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

ICRC

ICRC institutional Health Care in Danger strategy 2020–2022
Protecting health care from violence and attacks in situations of armed conflict and other emergencies[1]

Vision

The ICRC's Health Care in Danger (HCiD) 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.

It is a world where "my enemy's doctor is not my enemy".

The ICRC will contribute to the realization of this vision by:

- influencing the doctrine and practice of weapon bearers
- assisting States in strengthening their domestic legislation
- building up the resilience of health-care systems to violence
- campaigning for behavioural change among civilian populations.

The primary *modus operandi* for HCiD will be formation of partnerships with health-care workers and communities in countries affected by conflict and other emergencies. The ICRC and the International Red Cross and Red Crescent Movement (Movement) can have a broad or large-scale impact only if we work with and through the health-care communities we are aiming to protect.

This work will be underpinned by sound evidence generated locally and geared towards the development of preventive solutions.

The current strategy sets the objectives for the 2020–2022 period within the framework of this long-term vision.

Context

The nature of violence

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

Medical facilities and vehicles are attacked by parties to conflict – as a result of direct targeting in line with a deliberate military strategy, through reckless disregard, or because of an incorrect understanding of international humanitarian law and humanitarian principles. Parties to conflict also continue to misuse medical facilities and vehicles by employing them for military purposes.

In many countries, large swathes of land or portions of cities remain off-limits to national health workers and international humanitarian workers. Blockades, sanctions, and invisible borders established by States, non-State armed groups and other actors in communities prevent the movement of health staff, medical supplies and patients. All this results in the

[1] For ease of reference, the document will henceforth use the formulation "conflict and other emergencies".

suspension of preventive and curative health programmes and has disastrous consequences for the populations for whom these programmes are intended – and it also often reverses decades of development work or impedes the containment of epidemics.

Health-care facilities and vehicles are at times misused by belligerents committing acts of perfidy or appropriated by political actors to further goals that are out of line with medical ethics and that undermine the perception that these facilities and vehicles are accessible to all those in need.

Military units put in charge of protecting health-care facilities are often without the procedures and training necessary to do so in a way that does not interfere with care.

Some law enforcement agencies lack the mechanisms required to coordinate with health-care systems and the specific expertise to protect health-care facilities and personnel from violence; their operations often don't take sufficient account of access for pre-hospital services. Police activities inside and around health facilities disrupt both access to medical care and provision of such care.

Access to life-saving care is being withheld from people labelled "terrorists" as States criminalize – under their domestic laws and under international legal and political instruments – provision of health care to them.

But health care is coming under attack not only from actors who want to deprive others of access to it. Paradoxically, more often than not, it is coming under attack from the very people who are served by it. When, after an attack resulting in massive casualties, armed men – members of State armed forces, non-State armed groups, or even civilians – fill an emergency room and demand priority attention, their actions jeopardize the provision of life-saving care for themselves and for many others.

The role of health-care workers themselves is also not always benign. Many of them are allowing themselves to be co-opted by political or military strategies, or are simply following their own deeply held views, when they deny care, for unlawful reasons, to wounded and sick people.

Meanwhile, health-care providers around the world – in highly industrialized and peaceful countries, in developing countries, and in countries affected by crises – are sounding the alarm: respect for health-care providers is declining; death threats, and physical and verbal abuse, against doctors, nurses and paramedics are becoming routine; and medical facilities are being vandalized, and medical vehicles, obstructed.

The state of implementation

Eleven years since the ICRC first started working on the issue of protection of health care in a consolidated manner, and eight years since the adoption of the first HCiD resolution at the 31st International Conference of the Red Cross and Red Crescent, HCiD is well-established within the ICRC and a strong brand within the Movement and beyond.

Since 2011 the ICRC and its Movement and external partners have focused on such areas as humanitarian diplomacy, influencing policy-making, developing or creating normative frameworks, global awareness-raising, and expert consultations; they have also been

gradually expanding their operational response.[2] Several Movement components have provided, most notably through the HCiD Movement Reference Group, valuable support for this work.

