THE HEALTH CARE IN DANGER INITIATIVE

Eurasia Regional Meeting

3–4 February 2021

TABLE OF CONTENTS

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.

ICRC

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

THE HEALTH CARE IN DANGER INITIATIVE

Violence against patients, health-care workers, facilities and vehicles has long been a preoccupation of the International Committee of the Red Cross (ICRC). Protecting the medical mission and affording special protections to medical personnel is rooted in the very origins of the International Red Cross and Red Crescent Movement. Over the past 10 years, the ICRC and the Movement have placed special emphasis on protecting patients, health-care workers and their vehicles and facilities, and on ensuring safe access, through the Health Care in Danger (HCiD) initiative.

The formal establishment of the Health Care in Danger initiative took place at the 31st International Conference in 2011 when the Health Care in Danger Resolution was passed. Advocacy by the ICRC and its partners has led to significant mobilization around protecting health care, resulting in several resolutions at the World Health Assembly and 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 has rallied partners inside the International Red Cross and Red Crescent Movement while convening global experts including through communities of concern to implement practical measures to protect health care from violence and to mitigate its effects.

HEALTH CARE IN DANGER – THEORY OF CHANGE

THE HEALTH CARE IN DANGER STRATEGY

The **Health Care in Danger Strategy 2020–2022** is built around a theory of change (ToC) with four objectives. These are:

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 current strategy emphasizes the practical implementation and operationalization of concrete measures at the local and national levels. 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 to develop and reinforce local and national partnerships to prevent and address violence against health care. The partnership with the community of concern is a central pillar of advancing this common agenda.

Regional meetings took place in 2019 for the Asia-Pacific Region in Manila, and the Near and Middle East (NAME) Region in Beirut. Participants appreciated the opportunity to share similar or comparable experiences, dynamics and cultural issues with stakeholders from neighbouring countries.

In June 2020, the Africa Regional Meeting was held online due to COVID-19-related restrictions. It consisted of a more condensed two-day webinar format to adapt to the current circumstances. A similar approach was taken for the Eurasia Regional Meeting held on 3–4 February 2021 with a further co-organization innovation.

MEETING OBJECTIVES

1. **Facilitating the sharing of experiences and ongoing good practices and recommendations through presentations and interactions**

2. **Mobilizing actors working in Eurasia around the protection of health care in terms of practical action, research and resource mobilization**

3. **Making geographical linkages and strengthening partnerships by creating a forum on the protection of health care**

4. **Raising the profile of, and generating new interest in, the protection of health care as a critical field of work and a shared concern**

RED CROSS AND RED CRESCENT MOVEMENT CO-ORGANIZATION OF THIS MEETING

This meeting was co-organized with five national societies from the region, namely, the Belgian Red Cross, the German Red Cross, the Italian Red Cross, the Red Crescent Society of Kyrgyzstan and the Norwegian Red Cross.

We welcome such partnerships and hope that this will enhance the impact of the International Red Cross and Red Crescent Movement in this critical area of work.

We would like to take a moment to thank them for their partnership and contribution to our shared success.

QUOTES FROM RED CROSS AND RED CRESCENT MOVEMENT LEADERSHIP

From the opening remarks of Francesco Rocca, President, **International Federation of Red Cross and Red Crescent Societies and National President, Italian Red Cross Association**:

"To beat this pandemic, we also have to defeat the parallel pandemic of distrust."

"As President of the International Federation of Red Cross and Red Crescent Societies I deeply feel the responsibility to protect our volunteers and staff and I hereby reiterate my commitment to work together with the colleagues of the ICRC to advocate with high-level decision makers so that no further victims must be pitied."

From the opening remarks of Gilles Carbonnier, Vice-President, **International Committee of the Red Cross (ICRC)**:

"All those present can take our presence as a clear sign of our continued collective resolve in the International Red Cross and Red Crescent Movement to protect health care."

From the closing remarks of Bernt Apeland, Secretary-General, **Norwegian Red Cross**:

"We have moved from talking about the issue to tackling the issue. Yet much remains to be done."

"Health care is not something that only happens somewhere else and the protection of health care starts at home. It starts in peacetime. It starts with all of us."

From the closing remarks of Denise Duran, Deputy Regional Director for Eurasia, **ICRC**:

"We continue to work in partnership with all interested stakeholders so that political commitments and legal commitments do get fulfilled and translated into concrete action."

"We will do everything we can to accompany you in your communities to reinforce the resilience of health-care workers."

"We are on our way to forging a movement with integrity and a body of experience and actors that are leading by example, leading by doing, and we encourage that to continue."

ICRC

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

SUPPORTING THE PROTECTION OF HEALTH CARE THROUGH INTERNATIONAL HUMANITARIAN LAW IMPLEMENTATION: MILITARY DOCTRINE, PRACTICE & DOMESTIC LEGAL FRAMEWORKS

_____

Moderator	**Mr Frédéric Casier,** Legal Adviser in International Humanitarian Law (IHL) & Relations with the Movement, Belgian Red Cross

_____

Theme	**THE ROLE OF HUMANITARIAN ENGAGEMENT WITH ARMED ACTORS IN SAFEGUARDING HEALTH CARE & VACCINES**
Panellist	**Ms Marie Lequin,** Eurasia Regional Director, Geneva Call

_____

Theme	**AN EXAMINATION OF MEASURES CARRIED OUT TO INCORPORATE THE PROTECTION OF CIVILIANS INTO DOCTRINE & PRACTICE**
Panellist	**Ms Marianna Tonutti,** Governance Adviser – J9 Division, CIMIC Liaison Branch/Supreme Headquarters Allied Powers Europe, NATO

_____

Theme	**PROTECTING HEALTH CARE: THE ROLE OF STATE ARMED FORCES IN ARMED CONFLICT**
Panellist	**Mr Jan Tijmen Ninck Blok,** Legal Adviser in IHL, Netherlands Red Cross & author of Study on the Protection of Health Care by State Armed Forces

ICRC

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

Mr Frédéric Casier opened noting that effective respect for, and protection of, health care and the wounded and sick in armed conflict constitute the core of IHL and cannot be achieved without taking implementation measures in peacetime to ensure the full respect for the law. Besides IHL, international human rights law (IHRL) also affords protections related to health care, notably the protection from the arbitrary deprivation of life, the protection of human dignity and the right to health.

Protections offered by IHL and IHRL can be divided in four main areas. These are the protection of the wounded and sick and health-care personnel, facilities and vehicles; medical ethics and confidentiality; the use of distinctive emblems including those of the Red Cross and Red Crescent Movement; and sanctions in case of violations of international law perpetrated against health-care personnel.

Considering international obligations, implementation covers a broad range of measures including national legislation, which can contribute to the regulation of the use of emblems and covers sanctions for crimes perpetrated against health-care personnel or patients. National measures also include military doctrine and instructions, and the dissemination of international law.

The current session will seek to examine the specific areas where states and militaries can reinforce the protection of health care through training, policy measures and military instructions. It will also provide examples from the region of how organizations are reinforcing the protection of health care in operational settings and where other organizations can contribute.

Ms Lequin took the floor and first defined humanitarian engagement as the sustained and constructive process of interaction with armed actors, state and non-state, for humanitarian purposes only – there is no political discussion or discussion related to the peace process or the reasons why armed actors are involved in conflict. It can take a number of forms ranging from advocacy, negotiations and legal advice, to policy development and integration of policy into doctrine and concrete practice.

> THE LOCAL POPULATION LIVING IN CONTESTED OR NON-GOVERNMENT-CONTROLLED AREAS HAVE THE SAME RIGHTS TO MEDICAL CARE AS THOSE LIVING IN GOVERNMENT-CONTROLLED AREAS. THEY HAVE NOT CHOSEN TO BE AT WAR AND HAVE NOT CHOSEN WHO THE CONTROLLING FORCE IS
>
> *Ms Marie Lequin*

ICRC

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

Non-state armed actors take many forms and play a role in protecting civilians and health care. Irrespective of the type of actor, however, the key element is protecting and respecting civilians and medical care.

IHL is a state-centric process, where states are negotiating, signing and ratifying treaties. This leads non-state actors at times to believe they are not included and not obliged to respect the rules. Through humanitarian engagement, non-state actors are likely to take steps to reinforce respect for IHL, including on the protection of medical care. These steps can give these actors greater legitimacy when the time comes to position themselves during peace negotiations. Many non-state actors are driven by political motivations more than economic motivations, and many of them have a wish and desire for dignity and to respect civilians and infrastructure. This engagement taps into this motivation. Humanitarian engagement can also contribute to more fluid aid delivery in areas outside of government control and reinforce protections for the wounded in times of armed conflict.
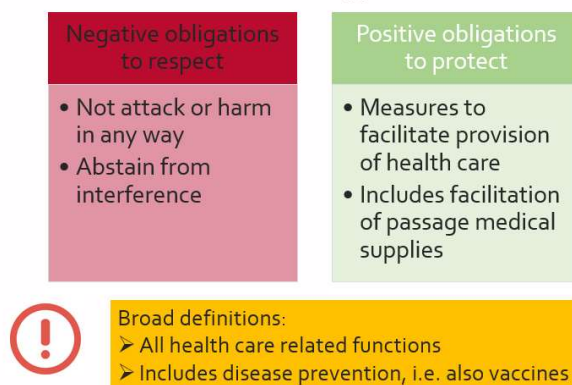
The protection of health care is one of several areas of thematic focus for Geneva Call. The discussion will now take the example of Ukraine and explore the question of whether the situation in Ukraine constitutes a complex emergency.

In the context of the pandemic there have been repeated attacks on medical care and damage to medical facilities. There is a lack of medical resources and some organizations have reported a heavy administrative burden and control on cargo. There are also controls on population movement related to the conflict and COVID-19. This has an impact on the provision of health care and leads to a deprivation of essential health-care services.

These factors are exacerbated in the current context, given, for example, a recent outbreak of diseases including measles and the fact that the lack of health care weakens the ability to carry out early detection. Engaging the armed groups in this context and promoting respect for IHL contributes to the resolution of this complex emergency. Promoting respect for IHL will not solve the problem by itself but it is one way to contribute to health objectives.

IHL obligations to respect and protect health care: facilities, personnel, vehicles and supplies

Negative obligations to respect	Positive obligations to protect
• Not attack or harm in any way • Abstain from interference	• Measures to facilitate provision of health care • Includes facilitation of passage medical supplies

(!) Broad definitions:
➤ All health care related functions
➤ Includes disease prevention, i.e. also vaccines

genevacall.org

When Geneva Call engages with fighting parties on IHL, including the rules on the protection of medical care, it engages on the negative obligations aiming to respect health care – don't attack, don't harm in any way, abstain from interference, don't harm staff. Geneva Call also works on the positive obligations and measures that armed entities can take to protect. What are the measures that can be taken to facilitate the protection of health care? How can they facilitate the provision of health care and the passage of medical supplies? This two-fold engagement on the negative and positive enhances ownership of the norms. The local population living in contested or non-government-controlled areas have the same rights to medical care as those living in government-controlled areas. They have not chosen to be at war and have not chosen who the controlling force is. Engagement with non-state actors is required to remind them of their obligations and does not confer legitimacy.

Who should give consent in non-government-controlled areas for impartial organizations to deliver assistance in those areas where the state cannot provide for basic needs, including medical needs? In armed conflict, under Article 3 common to the Geneva Conventions, people should live in dignity. This includes being provided access to medical care. Ms Lequin made the argument that when consent is not provided for such medical care, the only justification for denial can be around security. This justification should not be abused, however, as has been done in this region, since the lack of consent can render the civilian population more vulnerable.[1]

---

[1] There is no consensus IHL interpretation on questions like whose consent has to be sought for an offer of humanitarian activities by impartial humanitarian organizations, what amounts to an unlawful denial of consent, and the consequences of such denial. For the ICRC position on these issues, see for example, ICRC, Q&A and Lexicon on humanitarian access, 2014, https://www.icrc.org/en/doc/resources/documents/article/other/humanitarian-access-icrc-q-and-a-lexicon.htm

ICRC

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

THIS INCLUDES PAYING ATTENTION TO THE SECOND- AND THIRD-ORDER EFFECTS STEMMING FROM THE TARGETING OF A LEGITIMATE TARGET THAT COULD HAVE LONGER-TERM CONSEQUENCES. FOR EXAMPLE, A DAMAGED POWER LINE SERVING A MEDICAL FACILITY COULD HAVE REVERBERATING EFFECTS ON THE HOSPITALIZED PATIENTS

Ms Marianna Tonutti

Ms Tonutti next took the floor and opened her presentation with reference to the NATO Warsaw Summit of 2016, where, in recognition of the highest toll paid by civilians during armed conflict, NATO and heads of state and government adopted the NATO policy for the PoC. The policy is a capstone document that aims at creating a coherent, consistent and integrated approach to the PoC during NATO operations and missions.

The PoC refers to persons, objects and services, and includes all actions required to avoid, minimize and mitigate adverse effects that could arise from NATO operations and missions. The protection of medical workers and facilities is included in this definition. To implement the policy and make this the *modus operandi* of the Alliance, an action plan was created in February 2017 aimed at facilitating the integration of civilian protection into the planning and conduct of operations. In 2018, the North Atlantic Council (NAC) also approved the Concept for PoC, which translates the policy into a PoC framework.

The framework is composed of four independent but interrelated thematic lenses, all of which are linked with the protection of medical missions and medical personnel but from different angles. The first element or lens is "Understanding of the Human Environment" (UHE), which focuses on the need for a comprehensive and continuous assessment process that aims to generate awareness across all domains. The Mitigate Harm (MH) lens is focused on protecting civilians from physical violence during hostilities. It is
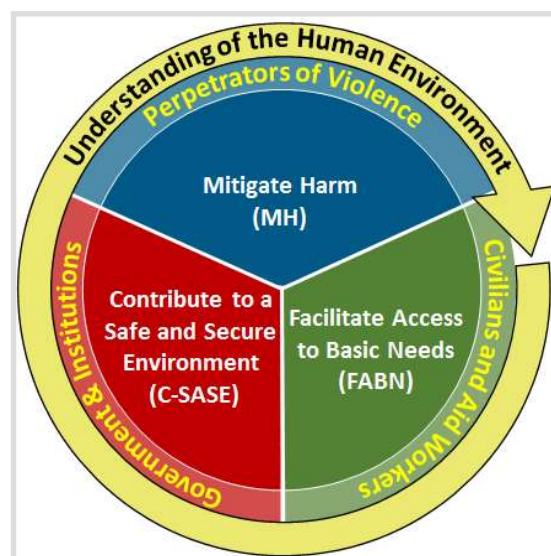
the element where the military have a leading role and a direct impact. This has two elements: the first addressing the actions carried out by NATO forces and the second addressing the action carried out by other forces. NATO forces seek to ensure they have the awareness, and have taken precautionary measures, to ensure the risk to civilians is minimized and, if harm exists, to take mitigating actions. Ms Tonutti included the medical mission and facilities in the term "civilians", noting the recommendations

on precautionary measures during kinetic actions.[2] This includes paying attention to the second- and third-order effects stemming from the targeting of a legitimate target that could have longer-term consequences. For example, a damaged power line serving a medical facility could have reverberating effects on the hospitalized patients. Actions undertaken by other actors refer to the use of military means, within the mission mandate, to prevent, deter, pre-empt and respond to situations where civilians are subject to unlawful violence or are under the threat of such violence from belligerents.

