



# A MATTER OF LIFE AND DEATH:

TACKLING VIOLENCE AGAINST HEALTH CARE  
IN IRAQ, LEBANON AND THE PHILIPPINES

SELECTED EXPERIENCES



# FOREWORD

More than 150 years since the signature of the original Geneva Convention of 1864, and four years since the adoption of United Nations Security Council Resolution 2286, health-care provision continues to come under attack during armed conflicts and other emergencies.

Medical facilities and vehicles are attacked by parties to a conflict – whether as a result of reckless disregard, deliberate military strategy or a lack of understanding of international humanitarian law and humanitarian principles. Parties to a conflict also continue to misuse medical facilities and vehicles by employing them for military purposes.

In many countries, large swathes of land or areas of cities remain off-limits to health workers and humanitarian workers, local and foreign alike. Blockades, sanctions and arbitrary boundaries established by States, non-State armed groups and others prevent the free movement of health staff, medical supplies and patients. All of this results in the suspension of preventive and curative health programmes and has disastrous consequences for the people for whom these programmes are intended – often also reversing decades of development work and impeding the containment of epidemics.

Faced with these challenges, the International Committee of the Red Cross (ICRC) and partners in the International Red Cross and Red Cross Movement launched the Health Care in Danger initiative in 2011. After almost ten years of activities promoting the protection of health workers, facilities and vehicles, the need for global efforts to solve this issue remains pressing. The international community, and parties to a conflict in particular, must recognize that protecting patients and health personnel in conflicts and other emergencies remains crucial – and commitments taken to prevent and mitigate attacks on health care must be backed by action.

Together we can put an end to this serious humanitarian issue which prevents millions of people worldwide from getting the health care they need.

*Maciej Polkowski*  
*Head of the Health Care in Danger Initiative*

A blast leaves a five-year-old boy in Mosul General Hospital with burns and multiple fractures.



# INTRODUCTION

Violence against health care should never be unavoidable. Yet the headlines in the press often tell of health-care staff and facilities being targeted, sometimes deliberately. This sobering reality should not, however, prevent us from taking the necessary steps at all levels to ensure the protection and safety of health-care provision.

This publication aims to do just that. By highlighting the positive experiences of field-based measures to protect health care in **Iraq, Lebanon and the Philippines**, we demonstrate that effective measures to protect health care from violence are feasible and within our reach.

In the city of Marawi, in **the Philippines**, a wide range of activities from the training of health workers to an agreement between the army and regional health-care facilities helped to mitigate the aftermath of the crisis in 2017 and restore access to safe health-care facilities.

In **Iraq**, a country known for high levels of violence in recent times, a large public media campaign was carried out in 2018. Its aims were to increase public trust in medical staff and to reduce the levels of violence that had been hampering access to much needed health care. The campaign also highlighted the need for future efforts to protect health workers so that they could continue to fulfil their medical duties in safety.

Finally, in the urban Palestinian refugee camp of Ein el-Helweh in **Lebanon**, several weapon-bearing groups signed an agreement brokered by the ICRC to respect the health-care facilities serving the community. This was a groundbreaking move that included weapon bearers in finding solutions and made them accountable should they fail to uphold their duty to protect and respect health workers and facilities.

## DEFINITIONS



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

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

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

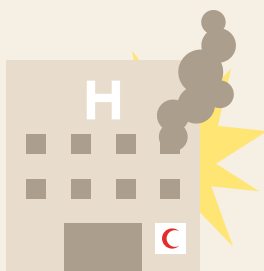
**The wounded and the sick** include all persons, whether military or civilian, who are in need of medical assistance and who refrain from any act of hostility. This includes pregnant women, newborn babies and the infirm.

So there are grounds for hope. The examples in this publication show that, although calls for respect for international humanitarian law and international human rights law, and for an immediate halt to attacks against health care, are right and important, solutions to this difficult issue also lie in long-term approaches, prevention work and the implementation of practical measures on the ground.

