



1st Asia-Pacific Regional Meeting on Health Care in Danger (HCiD)

13-15 JUNE 2019

MAKATI CITY, PHILIPPINES



ICRC



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

1st Asia-Pacific Regional Meeting on Health Care in Danger (HCiD)

Executive Summary

The Red Cross and Red Crescent Movement was born out of the intention to provide safe access to health care for the wounded at war. The Geneva Conventions defined that the wounded and sick be treated with respect at all times and those who provide them with care should enjoy special protection. Despite this, we are still witnessing violence against health-care workers, facilities, transport and patients in many countries around the world.

The International Committee of the Red Cross (ICRC) and Movement partners have been advocating for continued cooperation among all stakeholders towards sustained efforts in addressing issues on Health Care in Danger (HCiD). It is in this light that a regional forum was envisioned to foster better national-level action through peer-to-peer learning and development of regional strategies to counter violence against health care.

The 1st ever Asia-Pacific Regional Meeting on HCiD aims to foster better national level-action through peer-to-peer learning and development of regional strategies to counter violence against health care.

On 13-15 June 2019, 57 participants from 9 countries – Afghanistan, Australia, Bangladesh, Indonesia, Japan, Myanmar, Pakistan, Papua New Guinea, and the Philippines – convened to discuss the challenges in their different contexts, present various initiatives done to address issues on violence against health care, and recommend steps to strengthen protection of health care.

The participants – mostly ICRC staff, focal points of National Societies, and representatives of Ministries of Health, medical professional associations, but with few uniformed personnel from the Philippines as well – shared best practices and ideas on most appropriate ways to address the main factors that hinder the access to and safe delivery of health care in armed conflicts and other emergencies. They acknowledged that HCiD was a term not commonly used despite the prevailing incidents of violence against health care in their contexts. As such, they were keen to learn about the Theory of Change and how the many initiatives at global level can be translated to practical measures geared at protection of the medical mission at local level.

There was interest to know more about some of the projects and best practices presented by other countries. The hospital-based security improvements and crisis intervention tools in Pakistan, health information system in Afghanistan, legal framework analysis and policy advocacy in Australia, targeted communication in Papua New Guinea, and improving coordination mechanisms with military and police in the Philippines generated a lot of discussion and a move to share practical information for their adoption or replication.

In various group discussions and interactive plenary workshops, the participants defined enablers and prerequisite actions necessary to implement relevant and sustainable activities aimed at addressing violence against health care at all levels. These were summarized in a “Declaration on Protection of Health Care” that was eagerly endorsed by all participants on behalf of their organizations. This Manila Declaration, thus, can be viewed as a roadmap towards initiating and/or pursuing concrete measures towards protection of health care systems and their resilience in armed conflicts and other emergencies.

There was consensus amongst the participants that concrete measures need to be taken to strengthen the protection of health care systems and their resilience in the face of crises.



"Raising Awareness and Promoting Respect & Protection for Health Care"

1st Asia – Pacific Health Care In Danger Regional Meeting

Manila, 13 - 15 June 2018



DECLARATION ON PROTECTION OF HEALTH CARE

The 1st Asia – Pacific "Health Care in Danger" (HCID) Regional Meeting (RM) was organized in Manila by the International Committee of the Red Cross (ICRC) with the Philippine Red Cross (PRC) to bring together regional, national and local actors and representatives of the Communities of Concern to improve protection of healthcare from violence and attacks on a platform together with the ICRC and the other Red Cross & Red Crescent Movement components. In this context, the RM sought to encourage concrete efforts in the Asia – Pacific region on this issue.

Participants of the RM reaffirmed their conviction that improving the protection of health-care services is a collective responsibility requiring the active participation of many stakeholders, where the States have a primary role to play in mitigating violence against personnel and facilities involved in the provision of health care.

Within this context, there was consensus amongst the participants that concrete measures need to be taken to strengthen the protection of health care systems and their resilience in the face of crises. The following points summarize the main outcome of the deliberations during the RM, which were acknowledged for follow-up and implementation by the respective stakeholders.

1. Participants agreed that there is a need to strengthen the respect for safe and secure delivery of healthcare by weapon bearers and that the focus of this engagement should be on practical measures such as training manuals and SOPs allowing for exercises of principles of restraint and proportion in the vicinity of health staff, patients, facilities and transports, for non-disruptive performance of health facility searches and smooth ground evacuations of the wounded and sick. The participants stressed that such measures were at their most effective if approached with the spirit of constructive cooperation between health and security authorities guided by the logic of prevention and therefore they were applicable to all countries, including the ones not experiencing conflict.
2. Preventive and safety measures for protecting the provision of and guaranteeing safer access to healthcare should include encouragement of adoption of new legislations and education and training on, as well as dissemination of the existing domestic legislation – including that pertaining to protection of the emblem. Appropriate measures to train/ educate civil servants, healthcare workers and the population at large about the domestic legislation and relevant legal instruments are to be undertaken by authorities.
3. Participants agreed that there is a need to strengthen the resilience and preparedness of healthcare systems to face violence and attacks with a particular focus on the physical security of health facilities, the training of healthcare staff to prevent and to manage violence, as well as the strengthening of coordination mechanisms between the various components of health systems and other agencies, such as law enforcement. Academic institutions should play a particular role in integrating the topic of protection of healthcare and respect for medical ethics in the context of conflict and other emergencies into training curricula for all medical and health staff.
4. All those with a stake in protecting healthcare – representatives of the national/subnational ministries/departments of health, national medical associations, nursing councils, other allied professional medical bodies, medical universities, public health institutes, representatives of major hospitals/hospital associations, and representatives of ambulance services, ICRC National Societies, other components of the ICRC Movement, civil society and private organizations, as well as concerned government departments – should form national or subnational Communities of Concern in order to play a key role in documenting and analyzing violence with the particular goal of devising concrete preventive strategies.
5. All health-care personnel should be adequately informed about their rights and responsibilities prior to, during and after armed conflict and other emergencies. Suitable training manuals, specific to these circumstances and including security considerations, should be drafted and distributed. Proper training for health-care personnel to apply and to respect their ethical duties that are the same in all circumstances, should also be ensured.
6. Participants agreed to promote awareness and to educate the general public on the need to respect healthcare and to launch behavioural change and public communication campaigns to that effect.
7. Participants of the RM agreed to share their best practices and challenges to develop stronger policies and practical means of implementation, particularly through peer-to-peer learning.

