When Hospitals Become Frontlines: The Collapse of Healthcare in Sudan

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Lilien Pfiszter



African-american boy getting a checkup by a doctor

A hospital can be destroyed long before its walls collapse. It happens when laboratories stop functioning, when medicines can no longer be stored or moved, when trained staff flee and when the systems that detect disease begin to fail. They are part of a country's early-warning system and its biological safety net to recognise danger long before it becomes a crisis.

In Sudan, that capacity is being systematically stripped away. Hospitals are shelled, laboratories are occupied, warehouses are being looted, and supplies run down. What is being lost is not simply healthcare but the ability to detect and contain biological threats at the moment when doing so matters most. The WHO calls this the world's largest humanitarian crisis. This label is accurate, but undersells what is actually happening. The destruction of Sudan's health infrastructure is not only a humanitarian emergency but also a weakening of the Sudanese state itself, creating risks that will not stay within its borders.

Three ways to break a health system

Some incidents are direct strikes. For example, the assault on El Daein Teaching Hospital in East Darfur killed at least 64 patients (staff and children) and completely knocked out the region's main referral facility. Others are about seizing rather than destroying; armed actors occupied Khartoum's National Public Health Laboratory and the central medicine warehouse early in the war, choking national drug distribution without firing a shot at the buildings themselves. The third category is indirect. Facilities go dark because of nearby fighting, staff flee under threat in what amounts to an institutional brain drain, and sieges cut off fuel, water and supply routes.

The WHO's Surveillance System for Attacks on Health Care has verified 217 direct attacks since April 2023, tied to 2,052 deaths and 810 injuries. Insecurity Insight's broader monitoring of looting and obstruction adds several hundred more incidents on top of that. Nationally, more than a third of Sudan's health facilities are non-functional, a figure which the World Bank puts at as high as 75% inside active conflict zones.

Degrading civilian health infrastructure slowly erodes a state's ability to govern territory and removes one of the few visible services that gives a government's authority any legitimacy in the eyes of the people it claims to represent. It produces what conflict epidemiologists call indirect or excess mortality: deaths caused not by the battlefield itself but by the collapse of the systems that keep civilian life viable. That distinction between direct casualties and infrastructure-driven deaths is an alarmingly clear sign of how far a conflict has hollowed out a state from the inside.

The system that sees trouble coming

As mentioned previously, health infrastructure functions as a country's early warning system. In Sudan, that means an interconnected network of water, electricity, cold chain logistics, laboratories and trained personnel, all of it needed to catch an outbreak before it becomes a bigger catastrophe. Disease surveillance is what lets a state spot trouble early, allocate resources and stop a local outbreak from becoming a regional one. Cholera has recurred across Sudan since mid-2024; it was declared over in March 2026, after a vaccination campaign that reached more than 23 million people. Cases were already resurfacing in Kordofan and Darfur within months.

However, in October 2024, South Sudan declared a cholera outbreak in Renk, a border town absorbing returnees. The risk was not inherent to displacement; it emerged as the local system could not expand safe water access and surveillance quickly enough to keep pace with population movement.

Sudan's conflict has displaced roughly nine million people internally and pushed millions more into Chad, Egypt, South Sudan and beyond, into states that are managing plenty of fragility of their own. Disrupted surveil-

lance combined with displacement at this scale is exactly how a domestic health crisis quietly turns into a bigger, regional one.

The rules already exist; why is nobody enforcing them?

Crises get sorted into hard security, meaning weapons, terrorism, borders and softer humanitarian concerns, meaning hospitals, food, displacement. Sudan reveals why that line does not hold. The collapse of health infrastructure generates displacement, cross-border disease risk and weak governance- the same outcomes that get treated as hard-security concerns the moment they arrive through more familiar channels, like an armed border crossing or a terrorist network.

The Geneva Conventions already protect medical facilities, and the Security Council's Resolution 2286 unanimously condemned attacks on healthcare back in 2016. This year marks that resolution's tenth anniversary and the heads of the ICRC, WHO and MSF have already judged the decade a record of failure. This gap is too practical, and little evidence of violations reaches the mechanisms built to act on it, while repeated violations go unpunished; health protection stays siloed off from the civilian-protection and conflict-prevention work that already exists elsewhere.

What comes next

Closing this gap means treating whether hospitals can keep functioning as a factor in how security and peacekeeping risks get assessed instead of an afterthought once a conflict has already wrecked and drained them. This could be achieved by regular Council monitoring of Resolution 2286, documentation that actually feeds into existing accountability processes and real consequences when the evidence of repeated violations is sitting right there.

Protecting Sudan's hospitals is not charity for a distant war. It is what states already promised to do a decade ago, and it is insurance against the instability that keeps showing up whenever that promise goes unmet.