armed conflict that set out existing legal frameworks and accountability and the context of IHL.
3. Building resilience and preparedness through capacity building, exploring protective measures through adaptive design, engaging more effectively with armed forces and non-state actors, fostering greater community engagement and education and the challenges presented by the lack of standardized data collection.

There is no single actor, government or organization that can overcome these challenges. As a result, this report presents a series of priority recommendations addressed to the full range of stakeholders who have the capacity to prevent and mitigate attacks on health. These recommendations rely on the renewed hope that UN agencies, civil society groups and governments are increasingly beginning to speak more forcefully against the IHL violations occurring in conflicts around the world. We must capitalize on the momentum this has created and push forward with the steps outlined in the report to compel civil society, government and UN agencies to act now to end the suffering of millions around the world.

SECTION 1. INTRODUCTION

Attacks on healthcare (AHC) in armed conflict are increasing globally, with devasting impacts.[1] These attacks may constitute grave breaches of international humanitarian law and war crimes. They may also amount to serious and gross violations of the human rights of health workers and patients, detrimentally impacting rights to life, health and liberty.[2]

The right to health is enshrined in the World Health Organization's (WHO) constitution; the preamble states that "the enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".[3] AHC interferes with, obstructs, and denies the achievement of this fundamental, universal right at individual and wider population levels. The International Covenant on Economic, Social and Cultural Rights, signed and ratified by 164 countries, outlines the rights to equitable access to healthcare,[4] which is also jeopardized or worse during AHC. Existing binding legal protections are failing to deter attacks that target healthcare infrastructure, systems and personnel.

Lives are lost through the attacks and their consequences. AHC directly cause injuries and loss of life among patients, health workers and others. When a healthcare facility, transport/ambulance or the health system has suffers an attack, the ability to provide immediate and lifesaving interventions is compromised, impacting morbidity and mortality of those injured in the attack. AHC also affects the delivery of care for those with acute and chronic conditions (communicable diseases, non-communicable diseases, expectant mothers, neonates and children) that are not related to AHC injuries. This leads to poor health outcomes that could have been potentially avoided.

AHC can deter populations from accessing healthcare. Also, by reducing the availability of a viable workforce, patients will have reduced access to care. This can occur through targeted strikes on healthcare facilities, collateral damage, killing or injuring health workers, obstructing their access to work, exposing them to kidnapping or detention, or removing their license to practice as a form of punishment.

This paper adopts the WHO definition of 'attack on healthcare': "any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access and delivery of curative and/or preventive health services during emergencies."[5] Types of attacks cover a broad range and are not limited to those resulting in physical or material harm (see Table 1). The paper is set within the context of armed conflicts, where the threshold of armed conflict, either international or non-international, has been reached according to the Geneva Conventions and the Additional Protocols. Although this paper recognizes that AHC occur in non-armed conflict settings such as periods of civil unrest, the focus will be on armed conflict.

Without intervention AHC threaten to become a new norm of practice of parties to conflict, including governmental armies and non-state armed groups.

Table 1. Types of attacks

Abduction	Obstruction to healthcare delivery (eg, physical, administrative or legal)
Armed or violent search of healthcare personnel, facility or transport	Psychological violence/threat of violence/intimidation
Arrest	Removal of healthcare personnel or patients
Assault	Setting fire
Chemical agent	Sexual assault
Detention	Violence with heavy weaponry
Militarization of civilian healthcare facility	Violence with individual weaponry

Source: WHO SSA[6]

The objectives of this report are to describe the scale, scope and public health impact of conflict-related AHC today, and to propose actionable measures to protect health during conflict. Section 2 gives a brief overview of current trends in global conflict. It then examines the scale, nature and trends of AHC and their impact on health service delivery. The existing protective mechanisms for healthcare in armed conflict are outlined and explained in Section 3, including an overview of legal frameworks and norms. Options for mainstreaming protection of healthcare into health and humanitarian programs are presented, as well as approaches to scaling up advocacy and diplomacy. Section 4 presents key preventative, mitigating and accountability policy recommendations to consider, and Section 5 outlines the report's conclusions.

SECTION 2. TRENDS IN GLOBAL CONFLICT

International humanitarian law defines armed conflict in two ways: international armed conflict (IAC) and non-international armed conflict (NIAC). An IAC occurs when "one or more States have recourse to armed force against another State, regardless of the reasons or the intensity of this confrontation"[7] whereas an NIAC is: "protracted armed confrontations occurring between governmental armed forces and the forces of one or more armed groups, or between such groups arising on the territory of a State. The armed confrontation must reach a minimum level of intensity, and the parties involved in the conflict must show a minimum of organization."[8]

As of 2024, there are over 120 armed conflicts around the world, which involve over 60 states and 120 non-state armed groups.

Under this definition, the International Committee of the Red Cross (ICRC) reports a trend of increasing conflicts globally. As of 2024, there are "over 120 armed conflicts around the world, which involve over 60 states and 120" non-state armed groups. Since 2000, the number of NIACs has tripled, reaching 100 across the globe.[9]

The conflicts have significant impact on civilians. In 2023, the Armed Conflict Location and Event Data (ACLED) Project estimated that 14 percent of the global population were living within 5km of violent conflict.[10] NIACs have resulted in most of the violence directed toward civilians, who make up to 90 percent of war casualties.[11]

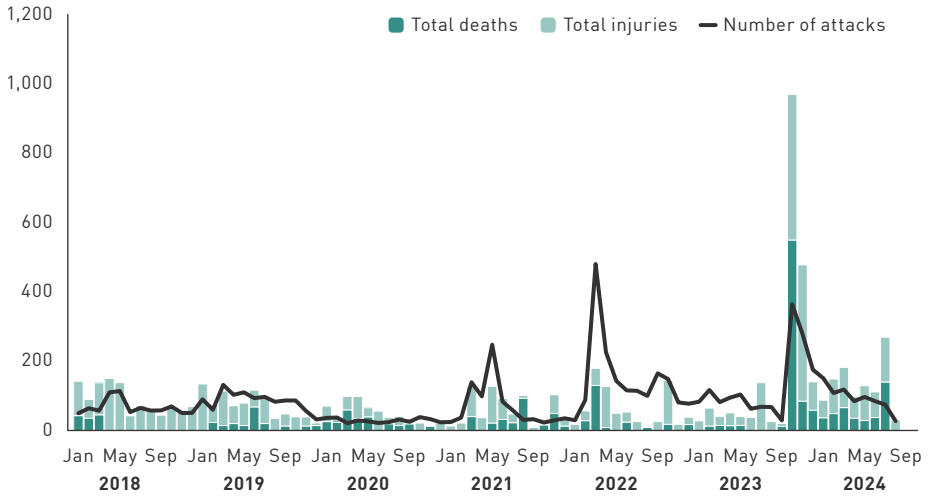
Armed conflicts have long-lasting impacts, and affected countries are less likely to reach United Nations (UN) Sustainable Development Goals.[12] Armed conflicts do not occur in a vacuum, but often arise in settings of state fragility, chronic underdevelopment, economic decline and denial of rights. These conflicts also intersect with other crises, such as the climate crisis, and (as seen recently), pandemics and other disease outbreaks. This leads to a wider impact on people's health and increased burden on the healthcare system.