International Committee of the Red Cross

Philippine Red Cross

International Federation of Medical Students

Ministry of Public Health, Islamic Republic of Afghanistan

Integrated Provincial Health Office – Maguindanao

Integrated Provincial Health Office – Sulu

Integrated Provincial Health Office – Lanao del Sur

Armed Forces of the Philippines Health Service Command

University of the Philippines-Manila College of Nursing

Afghan Red Crescent Society

Afghanistan Islamic Medical Association

Health Emergency Management Bureau, Department of Health, Philippines

Philippine Medical Association

Department of National Defense, Philippines

International Pharmaceutical Students Federation

Ministry of Health, Bangsamoro Autonomous Region of Muslim Mindanao (BARMM)

Myanmar Red Cross Society

Philippine Nurses Association

World Health Organization, Philippine Country Office

Indonesian Red Cross Society

Bangsamoro Medical Society



HIGHLIGHTS OF THE REGIONAL MEETING

Opening Ceremony

12 June



Mr. Martin Thalmann, Head of Delegation of the ICRC in the Philippines, kicked-off the event with a warm welcome and roll-call of countries in the region represented in the meeting. He recounted how two years ago when the issue of violence against health care was brought to the fore as a result of the Marawi conflict in the southern Philippines, the call to protect health care was readily taken up by the doctors, nurses and health

practitioners in the field. The message being espoused by HCiD was clear – that for people affected by conflict, getting to a health clinic or hospital makes all the difference in their lives!

Dr. Gloria Balboa, Director of the Health Emergency Management Bureau of the Department of Health (DOH) Philippines, conveyed the warm regards and commendation of Dr. Francisco Duque III, the Secretary of Health, in his absence. She thanked the ICRC and PRC for co-organizing the Regional Meeting to highlight protection of health care workers, who risk their own lives to save others during conflict and emergencies. Dr. Balboa recounted different initiatives with stakeholders at national level that the DOH is engaged with, all aiming to ensure stronger continuity of health services in emergencies – looking into inclusion of HCiD awareness in the health professional curriculum, pledge to put advocacy into policy, intensifying posting of “no weapons signages” and issuance of local policies by the police banning entry of firearms in hospital premises, and their Caring for Carers initiative which looks at the welfare of health responders through additional



insurance benefits, mandatory debriefing and compensation with days-off from work after any emergency response. She emphasized the importance of partnership and cooperation so the goal of ensuring safety, security and welfare of health care workers is translated from ideas, debates or proposals to actual programs and activities that will be felt by those working in the communities.

Ms. Elizabeth Zavalla, Secretary General of the Philippine Red Cross, also welcomed participants to Manila, on behalf of PRC's Chairman Richard Gordon. The PRC strongly



supports the convening of the HCiD Community of Concern (CoC) to promote protection of health care in the country – endorsement of medical ethics in conflict, inclusion of HCiD awareness in trainings, and advocacy to change policies. She encouraged everyone's active participation and sharing of experiences to come up with very good, realistic strategies to address the problem in the region.

HCiD – regional context and objectives

13 June

The two-fold objectives of the meeting were laid out – fostering better national-level action through regional peer-to-peer learning, and development of regional strategies to counter violence against health care. Participants were encouraged to share their experiences and concerns freely within a safe, confidential dialogue as is standard for the ICRC.

The first presentation was to introduce the concept of HCiD and the theory of change. **Mr. Maciej Polkowski**, head of HCiD initiative of ICRC, pointed out that addressing the issue of safe access to health care lies at the very core of the Red Cross/Red Crescent identity. The Geneva Conventions states that the wounded and sick deserve to be treated with respect and those who provide them with care should enjoy special

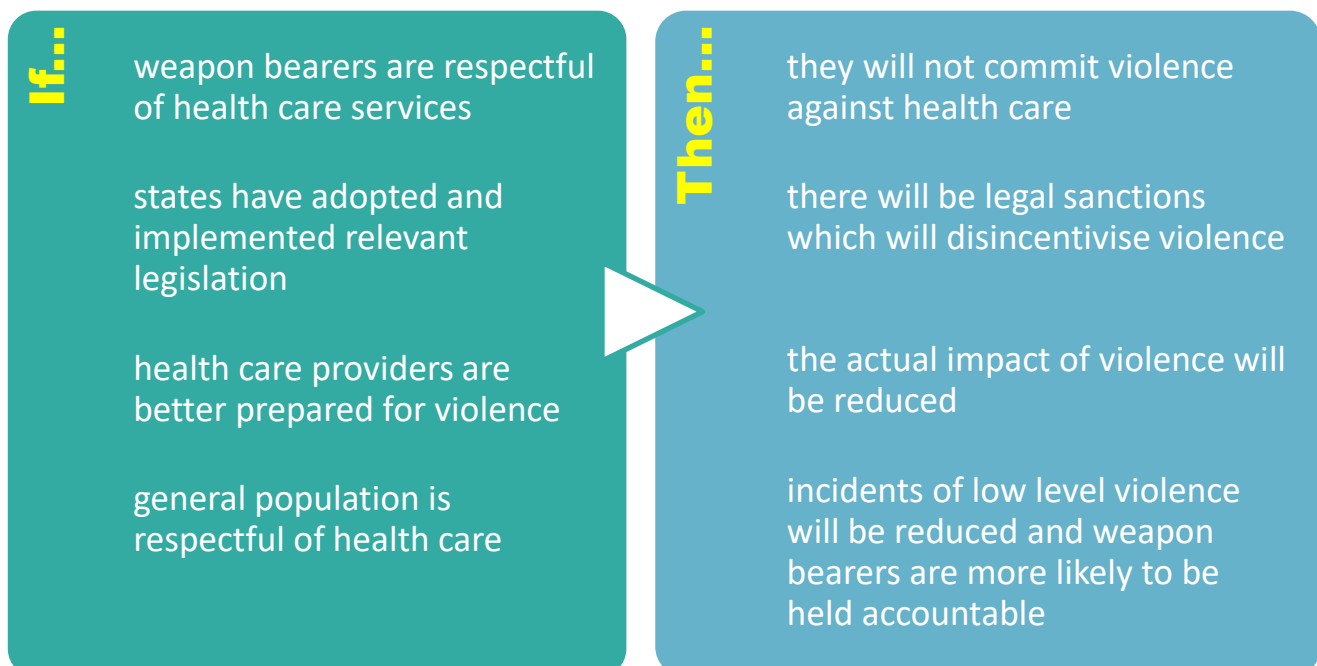


protection. Yet, we still hear of unacceptable attacks to health care such as the suicide bombing and shooting at a government hospital in Quetta, Pakistan, the aerial bombing of Kunduz Trauma Center in Afghanistan, and the direct attacks in Yemen which resulted to only 45% of their health facilities remaining functional.

Not restricted to war zones, health care falls prey to violence and intimidation by armed criminal groups, as seen in the *favelas* of Rio de Janeiro, Brazil. Even developed countries such as Australia reports intimidation and assault of ambulance workers. It came as a surprise to note that health care workers are the most exposed and vulnerable to violence among all professions globally.

