
THE HEALTH CARE IN DANGER INITIATIVE

SECOND ASIA-PACIFIC REGIONAL HEALTH CARE IN DANGER MEETING REPORT

21–24 June 2021

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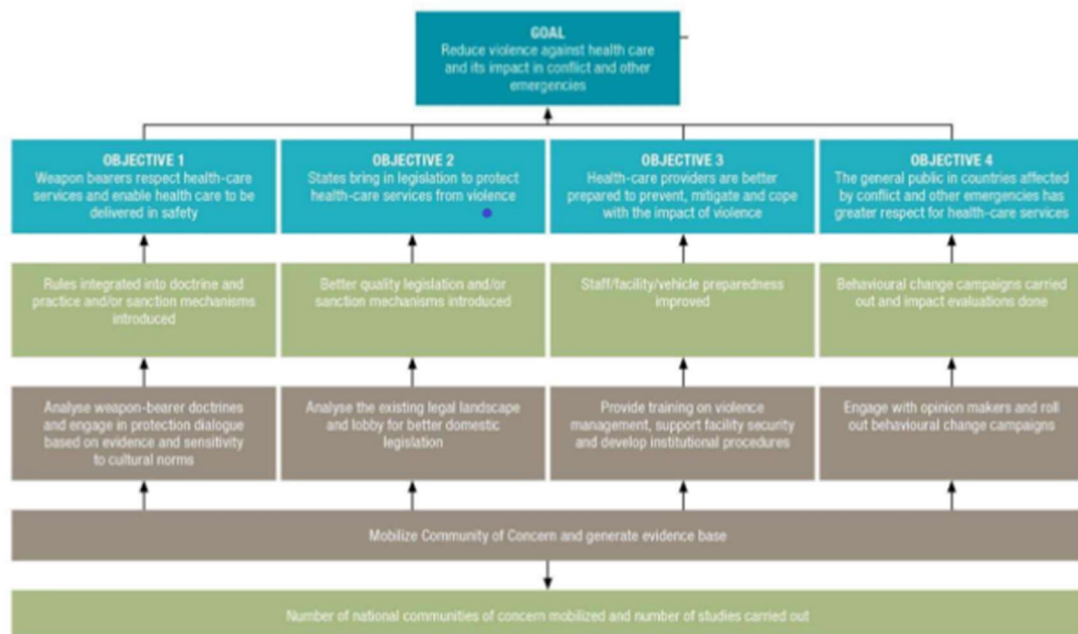
Disclaimer: This report provides a summary of the Health Care in Danger Initiative Asia-Pacific Regional Meeting, held online on 21–24 June 2021. The views expressed in it are those of the participants concerned and do not necessarily reflect the views of the organizations they represent or the organizers.

THE HEALTH CARE IN DANGER INITIATIVE

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

The formal establish the HCiD Project coincided with the adoption of Resolution 5 at the 31st International Conference in 2011 (further reaffirmed in 2015). Advocacy by the ICRC and its partners has led to significant mobilization around protecting health care, resulting in several resolutions at the World Health Assembly and UN Security Council Resolution 2286. This effort was accompanied by a global awareness and mobilization campaign that incorporated organizations representing 30 million health-care practitioners around the world. The campaign has rallied partners inside the Movement while convening global experts including through communities of concern to implement practical measures to protect health care from violence and to mitigate its effects.

HEALTH CARE IN DANGER – THEORY OF CHANGE



THE HEALTH CARE IN DANGER STRATEGY

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

- Objective 1: **Weapon bearers are respectful of health-care services and enable their safe delivery**
- Objective 2: **States have adopted and implemented legislation for the protection of health care from violence**
- Objective 3: **Health-care providers are better prepared to prevent, mitigate and or cope with the impact of violence**
- Objective 4: **The general population in countries affected by conflict and other emergencies has increased its respect for health care**

The ICRC will deliver on the objectives with partners along **three axes of engagement**:

- **Operationalization**
- **Evidence base generation**
- **Influencing and coalition building**

REGIONAL MEETINGS

The Health Care in Danger Initiative is focused on reducing violence and mitigating the effects of violence in areas affected by conflict and other emergencies. The current strategy emphasizes the practical implementation and operationalization of concrete measures at the local and national levels. In parallel, the Health Care in Danger Initiative has transitioned from organizing global meetings of stakeholders to holding regional ones. The regional focus allows stakeholders to share experiences on approaches and develop local and national partnerships to address violence against health care. The partnership with the community of concern is a central pillar of advancing this common agenda.

