

Health Care in Danger Initiative
Africa Regional Meeting
24–25 June 2020



ICRC

**VIOLENCE AGAINST
HEALTH CARE MUST END**

**IT'S A
MATTER
OF LIFE
& DEATH**

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The Health Care in Danger Initiative

Ensuring the safe delivery of health care and affording special protections to medical personnel, facilities and vehicles is rooted in the very origins of the International Red Cross and Red Crescent Movement. Over the past ten years, the International Committee of the Red Cross (ICRC) and the Movement have placed special emphasis on ensuring safe access to medical services through the Health Care in Danger initiative.

The initiative was formally established when the Health Care in Danger resolution was passed at the 31st International Conference of the Red Cross and Red Crescent in 2011. Advocacy by the ICRC and our partners led to significant mobilization around protecting health care, resulting in several resolutions at the World Health Assembly and the UN Security Council (Resolution 2286). This effort was accompanied by a global awareness and mobilization campaign that incorporated organizations representing 30 million health-care practitioners around the world. The campaign rallied partners inside the Movement and outside, bringing together global experts to highlight Health Care in Danger-related issues.

HEALTH CARE IN DANGER – THEORY OF CHANGE



Health Care in Danger Strategy 2020–22

The Health Care in Danger Strategy 2020–22 is built around the Theory of Change methodology and has four objectives.

- Objective 1: **Weapon bearers are respectful of health-care services and enable their safe delivery.**
- Objective 2: **States have adopted and implemented legislation for the protection of health care from violence.**
- Objective 3: **Health-care providers are better prepared to prevent, mitigate and/or cope with the impact of violence.**
- Objective 4: **The general population in countries affected by conflict and other emergencies has increased its respect for health care.**

Regional Meetings

The strategy emphasizes the implementation of concrete measures at the local and national level. In parallel, the Health Care in Danger initiative has transitioned from holding meetings of stakeholders at the global to the regional level. The regional focus allows stakeholders to share experiences on operations and approaches and develop and strengthen local and national partnerships, creating a Community of Concern to prevent and address violence against health care. The partnership with the Community of Concern is a central pillar of advancing our common agenda.

The Health Care in Danger initiative aims to better understand regional dynamics to support actions on the ground. It is mobilizing key actors through regional forums, working with regional institutions to support appropriate national legislation and encouraging Movement partners to explore avenues of collaboration and peer-to-peer support.

Regional meetings took place in 2019 for the Asia–Pacific Region in Manila and the Near Asia and Middle East Region in Beirut. Participants appreciated the opportunity to discuss similar experiences, dynamics and cultural issues with stakeholders from neighbouring countries.

A meeting for the Africa Region meeting was scheduled in Tunis from 23–25 June 2020. Owing to COVID-19 related restrictions, the face-to-face meeting was cancelled. In its stead, a condensed, two-day webinar took place. The agenda and four sessions of the Africa meeting were organized broadly along the four workstreams of the Theory of Change.

Disclaimer

This report provides a summary of the Health Care in Danger Initiative Africa Regional Meeting, held online on 24–25 June 2020. The views expressed in it are those of the participants concerned and do not necessarily reflect the views of the organizations they represent.



Day 1 Session 1

Respect for Health-Care Services by Weapon Bearers

Chair: Mr Mamadou Sow, Head of Regional Delegation for Southern Africa, ICRC

Panellists: Mr Jan Tijmen Ninck Blok, Health Care in Danger Military Researcher, Health Care in Danger Initiative, Geneva, ICRC

Ms Juliet Kelechi Unubi, Humanitarian Adviser, Nigeria Delegation, ICRC

Ms Catherine Hiltzer, Head of Africa Region, Geneva Call

Mr Mamadou Sow welcomed all those present virtually to the first session, before recounting a series of events around a devastating recent attack on a maternity centre. He described such attacks as attacks on our humanity and dignity. The engagement with weapon bearers in emergencies and conflicts to protect health care was critical to the ICRC's work, and he noted the critical engagement of a range of stakeholders on that issue.

Mr Sow recalled in 2013 in [Sydney](#) the ICRC bringing together military experts from 21 states and multilateral organizations which identified ground evacuation, the search for health-care facilities and precaution during attacks as areas where practical measures should be taken. In connection with this ongoing work, he introduced the first presenter, Mr Jan Tijmen Ninck Blok, who was a military researcher at the Health Care in Danger initiative and currently finalizing a research project on respect for health-care services by weapon bearers and the protection of health care by state armed forces.

Mr Ninck Blok explained that the objective of his research was to examine military conduct and practice in relation to the protection of health care in armed conflict in order to identify good practice that could be transferable to other contexts. It looked at how protections of health care had been integrated into military doctrine and practical measures. By reframing state armed forces as enablers of protection the research examined what armed forces had done and could do to contribute to the safety of and access to health care.

The research found that the current state of doctrine and practice suggested that there was very limited integration of the normative framework, particularly on the operational level. The default decision in the absence of clear guidance tended to be refraining from attack. There were questions of where the protection of health care figured in operational calculations given the urgent demands of military operations. Furthermore, the guiding doctrine was difficult to attain as states were hesitant to disclose sensitive issues around military doctrine.

Nonetheless, several areas were identified where armed forces could make a significant contribution to the protection of health care. A toolkit had been developed which included practical measures, focusing on understanding the operational environment, coordination with civilian health-care providers, regulating the behaviour of military personnel and area-specific measures.