Mr. Polkowski shared with the group the achievements of the ICRC and partners – from significant global resolutions, increasing number of relevant and active partners, publications on the topic gleaned from consultation with experts, to more current engagement within three main axes of (1) operationalization, (2) evidence base generation, and (3) influencing and coalition building.

He explained the **HCiD Theory of Change (ToC)** and how the specific objectives are expected to contribute to reducing violence against health care and its impact in conflict and other situations of violence and emergencies:



HEALTH CARE IN DANGER – THEORY OF CHANGE



He ended by informing the group of strategic projects in the pipeline, and the expectation for new long-term commitment and strategies be developed, fostered by regional collaboration that meetings such as this will promote.

The proposal for a **regional meeting consensus** outlining steps that participants would like to take independently or within a regional collaboration was introduced, and developed from a synthesis of the outputs during this meeting. This was later on finalized with the facilitation of **Dr. Kasbar Tashdjian**, head of Health sector of the ICRC's Asia-Pacific Region, resulting to the Manila Declaration on Protection of Health Care document.



The succeeding sessions were a mix of panel presentations, group discussion and plenary presentation of group outputs on various topics linked to HCiD ToC.

Respect of health care by weapon bearers – adaptation of (best) practices 13 June

The session started by showing the **HCiD Hope video** which powerfully depicts the consequences of attacks on health care to people needing medical care – no hospitals, no hope!



Session chair **Dr. Jose Antonio Bastos Amigo**, Health Coordinator for the ICRC Delegation in the Philippines, opened by saying that the first logical step to deal with issues on HCD is to answer how to convince those with potential to attack/disrupt health care not to do it, or how to instill respect among weapon bearers in general. Traditionally, the ICRC responds to these violations against IHL through interventions aimed at engaging weapon bearers in

confidential dialogue to arrive at conclusions that respect the rule of law even in conflict settings. To complement this, ICRC's Police and Security Forces (FAS/PGE) unit responsible for advocacy to military/police presented their preventive work aimed at promoting military practice that ensures respect for health care and IHL in general. Then finally, the experience of local health authorities in setting up coordination mechanism with military forces to prevent disruption of health care was presented.

“There are hundreds of thousands of people in critical situations for whom accessing health care is a matter of dignity, a matter of life and death.”

Ms. Zita Crener, Protection Coordinator of ICRC in the Philippines, emphasized that IHL explicitly protects patients, health care workers, health facilities, and ambulances or medical transport. ICRC contributes to this protection by reminding parties to the conflict of their responsibilities according to different bodies of Laws – including IHL and customary laws – and on humanitarian grounds. The ICRC is made aware of violations through observation, reports or allegations, and on the bases of such gathers relevant accounts then discusses these with parties to take measures and avoid future violations, improve conditions or reduce harmful consequences.





Mr. Ricardo Lucero, Jr., FAS Programme Adviser for the ICRC in the Philippines, drew attention to the number of violent incidents documented by the ICRC between 2012-2013 which was admittedly just a tip of the iceberg. He mentioned the engagement with military personnel around the world through broad consultation – dialogue with military units of 29 countries and two multilateral organizations of a military or defense character. This culminated in an expert workshop on military operational practices in Sydney, Australia on 9-12 December 2013 with 27 senior officers from 20 countries in attendance.

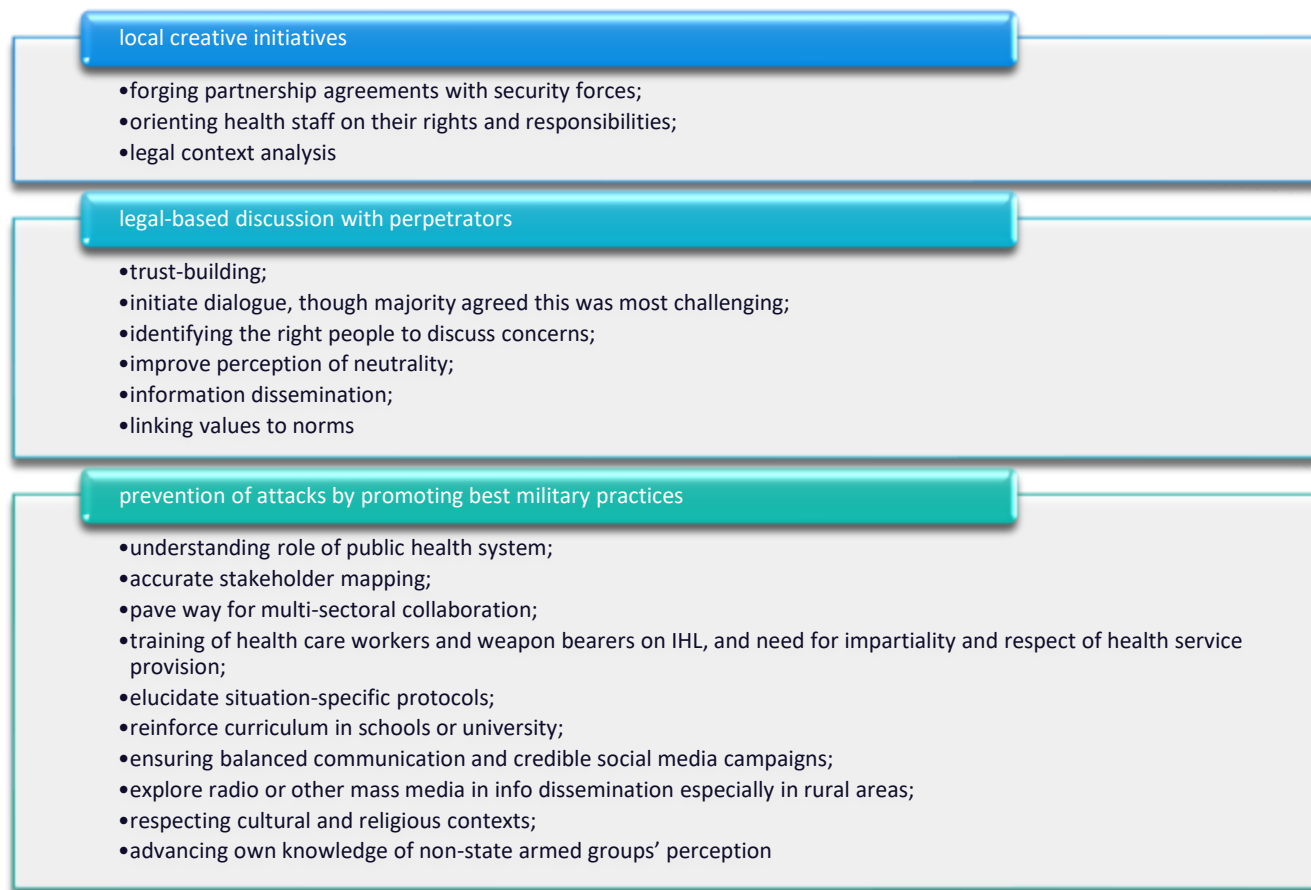
Noteworthy were the three focus areas discussed: (1) delays in or denial of passage to medical transport, affecting medical evacuation of wounded and sick; (2) negative impact of military search operations in hospitals and other health facilities; and (3) harm caused by deploying military objectives inside or in close proximity to health facilities. The practical recommendations are embodied in the publication *Promoting Military Operational Practice that Ensures Safe Access to and Delivery of Health Care*.

