

# ATTACKS ON MEDICAL AND HUMANITARIAN MISSIONS: STATE VIOLENCE, LOCAL VICTIMS, AND THE TARGETING OF TRANSPORT



PHOTO:  
**MSF ambulance destroyed in December 2023 in the city of Gaza.**

GAZA © CAROLINE SEGUIN / MSF

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## INTRODUCTION

MSF's article in the 2024 IECAH-MSF report, entitled "Attacks on Humanitarian Action: The New Normal? MSF's Experience in Gaza, Sudan, and Ukraine" highlighted how health services are increasingly threatened in armed conflicts, particularly in urban warfare. Attacks frequently violate international humanitarian law (IHL) yet continue with little accountability.<sup>1</sup> Beyond the immediate harm to staff, patients, and infrastructure, such violence disrupts or suspends medical services, denying people their right to adequate care. In accordance with said article, these patterns are no longer exceptional but are becoming the "new normal." Despite international commitments such as UN Security Council Resolution 2286 (2016) to protect healthcare in armed conflict, implementation of such resolutions remains gravely deficient. The article concluded with a call for stronger respect for IHL and systematic documentation of attacks on health care. Finally, it lamented that without political will and genuine commitment, civilians and medical-humanitarian personnel will continue to suffer the consequences of this disregard for basic humanitarian norms.

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**Health services are increasingly under threat in armed conflicts, particularly in urban settings**

One year on, the lack of protection remains a critical concern, with attacks on health care and humanitarians continuing unabated. In September 2025, Australia launched a new Declaration for the Protection of Humanitarian Personnel at the UN General Assembly. Signed by over one hundred States, the initiative aims to strengthen compliance and implementation of the UN Security Council Resolution 2730 (2024),<sup>2</sup> which calls on States to respect and protect humanitarian personnel in accordance with their obligations under international law. Such commitments are welcome and needed but need to be translated into practical action if they are to have impact.

This article examines three troubling trends in ongoing attacks against healthcare:

- i. The growing role of state actors as perpetrators of violence against health care;
- ii. The disproportionate impact on locally hired staff
- iii. The targeting of medical and humanitarian transports—including ambulances and supply vehicles—beyond static health facilities.

To illustrate these dynamics, this article focuses on two key case studies: Palestine and South Sudan. In Palestine, the unprecedented scale and intensity of attacks on medical facilities, personnel, and transports, coupled with the ongoing conflict, make it a central case for analysing attacks on medical missions. South Sudan, meanwhile, offers a different perspective. Over many years, South Sudan has invariably ranked among the countries with the highest number of attacks on humanitarian actors—first in terms of victims (killed, wounded, or kidnapped) between 2014 and 2020, and second between 2021 and August 2025, after

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<sup>1</sup> Alejandro Pozo, Helen Richards and Natasha Sax, "Medical Care Under Fire; The New Normal? The MSF'S experience in Gaza, Sudan & Ukraine", October 2024, in *Humanitarian Action Report 2023-2024*, Iecah-MSF, pp. 115-129.

<sup>2</sup> UN (2024) *Security Council adopts resolution on the Safety and Security of Humanitarian and United Nations Personnel*.

Palestine.<sup>3</sup> What makes South Sudan notable is that attacks on humanitarian workers far exceed those against medical staff, suggesting either a specific hostility toward general humanitarian aid or, conversely, a degree of respect and protection for medical care. This divergence is unusual: in most contexts—such as Palestine, Sudan, Myanmar, Afghanistan, Central African Republic (CAR), and Democratic Republic of the Congo (DRC)—attacks on health and humanitarian workers rise together, reflecting either the centrality of humanitarian support to health systems or indiscriminate violence that spares no one. The opposite pattern is also exceptional: contexts where health workers are targeted far more than other humanitarian staff, as seen in Ukraine and Lebanon.<sup>4</sup>

## 2

### STATES AS PERPETRATORS

The evidence is stark: the majority of attacks on medical and humanitarian missions are carried out by state actors. The Safeguarding Health in Armed Conflict Coalition (SHCC) reports that “approximately 81% 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.”<sup>5</sup> Since 2022, the “vast majority” of state-led attacks on medical missions have been attributed to Russian forces (in Ukraine, Syria, and Chechnya) and the Israel Defense Forces (in Palestine, Lebanon, and Syria). Other incidents were linked to national or foreign state militaries, including the South Sudan People’s Defence Forces—responsible not only for attacks inside South Sudan but also for attacks inside Sudan.<sup>6</sup>

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**81% of attacks on medical care in 2024 were attributed to state agents**

