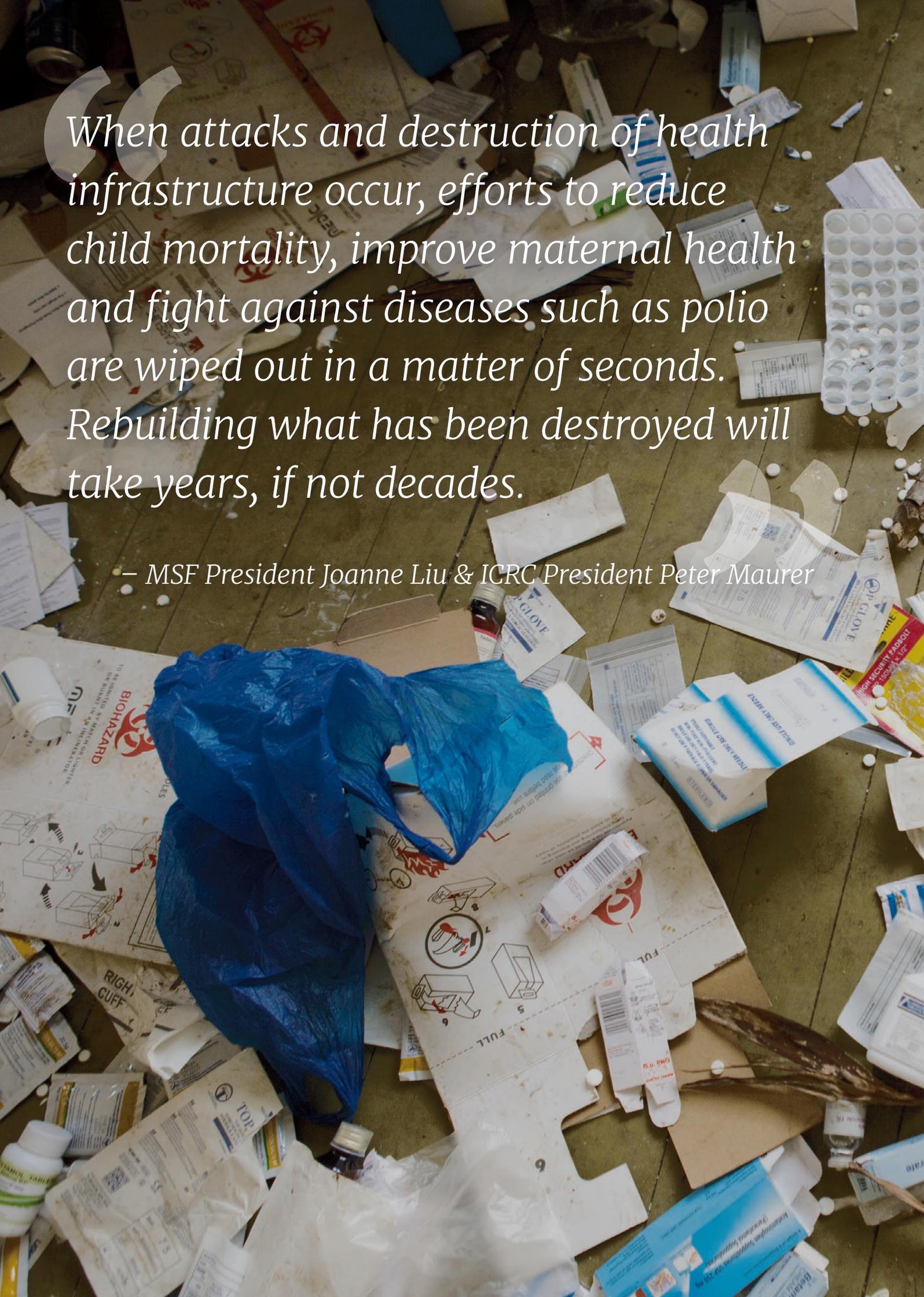




# A MATTER OF LIFE AND DEATH

TACKLING VIOLENCE AGAINST HEALTH CARE  
IN PAKISTAN, PERU AND EL SALVADOR

SELECTED EXPERIENCES



When attacks and destruction of health infrastructure occur, efforts to reduce child mortality, improve maternal health and fight against diseases such as polio are wiped out in a matter of seconds. Rebuilding what has been destroyed will take years, if not decades.

– MSF President Joanne Liu & ICRC President Peter Maurer





# FOREWORD

The causes of violence against health-care services are complex and varied. But its impact is the same everywhere. When people struggle to access the services they need, they die, suffer disabilities or fall ill unnecessarily. And the long-lasting human, social and economic costs, while harder to measure, are no less real. That's why doing something about this violence truly is a matter of life and death.

Six years ago, the International Red Cross and Red Crescent Movement launched the Health Care in Danger initiative to bring violence against health-care services to the world's attention.

The international community's response has been extremely encouraging. The political and diplomatic momentum culminated on 3 May 2016, when the United Nations Security Council adopted a landmark resolution – S/RES/2286 (2016) – calling on States to respect international humanitarian law and to protect health workers in conflict zones. The Security Council also asked the UN's secretary-general to promptly recommend ways to better protect the sick and wounded, health workers, and medical equipment and facilities, and to hold the perpetrators of violence to account.

On 18 August 2016, the secretary-general wrote to the president of the Security Council, setting out “practical measures that all States should implement to prevent acts of violence, attacks and threats against medical care in armed conflict, enhance the protection of medical care and ensure the documentation of acts of violence, attacks and threats against medical care, as well as accountability and redress”. Exchanging information and experience safeguarding health-care delivery were among the key recommendations set out in the letter.