Dr. Alinader Minalang, the Integrated Provincial Health Officer of Lanao del Sur in southern Philippines, recounted how health workers in his province found themselves between two fighting forces – SSF and the ISIS-affiliated armed group – in the city of Marawi. The five-month long siege displaced the 300,000 inhabitants of the city, with 1,000 killed and many more injured or sick. The attempted take-over of the city's main referral hospital was considered the start of the siege, one that brought home the fact that HCiD was a clear and present concern. In the next few months, several private hospitals were hit by aerial attacks or high-powered firearms, smaller facilities were



laid to waste, and the government health office was rendered unsafe due to stray bullets. While health authorities worked overtime to deliver emergency response and re-establish service delivery among the displaced population and the few who remained unable to evacuate the city, difficulties passing through security checkpoints were encountered. Health workers felt their safety and security were compromised. All these prompted him to seek ICRC's support in reinforcing coordination with military officials to facilitate work of health staff while improving their security. In April, both parties agreed to sign an agreement outlining their coordination mechanism. Main point of the agreement is ensuring the proper (clearly marked) identification for health workers, facilities and transport to ensure their recognition and respect by SSF.

In the ensuing group discussion, participants mainly shared experiences on HCiD in their various contexts. While it was intended that participants begin to draw conclusions and recommend specific measures, the output was rather general.



Dr. Mir Lais Mustafa from the Ministry of Public Health of Afghanistan lamented the impact in Afghan society of more than three decades of war and conflict, exacerbated by the shift from a post-conflict state back to active conflict. Through their impressive Information Management System (IMS) indices for health are readily retrieved. Incidence of violence against health care are recorded. In 2018, 90 incidents were reported, with 44 staff killed/injured and 73 others detained/kidnapped; 83 facilities closed/destroyed, and 39 others damaged/looted. In the first four months of 2019, however, already 51 incidents have been noted, with 28 providers and 114 facilities severely affected. The increasing number of HCiD incidents necessitated the Ministry to improve security of health facilities and ensure access to services by the population. Close coordination with SSF, engaging civil society and community councils to monitor open activities of health centers, and shifting of centers away from warring fronts towards more secure sites. Working with the ICRC and World Health Organization (WHO), they are currently developing strategies against attacks to hospitals and developing security guidelines to be shared with providers.



Dr. Mirwais Khan, Head of HCiD project in the ICRC Delegation in Pakistan, walked us through their practical approaches for securing one of the largest health care facility in Peshawar – the 1751-bed Lady Reading Hospital (LRH) that receives as many as 4000 emergency patients daily. A hospital security survey identified significant challenges such as proximity to a military installation, overcrowding, a

culture of carrying weapons, and reactive violence. There was a high risk for exposure and likelihood to hazards, with intrusion and bombing among top concerns.

Working with ICRC's HCiD project, security measures at LRH were instituted: internal communication using VHF radios, passive surveillance (CCTVs), installation of metallic grilles and walk-through gates, identifying waiting areas for attendants/relatives of patients, strict implementation of "no weapons" policy, installation of panic alarms, and development of standard operating procedures on de-escalation and managing violence.

Mr. John Carlo Pagaling, Health Field Officer of the ICRC Delegation in the Philippines, gave an overview of the Security Survey for Health Facilities tool that was used to assess as few health facilities in Mindanao in preparation for HCiD field workshops for health workers. The tool itself aims to identify level of preparedness required by a health care facility to be able to continue its operations during or following a conflict-related security event. The results of the survey can then support decision-makers in identifying the main areas for improvement, to complement already existing contingency plans that are more often than not considers only risks from natural disasters such as typhoons or earthquakes.



Considerations for GPS mapping of facilities, clear and visible signages of health facilities, banning entry of weapons, and securing of critical areas of hospitals (e.g., emergency room, intensive care units, water source, etc.) were discussed. Interestingly, there were spontaneous actionable interventions that came about following the assessment.

In groups, participants discussed the applicability of the presented measures to the contexts they are familiar with.



To address concerns on HCiD, it was vital to:

- Collaborate and share responsibility with relevant stakeholders/key players;
- Involve/engage both the public and private sectors, and most importantly, the community (grassroots level);
- Link legislations with relevant humanitarian principles, values and norms (customary laws) to effectively engage with perpetrators for them understand the message to respect Health Care;
- Abide with certain principles such as building trust and confidence, consistency, confidentiality and neutrality to engage with the perpetrators;
- Conduct stakeholder mapping or identify people/groups who may have influence over perpetrators to be able to convey message on respect of health care;
- Integrate the lessons/ideas learned from this forum in the development of modules for the Department of Health/Health Ministries to ensure protection of health care;
- Promote the use of Hospital Security Index and complementary tools;
- Find feasible solutions to address potential/actual problematics arising from utilization of advanced technology (artificial intelligence) – such as geographical mapping of health care facilities so that robotics that may be used in warfare will spare these facilities from deliberate or indirect attacks;
- Do responsible data collection, and ensure that this is well-understood by all parties (especially the non-state armed group)
- Initiate behavioral change campaign on violence against health care

Protecting health care through law: national legislation addressing violence against health care - from contextual analysis to legislative changes 14 June

Mr. Felix Onwudegu, HCiD Delegate for ICRC Delegation in Afghanistan, shared his experience in lobbying for amendments to domestic legislation in Nigeria based on contextual analysis of threats towards secure delivery of health care. Victims of gunshot in Nigeria have difficulty getting prompt medical attention due to a prohibitive requirement of a police report before any care is administered. Apparently, this stems from a misinterpretation of their Firearms and Robbery Act that linked providing care to gunshot victims with “knowingly giving quarters to person/s who committed an offence”. Following advocacy efforts of the HCiD working group in 2016, the Nigerian National Assembly passed a bill in 2017 which mandates immediate, adequate and compulsory treatment and care of victims of gunshot, whether in public or private hospitals, and with assistance from security agencies. The act allows for a two-hour window before medical practitioners must notify the police, and this is meant to remind practitioners to treat first before reporting.