#### 2.1. Palestine

In 2023 and 2024, Israel was responsible for the highest levels of violence against medical and humanitarian missions worldwide. According to the World Health Organization’s Surveillance System for Attacks on Health Care (WHO-SSA), in 2023 Palestine accounted for 623 of the 762 deaths (82%) and 824 of the 1,556 attacks (53%) against in medical staff; in 2024, the figures were 288 of the 944 deaths (31 %) and 729 of the 1,647 attacks (44 %). In addition, Lebanon recorded 238 deaths (25%) and 149 attacks (9%) in 2024, compared to 11 attacks and 3 deaths in 2023. Taken together, these figures mean that at least 53% of all attacks and 67% of all killings of medical personnel in 2023–24 occurred in

3 Before these periods, the situation was also dire 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. See: MSF (2014) *South Sudan Conflict: Violence Against Healthcare*.

4 The data used for these and other conclusions in the article come from seven databases: The WHO Surveillance System for Attacks on Health Care (SSA), The Safeguarding Health in Conflict Coalition (SHCC), Insecurity Insight, Aid Worker Security Database (AWSDB), International NGO Safety Organisation (INSO), Armed Conflict Location & Event Data (ACLED) and MSF. SSA, SHCC and ACLED provide data on attacks on the medical mission, while Insecurity Insight, AWSDB and INSO provide data on the humanitarian mission.

5 SHCC (2025) *Epidemic of Violence: Violence Against Health Care in Conflict 2024*, p. 13.

6 According to the SHCC, other foreign state actors involved in the commission of attacks against the medical mission were the Iran’s Islamic Revolutionary Guard Corps (in Syria), the Turkish Armed Forces (in Syria) and the Ukrainian Armed Forces (in Russia).

contexts where Israeli forces were responsible for the vast majority of such attacks. Some incidents in Syria have also been attributed to Israel.<sup>7</sup>

### 2.1.1. Attacks of Medical Facilities

In Gaza, attacks against health care have been prolific. As of 5 January 2026, only 18 of Gaza's 36 hospitals are "partially functional" and none "fully functional".<sup>8</sup> Since October 2023 MSF staff and patients have been forced to leave at least 18 different health structures and endured more than 50 violent incidents, which include airstrikes against hospitals and ground offenses into hospitals.

Israeli forces have frequently attacked medical facilities on the grounds that hospitals had "lost protection." Yet such claims have not been independently verified, and Israeli authorities have consistently denied access to international investigators and human rights monitors. Even in the rare cases where a hospital may lose protection under IHL, parties to the armed conflict are still obliged to issue warnings and ensure that any attack complies with the principles of proportionality and precautions. In Gaza, however, the repeated use of heavy weaponry against medical facilities shows that precautions to minimize civilian harm are inadequate, and insufficient (or no) weight is given to the "reverberating impacts" of attacks on health care—that is to say, the cascading effects on the wider health system. Since October 2023, the Israeli military's attacks that have effectively dismantled an entire health care system inflict a scale of civilian harm manifestly disproportionate.

On 25 August 2025, Nasser Hospital, one of the last fully functional hospitals in southern Gaza that was operating at more than double its capacity,<sup>9</sup> was struck four times in one day by the Israeli military.<sup>10</sup> In what is known as a "double tap" attack, nine minutes after the first strike, when first responders and journalists had gathered at the scene, Israeli forces struck the facility a second time. The attack was caught on video and widely broadcasted. The Israeli Prime Minister stated that he "deeply regrets the tragic mishap", which killed over 20 people and severely damaged a protected medical facility. MSF staff were working in the facility's maternity and paediatric wards. The attack forced MSF staff to temporarily suspend activities in the hospital. MSF's medical coordinator at Nasser Hospital, described that day: "We left the hospital with the feeling that no one is safe. Whether you are a patient or a medical worker, there is total impunity for bombing a hospital...It is very difficult for me to work knowing that at any moment they can bomb the hospital and nothing will happen. Nothing will change."<sup>11</sup>

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**'It is very difficult to work knowing that they could bomb the hospital at any moment and nothing would happen'**

7 By contrast, in 2022 the country which suffered the highest number of attacks was Ukraine, which accounted for 77% of all attacks and 45% of all killings. In 2025, Sudan became the epicentre, with 1,620 of the 1,981 deaths (82%) worldwide, in only 5% of the attacks registered (65 out of 1,348). As with SHCC data, these WHO-SSA figures cover attacks specifically against medical missions, rather than humanitarian actors more broadly.

8 *WHO & Health Cluster*, Unified Dashboard.