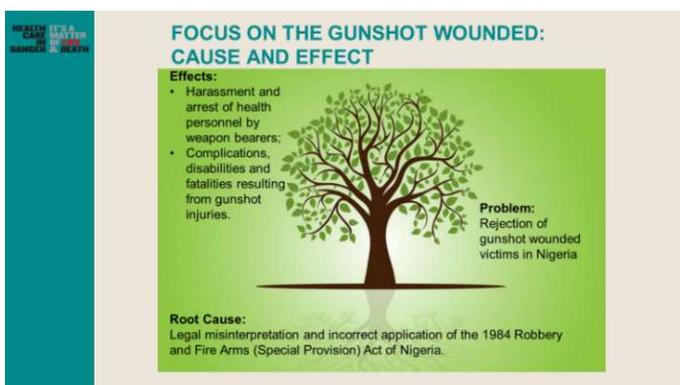
Mr Ninck Blok highlighted three key ways in which health-care providers could specifically contribute to the protection of health care. Firstly, through civil military coordination. It was important for humanitarian workers to remain neutral and independent in such an environment, but the exchange of information was essential. Highlighting ongoing activities and the consequences of unsafe access to

health care could ensure protection. A second avenue might be mobilizing military medical personnel, who could be called upon in times of crisis to save lives. A third element might be medical evacuations, which could be used when a higher level of care was required. Having a coordination mechanism in place could allow for the evacuation of civilians and military personnel. Mr Ninck Blok shared some initial considerations for carrying out an assessment when engaging with armed forces on these issues.

The outcome of carrying out such an assessment could be an increased respect for medical facilities and improved delivery of services. Military medical capacity might also be made available for routine or emergency services which could lead to improved care services. Greater communication might also provide safeguards for the continuity of services and contribute to contingency planning, especially in the event of the military’s departure.

In closing, Mr Ninck Blok noted that the report would be published in Q4 of 2020 and made available in a number of languages. At this, Mr Sow segued into the interaction between law enforcement, human rights and health systems, and with that the next session with Ms Juliet Kelechi Unubi began.

Mr Sow introduced Ms Unubi, a humanitarian adviser to the Nigeria delegation who had been working for other organizations in the humanitarian and development field for almost ten years, and invited her to take the floor. Ms Unubi focused the discussion on the Nigeria delegation’s multidimensional engagement on weapon bearers and gunshot injuries. She presented a context where levels of violence were high – the armed opposition were active in north-east Nigeria and across the Lake Chad basin, and clashes between government forces and gangs occurred in other parts of Nigeria, taking a major toll on the civilian population.



Those wounded by gunshots in Nigeria were often harassed or arrested by authorities or rejected by medical facilities, which led to health complications. This led to disabilities and needless deaths. It was becoming the case that being shot was like being handed a death sentence, either the victim died immediately or later. The problem lay in

THE CURRENT STATE OF DOCTRINE AND PRACTICE SUGGESTS THAT OVERALL THERE IS VERY LIMITED INTEGRATION OF THE NORMATIVE FRAMEWORK, PARTICULARLY ON THE OPERATIONAL LEVEL.

Mr Jan Tijmen Ninck Blok

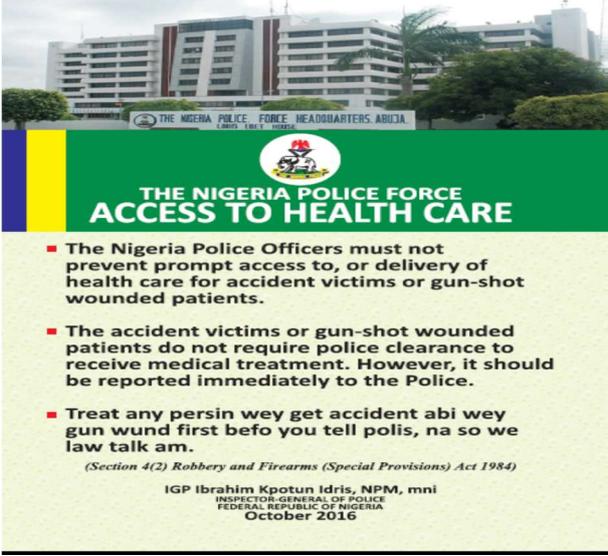
domestic law. Ms Unubi cited the Robbery and Fire Arms Act of 1984,¹ which had several ambiguities that left it open to legal misinterpretation and misapplication of the law.

In 2016, the ICRC formed a Health Care in Danger Community of Concern in Rivers State, Nigeria, which initiated two main actions. First, to raise awareness of the correct interpretation of the law among the population – there was no need to file a police report before getting care – by producing a communication tool kit and developing a state-wide data tool. This was followed by a call for advocacy to obtain a written directive from the inspector-general of police. The delegation met with the police in Abuja and this was agreed to, with the ICRC funding the printing of the written directive.

The directive that police must not impede access to health care and that patients were entitled to care before filing any report was issued that year. The ICRC has continued to disseminate the directive nationally. The National Assembly moved to support the measure and passed a law that made the treatment of gunshot-wounded patients at private and public health facilities compulsory, which was signed by the president in 2017.²

WE WERE TILTING TOWARDS A SITUATION WHERE SUSTAINING A GUNSHOT WOUND WAS LIKE BEING HANDED A DEATH SENTENCE – EITHER THE VICTIM DIED IMMEDIATELY, OR LATER.

Ms Juliet Kelechi Unubi



The ICRC would be conducting research on the application of this law and continuing its engagement with relevant stakeholders, including the health community. Mr Sow thanked Ms Unubi for her presentation, whose focus was on the police, before shifting the discussion to armed groups. He noted the work done in the ICRC’s 2015 publication³ on armed groups and how this document contained a declaration that armed groups could use to protect health care. He said that Geneva Call had taken up this banner and accomplished a lot in this field, and welcomed Ms Catherine Hiltzer, who had worked for Geneva Call since 2017 after working with several other organizations, including the ICRC.

Ms Hiltzer took the floor and opened the presentation by focusing on Geneva Call’s deeds of commitment and the Democratic Republic of Congo (DRC). She said that there was a history of attacks on health care in the country, and referred to a report published by the University of Manchester and the London School of Hygiene and Tropical Diseases which said that there had been 397 attacks between January and October 2019. According to the report, at least 65 of these attacks were carried out by non-state actors. The Ebola epidemic had exacerbated the situation and much of the violence was between members of different communities.

Ms Hiltzer explained that for this reason, Geneva Call had focused on safe access to health care there. The organization believed that well-informed communities were better at defending their rights. This

¹ <https://nlpw.com/robbery-firearms-special-provisions-act>
² For a study on gunshot-wound reporting, see <https://www.isdc.ch/media/1834/17-120-final-nov19.pdf>
³ <https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4243-safeguarding-the-provision-of-health-care.pdf>

process started with determining needs, raising awareness of legal rights and helping communities to design strategies to protect themselves. Geneva Call had four thematic deeds of commitment, whereby non-state armed groups could make a public commitment to supporting international humanitarian law and norms. This had to be accompanied by a detailed plan to implement measures and ensure behavioural change.