Lt. Col. Joven Capitulo of the Department of National Defense went through the implementing rules and regulations of the Philippine Emblem Law. The role of the Department of National Defense (DND) was to issue armlets and identity cards for authorized users of the emblems, namely military medical and religious personnel. In case of active conflict, DND shall authorize other government agencies, e.g., police, to use the same. The Department of Health (DOH) is responsible for issuing the armlets and identity cards to civilian medical personnel, facility and transport, in consultation with the PRC. The operational guidelines are still being developed in ongoing multi-agency consultations. The Emblem Law provides stronger push to prevent

misuse of the emblem, which until now has been a long-drawn process of imploring ambulances and medical business establishments to respect protective nature of the emblem. The steeper penalties, up to life imprisonment if the misuse of emblem led to death of individual/s, will hopefully be deterrent.

Mr. Mohammad Jawad Muradi of the Afghan Red Crescent Society (ARCS) shared similar concerns on misuse of the emblem, from imitations to improper use and even perfidy. They are now in the process of revamping their organization, and lobbying legislators to be stronger in the protection of the emblem. Meanwhile, they make sure ARCS emblem is visible on health facilities' roofs, location of health clinics are provided to authorities for protections, and dialogue with community on IHL and orientation on use of emblems are being conducted.



Ms. Tara Gutman, the Legal Adviser for Government Engagement of the Australian Red Cross, presented online their national law gap analysis. Australia has been a key partner in the HCiD initiative. It co-hosted one of the HCiD global expert consultations in Sydney in December 2013 and a roundtable dialogue with government where preliminary analysis of domestic laws pertaining to protection of health care during armed conflict and other emergencies took root. In the succeeding survey of their legal framework, a number of areas were recommended to be upheld, such as criminalization of impeding access to health care, considering perfidy as war crime, protection for health care personnel against assault and obstruction, and facilitating access during emergencies. In addition, consideration for the needs of sexual violence victims, medical ethics, confidentiality, privacy and laws that incorporate Australia's human rights obligations, particularly the right to health were included in the comprehensive analysis. It was interesting to see the disparity between state and territory rulings in certain areas, revealing areas for future improvement.

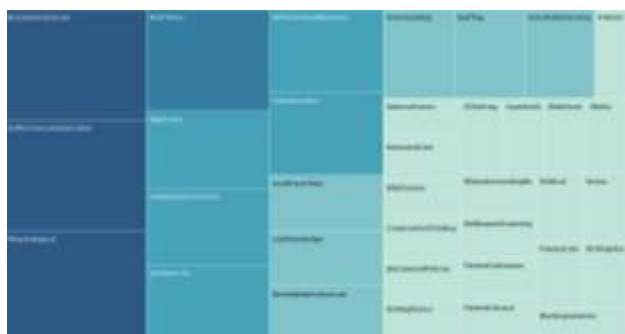
Respect of health care by the general population: adaptation of “interpersonal violence prevention” methodologies/tools to regional contexts

14 June

Ms. Jessica Yohana Ramirez Mendoza, HClD Data and Research Specialist for the ICRC, collated results of 19 studies in 9 countries on violence against health care staff. Over 36,400 health workers were interviewed using questionnaires from the Joint Programme on Workplace Violence in the Health Sector (ILO/ICN/WHO/PSI), with 53% of them subjected to violence. Perpetrators were either patients or their relatives. Verbal violence was more common than physical violence. The attributable causes, contributing risk factors and effects of violence were enumerated. Some recommendations proposed were training on violence and conflict management, deemed mandatory especially in dealing with psychiatric cases; advocate for “human-oriented” approach to patients with attention to their needs beyond physical (i.e., emotional, psychological, etc.); research on coping mechanisms related to culture and religion; system for rewarding workers for mental health-seeking behavior. Crisis intervention tools should be made available for patients, relatives, volunteers and health care staff, including employee assistance programs.



a) causes



b) contributing risk factors



c) effect of violence



d) recommendations

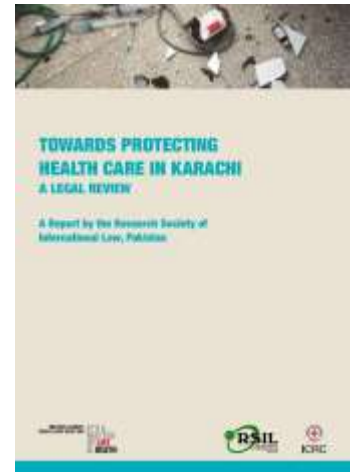


Ms. Hiba Ghandour, Liaison Officer for Human Rights and Peace Issues of the International Federation of Medical Students' Association (IFMSA), emphasized the need for the significance of understanding the impact of violence against health care as early as university education. IFMSA developed a HCiD Toolkit which transforms the Massive Open Online Course (MOOC) on HCiD offered by the ICRC and University of Geneva into a peer-to-peer 3-day workshop. It introduces future doctors to the Hospital Safety Index which provides a snapshot of the probability that a hospital or health facility will continue to

function in emergency situations, based on structural and non-structural factors as a way of managing risk for health. There is also an exercise on medical ethics, specifically linked to military medicine to allow students some introspection on decisions they may face in future. The toolkit itself has been received well by medical students, and interest from other countries to conduct it in their medical universities have been expressed.



Dr. Mirwais Khan shared ICRC Pakistan's approaches to behavioral change in public health. In expanding evidence base, they found out through surveys that male physician or hospital worker working for more than six years were at significantly higher risk of being abused physically or verbally. A legal review of their legal frameworks has shown the gaps but also highlighted some good models in other provinces. Subsequent consultations were made to arrive at consensus to draft "move-over" laws that allows prioritization of emergency vehicles in roads. Media campaigns on right of way and respect for ambulances were launched to heighten public awareness on the issue. Through radio programs and commercials, posters and campaign songs, creation of platforms in major social networking sites, obtaining pledge of endorsements by 90 celebrities, distribution of pledge stickers among motorists, and engagement of religious leaders to spread the message, there was resulting increase in the number of vehicles giving way, from baseline of 61% to a high of 80% during the campaign then to a still positive 77% after the campaign. In an assessment of effectivity, positive behaviors (i.e., gave way immediately) were seen to increase while percentage of those exhibiting negative behaviors (i.e., did not give space, obstructed ambulance) decreased. The campaign served not only as a catalyst for initiating debate on respect for ambulance services, but also served as the tool to widen the discourse and include the entire spectrum of violence against health care.



Mr. Rahiqul Islam Chowdury, Senior Health Field Officer of ICRC Delegation in Bangladesh, presented several case scenarios of security risks towards health staff for the group discussion. Issues highlighted were lack of respect for ambulances, culture of prioritization for VIPs, insufficient security measures to protect hospitals and health care workers, hospitals as targets and recipient of anger of patients' relatives, and lack of skills of health staff to communicate on their rights.