2.1 SCALE, NATURE AND DISTRIBUTION OF ATTACKS ON HEALTHCARE

To understand the scale and scope of AHC, it is vital to collect data across multiple settings. In recent years, data sets have been collected by different actors using various methodologies and objectives – for example, the Aid Worker Security Database (AWSD), Médecins Sans Frontières (MSF), ICRC, Physicians for Human Rights, Insecurity Insight, International NGO Safety Organisation, the Minimum Reporting Mechanism (MRM) on grave violations committed against children in times of armed conflict, and country-level monitoring initiatives. Despite the different approaches, all databases highlight some common themes on the scale and nature of AHC. In this section, data reported from WHO's Surveillance System for Attacks on Health Care (SSA) is used as the main reference to describe these themes, supplemented by additional sources.

Since 2018, WHO has documented more than 7,000 incidents of AHC. These attacks were associated with loss of life of more than 2,200 health workers and patients and more than 4,600 people injured across 21 reporting countries and territories with complex humanitarian emergencies (see figure below). Most of the incidents involved the use of heavy weapons (more than 2,800 incidents), followed by the use of individual weapons (more than 2,020 incidents) and obstruction to healthcare delivery (more than 1,600 incidents). More than 400 health workers have been abducted, while more than 650 have been arrested, further impeding the delivery of health services.[13]

Number of AHC, associated deaths and injuries January 2018 – July 2024

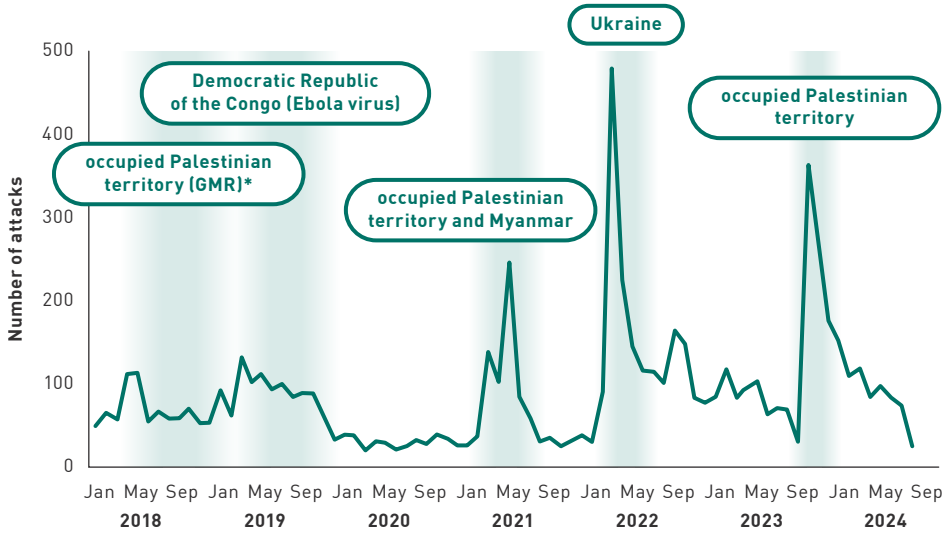


Source: WHO SSA[14]

The SSA collects data from countries with complex humanitarian emergencies.[15] Not all of these countries are represented in the SSA. This is due to difficulties in access, challenges in verifying incidents, reluctance to engage in this exercise, and other political sensitivities that impede data collection and verification. Other databases support the dire picture painted by the SSA in other settings. According to MSF, in Ethiopia's Tigray region, of the 106 health facilities that MSF visited between December 2020 and March 2021, "nearly 70 percent had been looted and more than 30 percent had been damaged; just 13 percent were functioning normally".[16]

Since the SSA was established in 2018, there has not been a consistent trend in the number of attacks. But there is a clear pattern showing that, when conflicts start and/or intensify, AHC increase (see figure on the following page) – the largest numbers of attacks in recent years have been between 2022 and 2024, associated with the wars in Ukraine and Gaza. This paints an alarming picture of AHC as 'the norm' in conflict situations with blatant disregard for the sanctity of healthcare. However, once situations stabilize, some countries have stopped reporting AHC altogether (for example, Iraq and Libya).[17]

Trends in number of AHC associated with recent conflicts, January 2018 – July 2024



*: GMR = Great March of Return

Source: WHO SSA[18]

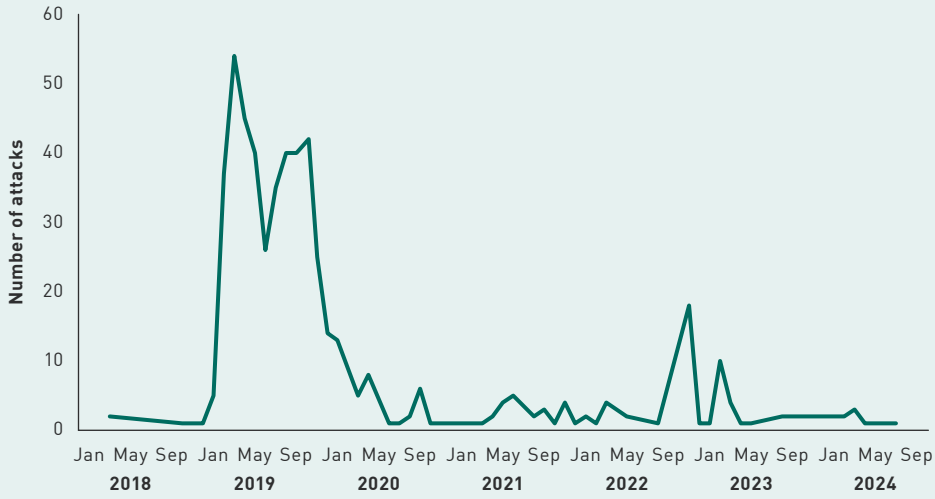
The contextual differences are also reflected in the types of attacks reported from each setting. For instance, in the Syrian Arab Republic, reports citing violence with heavy weapons – which accounted for the highest number of attacks in 2018 (87 percent of all incidents) – decreased considerably in 2022 (11 percent). In 2023, as sporadic cases of conflict took place, this number increased again (50 percent).

CASE STUDY 1. ATTACKS ON HEALTH IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

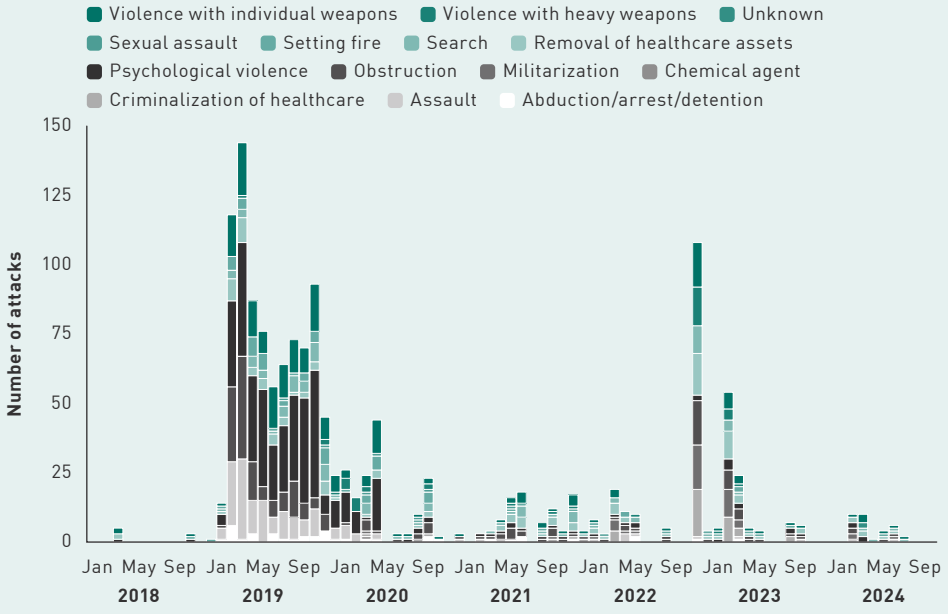
Between 2018 and 2020, eastern DRC faced the second largest Ebola outbreak in history.[19] During this time, numerous incidents of attacks on health workers at Ebola treatment centers were reported. Many of these attacks were motivated by mistrust and misunderstanding of the disease in an already vulnerable setting,[20] leading to a high proportion of lower-intensity attacks (psychological violence, assault, obstruction). These types of attacks represented 67 percent of all attacks in 2019.