In the case of the three initiatives presented in the following chapters, the aim is to better understand the root causes of violence in these three countries and the tailored responses to reduce the violence, and to learn from these examples to see what steps to take next at the local and global levels. The ability to replicate what works well is a key part of this strategy.

Another important aspect highlighted by all three cases presented here is the need to design, roll out and evaluate these preventive and protective measures with a partnership-oriented mindset, which requires engagement with a wide range of stakeholders. In this respect, the Philippines case study is a good example of how coordination between health authorities and the military can work well; the Iraqi experience shows how important it is to get everyone involved, from the authorities to the private sector; and in Lebanon, one of the main keys to success was the groundwork carried out with the local community and non-State armed groups.

Cooperation and a 360° approach to the issue increases the chances of building effective preventive and protective mechanisms. This is not asking too much to ensure access for those in need to safe health-care services.



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

**Violence against health-care facilities** includes bombing, shelling, looting, encircling, forcibly entering and shooting at or into health-care facilities, and any other forcible interference with the running of such facilities (such as by depriving them of electricity and water).

**Violence against health-care personnel** includes killing, injuring, kidnapping, harassing, threatening, intimidating and robbing health-care personnel; and arresting anyone for performing their medical duties, including the impediment and arrest of forensic professionals while performing their forensic medical duties.

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

# HEALTH CARE IN DANGER INITIATIVE

The ICRC's Health Care in Danger (HCiD) initiative seeks to create a world where weapon bearers, political authorities and populations in countries affected by conflict and other emergencies respect the inviolability of health care at all times. To realize our vision and reach our objectives, the ICRC will work together with its partners along three axes of engagement:

## OPERATIONALIZATION

The HCiD initiative supports the identification and implementation of concrete, practical measures and operational responses at national and local levels to prevent violence and safeguard health care in armed conflict and other emergencies. This is done by focusing on countries where it matters the most in order to achieve maximum impact.

## EVIDENCE-BASED STRATEGIES

It will not be possible to devise the right strategies to protect health care from violence, or to promote the use of these strategies on the proper scale, without the necessary evidence base. This is why the ICRC's approach to generating evidence on violence against health care, and on the effectiveness of activities to prevent it, focuses on partnering with public-health institutes and other relevant research bodies embedded within the health systems of countries affected by conflict and other emergencies. Research conducted locally in this way will not only enable local prevention strategies to be based on a nuanced understanding of patterns of violence, but will, in time, also contribute to creating a global overview of trends.

## INFLUENCING AND COALITION-BUILDING

The ICRC will focus its mobilization efforts at the national and subnational levels, where selected delegations will create and foster "communities of concern" that bring together representatives of health-care providers affected by violence, health-care policymakers, and other stakeholders who can contribute to developing a solution to the violence. Local communities of concern will play a role in mobilizing a broader range of government and civil-society stakeholders, generating evidence, and jointly designing and implementing activities or responses aimed at providing more effective protection for health care.

## MORE INFORMATION

[www.healthcareindanger.org](http://www.healthcareindanger.org)

@MPolkowskiHCiD #NotaTarget

PROTECT  
HEALTH CARE

IT'S A  
MATTER  
OF LIFE  
& DEATH

# PHILIPPINES: PROTECTING HEALTH WORKERS AND MEDICAL FACILITIES IN A POST-CRISIS CONTEXT

“*Even one attack on health care is one too many.*”

– World Health Organization

## INTRODUCTION

During the Marawi crisis, the International Committee of the Red Cross (ICRC) observed a spike in violence against health-care providers, affecting over 800 people directly and hundreds of thousands more indirectly.

Attacks on health workers and medical facilities are rare in the Philippines. But there is deep concern among professionals about frequent disruptions to the provision of health-care services – especially in a country where protracted armed conflict means the situation on the ground is already challenging.

More needs to be done to ensure that violence does not disrupt health-care delivery, that people suffering from the conflict can access medical care when they need it most, and that committed professionals do not pay a high price for choosing to work with communities affected by violence.

