RECOMMENDATIONS

....moving towards solutions

Health Care in Danger - the issue

VIOLENCE against:

Harassment, threats, intimidation, and robbery; and arresting people for performing their medical duties

Attacks

bombing, shelling, looting, etc.

Personnel

Facilities

Voluntary discrimination

Obstructions

Wounded & Sick

Vehicles

killing, injuring, harassing and intimidating patients or those trying to access health care, etc.

General Insecurity

attacks upon, theft of and interference with medical vehicles

Violent incidents against health care
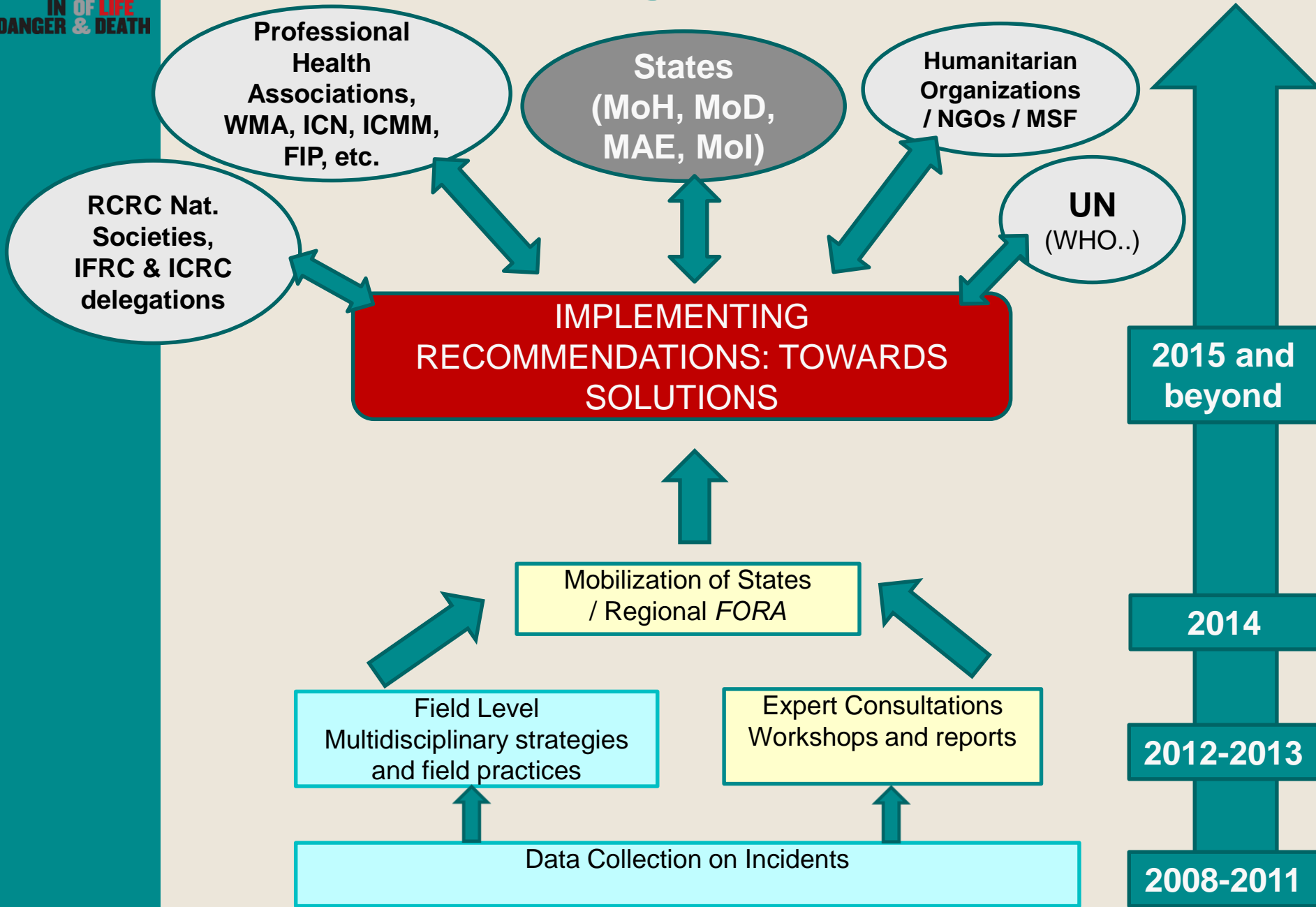## January 2012 to December 2015