In response, the International Committee of the Red Cross (ICRC) has started to gather together case studies. The purpose of this publication is to present three initiatives undertaken to safeguard the delivery of health care and prevent violence, or to mitigate its impact, in El Salvador, Pakistan and Peru. It is intended chiefly for humanitarian and health workers, and for members of the Movement in particular. It is meant both as a learning tool and as a source of inspiration for open discussion – with officials, legislators, policymakers and other relevant parties – about ways to solve this critical humanitarian issue.

Together, we can put an end to violence against health care.

*– Ali Naraghi, Head of the Health Care in Danger initiative*

# INTRODUCTION

In Karachi, Pakistan's largest city, 130 doctors were killed and 150 kidnapped between 2012 and 2014, according to major national newspaper *The News*.

In El Salvador, gang violence and crime are rife and homicide rates are among the highest in the world. According to the authorities, 1,776 people were killed in the first six months of 2017. This number is actually an improvement for the same period in 2016 (3,060 reported homicides). Because of this violence, health workers cannot get to the communities who need them, leaving these people without proper medical care.

In Peru's Apurímac-Ene and Mantaro Valley, access to and the safe delivery of health care are particularly challenging. The valley is a truly remote area, characterized by inadequate infrastructure and drug trafficking. Health workers here struggle with the poor working

conditions; they report threats, denial of access to patients, kidnappings, occupations of health centres and the theft of medicines as daily occurrences.

These examples from Pakistan, El Salvador and Peru are not isolated. Every day, health-care providers are being attacked, patients discriminated against, ambulances held up at check-points, hospitals bombed, medical supplies looted and entire communities cut off from critical services around the world.

Between January 2012 and December 2014, the ICRC documented nearly 2,400 violent incidents against health care in 11 countries experiencing armed conflict or other violence. In over 90% of cases, local health-care providers were affected, seriously threatening the effectiveness and sustainability of national health-care systems. These numbers might well just be the tip of the iceberg.

## DEFINITIONS



**Violence against health-care personnel** includes killing, injuring, kidnapping, harassment, threats, intimidation, and robbery; and arresting people for performing their medical duties.

**Health-care personnel** include doctors, nurses, paramedical staff including first-aiders, and support staff assigned to medical functions; the administrative staff of health-care facilities; and ambulance personnel.

**Violence against patients** includes killing, injuring, harassing and intimidating patients or those trying to access health care; blocking or interfering with timely access to care; the deliberate failure to provide or denial of assistance; discrimination in access to, and quality of, care; and interruption of medical care.

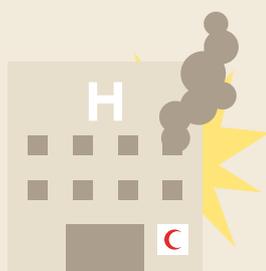
**The wounded and the sick** include all persons whether military or civilian who are in need of medical assistance and who refrain from any act of hostility. This includes maternity cases, newborn babies and the infirm.

When health-care services are disrupted as a result of violence and attacks, it is the sick and wounded who pay the immediate price. But it is the entire community that will bear the long-term effects: avoidable deaths, disabilities and diseases, which engender economic loss, social burdens and yet more human suffering. It is clear that in terms of the numbers of people affected, violence, both real and threatened against health workers, facilities and patients, is one of the biggest, most complex and yet most unrecognized humanitarian and public health issues today. But it can be tackled, as the three case studies in this publication show.

Karachi is host to an exemplary initiative to tackle violence against health care, which has brought together international organizations, national research institutes, academia, charities and civil society organizations. In Peru, the Ministry of Health, the Peruvian Red Cross and the ICRC have joined forces to improve access to health care in a dangerous remote valley.

In El Salvador, an inter-institutional protocol signed between government authorities and health-care providers is tackling some of the challenges associated with delivering health-care services to communities affected by high levels of violence.

These three initiatives, aimed at better understanding the root causes of this violence and how to counter them, represent opportunities to learn and should inspire further action, locally and elsewhere. Indeed, it is already happening: for example, in November 2015 a meeting of health ministers from the governments of Colombia, El Salvador and Honduras, and representatives from the countries' National Red Cross Societies, sought to share experiences, best practices and lessons learned in order to promote respect for and increase the safety of health-care services in the three countries. And the Rasta Dein campaign, a key component of the Karachi project, is being rolled out nationwide.



**Violence against health-care facilities** includes bombing, shelling, looting, forced entry, shooting into, encircling or other forceful interference with the running of health-care facilities (such as depriving them of electricity and water).

**Health-care facilities** include hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, and the medical and pharmaceutical stores of these facilities.

**Violence against medical vehicles** includes attacks upon, theft of and interference with medical vehicles.

**Medical vehicles** include ambulances, medical ships or aircraft, whether civilian or military; and vehicles transporting medical supplies or equipment.



I. Gröberg/ICRC

Details of the successes and shortcomings of these initiatives are covered in the individual case studies below. But a few things deserve mention here.

Violence against health care often goes unremarked, leading people to underestimate the size of the problem. There are various reasons behind victims not reporting incidents – the lack of an incident-recording system, the feeling that reporting the incident would be useless, the fear of further violence. But in the three case studies, talking about the problem and bringing it to public attention proved a catalyst for change. It was also, in the words of some of those involved, a cathartic experience. It is clear that inaction against recurring violence is dangerous because it can develop into acceptance, adding to the burden. Among the recommendations of the Health Care in Danger initiative is the need to establish national data-collection mechanisms. These would allow the issues to be better understood, trends and patterns analysed and suitable responses taken.

