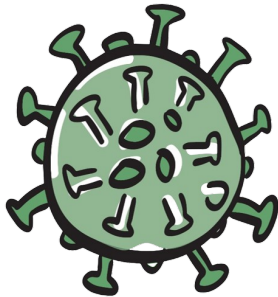# HCID: global qualitative trend analysis, guidance on multidisciplinary response and selected field practices for inspiration

Dear HCID focal points,

I hope you are well in these uncertain times. As you may recall, we messaged you on 25.03 with guidance on developing HCiD response in the context of Covid-19 pandemic. This is a follow up message which is meant to offer you a first attempt at **global qualitative trend analysis, guidance on multidisciplinary response and selected field practices for inspiration.**

COVID-19 AND VIOLENCE AGAINST HEALTHCARE - WHAT DO WE KNOW SO FAR

At that time anecdotal evidence of incidents of violence against healthcare was emerging and based on this, as well as prior operational experience we encouraged you to develop response to HCID-related incidents such as **individual assaults** against healthcare staff, disrespect towards confinement measures resulting in **violence by those confined**, **stigmatization** of healthcare workers, current and former patients, as well as **acts of violence** against health facilities by **communities** rejecting the presence and treatment of Covid-19 patients.

Since then, based on increased presence of reports in the mainstream media, as well as thanks to the work of many among you, but also the TRAK unit in Geneva, we have been able to identify many other forms of violence against healthcare linked to the pandemic. Indeed, violence against healthcare, especially that linked to the stigmatization of healthcare workers, as well as current and former patients, appears to be an emerging trend within the current situation.

In particular, **our first qualitative analysis of global trends** on violence against healthcare in relation to the pandemic, has shown the following:

New trends of inter-personal violence between the HC staff and the patients or their families, **due to the specific prevention and infection control** measures required by the Covid-19. E.g. individuals are required to separate from their families to be placed in quarantine facilities or are prevented from attending the body of the deceased loved ones.

What can be done?

Research from Ebola and other epidemics/pandemics points out that communication and community-engagement with local leaders are key. If pertinent, "survivors" from the communities could also be involved to explain the procedures they went through in the recovery process.
The actual conditions of the quarantine centers may play a role in individuals/families' resistance to HC staff taking them there. Research from SARS epidemic is available to identify minimum conditions in the centers and services that should be made available to the "guests".

Violence and stigmatization by the general public against HC staff, vehicles, premises, patients (or people showing symptoms associated with Covid-19, or just belonging to a group associated with Covid-19, e.g. Asians), due to a collective "moral panic", which is resulting in disproportionate reactions worldwide (in the Global North as well as in the Global South). E.g. attacks against Covid-19 hospitals/quarantine/testing centers from the community which does not want them in the neighborhood.

What can be done?

Misinformation from media has proven to be a factor which can confuse people and lead to anxiety. Some governments have signed agreement with social media e.g. Twitter to prevent the spread of misinformation
Need for campaigns/communication strategies to disseminate the actual transmission and counter balance the irrational fear with rational and scientific-based information

Religious groups opposing infection control and prevention measures and/or denying the pandemic. The consequence in terms of violence against HC may be: i-they keep on holding religious gatherings, law enforcement officials intervene and violent clashes may arise; ii-members of the groups attack HC staff because

they see in the latter a propagation of the government pandemic narrative. It is the most sensitive and complex type of violence, as multiple factors are involved (e.g. minority religious groups may perceive the prohibition to hold rituals from the government as a strategy to undermine them; group psychology dynamics such as peer pressure and group think…). Highly contextualized responses needed.

Use of force by law enforcement officials against the HC staff, mainly during demonstrations of the latter to ask for protective equipment and better working conditions. Protestors were injured or arrested and could not work for days/weeks

What to do?

Dialogue with authorities should address both IHRL and more practical considerations on the consequence of using violence against HC staff who will not be able to work afterwards Need to address the HC staff working conditions because from a medical ethic viewpoint they cannot be asked to perform without proper working conditions

If you have the time, we thoroughly recommend you read the full report under this link.