In the case of the DRC, the Alliance of Patriots for a Free and Sovereign Congo signed a deed in August 2019 that focused on protecting health care in North Kivu. The implementation plan developed in the following months came at an opportune moment as dissemination of the message took place while COVID-19 was becoming an issue in the community. The plan was still being implemented. Mr Sow thanked Ms Hiltzer for her excellent presentation.

In the Q&A, someone asked to what degree the public at large was aware of the issues. Ms Hiltzer said it was difficult to assess the degree to which communities understood their rights. For example, the population might be taxed by armed actors when trying to access health care. With information about the legal framework and a reframing of the issue, they could raise concerns about what they knew was wrong but might not otherwise have been able to. This was particularly clear concerning safe access to health care. Ms Unubi said how important it was to integrate messages about the protection of medical workers and patients into engagements with different communities’ work being done, whether that were through public communication or more subtle approaches like community-based protection.

**WELL-INFORMED
COMMUNITIES ARE
BETTER EQUIPPED
TO DEFEND THEIR
RIGHTS.**

Ms Catherine Hiltzer



Photo courtesy of Geneva Call

Another question was directed to Ms Unubi about the degree to which health-care providers needed also to be made aware of the issues. In her reply, she emphasized the importance of two-way communication, including with the health community. For example, health-care providers were obliged to treat the wounded and might need to be reminded of this obligation at times.

Another question concerned how making a declaration might elicit a reaction from non-state armed groups or armed forces. Mr Ninck Blok said that in his opinion the observance of international humanitarian law or medical principles was in general favourably viewed by state armed forces, but they did express concerns about legitimatizing non-state actors. Ms Hiltzer noted that sensitivities around deeds of commitment were perceived differently in different places. She reaffirmed that the deed was just one of many tools – a pragmatic approach was paramount. Tracking back to a previous question, she noted that violence could be threatened or carried out because of the absence of the full range of services in a location, citing an example from another context.

Another question came from Mr Kadio Harouna, who asked for the political and sociological reasons why health-care structures were targeted. Mr Ninck Blok replied that health facilities were often chosen as targets precisely because of the very serious consequences they had on the whole civilian population. One final question came with regard to ethics, triage and treating those most in need. Mr

Ninck Blok said that ethics were well integrated into the considerations of the armed forces. However, military medical personnel faced difficult choices when they had multiple casualties with potentially different affiliations, and the principle of non-discrimination was challenged. He said that there needed to be sanctions attached to non-respect of this principle.

Epidemic and Pandemic in a Conflict Area: The Challenge of Misperception of Health Workers

Chair: Dr Thiero Balde, Team Lead, Operational Partnerships, WHO Africa Region

Panellists: Ms Kate White, Medical Emergency Manager, MSF Holland

**Ms Ombretta Baggio, Senior Adviser, Community Engagement and
Accountability, Geneva, IFRC**

Ms Valentine Honoré, Protection Coordinator, DRC Delegation, ICRC

Mr Gianluigi Lopes introduced the chair of the session Dr Thiero Balde, assistant professor at the University of Montreal, with 40 years' experience in public health and a representative of the WHO usually based out of Brazzaville but currently deployed in Algiers as part of the COVID-19 response. Dr Balde introduced this session as a great opportunity to listen to representatives of major organizations that are engaged in responses to emergencies in Africa.

Dr Balde then introduced the first speaker, Ms Kate White, who is the emergency response manager at MSF Holland and the medical emergency and technical lead for MSF's COVID-19 response and was previously the lead on the Ebola virus/measles response.

Ms White opened the topic by saying that she struggled with the terminology used to describe the session. The challenge of the misperception of health workers hit a nerve for her as it meant that there was a wrong or incorrect understanding or interpretation. She noted that there were some assumptions there that health workers were inherently the good guys. By the same reasoning, it lay the blame implicitly with the community that health workers worked with. Ms White wished to challenge this set of assumptions.

Recognizing the vast and complex history of the DRC, Ms White briefly outlined the context from a humanitarian perspective. Tensions around Ebola exacerbated existing political ones. Pre-Ebola, the health system was fragile, but generally trusted, even though the formal system was not necessarily the first port of call. External funding of the humanitarian situation had been declining in recent years though MSF had remained present and been working in the community for the past 20 years. Broadly speaking, MSF had enjoyed relationships of mutual trust with local health authorities and access in the area.

The Ebola outbreak illustrated certain contradictions in prioritization six months into the outbreak, as 33% of the overall humanitarian response was funded while 100% of the Ebola response was. Within a week of the Ebola outbreak being declared in 2018, a measles outbreak was also declared. This measles outbreak killed three times as many people as the Ebola outbreak during the same period of time. Ebola was not the local population's highest priority, but a parallel system rose up, almost

exclusively staffed by people from outside the local community. This response was siloed and highly technocratic – focusing on key performance indicators and not holistically on the community – and became focused on security issues over time. The impact of this situation was the loss of access not only for Ebola patients but also for the wider population through the critical regular programming.

Ms White said the common good was decided by outsiders, and patient and local rights were overlooked or violated. There was a tension between the need to respond rapidly to control the disease and community acceptance. This was the case, even though breaking chains of transmission could only happen with community acceptance.

HCW & Trust	Barriers to trust
<ul style="list-style-type: none"> ▪ Trusting relationships form the basis of every good HCW-patient interaction ▪ Acceptance of patients as the experts in their own health ▪ Involving families and communities in their care ▪ Participative approach 	<ul style="list-style-type: none"> ▪ Many were “outsiders” ▪ Disease focused approach in a setting where traditional support mechanisms for patients are not there ▪ Siloed aspect of response impacted HCW’s ability to deliver holistic care ▪ Continuum of care was lacking ▪ Little to acknowledgement of informal HCW’s
	

Patients were perceived as vectors rather than affected people. This badly affected the community. If it is said there was a misperception, one must think about what a positive relationship would look like. The onus had to be on health workers to preserve a relationship of trust with their patients as the patient was in a vulnerable position when seeking care. This trust was often undermined by an ingrained idea that people were not telling the truth. Health workers had to accept that patients were experts in their own health and relinquish control.