Two years after the end of the Ebola outbreak, eastern DRC was subject to a violent conflict associated with the re-emergence of a notorious non-state armed group. AHC were a feature of the conflict, but the patterns were different from those documented during Ebola (see figure below) – lower-intensity attacks represented only 27 percent of all attacks.[21] In 2022–2023, high-intensity attacks (violence with heavy and individual weapons, removal of healthcare assets) accounted for 37 percent of all attack types. Militarization of healthcare was associated with 68 percent of attacks, noting that a single incident can be associated with more than one type of attack.

Attacks on healthcare over time in DRC



Types of attacks over time in DRC



Note: A single attack can be associated with multiple types of attacks.
Source: WHO SSA[22]

CASE STUDY 2. ATTACKS ON HEALTH IN OCCUPIED PALESTINIAN TERRITORY

In occupied Palestinian territory (oPt), a dramatic increase in the number of AHC was recorded in the context of the demonstrations that took place on the Gaza Strip between March 2018 and December 2019,[23] known as the Great March of Return.[24] Once the demonstrations ended, reports of AHC became markedly less prevalent. In 2021, the number of incidents increased slightly as a result of the Palestine-Israel conflict that accelerated in May.

Following 7 October 2023, however, the number of incidents spiked to an unprecedented level – between 7 October 2023 and 25 September 2024, WHO documented 1,135 attacks on healthcare in oPt (516 in Gaza, 619 West Bank), resulting in the loss of 790 lives (765 in Gaza, 25 in West Bank), and 1,082 injuries (982 in Gaza, 100 in West Bank).[25]

The attacks have been partly justified by Israeli authorities on the grounds that hospitals in Gaza have been used by Hamas for military purposes, including as command centers and for storage of weapons.[26] Such claims have been denied by health workers and Hamas, and disputed by some observers.[27,28] Regardless of the veracity of the claims, it is clear that healthcare and facilities do not fully lose their protection under international humanitarian law (IHL) even if used for military purposes. Under IHL, the principles of proportionality, distinction and precaution still apply – any such attack must: be proportionate to the threat posed and the military advantage gained; make distinctions between military targets and civilian objects; and apply all feasible precautions to minimize civilian harm.[29–31]

2.2 IMPACT ON HEALTH

While the number of incidents reported often attracts much attention, their implications infrequently come under the spotlight. Attacks on healthcare have the potential for profound impact on people's access to healthcare in the short, medium and long term – and, as a result, their health and wellbeing. The impacts of attacks include loss of life for health personnel, patients and bystanders, direct damage to health facilities, loss of supplies and obstruction of access to care. In the longer term, AHC can also interrupt service delivery. This can be due to related issues such as prolonged absenteeism among health workers due to mental health impact, fear in communities to seek healthcare, and increased cost of recovery and reconstruction.

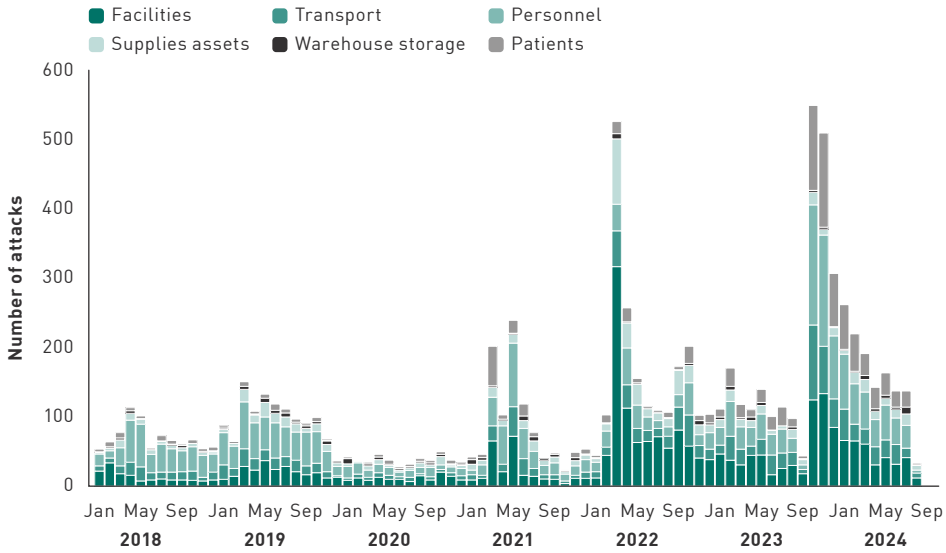
According to the SSA, the most frequent direct impacts of AHC were those that affect health personnel – for example, loss of life, injuries, abductions, arrests and intimidation (see figures below). In 2018 and 2019, attacks impacted health personnel in about two-thirds of reported incidents. Following the recent conflicts in Ukraine and oPt, the number of incidents affecting health facilities increased significantly, with health workers on the frontline of attacks. In 2022 and 2023, health facilities were affected in 72 percent and 56 percent of incidents respectively, and health personnel were affected in 23 percent and 60 percent of incidents.[32]

Since 2018, 8.3 percent of the incidents led to the loss of one or more lives, while 21.0 percent of incidents led to one or more injuries of health workers and patients. Health workers (1,513) and patients (209) have also been abducted, detained or arrested, leading to further impact on delivery of and access to healthcare.[33] The mental health consequences of attacks on health workers is also a major deterrent for health workers to function in these settings, including in the longer term.[34,35]

In 2022 and 2023, health facilities were affected in 72 percent and 56 percent of incidents respectively, and health personnel were affected in 23 percent and 60 percent of incidents.

Over the same period, more than 50 percent of incidents affected health facilities. This includes the physical destruction or removal of assets, and also the militarization of healthcare resources, which creates another layer of risk for health facilities. Militarization occurred in 4.5 percent of incidents reported. Among the health facilities affected, 21.5 percent were primary healthcare centers.[36]

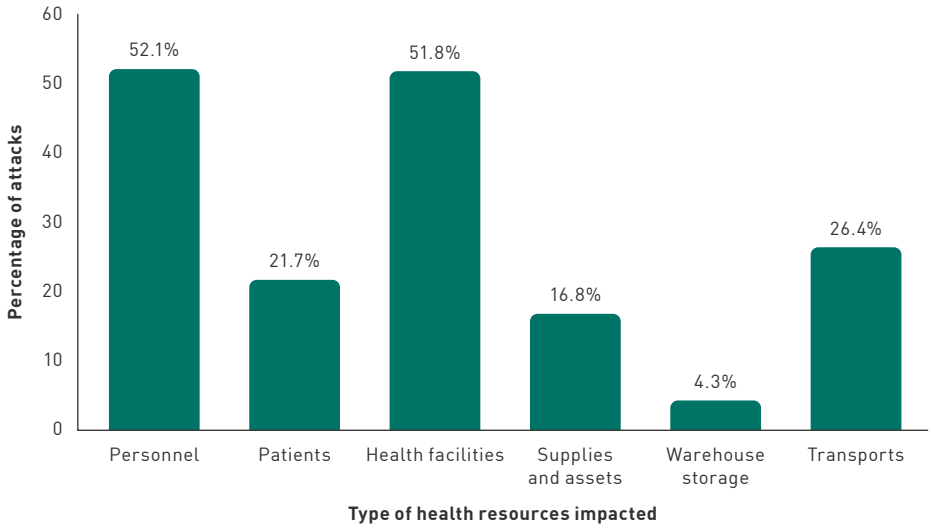
Direct impacts of AHC on selected health resources, January 2018 – July 2024



Source: WHO SSA[37]

It is important to understand the context that each attack occurs in to fully grasp its impact. Destruction of the only functioning health facility in a district would have wider reverberations compared to the destruction of a similar facility in a city with multiple health delivery points. The same impact can be seen when the only available doctor in a village is killed in an attack, depriving the entire community of a vital medical provider.