In particular:

- 2398 incidents collected in 11 countries were analysed;

- 1222 of them took place against, inside or within the perimeter of health-care facilities;

- 1933 incidents affected local health-care providers, including NSs, and national NGOs

HEALTH IT'S A CARE MATTER IN OF LIFE DANGER & DEATH

More than **4,200** people were victims of violence against health care.

Over **50%** of attacks were around, inside or targeted health-care facilities.

598 health-care workers were killed or beaten / wounded.

Over **700** medical transports were affected, directly or indirectly.

Stop the violence. #ProtectHealthCare

*Figures were collected by the ICRC from January 2012 to December 2014 and refer to incidents of violence against health care in 11 countries.

Health Care in Danger: The process (2008-17)

HEALTH CARE IN DANGER | IT'S A MATTER OF LIFE & DEATH

Professional Health Associations, WMA, ICN, ICMM, FIP, etc.

States (MoH, MoD, MAE, MoI)

Humanitarian Organizations / NGOs / MSF

RCRC Nat. Societies, IFRC & ICRC delegations

UN (WHO..)

IMPLEMENTING RECOMMENDATIONS: TOWARDS SOLUTIONS

Mobilization of States / Regional *FORA*

Field Level Multidisciplinary strategies and field practices

Expert Consultations Workshops and reports

Data Collection on Incidents

2015 and beyond

2014

2012-2013

2008-2011

A tool for all health-care personnel confronted to armed violence

Main topics addressed in the book:

❖International law

❖Medical ethics

❖Data protection & health records

❖Dead body management and issue

   of missing persons

❖Taking into account vulnerabilities

❖Witnessing abuses

HEALTH CARE IN DANGER
THE RESPONSIBILITIES OF HEALTH-CARE
PERSONNEL WORKING IN ARMED CONFLICTS
AND OTHER EMERGENCIES

VIOLENCE AGAINST
HEALTH CARE MUST END

IT'S A MATTER OF LIFE & DEATH

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RECOMMENDATIONS:
Ambulances and pre-hospital services in crisis situations

Some key points:

❖ Coordination Mechanisms in place between service providers and authorities (preparedness, legal basis)

❖ Alternative Communication Equipment (facing the risk of breakdown of communication system)

❖ Psychological support (incl. in insurances)

❖ Recognition & acceptance by communities

❖ Use of Personal Protective Equipment

❖ Key role of ambulance drivers

❖ FOLLOW UP ATTACK DILEMMA

AMBULANCE AND PRE-HOSPITAL SERVICES IN RISK SITUATIONS

RECOMMENDATIONS:
Safety of Health-care Facilities

INFRASTRUCTURE - PHYSICAL SAFETY
- ❖ management of access and control of entries to health-care facilities
- ❖ prevent and minimize damage in case of attack
- ❖ considerations during design and construction phase

PEOPLE
- ❖ ensure viable working conditions
- ❖ increase preparedness
- ❖ enhance security for patients
- ❖ support and management of relatives of patients

PROCESSES
- ❖ guide the process of preparedness planning
- ❖ receive patients and control flow of individuals
- ❖ guide supply management
- ❖ ensure functioning information management
- ❖ coordination with external actors
- ❖ engaging with media
- ❖ monitor and enhance the perception of neutrality of a health-care facility

TEMPORARY SAFE SOLUTIONS
- ❖ guide priority setting and the development of SOPs
- ❖ determine available services and level of care
- ❖ enhance access and protection of a temporary safe solution

RECOMMENDATIONS that National Societies are implementing

1. Within their own NS or with Movement partners
    - Implement the **Safer Access framework**
    - Incident **data collection & research**
    - Specific needs of **first line responders** including ambulance drivers
    - Protocols and sharing good practice (e.g. ambulances, follow-up attacks and use of PPE)
    - Ensure staff and volunteers have **access to insurance**

2. With health care community and with authorities
    - **Dialogue, advocacy, training and coordination** where appropriate
    - **Roundtables/ workshops** to discuss recommendations

3. With civil society
    - **Advocacy /awareness raising**
    - Dialogue with **religious and community Leaders**

RECOMMENDATIONS:
Promoting military operational practice that ensures safe access to and delivery of health care

1. **Ground evacuation** of wounded and sick across territory controlled by different parties to a conflict (including the issue of **checkpoints**).