While it may be difficult to disentangle cause from effect here – the media visibility of attacks in certain mediatized contexts may have played a role larger than advocacy – it is also indisputably the case that tackling the issue of violence against health care has now become an urgent priority in multilateral diplomacy and for specialized agencies. There are now a considerable number of non-Movement entities[3] working on the issue of protection for health-care personnel and facilities; most of them are operating at the global level and prioritizing advocacy.

Despite such progress, the discrepancy remains: between the declared consensus on protection and continuing violations on the ground. There is a need to focus efforts on the national and regional levels in order to translate normative language into practice and behavioural change.

Initiatives aimed at documenting, researching and quantifying the amount of violence against health care are growing in number. They are predominantly focused on the global picture and based in the Global North; and they have not yet achieved their goals of establishing reliable local baselines of violence and quantifying its impact.

Strategic direction

In this context, to realize our vision and reach our objectives, the ICRC will work together with its partners along three axes of engagement:

- operationalization
- evidence-base generation
- influencing and coalition building.

The operationalization of practical measures to protect health care more effectively in the countries where it matters the most,[4] is the main axis of this strategy. It is however interconnected with the axes of evidence-base generation and influencing and coalition building. The three are the most effective when they reinforce each other.

Evidence-base generation entails linking operational work to data and research developed through partnerships with health-care organizations in countries affected by conflict and other emergencies. The ICRC is uniquely placed to make this link, both as an operational agency and as a convener. Given the maturity of the normative framework, diplomacy and mobilization have to be brought closer to the ground – that is, to regional and national forums – where they can lead directly to better local ownership and action. After we have accumulated a critical mass of evidence and tested different operational approaches, we will

[2] I.e. context-specific action taken by ICRC delegations.

[3] For example, the World Health Organization, Médecins Sans Frontières, and the Safeguarding Healthcare in Conflict Coalition.

[4] The ICRC prioritizes its work on protection of health care geographically in order to achieve maximum impact.

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return to the various global forums to disseminate the evidence and our approaches to UN Member States and specialized international bodies.[5]

Operationalization

The ICRC will, in the years to come, focus its attention and resources in key operational contexts, where it will deploy its multidisciplinary tools,[6] with a view to achieving a tangible and measurable impact.

The main characteristics of the ICRC approach to protecting health care through its operations will be:

- Pragmatism – The ICRC will continue to test practical approaches and scale up those of proven effectiveness. It will aim to ease the burden of translating policy into practice, for its field teams and national health-care workers, by promoting tools that are simple, practical, and easy to use.
- Multidisciplinarity – Violence against health care is not a simple issue, one for which a single cause can be easily identified and which can be tackled with a simple strategy. It is a complex matter requiring multi-pronged and context-specific approaches. The ICRC, with its palette of prevention-protection-assistance programmes and its convening power, is uniquely well placed to carry out this task.
- "Walking the walk" – ICRC Health programmes will incorporate HCiD tools as standard practice to make sure that ICRC health staff and the personnel of the health facilities we support are and remain safe. ICRC Health programmeswill serve as HCiD's ambassador to the health systems in the countries where we work.
- Taking the long view – We will continue to respond to urgent needs and to violations in real time through our operations, but most of our efforts to assure better protection of health care will continue to focus on fuller incorporation of measures in doctrine and procedures, legislative amendments, health-system capacity building, and behavioural change among general populations. These require long-term strategic thinking and systemic approaches. Most of this work will happen within the logic of prevention, because changing behaviour is most difficult when a conflict is at its peak.
- Inclusiveness – Wherever appropriate and as much as possible, the ICRC's approach to protecting health care will include the broader Movement, local health-care organizations, civil society and communities. On one hand, this will allow complementarity in the deployment of specific expertise, and on the other, it will permit activities or responses to be scaled up to match the size of the health systems they aim to influence.
- Impact measurement – Given the progress the ICRC has made in this realm over the last several years and the continuing focus on partnerships with researchers, HCiD will make a significant contribution to institutional efforts to generate methodologically sound evidence on the impact of the ICRC's protection- and prevention-related activities. Findings obtained from work on impact measurement will be published in peer-reviewed journals and will also stimulate thinking on ICRC work in other thematic areas.