9 WHO (4 July 2025) *Gaza Nasser Medical Complex*.

10 Thomas, M., Garman, B. y Vandermeersch, S. (2025) 'New footage shows Israel struck Gaza's Nasser Hospital four times'. *BBC Verify*.

11 MSF (25 August 2025) *Palestine: MSF condemns Israel's double strike on Nasser hospital*.

### 2.1.2. Forcible Displacement Orders Hindering Access to Health Care

The Israeli military's conduct has also failed to respect and protect medical facilities. Repeated forcible displacement orders, issued under threat of military operations, have severely disrupted both the delivery of health care and patients' access to it. These orders raise grave concerns: critically ill patients must be rapidly moved despite scarce ambulances, inadequate equipment, damaged roads, traffic jams of fleeing civilians, and already overwhelmed hospitals. The most vulnerable are at highest risk. At the MSF-supported El-Helou Maternity Hospital in Gaza City, for example, 18 newborns often share just twelve incubators. Relocating these babies is a daunting task: incubators are bulky and difficult to transport, while newborns—with fragile immune systems—require sterile conditions and stable temperatures. Evacuating intubated patients poses another acute challenge, as they depend on portable ventilators. Yet the number of such devices in Gaza is uncertain—and their entry is frequently blocked under Israel's "dual use" restrictions.<sup>12</sup>

Since October 2023, the cynical use of "evacuation orders" have been used as a means of emptying health care facilities and forcibly displacing civilian populations in line with political and military objectives. According to OCHA, as of 25 August 2025, up to 88.5 per cent of the Gaza Strip had been placed under evacuation orders since 7 October 2023.<sup>13</sup> This has severely impeded the ability of health services to function or to be accessible to the civilian population. Israel's renewed offensive on Gaza City has followed the same destructive pattern. Despite the fact that Israel must respect and protect medical facilities, initial information its military has provided to humanitarian actors and published in the Israeli media is that all medical facilities in Gaza city, including those supported by UN agencies and international humanitarian organizations will be required to evacuate entirely; totally obliterating access to medical care in Gaza City.<sup>14</sup>

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**In the attack on Old Fangak, medical supplies worth €320,000 were destroyed at the MSF hospital**

## 2.2. South Sudan

The security situation in South Sudan sharply deteriorated in 2025, with renewed conflict between the South Sudan People's Defence Forces (SSPDF) – South Sudan's army - and the Sudan People's Liberation Movement-In Opposition (SPLM-IO) reigniting violent clashes in several areas of the country, particularly in Upper Nile and Jonglei States, but also in Western Bahr el Ghazal and Greater Equatoria.

Amidst these clashes, there have been several attacks on health facilities, medical staff, and non-governmental organisations. On 3 May 2025, two helicopter gunships deliberately bombed the town of Old Fangak in Jonglei state, killing seven people in the market. Just before, they also attacked the Old Fangkak hospital pharmacy, destroying medical supplies valued at €320,000 (the total damage cost was much higher), and shrapnel reached the hospital itself. The attacks in the town injured 20 people, including four MSF staff

<sup>12</sup> MSF (August 2025) *Choking Gaza. MSF's humanitarian supply activities in a context of collective torture.*

<sup>13</sup> OCHA (26 August 2025) *Humanitarian Situation Update #209 | Gaza Strip.*

<sup>14</sup> Fabian, E., Freiberg, N. and agencies (21 August 2025) 'Israel tells Gaza City hospitals to ready for mass evacuations as war plans advance'. *The Times of Israel.*

members, two patients, and two caretakers.<sup>15</sup> MSF urgently evacuated the patients to Toch, 33 km away, to an abandoned health facility previously decommissioned following USAID funding cuts that was rapidly reactivated and repurposed as a stabilization site.

No one claimed responsibility for the attack. MSF had been operating at the hospital for over ten years, which is well known in the region. The hospital was clearly marked including from the air. As a result of the attack, all medical services were disrupted at Old Fangak Hospital, the sole provider of secondary lifesaving care for 110,000 people, in an area difficult to access due to flooding. In 2024 alone, MSF carried out nearly 40,000 medical consultations there (in addition to another 34,000 in decentralized services in the region), nearly 24,000 patients received malaria treatment and at least 5,000 received prenatal care, among other services.