2. **Search operations** in health-care facilities.

3. **Fighting in proximity of medical infrastructure:** precautions in the attack and defense at either the planning or conduct of operations stages, in order to avoid or minimize potential dangers medical workers, Vehicles and facilities.

PROMOTING MILITARY OPERATIONAL PRACTICE THAT ENSURES SAFE ACCESS TO AND DELIVERY OF HEALTH CARE

RECOMMENDATIONS:
Domestic normative frameworks for the protection of the provision of health

Key issues:

1. How to make **legal protection** of the wounded and sick, health care personnel, facilities and transports more effective?

2. How to legally improve the **correct use of emblems** and distinctive signs?

3. How to legally **protect medical ethics** and confidentiality?

4. How to effectively **repress and sanction violations** of the law?

DOMESTIC NORMATIVE FRAMEWORKS
FOR THE PROTECTION
OF HEALTH CARE

HEALTH IT'S A
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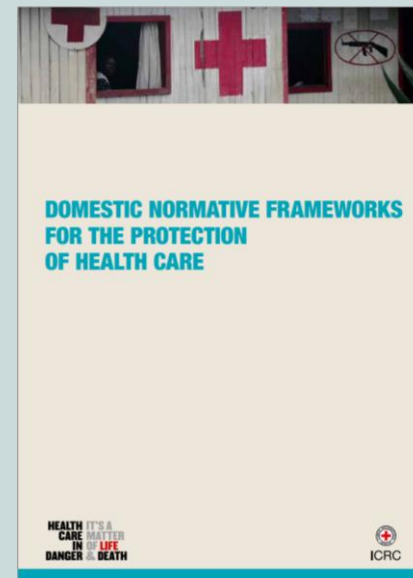
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Consultations on Health Care Ethics

▪Meeting 6-7 February 2014 in ICRC HQ **«Health Care Ethics in Danger»** with representatives from ICRC, World Medical Association, British Medical Association, Canadian Medical Association, International Committee of Military Medicine, MSF, MacMaster University.

    Aim: *Identify case studies & guide practitioners*

▪Meeting 8 September 2014 at ICRC HQ, with representatives of WMA, ICN, IHF and ICMM where an **agreement was reached on the final draft of a document on "*Ethical principles of health-care workers in times of armed conflict and other emergencies.*"** The various organisations plan to disseminate this among their members & in their respective networks.

Consultations with non-state armed groups

❖Consultations with **96 Interlocutors from 34 NSAGs** in **9 contexts**

❖June 2014: **Expert workshop** *"Promoting operational practices consistent with the protection and respect of health care to non-state armed groups"* in GVA