Percentage of attacks directly impacting specific types of health resources, January 2018 – July 2024



Source: WHO SSA[38]

Other risks arising due to the conflict can affect access to healthcare, including: general migration of health workers out of the area;[39] health facilities being abandoned due to fear and inability to access the facility;[40] and population movement to escape the conflict, and subsequent supply chain disruption.[41] While it is difficult to be clear about all risks in this report, it is important to contextualize each attack to fully understand its impact on the health of the population. All risks are linked and must be addressed holistically to ensure safe access to healthcare.

As well as the direct impacts on personnel, patients and physical assets, another serious consequence of AHC is reduced availability of, and access to, clinical and public health services. In many conflicts across the globe, functionality of health facilities and availability of health services have been severely diminished. Not all these disruptions have been entirely due to attacks; however, in most instances attacks have been a major contributing factor. Vulnerable populations such as pregnant women, children, the elderly, patients with chronic diseases, and those with disabilities are among the most disadvantaged.

WHO's Health Resources and Services Availability Monitoring System (HeRAMS) regularly tracks damage to, and functionality of, health facilities in fragile and conflict-affected situations. In an analysis of HeRAMS data from 16 countries classified by the World Bank as conflict-affected,* a median of 17 percent (range 2–89 percent) of health facilities were damaged and a median of 19 percent (range 4–100 percent) were only partially functional or non-functional.[42] Disruption of functioning health facilities during conflict denies the population access to health services precisely at a time when they need them most.

Among the most stark examples of the impact that AHC have on public health are the threats that they pose to the global eradication of polio and the dramatically reduced access to healthcare in Gaza (see Case studies 3, 4 and 5).

* Afghanistan, Burkina Faso, Central African Republic, DR Congo, Ethiopia, Iraq, Mali, Mozambique, Niger, Nigeria, occupied Palestinian territory (Gaza), Somalia, Sudan, Syria (northeast), Ukraine, Yemen

CASE STUDY 3. ATTACKS ON POLIO WORKERS IN AFGHANISTAN AND PAKISTAN – A CRITICAL THREAT TO ERADICATION EFFORTS

In Afghanistan and Pakistan – the last two polio-endemic countries in the world – eradication efforts have encountered significant security challenges due to violence by militant groups. Between 2012 and 2018, both countries experienced conflict and extreme militancy, with attacks directly targeting health workers. The resulting insecurity, inaccessibility and interruptions to polio campaigns further increased immunization gaps among children.[43]

In recent years, there has been a noticeable decline in attacks targeting polio workers. In Afghanistan, no attacks on polio workers have been reported since February 2022,[44] when a brutal attack killed eight frontline workers. Workers in security-compromised areas of Pakistan, particularly along the Pakistan-Afghanistan border in Khyber Pakhtunkhwa and Balochistan, continue to face threats by militants. In these regions, the Government of Pakistan implemented special strategies to deploy security personnel to safeguard polio teams. However, militant groups in these areas have now shifted their focus to targeting law enforcement personnel. During polio vaccination campaigns, security personnel guarding the polio vaccination teams came under attack.[45] These incidents jeopardize the safety of health workers, who are occasionally injured or lose their lives while on duty during these attacks. Vaccination campaigns can also be disrupted by attacks, leaving thousands of children unvaccinated, and allowing the virus to continue circulating.

As of 3 October 2024, both countries have continued to documented cases, with Pakistan reporting 28 new cases and Afghanistan 22 cases so far.[46] This insecurity has delayed progress toward polio eradication with the virus spreading across borders. Ensuring the safety of polio workers and sustaining uninterrupted vaccination campaigns in these volatile regions is essential to stopping poliovirus once and for all.

CASE STUDY 4. ATTACKS ON HEALTHCARE IN GAZA – DIMINISHED ACCESS AND ENDURING HEALTH CONSEQUENCES

In Gaza, the World Health Organization (WHO) documented 516 attacks on healthcare (AHC) between 7 October 2023 and 25 September 2024. The attacks impacted 110 health facilities, including damage to 32 of 36 hospitals (89 percent), and 115 healthcare transports/ambulances. Functionality of health facilities was severely disrupted, with no hospitals fully functional, and only 17 of 36 (44 percent) partially functional. Bed capacity across Gaza declined to 1,812 compared to about 3,500 pre-war.[47]

Of these attacks, 59 percent involved heavy weapons, 15 percent involved individual weapons, and 40 percent were associated with obstruction to healthcare facilities. Obstructions entailed limitations of movement of health staff, patients, ambulances and supplies to healthcare facilities inside Gaza. They do not include restrictions of movement of personnel and supplies into Gaza.

Attacks on healthcare have contributed substantially to the severe degradation of the health system in Gaza. They have also severely constrained the health system's ability to provide routine health services (such as childhood immunizations, maternal health, treatment of chronic diseases) or respond to increasing acute needs (for example, more than 96,000 injuries, outbreaks of hepatitis A, diarrhea, vaccine-derived polio, and growing rates of acute malnutrition).[48]

The decline in childhood vaccination across Gaza has placed children at increasing risk of preventable diseases. Before the conflict, vaccination coverage against polio was estimated at 99 percent in 2022, but then fell to below 90 percent in early 2024. The first polio case in Gaza in 25 years – due to a variant vaccine-derived strain – was detected in August 2024, requiring reactive vaccination campaigns.[49] While efforts to restore routine immunization services across Gaza are ongoing, coverage rates remain at below 90 percent, and the risk of additional outbreaks persists.

Other routine and essential services are also disrupted. There are about 50,000 pregnant women in Gaza: 1,400 are likely to need a cesarean section; but access is now not guaranteed for these women. More than 1,500 patients require kidney dialysis, and about 2,000 new cancer cases are expected annually in Gaza.[50] The health system has been unable meet the needs of all of these patients, with projections of high levels of excess mortality due to the lack of access to care.[51]

The heaviest burden on the health system has been the enormous number of trauma cases – more than 41,000 people have lost their lives, and 96,000 have been injured since the start of the war. Up to 67 percent of casualties are women and children.[52,53] The grossly diminished health system remains unable to effectively respond to the overwhelming number of mass casualty incidents, polytrauma cases and severe injuries. This is placing patients at risk of loss of life, infections, long-term disability and other complications. About 22,500 injured patients will require ongoing rehabilitation services resulting from war injuries – this is in the context of all three dedicated inpatient rehabilitation services being damaged or destroyed and the reported loss of life for 39 physical therapists.[54]

The health system has also been unable to respond to the rapidly increasing rates of acute malnutrition in Gaza. By September 2024, 96 percent of the population was projected to experience food insecurity at crisis levels or above.[55] Before the war, acute malnutrition was not a public health problem in Gaza, with about 0.8 percent of children under 5 years assessed as acutely malnourished.[56] But by March 2024, as the humanitarian situation rapidly declined, over 31 percent of children under 2 years of age in northern Gaza were acutely malnourished.[57] By mid-June 2024, only two of three stabilization centers for the treatment of severe acute malnutrition were functioning, with delays in the opening of new centers due to ongoing military operations.[58] While not all of these developments were directly due to AHC, they reflect the complex mix of soaring public health needs and rapidly deteriorating access to health services, to which attacks contribute significantly.