Evidence-base generation

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.

[5] https://blogs.icrc.org/law-and-policy/2017/11/24/changing-the-narrative-on-international-humanitarian-law/
[6] http://healthcareindanger.org/resource-centre/

- Local research partnerships – Health-care providers form part of the intellectual elites of their countries, and medicine and public health are evidence-based disciplines. This is particularly propitious for generating – together with the communities affected – high-quality evidence on patterns of violence and the cost to health-care provision and the health of populations. The ICRC, with its global network of delegations – and its presence in countries affected by conflict and other emergencies – is uniquely well placed to initiate partnerships with health-care researchers based in countries affected by conflict and other violence.

  This is why the ICRC's approach to generating evidence on violence against health care,[7] and on the effectiveness of activities to prevent it,[8] will focus on partnering 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. It will help us to make violence against health care – so often, invisible and normalized – visible.

- Influencing the global research agenda – The ICRC will also continue to influence the global research agenda for protecting health care from violence. It will do so by forming strategic partnerships with research bodies of global reach in order to mobilize funding and expertise in line with its objective of generating research geared towards concrete and localized solutions.

Influencing and coalition building

- From global to national – The ICRC will focus its mobilization efforts at the national and sub-national levels, where selected delegations will create and foster "communities of

[7] Building on successful pilots (Karachi and Peshawar in Pakistan) and departing from the usual practice of documenting and aggregating individual instances of violence, this will be achieved through mixed-methods research studies on specific national or sub-national contexts. Studies will have quantitative arms, which, with the use of social-science methods, will allow the ICRC to reliably quantify the burden of violence in a given setting, thus allowing for cross-contextual comparisons, as well as analyses of temporal and geographical patterns. This is an innovation that will contribute significantly to the overall capacity of the organization to analyse patterns of violence. Through their qualitative arms, the studies will capture the thinking of the health-care community on triggers of violence and viable preventive strategies. Implementing such studies in partnership with public-health institutes and other bodies embedded within national health-care communities will create ownership for the findings and pave the way for implementing the recommendations of the studies. In addition, because the results will consist of statistical patterns of behaviour rather than lists of individual incidents, it will be easier to communicate them publicly, both through peer-reviewed health-care journals and through the ICRC's own channels.

[8] The ICRC will draw on successful pilots it has carried out, and on experiences outside the organization, to rigorously measure the impact of its work. The ICRC's methodologies will include such means as: quasi-experimental observational studies that examine changes in the general public's behaviour towards health-care services (giving way or yielding to ambulances, for instance, or reducing overcrowding in emergency departments); real-time surveillance of violent events in hospital settings, in order to assess the impact of soft (staff training, working procedures) and hard (structural changes) measures to reduce violence; and assessment of learning outcomes of training for medical staff in preventing violence. These data will be used primarily to guide operations and prioritize those approaches that are more effective. Their secondary uses will include communication with donors and projection of the ICRC's image as an evidence-based and effective organization (through specialized publications oriented towards health-care stakeholders and, occasionally, public communication).

concern" (CoCs)[9] 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 CoCs 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. The ICRC's global connections will support regional and national coalition building by mobilizing the constituents of global HCiD CoC partners.[10] The ICRC will also include health-care clients in designing programmes to promote safe access to health care.

The participation of government, health-care and civil-society stakeholders in local CoCs will allow for operational approaches to be rolled out on the scale required by the size of a health system.

In line with the shift in our focus, from the global to the local and operational level, the ICRC will replace its annual HCiD meeting in Geneva with regional meetings that will take place in rotation. These meetings will aim to produce regional synergies between ICRC delegations, the International Federation of Red Cross and Red Crescent Societies, National Societies, and external partners; they will also seek to stimulate peer-to-peer exchanges between actors brought together by similarities of context and humanitarian challenges.