❖**Bilateral meetings** with States and other actors

❖**Report on NSAGs & HCID released in 2015**

A shared humanitarian concern: Multiple stakeholders
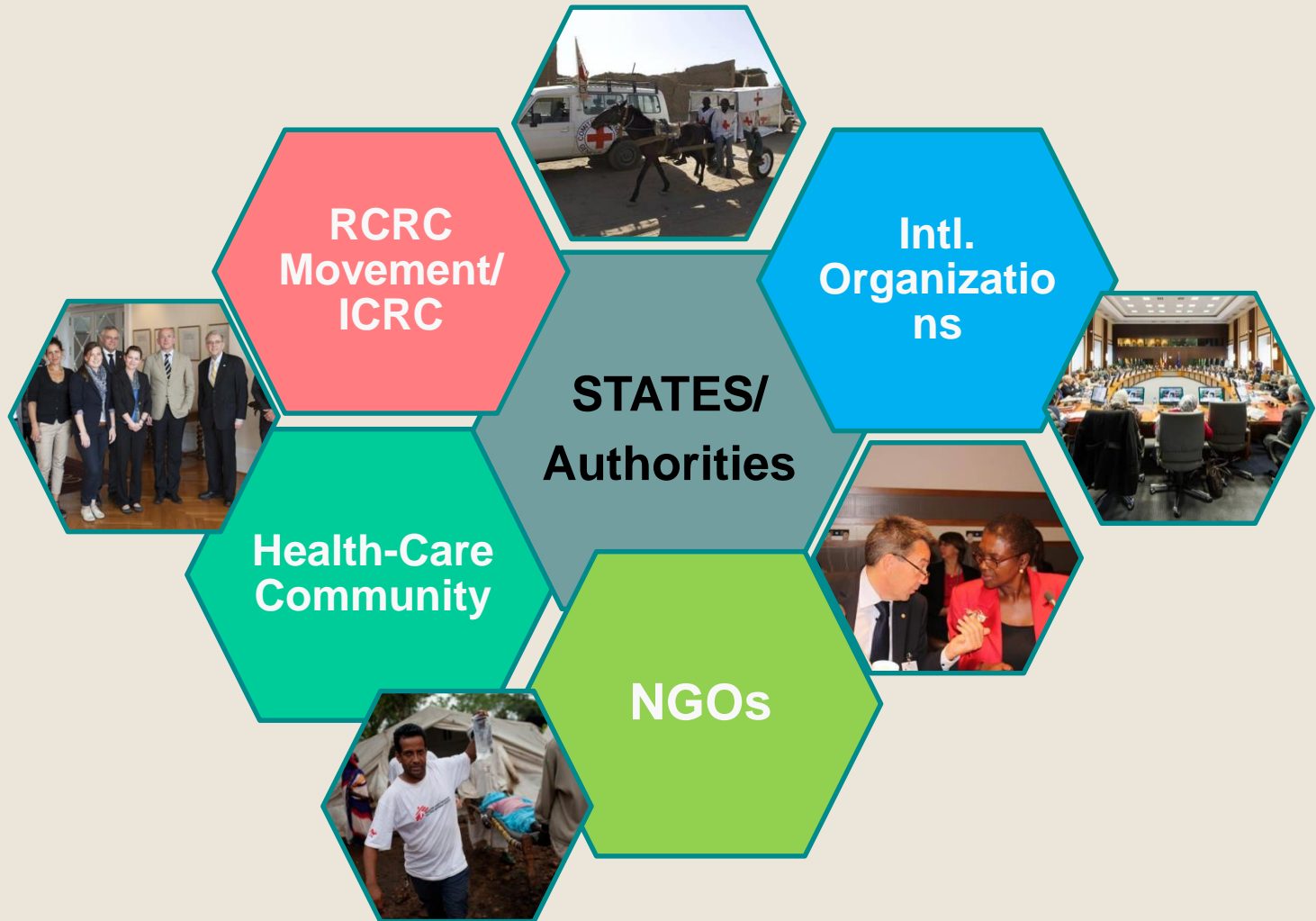
Mobilization at Global Level: Field Activities

➢ **HCiD Focal points**: over 60 delegations have a focal point to support the project in delegation.

➢ **HCiD Objectives:** Over 60 delegations have adopted HCiD objectives.

➢ **Transversal delegation strategies** developed in more than 15 operational delegations.

Field practices online

➢ **Incident gathering:** on a monthly basis field teams in more than 20 countries where the ICRC is operational collect information on HCiD related incidents. Release of annual report based on this data.

➢ **Field Practices:** More than 70 field practices were gathered from 2013 to 2015 by almost 30 delegations to provide a snapshot of what delegations have done & to facilitate sharing of experiences & lessons learnt.

Mobilization at the global level: The Movement

➢ 27 National Societies & the Federation part of the **Movement Reference Group** – provide guidance, support and initiate their own responses

➢ Over 70 National Societies **implementing responses** –a wide range of measures and contexts

➢ Many National Societies **supported expert consultations** through **co-hosting and participating** e.g. Canadian RC on *Security for health-care infrastructure*, NorCross on *National Society responses*, British RC on *Responsibilities and Rights of HC personnel* & Belgium RC on *National Legislation.*

➢ NorCross **supporting other NSs** to develop operational responses.