RESPONDING IN A MULTIDISCIPLINARY WAY

In our earlier guidance message, we had asked you to coordinate multidisciplinary response to this situation within your delegation depending on the specific needs and available resources.

With this message we would like to provide some further guidance and share some excellent field practices that have already come from some of the delegations: we have been very pleased to see some excellent work coming from many of you.

As you know, HCiD is a **transversal** initiative of the ICRC and most situations of violence against healthcare require **multidisciplinary response**. The following table outlines the relevance of the particular components of the Theory of Change to HCiD within the context of Covid-19 (clearly, this is not exhaustive and the relevance of the individual components will vary from context to context):
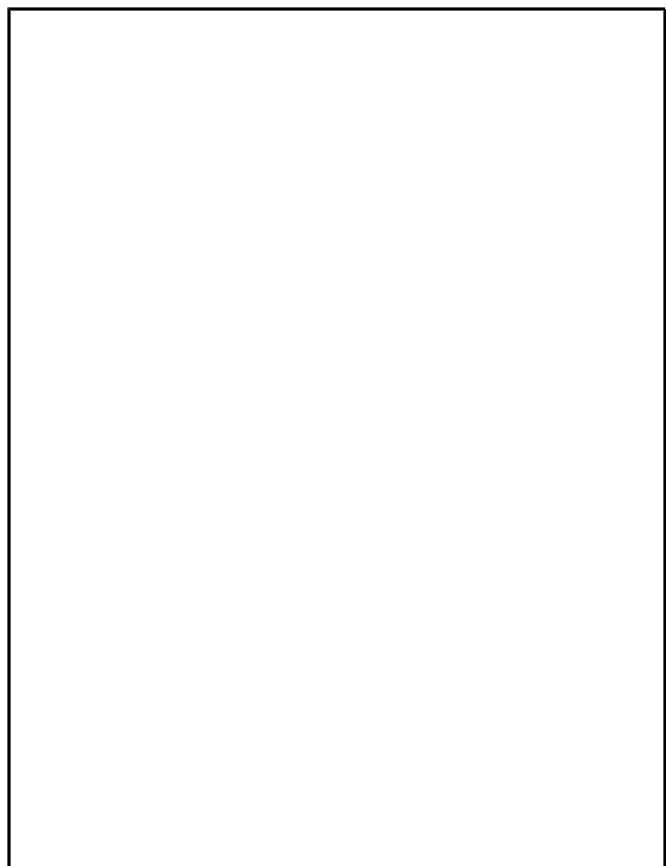
HOW THE SPECIFIC OBJECTIVES CONTRIBUTE TO THE OVERARCHING GOAL

Hypotheses:
- If weapon bearers respect health-care services, they will not commit violence against health care.
- If States have brought in relevant legislation, there will be legal sanctions for the perpetrators, which will disincentivize violence.
- If health-care providers are better prepared for violence, its impact will be reduced.
- If the general public respects health-care services, the incidence of low-level violence will be reduced and weapon bearers are more likely to be held accountable.

Specific objectives
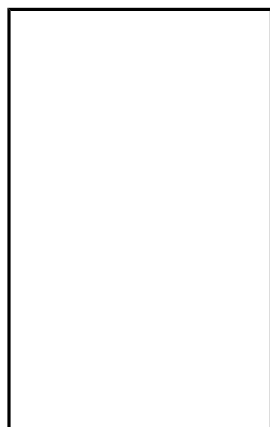
				Examples of HCiD problems in context of Covid-19 pandemic
• Lack of distinction between law enforcement and medical functions in medical facilities • Discrimination in access to	• Pandemic-related regulations result in impeded access to health services by e.g. excluding vulnerable groups	• Health staff prioritise care on grounds other than purely medical because of lack of expertise or biases they hold	• Individual acts of violence against health staff by exasperated patients and their families • Stigmatisation, ostra-	