In the ensuing group discussion, participants were asked to determine their actions should they be faced with similar scenarios of violence in their respective context, and what feasible recommendations to give to hospital managers or decision makers in each case.



Behavioral change campaigns: best practices and methodologies

14 June

Ms. Carol Makena Kaburu and **Mr. Reuben Gawun Tabel**, Heath Delegate and Communications Field Officer, respectively, of the ICRC's Regional Delegation in Papua New Guinea, listed down their concerns on violence against health care in a country marked by strong tribal associations with no recognition of health services' supposed neutrality. Tribal fighters burn down health infrastructures, threaten, chase or intimidate health workers belonging to rival tribes, and deny access to non-clan members who seek treatment in their clinics. In the best of circumstances, population choose to go to health centers farther away from their residence to avoid crossing "unfriendly domains". In the worst scenarios, premises of health clinics are used as battle field. For the last 3 years, HCiD messaging has been included in all dissemination activities, employing different communication tools – radio spots, drama shows, posters and flipcharts, murals and film. Regular dialogue with stakeholders remind them of their obligations to protect health staff, structures and patients' access to these services, through a Tribal Rules of Fighting project.



Dr. Khan in his 3rd presentation ran us through their development of training manuals in de-escalating violent situations. A multi-center study on violence against health care developed baseline data to understand the situation better, and later on to assess the effectiveness of interventions. It showed that sectarian killings, abduction for ransom and blasts were but the tip of the iceberg in terms of violence against health care. Less intense but more worrisome in that they affect a far larger number of respondents were threats to life, armed entry, abusive language, coercion, slapping, damage to property and obstruction to work. It was interesting to note that reasons for violence were primarily unreasonable expectations (by patients), failure of communication, human error and poor outcomes (i.e., patient or family not ready for negative outcomes). Further, research identified the need to develop training manual to build capacity of health care professionals to respond to situations of violence and harassment.



A clinical psychologist and a medical education specialist were brought onboard to develop content, the former directed towards psychological and communication skills, while the latter towards adapting a facilitators' guide for medical and nursing students and included more components on breaking bad news. The manual itself has five modules – introduction to HClD; understanding violence, its types and

consequences; importance of communication in health care; de-escalating violent situations; and rights and responsibilities of health care providers.

“Enhancing the communication skills of health care workers can have significant impact on de-escalating and managing violence in health care settings.”

Mr. Marc Joly, Campaign Manager and communications expert from the ICRC, relayed the public campaign on HCD in Iraq in a context where there is damage to health infrastructure, negative reputation of health care providers, and persistent conflict situation after end to combat operations. A pre-campaign survey revealed as many as 60% of medical personnel were verbally abused, threatened or attacked in the three months preceding the campaign, a quarter of which were perpetrated by relatives of patients, while 21% were by patients themselves. The forms of violence were mostly verbal abuse (50%), interference in provision of care (16%), threats (16%), attacks without weapons (12%), and attacks with weapons (4%).



Working with multi-sectoral partners from both public and private sector, the campaign took out TV and cinema spots, broadcasted SMS messages, distributed promotional advocacy items, and had social media influencers to highlight the humanitarian impact of violence against health care workers, raise awareness and improve public perception on the need to protect health personnel and facilities. Whether it resulted in behaviour change is still being evaluated at present, but some concrete outcomes were enforcement of Iraq's Ministry of Health on ensuring free treatment in hospitals or centers for children under five, and the regulation of hand-written encoded prescriptions. Key learnings were ensuring good range and high-level profile of partners, proper benchmarking, and use of local content and influencers as vital multipliers. Mr. Joly reminded the plenary that campaigns take time to come together, more so to see change in people's behaviour; nevertheless, it is a vital step on the road to structural and even generational changes.

“Some important lessons learned: benchmarking is key, local contexts speak the loudest, campaigns take time.”

Mr. Andrew Kobylinski, the Policy and Political Affairs Director of the ICRC in Australia, informed the panel on their campaign to curb violence and aggression against Australian health workers dubbed “It's Never Ok!”. In several taskforce reports on occupational health hazards, up to 95% of their health care workers have experienced verbal or

physical assault. In Victoria, the no. of assaults on health personnel increased by 60% in three years; in Queensland, the increase was 50% in two years. Doctors, nurses and security guards at West Australian hospitals expressed need on better protection from increasingly violent and aggressive patients and visitors. These were unnecessary and preventable risk for occupational violence. Through federal funding but state implementation, the Department of Health & Human Services (HHS) and partners, developed public messaging to improve community awareness of the impact of occupational violence, and promote importance of respectful behavior and personal responsibility towards health care workers. Posters, brochures, radio interviews and promotional items all carried the message.



Other behavioural change efforts were: the Queensland Nurses Union optimized staff engagement and patient safety, delivering a 50% reduction in aggressive patient episodes in one of the mental health wards at Robina Hospital; new personal threat/violence procedures for Gold Coast HHS staff which focus on how to prevent, prepare for, respond to and recover from aggressive incidents; staff communication campaign encouraging reporting of all incidents of violence throughout Children's Health Queensland; and, virtual reality training to help prevent occupational violence. All these ties perfectly with the underlying message of HCiD that health care workers are not a target. Moving forward, an analysis on outcomes will be developed, opportunities to integrate into key messaging of HCiD programmes, and further support on behaviour change training by Australian government will be explored.

A summary of the key learnings and realizations following the day's interactive workshops and discussions were summarized by the group as follows:

- Assuring that health personnel, on all levels, know the law's existence will foster protection to the health care mission. For example, domestic legislation to ensure immediate treatment is provided to gunshot wound victims in Nigeria was shown to be a major step in ensuring provision of health care there.
- Inter-agency (Health, Defense) collaboration, including less apparent entities (e.g., Trade & Industries), in enforcing the provisions of the law (Emblem) and imposing penalties will deter violations towards the use of the Red Cross/Crescent/Crystal emblems.
- In certain context (Afghanistan), where the provision of health care is essentially needed, but oftentimes endangered, the Emblems of Protection may be exceptionally offered to guarantee health care services are not impeded.
- The continuous effort in the analysis of cases in Australia, understanding the gaps, dialogue with the authorities and international counterparts in strengthening the protection of health care can be a model adaptable to other contexts.
- The recognition of interpersonal violence against health care workers may oftentimes be overlooked but is a crucial element. Health personnel should, by all means, be given respect and consideration; in reciprocity, the same for patients and their families.
- The initiative of the IFMSA in creating their toolkit of the MOOC to address "Violence Against Health care", with number of trainers increasing, will open a new avenue that would reach more people in different regions. Their willingness to work more with the ICRC in strengthening the HCiD initiative is a huge asset.
- The great work in developing training manuals that are evidence-based in Pakistan, can provide a rich perspective and guidance to countries, such as the Philippines, in strengthening the campaign on HCiD.
- Behavioral change campaign was one of the most interesting topic that most of the participants can relate to. The realization that going back to the "basics", where interpersonal skills, empathy and compassion matters a lot in assuring the relationship between the health care providers and the patients and relatives remain harmonious.