2.3 CHALLENGES WITH INFORMATION SOURCES AND ANALYSIS

There are currently many mechanisms that collect data and provide analysis and information on AHC. However, none have succeeded in providing a global and comprehensive database. Challenges are caused by the differences in approaches, and the distinctive mandates and objectives of the actors involved, as each database has been built for a specific need. WHO's SSA, a mechanism that stems from Member States' request to monitor and disseminate AHC information[59,60] is one of the mechanisms available for data collection. It specifically aims to provide verified reports of AHC occurring in complex humanitarian emergencies. The SSA provides the advantage of ensuring high reliability of data collected in a strictly neutral and impartial manner. However, this means that the SSA is unable to collect information on perpetrators or motives underpinning the attack. Due to the strong emphasis on verification, it also draws from a narrower range of sources than some other systems.

Other databases (such as Insecurity Insight, International NGO Safety Organisation, ACLED) have taken a different approach. They provide almost real-time information for different incidents. They also report on perpetrators, types of weapons used, and the impact based on open-source information. While complementary, these databases use different definitions and verification/data collection processes, which makes it difficult to compare numbers across different data sets.

The annual report from the Safeguarding Health in Conflict Coalition provides data and analysis on AHC. The report contextualizes incidents that affect medical facilities, health workers and patients in the most conflict-affected countries. By offering insights into patterns of violence and country-specific analysis, the report highlights the humanitarian impact of these attacks.[61]

Verification of incidents is important, yet also poses a challenge. Verification based on primary data collection mechanisms is not likely to consistently report in locations where capacities are already stretched to the limit, resources are scarce and security concerns exist. This is further compounded by the need to adhere to data ethics and ensure confidentiality of informants so that they are protected from potential retribution. Also, data collection alone is not enough: there is the question of 'what next?' And databases alone are not equipped to take the necessary next

steps. Databases relying on secondary data sources – for example, news articles – face the risk of reflecting the 'sensational' more often than the less dramatic. In both cases, the full spectrum of AHC may fail to be represented.

Despite the lack of an ideal methodology, and databases that comprehensively and consistently reflect the issues, all current mechanisms share a common goal of providing information to better protect healthcare against attacks. And, while we should continue to work toward improved methodologies and data consolidation, this should not divert from improving mid- and long-term analyses of the impact of AHC by using available data. The different actors and specific mandates bring complementary perspectives, with each benefiting from the success of the others.

Some roles and activities can be considered to be at odds with one another. For example, the neutrality and impartiality that is required to conduct surveillance at field level can be compromised by outspoken advocacy and/or accountability mechanisms. However, advocacy and/or accountability mechanisms are impossible without effective surveillance and evidence generation.

Rather than having a single strategy for collecting and analyzing AHC, different actors involved should recognize the differential and complementary roles that they each play in protecting healthcare.

SECTION 3. PROTECTING THE DELIVERY OF HEALTHCARE IN ARMED CONFLICT

Access to, and delivery of, healthcare in armed conflict depend on several factors: the security and protection of healthcare systems comprised; healthcare infrastructure; personnel; supply chains; and transport. Protection of healthcare during armed conflict requires adherence to established and well-developed legal instruments, frameworks and mechanisms dedicated to the right to health. It also entails making protection measures a mainstream part of health and humanitarian programs, plus scaled-up efforts on community engagement, advocacy and diplomacy.

3.1 LEGAL FRAMEWORKS AND ACCOUNTABILITY MECHANISMS

Legal frameworks provide a route to potential accountability for AHC. In this context accountability refers to consequences imposed on perpetrators, including criminal convictions, sanctions and reputational costs. These consequences should act as deterrents to AHC. While well-established, these legal frameworks have rarely led to convictions of those accused of AHC. Despite many thousands of documented attacks, there has been fewer than a handful of accused perpetrators held to account, and this has led to repeated claims of impunity.[62–65]

3.1.1 International humanitarian law

The four Geneva Conventions of 1949 and the 1977 Additional Protocols to them set out the obligations of parties to an armed conflict to protect and respect healthcare in conflict. Although the Additional Protocols have not been universally ratified, their key provisions, including principles of distinction, precautions, proportionality, and respect for medical ethics, have been recognized as binding on all parties as a matter of customary IHL.

Respect in the context of IHL means not attacking, obstructing access to or interfering with healthcare, including not punishing health providers for adhering to ethical obligations toward the wounded and sick.

A fundamental principle of IHL is that "the wounded and sick must be respected and protected".[66] Respect in this context means not attacking, obstructing access to or interfering with healthcare, including not punishing health providers for adhering to ethical obligations toward the wounded and sick. The duty to protect includes: affirmative obligations to collect and care for the wounded; to take all feasible precautions in the means and methods of warfare to avoid, or at least minimize harm to civilians; and to abide by the principle of proportionality in attacks.[67]

Willful killing or causing serious bodily injury or great suffering to the wounded and sick, intentionally attacking health facilities and personnel, and breaches of the principle of proportionality can be war crimes under the Geneva Conventions and

Rome Statute of the International Criminal Court. Abuses in or denial of medical care may also constitute torture or other forms of cruel, inhuman and degrading treatment. When part of a widespread and systematic attack on a civilian population, they can be prosecuted as crimes against humanity, as they can be understood as of a similar nature to crimes set forth in the Rome Statute.

3.1.2 The right to health

The right to the highest achievable standard of health, established in both the WHO Constitution and the International Covenant on Economic, Social and Cultural Rights, applies in armed conflict. It requires the state to respect, protect and fulfill the right to health. This also includes reducing the causes of ill-health, and ensuring non-discrimination in the availability, accessibility, acceptability (including adherence to medical ethics) and quality of healthcare for everyone in its territory. The right to health also requires that everyone has meaningful participation in decisions regarding healthcare and health systems. States must also be accountable to the population for adhering to the requirements for a right to health.

3.1.3 Other sources of law

UN Security Council resolutions adopted under Chapter VII on the UN Charter are binding. In 2016, the UN Security Council adopted resolution 2286 on the protection of healthcare in armed conflict. It calls on state armed forces and security forces to integrate practical measures for the protection of healthcare in their military planning and operations. It also urges all parties to armed conflicts to develop effective measures to prevent and address violent attacks on, and threats against, healthcare. The resolution encourages the development of domestic legal frameworks to ensure respect for international legal obligations, collection of data on obstruction, threats and physical AHC, and sharing of challenges and good practice. It emphasizes states' responsibility to end impunity. It urges states to conduct independent, full, prompt, impartial, and effective investigations of violations of IHL regarding healthcare.[68]

'Soft law', which includes declarations, arrangements and interpretations of obligations that are not legally binding, are also relevant. The use of aircraft bombs, artillery, rockets and missiles in villages, towns and cities, are the leading cause of destruction of healthcare armed conflict. The 2022 Political Declaration on Strengthening the Protection of Civilians from the Humanitarian Consequences Arising from the Use of Explosive Weapons in Populated Areas calls on states to take action to reduce the use of these weapons.[69] The Declaration's signatories committed to adopt policies and practices to avoid harm to civilians from explosive weapons in populated areas.