The particulars of this outbreak complicated meaningful participation and access. Patient participation in the provision of care was critical, including in what it looked like and how it was rolled out. As examples, the community interfaced through traditional healers or by allowing families to provide food. These were critical for families. The design of a facility could have a huge bearing on the provision of services. A transition centre in Ituri Province that was constructed based on specific requests from the community was a good example – a welcoming place that was not temporary. It was possible to respect infection prevention and control while being transparent and patient-friendly.

LISTEN WITH THE SAME FEROCITY THAT YOU WANT TO BE HEARD WITH.

Ms Kate White

In terms of barriers to trust, the proclivity to have personnel not from the area was a barrier. This also allowed for a disease-focused approach to persist and created the conditions for a siloed approach. These same issues also acted as a hindrance to a continuum of care, particularly if patients were discharged from non-Ebola care.

So, in sum, humanitarians failed in four areas: by being focused on the diseases and not the patients, which were seen as vectors; by failing to apply lessons learned and best practices; through the focus on security and the politicization of the response; and finally the “Ebola-over-all approach” that neglected the wider health of the community and humanitarian needs.

The implications for COVID-19 were that one had to place patients and communities at the centre of strategies. Two-way trust and community engagement were critical. The community must be not treated like one size fits all. One final recommendation: you should listen with the same ferocity that you wanted to be heard.

With this Dr Balde, the chair, took the floor to thank Ms White for the brilliant presentation, noting the complexity of the context and need for a deep understanding. He then presented the second presenter, Ms Ombretta Baggio. Ms Baggio has been working in this field with the IFRC since 2012 and was currently co-leading the COVID-19 risk communication and community engagement work with the WHO and UNICEF and had been the IFRC's global coordinator for the Ebola response since 2017.

Ms Baggio took the discussion out of health facilities and into communities. She underscored that there were hard lessons from the Ebola crisis that could and should be taken into consideration when working in other epidemics, including COVID-19. The IFRC and the Red Cross Society of the Democratic Republic of the Congo were normally engaged in safe and dignified burials, which formed a key part of tackling the epidemic; in Guinea, 60% of infections were related to unsafe burials; in Sierra Leone, it was 80%.

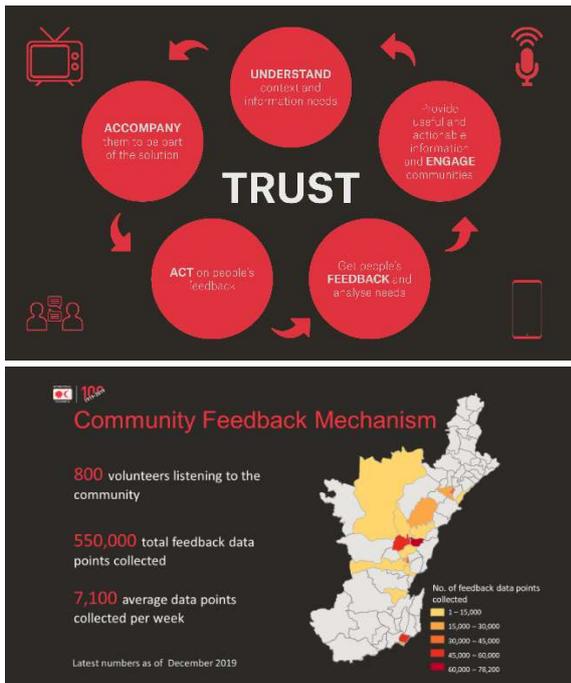
She said that trust in government and humanitarian responders was not as strong initially. The outbreak response started in August 2018, and by September and October the number of attacks against humanitarian workers and health-care personnel was increasing, until February 2019 when a serious attack took place at an Ebola Treatment Centre run by MSF in Butembo.

The teams had the best possible bio-medical capacity to respond to the outbreak in the DRC in terms of national and international staff, the availability of treatments and vaccines, much better than was available in the response in West Africa. At the same time, misinformation and mistrust of outsiders reinforced conspiracy theories about the origin of the disease. It was believed that outsiders fabricated the outbreak to make money. This led to the community not following prevention guidance and services, the underutilization of facilities and attacks against medical personnel.

Ms Baggio then said that trust and community volunteers were at the core of the response. The experience in the DRC illustrated that it was essential to spend time with local health-care providers, to listen to the community and understand the information needs and the internal power dynamics in a community. In the DRC, this was complicated by the numerous weapon bearers and by gender relations, which were key to having an accurate understanding and being able to dialogue. Listening to communities and acting upon dialogue was the most important part of the response. Changing the way services were delivered to align them with community needs was essential, and this also had to be the case when coping with an epidemic. Humanitarians had to co-create with communities, as listening to the community was not enough – the community had to be in the driver's seat.

In an epidemic, emotions drove perceptions, and those could be very different from reality. Perceptions were not always mutually understood, as they were driving actions that at times could become violent. This was one of the most elaborate and sophisticated feedback mechanisms. We had around 800 volunteers carrying out household visits. These volunteers were doing live monitoring of community feedback and feelings with over 7,000 data points per week on average. This provided an understanding of the narrative of the community and its evolution over time. There was a total disconnect between the Red Cross narrative (the response staff) and the community narrative, not because of a lack of understanding but a lack of trust and the negative perception of medical staff and facilities.

The community wrongly thought that people were being killed upon arrival at the treatment centres. In fact, people were arriving very late at facilities often at the point of death, exacerbating the perception problem. There was an incorrect perception that the safe and dignified burials were being used to harvest organs and that the health protocols put in place were there to hide what was actually



going on. These strongly divergent views put lives at risk and led to violence against health responders. The findings from October 2018 highlighted this problem with community perception.

Steps were taken to address these perceptions by changing the protocols around burials. Families were invited to be present for parts of the burial process and videos shown to better address concerns.