Regional meetings took place in 2019 for the Asia-Pacific Region in Manila, and the Near and Middle East (NAME) Region in Beirut. Participants appreciated the opportunity to share experiences, dynamics and cultural issues with stakeholders from neighbouring countries. In June 2020, the Africa Regional Meeting was held online owing to COVID-19-related restrictions with a two-day webinar format. In February 2021, the Eurasia Regional Meeting was held with a co-organization innovation.

The ICRC prioritizes the implementation of concrete measures to safeguard health care in conflict

settings in the Asia-Pacific region in line with its mandate. Many partners, both within and outside the Movement, are contributing to the protection of health care through a range of measures. The ICRC is operationally present in some contexts, but the field of action is wider, and the region has potential for broader engagement, for sharing and scaling up good practices, and for reinforcing regional linkages.

The COVID-19 pandemic has further demonstrated the durability and importance of the central tenet of Health Care in Danger – the inviolability of health care – and the cascading negative consequences of its non-respect. There is scope and, in light of the novel situation, a need to exchange on recent efforts and initiatives to protect health care from violence, including a review of promising practices during the pandemic. The protection of health care against violence is universally relevant and the ICRC seeks, through these meetings, to advance a common agenda and to reinforce regional and global partnerships, including two-way collaboration and exchanges of experience. Tools and approaches developed to reduce and mitigate violence in one context can serve as an inspiration and facilitate learning and adaptation in another.

This Second Asia-Pacific Regional Meeting sought to forge a link with the first meeting, including on the soft commitments made in 2019. The ICRC partnered with two leading medical universities in Pakistan – Jinnah Sindh Medical University (Karachi) and Khyber Medical University (Peshawar) – to organize the event. The ICRC extends its heartfelt thanks to them for their critical contribution to the field, and to the meeting as the latest manifestation of our ongoing collaboration.

MEETING OBJECTIVES

1. **Overviewing the activities carried out since the First Asia-Pacific Regional meeting in 2019 by signatories of the Manila Declaration on the Protection of Health Care, including the ICRC**
2. **Facilitating the sharing of experiences, good practices and recommendations through presentations and interactions**
3. **Raising the profile of, and generating new interest in, the protection of health care as a critical field of work and a shared concern**
4. **Forging and deepening partnerships, making geographical linkages and strengthening commitments to promote practical action, research, influencing and resource mobilization for the protection of health care**

CO-ORGANIZATION OF THIS MEETING



This meeting was co-organized with two prominent universities in Pakistan (Jinnah Sindh Medical University and Khyber Medical University) with which the ICRC has a history of collaboration.

The ICRC welcomes this partnership and believes it is critical to enhancing the collective impact of our work.

We would like to take a moment to thank Jinnah Sindh Medical University and Khyber Medical University for their contribution to our shared success.

EXECUTIVE SUMMARY

This second regional meeting reviewed progress made in several key contexts against the soft commitments affirmed during the first meeting in 2019. This update was complemented by a review of the ICRC's contribution to implementation, where pockets of significant progress were cited amid a need for stronger diplomatic resolve to prevent violence against health care in armed conflict.

The meeting privileged diverse voices from the region in order to convey the particularities of this experience. When protecting health-care workers, the need to take a holistic view and to widen the lens beyond just doctors came through, in order to ensure that those most in need are prioritized.

While an emphasis was placed on contexts experiencing armed conflict, the similarities in terms of experiences between conflict-affected and peaceful contexts for health-care workers experiencing violence were also apparent. Levels of violence in peaceful contexts can be elevated and there is scope for an exchange of practices and learning across contexts (with appropriate adaptation). The need to address the psychological consequences of violence against health care was emphasized, with relevant examples cited.

A thread that ran through a number of presentations in the meeting was the key role played by the individual health-care worker in reinforcing respect for medical workers in the current climate. By upholding the highest standards of professional conduct and medical ethics, the individual can engender and reinforce a climate of respect. Community and religious leaders can also wield significant influence, as has been the case during the COVID-19 pandemic in particular, when misinformation and disinformation have been rife. Voices local to diverse contexts distilled the different experiences around the COVID-19 pandemic and how this influenced the dynamics of stigmatization and discrimination. Examples were shared of how organizations addressed specific concerns of the community by adapting existing approaches and forging new initiatives to foster a conducive climate and to prevent violence.