The Facilitate Access to Basic Needs (FABN) lens is focused on basic needs and services and is particularly relevant to this discussion as it covers civilians, civil society and aid providers. While NATO recognizes that the host nation retains the primary responsibility to ensure that such needs are met and such services are provided, conflict environments often prevent local authorities from fulfilling their obligations. Humanitarian actors and aid providers will at times provide services and carry out work to meet the basic needs of the civilian population. In such situations, what is the role of military actors? In such situations, NATO can play a supporting role if mandated, for example, by supporting aid organizations to provide humanitarian aid if required. NATO recognizes that military forces are to be used for the provision of humanitarian aid as a last resort, and only if no other organization or agency is able to provide essential services.

Focusing on NATO's own actions, the FABN lens relates closely to the medical/humanitarian concept "first, do no harm", which translates into reducing the adverse effects arising from the mere presence of NATO forces in the same space as the local population and aid providers. The contracting of local professionals like teachers, doctors and engineers to support its own mission can create a "brain drain" by taking them away from their work of developing their own state.

Gaining humanitarian access and facilitating freedom of movement for the population and service providers falls under this lens. NATO forces can contribute to facilitating access by supporting the safety and security conditions to allow for freedom of movement for the population and aid providers. This links us to another element of the framework: Contribute to a Safe and Secure Environment (C-SASE). This lens focuses on understanding the capacities and resilience of essential public services, to ensure the provision of security and the rule of law in a given area. NATO may play a supporting role, including in the development and capacity-building of local institutions and the training of local forces.

---

[2] https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4208-promoting-military-op-practice-ensures-safe-access-health-care.pdf

Military assets can, for instance, be used to defend vital infrastructure, humanitarian safe zones or IDP camps, which includes the establishment and maintenance of safe corridors for the movement and evacuation of personnel. While these tasks generally fall under the responsibility of local security forces, this task can become the responsibility of NATO forces if local actors are either unwilling or unable to perform them.

The framework highlights how NATO intends to strengthen the PoC in the planning and conduct of its operations. Based on the framework, there are a number of additional practical measures that have been conducted in recent years in doctrine, training and exercises.

PoC considerations have been integrated into relevant NATO doctrine, to include Allied Joint Publications (AJP) in a number of thematic areas (joint targeting and others).[3] Also, PoC has been included in the revised NATO Comprehensive Operations Planning Directive (COPD), which guides NATO's planning process. Engagement with non-military actors has been vital to this task; for instance, the ICRC has collaborated with SHAPE to revise its doctrine.

Specific training on the PoC has also been developed as another measure. For instance, a joint NATO-UN course is conducted annually at the Finnish Defence Forces International Centre (FINCENT). An Immersive Training Environment tool has been developed to provide awareness training, and the ICRC has been involved in the development and execution of such training tools. NATO is also developing standardized modules of education through the Training and Education for Peace Support Operations (TEPSO) programme. Following the last round of consultations within TEPSO and the ICRC, specific recommendations on Health Care in Danger have been integrated into TEPSO standards.

These recommendations relate to the set-up and management of check points with specific reference to the application of appropriate measures for the passage of casualties and prioritization measures to minimize medical evacuation delays; the set-up and management of observation posts with specific reference to the need to maintain situational awareness and to consider the effects of military operations to health-care facilities; and to the conduct of cordon and search operations with specific reference to the behaviour of military personnel in minimizing the impact on health-care facilities, personnel and patients and to ensuring coordination with health-care professionals and authorities to minimize the impact of search operations.

---

[3] 3.9 Joint Targeting, AJP 3.2 Land Operations, AJP 3.19 Civil Military Cooperation, AJP 3.4.3 Military Contribution to Humanitarian Assistance, AJP 3.14 Force Protection, AJP 3.3.2. Close Air Support and Air Interdiction

Exercises are key for the transfer of knowledge within the military, and NATO conducts numerous exercises for this purpose. "Training by doing" improves the preparation and conduct of operations, and the PoC has been incorporated into a number of exercises conducted in recent years in order that military officers are confronted with humanitarian dilemmas. The ICRC, alongside other international organizations and NGOs, has been participating in major NATO exercises in order to provide a more realistic scenario and to challenge the application of PoC principles.

The constant liaison, dialogue and exchange of information between NATO and non-military actors are essential to properly integrate the PoC framework into the *modus operandi* of the Alliance. SHAPE has signed, for instance, an MoU with the ICRC and has relationships with other organizations to support this integration. Good liaison at the strategic level translates into better communication lines in the field, which are essential, for instance, to coordinate the passage of ambulances or the identification of medical facilities during operations.

During the 33rd International Conference of the Red Cross and Red Crescent, held in 2019, NATO reaffirmed its commitment to including measures to protect civilians affected by armed conflict in the Alliance's military doctrine, education, training, planning, exercises and conduct of operations. This will further advance the integration of PoC considerations into the planning and conduct of current and future NATO operations and missions.

Mr Casier thanked Ms Tonutti for her presentation and then introduced Mr Jan Tijmen Ninck Blok. Mr Ninck Blok opened noting that, prior to joining the Netherlands Red Cross, he was a military researcher with the ICRC's Health Care in Danger team between 2018 and 2020, when he wrote the *Study on the Protection of Health Care by State Armed Forces*.[4] The study, which is a collaboration between the ICRC and the Swedish Red Cross with the generous support of the Government of Sweden, will be launched formally in March 2021.

Mr Ninck Blok opened noting that his presentation will cover the objective of the study and the publication itself and will look into the research findings and how the findings are transformed into recommendations for state armed forces. Armed conflict generally corresponds with a higher demand for services at the same time as those very services are disrupted by hostilities. Combatants have an obligation not only to refrain from causing harm to the medical mission, but also to actively contribute to its protection, as was pointed out by Ms Lequin in her presentation. The ICRC engaged with over 15

---

[4] https://shop.icrc.org/protecting-healthcare-guidance-for-the-armed-forces-pdf-en?__hstc=163349155.66802924a26554a162d46ba5c445f7c3.1594715570558.1616342223451.1616348735473.126&__hssc=163349155.4.1616348735473&__hsfp=445282746

armed forces for this study and complemented this with research through open-source and archival materials of many others. The research looked at how the legal framework has been implemented within the doctrine and practice of armed forces. It examined how the protection of health care has been operationalized and how to draw good practices that can be decontextualized and used in the instruction of other weapon bearers.

By reframing state armed forces as enablers of protection, the study examined what armed forces have done, or could do, to contribute to the safety of, and access to, health care. A publication has been produced grounded in the findings of the research. This will be made available in hard-copy format and translated into a number of other languages shortly, including Russian.

The observed practice noted significant but limited integration of the legal framework. It could be described as top-heavy, as the inclusion of the relevant provisions of IHL is appropriately reflected in military manuals and other doctrinal documents. However, this does not generally translate into further implementation formulating specific operational outcomes. The understanding of protection of health care in the theatre of operations for armed actors becomes a pragmatic one of working to refrain from committing harmful acts.

At the same time, there are practical measures in place relevant to the protection of health care. However, these measures are not necessarily purposefully connected to the legal framework and the protection of the medical mission and might have a different aim. For example, medical services are provided to the civilian population by a number of multinational operations, but with the objective of winning the hearts and minds of the local population. Such a service could be a practical measure of significant benefit to the civilian population, particularly if contingency planning is carried out and an exit strategy is devised. Another example is the standard procedures that are included in the rules of engagement, which are often disconnected from the protection of health care. However, after kinetic engagement, the post-fire procedures describe how to take care of injured colleagues, but they lack the inclusion of wounded civilians at times. Safety zones are described but they should always include medical facilities and be specifically mentioned, though they are often left out of rules of engagement. Another example is the search and detention procedures in rules of engagement, which do not consider the need for medical attention during these procedures. These are a few examples of practical measures that are currently applied but that do not focus on the protection of health care.
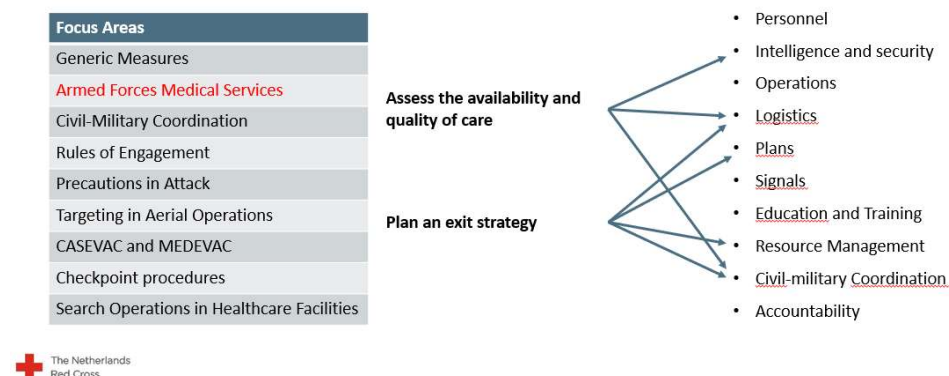
It is critical to understand the operational environment and that the call for a specific focus on the protection of health care can be perceived as yet another task among the array of duties of commanding officers. There is sensitivity to the need for an inclusive approach that captures health

care while performing regular duties. The ICRC has collected and reinterpreted sets of existing practical measures and expanded the applicability to include the protection of health care. The practical measures are concrete and applicable to military operations. By no means is the list exhaustive. Nor does the adoption of this set of measures indicate that an actor is, as a result of taking these measures, compliant with the legal framework. The list does, however, provide a framework for how to include the protection of health-care-focused activities.

With a basic understanding of the guidance document, one should be able to conceptualize other measures that, while not included, could equally contribute to the protection of health care. As such it works to be incorporated in the thought processes for an active inclusion of the protection of health care. The guidance document is set up based upon the practical measures identified and reframed to incorporate the protection of health care; there are nine specific focus areas. These areas are further sub-divided according to the standard military reference system on the right. While recognizing that not all armed forces have the same structure and set-up, this is generally understandable in terms of the functional categories, which can be related back to the practical measures.

To give some relevant examples, armed forces medical services can assess the availability of medical personnel, the quality of care they provide, the presence of medical stocks and the coordination

Example: Protecting Healthcare Guidance for the Armed Forces

Focus Areas
Generic Measures
Armed Forces Medical Services
Civil-Military Coordination
Rules of Engagement
Precautions in Attack
Targeting in Aerial Operations
CASEVAC and MEDEVAC
Checkpoint procedures
Search Operations in Healthcare Facilities

Assess the availability and quality of care

Plan an exit strategy

- Personnel
- Intelligence and security
- Operations
- Logistics
- Plans
- Signals
- Education and Training
- Resource Management
- Civil-military Coordination
- Accountability

The Netherlands Red Cross

between national and international health-care providers in the area of operation. This is an assessment that can be done prior to deployment, but that also needs to be done continuously during operations and, as such, is relevant to officers working in intelligence and security, logistics, resource management and civil-military coordination.

As another example of a focus area (Civil-Military Coordination), the first element is to provide health-care providers with security information on the presence of curfews, mines, border statuses and routings, and to share maps of the explosive remnants of war that may affect health-care services. The last element is to prepare a contingency plan together with civilian health-care providers to plan for a

ICRC

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

disruption to care provision in order to limit the disturbance to services and to ensure the re-establishment of services as soon as possible. These include the evacuation of patients and medical personnel. This measure links to intelligence and security, logistics, plans and civil-military coordination.

While the document is geared towards the military, and in particular towards commanding and staff officers, it can increase one's understanding of the armed forces and of areas where armed forces may need to link with health-care providers and Red Cross and Red Crescent National Societies. Many of the specific measures that are intended for times of armed conflict also are relevant in peacetime.

Mr Casier thanked Mr Ninck Blok and noted that practices could be implemented by state armed forces but can also be relevant to civilian and medical actors. He then opened the Q&A with a question addressed to Ms Lequin, asking to hear more about the practical materials in the region that Geneva Call has developed to reinforce IHL protections, especially related to protecting health care. Ms Lequin shared that the development of documents depends on needs and must be tailored to the audience, whether that be commanders or regular combatants, and also in the relevant languages. They can be pocket booklets[5] or posters accompanied by extensive media campaigns: for example, in Ukrainian and Russian, and we have similar materials in Azeri and Armenian in the South Caucasus. Geneva Call has also developed several video materials on the protection of medical care, on ambulances and on the notion of consent, many of which are publicly available.[6] Finally, Geneva Call is developing an online virtual training tool promoting respect for IHL for use in Donbas, which will be shared in the coming weeks.

Ms Tonutti was then asked about the specific protections for medical facilities during hostilities in the NATO PoC framework, or whether this is part of PoCs in general. She explained that the doctrine on the PoC and the forthcoming handbook that will be made publicly available make reference to IHL where medical facilities are protected.[7] The NATO approach to PoCs builds on IHL and there are references with respect to the specific protection of the medical mission and facilities, but the approach is generally broader. To a separate question about mitigating harm and considering the impact on mental health, Ms Tonutti shared that the focus is on NATO's own action when attempting to mitigate harm to the civilian population. As NATO works to mitigate the overall impact on the civilian population, the impact on mental health will also be part of the assessment of the second- and third-

---

[5] https://www.genevacall.org/wp-content/uploads/2020/11/Healthcare-booklet.pdf
[6] https://www.youtube.com/watch?v=2HaBODnrPWE and https://www.youtube.com/watch?v=SU4P_8hUC1k
[7] https://shape.nato.int/resources/3/website/ACO-Protection-of-Civilians-Handbook.pdf

order effects stemming from the targeting of a military objective. Specific mentions on mental health are not made explicit in NATO PoC documents, however, though this is certainly one of the elements to be considered when conducting a long-term analysis.