Transparent body bags were used so the family could see the body and have confidence in the process. This

COMMUNITY ENGAGEMENT GOES WAY BEYOND SPREADING MESSAGES OR DOING POSTERS AND T-SHIRTS. IT'S CO-CREATION AND SHARING A DIALOGUE WITH THE COMMUNITY.

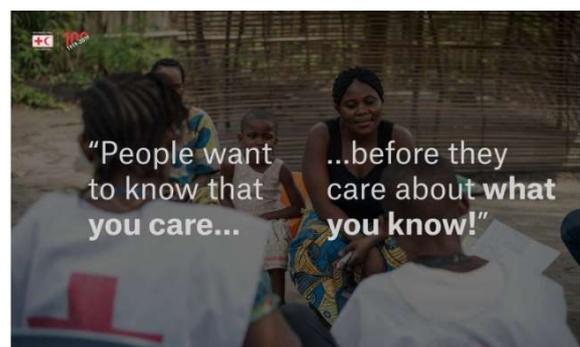
Ms Ombretta Baggio

facilitated a major shift in perceptions so that the Red Cross was more frequently called upon following a death to carry out burials. It was important to be accessible and listened to, that people had a way to reach those responding and concerns and suggestions were followed up.

In conclusion, there were five lessons. First, it was the actions of the community that would bring an end to an outbreak and protect their loved ones. Community acceptance was necessary for success, as it was with safe and dignified burials. Second, communities had to be treated as partners and owners of the response. This meant letting go of power and control. In this instance, taxi drivers were initially blamed for spreading the disease and then they became champions of preventative action. Community engagement went way beyond spreading messages or doing posters and T-shirts; it was the work of co-creation and dialogue with the community.

The third lesson was around acting and understanding what people were saying, thinking and perceiving at any given time. It was about understanding belief systems and doing something with that understanding. Fourth was trust, two-way trust. By trusting those involved in the response the community would adhere to health advice, but those responding had to do the same and find workable compromises. Local and agile was essential. COVID-19 was multiple epidemics at the same time, so organizations had to support and invest in local actors constantly as communities fought the epidemic and not use static messaging.

Finally, the community should not be placed only in the centre, but in the driver's seat. With that Dr Balde thanked Ms Baggio for the excellent presentation, which highlighted the importance of trust, feedback and adaptation. Dr Balde then presented Ms Valentine Honoré, who was an ICRC protection coordinator and the Health Care in Danger focal point in the DRC.



Ms Honoré opened the discussion by highlighting the history of violence against health-care personnel in the DRC, which has grown with the COVID-19 pandemic. She highlighted the importance of freedom of movement for medical personnel and patients and the life-saving nature of medical evacuations through a recent dramatic real-life account.

WE FEAR THE STIGMATIZATION OF HEALTH-CARE WORKERS, THEM BEING SEEN AS BEING INVOLVED IN “COVID BUSINESS”.

Ms Valentine Honoré

Ms Honoré outlined three patterns of violence against health care. First, the violence carried out by individuals, second the collective violence and third violence carried out by armed actors. More in detail, she noted the history of attacks against health care was linked to restrictions of free movement. Patients suspected of COVID-19 and medical personnel believed to have been treating patients had been subject to discrimination and stigmatization. The ICRC feared stigmatization of health-care workers, with them being seen as being involved in “COVID business”. The announcement of deaths by medical personnel could result in violence. Facilities had also been attacked, such as a quarantine centre recently. The use of force against those

not wearing masks had been recorded.

Ms Honoré noted a repetition of similar trends seen under Ebola three months into the COVID-19 pandemic. Saying that these points had been covered by the two other presenters, she focused on learning lessons from recent experiences that had had dramatic consequences, including on staff safety and security.

First, the absence of clear information and communication was a major concern. There had been a plague of rumours, particularly around dead body management. The late referrals of suspected Ebola cases reinforced the impression of Ebola treatment centres as dying places. The deficit in community engagement engendered hostility and was perceived as an external imposition. The exclusive treatment of Ebola exacerbated the trust crisis.

Ebola accelerated and exacerbated the negative perception of health-care providers. The community prioritized sexual violence, malnutrition, cholera and measles while external actors did not. Approximately 6,300 deaths were caused by measles while Ebola accounted for 2,000 during this period, for example. The use of armed escorts for health personnel fed negative perceptions and reinforced the view that this was a business.

The same kind of rumours were rife in the COVID-19 pandemic and the perception that it was fabricated by outsiders for economic and political motives. Reflecting on the experience and thinking about how to improve the COVID-19 response, Ms Honoré presented six messages on responding to COVID-19 in the DRC.

First, fight stigmatization and conceive the response with community at the centre. In particular, take time to explain the importance of quarantine measures. Participatory methods were key in this regard. Second, guarantee non-discriminatory access to health care as provided for by law – including in remote areas and areas affected by violence. Third, protect health-care staff and preserve the medical response for other needs. Issues that the local population saw as priority had to be central. Fourth, find the right balance between protecting health workers and using force, avoiding armed escorts where possible. Fifth, protect actors involved in dead body management and ensure the dignified treatment of the dead. Training and support should be provided. Finally, protect the personal data of



patients and obtain the contact information of family members of patients who were admitted to keep them updated, which was not always done.

The ICRC was sharing such information with actors in the DRC that week in the form of an advocacy note to support the response to the unprecedented situation. It would alert actors to the risk of violence and urge them to protect medical personnel, vehicles and facilities. With this, Dr Balde thanked Ms Honoré for the presentation, noting the continuity in messaging from all three presenters.

The Q&A started with a question on how to put community at the centre of the work. Dr Balde noted that colleagues in their comments had pointed at how in the Sahel these issues were affecting the response, with many armed attacks occurring against health-care facilities. He also noted that there were several initiatives by the large actors working in this field to protect the delivery of health care and asked how to gain the community's trust and build preparedness in the current circumstances.