The case studies also highlight the need for cross-sector collaboration to ensure that initiatives are coherent, sustainable and imaginative

enough to work. Also, no single group usually has enough influence to promote the changes necessary. Broad coalitions, formal or informal, of different groups connected by an interest in this complex issue are needed. Therefore, another recommendation of the Health Care in Danger initiative is to capitalize on the different abilities of such groups. Ideally, various domestic initiatives should be brought together under a common national plan of action to prevent and address violence against health care. These efforts should also be integrated into public health plans, so that their implementation is monitored and measured against indicators, and sufficient resources allocated.

Lastly, the need for policy change is highlighted in all the three case studies. This includes not only changes to legislation, but also regulations, resource allocation, etc. Policy change requires time and commitment by the authorities. We need a collective effort from the humanitarian, development and health communities, together with civil society organizations, if we are to keep this issue at the top of global and national agendas and continue to produce the results so desperately required.

# HEALTH CARE IN DANGER

Health Care in Danger (HCiD) is an initiative of the International Red Cross and Red Crescent Movement aimed at addressing the issue of violence against patients, health workers, facilities and vehicles, and ensuring safe access to and delivery of health care in armed conflict and other emergencies.

Launched in 2011, HCiD's work extends over three distinct but interconnected areas:

## **RAISING PUBLIC AWARENESS ON VIOLENCE AGAINST HEALTH CARE**

The HCiD initiative seeks, through public communication activities highlighting the humanitarian impact of violence against the medical mission, to broaden public understanding of and support for international and national initiatives for the protection of health care.

## **CONSOLIDATING AND IMPROVING FIELD PRACTICE AND NATIONAL RESPONSE TO VIOLENCE**

The HCiD initiative supports the identification and implementation of concrete, practical measures and operational responses at national and local levels to prevent violence and safeguard health care in armed conflict and other emergencies.

## **THE MOBILIZATION OF GLOBAL AND LOCAL COMMUNITIES OF CONCERN**

The Community of Concern is a catalyst for change, supporting, at the local level, the implementation of recommendations and measures to protect health care. It is made up of health professionals, governments, weapon bearers, civil society representatives, NGOs, international organizations and more. Together with this community and through research, debate, consultations and workshops worldwide, the HCiD initiative has identified a number of recommendations and practical steps to safeguard health-care services and now advocates for their wider dissemination and implementation where needed.

### **MORE INFORMATION**

[www.healthcareindanger.org](http://www.healthcareindanger.org)  
<http://community.healthcareindanger.org/join/>  
[@HCIDproject](https://twitter.com/HCIDproject) [#NotaTarget](https://twitter.com/NotaTarget)

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

# THE WAY FORWARD

## SAFEGUARDING HEALTH CARE IN KARACHI

### A SNAPSHOT OF VIOLENCE AGAINST HEALTH CARE IN KARACHI

Karachi, in the province of Sindh, is Pakistan's largest city, main port and economic hub. It has a population of around 20 million.

Like in many other cities in developing countries, most of Karachi's health-care services are delivered by private companies and charities. This makes it difficult to deliver the same level of care across the city.

The ambulance system is a case in point. It is run by three large charities, alongside a host of smaller NGOs, faith groups and private companies. The system is largely unregulated, and it is estimated that 75% of the fleet are basic transport vehicles that have no life-saving equipment on board. Moreover, most ambulances are staffed by drivers with limited paramedical training.

Violence is an ever-present danger in health-care settings. Yet there seems to be little in the way of a blanket response. Some hospitals have reacted to attacks by stepping up security measures, but health workers get no formal training on managing violence, and the issue is not addressed by specific laws or policies.

Many health workers in Karachi have reported attacks and extortion attempts by criminal gangs. Some have even fled the country to protect themselves and their families. But the evidence shows that most attacks on health workers are by patients' relatives. Many complain of a general lack of respect for the medical profession.



ICRC

## AMBULANCE SERVICES

RESULTS OF A STUDY CONDUCTED BY THE ICRC AND PARTNERS IN KARACHI

AMBULANCE DRIVERS ARE AT GREATER RISK OF VIOLENCE THAN ANY OTHER CATEGORY OF HEALTH WORKER.



PEOPLE SHOW LITTLE RESPECT TOWARDS AMBULANCE DRIVERS.



AS ALL LARGE HOSPITALS WITH TRAUMA WARDS ARE LOCATED IN THE CITY'S SOUTH DISTRICT, PATIENTS WITH LIFE-THREATENING INJURIES OFTEN HAVE TO TRAVEL LONG DISTANCES FOR TREATMENT.



THE STREETS ARE CONGESTED AND DRIVERS DO NOT USUALLY PULL OVER TO LET AMBULANCES PAST.



## WORKING IN THE FACE OF DANGER

*We had been on high alert that particular day, as there were several religious processions taking place. Two bombs exploded in the city. The entire hospital's medical staff came in to deal with the casualties. Then a bomb exploded right outside the main entrance, killing 18 innocent bystanders. A second, larger bomb was found later and defused. We were fortunate that none of our staff was hurt. I remember the flash, and the horrifyingly loud noise that followed. I remember the shock wave, being flung across the floor, dust everywhere, and people screaming as they fled. I remember the voices of my fellow doctors shouting at me "Run! Run! It's a bomb!" , but I could not move.*

*We have increased security considerably here since, and we have a stronger paramilitary police presence near the hospital to help. But it still isn't enough. We face assaults, verbal abuse and even death threats all the time. But we try to show people that we care still, because we know they are dealing with terrible emotional trauma and despair, particularly here in the emergency room. Some people think health workers are heroes. But that doesn't mean they should have to put up with this senseless violence that stops them from doing their work. We must not be afraid to say no to violence against health care.*

*– Dr Seemin Jamali, executive director of the Jinnah Postgraduate Medical Centre (JPMC) in Karachi*