A third question was asked about the extent to which PoC considerations in general, and measures to ensure the protection of health care specifically, are included in the capacity-building of local partners in NATO operations. Is it a significant topic in military-to-military cooperation? NATO engages in a range of different partnerships. Training of military personnel is first and foremost the responsibility of the military's host country and the TEPSO manual includes guidelines on the training of military forces in many areas related to the protection of medical personnel. This is one of the key elements partner nations can use to strengthen training at home. With respect to capacity-building of local forces during operations, this is a separate area and NATO is working to ensure that the PoC is integrated into the mindset and *modus operandi* of NATO, which will translate into the tactical level when speaking of the capacity-building of local forces. The approach in this case will be broader than just the protection of health care and will address several areas including, for example, the protection of humanitarian aid and aid workers.

As a follow-up, Mr Casier asked if this means that NATO can positively influence compliance with IHL by other armed actors. Ms Tonutti replied that this is a difficult question, especially at the strategic level, as it goes much more into the tactical level. She shared that NATO has this capacity if the mandate of a mission has a capacity-building component – it will depend on the type of training, advising and mentoring to be done.

Mr Ninck Blok was then asked if he gets the impression from militaries that they believe that health care is sufficiently protected by the PoC rules. Mr Ninck Blok responded that the impression is that the protection of health care is covered by the PoCs, while sharing that though he agrees it is covered at the strategic level in terms of PoC policies, there are specifics that need to be addressed on the protection of health care at the operational and tactical levels. The guidance document provides the conceptual grounds for how to develop these specific protection activities that cater to health-care providers in armed conflict. Collaboration is required to make sure that all actors understand the specific needs of the medical mission.

Ms Lequin responded to a question on how deeds of protection related to the protection of health care are monitored, noting that it is a trilateral agreement between the armed group, Geneva Call and the City of Geneva – the custodian of the deed. When Geneva Call signs the commitment, this is

accompanied by a dialogue about the ability of an armed group to uphold this commitment. When an armed group makes a commitment with respect to medical care, Geneva Call needs proof that if they cannot facilitate access to medical care, then they will reach out to other groups to ensure that, through this collaboration, they will be able to facilitate access to medical care. This is laid out in an implementation plan that is agreed together and includes monitoring (most effectively done by being on the ground), often accompanied by visits to military camps to discuss with commanders and troops. Geneva Call also works with civil society organizations working in the area.

In case of IHL violations, Geneva Call does not go public, but tries to work with the non-state armed actor to see why violations have taken place. Is it due to a lack of capacity or deliberate? Geneva Call also looks at the reparations provided to the victims. If there are repeated deliberate violations, Geneva Call will cancel the deed of commitment.

In response to a question about the motivation of non-state armed groups to sign a deed of commitment on the protection of health care, Ms Lequin responded that some armed groups are fighting for their community and so signing such a deed of commitment facilitates, and sends a clear message on, access to medical care. Respect for medical care by one party to the armed conflict can also contribute to expectations that the other party will improve respect. By better taking care of their own facilities, non-state armed groups can also better ensure that they take care of their own wounded and sick. With the COVID-19 pandemic, many armed groups have had problems setting up treatment posts and vaccination centres.

Mr Ninck Blok responded to a question about the role that medical actors and members of the International Red Cross and Red Crescent Movement can play in promoting the recommendations and contributing regarding the implementation of these recommendations, noting the connection that many National Societies have with the Ministry of Defence. He recommended that this study can be brought to the attention of counterparts at legal affairs, military medical services of the armed forces and civil-military coordination. In some countries there are civil-military working groups and this study can be put on the agenda. With respect to exercises, there have been exercises at the national and multinational levels, where the protection of health care has been a central or niche component of the exercise. This document could be very useful as an instructional document for these activities.

Mr Casier concluded the session with remarks noting the importance to continue to have a clear and comprehensive military doctrine that specifically addresses the protection of health care for state armed forces, non-state armed groups and international organizations with a military component.

ICRC

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

Coordination is also critical not only between civilian organizations but also with military actors to have a better understanding of respective approaches and to reach a common understanding on the application of IHL.

It is relevant to highlight the importance of IHL and IHRL dissemination for military actors as well as for medical personnel. Training and exercises for military actors are essential to transfer knowledge on the relevant rules relating to the protection of health care. Relevant medical and humanitarian organizations can be associated to provide inputs, realistic scenarios and challenges on the application of specific rules. Sharing good practices between state armed forces can also influence potential partners in military operations to minimize the impact on health-care services. The development of domestic normative frameworks that include clear provisions on the protection of health care in armed conflict and other emergencies can ensure effective protection beforehand and could include steps to reinforce the protection of the emblem and measured for sanctioning violations of IHL.[8]

---

[8]National IHL Committees and similar bodies can play an important role to support the development of legislative and regulatory measures. The ICRC, the Belgian Red Cross and the National IHL committee organized in Belgium in 2014 an international conference that adopted a number of recommendations to strengthen the domestic normative frameworks in accordance with IHL and IHRL, see https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4215-domestic-normative-frameworks-for-the-protection-heath-care.pdf

PROTECTING HEALTH CARE IN A TIME OF COVID-19

_____

Moderator	**Ms Áine Markham**, Vice-President, Médecins Sans Frontières (MSF), International Board

_____

Theme	**THE IMPACT OF COVID-19 ON NURSES AND NURSING & THE REALITY OF VIOLENCE AGAINST HEALTH CARE**
Panellist	**Ms Hoi Shan Fokeladeh MSGH RN,** Policy Adviser on Nursing & Health Policy, International Council of Nurses

_____

Theme	**VACCINE HESITANCY, PUBLIC TRUST & COMMUNITY & RISK COMMUNICATION IN CENTRAL ASIA**
Panellist	**Mr James Sport**, Community Engagement & Accountability Delegate, International Federation of Red Cross & Red Crescent Societies (IFRC) & **Mr Alisher Assylbekov**, Community Engagement Specialist, Red Crescent Society of Kazakhstan (RCSK)

_____

Theme	**MENTAL HEALTH & PSYCHOSOCIAL SUPPORT, COVID-19 & VIOLENCE**
Panellist	**Dr Barbara Juen**, Associate Professor, Institute of Psychology at the University of Innsbruck, Head of Psychosocial Support at the Austrian Red Cross, and member of the No-Fear project

ICRC

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

This session was opened by Ms Áine Markham, Vice-President of the International Board of MSF, a general paediatric nurse by training with more than 25 years of experience in the humanitarian sector in global health who served as the Director of Operations at MSF between 1999 and 2004.

Ms Markham laid out the objectives of the session: to illustrate how the COVID-19 pandemic has triggered and increased the risk of violence against health-care personnel and how organizations have adapted; to analyse the consequences of the pandemic on health-care providers and focus specifically on the impact on nurses and the mental health and psychosocial well-being of individuals; and to track the role that information and perception have played during the pandemic and stress the importance of dialogue, feedback and trust in mitigating and preventing violence against health-care providers.

Ms Markham then introduced the presenters noting that they will provide global, regional and local perspectives. The first was Ms Hoi Shan Fokeladeh, Policy Adviser on Nursing and Health with the International Council of Nurses (ICN). She has done a lot of work on the protection of nurses during this pandemic and been involved in providing advice and working closely with a number of organizations, including WHO, on global health challenges. She is a registered nurse who has been involved in emergency operations in the humanitarian sector with refugee populations.

Ms Markham then introduced Mr James Sport, Community Engagement Delegate for the IFRC in Central Europe, who has worked in the International Red Cross and Red Crescent Movement for over 10 years in community engagement and in accountability and communication. Joining him is Mr Alisher Assylbekov, Community Engagement Specialist at the Red Crescent Society of Kazakhstan, who has been a public relations specialist in the Movement for six years, the majority of those years as a volunteer.

The final panellist is Dr Barbara Juen, Associate Professor at the University of Innsbruck in the Institute of Psychology. Dr Juen is the Head of Psychosocial Support at the Austrian Red Cross and the Scientific Adviser of the European Network for Psychosocial Support and in the IFRC Reference Centre for Psychosocial Support. She is a clinical and health psychologist and a member of the No-Fear project.

The first panellist, Ms Fokeladeh, took the floor noting that since the pandemic people have become more aware of the true value of nurses and health-care workers as they have taken some of the spotlight. The pandemic has also highlighted the skills, selflessness and resilience of the workforce. ICN, as an international organization based in Geneva, wants to support urgent action to protect health-care workers worldwide.

ICRC

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

ICN represents over 20 million nurses worldwide and a federation of over 130 national nurses' associations (NNAs). The world designated 2020 as the year of the nurse and midwife before the pandemic. Before the COVID-19 pandemic, the global nursing workforce was estimated at 28 million nurses, of which nine out of ten were women. They make up the largest occupational group in the health sector, and 60 per cent of the health profession. Nurses are at the centre of making health care sustainable and are critical to reaching global targets.

According to statistics, the nursing workforce is not commensurate with global health coverage and the Sustainable Development Goals. The global shortage of nurses is estimated at 6 million and concentrated in low- and middle-income countries. The COVID-19 pandemic has exposed the flaws in the global health system. 2020 was not the celebration many had in mind. The pandemic has placed nurses under immense pressure to perform, often working shifts that run for days and sleeping in the facility where they work. ICN has been working with the NNAs to share information and lessons learned throughout this period.

In August 2020, ICN carried out an online survey of 52 associations in 50 countries with high COVID-19 caseloads.[9] The survey looked at the number of infections and deaths, personal protective equipment (PPE) supply, infection prevention and control (IPC) training, violence against the health work force and the psychological support provided to nurses. It indicated that the pandemic continues to take a heavy physical and psychological toll on the well-being of nurses.

The key findings of the survey were that COVID-19 was recognized as an occupational disease for health-care workers in less than half of the contexts. In most cases, the access of health-care workers to entitlements and compensation was linked to the designation of this as an occupational disease. Less than half of the NNAs report that compensation is available from the government following exposure to COVID-19 and that, where compensation is provided, the eligibility criteria vary highly across countries. A few governments only provide compensation if the health-care worker dies of COVID-19, or according to the severity of the disease.

The additional occupational risk and pressures have led to a wide debate about wage levels and remuneration. Some 60 per cent of the NNAs report having sometimes or regularly received reports during the COVID-19 response of burnout, anxiety and depression. Fear of stigmatization and discrimination are common mental-health issues. The review also revealed a lack of protection for

---

[9]https://www.icn.ch/system/files/documents/2020-09/Analysis_COVID-19%20survey%20feedback_14.09.2020%20EMBARGOED%20VERSION_0.pdf

nurses in many countries. In the first wave in Europe, some NNAs mentioned that nurses and doctors were forced to wear masks long after their expected use and some have had no PPE at all. Over 70 per cent of the NNAs report instances of violence or discrimination against health-care workers in this period.

Since March 2020, ICN has been in close contact with its NNAs and collecting data on infection and death. As of 31 December 2020, over 1.6 million health-care workers have been infected with COVID-19 in 34 countries, and the cumulative number of reported COVID-19 nurse deaths is over 2,000. There is significant underreporting of these two figures. ICN data also found that there is a high range of health-care workers infected, up to between 6 and 10 per cent, and that nurses generally made up the highest number of those who died. The systematic collection of this data is not taking place, however. Governments must take more action to ensure that both health-care workers and patients are better protected.

NNAs report an alarming increase in violence against health care since the start of the pandemic, including threats, attacks and stigmatization. Nurses have been abused and physically attacked because they have been exposed to COVID-19 patients in both conflict and non-conflict settings. For example, some nurses were denied accommodation and driven out in the streets. Nurses were sprayed with bleach in the streets, the cars and houses of health-care workers have been burned, and nurses and midwives have also been denied childcare because of their profession. We see fear and panic, misinformation about how COVID-19 is spread and displaced anger as likely drivers of violence.

Violence against health-care workers is not a new phenomenon and is a daily reality that pre-dates the pandemic. Attacks against health care are also a deplorable tactic of war that defies IHL and IHRL. Health-care workers are risking their lives daily to care for COVID-19 patients, for which they can be subjected to attack, while not being themselves protected and experiencing unprecedented levels of stress and burnout as individuals and in their families.

According to Ms Fokeladeh, attacks against health-care workers undermine the duty of care at a time when we need health-care workers more than ever to provide care for individuals, families and communities. ICN has flagged the increased risk of burnout and other stress indicators due to workloads and exposure to the virus. The workforce is at breaking point and there are significant numbers burning out or even leaving the profession. This will have a significant impact on the performance of the health system.

There is a need for an effective response to address the root cause of the problem. ICN, WMA and Physicians for Human Rights have joined a call for urgent action to end violence and discrimination against health-care workers during the pandemic. ICN and partners call for accurate and systematic data collection on incidents and types of attacks on health-care workers. It is necessary to understand the scope of the problem to be able to prevent and respond to violence. ICN takes a zero-tolerance approach towards attacks against health care. Local government must work with stakeholders to engage with the community on prevention. Widespread misinformation, including conspiracy theories, have contributed to the demonization of certain groups including governments, medical organizations and international collaborative bodies. Social media companies must play a strong role when it comes to combating misinformation and disinformation. State and local governments should invest in health security measures to protect workers. Health professional associations should speak out forcefully against all acts of discrimination and violence and protect the workforce.

> VIOLENCE AGAINST HEALTH CARE HAS BEEN EXACERBATED BY THE PANDEMIC AND IS AN ALARMING GLOBAL PHENOMENON. THE VIOLENCE IS SHOCKING, AND THE ONLY RESPONSE IS ZERO TOLERANCE
>
> *Ms Hoi Shan Fokeladeh*

Nurses have experienced a mass trauma in working on the COVID-19 response. Violence against health care has been exacerbated by the pandemic and is an alarming global phenomenon. The violence is shocking, and the only response is zero tolerance. The pandemic has demonstrated the importance of having a strong health work force as an integral part of a resilient system. ICN calls on governments to take steps to protect health-care workers by investing in decent working conditions and adopting a gender lens. The risk of damaging a generation of nurses is real unless immediate steps are taken.

Ms Fokeladeh closed the session quoting the **President of ICN, Annette Kennedy:**

The pandemic has seen front-line nurses rightly recognized as heroes, but they are also ordinary mothers and fathers with their own families to protect. They deserve to be able to work free from fear, whether because of a lack of PPE or because of harassment and attack.