3.1.4 Accountability mechanisms

3.1.4.1 Criminal prosecution of atrocity crimes

State parties to the Rome Statute can refer cases of atrocity to the International Criminal Court when these crimes are committed on their territory or the territory of another state party. Non-state parties can consent to International Criminal Court jurisdiction over cases of atrocity crimes committed on their territory. The UN Security Council can refer such cases involving acts by individuals associated with a non-state party, regardless of consent.

Domestic civil and military justice systems can prosecute atrocity crimes by their own nationals as local law provides. Under principles of universal jurisdiction, atrocity crimes can be prosecuted in national courts by any state that chooses to do so, irrespective of where the crime was committed or where the alleged perpetrator is located. In some cases, joint or hybrid national/international courts have been established to prosecute such cases – such as the International Criminal Tribunal for the former Yugoslavia.

3.1.4.2 United Nations accountability mechanisms

The UN has numerous mechanisms for reporting on and exerting pressure on state and non-state perpetrators of IHL and human rights law (HRL) violations. They include: reporting and 'naming and shaming' by investigative commissions established by the Human Rights Council; country reporting by the UN Office of the High Commission on Human Rights and the Special Rapporteur on the Right to Health; UN human rights treaty bodies; and the Secretary General's Special Representative for Children and Armed Conflict. Attacks on hospitals and schools are one of six grave violations committed against children in situations of armed conflict. These instances are reported in the Secretary General's Annual Report on Children and Armed Conflict.

The UN Security Council can impose economic sanctions, establish protection mandates for UN peacekeepers, and order arms embargoes and other coercive measures to end breaches of law.

The UN General Assembly and the Security Council have the authority to adopt resolutions on particular conflicts. The latter can impose economic sanctions, establish protection mandates for UN peacekeepers, and order arms embargoes and other coercive measures to end breaches of law. The Security Council also has the power to dedicate a meeting to addressing violence against healthcare in armed conflict.

The International Court of Justice can hear civil cases brought by one state against another where the states consent. In cases on genocide, an international convention provides for jurisdiction by the court, including the Genocide Convention.

3.1.4.3 Other accountability mechanisms

There are a range of other accountability mechanisms at global, regional and national levels, although their effectiveness in preventing AHC remains minimal.

- **Regional bodies.** Regional human rights bodies, such as the European Court of Human Rights, can report on and put pressure on those suspected of violence that attacks healthcare.
- **National reporting.** National parliaments may conduct investigations, hearings and discussions of violations toward action by their governments. The US State Department issues annual country reports on human rights practices that include AHC.[70]

- **Bilateral and diplomatic tools and pressure.** States that have relationships with state or non-state armed groups can exert their influence through private communications, diplomatic channels and public condemnations. They can also impose direct sanctions, trade restrictions and other economic actions. The Arms Trade Treaty and many domestic laws prohibit arms transfers to states or military units where they are used (or where there is a risk of use) to commit violations of IHL.
- **Voluntary mechanisms to encourage compliance:**
    - The ICRC engages in confidential communications with parties to conflicts to encourage compliance.
    - The International Humanitarian Fact-Finding Commission has the authority to inquire into allegations of grave breaches or serious violations of IHL. However, it has only been activated once since its establishment in 1991.

3.1.5 Adherence to health professional ethics

The World Medical Association has declared that medical ethics in war are the same as in peacetime.[71] Ethical obligations particularly important in wartime include: impartiality of care; exercise of independent professional judgment; beneficence; and non-maleficence ('do no harm').

3.2 MAINSTREAMING PROTECTION OF HEALTHCARE – RESILIENCE AND PREPAREDNESS

In areas prone to, or exposed to, active armed conflict, it is critical to make healthcare protection a mainstream part of health and humanitarian programs. This includes ongoing contextual analysis and risk assessment. It also involves taking steps to strengthen health systems' resilience and capacity to: maintain essential health services; continue functioning under duress; and responding effectively to the increased patient load arising from mass casualty incidents, disease outbreaks, and closure of other facilities. The key measures required include those discussed in the sections that follow.

3.2.1 Contextual analysis and risk assessment

A contextual analysis will inform the understanding of the specific risks that healthcare systems face in conflict zones. This analysis should include identifying key actors, their motivations, and potential threats to healthcare services. Stakeholder mapping is also important: it helps to identify all relevant parties, including belligerents, local communities and international organizations; and it helps to understand their perspectives and influence on the healthcare system. The UN Security Risk Management System (UNSMS), (which all UN partners participate in), implements an ongoing nine-step security risk management process in-country to effectively manage the risk to UN personnel, assets and operations. Information from the situational analysis, threat assessment, security risk assessment, and other activities can help to inform threats to healthcare.[72]

A health system assessment – for example, using the Health Resources and Services Availability Monitoring System (HeRAMS)[73]– should be conducted to evaluate the existing capacity, vulnerabilities and resilience of the healthcare system. HeRAMS is undertaken by WHO in humanitarian settings across 27 countries in collaboration with government officials and operational agencies. It is used to monitor trends in the operationality of health systems and inform decision-makers on service delivery and operational priorities.

CASE STUDY 5. AMIR MEDICAL SCHOLARSHIP FOR YOUNG PALESTINIAN DOCTORS (QATAR)

Established about two decades ago, this scholarship program is a collaborative initiative that involves three main stakeholders: Hamad Medical Corporation, Qatar Red Crescent Society, and the Palestinian health authorities in Gaza and the West Bank. The program's primary objective is to cultivate a group of highly skilled medical professionals to establish new healthcare services in the oPt, or elevate those already existing to higher standards. The program also aims to enhance medical education in the oPt through the contribution of returning specialists.

The program has significantly contributed to the development of medical leadership in Gaza and the West Bank. Graduates often return to assume leadership roles in their fields, and often become heads of clinical departments.

Since its inception, the program has successfully facilitated the graduation and return of 41 physicians from 23 distinct specialties and subspecialties. Currently, 54 doctors are undergoing residency or fellowship training across various specialties.

Before the conflict escalation in October 2024, the program had enhanced self-sufficiency and reduced the need for patients to seek medical care in Israel or neighboring countries such as Egypt and Jordan.

The program typically spans four to seven years of residency, depending on the specialty, followed by two to three years of subspecialty (fellowship) training. Graduates usually obtain the Arab Board certification during this time and, more recently, the Qatari Board certification, before their return to the oPt.

The scholarship program has made a profound impact on medical care in the oPt by developing a skilled workforce that is capable of addressing local healthcare needs. The program strengthens the healthcare system and also fosters international collaboration and knowledge exchange, advancing medical standards within the region.

3.2.2 Capacity building and preparedness training

Capacity building is fundamental to strengthening resilience. It also empowers staff to articulate the value of healthcare as a common good, understand their rights and responsibilities, and actively participate in their own protection.[74]

Healthcare workers, along with all humanitarian staff, should receive training on emergency preparedness (for example, mass casualty management training), security protocols, and the specific challenges of delivering healthcare in conflict zones. Several humanitarian organizations have designed training programs tailored for healthcare personnel operating in insecure and low-resource environments.*

The training should also emphasize medical ethics, underscoring the protective value of the trust established between healthcare providers and the community. By adhering to the principles of impartiality, non-maleficence, and justice, healthcare providers fulfill their ethical obligations and also help preserve the sanctity of medical action and maintain their protected status under IHL.[75,76] This ethical foundation, combined with knowledge of IHL and humanitarian principles, can help healthcare personnel to advocate effectively for the protection of civilians, the wounded and the sick, while clearly communicating the duties and responsibilities of armed actors.

Investment in resilient supply chains is also necessary for the continuity of service delivery in the face of armed conflict-related disruptions.