The importance of understanding local and domestic laws and policies governing the protection of health care, and of where gaps exist, was underscored. Useful guidance was provided by breaking down this work, sharing guidance, providing an example of a local lawmaker and outlining the efforts of an international organization working to develop a common understanding and use its influence to reinforce protections of health care. Beyond passing laws, resourcing and following through the

implementation of legal and policy measures – including their dissemination, sensitization of stakeholders and application – are key practical measures.

The need for weapon bearers and state armed forces to integrate IHL considerations related to the protection of health care into their operations was highlighted. Military operations should be shaped through the adaptation of doctrine, education, training and equipment, and sanctions. The relationship between Islam, IHL and the protection of health care in armed conflict was treated from a context-embedded perspective to bring commonalities to light.

Through the spotlight session and several of the other sessions, the networked and multidisciplinary collaboration that is taking place in Pakistan was highlighted as a best practice. In this example role, the partnership with academic institutions and the role research plays in laying an evidentiary foundation are critical ingredients for success.

MEETING OBSERVATIONS & RECOMMENDATIONS

Session 1: Stakeholder experiences in reducing violence, mitigating its impact & coping

- Data collection and evidence-base generation are needed to understand the context and contribute to a robust context analysis.
- Undertaking a contextual analysis is required to understand the root causes of violence against health care.
- The resilience of health care to prevent, mitigate and cope with violence against health care needs to be strengthened and the mental health and psychological dimension of health and well-being must be integrated into programming.
- Multidisciplinary responses, through engagement with all concerned stakeholders for collective action, are key to success.

Session 2: Policy & legal measures to protect health care

- Legislative approaches need to be grounded in local realities. A comprehensive evaluation of existing legal and policy frameworks should guide the development of legal and policy solutions tailored to address local challenges to the protection of health care.
- Working with different stakeholders is a critical step in order to achieve meaningful results – not only to put the necessary policy and legislative frameworks in place, but also to ensure their implementation.

- Weapon bearers have an obligation to protect health care beyond not attacking facilities, staff and transport.
- Taking a health-systems approach, particularly in contexts enjoying peace and stability, is an effective way to tackle the issue.

Session 3: Promoting respect for health-care services among weapon bearers & ensuring safe service delivery

- Humanitarian actors and health-care providers should maintain regular dialogue with weapon bearers in order to promote respect and the protection of the medical mission.
- There is a need to promote respect for health care by reinforcing of broader community values and norms that can influence the long-term conduct of weapon bearers. The promotion of respect for IHL in relation to protection of health care by weapon bearers should be conducted with both weapon bearers and those wielding formal and informal influence on their conduct.
- Understanding the sources of domestic rules, laws, regulations and norms and their parallels in international law is key to reinforcing respect and protection of health care.
- Translating legal rules into practical measures is a critical ingredient for reinforcing compliance.
- Learning and dissemination tools and approaches are key to promoting compliance.
- There is a need to demonstrate greater willingness to implement the guidelines for armed forces and to integrate explicit approaches with respect to the protection of health care into military doctrine.

Session 4: Creating a climate of respect & free from violence for health-care workers

- There is a need to adopt a holistic view of protection of health care that is inclusive of patients, facilities, medical transport and equipment, and all categories of health-care personnel, including support staff.
- There should be greater engagement with communities and community influencers for safeguarding health care. The specific needs and vulnerabilities of health-care workers, including support staff, and diverse community members call for specific support from all actors in a community, in order to create environment that is conducive to safeguarding health care.
- The principle of the inviolability of health care is enshrined in different faiths and social codes. Religious and community leaders are vested with significant influence that can be leveraged to ensure the community has access to health care, and that health-care workers can carry out their work in a climate free from violence.
- Addressing the trends of stigmatization, harassment and violence associated with the COVID-19 pandemic calls for taking the long view, considering that the current pandemic may persist. Greater will and efforts need to be dedicated towards understanding and addressing the problem and informing thinking when addressing possible future pandemics.

REPORT BACK ON THE FIRST ASIA-PACIFIC REGIONAL HEALTH CARE IN DANGER MEETING DECLARATION OF 2019

Elizabeth S. Zavalla, Secretary-General of the Philippine Red Cross, presented an overview of progress on the pledges and commitments made in the Manila Declaration, which was signed at the First Asia-Pacific Regional HCiD meeting jointly hosted by the ICRC and the Philippine Red Cross in Manila in June 2019. The Manila Declaration is a collective aspiration to pursue concrete measures for the protection of health care. The COVID-19 pandemic and the ensuing challenges call for ensuring even greater respect for health care, as enshrined in the Declaration. There has been significant progress on the various areas of work outlined in the Declaration.