More than 2,000 displaced families in this evacuation centre have received relief items from the ICRC and the Philippine National Red Cross.



# HOW VIOLENCE DISRUPTS HEALTH-CARE PROVISION IN THE PHILIPPINES

In the afternoon of 23 May 2017, an ICRC health field officer received a call from Amai Pakpak Medical Centre in Marawi City. The nurse on the other end of the line explained that armed men had killed an ambulance driver and entered the hospital carrying heavy weapons, causing fear and panic among patients and staff. She said she was hiding and feared for her life, believing the armed men would target her because of her religion. The terror and distress in her voice were palpable.

In the hours that followed, around 300 patients fled the hospital – some seriously ill, others still hooked up to drips and equipment. Most reportedly returned home before eventually fleeing the city when the fighting reached its peak. Critical patients were transferred, alone and on foot, to other nearby hospitals or to rural medical centres with no critical care capacity.

## THE MARAWI CRISIS

The phone call marked the start of the Marawi crisis. The five-month conflict saw the occupation of central Marawi City by Islamic State Ranao and Abu Sayyaf – two armed factions aligned with the Islamic State group – followed by a counter-offensive by the Philippine armed forces. The fighting claimed over 1,000 lives and left 300,000 displaced. By the time it was over, the city centre had been reduced to rubble.

As the conflict raged for months on end, access to health-care services was severely disrupted. Almost 50% of the city's medical facilities were damaged or destroyed. Many primary-health-care centres closed, meaning people with tuberculosis, high blood pressure and other chronic conditions had their treatment interrupted. And security checkpoints and power outages forced some rural medical centres to close, depriving local communities and people displaced from the city of much-needed care.

The fighting also took a heavy toll on health workers. Many fled along with the city's residents. Those who remained braved threats to continue tending to victims. Although health workers were not targeted and killed directly, the conflict was, in many cases, a psychologically distressing experience. According to reports from the Integrated Provincial Health Office, a nurse in Mulondo, Lanao del Sur Province, was held at gunpoint at a checkpoint after being accused of providing medical supplies to the enemy forces. Recounting her experience, she said, "I'd never felt so afraid in my whole life. I decided that was the end of my career as a health worker."

## A NEW INITIATIVE

In early 2018, we teamed up with health professionals in Lanao del Sur Province to run a series of workshops on the Health Care in Danger (HCiD) initiative, the challenges health workers face in conflict zones, and how best to protect them. In total, 174 doctors and nurses from the worst-affected parts of the country attended the sessions. From the discussions, it became clear that concerns and issues differed from one location to the next. But the attendees also raised some common themes:

- Health workers are exposed to violence on a regular basis.
- Violence against health workers and medical services is neither acceptable nor unavoidable.
- All armed actors carry out attacks on health-care providers (security forces, non-State armed groups and criminal gangs).
- There is a willingness to make practical improvements.

One of the most striking insights to come out of the workshops was that attendees understood why, for security reasons, it was so important for civilians to see health workers as being neutral – and how having military or security forces protecting staff in the field can cause



confusion about their status. The health workers talked about service delivery challenges in conflict zones and made the following recommendations:

- Introduce a no-weapons policy across all health-care facilities.
- Ensure medical staff, facilities and vehicles are clearly marked and identified as such.
- Promote the rights and responsibilities of health workers in times of conflict.
- Liaise with State security forces to ensure that ambulances and other medical transport vehicles can pass through checkpoints, and that health workers are treated with respect.
- Provide training for staff on safety and security.

## NO-WEAPONS POLICY

Aside from the workshops, some health-care facilities and authorities have taken matters into their own hands. At Tamparan District Hospital on the eastern shore of Lake Lanao, a clan war hotspot at the epicentre of the Marawi crisis, management have introduced a no-weapons policy.