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### LOCAL STAFF BEARING THE BRUNT

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**The figures suggest that locally hired and national staff face a disproportionate level of risk**

As attacks on humanitarian and medical staff appear to have become the ‘new normal,’ it is clear that national and locally recruited staff have borne the brunt of the violence. In May 2024, the UN Security Council adopted resolution 2730 on the protection of humanitarian personnel and UN and associated personnel and their premises and assets. The resolution highlighted the specific vulnerability of national and locally recruited humanitarian staff who “accounted in recent years for the majority of safety and security incidents”.<sup>16</sup> This pattern has been clearly reflected in the two contexts under analysis here: Palestine and South Sudan.

The Aid Worker Security Database (AWSD) confirms that the vast majority of victims of violence against aid workers are national staff. Between 2014 and 2020, 814 national staff were killed, 914 injured, and 681 kidnapped, compared with 49 killed, 110 injured, and 56 kidnapped among international staff. This means national staff accounted for 94% of those killed, 89% of those injured, and 92% of those kidnapped. The disparity has grown even sharper in recent years. From 2021 to 2025, 1,241 national staff were killed, 1,006 injured, and 604 kidnapped, while international staff recorded 29 deaths, 42 injuries, and 38 kidnappings. In this period, national staff represented 98% of all those killed, 96% of those injured, and 94% of those kidnapped. These figures point appear to point to locally hired and national staff facing a disproportionate level of risks.

Given that national staff often make up around 90% of the humanitarian workforce (though proportions vary significantly across organizations), the scale of incidents affecting them is disproportionately high—and rising. These figures should also be read in light of two caveats: first, the increasing localization of assistance and organizational risk-aversion have raised the proportion of national staff, particular in more ‘hard to reach’ locations where security conditions are fraught; and second, across contexts, the persistent lack of reliable information on

<sup>15</sup> MSF (4 May 2025) *South Sudan: MSF strongly condemns the deliberate bombing of our hospital in Old Fangak, Jonglei state.*

<sup>16</sup> UNSC (May 2024), *Security Resolution 2370*, p.2.

national staff underscores a pattern of systematic underreporting of incidents impacting national and locally recruited staff, which may distort the full picture.

When it comes to underreporting, at least three factors suggest that the real number of incidents affecting local humanitarian workers, including medical personnel, is likely higher. First there is the inherent complexity of classifying a person as a “humanitarian worker”. 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. Second, 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. Third, incidents involving national staff tend to attract far less media, political, and institutional attention than those involving international personnel, which further contributes to underreporting. The disparity in attention to attacks affecting locally recruited aid workers—evident in Gaza, where incidents involving international staff receive far greater visibility than those impacting locally hired Palestinian colleagues— vividly underscores this point.

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## **Incidents affecting national staff tend to attract much less media, political and institutional attention**

### **3.1. Palestine**

In recent years, the highest number of killings among national and locally recruited medical and humanitarian staff occurred in Palestine. According to the WHO’s Surveillance System for Attacks on Health Care (SSA), 47% of all attacks, 34% of killings, and 49% of injuries affecting medical facilities and medical workers between 2023 and June 2025 took place in Palestine. Insecurity Insight reports similar figures: 32% of all attacks, 45% of aid workers killed, 33% of injuries, and 24% of detentions or kidnappings in the same period. Data from the Safeguarding Health in Conflict Coalition (SHCC) show that 35% of all attacks in 2023–24 occurred in Palestine.

The scale of fatalities is especially stark. According to the Aid Worker Security Database (AWSDB), 56% of aid workers killed between 2023 and 2025 were in Palestine—far more than in Sudan, the next highest country with almost 13%. The 572 aid workers killed in Palestine during this period exceeds the toll recorded in any other country not just recently, but across the entire history of the AWSDB since it began in 1998. Over the past 27 years, Afghanistan recorded 490 killings of aid workers, Syria 310, South Sudan 282, Sudan 274, and Somalia 261. In both Palestine and South Sudan, the overwhelming majority of those killed were national staff (98% and 94% respectively). These figures mark Palestine as an unprecedented epicentre of violence against aid workers, specifically Palestinian staff, with levels of risk unmatched in recent humanitarian history.

#### **3.1.1. Disparity in attention?**

One of the most high-profile attacks on humanitarian workers in Gaza was the strike on a World Central Kitchen (WCK) convoy on 1 April 2024. The attack, carried out by the Israeli military, killed seven WCK staff, six of whom were international aid workers: three from the United Kingdom, one from Australia, one from

Poland, and one holding dual United States–Canadian nationality.<sup>17</sup> The incident received extensive international media coverage and prompted strong public condemnation from the governments of the victims.