In the Philippines:

- The ICRC has engaged with the Armed Forces of the Philippines to create a national-level working group that will review the standard operating procedures of the armed forces and integrate awareness on the protection of health care into their training programmes.
- The Department of Health in the Philippines has included a communication skills component aimed at the de-escalation of violence in its training programmes for health-care workers responding to the pandemic.
- An abundance of mental health and psychosocial support has been provided to health-care workers and emergency responders.
- The Red Cross, during International Humanitarian Law Month, organized an online forum on humanitarian responses in armed conflict and the protection of health care, and integrated messages promoting respect for health care into training programmes.
- Members of the community of concern in the Philippines have incorporated principles of protection of health care into their general work.
- The community of concern in the Philippines has been vocal on advocating respect for health care, on promoting the rights of health-care workers, and on preventing discrimination against, and stigmatization of, health care during the pandemic.
- Local health-care authorities, the ICRC and the Philippine Red Cross have undertaken various initiatives, including displaying signs, implementing no-weapons policies and conducting

ongoing security assessments in health-care facilities, and providing guidance for communities in conflict-affected regions.

In Afghanistan:

- The Afghan Red Crescent Society is initiating Safer Access in communities, equipping health-care facilities with protective emblems, and conducting awareness-raising sessions with communities and parties to the conflict.
- The Afghanistan Islamic Medical Association has raised the issue of the protection of health care at social and academic forums.

ICRC REVIEW OF IMPLEMENTATION

Maciej Polkowski, the Head of the HCiD Initiative at the ICRC, presented a review of the implementation of the ICRC HCiD Strategy. This strategy is guided by the HCiD Theory of Change (ToC), which aims to reduce violence against health care and to mitigate its humanitarian consequences.

A survey conducted with ICRC delegations in 2020 captured progress along the four critical tracks of the ToC. It identified progress in engagement with weapon bearers in conflicts across the globe in order to promote respect for and protection of health care, especially in Afghanistan, Central African Republic and the Philippines. In the Americas, integration of respect for and protection of health care into the doctrine and practice of law enforcement agencies was boosted by the focus on issues of the protection of health care due to the COVID-19 pandemic. Progress was made on strengthening domestic legislation for the protection of health care in many contexts across the globe.

The ICRC engaged with states, Movement partners and local academia in many contexts to undertake analyses of the domestic legal frameworks from the perspective of protection of health care from violence. Over the years, changes in domestic legislation have been enacted in some contexts, such as in Iraq and Nigeria. In Nigeria, the ICRC is working with the Association of Public Health Physicians of Nigeria to gauge the impact of the legislative changes on the protection of health care and on access to emergency health care for victims of gunshot wounds. The ICRC has developed a checklist to guide lawyers, as well as non-legal experts, in analysing domestic legal frameworks. Numerous initiatives, employing a range of tools addressing individual and systemic elements, have commenced across the

globe in order to strengthen the resilience of local health-care systems against violence. In 2020, the ICRC conducted media campaigns in seven major contexts across the globe in order to raise awareness and enhance respect for health care. Mr Polkowski presented glimpses from two campaigns, in Colombia and Nigeria, with emotive and evidence-based messages. The ICRC promotes evidence generation vis-à-vis violence against health care and its impact/consequences in order to guide action, and research studies are ongoing in several contexts. The ICRC and Johns Hopkins University, with the support of universities in Brazil, Nigeria and Pakistan, completed a research study to develop a tool to assess a city's preparedness for a mass-casualty emergency response. The emphasis is on partnerships at sub-national and national levels to implement concrete measures and partnerships at the global level in order to mobilize key global actors. Collective effort at the global level has previously contributed to UN Security Council Resolution 2286 calling for increased protection of health care from violence, which has led to considerable, yet far from ideal, progress.