Amai Pakpak Medical Centre, the facility from which the first calls linked to the crisis were made, has followed suit. The centre's director liaised with the head of the Philippine police in Marawi City to draw up a similar policy that bans police and law enforcement officers from carrying firearms while on duty inside the hospital, and requires all licensed firearms to be left at the gate.

## LIAISING WITH STATE SECURITY FORCES

In June 2019, we brokered a landmark coordination agreement between the Integrated Provincial Health Office of Lanao del Sur (the local health-care authority) and the military unit operating in the area. The accord addresses some of the many issues facing health workers on the ground, such as passage through military checkpoints, the occupation of medical facilities by armed actors, and the disruption of routine health-care programmes during armed clashes.

The agreement has made a real difference to perceptions on the military side. One officer said: "Our first priority is to maintain tight security and neutralize the enemy. But my eyes have been opened to the real risks that health workers face every day just doing their job. For that reason, I fully support these new coordination arrangements."

Both parties will continue discussing ways to keep health workers safe and support service delivery. These include ensuring medical facilities are clearly identified as such, and educating personnel about the importance of protecting health-care providers.

## ONGOING ICRC SUPPORT AND NEXT STEPS

We will continue working with the authorities to safeguard health workers and medical facilities in the aftermath of the Marawi crisis by:

- sharing details of agreed coordination arrangements and medical ethics rules with health workers and security forces
- taking local, targeted initiatives to make clear that health-care facilities are protected under international humanitarian law, for instance by:
  - producing maps showing the location and coordinates of facilities
  - putting up clearly visible signs
  - displaying posters about the HCiD initiative
  - affixing "No weapons" stickers, in line with local policy
- providing information about the HCiD initiative to health workers and security forces
- surveying security arrangements at health-care facilities
- setting up a province-wide incident reporting system to inform future policymaking.

# LEBANON: CHANGING THE BEHAVIOUR OF WEAPON BEARERS THROUGH A UNILATERAL MODEL DECLARATION

## INTRODUCTION

Ein el-Helweh is the biggest Palestinian refugee camp in Lebanon. Measuring just one square kilometre, it is home to as many as 70,000 people, including Palestinian refugees from Syria and smaller numbers of Syrian refugees and Lebanese nationals. Conditions at the camp are akin to an urban slum, with inadequate infrastructure and limited access to basic services. Since most residents are marginalized from Lebanese society and do not enjoy the same rights as Lebanese citizens – including the right to State-subsidized health care – they are becoming increasingly reliant on humanitarian aid. The United Nations Relief and Works Agency for Palestine Refugees in the Near East is the main provider of aid in the camp.

The Lebanese armed forces have set up four checkpoints around Ein el-Helweh and control all the entry and exit points. Inside the camp, security duties are shared between 15 or so Palestinian factions, each serving different interests and agendas. The carrying of weapons is widespread and people tend to settle their differences through armed violence, which can quickly escalate. Rocket-propelled grenades and heavy machine gunfire are common in the cramped, narrow confines of the camp. The clashes often cause damage to buildings, leave roads impassable and claim civilian casualties. In some cases, armed groups have even entered hospitals and clinics.

We have been working at Ein el-Helweh since 2014, engaging with non-State armed groups (NSAGs) to foster a culture of accountability and promote behaviour change among weapon bearers. Following a process of consultation, the armed groups agreed to sign a unilateral model declaration setting out their commitment to safeguard health-care provision and protect wounded and sick people in the camp.

Ein el-Helweh Palestinian refugee camp in Lebanon.



# UNDERSTANDING AND ADDRESSING THE ISSUES

The sad truth is that health workers at Ein el-Helweh face the same issues as their colleagues operating in other situations of violence, with weapon bearers targeting staff, ambulances and hospitals, and preventing sick and wounded people getting the care they need. We launched a multi-year, cross-department project to tackle the causes of the problem, engage with NSAGs and achieve a lasting solution to the violence. The project, which was largely inspired by the ICRC guidelines on safeguarding the provision of health care,<sup>1</sup> was divided into three phases:

1. In phase one, we talked to NSAGs about safeguarding health care, including at ICRC-run first-aid training sessions.
2. In phase two, we drafted a unilateral model declaration based on the outcomes of this consultation process, then shared the draft with the NSAGs and health-care providers for comment and approval.
3. In phase three, we organized a public ceremony at which the NSAGs pledged to abide by the declaration in front of their community of concern<sup>2</sup> (including camp health workers and civil society representatives). As part of this final phase, which is ongoing, we will continue monitoring how the NSAGs implement the terms of the declaration, providing support or intervening where necessary.