healthcare by arms bearers acting in good or bad faith • Heavy-handed management of security at medical facilities resulting in harm/injury and negative perception of health facilities • Use of force against healthcare staff	or preventing ambulance movements • Pandemic-related regulations contradict ethical principles of healthcare such as confidentiality and impartiality of care resulting in stigmatisation and loss of trust	• Health managers do not have the skills or resources to prepare their facilities for an increased influx of patients • Individual healthcare workers do not have the skills to manage aggressive patients and communicate effectively • No clear security protocols for provision of health care into areas where the health teams have low acceptance • Lack of cultural sensitivity leading to reduced acceptance and trust	cisation and assaults against health staff, patients and former patients seen as spreading the disease • Violent escape from quarantine facilities • Conspiracy theories and narratives undermining trust in health response	
				Potential ICRC departments involved
Analyse weapon-bearer doctrines, practice and SOPs and engage in protection dia-	Analyse the existing legal landscape and lobby for better rules and their ap-	Provide training on violence management, support facility security and develop institutional pro-	Engage with opinion makers and roll out behavioural change campaigns while focusing on	**Actions the ICRC takes with Movement and Community**

logue based on evidence and sensitivity to cultural norms

[PGE Aide Memoire (page 6)](#)

[PCP checklist (including HCiD aspects)](#)

[Military in Security Operations (esp. slide 26)](#)

propriate implementation

[Domestic Legal Frameworks for Protection of Healthcare](#)

cedures, on security/safety but also on communication and engagement with the community

[Training manual on Interpersonal violence prevention](#)

[Checklist for health services](#)

positive portrayal of the role of healthcare.

[Comms on stigma and violence - step-by-step guide](#)

[HCiD and Covid-19 key messages](#)

of Concern partners + selected resources

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[data collection template]

EMERGING GOOD PRACTICES BY DELEGATIONS

Below we are sharing with you some interesting practices from the field, which exemplify some of the approaches above:

- The delegation in Bangladesh has put together a highly multidisciplinary plan for response which involves action by the management, Cooperation, Protection, Health and COM. Of particular interest here is the integration of HCID/Covid response into the Health programming as per the "walk the talk on HCiD" approach expressed in the HCID and Health strategies.

- Philippines, Pakistan and Iraq have produced highly attractive **public communication campaigns** in support of respect for healthcare workers. While both countries had prior experience of delivering hard-hitting visual content explicitly addressing aggression and obstruction of healthcare, it was interesting to see their thinking evolve towards more nuanced and positive message. While incidents of violence in those contexts are a reality, so is an increase in positive sentiment towards healthcare workers and the delegations did not want their communication to be perceived as dissonant with that general sentiment. [SEE ATTACHMENT]

- PCP regional adviser NAME and the delegation in Mexico have been working on **collecting incidents of violence against healthcare reported in the media**, as well as in other sources in order to keep track of the evolution of the patterns of violence. Please note that while open sources can give us a good taste of what is happening the descriptions of individual incidents contained in such reporting requires verification, especially at such a sensitive time. [SEE ATTACHMENTS]

- The delegation in DRC has elaborated a sophisticated strategy involving **bilateral interventions with and advocacy** towards state and non-state weapon bearers, international organizations, embassies and other actors. There is also a strong public communication component.

- In Ethiopia, the delegation built on the opportunity of the creation of a Covid-19 response **masterplan by the Federal Police Commission** to provide comprehensive advice, including on protection of and access to healthcare services during the pandemic. [SEE ATTCHMENTS]

- Needless to say, many HCiD country strategies are already written jointly with Movement partners. The fact that the IFRC and NSs have the lead on pandemic response makes Movement coordination and joint response even more pertinent.

Please feel free to reach out to the HQ HCiD team with whatever request for clarification or further assistance you may have. We would also be immensely grateful if you could share with us any strategies, tools and products you develop with specific relevance to violence against healthcare in the context of Covid-19.

We thank colleagues in CIM, Prot and other HQ units for their collaboration.

Warm regards,

Maciej and the HCID team

Attachments

1. ICRC Comments on Covid 19.docx
2. 2020 04 HCiD open sources only NAME.XLSX
3. APAC_HCiD PUBLIC MESSAGING.DOCX
4. Registro eventos HCiD COVID19 15.04.20.xlsx
5. FPC Master Plan Covid 19 SoE.DOCX