Mr Ambele first thanked the three presenters before noting the challenge of how to deploy teams when there was an epidemic – there tended to be limited access and a treatment-centre focus. How should teams be deployed and areas accessed so one could get beyond focusing overwhelmingly on treatment and consider the community's needs more fully? A second question came from the ICRC's deputy director of operations, Ms Mary Werntz. She noted the points on letting go of power and control, co-creation, two-way trust, no more static messaging, being obsessed about being accessible as opposed to gaining access, before asking how to accelerate this culture shift in the humanitarian sector. Then Mr Maciej Polkowski, head of the ICRC's Health Care in Danger initiative, noted that actors with global reach and audiences were increasingly fomenting stigma, distrust and violence and asked whether a global response was required as a complement to the local one. Finally, a question was asked to elaborate on tools used to gather feedback.

Ms Baggio took the floor in response and said that technology was not the solution for getting feedback. The technology needed was volunteers with pen and paper and then compiling this data on Excel. Coaching local staff to code data was also done so that this work could be done locally. Kobo could be used as a mobile solution. A cultural shift was the biggest requirement – listening and co-creating. Without it humanitarians became irrelevant. Perception surveys by Ground Truth Solutions found that 75% of people in ten countries thought aid did not match their perception of their needs. In the DRC a participatory planning process was being implemented with the community. Humanitarians needed to be ready to relinquish decision-making power and to do what the community decided. Humanitarians needed to be agile.

COVID-19 was global, but COVID-19 was also local. COVID-19 was a multiplicity of epidemics occurring at different paces. There was an effort to tackle disinformation and rumours together and a desire to unify messaging. Ms White complimented the response and tackled the need to be truly transparent about what was taking place. Humanitarians often imagined the community did not understand what was being said, while the community understood very well. Humanitarians talked about “our” access, but the question should be inverted – did the communities have access to the humanitarians? Were humanitarians open enough to enable that? Clinical care was the end point. It would never stop an outbreak itself. With this, Dr Balde emphasized that the time to prepare a response was before an emergency took place.

TECHNOLOGY IS NOT THE SOLUTION FOR GETTING FEEDBACK.

Ms Ombretta Baggio

Ms Honoré responded to the issue of access and said that a few years ago Geneva Call worked a lot with communities in North Kivu and published a report whose key finding was that actors had to be involved in NIIHA (Neutral Impartial Independent Humanitarian Action).⁴

Finally, Mr Enawaru made a comment on the importance of shifting from a needs-based to a rights-based approach which would make external actors more accountable. Dr Balde said that community should also be understood in a differentiated sense, with different needs and capacities. Dr Balde asked how to move beyond a siloed or pillared approach, including seeing community engagement as a pillar when tackling issues at the ground level before thanking all those present.

⁴ https://www.genevacall.org/wp-content/uploads/2019/05/WHS_Report_2016_web.pdf

Building Coalitions and Mobilizing for Change: Experiences in Working Together to Enhance Respect for Health Care

Chair: Ms Thembeke Gwagwa, Second Vice-President, International Council of Nurses

Speakers: Prof. Dr Benjamin Uzochukwu, Chairman, Association of Public Health Practitioners of Nigeria

Mr Kadio Harouna, Legal Adviser, Ministry of Health, Burkina Faso

Prof. Dr Laurel Baldwin-Ragaven, Professor of Family Medicine, University of the Witwatersrand

The aim of this session was to present successful experiences of partnerships that jointly mobilized stakeholders to develop local measures to protect health care. Contributions from Nigeria, Burkina Faso and South Africa were shared to exemplify sets of interventions in very distinct domains, where the key was the connection established between actors gathering around a common goal and working together to reduce violence against health care.

The session was moderated by Ms Thembeke Gwagwa, second vice-president and African representative on the board of the International Council of Nurses, an institution that is a longstanding partner of the ICRC's Health Care in Danger initiative and which has lived up to the model of joining hands to establish a high-level agenda for the protection of health workers.

The first speaker, Dr Benjamin Uzochukwu, began his presentation by saying how the Association of Public Health Practitioners of Nigeria (APHPN) was approached by the ICRC to discuss violence and attacks against health care. To train the members of APHPN and raise awareness on this specific agenda, a joint training session was carried out, gathering members from all regions of the country.

After this initial step, a series of round-table discussions – gathering not only APHPN but also members of the Ministry of Health and other stakeholders – were held, and the group came up with a proposal to develop a minimum curriculum to be inserted into medical education in Nigeria. By doing so they provoked a reflection on the issues of protection of health care already in the study years of physicians. This curriculum had already been reviewed by the group and was going to be forwarded to the authorities for approval and implementation. In addition, a technical working group was formally established to encourage and steer discussions on the topic, and to promote a research agenda for the protection of health care.

Ms Gwagwa then introduced the second speaker, Prof. Laurel Baldwin-Ragaven, who was a professor of family medicine at the University of the Witwatersrand and had been working in this field

WE INTEND TO BUILD AND INSITUTIONALIZE A CURRICULUM IN MEDICAL SCHOOLS THROUGH THE MEMBERS OF APHPN WHO ARE TEACHING ETHICS IN DIFFERENT UNIVERSITIES.

Dr Benjamin Uzochukwu

for over 25 years. Prof. Baldwin-Ragaven presented a comprehensive analysis of the development of a network for the protection of health care by enhancing security forces' respect for health-care providers.

To do so, she gave a recent history of South Africa, covering the Soweto Uprising, the inquest into the killing of Steve Biko, the Truth and Reconciliation Commission and recent violence against miners and foreigners. She presented historical events in which medical neutrality was called into question and access to health care delayed or blocked to illustrate the overlapping issue of respect for human rights and the ethical provision of health care. In 2012, amid xenophobic attacks, two initiatives were launched to combat this: Student Advocates for Health and the Pfulandela Pledge, recognizing a need for transformation given the legacy of apartheid.

Prof. Baldwin-Ragaven next focused on 2016, when a number of violent protests took place on University Campuses across South Africa during the "Fees Must Fall" campaign, which called for systemic changes to the university system. She said that ethical behaviour was crucial for the provision of health care, and it should be connected to discussions of human rights.

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DOMAIN.**

Prof. Laurel Baldwin-Ragaven

conversations and focusing on common ground and a specific product and output that a document on human rights and medical neutrality was generated. The guidelines were accepted and adopted by the authorities, and they are in the process of being incorporated into national police directives. She closed by speaking of the transformation that this experience had had on the students and everyone involved; out of the trauma of this formative moment came incredible resilience.