ICRC

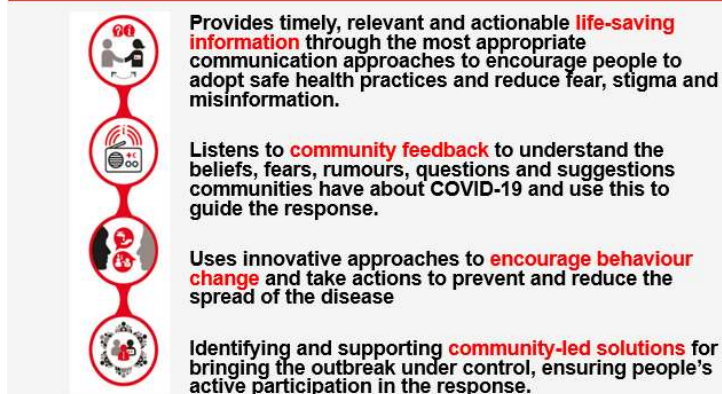HEALTH IT'S A CARE MATTER IN OF LIFE DANGER & DEATH

With that, Ms Markham gave the floor to the next speakers, as part of a joint presentation by Mr James Sport and Mr Assylbekov. Mr Sport took the floor and explained that risk communication and community engagement (RCCE) is a component of any public health response to an infectious disease outbreak, where it is vital to equip the population with the tools they need to take steps to reduce risks. Infectious diseases like COVID-19 thrive in environments where communities, for whatever reason, do not follow public-health guidance. There may be simple explanations for this behaviour, like the absence of information, misinformation or the politicization of health guidance leading to a lack of trust or even aggression towards health-care personnel.

> **WHEN PEOPLE DON'T FEEL CONSULTED OR THE REPONSE DOES NOT MEET THEIR EXPECTATIONS, INTERVENTIONS MAY FAIL. DURING THE PANDEMIC THIS TREND HAS PLAYED OUT ALMOST DAILY IN VARIOUS GUISES THROUGHOUT THE WORLD**
>
> *Mr James Sport*

Four points are common to an RCCE intervention. People's feedback, including questions, and life-saving information must be provided and feedback and rumours must be listened to and acted upon. It has been seen with the COVID-19 pandemic how quickly information has evolved, including people's current questions. There are many novel questions and rumours today about vaccines and the different versions of the virus that have evolved in the UK and South Africa. Ultimately, RCCE seeks to enact changes in behaviour, in order that people behave safely and take steps that they might not otherwise have taken to manage their risks and to keep others safe, including health-care personnel. Behaviour patterns might have to shift as a result of a pandemic and so widespread behaviour change is called for. Finally, designing interventions with communities and involving communities are essential to developing sustainable, trustworthy and effective responses to infectious diseases.

ICRC

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

When people don't feel consulted or the response does not meet their expectations, interventions may fail. During the pandemic this trend has played out almost daily in various guises throughout the world. More than other emergencies, people feel a sense of ownership in the COVID-19 response and so they want to be involved in tackling it as well.

A misunderstanding of risk, the adoption of unhealthy behaviours and the mistrust of health-care institutions all cause harm. For example, in the United States, people misused cleaning products leading to five deaths after public discussion of how bleach kills the coronavirus. In another example from the UK, a person was arrested for insisting on removing a COVID-19 patient from the hospital while claiming that health-care staff were lying about the outbreak and keeping patients there against their will. A head of state was mentioned taking a herbal remedy for COVID-19 that is not only ineffective, but also increases the risk of developing drug-resistant malaria. All these cases are examples of harm due to myths or disinformation stemming not only from a lack of access to information but also from the presence of inaccurate information.

Vaccines have long faced particular scepticism: the first vaccine treating smallpox was subjected to what would now be called a misinformation campaign. Globally, there is a huge variation in rates of vaccine hesitancy in those who believe vaccines are safe and effective. They are low in some countries and high in others. There is a cultural variation to this data that can be related to completely unrelated factors. Many people who say that a vaccine is effective also say that they will not take it. A country-by-country research approach is necessary to identify the underlying issues.

The IFRC aims to work in partnership with National Societies to tackle these issues. To begin with, it is essential to understand peoples' understanding, perceptions and practices relating to COVID-19. Engaging with communities is critical and two-way communication is critical. Humanitarians must adapt to the beliefs of the community in real time. Providing information that is accurate and accessible is critically important. In Central Asia, the IFRC works closely with WHO and ministries of

health on communications and uses evidence to inform interventions. Relying on assumptions is never a good idea, particularly in the case of infectious diseases. Humanitarian organizations must use media and messages that people actually trust. Researching people's preferences and ensuring clarity and accuracy in language usage are vital.

Mr Assylbekov, who is engaged in the work of the health department of RCSK, then spoke in more detail about some of the surveys that have been conducted in Kazakhstan. He opened noting that the situation last spring and summer in the country was difficult, but that the situation is largely stable at present.

Over the past year, RCSK has been involved in the response to COVID-19 by supporting the medical services through transfer and tests, protective equipment, distributing food, medicine and drinking water, and providing food baskets for vulnerable people.

RCSK has also carried out work to inform the population about COVID-19 prevention measures, with 4,000 volunteers reaching more than 7 million people out of a population of 18 million (approximately 40 per cent of the population). Offline activities have included the provision of information materials including posters and billboards and holding conversations with people during the delivery of food baskets with prevention materials inside. Videos have been placed in subways, buses and other public areas like hospitals and train and bus stations, in collaboration with government bodies.
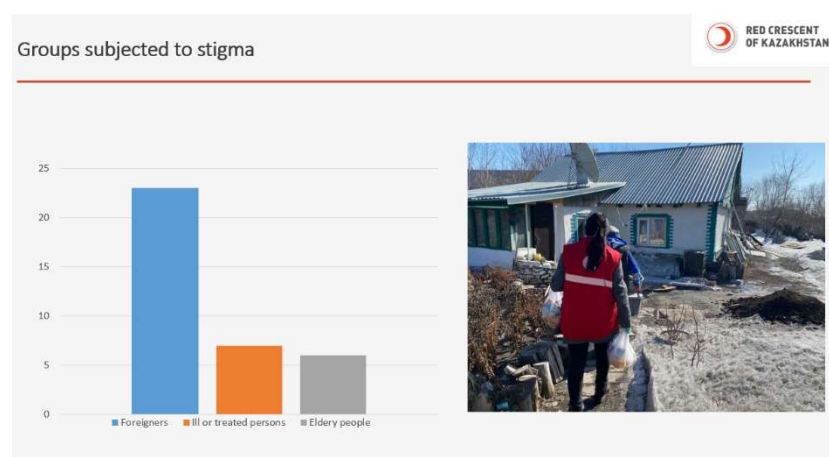
Online activities consist of direct work through social networks to produce and share materials about COVID-19, collect feedback and destroy myths around the pandemic. Information sessions were held with various public educational and social institutions where RCSK volunteers talked about prevention methods. The main focus has been online, as the conditions required a rapid adaptation and social media platforms like Instagram and Facebook were more relevant, as was information shared through a telephone-chat platform. Most people prefer getting information from their own contacts including neighbours, colleagues and friends.

At the end of 2020, with the support of the RCCE, RCSK conducted a survey with some interesting results. The results found that most people were aware of the coronavirus and the danger it poses (95 per cent). Only 2 per cent said they were not aware at all about the coronavirus: this was felt to be due to the large amount of information in the media about COVID-19.

Respondents preferred to seek medical help when symptoms occur in hospitals and medical centres (44.9 per cent). About a quarter of respondents (27.9 percent) preferred to be quarantined, but 19.6 per cent bought medicine at the pharmacy. Fewer sick persons sought advice from a relative or a familiar medical professional. Only a third of respondents felt that areas where people were infected were a transmission vector.

According to a survey conducted by the National Society, around two out of three respondents responded negatively about their readiness to get the vaccine (74 per cent). Most respondents are not willing to get vaccinated or have their children vaccinated, stemming from concerns about the consequences of the vaccine and the low level of trust in the health-care system. Many people believe in conspiracy theories about the virus and vaccination.

A little later in January, a new study was conducted by another independent organization on the level of vaccine acceptance. The survey shows that 56 percent of citizens are ready to receive the coronavirus vaccine. However, the situation is highly volatile, and more people are trying to get vaccinated and the level of acceptance has increased significantly compared to last year. Kazakhstan has launched a large-scale vaccination program, which should cover much of the population.

The survey tried to take stock of stigmatized groups. Few people indicated that they were concerned about specific groups, but foreign citizens were mentioned along with ill or treated persons and the elderly who received the most attention. The absence of a single portrait on stigma indicates that the most stigmatized groups correspond broadly with those most at-risk groups that may be exposed to infection.

RCSK will follow up to draw the attention of the population to the danger of infection and prevention measures. A wait-and-see policy has been adopted on vaccines, given their limited availability. Crisis communications will need to be carefully considered given the complexity nationally and regionally – poorly managed communication could further undermine the confidence of the population. To close, Mr Assylbekov stated that, in 2021, the government is planning to vaccinate at-risk groups in six stages, and that RCSK intends to focus on supporting the Ministry of Health in this work.

Dr Juen took the floor next and opened by introducing the No-Fear project.[10] She then shared the overwhelming evidence that the COVID-19 pandemic has had a severe mental-health impact on the population. Many studies are coming out indicating that this trend is particularly acute in health-care workers, women and young people.[11] In terms of the impact on health-care workers, specific causes of stress are insufficient PPE, the fear of infecting family, friends and colleagues, the workload, and being asked to take on responsibilities for which staff are untrained (for example, working in the intensive care unit). Other causes include being placed in new teams and, finally, moral stress and stigmatization.[12]

Moral stress can be explained by the notion that health-care workers are having to do work or be a part of an organization that runs against their moral beliefs. For example, this could be the way that dead bodies are being handled or having to isolate terminally ill patients from their family members. Many also feel that, at times, they are inadequately protected by their organizations and they have lost trust in their organization. Stigmatization can be this contradiction of on the one hand being a hero and on the other the virus spreader.

IF YOU TAKE STIGMATIZATION, VIOLENCE AND MORAL DISTRESS COLLECTIVELY, THE FEELING OF TRUST AND SAFETY IN THE SYSTEM IS WEAKENED, AS IS THE JOB COMMITMENT OF HEALTH-CARE WORKERS

Dr Barbara Juen

A lot of stigmatization data exists from this outbreak and stigmatization has also been a problem in past outbreaks, including from health-care workers' own communities and family members out of fear that they are sources of infection. Recent research from a cross-national study from 173 countries confirms that health-care workers are more stigmatized than other population groups. Health-care workers are significantly more likely to experience stigma and bullying, and this often exists in the intersectional context of racism, violence and police involvement in community settings.[13] Intersectionality plays a big role: for example, being a woman, being a different colour, being a member of a certain group and being a health-care worker enhances this tendency.

---

[10]https://no-fearproject.eu/
[11]https://journals.sagepub.com/doi/full/10.1177/0020764020915212
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7177038/
[13]https://bmjopen.bmj.com/content/10/12/e046620.long

ICRC

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

With respect to the question of whether health-care workers see themselves as stigmatized, one study from Egypt indicates that over 30 per cent of doctors reported a severe level of COVID-19-related stigma.[14] This is particularly concerning as nurses are generally more subjected to stigma than doctors. Moving to the population's view of health-care workers during the COVID-19 pandemic, a study in the United States and Canada indicates that over 25 per cent of the population believe that health-care workers should have severe restrictions placed upon their freedom, such as being kept in isolation from their communities and families.[15] Over 33 per cent avoided health-care workers for fear of infection. Interestingly, there is a strong correlation between those applauding health-care workers and those stigmatizing them. Stigmatized health-care workers also tended to avoid others and services, which tends to exacerbate stress levels. If you take stigmatization, violence and moral distress collectively, the feeling of trust and safety in the system is weakened, as is the job commitment of health-care workers. This can also lead to burnout not from stress but from a sense of meaninglessness.

INTERESTINGLY, THERE IS A STRONG CORRELATION BETWEEN THOSE APPLAUDING HEALTH-CARE WORKERS AND THOSE STIGMATIZING THEM

Dr Barbara Juen

Studies indicate that staff in higher positions see greater coherence and feel less stress than rank-and-file staff and volunteers. Younger staff and trainees often have much less resilience. Those who are exposed to COVID-19 patients also have much higher stress and female staff have much higher levels of stress than male staff. Some of the reasons for this are because women often have additional caring roles at home and struggle finding support with their children. There is also an increased level of violence at home. On a separate note, regular staff also feel higher levels of stress than volunteers.

Stress has also risen from the first to the second wave. Although young people were more stressed initially, those between 30 and 40 years of age, often with young families, have become more stressed over time. Women are more at risk and their well-being has declined more significantly than men from the first to the second wave. The emotional well-being of the population has also changed from wave 1 to wave 2. The main issue initially was anxiety, but this has translated to a feeling among health-care workers and the general populace of powerlessness, concern, sorrow, stress and tension.

---

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7484807/ and
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0244172
[15] https://www.sciencedirect.com/science/article/abs/pii/S0887618520301031

ICRC

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

The interviews tried to identify causes of stress to collect best practices and identify resilience factors. They found that moral distress and injury are the main stresses experienced by health-care workers. Stigmatization is one part of this, like at triage or not being able to transport a patient to a hospital.[16] Leadership plays an important role in protecting staff and volunteers, and organizational resilience depends highly on experiences with leadership and a sense of organizational justice. Leadership is critical: leaders must be open and transparent in communication but also open to dialogue and able to listen to concerns. Basic support is also needed in the mental-health sector. It is not well accepted that psychologists disappear in the background and can be called by telephone. Not only psychologists, but also management and team leaders, must go to the wards and provide support in a face-to-face setting. It is good to integrate psychological support into the overall approach, meaning mainly into technical support. This can be done by field supervisors in the emergency medical service (EMS) or by experienced staff or volunteers.

To support people, the five Hobfoll principles, derived from long and varied studies, are recommended as they have proven effective in stressful situations.[17] On the second principle, connectedness and mutual support, for example, in some wards staff regularly meet on balconies and find places for

Adopting the Hobfoll Elements in our mental health approach
(HCW and population, individual and community level)

- Safety (safe places, information)
- Connectedness (social support, networks)
- Self and Collective Efficacy (participation, feedback loops)
- Calm (rituals, normalcy)
- Hope (resources, positive affect, future orientation)

Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M. J., Friedman, M. J., Friedman, M., Gersons, P.R., de Jong, J.T.V.M., Layne, C.M., Maguen, S., Neria, Y., Norwood, A.E., Pynoos, R.S., Reissman, D., Ruzek, J.I., Shalev, A.Y., Solomon, Z., Steinberg, A.M. & Ursano, R.J. (2007). Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. Psychiatry, 70 (4), 283 315

AUSTRIAN RED CROSS

PSYCHOSOCIAL SUPPORT   25

---

[16] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7470723/
[17] https://pubmed.ncbi.nlm.nih.gov/18181708/

ICRC

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

informal social contact. Participation and feedback loops are critical, and calm rituals and normalcy are required. In one setting, a health-care worker played the piano each day for one hour, which gave a feeling of normalcy. Nurses often say that humanity has to be brought back to the health sector in this pandemic. Hope is key and will be critical around the question of vaccines: health-care workers are often very critical of vaccines and it is essential to involve them in the campaign. They are models for the population.