Following the attack, the Israel military launched an investigation and a public apology for the incident stating that a “misidentification” had led to the strike on the aid convoy.<sup>18</sup> This is notably one of the very few known instances where the Israeli military has undertaken an investigation and issued an apology, despite the fact that 548 aid workers have been killed in Palestine as of August 2025. It is feasible that the wide international media coverage of the case, and pressure by the victims Governments compelled Israeli authorities to respond more substantively—a level of recognition not extended to the analogous killings of Palestinian aid workers in Gaza.

While Palestinian medical workers and humanitarians make up the bulk of frontline responders in Gaza, the high rate at which they have been killed (98% of the total) leaves us questioning whether locally hired staff are being afforded a lower level of protection than their international colleagues; an observation which would fit the broader patterns of dehumanization of Palestinians. Equally, as attacks on locally hired staff tend to garner less international media attention and criticism from foreign governments, the deterrence for attacks killing locally hired aid workers may be lower. Some humanitarians who have worked in Gaza and were interviewed have expressed the perception that the Israeli military takes more seriously the safety and security of international humanitarian staff, rather than locally hired Palestinian colleagues; even within the same organization.

In Gaza, this perception of ‘dual standards of protection’ is echoed in practices of “humanitarian notifications” (often referred to as “deconfliction”) in which humanitarians provide coordinates of medical facilities, guest houses and convoy movements to the armed actors in order to request that such sites are on “no strike” lists. The Israeli military practice often requires MSF to provide information for deconfliction which distinguishes between international and locally hired staff. While it is feasible that locally hired staff are subjected to additional scrutiny, beyond this it is unclear why distinctions between local and international staff should be made in deconfliction processes. Under IHL, there is no provision which should accord a higher level of protection to international medical workers or humanitarian, compared to those who are locally recruited. Civilians are civilians and must be protected without discrimination based on their area of origin. Equally UN Security Council Resolution 2286 recalled that locally recruited medical and humanitarian personnel account for the majority of casualties in armed conflict and called for the protection of all humanitarian aid workers, regardless of their recruitment status. At the time of writing, MSF has had 15 colleagues killed in Gaza, all of whom have been Palestinian.

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## **Israeli military practice often requires MSF to distinguish between international and local staff**

<sup>17</sup> World Central Kitchen (2 April 2024) *7 WCK team members killed in Gaza*.

<sup>18</sup> Magid, J. (3 April 2024) “We are sorry”: IDF chief says “misidentification” led to strike on aid convoy. *The Times of Israel*.

### 3.2. South Sudan

According to AWSD, since the first full year of its existence in 2012, South Sudan has consistently ranked among the most dangerous places for aid workers, with 983 victims (which includes killed, wounded, kidnapped and detained staff) over the last 13 years – the highest total of any context recorded. South Sudan is also one of the countries where international humanitarian workers are killed the most. According to the AWSD, there have been seven such deaths since 2021, surpassed only by Palestine, with eight (six from WCK, in a single attack). Except for Ukraine (with six), no other context had more than one killing in that period. In South Sudan, since 2021, 106 national aid workers have been killed (94% of the total), but probably the most significant difference has been in kidnappings. The last kidnapping of an international aid worker occurred in October 2018. Since then, the AWSD has recorded 84 kidnappings among national staff.

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#### **On 14 April 2025, dozens of armed men entered the MSF hospital in Ulang and looted it**

On 5 August 2025, MSF suspended all operational activities in Yei River and Morobo counties in Central Equatoria State, in southern South Sudan, following the abduction of an MSF staff member during an evacuation of MSF staff from Morobo to Yei, amid deteriorating security conditions. The abduction took place just four days after the abduction of a Ministry of Health employee in an MSF ambulance on the same road and location. The four-vehicle convoy was stopped by armed men. They ordered the MSF staff member, who was serving as the team leader of the convoy, to exit the vehicle, while allowing the other vehicles and staff to proceed to Yei. The MSF staff member was released some hours later. These abductions are part of a disturbing trend of violence targeting health and aid workers. In Morobo, for example, several violent incidents against medical and aid workers and facilities were reported between June and August 2025, including forceful abductions, arson, violent looting of hospitals, and damage to medical infrastructure. Seven of these incidents involved the abduction of aid workers.<sup>19</sup>

A recent example of an attack on health care, primarily impacting MSF's locally hired staff occurred in Ulang. On 14 April 2025, dozens of armed men entered the 60-bed MSF hospital in Ulang, where more than 100 patients were receiving critical treatment. Probably fearing the incursion, some patients had fled the day before. Others were forced under threat to leave the hospital after the attack. The hospital was looted room by room. No one was physically harmed—the psychological impact was significant—but medical and nutritional supplies to support more than 200,000 people for nine months were robbed. MSF had no choice but to close the hospital. In 2024 alone, more than 10,000 outpatient consultations, 3,284 hospital admissions, 650 assisted births, more than 2,400 antenatal care consultations, and other medical services were provided, and more than 10,000 patients were treated for malaria. At the time of the attack, MSF had more than 800 patients with HIV, tuberculosis, and other chronic conditions. There are no other hospitals, not even functioning secondary care centres, in the area.<sup>20</sup> There were 167 locally hired staff working at that hospital, each with their families who, in addition to relying on that income, also received care there.