## 1. PHASE ONE: ENGAGEMENT AND CONSULTATION (2014–2015)

When armed violence erupted at the camp, weapon bearers were acting as de facto first aiders – despite lacking the requisite training and equipment – because it was unsafe for emergency services to try to reach sick and wounded people.

In our initial conversations, all the armed group leaders we met said they were willing to engage further with our HClD activities at the camp, mentioning that rival factions were failing to allow people to access health-care services safely. They also asked us to provide first-aid training to their armed men.

“ Now that I’ve had some training, I understand what first aiders go through during armed clashes and why safe access is so important. ”

*Ahmed, weapon bearer, at one of the HClD consultation sessions*

1 <http://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4243-safeguarding-the-provision-of-health-care.pdf>

2 In the context of the HClD initiative, a community of concern is a coalition or consortium of organizations working together to better protect health workers and medical facilities from violence in a given country or territory. Typically, a community of concern will involve the relevant National Red Cross or Red Crescent Society and other components of the International Red Cross and Red Crescent Movement; the medical association, the relevant nursing council and other professional medical bodies; representatives of national or subnational ministries or departments of health; medical schools; public health institutes; representatives of major hospitals or hospital associations; and representatives of ambulance services. A community of concern may also include other State bodies relevant to the particular approach taken by a delegation, such as the Ministry of the Interior, law enforcement agencies, and the military medical corps.

After approaching several NSAGs, we held the first round of first-aid training and HClD consultations in March 2014. Each session began with a general overview of the ICRC, our mandate and principles, and our work in Lebanon. After two days of hands-on first-aid work, we talked to senior members about HClD-related issues. This approach made it easier to hold an open discussion about safeguarding health care, since the weapon bearers trusted us, understood our organization and were more willing to talk after completing two days of training.

At the consultation sessions, we asked members of armed groups for their views on HClD issues from two angles: as patients and as weapon bearers. Our focus was very much on listening to their needs, concerns and recommendations, as opposed to talking to them about international humanitarian law or HClD principles. As a result, they were comfortable enough to share their perceptions freely and openly without feeling judged.

The key takeaways from this consultation exercise are summarized below.

#### *Weapon bearers as patients*

- What are the main obstacles you face when seeking health care?
  - Shortage of health-care provision inside the camp (quality and capacity)
  - Delays at armed forces checkpoints when being transferred to hospitals outside the camp
  - Lack of safe access when fighting breaks out.

#### *Weapon bearers as perpetrators*

- Why do weapon bearers endanger health workers, medical facilities, and sick and wounded people?
  - Lack of education and widespread drug abuse
  - No accountability or sanctions
  - Lack of advanced military training in the use of force in densely populated areas
  - No formal coordination or communication within factions or with the Lebanese armed forces.

#### *Weapon bearers' recommendations*

- What do you think could be done to remedy the problem?
  - Set up formal coordination or communication arrangements between factions to organize temporary ceasefires and allow ambulances to safely reach sick and wounded people.
  - Equip and train health-care providers inside the camp.
  - Introduce a drug rehabilitation programme and run awareness-raising activities.
  - Tackle the social, economic and political problems facing Palestinian refugees in Lebanon at their root.

## **2. PHASE TWO: CONSOLIDATION AND APPROVAL (2016–2017)**

Having completed the consultation process, developed a shared understanding and identified ways forward, we drafted a unilateral model declaration with the support of ICRC legal and protection staff in Geneva. The document, which signatory NSAGs were expected to share with their members, contains a set of principles and measures for safeguarding impartial health-care delivery.