Ms Markham then took the floor and opened the Q&A with a question on how to respond to the current situation in terms of practical recommendations for facilities management in relation to issues of intersectionality and risks. Dr Juen responded that a zero-tolerance approach is highly relevant, as was mentioned in Ms Fokeladeh's presentation. She also noted that entry controls are relevant to this question and culturally bound, citing the tight controls that exist in Israel that do not exist in Austria. In Austria, Germany and Italy, violence-prevention groups work on hot spots as one solution. Most important is a clear stance from management to the nurses that they are well-protected by the organization and that this support is visible.

Mr Assylbekov was asked to further elaborate on stigmatized groups and shared that, based on his opinion, some citizens believe in conspiracy theories and media stereotypes about foreigners, which contribute to stigmatization. Many people are understandably afraid to get infected by health-care workers who are in direct contact with infected people: for example, his own neighbours avoided him when they heard he works for the Red Crescent, so this issue is real.

Another question addressed to the panellists noted the importance of communication and community engagement, while asking whether they are enough and the only way to combat misinformation or disinformation and stigmatization. Are there are other examples where states, for example, prosecute individuals who willingly engage in disinformation and stigmatization campaigns against health-care workers? Mr Sport responded that this is a source of debate, differentiating between misinformation and disinformation. Disinformation has been legislated against but it's harder to legislate or even provide guidance around misinformation. China, Belarus and Burkina Faso have introduced specific laws about disinformation. It's risky to take legal action based upon these grounds and doing so can be counterproductive. WHO and UNESCO have done some research and the general guidance is that the best possible approach is through fact-checking and addressing rumours and misinformation as much as possible.

This changes where there are deliberate or often paid efforts to foment disinformation. Facebook, Twitter and Telegram have to some extent introduced rules and guidance to ban disinformation. To what extent should this be a state responsibility and that of a private company? There is less legislation on stigmatization as private companies may ban those who contribute to harm and violence. One interesting example around this trend is the oversight board of one social media organization, which is independent and works on big cases of misinformation and disinformation and threats of violence.

> COVID-19 IS NOT AN "US AND THEM" PROBLEM, IT IS AN "US AND US" PROBLEM: ALL COMMUNITIES AND ALL PEOPLE ACROSS THE WORLD ARE AFFECTED
>
> *Ms Áine Markham*

Mr Assylbekov shared that, In Kazakhstan, at the legislative level, there is some criminal prosecution for spreading false information, misleading and discriminating on various grounds, including inciting any discord. In any case, it is necessary to work in the field of securing certain rights of medical workers in the field of their activities to mitigate the dangers associated with the performance of their professional duty. In particular, increasing work within the framework of community engagement activities.

Ms Fokeladeh agreed that communication and community engagement are extremely important but that, at the same time, governments need to invest in health-care workers. In one country at the onset of the pandemic, 30 per cent of health-care workers had been infected due to a lack of PPE and IPC training and the absence of measures. As a result of the lack of protections, the general public associated health-care workers with being a vector of infection. The government should work to reduce infection rates by providing PPE and ensure that the IPC measures are in place so that the protectors can be protected at a physical well-being level. When people look at social media they may draw the conclusion that health-care workers are the source of the virus, which is not true. The right messages must be promoted but health-care workers must also be protected.

Another question noted that Norway supports the WHO Attacks on Health Care initiative and asked whether ICN is collaborating with the WHO on this. Ms Fokeladeh responded that ICN supports this work and works closely with WHO colleagues. At the data collection level, ICN does not contribute, but it does have a close collaboration with WHO in terms of campaigns against attacks on health care and on COVID-19. In July 2020, WHO published some very strong materials and ICN adapted this campaign material and has communicated with NNAs across regions to communicate on their needs and how to respond to attacks on health care.

ICRC

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

Ms Markham closed the session noting how the session has provided a lot of evidence of health-care workers bearing the brunt of the burden of the COVID-19 pandemic. There is non-stop pressure from the pandemic and nurses are at the forefront of the response – as it is a nursing care disease. COVID-19 is not an "us and them" problem, it is an "us and us" problem: all communities affecting all people across the world. Everybody feels the pressure, which makes it unique in one's lifetime, and everybody needs to be engaged. There is a growing body of good public-health practice and an understanding of transmission prevention and best care practices for those people suffering from COVID-19. This will remain important with vaccination; taking a context-specific approach is required: knowing the audience, their fears and how to address the issue while rallying support from a broader group of stakeholders.

ICRC

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

THREATS, PREPARATION & RESPONSES TO THE PROTECTION OF HEALTH CARE

_____

Moderator	**Dr Duncan McLean**, Senior Researcher, Research Unit on Humanitarian Stakes & Practices (UREPH), Médecins sans Frontières

_____

Theme	**DATA COLLECTION SYSTEMS TO MONITOR & ADDRESS VIOLENCE AGAINST HEALTH CARE**
Panellist	**Dr Tomás Cobo Castro**, Vice-President of the General Counsel of the Official Medical Colleges, Spain

_____

Theme	**PASSING THE LAW ON THE PROTECTION OF HEALTH CARE IN ITALY & ITS IMPLICATIONS IN THE CURRENT CONTEXT**
Panellist	**Mr Rosario Valastro**, Vice-President, Italian Red Cross Association

_____

Theme	**STRATEGIES TO PREVENT, DETECT & HANDLE CYBERATTACKS AGAINST HEALTH INFRASTRUCTURE**
Panellist	**Mr Bruno Halopeau**, Chief Technology Officer, CyberPeace Institute

The moderator, Dr Duncan McLean, was introduced. He holds a PhD in history, has extensive operational experience and is the Senior Researcher at the Research Unit on Humanitarian Stakes and Practices at MSF. Dr McLean opened the discussion laying out a broad objective looking at sharing experiences documenting incidents of violence and enacting legislative changes to better protect health-care workers and infrastructure. He noted the existence of broader initiatives like WHO's Surveillance System on Attacks and the work of the Safeguarding Health in Conflict Coalition, adding that this session goes beyond global systems and looks at what can be done within countries to document and trace this violence. A second, narrower objective is to examine a threat that has been amplified this year: cyberattacks on health infrastructure, the vulnerabilities and what can be done to mitigate these vulnerabilities.

Dr McLean introduced the three panellists, and Dr Castro took the floor and shared that he will present the data collected by the Spanish General Medical Council (observatory of aggressions) in 2019. Dr Castro said that he would be delighted for the data or observations made to be shared more widely. The total number of attacks reported in Spain in 2019 was 677, which was a significant increase: 178 more attacks than in to 2018. In 2019, rates were at their highest in the past ten years. The number and proportion of assaults on women have increased to 61 per cent of the total proportion. They reached 2.57 per 1,000 registered doctors and the greatest number of attacks by region was 170, which took place in Andalusia.

He shared the distribution of violence by age, noting that those most subjected to violence were doctors between 36 and 45 years of age. Examining distribution by age and sex he noted that, in 2019, the older the age, the more male doctors were attacked. In the case of women, the trend was the opposite: the lower the age, the higher the proportion of aggression.

The profile of the aggressors was mainly between 40 and 60 years of age. In 2019, by institutional practice, there were more attacks in primary care (43 per cent), followed by hospitals and primary care emergencies. The types of practice where attacks took place were clearly public: in nine out of ten cases, the rate between attacks in private and public has been stable over the past decade. By type of aggressions, threats constitute six out of ten cases, and these threats were mainly made against women. Some 46 per cent of threats took the form of insults, which were directed mainly against women.

Reviewing the data according to the cause of the aggression, the main reason for attacks was discrepancy in the quality of care received (42.2 per cent). Other reasons were not prescribing what

the patient requests and waiting times (13.5 per cent). Workplaces provided support in six out of ten cases of assault, compared with 45 per cent of the time in 2018. Over the last 10 years, the percentage of those receiving support has increased relatively constantly (over 23 per cent).

A total of 15 per cent of the assaults resulted in the victim taking sick leave. Reports were mainly made in the workplace (27.3 per cent), to the national police and civil guard (27.3 per cent) and, to a lesser degree, to the college of physicians. Only 8 per cent were reported to the courts, which Dr Castro believes is often because doctors are afraid of retaliation.

In closing, Dr Castro stated that it is massively important to collect data in order to be able to make claims and to forge a direct link with the police department for reporting on health-care assaults. This facilitates the action of the judiciary. Dr McLean noted the rather grim statistics and moved the discussion directly to the Q&A about the presentation, which opened with a question about the categorization of violence.

Dr Castro said that the data comes from the doctors and health authorities themselves and covers a range of issues. Asked about more recent data and whether there are early indications with respect to the impact of COVID-19 in Spain, Dr Castro said that these data are not yet ready, but that he believes there will be more aggressions, based upon his observation of trends. He also noted that there is a gradual shift in the perception of the doctors and health authorities as to what constitutes violence.

Dr Castro was then asked to explain the difference in violence between public and private institutions and whether he thought the differences could be linked with the quality of care or the socio-economic

characteristics of the users of the services. Dr Castro said this is not really known, while noting that patients arrive at facilities with high expectations in terms of care and that they quickly become unhappy when the high expectations are not fully met. The two main triggers are a perceived discrepancy of care and another is when a doctor refuses to sign off on sick leave; these have been steady over time.

When asked about the impact of reporting to the police, Dr Castro noted that three to four years ago they started having a more direct link with the police and the General Secretary of the Ministry of Interior in order to better understand the impact of this violence against health-care personnel. As a result of this work and direct link, this violence is now treated with the same seriousness as if it were violence against the police or the civil guard.

In answer to a question on the focus of the data collection, which seems focused more on doctors and not on nurses and paramedics for example, Dr Castro shared that they are currently trying to expand the network to pharmacists, for example, and other medical professionals. As to how the difference in violence between regions is explained, Dr Castro said this is perhaps because the college of physicians in Andalusia functions better than in other regions. A question was asked about how they use the data collected to protect staff and facilities, beyond reporting to the police. He reiterated the importance of data and responded that one of the results of having this data was to get direct links to courts and the police. Protocols are being developed, including emergency numbers and psychosocial support delivered to health workers while ensuring respect for confidentiality. This support can be provided irrespective of whether the incident goes through the judicial system or not. Dr Castro also noted that the data can be used to make citizens more aware of the existence of the problem, as awareness is low. He feels the number of incidents is increasing, as is recognition and willingness to report. Dr Castro reiterated the importance of data collection not only for doctors and health-care staff, but also for all support staff such as porters.

Dr McLean then moved to the next panellist, Mr Rosario Valastro, Vice-President of the Italian Red Cross Association, who was set to present about legislative changes made as a means to treat the same type of problem. Mr Valastro opened by presenting the topic of discussion: the passage of Italian law 113 of 14 August 2020, the Observatory of the Italian Red Cross and the impact of the Italian Red Cross in parliament's approval of the law on safety provisions for health and socio-health professionals in the exercise of their function. This law entered into force on 24 September 2020 after a long debate in the Senate and the House of Deputies.

During the debates, parliament asked different health associations to speak alongside the Italian Red Cross on the importance of this law and the protection it affords. The law seeks to put in place effective measures to protect health professionals from acts of violence, noting the higher frequency of such violence in this sector and the impact that it has on their safety. He noted that these acts of violence can take place inside and outside facilities and can be carried out by patients or the family of patients. This violence has increased significantly in the COVID-19 emergency period.

Mr Valastro shared that the Italian Red Cross spoke in parliament about their "Not a Target" campaign and made an appeal for civilization, stating that while those working in zones of conflict should be afforded protection, there is also a need for protection from violence in Italian cities and provinces. There is also a need to protect the psycho-physical integrity of volunteers.

The law is composed of ten articles which indicate, in Article 1, the professions protected by the law and also that volunteers engaged in providing support are protected. Article 2 of the law regulates the National Observatory on the Safety of Health and Socio-health Professions. The Italian Red Cross, which has its own Observatory, offered its experience to the Minister of Health, arguing that it is important that the National Observatory is represented by the different professions and workers engaged in this field.

The National Observatory's intended role will be to monitor events, to promote studies and analysis to identify mitigating measures, and to monitor the implementation of prevention and protection measures including training courses. It has equal gender representation. Mr Valastro emphasized that it was not enough to have a law that has only repressive measures: it must contain prevention measures, campaigns and training for professionals engaged in the field.

Article 3 concerns the promotion of information initiatives. The Italian Red Cross advocated for the inclusion of this article concerning information and awareness of the importance of respecting the work of health-care personnel. Italy is seeking to inform but also to mobilize. With Article 8, a national day of education and prevention against violence against health and social health workers was created to highlight the issue.

Other articles have a repressive intent for violence through penalties and sanctions. The determination of who enjoys special protection is based firstly upon the membership of a person in these professional groupings and includes the auxiliary service and volunteers. Secondly, it is based upon the exercise of their qualification or trained area.

The Italian Red Cross Observatory on Aggressions against Volunteers started on 10 December 2018 when the Italian Red Cross launched the "Not a Target" campaign on Human Rights Day. The Observatory gathers data on the incidence of violence, including the gender of those involved, and the time and date of the incident. It also captures the type of aggression, the damage caused, the place of the incident, and the identity of the aggressor or aggressors.

The Observatory keeps a record of whether the police are involved, whether the volunteers participate in defusing and whether they receive psychosocial support. In 2020, the Italian Red Cross added new elements related to the COVID-19 emergency, noting stigmatization and verbal abuse at times against volunteers engaged in emergency response activities who may be bringing food to the elderly and

THE OBSERVATORY

Segnalazioni rispetto ad anno dell'avvenuta segnalazione

Anno dell'avvenuta segnalazione
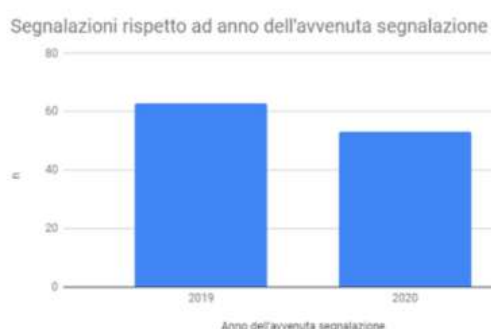
- 53 reports were processed in 2020 (-15% compared to 2019)
- 26% (14) occurred during services strictly related to the COVID-19 emergency

www.cri.it

unable to leave their homes. So, the Italian Red Cross incorporated these elements and did a mapping to identify the local branches that can provide support and that are more affected by cases of aggression.