- Peer-to-peer learning – A significant amount of the ICRC's work is carried out in cooperation with government actors. The ICRC will draw attention to its growing body of operational practice among national, provincial and city governments through bilateral exchanges and regional forums.[11] The primary focus of this approach will be to seek to replicate practical programming.

  A dedicated project will continue exploring city partnerships as a vehicle for sharing good practices and initiating new programming aimed at improving protection for health care from violence.

- Stakeholder-oriented communication – In line with this more localized approach, the ICRC's communication will target national, regional and global health stakeholders – international organizations, humanitarian agencies, think tanks and academia – in order

[9] A "community of concern" (CoC) is a coalition or consortium of organizations working together to improve protection for health care from violence within a given country/territorial boundaries. Typically, a CoC will involve the pertinent National Red Cross or Red Crescent Society and other components of the Movement; the medical association, the pertinent nursing council, and other professional medical bodies; representatives of national/sub-national ministries/departments of health; medical universities; public-health institutes; representatives of major hospitals/hospital associations; and representatives of ambulance services. A CoC may also involve 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.

[10] The ICRC's global HCiD community of concern currently consists of the following: the International Committee of Military Medicine; the International Council of Nurses; the International Federation of Medical Students' Associations; the International Hospital Federation; the International Pharmaceutical Federation; the International Pharmaceutical Students' Federation; Johns Hopkins University; the Junior Doctors Network; Médecins Sans Frontières International; Médecins Sans Frontières Switzerland; Médecins du Monde; the Centre for Ethics, University of Zurich; the World Confederation for Physical Therapy; the World Health Organization; and the World Medical Association.

[11] Such as past and ongoing initiatives with the African Union and the Parliament of the Economic Community of West African States.

to position the ICRC as a unique actor working across the entire spectrum of humanitarian action – from field operations to humanitarian diplomacy – and distinctly oriented towards finding practical solutions to the issue of violence against healthcare.

- Building solidarity – We will use the association between the emblems and health care, and capitalize on the fact that health care forms the largest share of Movement programming, to mobilize around the notion of the inviolability of health care. Movement partners will be included whenever possible in national strategies. This will be of particular importance where situations of conflict overlap with epidemics and natural disasters.

  The ICRC – together with other components of the Movement and especially with National Societies in highly industrialized countries not affected by conflict, and with professional health-care organizations – will build bridges between health-care workers experiencing growing workplace violence in those countries and health-care workers in countries affected by conflict. The sense of solidarity[12] built in this way will push governments towards more practical action, bilateral support, will foster bilateral exchanges of expertise and allow others to lead. This will be done carefully, without giving rise to any perception that the situation in places experiencing conflict or other emergencies is being equated to that of countries at peace.

Strategic objectives

The structure of the ICRC's HCiD objectives is determined by the HCiD Theory of Change.[13]

The goal of ICRC work in connection with HCiD is twofold: reducing the incidence and the impact of violence against health care.

This goal covers the violence during conflict and other emergencies, which encompasses not only military attacks on health-care facilities and staff, medical vehicles, and patients, but also obstruction, misuse and violence by individuals.

To meet this goal, four "objectives" and two "cross-cutting objectives" have to be achieved. HCiD is a complex initiative, from both the strategic and the management point of view; and defining clearly measurable objectives is challenging. In line with its emphasis on strong effectiveness of its actions, and in the spirit of making objectives and targets[14] as clear and as concrete as possible, the ICRC will measure the impact of its HCiD strategy by aggregating results from the field:

Objective 1: Weapon bearers adopt policies and practical measures in order to ensure respect for health-care services and enable the safe delivery of health care.

The ICRC will work with Movement and CoC partners to assess the extent to which measures to protect health care have been incorporated in the policies and/or operational

[12] One example is the recent campaign by the Italian Red Cross: https://www.cri.it/nonsonounbersaglio

[13] See page 10 for the HCiD Theory of Change graph.