We held meetings with armed group leaders where we presented the outcomes of the consultation process (including recommendations made by their members) and shared the draft declaration for comment and approval. We also shared the document with religious and political leaders, as well as with health-care providers operating at the camp and the wider community of concern, in an effort to build a broad consensus. (see box).

# UNILATERAL DECLARATION ON THE RESPECT AND PROTECTION OF THE WOUNDED AND SICK AND ACCESS TO HEALTH CARE

*Acknowledging* the need for all the wounded and sick, i.e. those needing health care and refraining from any act of hostility, to receive health care and *deeply concerned* about the devastating impact of their hampered access to health care,

*recognizing* that the provision of health care shall be guided by the principles of humanity and impartiality,

*convinced* that we can play an important and positive role in improving the safe access to, and delivery of, health care, and *resolved* to do so,

*recognizing* that this declaration is no substitute for existing and applicable legal rules,

we hereby commit to:

- (1) respect and protect the wounded and sick regardless of affiliation, and actively support and facilitate their access to health care, that is:
  - (a) not to attack, harm or kill the wounded and sick and to treat them humanely in all circumstances
  - (b) not to prevent medical care from reaching the wounded and sick
- (2) respect and protect health-care personnel, facilities and vehicles, irrespective of their affiliation and at all times, that is:
  - (a) not to attack, threaten or pressure any personnel providing health care
  - (b) not to interfere with the work of health-care personnel
  - (c) not to compel health-care personnel to carry out acts contrary to the ethical principles of health care
  - (d) to respect the distinctive red cross and red crescent emblems and those of the health-care providers, and not to misuse them
  - (e) not to attack medical vehicles, even if they are not identified as such
  - (f) to allow and facilitate the medical evacuation of the wounded and sick to health-care facilities
  - (g) to allow unimpeded and fast passage to ambulances and vehicles dedicated to health care
  - (h) not to use medical vehicles for military purposes
  - (i) not to attack health-care facilities
  - (j) not to use health-care facilities for military purposes
  - (k) to take all feasible precautions to avoid carrying out military operations near health-care facilities and incidentally damaging or destroying them
  - (l) to refrain from armed entry to health-care facilities.



To make the terms of this declaration known to and respected by the members of the armed group, we hereby commit to:

- (1) integrate the rules reflected in this declaration into our doctrine and training and ensure that they are clearly translated into orders
- (2) apply sanctions and take concrete measures to repair the damage done, in the event of violation of the rules contained in this declaration
- (3) widely and publicly disseminate the terms of this declaration
- (4) encourage and support, when feasible, the application of those principles by other actors.

We hereby pledge to abide by our obligations and commitments regardless of the behaviour of the adversary or other parties.



M. Tahhan/CRC

Ein el-Helweh Palestinian refugee camp in Lebanon.

### 3. PHASE THREE: SHARING, IMPLEMENTATION, MONITORING AND SUPPORT (2018–)

In July 2018, we organized a ceremony inside the camp where all 15 of the main factions signed the declaration (see photo in text box) and publicly pledged to abide by its terms and principles. At the event, which marked the start of phase three of the project, we also held a session on law enforcement operations and the use of weapons in the densely populated camp.

The priorities of this third phase were twofold. First, we wanted to encourage NSAG leaders to share the declaration with their subordinates (the very people whose input informed its contents). And second, we needed to work with health workers affected by the fighting to make sure armed groups abided by the agreed terms. For instance, many weapon bearers from Ein el-Helweh took part in clashes in Mieh Mieh refugee camp in October and November 2018. We raised reported HClD incidents with the alleged perpetrators where possible, as part of our ongoing dialogue with NSAGs.

There is broad agreement that the declaration has made a real difference on the ground. In March 2019, for instance, a wounded weapon bearer was treated at one of the camp's hospitals without interference from the faction controlling the area. This incident, which is held up by all sides as an example of the declaration's positive impact, should be followed by others as the gradual shift in behaviour takes hold.