In terms of data, in 2020 the Observatory noted 53 reports of violence, a 15 per cent decrease from 2019. This decrease is in part due to complications volunteers faced in reporting when responding to emergencies where many of the incidents occurred. Two years after its creation, the Observatory received around four reports per month, mainly related to health transport and ambulance rescue services. Victims and aggressors were primarily men, and 14 per cent of the cases resulted in damage to vehicles. In a significant number of cases, the aggression was carried out by a group and, in over a

ICRC

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

third of the cases, the aggressors were not involved in the event (bystanders). The Italian Red Cross made the case in parliament, based upon data, that this is a social problem. It is the belief that there is hate for the health service and that this needs to be analysed further.

In 72 per cent of the cases, the victim was provided debriefing and defusing by the team. Although there is a high awareness of psychosocial services, few victims considered it appropriate to access this support.

In future, the Italian Red Cross wants to promote the existence of the Observatory for both volunteers of the Italian Red Cross and volunteers of other health associations. Mr Valastro explained that they would like to have more training sessions for their IHL trainers, as a big part of their specialization is the protection of health care. The Italian Red Cross has the ambition to deliver training sessions in every Italian Red Cross branch in 2021. They want to identify the essential data and to be able to correctly interpret the phenomenon of aggression against health-care personnel so that they can better respond to this problem. Health Care in Danger is not only a problem in countries at war: it's a problem for the whole world and a measure of how much health-care personnel are respected.

> **HEALTH CARE IN DANGER IS NOT ONLY A PROBLEM IN COUNTRIES AT WAR: IT'S A PROBLEM FOR THE WHOLE WORLD AND A MEASURE OF HOW MUCH HEALTH-CARE PERSONNEL ARE RESPECTED**
>
> *Mr Rosario Valastro*

Mr Bruno Halopeau of the CyberPeace Institute opened by saying that he will be speaking on their latest research. He explained that health care is a globally lucrative business for criminals, who tend to be present where there is money to be made, and that it is relatively risk-free. Health-care organizations are keepers of sensitive data including medical data, and stolen medical records are traded in the underground market and generate profits. Medical research and intellectual property are also profitable targets. Health-care organizations are also more likely to pay ransoms since the service disruption can have a direct impact on patient health and system availability. This phenomenon is global and a target for two sets of actors: cybercriminals and state actors.

Health-care cybersecurity is undersized. Health-care organizations often operate complex, sensitive but outdated infrastructure. A minority of big health actors have well-developed cybersecurity programmes, but the majority of health providers suffer from a systemic lack of resources. They cannot develop and maintain the infrastructure, train personnel or retain sufficient cybersecurity staff. As a result, protections are weak, and there is a decrease in preparedness exercises and an ability to respond effectively. The health-care sector spends between 4 and 7 per cent of its ICT budget on

cybersecurity, which is comparatively far less than the typical 15 per cent seen in other sectors. This is despite the fact that 93 per cent of health-care organizations have suffered from cyberattacks, and that this trend has experienced a six-fold increase in 2020 since the pandemic.

With respect to the victims, cyberattacks – while not physical – have dire effects on individuals and health systems. To take a few relevant examples of victims from hospitals and medical facilities, last year Universal Health Services, operating a network of health-care facilities including hospitals, was hit by ransomware and 250 facilities were not able to provide health care while under attack. In another example, Singapore Health saw an exfiltration of 1.5 million patient records in 2018. Once records are out, they cannot be deleted, and this represents a major breach when one considers the obligation to keep such records confidential. Another subsector is medical and bio-medical research institutes where, for example, in 2020, Hammersmith Medicines Research had its IT system and email disrupted for one day and had the theft of sensitive data of 2,300 patients.

Governments can also be targeted. For example, the Ministry of Health in Georgia had both the theft and leakage of data but also the falsification of documents about the management of the COVID-19. This issue of data integrity can be used to manipulate and to demonstrate that a certain government is not responding correctly to the crisis. Supply-chain contactors are also very important and can be hacked as targets. For example, Huiying Medical Company in China saw the leak of AI-assisted source code for the detection of COVID-19. The manipulation of data linked with AI algorithms can have serious implications and can lead to erroneous recommendations. In another subsector, pharmaceutical companies, Dr Reddy's Laboratories saw the closing down of operations in the US, UK, India, Brazil and Russia following a ransomware attack and suspicion of a data leak about COVID-19 vaccine trials. Health insurers are also not protected: Anthem Blue Cross saw 80,000,000 patient data records stolen in 2015. And lastly, civil society is also targeted: as an example, Northern Light Health Foundation had data on about 660,000 donors and patients compromised from one of their databases.

The problem is real and it is big. Let's shed some light on the threats and techniques and how they are evolving. There are three main families of threats and techniques, the first of which is ransomware. The first case of recorded ransomware attacks in 1989 was already targeting health care. Data were shared at a WHO conference, which was circulated with thousands of floppy disks. When inserted into a computer, these would encrypt the files and ask that money be wired to Panama to recover the data. This is not a new technique. Since then, however, the number of techniques and vectors to infect have grown tremendously, with 177 known techniques to infiltrate a network. Systems and individuals are

ICRC

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

currently mainly prone to ransomware owing to two main vectors. The first vector is through a phishing email that will infect one's network and the second is through remote vulnerabilities, where a network is not well-protected or has outdated software. In the early days of ransomware, infection was widespread and not particularly targeted, with a small amount to pay, generally in Bitcoin. Criminals tried to target as many people as possible to gain money, knowing very few will pay. Nowadays, the approach is much more specialized and targeted, with higher payment amounts.

The underground markets have professionalized, and criminal networks are developing ransomware toolkits as a service. In other words, such a kit can simply be bought on the underground market for as little as USD 40 and as much as USD 1,000. An ecosystem of affiliation exists: people who develop these kits engage affiliates to try to find new ways to infiltrate networks and the operator maintains the toolkit. They work together, with the affiliate typically receiving 70–80 per cent of the profit and the operator the rest, which can already be a lot of money.

Since November 2019, a trend called double extortion has emerged. Initially ransomware was just payment to decrypt files, but since more and more organizations were deploying a backup system, payment rates were decreasing. Thus, the attackers created a new model whereby before encrypting they extract data. This creates additional pressure on the victim to coerce them even more by pressuring that if the victim doesn't pay, extracted data will be disclosed or sold on the underground market. Since the end of last year, a triple extortion approach has emerged, encompassing the first two approaches with the criminals also looking at the individual files for patient records and contacting every single patient to extort them directly. This was an approach that was used at Vaastamo Psychotherapy Centre in Finland.

The second level of threats is cyber espionage, which is mainly employed to steal intellectual property and to carry out intelligence-gathering. Typically, access is gained by phishing with the intention to do two things: firstly, to maintain a presence in a network through a remote access programme so that cybercriminals can monitor and access the organization's secrets, and secondly to compromise sensitive information by capturing, exfiltrating, modifying or deleting data. Lastly, they also implement mechanisms to hide/delete any traces of their presence in the victim's network in order to avoid being exposed by any investigations.

Another element is disinformation and the infodemic. What is meant by infodemic? Infodemic is an overload of information, using often false information, especially during crises. There are two main sets of actors. One is criminal actors who may exploit a crisis to further malicious activities. As an

ICRC

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

example, criminals may use a legitimate vaccine campaign to pose as the government to have people click and install malware. The other major actors are state actors, who may use cyber operations to exfiltrate, plant or manipulate information related to the COVID-19 pandemic in order to confuse and contribute to information ambiguity. For example, troll farms of dozens or hundreds of people can spread false information or lobby the press to release fake information. This undermines public trust and trust in health-care professionals and in those involved in making decisions around the response and creates a climate of fear and conspiracy.

There are 25 main ransomware operators. Some of them are well known, such as DoppelPaymer, Egregor, Maze, Ryuk and Networker, which all operate in largely the same way by trying to exploit systems through emails. Their targets are mainly health care, education, ICT and the retail sector, as this is where they have the greatest likelihood to succeed.

What is the impact? Each data breach has a cost, but the impact on the health-care sector is 60 per cent greater than in other sectors. The impact, in terms of not only the physical impact on people but also the business cost and the societal and psychological cost, is huge. Intellectual property loss can bankrupt a business. Businesses often experience a downturn or failure after information is compromised, especially if it is poorly handled, including in reputational terms. Some damage also cannot be repaired. In December 2020, there was a case where a patient could not be accepted due to a ransomware attack and the person was transferred to a hospital further away and died as a result. While this does not prove that ransomware kills, it shows that it can seriously disrupt operations, potentially leading to serious consequences in real life.

CyberPeace Institute

06 – IMPACT WHAT ARE THE DIRECT AND INDIRECT IMPACTS OF ATTACKS ON SOCIETY?

Societal Cost

Physical Impact on People

Business & Economic Cost

Psychological Cost

The loss of sensitive personal data leads to a feeling of violation, betrayal and powerlessness and causes stress to patients and medical staff. Getting back your identity once it is released is extremely difficult. At a societal level, the reputation of the health-care sector is undermined as a result and leads to businesses shutting down, which can hinder the ability of the health sector to carry out an emergency response during a disaster or crisis.

Medical records stolen through ransomware can be sold on the dark net for upwards of USD 363 per record. In the period between November 2020 and January 2021, the incidence of ransomware attacks increased by 22 per cent on average, and by 45 per cent in the health-care sector. The ransom amounts from ransomware are also increasing significantly: in 2018 it was USD 6,000, but in 2019 it increased to USD 84,000 and in 2020 the amount was in the range of USD 178,000–273,000. An estimated 25 per cent of victims are said to pay, believing that the cost to them of having their information shared is higher than the ransom. An estimated half of the companies are not prepared and able to restore their systems and files through backups and a continuity plan. As long as there are a high number of paying victims and systems are not prepared, this trend is likely to continue.

As a final point, Mr Halopeau put this situation into a normative and legal context. The intention is to make perpetrators accountable and there are a variety of laws and treaties that can be better utilized for this purpose. In terms of recommendations, governments should enforce extradition and prosecute criminals wherever possible, meaning better cooperation between states. It is also critical to better enforce asset tracking and freezing, because payments are made in cryptocurrencies and then at some

ICRC

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

point go back into the traditional banking system. There is also a need to facilitate cross-border cooperation and mutual assistance. For this, there is a convention on cybercrime, also known as the Budapest Convention (Council of Europe, 2001),[18] which has been ratified by 65 countries. It's not a perfect treaty but it forms a good basis to harmonize legislation and international investigations across jurisdictions, to enhance public/private cooperation and to increase the capacity of criminal-justice entities. This treaty improves access to evidence and data in clouds.

To conclude, numerous stakeholders can work together to reduce the threat and take coordinated action at four levels. Firstly, around laws and norms, it is essential to document, as was mentioned by Dr Castro and Mr Rosario, so that impacts can be better measured. It must be stated clearly that cyberattacks against health care are unlawful and unacceptable. This can be helpful to raise awareness and pressure governments to take it more seriously. Secondly, it is essential to better secure critical health-care infrastructure by investing in skills and ICT equipment, and to have a good set of policies around cybersecurity. It is essential to exercise resilience and to be adequately prepared in terms of processes. Cybersecurity is everyone's concern and not just ICT professionals' problem. Thirdly, it is important to build active information-sharing – not only inside the sector but also between public and private actors, and not only national but also regional and international. Finally, hold those who perpetrate crimes accountable: take steps to find out what happened and ensure that reporting takes place. All the information shared today will be published in a Strategic Analysis Report to be released in March 2021 to the public.[19]

To open the Q&A, Mr Valastro was asked about the themes of the parliamentary debate and what could be learned from that in terms of other contexts. Mr Valastro explained that all the political parties agreed that such legislation was necessary, but they did not agree on how and who to protect. Initially, the protections were to be extended only to doctors and nurses, and this was eventually made more comprehensive and to include volunteers. Changes were also made to cover not only repressive measures but also preventive measures. Other changes were made to the law to not only have an advocacy role with the constitutional bodies but also with the media. This is done to ensure a public information component for the population. If the people understand the phenomenon, they will be better able to support Red Cross action.

---

[18] https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/185
[19] https://cyberpeaceinstitute.org/report/2021-03-CyberPeaceInstitute-SAR001-Healthcare.pdf and for the launch see https://www.youtube.com/watch?v=g9ZJzROQ4G0

Mr Valastro explained further that the National Observatory of the government has not yet been established as it is still awaiting the decree. For now, the only observatory in existence is the Italian Red Cross Observatory. When the National Observatory is established, the Italian Red Cross will consult with the Ministry of Health to determine whether the Italian Red Cross Observatory should be maintained. This depends on how the National Observatory will function – the Observatory of the Italian Red Cross reports anonymously and the data collected is analysed by the headquarters of the Italian Red Cross. Responding to a question about the scope of the law, it requires that the assault is linked to the work of the health-care personnel. If it is related to their work and the patient or their friends or family assault the medical personnel, then the law would apply.

Mr Halopeau next replied to a question on fragile contexts, explaining that it is critical to understand whether the systems in place across the planet should be kept up to date as a basis. The generalized trend in health care is that equipment is ageing and that software is not updated and, at times, is not even supported by the reseller. But this is not particular to any one area: it has more to do with the specifics of the system in place. The weakest link is always the entry point. For example, medical devices running on Windows XP are no longer supported and updated and if those devices are still in use in a network they could be readily exploited.

He responded to a question about how to decrease the vulnerability of electronic medical records across the continuum of care by underscoring the need for good cyber hygiene. Systems and records should have proper protections like being encrypted and therefore not accessible even if stolen. He noted that having such a regime has an additional cost and stressed the need to increase security standards. Today the trend is that everything will go digital; there is no going back. It is better to look at how to secure this digital footprint.

Responding to a question about the sensitivity of data in relation to ethics, he noted that states and companies have rules regarding data protection. For example, under the GDPR, an entity that is found incapable of protecting its data can be subjected to fine of a 2 per cent of its global turnover. So, it is important to monitor data flows, to understand where sensitive data are located and to work to protect them. With respect to availability, this is a matter of preparedness, and so it is important to understand what would happen in the event of a major failure in terms of how to recover and if the system is down, how doctors can take care of their patients. Communication between the ICT team and health-care professionals will also be critical to mitigating the impact.