➢ National Societies to play a vital role at the **32nd International Conference**

A snapshot of NS activities

Within their NS:

➢ Implementing SAF (Egypt, Lebanon, Mexico, Philippines, CAR, Colombia, Egypt, Lebanon, Indonesia)

➢ Data collection (Afghanistan, Nigeria)

➢ Incorporated into training (Australia, Afghanistan, Sweden, Netherlands)

With authorities:

➢ HCiD training/ dissemination with military (Afghanistan, Australia, Norway, Sweden, Belgium, Portugal, Uganda)

➢ Coordination with ambulance services and hospitals (Egypt, Nepal, Kenya, Lebanon)

➢ Roundtables to identify possible responses (Nepal, Australia, Afghanistan, Colombia, Canada, Sudan, Bulgaria, Ivory Coast, Iraq, UAE)

➢ Dialogue & sensitisation with MoH (PMI, Colombia, S Sudan, Nigeria, Guatemala, Salvador, Lebanon)

Mobilization at Global Level: External Partnerships – STATES & Regional Organizations

ICRC President, Peter Maurer (left) speaks with UN Under Secretary General, Valerie Amos (right) at the UNGA panel.

Main info:

- **Global Health and Foreign Policy initiative:** UNGA resolution adopted
- **Other UNGA resolutions adopted** with HCiD references
- **Norway, South Africa, Australia** – key partners of the Project
- **ECHO** & the funding of the HCiD Campaign in 7 EU capitals

Main Events:

- **Regional workshop** in Colombia (10 countries) July 2014
- **Panel debate at UNGA NY** 25 Sep 2014
- **1-day event** for the members of the **African Union Peace and Security Council** 22 Oct 2014

Mobilization at Global Level: External Partnerships – the Health Care Community

MoU ICRC-WMA

Health Associations/ MedNGOs

- ➤ **World Medical Association** (*MoU signed*)
- ➤ **International Council of Nurses** (*MoU signed*)
- ➤ The **International Committee Military Medicine** (*exchange of letters*)
- ➤ **International Pharmaceutical Federation** (*regular exchange*)
- ➤ **International Hospital Federation** (*MoU signed*)
- ➤ **MSF** (*regular exchange*)
- ➤ **WHO** (*regular exchange*)
- ➤ **World Conferderation for Physical Therapy** (*MoU signed*)

Academia/ Medical Students:

- ➤ **International Federation of Medical Students' Association** (*regular exchange*)
- ➤ **World Federation for Medical Education** (*endorsement*)

2015 & Beyond – IMPLEMENTATION

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KEY ROLE FOR STATES:

UPCOMING PRIORITIES :

- Mobilize/Support concrete national initiatives

- Implement recommendations from expert workshops

- Mobilise for resolution/pledges (UNGA, WHA, RCRC IC, WHS)

- Publish project results

LAUNCH NATIONAL HCID INITIATIVES:
1. Identify issues
2. Mobilise for action
3. Share good practice

ADOPT RESOLUTIONS: GLOBAL FORA
1. UNGA: Unacceptable. Need to act
2. WHA: Agenda Issue + States role + WHO role
3. IC RCRC: Endorse recommendations Pledges
4. WHS: Short & long term issue + Partnerships for action

LINK GLOBAL TO NATIONAL
1. Ensure international obligations are integrated in national legal frameworks
2. Reinforce accountability -national level

PROMOTE PARTNERSHIPS FOR ACTION
1. Between States – specific issues
2. Multiple stakeholders – specific issues

32nd International Conf

How we get there

➢ MRG & ICRC working groups

➢ Consultation – conference process, bilaterals, upcoming events

➢ Model pledges & targeting

➢ Briefing kits for delegations & NSs

➢ Videos, interactive elements to showcase good practice

➢ Engaging community of concern

32nd International Conf

Planning is well advanced:

➢ **Draft 0 Resolution** which commends efforts to date and highlights areas for future work

➢ **Background report –** highlights progress over past 4 years and presents rationale and possible actions for future work

➢ **Pledges -** 12 model pledges developed in 3 areas: partnership, coordination & advocacy; training & support; & national legislation, policy and military operational practice.