<sup>19</sup> MSF (5 August 2025) *MSF suspends activities in two South Sudan counties after second abduction*.

<sup>20</sup> MSF (14 April 2025) *MSF hospital forcibly closed in Ulang, Upper Nile state, following armed looting*.

### 3.3. Attacks on locally hired staff: an upwards trajectory?

In MSF's history, 107 locally hired staff have been killed:<sup>21</sup> 27 between 1989-2000, 24 between 2001-2010, 28 between 2011-2020 (including 14 in Kunduz hospital in Afghanistan), and 120 since 2021 and 2025.<sup>22</sup> While this does not show a sharp increase or decline, it is to factor the steady increase in the number of locally contracted staff. Kidnappings, however, reveal a clearer trend: incidents involving international staff have decreased (61 kidnappings in 1980-1999 to 46 kidnappings in 2000-June 2025), whereas kidnappings affecting national staff have risen sharply (10 in 1980-1999 to 82 in 2000-June 2025). Data from AWSD confirm this pattern, recording 578 kidnappings and 30 "kidnap-killings" of national staff between 2021 and 2025 (122 cases per year), compared with 665 kidnappings and 41 kidnap-killings between 2014 and 2020 (101 per year). This shift—despite declines in traditional hotspots such as Afghanistan, DRC, Nigeria, Syria, Somalia, and South Sudan—reflects the spread of kidnappings into contexts where they were previously rare, including Ethiopia, Ukraine, Haiti, and Myanmar. By contrast, Palestine has recorded only two kidnappings since 1998: one international staff member in 2006 and one local staff member in 2007.

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**The kidnappings reveal a clear trend: there has been a dramatic increase in incidents affecting national staff**

Attacks, deaths and other violent incidents documented by statistics are the most serious and direct effects suffered by national personnel, but they are not the only ones. The cascading impact on the population of interrupted medical and humanitarian services—even leading to the permanent closure of medical facilities—also affects them, as part of the community and as professionals. International personnel change contexts and do not lose their jobs and income when a certain health care program shuts down, while local personnel may not find an alternative source of employment in contexts of extreme shortage.

## 4

### ATTACKS DURING MEDICAL AND HUMANITARIAN MOVEMENTS

Much of the literature has focused on the protection of medical and humanitarian facilities and workers. A lesser-known area of focus has been the protection of ambulances and other forms of "transports", which are protected in IHL. There are increasing indications that frontline medical and humanitarian responders are at increased risk.

Conducting medical evacuations, or transferring patients between health facilities, may entail risks for patients, their caretakers and medical and/or humanitarian staff. When ambulances or vehicles are stopped on their way to the health facilities, soldiers or members of armed groups may identify the patients as combatants or associate them with their "enemy" or with their perceived bases of support. In either case, harassments, arrests and even killings may occur. This has unfortunately happened to

<sup>21</sup> The victims of the Rwanda genocide are not included.

<sup>22</sup> In MSF's history, there has been other 14 international staff killed, in 1989 (two cases), 1990, 1992, 1997, 2004 (3), 2007, 2008 (2), 2011 (2) and 2021 (1). They were mainly killed in Somalia (5) and Afghanistan (4).

MSF in several countries, including Sudan<sup>23</sup>, Mali<sup>24</sup> and Haiti<sup>25</sup>, among many others.

According to the AWSD, from 2014 to 2020 (in seven years), 967 humanitarian staff were affected (killings, wounded and kidnapped) on the “road”, including 246 people killed (223 of them national staff), 306 wounded (287 national staff) and 411 kidnapped (385 national staff). In the subsequent period, 2021-2025, 1,057 humanitarian staff were affected, including 260 killed (239 national staff), 385 wounded (369 national staff) and 363 kidnapped (3335 national staff). 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 significantly reduced the number of attacks on the road, 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), Ethiopia (from 9 to 58).