*“I remember the voices of fellow doctors screaming at me "Run! Run! It's a bomb!" , but I could not move”.*





*“It is rare for such extreme situations to occur, but when they do, you know it could be your last day at work”.*

*It was about two years ago. I was on evening duty in the emergency room, and a young man was brought in. There had been a gunfight between supporters of rival political parties, and patients were being rushed in. We had started treating the first patient, when another young man, accompanied by a crowd of about 20 men, was rushed in. We do not usually allow so many people to come in with a patient, but they sometimes threaten or actually attack our security guards and push their way in.*

*It turned out that the two men were from opposing sides. Someone from the second group noticed that the first patient – a man they had been trying to kill – was right there in the same emergency room. One of them drew his gun and tried to shoot the first patient. When we saw a drawn weapon, we ran for cover. I am not sure how we prevented the killing, but I know that we got the Rangers [paramilitary police] to intervene swiftly. Such extreme situations are rare, but when they happen, you think it could be your last day at work.*

*– Naseem Akhtar, Second Nurse, JPMC Emergency Ward*

## UNDERSTANDING THE PROBLEM

The Health Care in Danger team in Karachi wanted to understand how violence affected different groups in different ways and what impact it had on the health-care system. First, we spoke to members of the medical profession, academia, civil society and the authorities. Then we carried out a wide-ranging study. We collected data, organized focus groups and interviewed staff, activists and policymakers. By the end of the study, we had built close ties with several organizations in the city.

Our findings gave us insight into the patterns of violence that plague Karachi's health-care system. Alarmingly, 66% of health workers

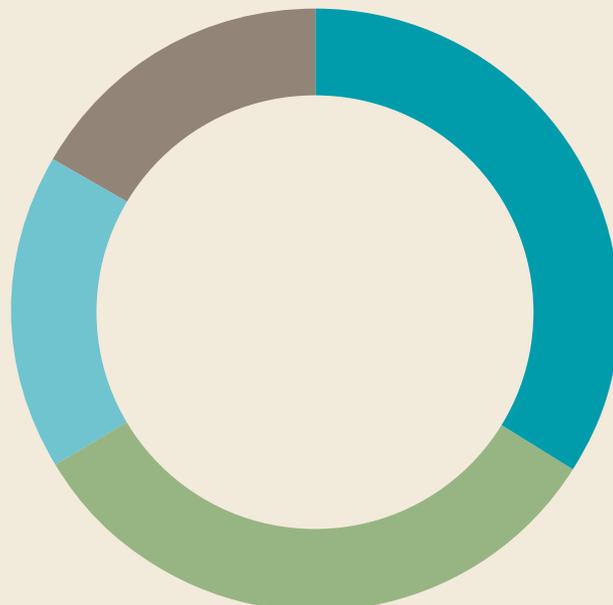
said they had been attacked or had witnessed violence in the 12 months leading up to the study – although most incidents were not serious and were carried out by members of the public and patients' relatives. We also found that public hospital staff and ambulance drivers were at the greatest risk.

During the initial interviews, some doctors said they were reluctant to report incidents because they feared reprisals. More worrying still, many health workers said that violence was a fact of life they simply had to accept. Some even thought that patients were entitled to be violent.

## VIOLENCE AGAINST HEALTH CARE: RESULTS FROM A MULTI-CENTRE STUDY IN KARACHI

### VIOLENCE EXPERIENCED OR WITNESSED

Experienced	16.90%
Witnessed	32.50%
Both	16.50%
Neither	34.10%



# BUILDING THE CAPACITY OF HEALTH WORKERS TO MANAGE VIOLENCE

We hired a psychologist as a consultant to develop a training programme for health workers. Because we had found that many violent incidents started as verbal altercations, we commissioned a guide explaining how to use communication techniques to de-escalate situations. We tested the programme and found that, while the number of incidents fell only slightly, they were managed better and the violence was less serious.

We have now published a package of multi-media materials and handbooks. They include

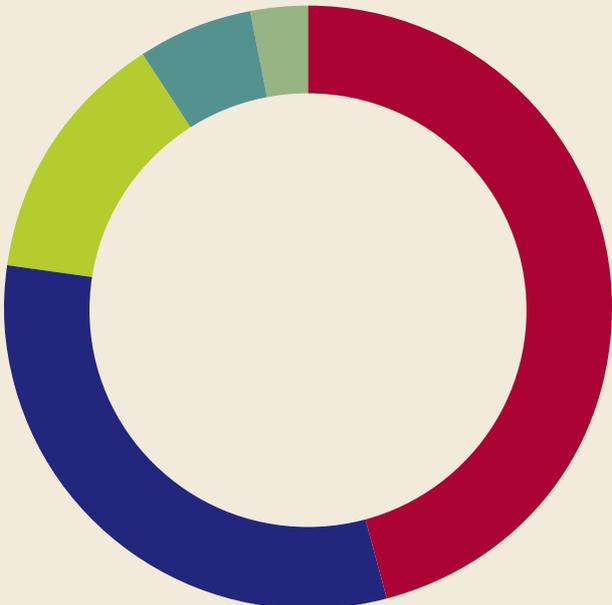
new teaching materials on issues such as how to break bad news to patients and relatives, what the relationship is between medical ethics and violence, and how to prevent violence against health-care providers.

The materials were very well received by the hospitals and ambulance services that took part in our pilot training courses. We are now looking to make them part of the syllabus at medical colleges throughout the province of Sindh, so that all newly qualified doctors are ready to cope with violence in their jobs.