Ms Gwagwa recognized the many powerful messages in Prof. Baldwin-Ragaven's presentation, including the challenge to health professionals to uphold their ethical obligations in practice when subjected to political pressures. She then opened the floor to Mr Kadio Harouna who was a legal

During this period, a number of protests were met by the police with force, and several protesters (mainly students) had severe trauma, were struck by rubber bullets, lost their eyesight and suffered injuries due to the inhalation of gas. The universities and other facilities, including the one where Prof. Baldwin-Ragaven worked, organized first aid and health care for the injured, and were then also attacked. Prof. Baldwin-Ragaven presented documentation with pictures to illustrate the situation.

In a powerful example of mobilization for change and for protection of health care, the Nelson Mandela Foundation, began mediating between multiple parties engaged in the protests and the authorities to establish a common ground of respect and dialogue. One of the working groups that was established was tasked with developing the Guidelines for the Provision of Health-Care Services on University Campuses during Protest, to ensure the need for respect by the police forces and the neutrality of the health-care providers. This group was composed of the police, university teachers, the Nelson Mandela Foundation, MSF, the ICRC, representatives of Student Advocates for Health and students. The dialogue was not always easy, and the group had to develop trust among its members to come to a position where they could find a constructive path forward. It was by avoiding certain

adviser from the Ministry of Health in Burkina Faso and a technical adviser and expert in human rights and health.

Mr Harouna presented the experience of the Ministry of Health in Burkina Faso alongside the ICRC and the health services from the military forces, working to develop a joint agenda on the protection of health care and reaching out to local health authorities in areas affected by conflict and violence.

Avantages du travail en partenariat

- Le soutien dans la mobilisation des acteurs invités en particulier les médecins chefs des districts sanitaires ciblés
- La qualité de la représentativité du côté des autorités sanitaires qui témoigne de l'intérêt accordé à la thématique
- Dans le fond : le fait que les districts sanitaires situés dans les zones touchées par les violences étant là avec le feu vert de leurs responsables se sont sentis plus à l'aise de partager leurs vécus, leurs difficultés et proposer des recommandations
- La formulation de recommandations pertinentes pour une meilleure protection de la mission médicale

Since 2014, the crisis in Burkina Faso had escalated and public goods, including medical services, had not been spared. The escalation accelerated in 2019 with the closure of more than 100 health centres across the country. The ICRC had been following the issue since 2018 and organized a series of discussions, including a round table with civilian and health authorities in 2019, to take

WE WANT TO MAKE SURE THESE RECOMMENDATIONS DON'T END UP ON A SHELF

Mr Kadio Harouna

stock of legislation related to the protection of health care, including the challengers and the measures taken so far. These included the elaboration of a health code, steps taken at the legislative level and the drafting of recommendations with civilian and military health authorities in the country.

Mr Harouna stressed that it was through the exchanges between key actors that concrete recommendations were developed, and it was through trust-building efforts (between the central and local authorities) that an open channel to address the real challenges was created. He pointed out that this communication allowed other challenges to be addressed, including collecting and protecting health-care data and exchanges and dialogue between the authorities and health-care providers in high-risk areas.

The group was currently working on the development of domestic legislation to strengthen the protection of health care, as well as the integration of the issue into medical education. The partnership built around protection of health-care concerns had proved fruitful recently as a platform for dialogue around pandemic-related issues.

The Q&A part of the session was very dynamic. The question of designing curricula for medical students was addressed by Dr Uzochukwu, who explained the different modules of the Nigerian proposal, which were intended to present not only the reality of violence against health care, but also the rights and responsibilities of medical staff, the legal framework on protection and other relevant topics.

Prof. Baldwin-Ragaven made it clear that she was not challenging medical neutrality in a legal sense, but was presenting a perspective that health-care provision in practice might not be carried out impartially, as it was carried out by human beings and there was, therefore, a constant tension regarding respect for human rights. The process was also gendered, as is evidenced in the current pandemic. She spoke about a new PhD under her orientation regarding the overlap between violence against health workers and gender-based violence, to investigate whether women were being targeted more.

Mr Harouna spoke about a law on the emblem being developed to be incorporated into domestic legislation in Burkina Faso. They were also working on a public health code, with a provision on the neutrality of health care, to be applied in times of conflict. He reinforced the point that those documents were only valid if implemented, and therefore a greater effort needed to be focused on implementation mechanisms in partnership with the different actors involved in the process.

In closing, Dr Uzochukwu signalled the need for further research on this issue and Prof. Baldwin-Ragaven emphasized the need for significant measures to be taken to ensure the principle of medical neutrality be upheld. Mr Harouna noted that many of the initiatives had not been well known and that forums like this meeting were extremely useful.

**AS LONG AS SOCIETY
DOES NOT RESPECT
WOMEN’S RIGHTS, THAT
WILL BE PICKED UP IN THE
HEALTH-CARE SERVICES
AS THE MAJORITY OF
WORKERS ARE WOMEN**

Ms Thembeke Gwagwa

Mitigating the Impact of Violence Against Health Care: Preventative Tools for Health Care and Facilities

Chair: Dr Mohammed El Sahili, International Hospital Federation, Zambia

Speakers: Ms Delphine Marcé, Protection Coordinator, CAR Delegation, ICRC

Dr Anthony Garang, Ministry of Health/Chairman of Doctor's Union in South Sudan

Mr Abdulkadir Ibrahim "Afi" Haji, Director of Organizational Development and Communication, Somali Red Crescent Society

Mr Issack Gerad, Senior Protection Field Officer, Somalia Delegation, ICRC

The fourth and last session was chaired by Dr Mohammed El Sahili, a member of the International Hospital Federation in Zambia, who kindly stepped into the role to moderate the discussion and represent the international organization with whom the ICRC has worked since the beginning of the Health Care in Danger initiative.

The first presentation was delivered by Dr Anthony Garang, the chairman of the Doctor's Union in South Sudan, who opened by pointing out that the COVID-19 pandemic had brought new relevance to the issue of violence against health care, given that the South Sudanese Doctor's Union had witnessed problems of harassment and violence related to the disease. He said that the union had been helping to identify members to be able to still circulate after curfew and provide care. He explained that the ethical provision of health care was already enshrined in national legislation, but explained the reality on the ground in South Sudan and the challenges they had with weapon bearers (military and civilian). This explained the need for a "no-weapon policy" to foster a respectful and safe working environment within health-care facilities.