[14] Progress towards the targets will be reviewed in mid–2021, with a view to revising failing or unsuccessful approaches or to upgrade targets and scale up particularly successful approaches.

procedures and practices[15] of State and non-State weapon bearers; where gaps are discovered, it will seek – through its protection dialogue, behavioural-change programming and humanitarian diplomacy – to influence these armed actors to make the necessary changes.

Target 1: By the end of the period covered by the strategy the ICRC will have obtained formal commitments from five armed actors to change their policies, practices and sanction mechanisms[16] in this regard, including actors in two of the ten largest ICRC operations.[17]

Objective 2: States adopt and implement legislation to protect health care from violence.

Domestic legislation has to enshrine measures protective of health care. To that end, the ICRC will work with its Movement and CoC partners to analyse the quality of domestic legislation in this regard and, where applicable, it will propose new laws or lobby for amendments to existing legislation. This area of legislation is understood as encompassing not only suppression of violations and non-criminalization of access, but also frameworks of many kinds – regulatory, administrative, medical-accountability, and policing – and legally sanctioned coordination mechanisms that may have an impact on safe and impartial provision of health care during conflict and other emergencies. The exact angle of a legal intervention will always be based on contextual needs analysis; and it will be narrowly focused on solving a specific problem, one that contributes to the prevalence of violence against health care.

Target 2: By the end of the period covered by the strategy the ICRC will have influenced five constituencies to commence legislative change in this regard, including in two of the ten largest ICRC operations.[18]

Objective 3: Health-care providers are better prepared to prevent violence and/or mitigate and cope with its impact.

Given that attacks in one form or another are likely to persist into the foreseeable future, it is essential to foster the resilience[19] of health systems, so that they can manage the violence and limit its impact. The ICRC will work together with its Movement and CoC partners – and with national authorities, especially ministries of health – in order to incorporate staff training, securing of facilities, and relevant standard operating procedures in vulnerable health systems.

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

[16] The threshold for this measurement is a formal commitment by the armed actor in question (that is, the signing of a unilateral declaration or the commencement of a formal process to change practices that have been documented), and not just the ICRC's efforts to secure such commitments or the resulting behavioural change.

[17] Eight of those ten, as of 2019, are also priority contexts for HCiD.

[18] The threshold for this measurement is the existence of a formal process to amend the legislation of the State or other legislative unit in question, and not just the ICRC's efforts to bring about such amendment or the resulting behavioural change.

[19] "Resilience" is the ability of individuals, communities, institutions and systems to anticipate, absorb, adapt or respond to and/or recover from shocks and stressors arising from conflict or other violence, or hazards without compromising their long-term prospects.

Target 3: By the end of the period covered by the strategy the ICRC will have incorporated such measures in four constituencies, including in two of the ten largest ICRC operations.

Objective 4: The general population in countries affected by conflict and other emergencies has greater respect for health care.

In many conflicts and emergencies now, the civilian population is a major source of the insecurity affecting the delivery of health care. It stands to reason that it will be difficult to hold weapon bearers to account if their civilian constituencies are not themselves respectful of health care. Together with its Movement and CoC partners, the ICRC will carry out behavioural-change campaigns addressing the attitudes and behavioural patterns underlying such violence.

Target 4: By the end of the period covered by the strategy the ICRC will have carried out such campaigns in four constituencies and three of them will have been accompanied by impact evaluation studies.

Cross-cutting objective 1: Methodologically sound evidence supports analysis and prevention of violence against health care.

Evidence-base generation is one of the three main axes for ICRC engagement on HCiD: it cuts across all objectives and all levels – from the global to the local. But capturing the amount and the patterns of violence is most crucial at the local level. This is why the ICRC will capture the impact of its multi-layered work on research and data at the field level.