*Many health workers said that violence was a fact of life they simply had to accept. Some even thought that patients were entitled to be violent.*

## PRIMARY REASONS FOR NOT REPORTING THE INCIDENT

● It was not important	45.70%
● Useless	31.10%
● Afraid of negative consequences	13.40%
● Did not know whom to report to	6.10%
● Felt ashamed /guilty	3%



## GIVING WAY TO AMBULANCES

We also worked with ambulance drivers. Because Karachi's ambulance drivers are on the front line in a big city, they are more likely to be assaulted than other medical professionals. Assaults can seriously affect patient recovery and survival; yet drivers' chief complaint is obstruction by other motorists.

To see how motorists behaved towards ambulances, the Institute of Public Health posted observers on some of Karachi's busiest roads. Encouragingly, they found that two-thirds of the city's drivers gave way. Yet the remaining one-third, including many private transport operators, did not.

*“People know us in the community and know what we do. I never once thought I would become a target. Our founder, Edhi Sahib, had always told us that saving even one life helps save all of humanity. But one day I was running with a stretcher towards injured people lying in a street, when I felt something like a stone hitting me in the back. Although I was in uniform and my ambulance lights were on, someone had shot me. I don't remember much after that. I think I passed out, though I do remember an injured old man lying close to me, speaking to me, encouraging me to remain still, to pray and to be patient. There was nothing I could do but lie still. Bullets were flying around, and people were too scared to come out of their homes to help.”*

*—Mujadid Rehman, Edhi Emergency Services  
Ambulance operator*

*“People know us in the community and know what we do. I never once thought I would become a target”.*



## A STEP IN THE RIGHT DIRECTION

In order for our initiative to succeed in such a big city, the government must be involved and the tools must be promoted widely. So our strategy has been to develop and test tools at a grassroots level, but to promote them with the government nationwide. While we and our partners can offer technical assistance, lasting change will only come about if the political will is there.

We gave a presentation on our study in Karachi in November 2015. One participant said a lot of health workers were grateful that somebody was “finally coming to ask about their plight”.

Talking about a problem and bringing it to public attention can often be a catalyst for change. It can also be a cathartic experience for those involved. But we’ve set the bar higher. We want to cut the number of incidents of violence in health-care settings dramatically and get people to treat health workers with greater respect right across the country. But this can only come about through concerted, long-term effort.

## GETTING THE MESSAGE ACROSS

The Health Care in Danger team ran a high-profile media campaign on giving way to ambulances. After Pakistani media picked up the campaign, we were invited on to prime time talk shows on some of the country’s leading TV channels. There were also media appearances by figures from the medical profession, ICRC staff and ambulance drivers.

The campaign was a bigger success than we expected, with many health-care providers and journalists speaking out about the horrifying acts of brutality suffered by first responders. We found an impressive 16% improvement in motorists’ behaviour towards ambulances. While this is encouraging, we need to carry out more of these campaigns and on a bigger scale.

The law also needs to be changed so that motorists in Sindh are required to give way to ambulances. In 2015, we had teamed up with Islamabad-based think-tank the Research Society of International Law to look at areas where a change in the law was needed.

We discovered that ambulance services were insufficiently regulated and that there was no formal coordination between different parts of the health-care system, especially in emergency care. We also found no specific measures to prevent violence or protect health workers and patients from violence in health-care settings.

We are now looking into the feasibility of changing the law and promoting such changes together with the authorities.

## RESOURCES

### Main publications and reports

- *Violence against Health Care: Results from a Multicentre Study in Karachi*
- *Towards Protecting Health Care in Karachi: A Legal Review*

### Training material

- Training package on reducing violence in health care
- Training materials for de-escalating violence in health-care facilities

# GOING THE EXTRA MILE

## SAFEGUARDING HEALTH CARE IN THE VRAEM

### GETTING TREATMENT IN A REMOTE VALLEY

Violence has reached disquieting levels in Peru's Apurímac-Ene and Mantaro Valley (VRAEM), which spans five administrative regions – Apurímac, Ayacucho, Cusco, Huancavelica and Junín.

The VRAEM is a remote area, making it particularly difficult to access. For this reason, in certain zones, the authorities do not have much of a presence. This makes it the perfect breeding ground for drug trafficking and other illicit activities, which are, indeed, rife.

There are occasional outbreaks of violence between the armed group led by the Quispe Palomino brothers and the armed forces and police, as well as between armed drug traffickers. These tensions mean that local people live in fear.

The combination of all these factors has had devastating effects on many aspects of the lives of people there, particularly on their access to health care.



B. Heger/ICRC



B. Heger/ICRC

*“To come here, one really has to be brave. There are so many people who need our help, but we lack even the most basic resources”.*

*– A health worker dispatched at the Alto Mantaro health post*

*“There are no roads. For a number of communities in the Ayacucho region, it takes 10 hours to walk to the nearest health post. But it’s even worse for others living in the Junín region: it can take them up to two days”.*

*– An ICRC delegate talking about access to health care in the VRAEM*



B. Heger/ICRC

A community leader in Junín smiles after receiving a stretcher from the ICRC which will make it easier to transport sick and wounded people to the nearest health post.

## UNDERSTANDING THE PROBLEM

Between May and December 2014, staff at the ICRC's regional delegation in Lima carried out 20 group interviews with a total of 295 workers from 92 health-care facilities in the VRAEM. The aim was to determine the extent to which the presence of the armed forces, other armed groups and drug traffickers had affected health care in the region and to assess what risks health workers were exposed to.

We discovered that health workers in the region had experienced various forms of violence. Those interviewed spoke most frequently of armed individuals robbing and stealing medicines, entering health-care facilities with their weapons and interrogating health workers.

Several people said they had been threatened by armed groups, often to prevent them from reporting the theft of medicines. Health workers were also put under pressure to provide information about their patients, in total disregard of their duty to uphold medical confidentiality.