3.2.3 Adapting service delivery

Healthcare services and programs should be designed to allow adjustments based on the evolving security context. Contingency plans should include flexibility in resource allocation, operational strategies, and the ability to switch to alternative delivery models.

Decentralization of health services through field hospitals, mobile clinics and maternity units, community health services and remote care can all reduce risks of AHC. Another option is to move relevant services that do not require inpatient care – such as outpatient and laboratory services – outside of the hospital settings. Pre-planned options should be considered, such as relocation of hospitals and other health facilities in the face of advancing or escalating military operations. In northwest Syria, one hospital was forced to relocate six times as the conflict evolved.[77] In southern Gaza, a public hospital identified other facilities, where it subsequently relocated its services and equipment, while one non-governmental organization (NGO) operated field hospital identified a new location, which it then moved to in advance of the Rafah incursion by the Israel Defense Forces in May 2024.[78]

When populations are forcibly displaced, health services will often need to move with them, especially if they settle in areas with limited access to healthcare. Options for temporary or semi-permanent field hospitals, medical centers and basic health units can be considered, as well as community-based healthcare.[79]

* The World Health Organization's 'Red Book' or Guidance Document for Medical Teams Responding to Health Emergencies in Armed Conflicts and Other Insecure Environments offers a practical framework for medical teams preparing for, or who are involved in, responding to health emergencies in armed conflict and other insecure environments.

Women and children, the elderly and disabled, and the critically unwell should be prioritized, with healthcare made available free-of-charge for these groups wherever possible. Healthcare teams may be rapidly reconfigured to target these populations in decentralized units at community level where possible.

3.2.4 Protective measures in health facilities

Healthcare facilities in conflict zones should be designed or retrofitted to reinforce physical infrastructures to minimize their vulnerability to attacks. This includes using blast-resistant materials and reinforced structures, and strategically placing facilities or critical services (for example, operating theatres) away from high-risk areas whenever possible. The design should also incorporate secure areas within the facility where patients and staff can shelter during an attack.[80]

It is also essential to ensure that the facility, its means of transport, equipment and other associated medical facilities are clearly identifiable as healthcare services. The use of distinctive emblems – such as the Red Cross or Red Crescent – is to be encouraged in conflict settings, as these symbols confer a special status of protection under IHL, beyond general IHL protection that prohibits direct attacks on civilians.[81]

Also, integrating early warning systems, such as alarms, video cameras, or radio communications, can enhance the facility's preparedness by allowing staff to swiftly initiate emergency protocols. The design of the immediate surroundings may include buffer zones and natural barriers that provide additional protection against explosive weapons or small arms fire. Implementing robust access control measures, including secured entry points and perimeter fencing, can further prevent unauthorized access and reduce the risk of attacks.

Integrating structural resilience measures into early recovery strategies in ongoing crises is crucial. Embedding these measures in recovery plans will foster a more comprehensive approach to rebuilding health facilities that are less vulnerable to future attacks. Also, promoting donor openness to support these investments is essential for ensuring sustainable recovery efforts and strengthening protective measures for the future.

3.3 ENGAGEMENT, ADVOCACY AND DIPLOMACY

3.3.1 Engagement with armed forces and non-state actors

Engaging with both state and non-state armed actors is crucial to ensure the protection of healthcare in conflict zones. This engagement should include education on the right to health, the impartiality of medical care, the use of the emblem, and the obligations of all parties under IHL, HRL, and relevant domestic laws to protect medical personnel, facilities and patients. The ICRC has developed training programs specifically designed for military forces, which can be expanded and adapted to different contexts. Also, creating clear communication channels between healthcare providers and armed actors can help mitigate misunderstandings and reduce the risk of attacks on healthcare facilities.

3.3.2 Community awareness and engagement

Raising awareness among local communities about the importance of protecting healthcare is a vital component of advocacy and the overall protection of the healthcare system. Community involvement can range from participating in the design and implementation of healthcare programs to taking active roles in disseminating key messages and establishing early warning systems.

Raising awareness among local communities about the importance of protecting healthcare is a vital component of advocacy and the overall protection of the healthcare system.

Community-led initiatives, such as the Alrasid (Sentry) system used in Syria, demonstrate how local populations can contribute to the protection of healthcare facilities.[82] Systems that use community observers to provide early warnings of attacks can protect healthcare and also foster a sense of ownership and responsibility among local communities. When healthcare providers adhere to ethical principles, they build trust with the community, which has its own protective value. This ethical conduct reinforces the perception of healthcare as neutral and impartial, encouraging local actors and belligerents to respect and protect these services.

Community engagement can be fostered through participatory programs that involve local leaders and influencers in advocating for the understanding and protection of healthcare as a common good. Public campaigns can educate communities on their rights under IHL and the consequences of attacking healthcare facilities. These campaigns should use local languages and culturally appropriate messaging to ensure broad understanding and support.

3.3.3 Diplomatic strategies and international advocacy

Diplomatic efforts are essential to ensure that all parties in a conflict adhere to international standards for the protection of healthcare. This includes engaging states committed to IHL to actively use diplomatic leverage to protect healthcare in conflict settings and to advocate for greater compliance and accountability. Leveraging platforms such as the UN Human Rights Council and the Office of the UN High Commissioner for Human Rights can help place healthcare protection at the forefront of international human rights and IHL discourse. Diplomatic pressure, co-ordinated across multiple countries, can also be used to issue joint statements, apply sanctions, or take other measures against violators.

International collaboration is also crucial. Organizations such as the ICRC, WHO and other international bodies play pivotal roles in advocating for healthcare protection. They do this through participation in bilateral and confidential dialog, setting standards, and supporting health systems resilience. Multilateral diplomacy should be leveraged to build global consensus on the need to protect healthcare, using platforms such as the UN Security Council to issue and enforce compliance with resolutions.

Coalitions of civil society organizations, such as the Safeguarding Health in Conflict Coalition, play an increasingly important role in advocating for the protection of healthcare in conflict zones. Through research, reporting and strategic advocacy, these coalitions can amplify the voices of affected communities, and also call for accountability and compliance with IHL, and encourage policy changes aimed at safeguarding health workers, facilities and patients in conflict settings. Engagement with donors to secure funding specifically designated for the protection of healthcare in conflict zones is also crucial. Also, providing flexible or loosely allocated funding allows for adaptability in responding to changing health needs in volatile and insecure environments. Regularly updating donors on the security situation and demonstrating the impact of their contributions on healthcare protection ensures transparency and fosters continued support. This can ultimately safeguard access to essential healthcare services.

3.3.4 Strategic communication

Effective strategic communication is important in influencing stakeholders and mobilizing international support for healthcare protection. This includes the use of data, case studies and testimonies to build a compelling narrative that resonates with legal experts and the general public. For example, systematic documentation of AHC – for example, as done by WHO's SSA, and the detailed annual report from the Safeguarding Health in Conflict Coalition – can be used to support advocacy efforts and inform global policy recommendations. Reliable data collection can also provide greater visibility on the scale of the problem, with further work to assess the impact of attacks on lives lost and also in terms of resources, economic loss and subsequent development setbacks.

Strategic communication should leverage high-profile figures, international organizations, and media platforms to amplify the message globally. Communication should also ensure the widespread understanding and prioritization of healthcare protection in conflict zones.

3.3.5 Health and peace

Ultimately, the most effective way to protect healthcare in conflict is to prevent wars before they start – and to bring them to a swift and just conclusion when they do occur. Addressing the root causes of conflict – such as the denial of rights, social and economic inequality, poor governance, power struggles and cultural, ethnic and religious divisions – requires concerted efforts that extend beyond the health sector. However, health professionals, in their own modest way, can contribute to building trust, social cohesion and resilience at community level and beyond. By upholding the right to health of their communities without discrimination, adhering to medical ethics at all times, and fulfilling their professional responsibilities in a conflict-sensitive manner, they can contribute to prospects for achieving, maintaining and sustaining peace.