## LESSONS LEARNED

- First-aid training sessions are a particularly effective setting for talking about HClD issues (perhaps more so than any other) because weapon bearers, once trained, can empathize with first aiders.
- The HClD initiative serves other purposes beyond safeguarding health-care provision: it helps us increase acceptance of our presence and work, and talk informally about our principles and values.
- Making the consultation a participatory process paid dividends: rather than being lectured by an outside organization, NSAG leaders felt as though they were part of the solution, and developed a sense of ownership and accountability, because the recommendations had come from their own fighters.

# IRAQ: SAFEGUARDING HEALTH-CARE SERVICES THROUGH PUBLIC COMMUNICATION CAMPAIGNS

## INTRODUCTION

Violence has plagued Iraq's health-care system since at least the outbreak of the 2003 war. The fighting has taken a heavy toll on health workers and medical facilities, as well as eroding public confidence in the system in general. Moreover, a culture of tribal justice and legal impunity, coupled with the ready availability of weapons, has led to a spate of attacks against providers.

Public communication campaigns have an important part to play in reducing the level of violence against medical staff – by showing that violence only makes matters worse, and by helping to rebuild trust in health workers and the wider health-care system.

A medical team transfers injured people to the emergency room in Mosul General Hospital.



# UNDERSTANDING THE ISSUES

The priority was to assess the scale of violence against health workers, as statistics are not readily available, even from the authorities. We joined forces with the Health and Environment Volunteer Team, an organization that works to protect people delivering health-care services in Iraq. In 2018, the team conducted a pre-campaign survey of 621 health workers across 16 health-authority areas (including Anbar, Baghdad, Basra, Kirkuk, Najaf and Salah ad Din) in order to build a nation-wide picture of the issues and inform campaign design. The findings revealed that:

- 60% of health workers had been verbally abused, threatened or attacked in the three months prior to the survey.
- 75% of these incidents were attributable to patients' relatives, and 21% to patients themselves.
- 50% of the incidents were limited to verbal abuse but, in 17% of cases, staff were either detained or physically attacked, in some cases with weapons.

# DESIGNING THE CAMPAIGN

The objectives of the campaign were to:

- highlight the humanitarian impact of violence against medical staff (targeting patients' relatives as the most common perpetrators of such violence), and show how attacks and abuse can undermine health-care provision when staff choose to quit
- improve public perceptions of health workers and call for greater respect for providers and their equipment
- remind medical staff of their responsibilities and duties towards patients

The campaign team partnered with the Iraqi ministries of health, justice and defence, as well as with mobile operators, major TV channels, cinemas, radio stations and other organizations, to reach a broad and diverse audience, using a wide range of audiovisual and other media across analogue and digital channels:

- 240 large flex banners and 12,000 posters with key campaign messages were produced and distributed to health centres around the country.
- Promotional items (such as t-shirts, mugs, bracelets, notebooks, pin badges and pens) were produced and distributed at the launch and during ICRC-run events.
- Five TV adverts were made, all highlighting the importance of treating health workers with respect – a flagship advert produced by advertising firm Leo Burnett, plus four produced locally in Baghdad, including one featuring Iraqi celebrities.
- Major Iraqi TV networks Al Sumaria and Al Iraqiya broadcast the adverts in prominent slots, including before news bulletins.
- Mobile operators Zain and Asiacell sent two rounds of bulk texts containing key messages to subscribers across the country (other than in the Kurdistan Region of Iraq), reaching a total of 18 million people.
- The campaign materials were shared by prominent social media influencers and on the social media accounts of Zain and Asiacell, bringing the messages to an even bigger audience.
- A major cinema chain covering Baghdad and southern Iraq agreed to show the adverts before film screenings over the ten days of the campaign, reaching a reported 25,000 viewers.
- The Iraqi Red Crescent Society put up banners and posters in the six health centres it runs.