*Health workers were also put under pressure to provide information about their patients, in total disregard of their duty to uphold medical confidentiality.*



## RESULTS FROM INTERVIEWS WITH 295 HEALTH WORKERS OPERATING IN THE VRAEM

What are your proposed actions to prevent violence or mitigate its effects?	%
Training for health workers	56%
More equipment and supplies	56%
Give a bonus to staff living in VRAEM	44%
Improve security in facilities	33%
Draw up contingency plans	22%
Coordinate action with community authorities	22%
Make health vehicles and staff identifiable as such	22%
Set up means of communication	22%
Coordinate call-outs	22%
Request more staff	11%
Have a designated emergency vehicle	22%
Implement mental health programme for people affected by the armed conflict in the 1980s	22%
Provide ID	22%
Communicate by radio	11%
Report call-out times (leaving and arriving)	11%
Set up an incentive programme for staff pay	11%
Request life insurance be covered by the State	11%
Improve working conditions	11%
Assess notification mechanisms at military counter-terrorist base	11%
Train security guards	11%
Broadcast TV and radio messages on neutral role of health workers	11%
Raise awareness among the public of what health workers do	11%
Build latrines, provide family jobs and improve health in communities	11%

## PHASE 1: USING THE DATA

We shared our findings with the authorities in an effort to find ways together to improve access to health care, and its safe delivery, in the VRAEM. Sharing our findings with the health ministry bore fruit.

The deputy health minister set up a working group in March 2015 comprising individuals from ministry departments, the ICRC and the Peruvian Red Cross. The aim of the working group was to develop legal and operational tools to strengthen the protection and safety of health workers, vehicles and facilities.

The ICRC mainly contributed by preparing technical documents, which were then submitted to the other members for comments and observations before approval. Two documents came out of this process:

- A report – *Sistematización de la normativa peruana relacionada con la asistencia de salud en situaciones de riesgo a la luz del derecho internacional* – that maps out existing legislation aimed at safeguarding health care in dangerous situations; compares domestic law with international standards;

and identifies gaps in, and incompatibilities between, domestic law and international standards.

The report also contains a series of recommendations, including:

(i) establishing a standard sign or emblem to identify health-care services, which would afford them better protection; and  
(ii) creating a centralized reporting system so that all health workers could report incidents of violence, in order to increase visibility of the issue and implement solutions.

- A primer – *Respetar y proteger los servicios de salud* – that serves as a tool for strengthening the protection afforded to and safety of health workers. The primer provides general, easy-to-understand explanations of the rights and obligations of all health workers – including volunteers of the Peruvian Red Cross – and particularly those working in situations of social unrest and natural disasters, and in vulnerable areas such as the VRAEM.



*We shared our findings with the authorities in an effort to find ways together to improve access to health care, and its safe delivery, in the VRAEM. Sharing our findings with the health ministry bore fruit.*



M. Burgos/ICRC

**Pledge taken by the National Committee for the Study and Implementation of International Humanitarian Law in furtherance of Resolution 4, “Health Care in Danger: Continuing to protect the delivery of health care together”.**

Promote and adopt various legislative, institutional and other relevant measures, along with public policies, to ensure that the wounded and sick and health-care workers are treated respectfully and that they, as well as facilities and resources provided by States and/or humanitarian organizations for medical services, are protected in armed conflicts and other emergencies.

With the support of the organizations involved, ensure that the international legal obligations relating to the protection of the wounded and sick, health-care workers, and medical facilities and vehicles are complied with so as to guarantee timely care for those affected.

Adopt legal and enforcement measures under the responsibility of each organization, and those concerning the use and protection of national, international and humanitarian-organization emblems worn by health-care workers and displayed on medical facilities and vehicles, taking the steps necessary to prevent and punish their unauthorized use in accordance with the Geneva Conventions and their Additional Protocols.

## PHASE 2: GETTING THE MESSAGE OUT

Peru’s health-care system is decentralized, with regional health authorities that are independent from the central government’s health ministry. In 2015 and 2016, the ICRC worked with the regional health authorities to raise awareness of the importance of the protection of the health services.

As part of this work, ICRC staff presented the primer to health workers in facilities most at risk of violence in the VRAEM. They did the same for volunteers of the Peruvian Red Cross. Three regional workshops were held for volunteers, in Piura, Lima and Islay, to raise awareness of the issue of violence against health care and promote the primer.

## WORKING WITH THE MOVEMENT

In 2017, as part of its cooperation agreement with the ICRC, the Peruvian Red Cross added Health Care in Danger activities aimed at its volunteers to its annual operational plan, with a view not only to raising awareness among volunteers but also to training future trainers on the issue, thereby strengthening the capacities of the Peruvian Red Cross.



## PRIMED TO RESPOND

By September 2017 the health ministry had distributed the primer to 3,458 health-care professionals in the SERUMS programme, of whom 2,437 were working in the VRAEM. The primer will be sent out to all 13,000 health workers in the SERUMS programme. After the pilot phase, the aim is for the primer to be distributed to all health workers – over 200,000 – across the country.



## FOSTERING THE ENGAGEMENT OF AUTHORITIES

The Peruvian government's engagement with the issue has continued to grow.

In August 2016, the government made a pledge to adopt domestic measures to ensure respect for and the protection of health-care services in relation to Resolution 4, "Health Care in Danger", passed at the 32nd International Conference of the Red Cross and Red Crescent in December 2015.

In the same month, the health ministry and the Peruvian Red Cross officially endorsed the primer drawn up by the working group, which is why the logos of both entities appear on the document.