When asked about National Red Cross and Red Crescent Societies that are part of national responses and have access to certain data, Mr Halopeau noted that National Societies don't want to be the weak point and must work with governments to ensure that systems are maintained on an ongoing basis.[20]

> **WITH RESPECT TO CYBERATTACKS, WHAT IS STRIKING IS NOT ONLY THE SCALE OF THE ISSUE BUT ALSO THE LETHARGY AND LACK OF PROTECTIONS WITHIN THE HEALTH-CARE SECTOR. THIS IS NOT ONLY FOOD FOR THOUGHT BUT FOOD FOR ACTION AS WELL**
>
> *Dr Duncan McLean*

In closing, Dr McLean remarked how attacks on health care tend to evoke thinking about bombardments and the kidnapping of staff, but actually, as MSF data have also shown, the majority of the attacks are much more banal. It is the frustrations of patients or those accompanying them. This is not something found only in conflict zones, but universally. With respect to cyberattacks, what is striking is not only the scale of the issue but also the lethargy and lack of protections within the health-care sector. This is not only food for thought but food for action as well.

---

[20]The ICRC and the Brussels Privacy Hub (Free University of Brussels - VUB) published in May 2020 the second edition of the "Handbook on Data Protection in Humanitarian Action". The Handbook seeks to raise awareness and assist humanitarian organizations in ensuring that they comply with personal data protection standards in carrying out humanitarian activities, by providing specific guidance on the interpretation of data protection principles in the context of humanitarian emergencies. The second edition of the Handbook was launched in the framework of an expert panel entitled "Data Protection in the Time of COVID-19": See https://www.icrc.org/en/data-protection-humanitarian-action-handbook

ICRC

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

INTERNATIONAL COOPERATION & THE ROLE OF EURASIAN STAKEHOLDERS

Moderator:	**Ms Kaja Sannerud Andersen**, Senior Adviser on Protection & Policy, Norwegian Red Cross, Norway

Theme	**INTERNATIONAL MOBILIZATION AROUND COOPERATION IN THE PROTECTION OF HEALTH CARE**
Panellists:	**Mr Chaim Rafalowski,** Disaster Management & EU Projects Coordinator, Magen David Adom (MDA) & member of the No-Fear project

Theme	**EU SUPPORT FOR RESEARCH & PRACTICES IN THE PROTECTION OF HEALTH CARE**
Panellists:	**Ms Reka Dobri,** Team leader, Humanitarian Aid Thematic Policies Unit of the Directorate-General for European Civil Protection & Humanitarian Aid Operations (DG ECHO)

Theme	**REVIEW OF THE STATE OF ONGOING CONCRETE INITIATIVES & ICRC STRATEGY ON THE PROTECTION OF HEALTH CARE**
	Mr Maciej Polkowski, Head of the Health Care in Danger Initiative, International Committee of the Red Cross (ICRC)

ICRC

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

The fourth and final session was moderated by Ms Kaja Sannerud Andersen, Senior Adviser on Protection and Policy at the Norwegian Red Cross, a longstanding champion of Health Care in Danger and representing one of the National Societies most actively involved in the protection of health care.

The first presentation was delivered by Mr Chaim Rafalowski, MDA Disaster Management and EU Projects Coordinator. Mr Rafalowski presented the No-Fear project, a network funded by the European Commission with the goal of bringing together practitioners, industry and researchers involved in emergency medical care in Europe, allowing them to share knowledge and identify gaps in the field of emergency medical care in security-related incidents. The sector is a very fragmented one, as it includes the citizens providing the very first response in the aftermath of an incident, the first-aid services receiving the emergency call, the ambulance services and the hospitals, among others. The No-Fear project aims to bring these different actors together. It is based on three pillars: acute care for patients, the training of personnel and volunteers, and emergency operations in security-related incidents. The latter is coordinated by Magen David Adom, whose efforts have also focused on COVID-19 since the beginning of the pandemic. Mr Rafalowski stressed that the pandemic has spread at a different pace and time in different countries, allowing the circulation of lessons observed. For example, Israel learned from Italy, which was hit first, and further shared its experience with other countries.

Mr Rafalowski presented three main issues that emergency responders are facing. The first is the problem of scene safety. Traditionally, in the aftermath of an incident, first responders have had to wait for the scene to be declared safe. However, in the contemporary world this paradigm is no longer valid and there is a need to redefine it. As terrorist attacks in recent years have shown, incidents often do not occur in one defined spot, as perpetrators operate over a larger area – citing the terrorist attack all along La Rambla in Barcelona, which is several kilometres long – and the scene evolves quickly. Hence, paramedics nowadays should rather examine what makes the scene unsafe and should separate issues that can be addressed (e.g. calling firefighter if there is a fire) from issues that cannot be addressed.

The second is the issue of bystanders, namely those citizens who, in the immediate aftermath of an incident, provide first aid to their injured fellow citizens. Currently, there is no ethical framework for the bystanders and, from an operational viewpoint in Europe, professional first-aid responders remove the bystanders from the scene as soon as possible. Mr Rafalowski suggested that a legal and ethical framework for bystanders is important and that they should be provided with psychosocial support.

Their role is important and they need to be reassured: they have helped other people without any equipment or training and they need to be told that their action was beneficial to others.

Third, Mr Rafalowski observed that protective equipment is essential for emergency health workers, who are sometimes even targeted by perpetrators. However, such equipment is normally received from the police or the military. Hence, it does not respond to the specific needs of the health-care workers, e.g. allowing them to perform "gentle" gestures towards the people in need or having small sizes for the many women in the emergency services.

Mr Rafalowski made some concluding remarks on the impact of COVID-19 on the health-care services, stressing the issue of attacks against health-care providers in connection with the pandemic response. He highlighted the difficult material conditions that health-care workers endure when wearing COVID-19 protective equipment in a hot country like Israel. Health-care workers are currently experiencing emotional challenges, as they have been taught to comfort patients through physical gestures including contact, and now they are forced to work while respecting physical distance and wearing equipment that covers their face and masks their expressions.

Ms Reka Dobri, Team Leader from ECHO, presented the objectives of DG ECHO: to provide protection, relief and assistance in third countries to people affected by natural or man-made disasters and to encourage cooperation between Member States for preventing and protecting against such situations. She stressed the importance of working in partnership on topics of humanitarian assistance, and recalled the longstanding cooperation with the ICRC, which in 2020 alone received over EUR 110 million from ECHO, as well as with EU-based National Societies and various NGOs. As a humanitarian donor, ECHO is concerned by the overwhelming number of attacks against medical personnel and facilities, which endanger not only the lives of health-care workers, but also the assistance available to civilians who are already vulnerable. ECHO has been advocating for compliance with IHL in armed conflicts and for the protection of health and humanitarian workers. In 2019, this commitment to protect health care in armed conflict was reaffirmed through an EU pledge made together with some Member States and some EU-based National Societies at the 33rd International Conference of the Red Cross and Red Crescent.[21] ECHO has pledged to take several measures, including supporting training sessions on

> **ATTACKS AGAINST HEALTH CARE ENDANGER NOT ONLY THE LIVES OF HEALTH-CARE WORKERS, BUT ALSO THE ASSISTANCE AVAILABLE TO CIVILIANS WHO ARE ALREADY VULNERABLE.**
>
> *Ms Reka Dobri*

---

[21] https://rcrcconference.org/fr/pledge/protecting-humanitarian-and-medical-personnel/

IHL and on the rights and responsibilities of health-care personnel, awareness-raising and trust-building to ensure respect for principled humanitarian action, supporting states and non-state actors to enhance the physical safety of medical personnel, and supporting the collection and analysis of data on attacks.

Ms Dobri underlined that ECHO is committed to continue keeping the focus on the challenges of health-care protection and to find solutions. This commitment is expressed in several resolutions. For example, in 1998, Austria – on behalf of the EU – proposed the UN General Assembly Resolution on safety and security of humanitarian personnel and protection of UN personnel. Furthermore, the European Union supported Security Council Resolution 2286 of 2016 on the protection of health care as well as the implementation of the measures proposed in relation to it by the UN Secretary-General. This year, the EU is launching a discussion series on the protection of humanitarian workers and medical personnel in armed conflicts, which will involve UN Member States, specialized organizations and humanitarian actors, in order to identify challenges and explore practical solutions that the international community can take in the short and long terms. Concretely, four topics will be addressed in this discussion series: data collection and analysis for monitoring purposes, security risk management practices, preventing and countering the criminalization of humanitarian work, and preserving humanitarian space and strengthening accountability in the fight against impunity for attacks.

Ms Reka Dobri underlined that, apart from its engagement in these multilateral forums, ECHO is committed to maintaining attention on the challenges posed to the protection of health care in humanitarian settings. This

European Commission

Commitment to protect healthcare in humanitarian crises

"*Attacks against humanitarian workers and volunteers as well as medical personnel or patients in situations of armed conflicts are to be resolutely condemned, as they constitute violations of international law and reduce humanitarian access to populations in vulnerable situations.*

1. **Training on IHL & on rights and responsibilities of humanitarian and healthcare personnel**
2. **Awareness-raising and trust-building to ensure respect for principled humanitarian action**
3. **Support States and non-state actors to enhance the physical safety of medical personnel**
4. **Collection and analysis of data on attacks against medical workers and infrastructure**

–EU/EUM/EU RCNS pledge - 33rd International Conference of the Red Cross and Red Crescent

LET'S HONOUR THOSE WOUNDED WHILE DOING THEIR JOB

MORE THAN 3 HUMANITARIAN WORKERS WERE ATTACKED AND WOUNDED EVERY WEEK IN 2013.

THE EUROPEAN UNION SUPPORTS THE WORLD HUMANITARIAN DAY

ICRC

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

theme is actually central to ECHO's engagement with humanitarian actors and the donor community. For example, two years ago, ECHO chaired the Humanitarian Liaison Working Group discussion on the protection of humanitarian and medical workers and held a number of discussions with states and organizations, focusing primarily on how to improve data collection. Currently, ECHO is co-chairing the Good Humanitarian Donorship (GHD) initiative, which brings together 42 humanitarian donors. The protection of humanitarian space and IHL is one of the themes discussed within this forum. ECHO has carried out an internal survey among GHD members to better assess what members are doing. ECHO's engagement in the GHD includes funding, advocacy, exchanging of issues on concrete field cases and elaborating synergies with other actors. Ms Dobri also expressed ECHO's pleasure at hosting ICRC President Maurer's speech to the GHD on these topics.

As a humanitarian donor, beside working on advocacy and supporting international cooperation, ECHO is committed to promoting the protection of health care by supporting training sessions, research and operational initiatives. Examples of this include funding IHL dissemination to militaries, security forces and non-state armed actors, and promoting IHL in the EU training mission as part of the EU Common Security and Defence Policy. Additionally, ECHO was able to support Geneva Call in developing training resources to engage with non-state armed actors, including on the protection of health care, and it is currently evaluating the proposal for a new call aimed at supporting data collection and research on the protection of health care. Ms Dobri also acknowledged the key role played by the ICRC Health Care in Danger initiative in this area, whose work is supported by ECHO in various countries including Afghanistan, Myanmar and Ukraine. ECHO's vision is that personnel in health-care facilities are aware of their duties and rights and are aware of and able to implement measures to reduce exposure to risk and develop self-protection mechanisms. Ms Dobri stressed the importance of operational standards, which include, for example, medical neutrality, as well as concrete measures to provide health-care personnel with a maximum level of protection, citing the example of security precautions taken during vaccination campaigns.

Ms Dobri concluded by presenting ECHO's perspective and actions to facilitate the response to COVID-19 in humanitarian settings. The pandemic has posed a great challenge and risks for health-care workers. ECHO has provided EUR 450 million, most of which was used within the health and water and sanitation sector, including to provide PPE for health-care staff and humanitarian workers. It set up a temporary EU humanitarian air bridge to deliver relief items for the COVID-19 response and to facilitate the movement of medical and humanitarian staff, with around 67 flights since early May.

The third and last presentation was from Mr Maciej Polkowski, Head of the Health Care in Danger initiative at the ICRC. Mr Polkowski underlined that the protection of health care has been at the core of the International Red Cross and Red Crescent Movement's mandate since its beginning. Health is the biggest cluster of programmes for National Societies worldwide. Therefore, the protection of health care also entails the protection of National Red Cross and Red Crescent Society volunteers and staff. Nevertheless, the protection of health care is first and foremost directed to national health-care staff, since out of 200,000 aid workers globally, only a small portion are health workers. According to WHO, there are more than 40 million health workers worldwide, and only a very small number of them are humanitarian workers. Therefore, the problem of violence against health care affects the humanitarian community only marginally. It primarily affects national health-care workers, who bear the main burden of violence.

Mr Polkowski explained that the Health Care in Danger initiative covers a wide spectrum of violence. The most emblematic cases are those from the Middle East, where attacks against health care are the result of direct targeting or of disregard for the rules of war. However, the Health Care in Danger initiative also includes issues of violence against emergency services in contexts where the general security situation has an impact on health care, preventing health programmes from functioning effectively.

Mr Polkowski also clarified that the protection of health care means not only preventing harm and refraining from illegal acts, but also undertaking positive obligations under international law, such as the duty to actively protect health-care services in times of conflict and other emergencies and to facilitate the fast passage of ambulances at checkpoints. Furthermore, not only belligerents, but also health-care workers play an important role, as they should not discriminate between the segments of the community receiving health care. Finally, the protection of health care should not be understood as being limited to situations of conflict and to acts perpetrated by weapon bearers. Violence against health care is a global trend that also affects peaceful and highly industrialized contexts. Even if these contexts are not of primary concern for the ICRC, there is a lot to learn there. Additionally, new trends of violence against health care have been observed during the pandemic, perpetrated by individuals, communities and law enforcement bodies.

THE PROBLEM OF VIOLENCE AGAINST HEALTH CARE AFFECTS THE HUMANITARIAN COMMUNITY ONLY MARGINALLY. IT PRIMARILY AFFECTS NATIONAL HEALTH-CARE WORKERS, WHO BEAR THE MAIN BURDEN OF VIOLENCE

Mr Maciej Polkowski

Mr Polkowski detailed the Health Care in Danger response to the issue of violence against health care, which is depicted in the Health Care in Danger initiative's theory of change, whose overall goal is not only to reduce violence, but also to mitigate its impact, integrating both a resilience and a preparedness component. Four specific objectives are leading to this main goal: to promote respect for health care from weapon bearers; to advocate for the adoption of domestic legislation to protect health care; to enhance preparedness of the health-care system; and to build respect for health care among the general public. There are two cross-cutting enablers underpinning these objectives, namely the mobilization of the community of concern and the generation of evidence-based analysis.