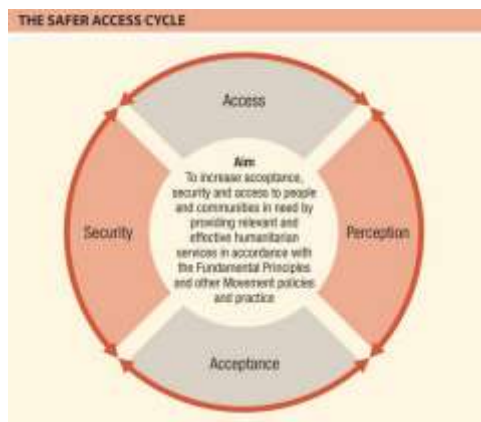
On the last day of the meeting, **Dr. Sarji Muldong**, Health Programme Responsible for the ICRC, directed participants' focus on what health workers on their own can take to protect themselves. She added that health care workers are often victims themselves, so certainly measures to support them should not be taken for granted. Co-chair **Dr. Kadil Sinolinding, Jr.**, former Secretary of Health for the Autonomous Region of Muslim Mindanao (ARMM), raised the question "are health workers prepared to face danger?".



Ms. Catherine Marie Martin, Regional Movement cooperation and Safer Access Advisor for the ICRC based in the regional delegation in Bangkok, challenged when health care workers say they are prepared, or that there are laws and policies that offer protection to health care workers. With the changing humanitarian context in conflict, armed groups and sometimes the community may not understand our work. Or even when they know your role as health care worker, people may not be able to separate that from your racial or cultural affiliation, as in tribal conflicts. Or your neutral role as health worker may not be sufficient when other considerations are

foremost; she gave as example the Zamboanga siege when 11 or 13 first aid volunteers were injured because they were on standby ready to give aid in an area where active fighting is on-going. Or there may be mistrust in your intentions, as the low turn-out of the polio immunization campaign in Pakistan allegedly linked to when other entities collected DNA samples to flush out Osama Bin Laden. The perception of health care workers by the community and its people is paramount; if you are perceived positively and your services are valued, acceptance is increased. If you are accepted, your security is increased, and thus your access to the population.

Ms. Martin was quick to note that security is only increased, not guaranteed, because the cycle of perception-acceptance-security-access is simply a way of managing risks



and puts at level of institution the duty of care and due diligence for its staff. This is what the Safer Access Framework (SAF) of the Red Cross/Red Crescent Movement espouses. She ended by saying that SAF should not be seen as a separate program, but rather as a lens through which we develop response activities as it helps analyze considerations in order to improve acceptance and security, applicable in conflict, other situations of violence, or in general.

Dr. Maridith Afuang of the Preparedness Division of Health Emergency Bureau (HEMB) of the DOH in the Philippines presented how they provide support to health care workers, specifically Mental Health and Psychosocial Support (MHPSS). Routinely, HEMB already provide within a cluster-approach system MHPSS services to the population affected by the disaster – basic (e.g., food, water, shelter), community and family support (e.g., play, art, recreational & sporting activities, child-friendly spaces, cultural & spiritual activities, social networking, etc.), non-specialized (psychological processing, psychological first



aid, case management, etc.), and specialized (clinical psychological treatment, use of antipsychotics, psychotherapy, cognitive behavior therapy, treatment of known psychotic clients in relapse & new cases, confinement in a mental hospital, etc.). But what about for the providers themselves? DOH-HEMB in its “Caring for Carers” program, aims to provide preparedness sessions, stress management, and adequate rest and reflection for health care workers. It was acknowledged that until recently, this was an aspect that was not given priority, but with the Mental Health Law for the country signed in previous year, they are gearing up to expand this program and their services to their own. Already, they thought up of some innovative ways to de-stress

after an emergency response such as organizing massage therapies, laughter yoga. A policy issuance mandates that all sending agencies and their response teams have to comply with, including maximum 2 weeks deployment, MHPSS services available to their families while on mission, mandatory post-incident evaluation and debriefing. There is also a move to increase insurance and other benefits for those in mission. So far, the program has received good feedback from health staff, and other agencies are collaborating to provide the same to their personnel.

Ms. Princess Joy Maulana, Senior Health Field Officer of the ICRC based at the sub-delegation in Davao, recounted the field initiatives on HCiD following the Marawi crisis.



In a total of four field workshops, participated in by 174 health workers from critical conflict areas throughout the country, the fact that violence against health care is a concern in the country was acknowledged. The interactive 2-day workshop introduced explicit protection of health care in IHL, national laws (IHL and emblem) that can be referenced, globally accepted

medical ethics, rights and responsibilities of health care workers, and the SAF as they relate to ensuring provision of care even in conflict settings. For most of them, the concepts were not new, but have never been discussed in a way that it relates to the everyday realities of their work. The main issues that came out of the workshop were: (1) the regular exposure of health staff to violence (2) the realization that violence against health care is not unavoidable or acceptable; (3) the lack of awareness of the protected status - by national law and by IHL- of health care workers; and probably the most striking was (4) the importance of the perception of neutrality of health workers for their security in conflict areas. Participants' recommendations were compiled and deliberated with key stakeholders in a consultative meeting resulting in a commitment to prepare a Regional HCiD plan to promote protection of health care. At facility-level, practical measures such as agreeing with local law enforcement to institute a "no weapons" policy in the hospital, and coordination with military units to limit unnecessary presence in health infrastructures.

The session was concluded aptly with a presentation on medical ethics and humanitarian principles in the protection of health care by **Dr. Bastos Amigo**. He waxed eloquent on the principles of beneficence, non-malevolence, autonomy, justice, trust and confidentiality that binds all health workers in their sworn profession. He reminded the plenary that for as long as they do their exclusively medical tasks, they are protected by international and local laws. Moreover, the perception of one's neutrality (i.e., responding to health needs without discrimination) is validated. And in the course of doing their work, it should not be forgotten that health workers have rights, not just responsibilities, and that these rights should be respected.



On query of initiatives to protect health worker from burn-out, panelists commented for the need to strive for a work-life balance - take time to recover, days off to compensate for overtime, self-limit within the mandated work hours; agencies should ensure support is given not only to their staff but also to the families of their staff, often the ones forgotten when immediate needs of

affected population are considered. It was raised, as well that SAF do not only target specific activities of national societies, but also structures, management and operational levels, so can be adapted in other agencies. **Dr. Tashdjian** commended the health workers' commitment and reminded everyone of the nobility in their profession – one that should be protected indeed if we are to continue being able to do the best of our work.