➢ **Plenary Commissions –** championing good practice & galvanising participants to take further action

Exhibition –interactive and showcasing good practice

Communication Campaign: Support to all project activities: *Local/ Regional/ Global*

HEALTH **IT'S A**
CARE **MATTER**
IN **OF LIFE**
DANGER **& DEATH**

PHASE 1: Making the case on the issue of safe access to health care

PHASE 2: Call to the implementation of practical recommendations on various areas

I DIDN'T DIE BECAUSE A BULLET
TORE THROUGH MY ABDOMEN

I DIDN'T DIE BECAUSE OF THE
SLOW INCESSANT BLOOD LOSS

I DIED BECAUSE THE PEOPLE WHO
COULD HAVE SAVED ME WERE
NEEDLESSLY BLOCKED AT A CHECKPOINT

VIOLENCE AGAINST
HEALTH CARE MUST END

IT'S A MATTER OF LIFE & DEATH

I WAS REALLY SICK.

I COULD HAVE DIED.

I SURVIVED BECAUSE THE SOLDIERS
LET THE AMBULANCE THROUGH THE
CHECKPOINT FIRST.

PROTECT HEALTH CARE **IT'S A MATTER OF LIFE & DEATH**

Wide range of audiences: States, Health care professionals, IIOO, General Public, Academia

Health Care in Danger: E-tools

WEBSITE

HCID Network

Twitter

Health care in danger: E-learning

THE LEGAL FRAMEWORK

www.icrcproject.org/elearning/health-care-in-danger/beta/

THE RIGHTS AND RESPONSIBILITIES OF HEALTH-CARE PERSONNEL

www.healthcareindanger.org/elearning
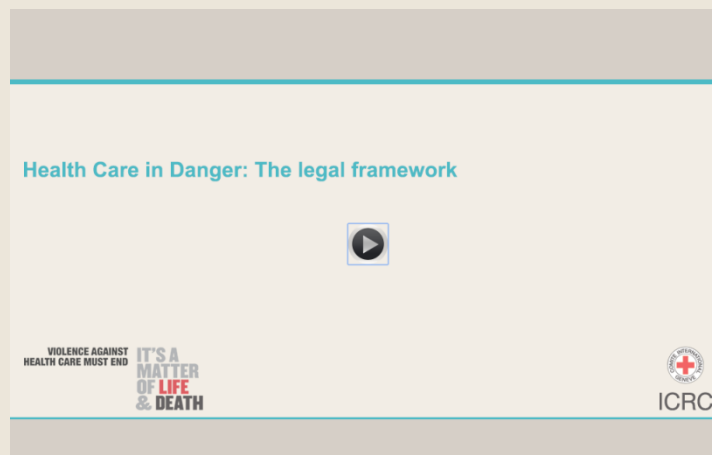
Health Care in Danger: Publications / Tools

HEALTH CARE
IN DANGER
THE HUMAN COST

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AMBULANCE AND
PRE-HOSPITAL SERVICES
IN RISK SITUATIONS

NEWSLETTER

MORE NEEDS TO BE DONE TO PROTECT
HEALTH-CARE WORKERS

PROMOTING MILITARY
OPERATIONAL PRACTICE
THAT ENSURES SAFE ACCESS TO
AND DELIVERY OF HEALTH CARE

INTERNATIONAL
REVIEW
of the Red Cross

Violence against
health care

HEALTH CARE IN DANGER
THE RESPONSIBILITIES OF HEALTH-CARE
PERSONNEL WORKING IN ARMED CONFLICTS
AND OTHER EMERGENCIES

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VIOLENT INCIDENTS AFFECTING
THE DELIVERY OF HEALTH CARE

HEALTH CARE
IN DANGER

JANUARY 2012 TO DECEMBER 2013

ICRC

VISIT:

www.healthcareindanger.org

Register to the HCiD NETWORK:

www.healthcareindanger.ning.com

Contact **czanette@icrc.org** to be invited

Follow us on TWITTER:

@HCIDproject