In April 2017 the health ministry's general directorate for health-care personnel started using the primer. In order to reach the target audience, the primer was given to some of the health workers entering the marginal rural and urban service programme (known as SERUMS), which accounts for 3% of the national health workforce.

The health ministry sees the primer as a useful tool for delivering practical messages and raising health workers' awareness of their rights and obligations when performing their duties.

## WHAT WE HAVE LEARNED

The fact that the primer was approved by the health ministry, in addition to the ICRC and the Peruvian Red Cross, was key to ensuring that it was successfully distributed. The health ministry's general directorate for health-care personnel finds the primer useful, as it has had an impact on workers in the SERUMS programme and provides straightforward information on how health workers can protect themselves. It was essential to involve the health authorities in the project, as they are the ones in charge of implementing recommendations and distributing information to health workers.

Dialogue with the authorities, together with work to ensure that recommendations are implemented, will focus on the central government in Lima, given that action taken at the central level will have more of a nationwide impact.



M. Cohen/DFG

## THE BUMPY ROAD AHEAD

There are still a number of challenges on the road ahead. First, there are around 200,000 health workers in Peru, and distributing the primer to all of them – in close cooperation with the Peruvian Red Cross, the health ministry and the regional health authorities – can only happen in stages.

In addition, the health authorities do not centrally collect, organize or analyse data on incidents of violence against health workers. Incidents are also underreported, making it difficult to gauge the true extent of the issue. For initiatives to succeed, such as an effective reporting system, there has to be the political will behind them at the highest level.

In Peru, there is still no community of concern to foster a culture of responsibility among all those concerned. Such a community would mobilize support for this issue and encourage the health-care community, law enforcement officials, humanitarian organizations and government authorities to work together.

Finally, although the Peruvian Red Cross is a key partner in this initiative and is present across the country, the project will only be sustainable if it takes responsibility for this issue and successfully makes Health Care in Danger an integral part of its identity.

## WHERE WE GO FROM HERE

While there is still a lot of work to be done, we think that the distribution of the primer is a solid first step in better informing health workers of their rights and obligations. This, in turn, helps to raise awareness among other groups, such as the armed forces, the police and the health authorities.

After all, although it is important to raise awareness among the victims of such incidents, it is also important to raise awareness among those who can prevent such incidents from happening.

The next step is helping the health ministry and the Peruvian Red Cross to act on the recommendations set out in the report (see above). This includes creating a standard sign or emblem for all health-care services and setting up an incident reporting system.

The ICRC will continue to offer technical assistance, although the political will of the authorities will be essential if we are to move forward.



B. Heger/ICRC

## RESOURCES

### Main publications and reports

- *Sistematización de la normativa peruana relacionada con la asistencia de salud en situaciones de riesgo a la luz del derecho internacional.\**
- *Respetar y proteger los servicios de salud.\**

\* Only available in Spanish.

# A DANGEROUS CALL

## SAFEGUARDING HEALTH CARE IN EL SALVADOR

### THE INVISIBLE BARRIERS

El Salvador's health-care service is significant for the size of the country: 576 community health units, five regional networks, 17 basic health-care networks (SIBASI) and 68 micro-networks, which together cover 67.2% of the population. Notwithstanding, getting access to health care can be difficult.

The levels of violence are badly affecting health-care services, whether delivered by the Salvadorean Red Cross or by the public or private sectors.

Health workers deemed outsiders are often prevented from getting to communities living under the territorial control of criminal groups, a so-called invisible barrier thrown up around them that clearly undermines the idea that health services should be universal and accessible to all.

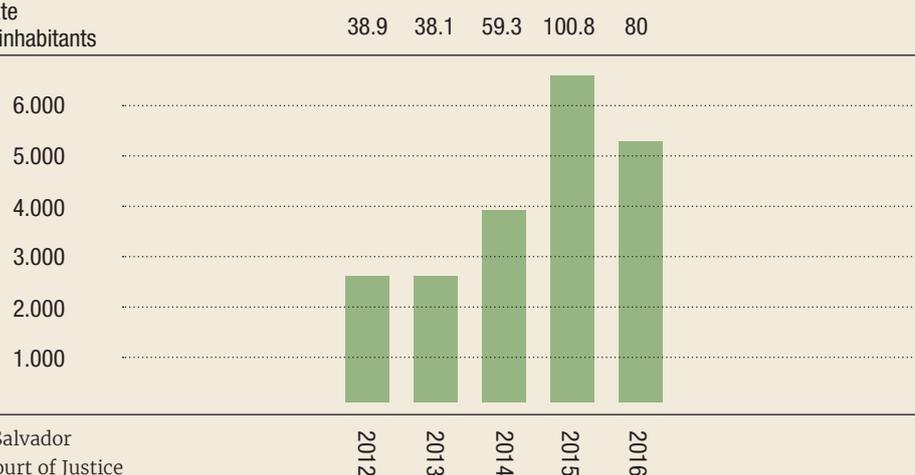


C. Salvadoreña

## A SNAPSHOT OF VIOLENCE IN EL SALVADOR

- Armed violence is the leading premature cause of death in the country. El Salvador is ranked as one of the most dangerous countries in the world.
- Twelve years of civil war (1980–1992) claimed the lives of over 75,000 people and left an estimated 10,000 people missing.
- From January 2009 to December 2016, the National Civil Police received 11,252 reports on missing persons.
- 17,000 public sector students have dropped out of school in 2017, mainly due to violence and the lack of security.