SECTION 4. RECOMMENDATIONS TO BETTER PROTECT HEALTHCARE IN ARMED CONFLICT

The following recommendations are proposed as robust steps to prevent and mitigate AHC. They are directed at the full range of stakeholders whose influence is needed to protect healthcare in conflict. These include: governments; United Nations agencies; international organizations; NGOs; civil society organizations; professional bodies; and experts and practitioners of IHL and HRL.

4.1 GLOBAL AND REGIONAL MEASURES

4.1.1 Convene a global alliance for the protection of healthcare in conflict

Establish an alliance of committed Member States, UN agencies, international organizations, NGOs, and civil society organizations to exert diplomatic pressure and co-ordinate actions for the protection of healthcare in armed conflict. The alliance would facilitate data sharing, regularly review data collection methods, pool resources, promote robust measures to protect healthcare, and advocate for greater accountability. Initial priorities could include intense advocacy regarding ongoing attacks and diplomatic outreach by Member States to the International Criminal Court. Regional subgroups may be established, such as for the Middle East, Africa and Europe.

4.1.2 Establish a UN Special Rapporteur on the Protection of Health in Armed Conflict

Member States should urge the UN Human Rights Council to create a Special Rapporteur on the Protection of Healthcare in Armed Conflict. The special rapporteur's main responsibilities would be to monitor, report on and advocate for the protection of healthcare in conflict, and to facilitate international co-operation to safeguard health. If the Council is not in a position to establish such a post, an alternate option would be for the Secretary General to establish a Special Representative for the Protection of Healthcare in Armed Conflict.

4.1.3 Improve documentation on AHC, including impact on public health

The various data collection mechanisms and platforms should continue to refine their methodologies, based on organizational mandates and objectives. Data sources and verification systems should be strengthened and – as far as possible – consolidated to share data. Donors should support efforts to document the public health impact of AHC and operational research to advance the evidence base for protective measures. Academic partners can play an important role in improving data collection methodologies, documenting the public health impact and undertaking operational research.

4.1.4 Intensify and sustain diplomacy for the protection of healthcare in armed conflict

Governments, UN agencies, international organizations, and human rights bodies should engage in rigorous diplomatic efforts with state and non-state actors who are confirmed to be, or suspected of, attacking healthcare. Where these efforts are unsuccessful, valid lawful measures aimed at public shaming, trade restrictions and sanctions could be considered. Governments should be encouraged to exercise universal jurisdiction for violations of international law on the protection of healthcare in armed conflict. National parliaments, Ministries of Justice, international legal bodies, and human rights organizations should collaborate to bring those responsible for violations of IHL to justice.

4.2 NATIONAL MEASURES

4.2.1 Build capacities on health and humanitarian diplomacy

Develop and implement training programs for healthcare professionals and other relevant groups to advance skills in advocating for healthcare as a global public good, and in navigating the complexities of armed conflict. This training could include sessions on negotiating access to healthcare, protection of health, trust building, and communications. A modest number of training sessions and symposiums on these topics are conducted by various institutions, but a more formal curriculum should be developed and promoted – for example, by WHO, together with academic and operational partners.

4.2.2 Integrate IHL and HRL into educational curricula

Encourage Ministries of Education to incorporate humanitarian and human rights education into secondary and tertiary education – including for healthcare professionals – with technical support from international bodies. To ensure global co-ordination and consistency in education, standardized educational materials on IHL, HRL and medical ethics should be developed in collaboration with global organizations such as the ICRC and UN agencies. Ministries of Defense should ensure that armed forces personnel are thoroughly trained on their obligations under IHL and are provided with practical guidance on how to protect healthcare in armed conflict. Where there are gaps, related policies and programs should be developed and implemented; where policies exist, they should be reviewed and strengthened.

4.2.3 Address physical and psychosocial trauma among healthcare workers

Establish comprehensive support programs for healthcare workers to manage the trauma caused by conflict. Develop policies ensuring that healthcare workers receive adequate protection, including psychological support and mental healthcare. This is especially important for local health workers who often work on the frontlines for protracted periods and are exposed to enormous stress. Where possible, adopt existing frameworks, such as those outlined in *Our duty of care: A global call to action to protect the mental health of health and care workers*.[83]

4.3 LOCAL MEASURES

4.3.1 Enhance emergency responsiveness and health system resilience

Ensure that emergency preparedness and response plans include options for service continuity in the context of armed conflict and potential system disruption. These can include early warning systems for potential AHC, decentralization of health services, contingencies for rapid relocation of facilities/services, and sheltering. They can be complemented by pre-positioning of medical supplies in different locations to allow for rapid redistribution. Health authorities should prioritize the strengthening, upgrading, or retrofitting of health facility infrastructure to withstand the physical impacts of armed conflict. Options include reinforcing above-ground structures to protect against blasts and small-arms fire, and establishing underground bunkers. Ideally, any upgrades and retrofitting should incorporate fireproof and blast-resistant materials to maintain operations during attacks.

4.3.2 Increase community engagement in protecting healthcare

Community members can be associated with AHC from several perspectives – they can be the victims (for example, through loss of life or injury incurred as patients during an attack, or loss of access to health services resulting from an attack), the perpetrators (as documented during recent conflicts and outbreaks), or the protectors (as advocates and negotiators for protection of healthcare). Communities play a central role in the response to and resolution of all health and humanitarian emergencies. Strong and open community engagement can mitigate the risks of community members being victims and perpetrators of AHC, while also engaging them as forceful contributors to the protection of healthcare.

SECTION 5. CONCLUSION

Throughout history, the brutality of war has been felt mostly by innocent civilians. While AHC have long been a feature of armed conflict, the full realization of their scale and public health impact have become clear only in recent years, including as a result of more consistent documentation and reporting. Our understanding of their direct impact on health workers, patients and health systems has also improved, along with the disruption they cause to health services and access to care.

In spite of this better understanding, what has not changed is the impunity associated with AHC. For example, during the years 2022–2024, there were the highest number of incidents since reporting began. Well-intended diplomatic efforts – while they must continue – increasingly have no influence. And while thousands of attacks have been documented, accountability remains extremely rare. Therefore, the attacks continue. As a result, health staff, humanitarian workers and communities have been forced to develop locally specific adaptations to health service delivery that aim to protect healthcare and mitigate the impact of attacks.

To protect the right to health and healthcare effectively, we must implement comprehensive strategies that:

- strengthen accountability mechanisms.
- enhance awareness of international humanitarian law and the right to health.
- build resilience and preparedness.
- foster improved engagement, advocacy and diplomacy.

The recommendations in this report address prevention, mitigation, and accountability and responsibility on a global, regional, national and local level. They aim to provide a strategic framework to guide policymakers, human rights organizations, Member States and UN agencies on future action. By adhering to these guidelines, these actors can play a pivotal role in enhancing the protection of healthcare amid armed conflict. They can also ensure that future interventions are effective and enduring for years to come.

ABBREVIATIONS

ACLED	Armed Conflict Location and Event Data
AHC	attacks on healthcare
HeRAMS	Health Resources and Services Availability Monitoring System
HRL	human rights law
IAC	international armed conflict
ICRC	International Committee of the Red Cross
IHL	international humanitarian law
NIAC	non-international armed conflict
SSA	Surveillance System for Attacks on Health Care
UN	United Nations
WHO	World Health Organization

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