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**MSF was informed that permission for any medical transfer to Nasser Hospital must be granted at least 24 hours in advance**

A particularly egregious attack on medical transports occurred in Gaza when ambulances being driven by the Palestinian Red Crescent Society (PRCS) came under direct attack by the Israeli military on 23 March 2025, resulting in the killing of 15 first responders. After initially obfuscating details of the attack, the Israeli military later acknowledge several “professional failures” occurred in the led up to the killings and how the situation was dealt with in the immediate aftermath. However, the statement by the Israeli military repeated accusations that ambulances were routinely used by Hamas to “transport terrorists and weapons”, while providing no independently verifiable evidence to support such claims.<sup>26</sup> Such unverified claims put in danger the safety of medical transports which provide a critical and life-saving role.

A fundamental principle of IHL is that wounded and sick must be protected and cared for, thus subsidiary protection is provided to medical transports to ensure the wounded and sick have access to medical care. In Gaza, in June 2025, repeated “evacuation orders”, displacing civilians from the blocks around Nasser hospital impaired the access of staff, patients and medical supplies from reaching the hospital. On 3 June MSF teams were informed that any movement to Nasser hospital would require prior authorization from the Israeli authorities, which would need to be requested 24 hours in advance.<sup>27</sup> For the period during which this directive was in place, ambulances carrying emergency cases accessed the hospital taking the risk they would be shot at for lack of authorization. MSF was highly vocal about these restrictions, noting that military operations that render Nasser Hospital inaccessible to ambulances and medical staff would amount to a death sentence for severely injured and critically ill patients, including children and women in need of obstetric care. This is just one example of how military operations frequently do not account for the need to protect and respect medical transports as part of their overall obligations towards medical missions.

<sup>23</sup> MSF (13 January 2025) *MSF condemns a despicable attack on its ambulance in El Fasher, killing one passenger.*

<sup>24</sup> MSF (7 January 2021) *Patient dies after an MSF ambulance is violently detained in Mali.*

<sup>25</sup> MSF (13 November 2024) *MSF outraged by police attack on ambulance and execution of patients in Haiti.*

<sup>26</sup> Israel Defence Forces (20 April 2025) *IDF Spokesperson's Statement: Summary of the Examination Into the Incident Involving Rescue Teams and Vehicles In the Gaza Strip.*

<sup>27</sup> MSF (5 June 2025) *Israeli Forces Impose New Restrictions on Nasser Hospital.*

The danger is not limited to the road. On 14 January 2025, a six-person MSF team was returning from Ulang, South Sudan, along the Sobat River, after dropping off medical supplies at Nasir County Hospital, when unidentified gunmen opened fire on two boats clearly marked as MSF. The staff swam away and while fleeing, one MSF staff member was injured. MSF was forced to suspend all outreach operations in Nasir and Ulang counties.<sup>28</sup>

A particularly traumatic attack for MSF that deserves mention even if it was not in Palestine or South Sudan occurred in Ethiopia: three MSF staff members, the Spanish María Hernández and the Ethiopians Tedros Gebremariam and Yohannes Halefom, were killed in Tigray on 24 June 2021 after their vehicle was intercepted as they raced to medically evacuate wounded individuals. Three clearly identified humanitarian workers, travelling in ‘MSF’ marked vehicle being deliberately shot multiple times at close range, while facing their attacker. MSF carried out an internal review into the incident, which found that an Ethiopian National Defence Forces (ENDF) convoy was present on the road at the time of the attack. These findings were shared with the Ethiopian authorities, but four years after their brutal killing, the authorities have failed to conduct a credible, transparent, impartial, or timely investigation into the killings, despite MSF’s relentless attempts to get answers.<sup>29</sup>

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## **We need to redouble our efforts to protect humanitarian and health personnel, facilities and transport**

Attacks on medical personnel and aid workers while “on the move” in the course of their duties represent a particularly concerning yet relatively under-examined phenomenon. The risks faced during movements—whether between facilities, along supply routes, or in the course of field visits—are heightened by both the inherent exposure of travel and, in some cases, due to armed actors utilizing weak or inconsistent humanitarian notification practices for non-static humanitarian activities. This gap warrants deeper analysis, as it raises critical questions about how aid actors and warring parties manage the safety of humanitarian movements beyond fixed facilities.

## **5 CONCLUSIONS**

The concern that attacks on health care and aid workers have become the “new normal” has only deepened in 2025 and shows no sign of abating. In armed conflict zones across the globe, we require renewed efforts to protect humanitarian staff, medical personnel, facilities, and transports. The stark impunity on display—particularly in Gaza—signals that core humanitarian norms are under direct assault. When basic humanitarian principles fail in one context, there is a risk that this erosion of protective norms spreads to other contexts. Without the basic protections, medical workers and humanitarians may no longer be able to reach the most vulnerable with life-saving assistance.