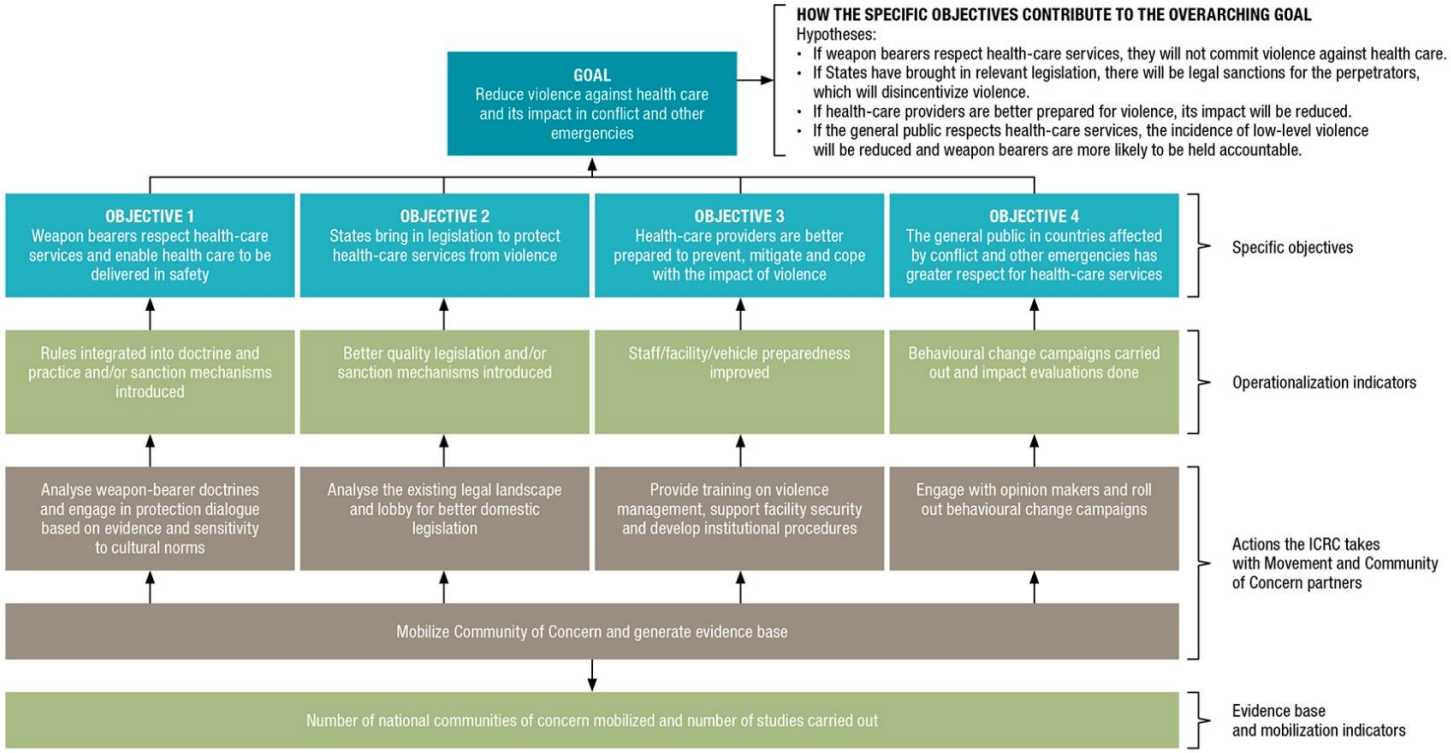
Cross-cutting target 1: By the end of the period covered by the strategy ICRC delegations will have carried out – in partnership with local research institutes – four studies on the prevalence of violence in health-care settings in their area of responsibility, or studies on the effectiveness of HCiD activities, including in one of the ten largest ICRC operations.

Cross cutting objective 2: Health-care stakeholders coordinate closely to prevent violence.

The ICRC will continue its activities – influencing and coalition building – across global, regional, urban and national platforms. The impact of this axis of engagement will also be captured at the field level, where this is a cross-cutting activity contributing to the achievement of all four of the objectives listed above.

Cross-cutting target 2: By the end of the reporting period, ICRC delegations will have convened eight regional, national or sub-national CoCs in such a way that the actors gathered in those CoCs are either strongly integrated into the process of designing and implementing the ICRC's HCiD programming or lead relevant initiatives themselves.

HEALTH CARE IN DANGER – THEORY OF CHANGE



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

ICRC