No-weapon Policy

- **Weapon:** all things designed or used for inflicting bodily harm or physical damage. These include, but are not limited to, firearms, knives, swords, bludgeons, spears and sticks.
- Policy developed in July 2019 by the SSD Ministry of Health, Red Cross and other stakeholders
- Protects healthcare providers and patients from harassment, threats and violence
- Prohibits entry of those bearing weapons into health facilities
- Helps avoid violent escalations within healthcare facilities
- Ensure recovery of those wounded or sick during conflicts
- Ensure provision of medical care in a safe environment.

THERE'S A LOT OF GUNS CIRCULATING, ALSO IN THE HANDS OF CIVILIANS, AND THAT IS A THREAT TO THE LIFE OF PATIENTS, OF THE HEALTH-CARE PERSONNEL, AND OF THE PUBLIC.

Dr Anthony Garang

This policy, that was almost finalized, would serve as a guide to health-care facilities that wanted to address the issue of weapons, as they were a very common cause of security incidents in these facilities. Other incidents in facilities included the harassment of health workers, looting and the deliberate obstruction or delay to the provision of health care due to the conduct of weapon bearers or the existence of checkpoints. Dr Garang explained the terms present in the policy, which in a very comprehensive way covered the right to access to health care, presenting concrete measures that could be adopted by facilities to counter the entry of armed actors into facilities. The measures ranged from community-awareness campaigns to the training of health-care staff and guards working at facilities, from displaying clear signs to reporting incidents.

The next steps for the policy will be approval by the highest ranks in the government and the implementation of the text in practice throughout the country.



NO WEAPONS ALLOWED

The two presenters from Somalia opened their presentation with an overview of the current situation of violence and conflict in the country, providing examples of the many types of attacks against health care that were carried out. Mr Haji presented the strategies the Somali Red Crescent Society followed to prevent violence against its personnel and health centres and to mitigate the risks. He mentioned the training of staff in analysing the security environment, engaging with the community and reporting security incidents. The Somali Red Crescent Society is clearly identified with the appropriate use of the emblem and had shared the coordinates of the locations of all health centres with the parties to the conflict. In some more dangerous situations, they chose, after careful deliberation, to have armed escorts for certain operations to deter looting and kidnapping.

PEOPLE DON'T WEAR MASKS. WE HAVE NOTICED THAT PEOPLE WHO WEAR MASKS IN THE LOCAL MARKETS ARE SUSPECTED OF HAVING COVID-19.

Mr Abdulkadir Afi

checkpoints prevented health workers from moving freely to and from the workplace. Moreover, the external perimeter of the hospital was very much exposed, and there were no proper protocols for controlling entry and exit points.

Objectives of the Survey:

The main objective of the survey was to better understand the issues to which the health staff and the patients could be confronted to, looking more precisely at the following aspects:

- A) The safety of the hospital – **real or perceived**;
- B) The **frequency** and the type of **weapons** brought into the hospital and how to possibly **mitigate** the related **risks**;
- C) The **access** to the health facility for **both** the health staff and patients;
- D) The **interference/obstruction** of the provision of healthcare services.

Mr Issack Gerad presented the ICRC's experience assessing the security and safety of a hospital in Somalia, through a survey that was carried out and answered by more than 100 local health workers and other individuals working in the hospital between October 2018 and August 2019. They investigated safety of access, security within the hospital setting and the control of entry and exit points. In terms of access, it was noted that

Using the findings of the survey, a plan of action to enhance security at the hospital was developed and discussed with local authorities. Implementation of the measures, including communication measures to strengthen respect for them and the no-weapons policy inside health care facilities, was ongoing. Finally, raising awareness of the ethical principle behind the impartial provision of health

care increased the community’s understanding (and indirectly, that of weapon bearers) of the importance of respecting clinical needs in prioritizing care.

Ms Delphine Marcé delivered the final presentation on lessons learned in the Central African Republic, where there were recurring armed entries into an ICRC-supported hospital in the north of the country. The armed entries were not only related to the presence of armed groups in the area, but also to patients and family members carrying knives and machetes. The problem was that at times relatives of patients were

THE MEASURES RESULTED IN AN OBSERVABLE REDUCTION IN ARMED ENTRIES AT THE HOSPITAL FOLLOWING ITS IMPLEMENTATION.

Ms Delphine Marcé



frustrated with the treatment offered, and in some cases patients themselves harassed staff for priority treatment.

There were discussions with the commanding officers of the United Nations Peacekeeping Mission forces to increase their presence and their control at the entrance to the hospital. As a result, they set up a checkpoint at the entrance and exit, with a corridor structure made of sandbags. These measures lead to an observable reduction in armed entries at the hospital during the year following its implementation, resulting in a safer environment for staff and patients.

During the Q&A, a question was put to Dr Garang on the difficulties of changing weapon bearers’ behaviour and in making security forces and guards in the health-care facility understand that they had to respect the facility. He said that this was indeed a great challenge and that it took time and a lot of dialogue with communities and weapon bearers.

The Somali presenters explained that the highly volatile and risky environment called for context-specific measures coupled with enhancing networking and dialogue with weapon bearers so they could understand protection and respect for the delivery of health care.

A question about the application of no-weapon policies in other countries that were affected by similar

problems was answered by different speakers, who explained that this type of policy was very important, but its implementation took time and efforts from all the actors engaged in health-care provision, as well as the authorities and security forces. It was nevertheless noted that such a policy should not simply be copied but adapted to each context and developed according to local needs. Also,

the reporting of security incidents and the issue of where weapon bearers (such as police officers or soldiers) could actually wait and/or leave their guns in the health-care facility should be planned for.

Finally, the speakers touched on the importance of dialoguing with the community to ensure acceptance, as well as with the weapon bearers present. In this sense, direct dialogue and indirect messaging – via radio, WhatsApp groups or public campaigns – might be very helpful.