Homicide rate per 10,000 inhabitants



Source: El Salvador Supreme Court of Justice

## WORKING IN THE FACE OF DANGER

*In May 2017, four health promoters working in San Salvador were held at gunpoint by members of a criminal group and sexually abused.*

*– A staff member of the Salvadorean Red Cross*



UNIDAD DE ATENCION A  
VICTIMAS DE VIOLENCIA



*In April 2016, a 14-year-old boy was killed while attending a first-aid training session in La Libertad. He was a volunteer for Comandos de Salvamento. Unknown men burst into the building brandishing high-calibre weapons and, without saying a word, shot the boy.*

*– Incident reported to the local media by a member of the Comandos de Salvamento, a local emergency service organization*



*Health workers, just doing their jobs in the communities, were worried that something could happen. There had been incidents of violence against ambulance drivers, doctors, nurses, paramedics, volunteers and admin staff in health centres. They continued to carry out their humanitarian work, despite the fear of being attacked. But something had to be done.*

*– A Salvadorean doctor*

## **WORKING TOGETHER TO FACE THE CHALLENGE**

In July 2014, the Salvadorean Red Cross brought together representatives from the main health-care providers in El Salvador to discuss how best to deal with attacks on health-care staff and manage health-care provision given the general lack of security. An interagency committee was set up in November 2014 and tasked with developing an inter-institutional protocol for the coordination and safe delivery of emergency pre-hospital care.

The committee delivered a protocol: a set of rules and regulations for health-care institutions to improve coordination and minimize security risks, adopted the same year.

But one year on, after a series of new security incidents, it was agreed that the protocol urgently needed to be updated to consider the physical as well as the psychological well-being of health workers, and include all types of health-care services.

In October 2015, work began with representatives from the Ministry of Health and Social Welfare, the Comandos de Salvamento, the Fire Brigade, the Health Solidarity Fund, the Medical Emergency System, the National Police Force, the Salvadorean Green Cross, the Military Health Command, the Salvadorean Association of Private Hospitals and the Salvadorean Social Security Institute. The Inter-Institutional Protocol for the Coordination and Protection of Health-care Services was signed on 30 May 2016.

The committee was asked by the Ministry of Health to develop the tools needed to implement the protocol effectively. So they set up working groups to act on specific parts of the protocol, e.g. awareness-raising, zoning and procedures. As part of this work, the Salvadorean Red Cross drew up an action plan for 2016–2017.

On 30 May 2016, the Inter-Institutional Protocol for the Coordination and Protection of Health-care Services was signed by the following organizations:

- Ministry of Health
- Salvadorean Red Cross
- Comandos de Salvamento
- Fire Brigade
- Health Solidarity Fund
- Medical Emergency System
- National Police Force
- Salvadorean Green Cross
- Military Health Command
- Salvadorean Association of Private Hospitals
- Salvadorean Social Security Institute



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## THE SALVADOREAN RED CROSS ACTION PLAN

The Protection for Health-Care Services plan operates on three levels:

1. **Internal:** It seeks to give the Salvadorean Red Cross the tools to ensure its health-care services and humanitarian work can be carried out safely.
2. **External:** It seeks to enable the Salvadorean Red Cross to continue working with others to monitor and help improve the safety of health workers in other organizations.
3. **Movement-wide:** It seeks to build support for a new safety manual for health-care services, which could be used by other countries in the region experiencing similar social instability.

## PEER-TO-PEER TECHNICAL COOPERATION

As part of the process of updating the protocol, a meeting of experts was held in November 2015 on the issue of protecting medical personnel and facilities. It brought together health ministers from the governments of Colombia, El Salvador and Honduras, and representatives from the countries' National Red Cross Societies, in recognition of the fact that El Salvador was not the only country in the region experiencing problems with violence. The objectives of the meeting were:

1. to share experiences, best practices and lessons learned with regard to promoting respect for and increasing the safety of health-care services in Colombia, El Salvador and Honduras;
2. to strengthen joint initiatives between governments and National Societies (in their auxiliary role), tailored to the situation in each country;
3. to draw up action plans for protecting health-care services in El Salvador and Honduras and to secure support for monitoring and implementing these plans, within the framework of expert cooperation in Colombia.

The attendees recommended taking steps to:

- (a) create mechanisms to boost international cooperation between the governments of Colombia, Honduras and El Salvador, their National Societies and the ICRC, with the support of Colombia's expert panel on medical personnel and facilities and the Norwegian Red Cross, with a view to increasing safe access to health-care services in El Salvador and Honduras;
- (b) establish means of assessing the impact on the local population of a lack of respect for and protection of health-care services in each country;
- (c) increase opportunities for dialogue between government authorities and National Societies;
- (d) amend existing legislation on the protection of health-care personnel, transport, infrastructure, codes of medical ethics and access to health-care services.





## CHALLENGES AND PROJECTIONS

Internally, the Salvadorean Red Cross aims to:

- reach all National Society staff to raise awareness of the new tools;
- create a culture of reporting incidents within the National Society;
- institutionalize the use of the risk assessment tool;
- set up special psychosocial care for health providers who have been victims of violence;
- strengthen the communication campaign on respecting health services.

Externally, the Salvadorean Red Cross aims to:

- expand the network of actors who can raise awareness of and implement the protocol;
- create a completely anonymous online incident reporting form;
- set up an inter-agency network of protocol facilitators;
- propose an inter-institutional technical group at departmental level to ensure that information is accessible across the health-care system;
- create cross-sectoral alliances to carry out a mass campaign on respecting health services.



We help people around the world affected by armed conflict and other violence, doing everything we can to protect their dignity and relieve their suffering, often with our Red Cross and Red Crescent partners. We also seek to prevent hardship by promoting and strengthening humanitarian law and championing universal humanitarian principles. People know they can count on us to carry out a range of life-saving activities in conflict zones and to work closely with the communities there to understand and meet their needs. Our experience and expertise enable us to respond quickly, effectively and without taking sides.

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