IHL requires not only a negative obligation to refrain from attacking medical facilities, but also a positive obligation to safeguard the capacity of medical facilities and personnel to performing life-saving services.<sup>30</sup> The erosion of these norms has

<sup>28</sup> MSF (16 January 2025) *MSF strongly condemns armed attack on our healthcare workers in Nasir county*.

<sup>29</sup> MSF (July 2025) *MSF review into the killing of three MSF staff on 24 June 2021 in Tigray, Ethiopia*.

<sup>30</sup> ICRC. *Customary IHL, Rule 28*.

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## **States have become the main perpetrators of violence against medical and humanitarian missions**

dangerous implications not only for aid and medical workers, but more widely for civilians living in zones of armed conflict. Attacks against medical and aid workers have continued with impunity. States are failing to properly investigate incidents or hold perpetrators to account for these acts. Indeed, State actors have become the main perpetrators themselves. The impunity for the killing of aid and medical workers is pure hypocrisy that shows double standards by most member states of the UNSC. As recently as May 2024, the 2370 UN Security Council Resolution reiterated the need to protect humanitarian aid workers, a primary responsibility of the State hosting the relief efforts. The said resolution emphasized that when attacks on aid workers do occur, States have an obligation to “thoroughly investigate and prosecute persons responsible”, in order to “prevent these crimes [and] avoid their recurrence”. The spiralling number of aid and medical workers being killed in armed conflicts today requires urgent action to end impunity and take steps to prevent recurrence. The ongoing impunity requires a critical examination of international mechanisms' failure to investigate and regulate compliance by state actors.

Statistics indicate that states have become the primary perpetrators of violence against medical and humanitarian missions. The use of explosives and the concentration of armed activity in urban areas have had devastating effects on the civilian population, including patients and medical and humanitarian staff. Since October 2023, Israeli forces have carried out the largest number of attacks on health-care facilities and killings of aid workers, and Palestine has become the context with the most killings of aid and medical workers—at levels unprecedented since the databases consulted began record-keeping. While state violence against medical and humanitarian staff in other contexts has drawn condemnation and even sanctions, Israel has displayed unprecedented impunity, enabled by allies who had sworn to “respect and ensure respect” the same international humanitarian law that dies a bit with each attack on sites that until recently were claimed as protected.

Perceptions and some statistics suggest that the risks assumed by the locally hired staff are increasing. Drawing more conclusive conclusions would require addressing various analytical elements, including the lack of denominators; underreporting affecting local staff; trends that affect specific countries differently, with Palestine accounting for a large part of the increase in the statistics; the impact of cuts in humanitarian funding and the reduced presence of international organizations—local response teams make up the majority of humanitarian response teams, and the trend is upward; the higher levels of perceived impunity—the case of Israel and the reactions of its allies being highlighted; and the risk transfer resulting from humanitarian organizations' increasing risk aversion, which leads to international gaps covered by local responses or greater dependence on local partners. In sum, locally recruited staff are increasingly bearing the brunt, personally and as part of the community that international law and morality seem to protect less and less.

Under international humanitarian law “medical transports” must be respected and protected by parties to the armed conflict.<sup>31</sup> This includes any vehicle which exclusively assigned to transport the sick and wounded in situations of armed conflict. Like in the case

<sup>31</sup> ICRC. *Customary IHL Rule 29*

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**Without decisive action,  
the foundations of  
humanitarian action  
and medical care will  
continue to erode**

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 humanitarians to perform their life-saving function.

Attacks against health care and humanitarian workers cannot become the new norm. This article argues that greater efforts are urgently needed to hold perpetrators accountable, including when attacks are carried out by states. Special attention must be given to the safety of locally hired staff, whose security is further undermined by impunity and by the lack of international visibility. Equally critical is the protection of medical and humanitarian missions in their entirety, including the often-overlooked safeguarding of movements and means of transportation.

On 22 September 2025, 106 States signed a ministerial declaration reaffirming their support for the protection of humanitarian personnel, including national and locally recruited staff, explicitly acknowledging the need to reverse the need to ‘reverse the deadly trends impacting the safety and security of humanitarian personnel’.<sup>32</sup> Such declarations are a good step; but MSF believes that actions speak louder than words. Unless decisive action is taken, we risk a continued erosion of the fundamental norms that underpin humanitarian action, medical care, and the protection of the communities we serve. Now is the time for real action.

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<sup>32</sup> *Declaration for the Protection of Humanitarian Personnel* (22 September 2025).