**ATTACKS ON HEALTH CARE PROVIDERS ENDANGER US ALL**



**VIOLENCE AGAINST HEALTH CARE MUST END**

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



**DOCTORS TAKE AN OATH TO SAVE LIVES, NOT TO TAKE THE BLAME**



**DOCTORS TAKE AN OATH TO SAVE LIVES, NOT TO TAKE THE BLAME**



**VIOLENCE AGAINST HEALTH CARE MUST END**  
**IT'S A MATTER OF LIFE & DEATH**



**VIOLENCE AGAINST HEALTH CARE MUST END**  
**IT'S A MATTER OF LIFE & DEATH**

# LESSONS LEARNED AND NEXT STEPS

Although the figures above give a flavour of the campaign's reach over the ten-day period, it is harder to gauge qualitative and quantitative changes in public perceptions of medical staff. We nevertheless learned a number of important lessons from the campaign:

- It takes time to design a campaign that is meaningful and fit for purpose.
- Engaging with high-level partners, and getting the partnership mix right, is essential to reaching a broad and diverse audience.
- Campaign products, channels and messaging need to be contextualized since, in Iraq at least, local content speaks loudest.
- Local influencers significantly increase engagement and act as key multipliers of campaign messages.
- Partnering with mobile operators is a cost-free way to spread messages further and wider (provided a deal can be reached).
- Benchmarking is a necessary (albeit imperfect) exercise, since it helps to decide what behaviours or protection aspects the campaign should target, and makes it easier to measure the campaign's short- and long-term impact.

Based on audience interactions on social media, the campaign was relatively well received. Users broadly supported the idea behind it, and agreed with the message about not blaming medical staff. Some of the comments, however, were more negative in tone, with users recounting their own bad experiences with medical staff and services, or criticizing the high cost of medical services. These perceptions reveal a persistent climate of mistrust towards and negative perceptions of health-care providers, underscoring the fact that behaviour change is an interactive process that takes time, and that more needs to be done to rebuild trust and better protect health workers and medical facilities.

A post-campaign survey was conducted in August 2019, again by the Health and Environment Volunteer Team. This time 393 health workers across 17 health-authority areas took part in the survey, almost 40% fewer people than the pre-campaign survey (NB respondents were self-selecting in both the pre- and post-campaign surveys). However, the proportion of nurses that took part was similar, accounting for almost 50% of the respondents in both surveys. There were also differences in the geographical scope of those who answered: for the pre-campaign survey, the majority were from Di Qar; whereas for the post-campaign they were from Kirkuk.

Keeping these limitations and differences in mind, the findings were:

- In the three months immediately prior to the post-campaign survey, 39% of medical personnel had been verbally abused, threatened or attacked.
- 75% of cases were perpetrated by relatives of patients; in 21% of cases, the patients themselves were responsible.
- 12% of reported incidents were attacks without weapons, and 2% attacks with weapons. Threats constituted 16% of cases and verbal abuse 51%, while interference in the provision of care accounted for 17%.




What stands out from the post-campaign survey is that there seems to have been a substantial reduction in self-reported incidents between October 2018 and August 2019 and that relatives of patients continue to be the principal perpetrators. We should approach this statistic with great caution, given the survey's methodological limitations, and because we know that the issues are entrenched, systemic and will not change with just one ten-day campaign. Much more work is needed and HCiD incidents continue to be constantly reported across the country. Nevertheless, we now have a much better picture at a national and subnational level of the prevalence of violence against medical staff in Iraq. Meanwhile, the ICRC delegation continues to build on the positive momentum achieved to date, for instance by encouraging the Ministry of Health to continue convening its interministerial committee as a way to pass on key messages and effect change.



We help people around the world affected by armed conflict and other violence, doing everything we can to protect their lives and dignity and to relieve their suffering, often with our Red Cross and Red Crescent partners. We also seek to prevent hardship by promoting and strengthening humanitarian law and championing universal humanitarian principles.

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