The session concluded with a dynamic group exercise facilitated by **Dr. Muldong**, tasking groups to list down any and all practical measures they could think of in order to protect health care under different sub-headings which aptly sums up the actionable points for each of the participants:



<i>Increasing awareness by others of health care workers' rights</i>	<i>Improving quality of medical practice/ health care to ensure protection</i>	<i>MHPSS and other support for health care workers</i>	<i>Improving security in general</i>
<p>Review existing legislation;</p> <p>Disseminate fully workplace policy;</p> <p>Use of social media in delivering key messages that will contribute to behavior change and increased awareness;</p> <p>Ensure localization of stipulations on IHL and HCD;</p> <p>Conduct meetings with partners, communities, elders and religious groups;</p> <p>More FGDs, lectures and seminars;</p> <p>Use popular/influential people;</p> <p>Integrate HCD into education curricula;</p> <p>Waiver form to remind of their liabilities/ responsibilities in specific care;</p> <p>Signages in the health facilities</p>	<p>Personal/self-care;</p> <p>Balanced workload;</p> <p>Therapeutic care, patient-centered, empathy, impartiality;</p> <p>Understand the context where you are working;</p> <p>Establish feedback mechanism between health workers and patients;</p> <p>Ensure medical ethics are respected;</p> <p>Provide suitable and enabling environment to learn;</p> <p>Capacity building activities;</p> <p>Team work</p>	<p>Recognition of efforts and achievements through incentives, compensation, trips abroad, awards and promotions;</p> <p>Incorporate HCD in MHPSS module;</p> <p>Laugh often;</p> <p>Rest and recreation;</p> <p>Emotional support with other colleagues, sharing experiences;</p> <p>Regular stress management activities;</p> <p>Management of case workload</p>	<p>Collaborate with security operatives and community stakeholders;</p> <p>Sensitize all how to do conscious self-security;</p> <p>Improve perception and acceptance;</p> <p>Maintain neutrality and impartiality;</p> <p>Use key messages through different social media;</p> <p>Encourage participation of community members;</p> <p>Engagement of LGUs</p>



Mr. Polkowski summarized the achievements of the regional meeting, emphasizing the key learnings previously shared, and lauding enthusiasm by which the initiative has been embraced by the participants. He committed to bridging the gap between global initiatives and policies with the needs expressed by participants in their work setting. He affirmed that from a previous practice of conducting the HCiD meeting as an annual international event, a regional track is a more perceptive approach to addressing the problematics through coming together of people with varied yet relatable contexts.

In an inspiring conclusion to the regional meeting, participants agreed to affix their signatures and organizations in a consensus of concrete measures acknowledged for follow-up and implementation – the *Manila Declaration of 2019 on Protection of Health Care* seeks to:

- *Strengthen respect by weapon bearers*
- *Protecting the provision of and guaranteeing safer access to health care*
- *Strengthen the resilience and preparedness of health care systems*
- *Play a key role in documenting and analyzing violence with the particular goal of devising concrete preventive strategies*
- *Promote awareness and educate the*



Finally, a list of all other organizations that should be engaged within the HCiD initiative was to be established, with pledge that participants will reach out to them at all levels possible to seek their collaboration and support of HCiD endeavors.

“We work together towards a common goal of achieving unimpeded health delivery... as people working for humanity.”

Snapshots of the Conference

During lunchbreaks, set-ups for coffee-table chats with different country delegations to understand more of their context, HCiD initiatives or other projects and programs.



An exhibit of photo panels was kept outside the meeting room, changed intermittently to show ICRC's activities, HClD posters and sample legislation on IHL with emphasis on protection of health care.



At the end of the day, the group watched a same-day edit video showing the participants as they engage with one another, discussed in groups or feature in candid moments during the meeting.



Photos of the group was taken for posterity, made interesting by asking participants to collectively raise their voice on key messages – #NotATarget and Protect Health Care: It's a Matter of Life and Death!



An evaluation of the meeting was done, with glowing feedback from participants, further reinforcing the value of such meetings, with suggestions on next meetings. Everyone clamored for the next meeting to be hosted by Pakistan delegation to learn more from their evidence-based experiences.



Participants and speakers were presented with certificates of appreciation and USB token containing copies of the presentations and relevant reference materials.



During the closing ceremony, a few of the participants were asked to share their feedback to the group:



Dr. Rolanisah Dipatuan-Dimaporo, Chief of Staff of the Minister of Health for BARMM, expressed gratitude of the opportunity to be invited in the meeting. She deemed it fruitful and fun, and appreciated the inputs and took note of the significant learnings from the speakers.

Ms. Eka Wulan Cahyasari of the Indonesian Red Crescent Society, said the meeting was powerful and dynamic with good and energetic emcees/facilitators. The topics she found very useful and allowed ownership for the region on the HCiD initiatives. She lauded the organizers for a very well-arranged event.



Ms. Kaburu showed appreciation and gratitude to everyone. She thought that the meeting would be more focused on Marawi, so was glad that it presented and shared different scenarios and other ideas. She emphasized the realization on the importance of good communication to ensure own security, and vowed to take positive learnings back home.

Dr. Balboa, herself a participant during most of the sessions, committed to integrating more of HCiD in their work with the DOH, especially on their Caring for Carers MHPSS module.



Ms. Zavalla, co-hosts for the event, expressed gratitude to everyone, and accepted the challenge on implementing the discussed recommendations, putting more emphasis on the outcomes for the beneficiaries rather than just outputs of the meeting.

To formally close the regional meeting, **Mr. Kelecevic** thanked all for honoring the delegation's invitation. He valued the exchange of ideas and shared experiences, the showcasing of best practices, and the warm engagement of the participants. He expressed sincere appreciation to the members of the CoC for being in the same line with the ICRC and Movement in recognizing HCiD to be a core issue for health, and of the need to generate more positive impact on the way forward. He also thanked ICRC colleagues from Geneva and the delegation staff for the successful organization of the event.



Annexed Supporting Documents

- HCiD in a Nutshell
- Program Agenda
- List of Attendees
- Conference Evaluation
- Declaration on Protection of Health Care, Manila, 2019

Acknowledgement

The Health Team of the ICRC Delegation in the Philippines thanks our colleagues, our co-chairs and partners in the Philippine Red Cross, and all the speakers, facilitators, participants and support who made this Conference happen. We thank everyone for their commitment and for being the strongest advocates for the protection of health care. Mabuhay!



Prepared by:

Pamela “Sarji” C. Muldong
Health Program Responsible
ICRC Delegation in the Philippines



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***“The output is amazing, but what’s more important is to arrive at the desired outcome.
Our challenge is how to implement the strategies discussed and adopt best practices to contribute to the protection of health care in our respective contexts”.***

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HEALTH CARE**

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