Finally, Mr Polkowski presented a few examples of concrete measures taken under the Health Care in Danger initiative, which correspond to the above-mentioned specific objectives. First, in Palestinian refugee camps in Lebanon, the ICRC was able to engage with communities and more than a dozen armed groups, and developed a Unilateral Declaration on Respect for Health Care, which is now being

monitored with the community. The second example was the adoption of a regulatory framework in El Salvador, which started in 2016 with an action led by the Salvadoran Red Cross aimed at developing an inter-institutional coordination protocol supported by large-scale capacity-building and promulgated into law in 2019. Third, hospital management in Pakistan adopted SOPs and a coordination mechanism in order to allow those who manage the department to prevent the entry of weapons. The fourth example was a behaviour change campaign in Iraq to address violence perpetrated by civilians and tribal revenge against doctors, leading to positive, measurable results.

Mr Polkowski continued by presenting the cross-cutting enablers underpinning this work: the mobilization of communities of concern and the importance of generating evidence-based analysis and research. There is a great need for highly localized analysis and research, which can inform the prevention and protection approach and measure its impact. The Health Care in Danger initiative has worked with Enhancing Learning and Research for Humanitarian Assistance (ELRHA), in order to review what evidence-based research on violence against health care exists in this field.[22] The study found that the majority of this research is in high-income countries (Japan, US and EU), but that nothing or little exists in other places like Central Africa Republic and other humanitarian contexts. At the very beginning of the Health Care in Danger initiative, it was important to mobilize the international community and to gain global support for a diplomatic strategy. However, currently, mobilization and evidence-based research are required at country and sub-national level, involving ministries of health, health workers' associations, municipal health departments and all other concerned actors.

Mr Polkowski highlighted that the Health Care in Danger initiative also has a strong diplomatic component, and that 2021 marks the fifth anniversary of UN Security Council Resolution 2286, adopted unanimously by Security Council members in May 2016. While this has been generally regarded as a success, the fifth anniversary provides an opportunity to assess what has been achieved so far. It cannot go unnoticed that there is a contrast between states' enthusiasm in diplomatic circles and very poor implementation at the national level. It is important to recall that the UN Security Council, in its recommendation, calls on all states – not only the states in conflict – to implement this resolution through practical steps. Hence, all countries, and in particular those that position themselves as global leaders on humanitarian issues, should increase their credibility by making sure that they implement mechanisms to protect health care.

---

[22] https://www.elrha.org/researchdatabase/researching-vahc/

Mr Polkowski concluded by stressing that the regional meeting discussion showed that, on the one hand, violence against health care in peaceful contexts and armed conflict during the COVID-19 crisis are not the same phenomenon. There is a large spectrum of manifestations of violence. Nevertheless, there are also overlaps and mechanisms that should be deployed to address this issue that can work in diverse contexts. For example, the observatory on violence against health care adopted in Italy could also work in countries affected by conflict. Therefore, the exchange of experiences, peer-to-peer support, and more generally solidarity among health-care providers who face similar situations would strengthen the voice of health-care workers worldwide. Along the lines of solidarity, health-care workers who face similar challenges should work jointly and make their voices heard at home and internationally.

> ## HEALTH-CARE PERSONNEL HAVE NOT BEEN PREPARED TO DEAL WITH THIS ENVIRONMENT, AND EVEN THE BEST DE-ESCALATION TECHNIQUES DEMAND COMMUNICATION EFFORTS THAT ARE CHALLENGED BY THE NEED TO WEAR PROTECTIVE EQUIPMENT THAT COVERS THE WHOLE BODY
>
> *Mr Chaim Rafalowski*

After the three presentations, there was an intervention from the floor from Mr Moritz Seiler, Desk Officer Humanitarian Assistance – Policy, International Organizations, Multilateral Coordination at the German Federal Foreign Office. He noted that the second half of 2020 provided Germany with unique political exposure and opportunity, since Germany was a member of the Security Council and held the Presidency of the Council of the EU simultaneously. This was an opportunity to bring forward concrete policy measures to better protect the humanitarian space. During the Presidency of the EU, Germany addressed challenges to humanitarian assistance stemming from both the pandemic and from sanctions and counter-terrorism measures. Germany produced a non-paper for EU Member States on the challenges posed by sanction mechanisms and counter-terrorism efforts. This non-paper describes the status quo and provides guidance on dealing with such measures. It also features tripartite dialogue between humanitarian organizations, governments and financial institutions on best practices.

Mr Moritz also provided an overview of the work of Germany in New York as a member of the Security Council. He recalled that the launch of the German-French Humanitarian Call for Action was a major highlight during Germany's membership of the Security Council. To date, 46 countries and the EU have endorsed the call. He stressed that it is very important to fight for the humanitarian space, humanitarian principles and humanitarian language, since during negotiations on numerous resolutions, Germany has witnessed efforts to undermine humanitarian principles. Nevertheless,

ICRC

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

Germany was successful in advancing the humanitarian cause in numerous resolutions. Mr Moritz pointed out that Germany is supporting several initiatives to preserve and expand the humanitarian space, such as the Centre of Competence on Humanitarian Negotiations and Geneva Call. Germany also appreciates its strong partnership with the International Red Cross and Red Crescent Movement.

In the Q&A session, Mr Rafalowski was asked whether there are figures on attacks against first responders in Israel during the COVID-19 crisis. He replied that, even though there are currently no statistics available, many forms of abuse have emerged during the pandemic crisis because the situation was very tense. This has led to physical, but mainly verbal, abuse because patients are transported out of town (due to lack of space in nearby hospitals) and far from the family, because there is a lot of anxiety and stigma, and because of the idea that, when patients leave, they will never recover and come back. Family members are not allowed to visit them and there is a tense atmosphere with health-care providers. The feeling is that health-care personnel have not been prepared to deal with this environment, and even the best de-escalation techniques demand communication efforts that are challenged by the need to wear protective equipment that covers the whole body.

Mr Rafalowski was also asked to describe the cooperation between emergency services and security forces within the framework of scene safety in the aftermath of an incident. Mr Rafalowski pointed out that, on the scene, there might be a second perpetrator, for instance, an unexploded device, and that the most important thing according to his own experience and the findings of the No-Fear project is that law enforcement agencies train emergency medical services (EMS) personnel on what risks and clues to look for. At the same time, the police need to understand the EMS side, such as the need for triage. Law enforcement and EMS are not replacing each other but should understand each other better in order to work jointly on the scene. They share some common objectives, such as removing the patient from the scene as soon as possible, in order to allow EMS personnel to treat the patient in a safer environment, as well as allowing the police to better work on the scene.

Ms Dobri was asked whether ECHO has developed a mechanism to ensure follow-up to the 2014 guidelines on health. She explained that the follow-up work is done by a network of humanitarian experts based in the countries where humanitarian action takes place. They monitor projects supported by ECHO to ensure they are in line with those standards. Additionally, there are eight doctors based in regional hubs around the world who are thematic experts charged with providing follow-up and monitoring health projects against operational standards.

Ms Dobri also received a question about the EU's position on counter-terrorism and humanitarian action. She replied that ECHO believes that humanitarian action should not be politicized or criminalized, including by counter-terrorism measures. The EU counter-terrorism measures shall comply with international law, including IHL. On non-state actors specifically, ECHO recognizes that most of today's armed conflicts are non-international and involve non-state actors. There are millions of people under the effective control of non-state armed groups; hence it is critical that humanitarian actors are allowed to engage with those groups in order to secure humanitarian access as well as the safety and security of their own staff, in order to provide humanitarian assistance to the population.

Furthermore, a question was asked about a comparison between the 1998 UN General Assembly Resolution, and the 2016 UN Security Council Resolution: what are the similarities and differences between these resolutions? Mr Polkowski mentioned that the Security Council Resolution clearly speaks about the protection of "health-care workers and humanitarian workers *exclusively engaged in medical duties*". This clarification is important because humanitarian workers and health-care workers are two distinct categories with a small area of overlapping. National health-care workers are bearing most of the burden of violence against health care. Ms Dobri agreed and acknowledged that the protection frameworks for health workers and humanitarians are different but stated that, in humanitarian settings, measures at field level are intertwined. This is why, with the discussion series, ECHO will look broadly at humanitarian work in the field but also specifically address the protection of health-care workers.

The final question, directed at Mr Polkowski, concerned the declaration to respect health care promulgated in the Palestinian refugee camp in Lebanon: was it followed up and was it repeated in other contexts? Mr Polkowski commented that this declaration is a fairly recent achievement, and that it is too early to speak about the success. However, we have encouraging anecdotal evidence that it has made a difference, as we are aware of cases of wounded members of an armed group taken to a community hospital without obstruction from the rival group. Furthermore, there are currently ongoing attempts to introduce the protection of health care as a theme of negotiations between different parties to the conflict in several humanitarian settings.

MEETING OBSERVATIONS & RECOMMENDATIONS

Session 1: Observations & recommendations

- Encourage further coordination between military actors and civil actors, including medical organizations, to ensure the protection of health care and safe access to medical services as a matter of common concern: exchange on their respective missions and operational approaches, the medical needs of civilians, their specific concerns and the relevant IHL and IHRL rules to be incorporated into military doctrines, directives and orders.

- Develop comprehensive military instructions that specifically address the protection of health care: integration of the relevant rules into the planning and conduct of military operations to minimize their impact on health-care services, to ensure that medical personnel are able to perform their duties and to allow safe access to medical services. The ICRC *Guidance for the Armed Forces*[23] provides examples that can support the implementation of protective actions within military engagement.

- Train and exercise these operational procedures that incorporate the relevant IHL and IHRL rules, if possible with the inclusion of diverse actors that might enhance the effectiveness of these experiences. Relevant humanitarian organizations can provide inputs, enhance realistic scenarios and highlight challenges in the application of specific rules.

- Promote the exchange of good practices (military doctrine and instructions) between states' armed forces and relevant international organizations that have a military component.

- Develop or strengthen a domestic normative framework to protect access to health care and to ensure its safe delivery in accordance with IHL and IHRL. National IHL Committees and similar bodies on IHL can play an important role in this regard.[24]
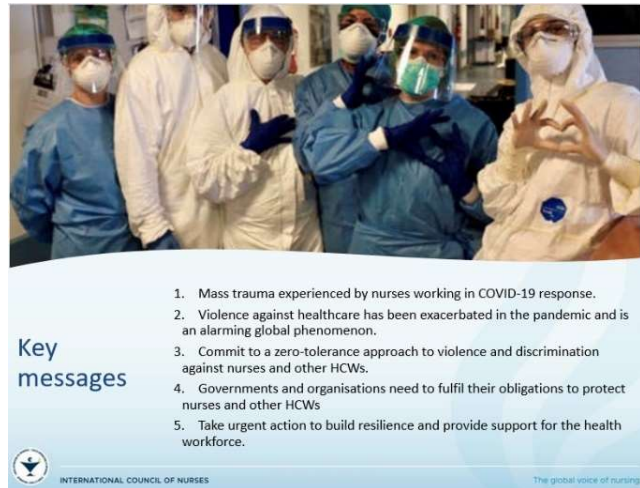
Session 2: Observations & recommendations

- Counter misinformation and disinformation with inclusive and comprehensive community engagement activities, transparent communication and appropriate domestic legislative measures.

- Implement zero-tolerance policies on violence against health-care workers.

---

[23] See https://healthcareindanger.org/wp-content/uploads/2021/03/4504_002-ebook.pdf to access
[24] See https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4215-domestic-normative-frameworks-for-the-protection-heath-care.pdf, the report of the HCiD workshop held in Brussels on 29-31 January 2014 which also includes a broad set of recommendations building on this theme

- Engage with interlocutors at all levels to ensure that health-care workers are protected, including with state authorities, health facility managers and community members themselves.

- Provide specific, dedicated support to address the mental and psychosocial needs of health-care workers. The visibility of management and organization or business leadership in actively supporting and engaging with health-care workers is critical for those delivering health care.

Key messages

1. Mass trauma experienced by nurses working in COVID-19 response.
2. Violence against healthcare has been exacerbated in the pandemic and is an alarming global phenomenon.
3. Commit to a zero-tolerance approach to violence and discrimination against nurses and other HCWs.
4. Governments and organisations need to fulfil their obligations to protect nurses and other HCWs
5. Take urgent action to build resilience and provide support for the health workforce.

INTERNATIONAL COUNCIL OF NURSES   The global voice of nursing

Session 3: Observations & recommendations

- Collecting data to document incidents should be directed not only towards doctors but also towards nurses and other health-care workers – including non-clinical personnel - with the ability to disaggregate the information.

- The body that is best positioned to collect data is a critical concern. Any data collected must have a clear purpose and supporting the safeguarding of health-care workers must be its primary purpose. Careful consideration must be given, prior to the commencement of data collection, to the capacity to collect data, to its analysis to guide protective and preventive measures, and to risks associated with data collection and storage, in order to ensure that harm is not inadvertently caused to those the data collection is seeking to protect.

- Using data to increase public awareness of the magnitude of the problem is extremely important, given the relatively hidden nature of the issue, while striking the right balance so as not to generate unwanted risks and potentially cause harm.

- A host of actors, including law enforcement agents, professional associations, health authorities, academia and other stakeholders, must be part of the collaboration in order to have an effective response to violence against health care. This engagement will increase the potential for not only the immediate reaction, but also the long-term elements of any response, to be coordinated and supportive of victims of violence in health-care settings.

- When developing and implementing comprehensive domestic legislation to set in motion or reinforce measures that safeguard the protection of health care, it is recommended to advocate for the development of domestic legislation to also include a communication component in order to foster the involvement of the media. This will promote a climate conducive to the protection of health-care personnel in their workplaces and the community.

- New risks of obstruction and attacks are arising with the use of digital resources and technology. The health sector is particularly at risk and targeted. These risks must be adequately assessed and mitigated, in close collaboration between ICT and health experts.

ICRC

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

- Legal and law enforcement aspects of the protection of health care must be coordinated in order to promote adequate responses and to hold perpetrators responsible.

Session 4: Observations & recommendations

- Technical solutions to reduce the risk faced by first responders must continue to be sought. Physical protective equipment might create a false sense safety and the decision on whether or not to use such equipment should be carefully weighed.

- Work to improve the communication skills of health workers over time, including through in-service training (not only for new professionals) as a relevant means to reinforce staff resilience and to reduce violence.

- Emergency medical staff (EMS) must be trained and must have procedures in place to ensure the safety and security of the scene. It is important that the police understand these procedures (triage, other medical procedures) in order to facilitate joint work on the scene.

- The support of international organizations is required in funding, training and capacity-building, in IHL promotion, and in the development and implementation of operational standards, data collection and research projects.

- International cooperation and exchange of experiences among health-care providers remains critical to building solidarity in order to address the problem and should be reinforced.

ICRC

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