STAKEHOLDER EXPERIENCES IN REDUCING VIOLENCE, MITIGATING ITS IMPACTS & COPING

Moderator **Dr Lubna Ansari Baig**, Founding Dean & Chairperson of APPNA, Institute of Public Health, Jinnah Sindh Medical University

Theme **PREVENTING VIOLENCE AND HARASSMENT IN THE MEDICAL FIELD**

Panellist **Mineko Moriuchi**, Executive Officer, Japanese Nursing Association

Theme **HELPING THE HELPERS DURING THE PANDEMIC**

Panellist **Sherzod Musrifshoev**, Mental Health Delegate, Philippines delegation, ICRC

Theme **MITIGATING VIOLENCE AGAINST HEALTH-CARE WORKERS: BRIDGING COMMUNICATION GAPS & BUILDING TRUST**

Panellist **Dr Jugal Kishore**, Director Professor & Head of the Department of Community Medicine, Vardhman Mahavir Medical College & Safdarjung Hospital, India

This session was opened by Dr Lubna Baig, who framed and focused the discussion on the phenomenon of violence against health care, assessing its impact and best practices in reducing violence against health care. Dr Baig also focused on mental health and the dimension of psychosocial support for health-care workers coping with violence. Dr Baig then introduced the first speaker, Ms Mineko Moriuchi, Executive Officer of the Japanese Nursing Association. Ms Moriuchi opened her presentation with a review of the findings of a survey conducted in Japan with nurses at hospitals to determine the actual status of, and measures against, violence and harassment. The purpose of this study was to:

- understand the working environment of nurses, including supply and demand trends related to nurse security and retention, and responses to nursing-related systemic reforms
- identify issues related to past labour policies in nursing
- obtain materials and data to support proposals that foster working conditions and a workplace where nurses can work safely and securely.

This survey was conducted in 2019 at all 8,300 hospitals nationwide both for hospitals and nurses, and data were collected through a self-reporting questionnaire. The response rate from the hospitals was 3,385 (40.8%) and 15,026 nurses also responded. The survey found that 42.9 per cent of respondents had experienced violence/harassment in the workplace during the past year. Some 24.9 per cent of participants had experienced mental abuse, followed by physical abuse, segregation, sexual abuse, imposition, invasion of privacy and insufficient work demands. There is a difference in terms of the main perpetrators depending on the nature of the harassment. Employees were the main perpetrators of mental abuse (53.7%), segregation (85.4%), excessive work demands (72.6%), invasion of privacy (85.4%) and insufficient work demands (73%), followed by patients and families, whereas sexual abuse (71%) and physical abuse (92.1%) were most commonly perpetrated by patients.

A number of measures have been taken for employees to combat violence and harassment from patients/families/employees:

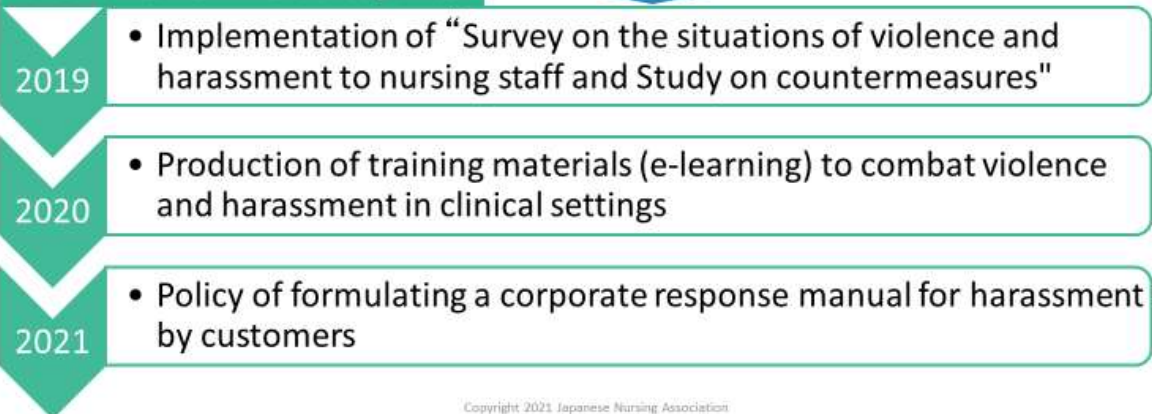
- clarification of the basic policy on violence and harassment
- stipulation of disciplinary policy and the taking of action in confirmed cases
- dissemination and awareness-raising among employees about the basic policy and disciplinary action
- consultation services on violence and harassment

- implementation of prompt and appropriate response measures
- measures to improve the workplace environment.

Promotion of measures against harassment by customers

In 2019, JNA submitted to the Minister of Health, Labour and Welfare, a request for "Promotion of measures against harassment from patients and their families to nurses"

National Government's response



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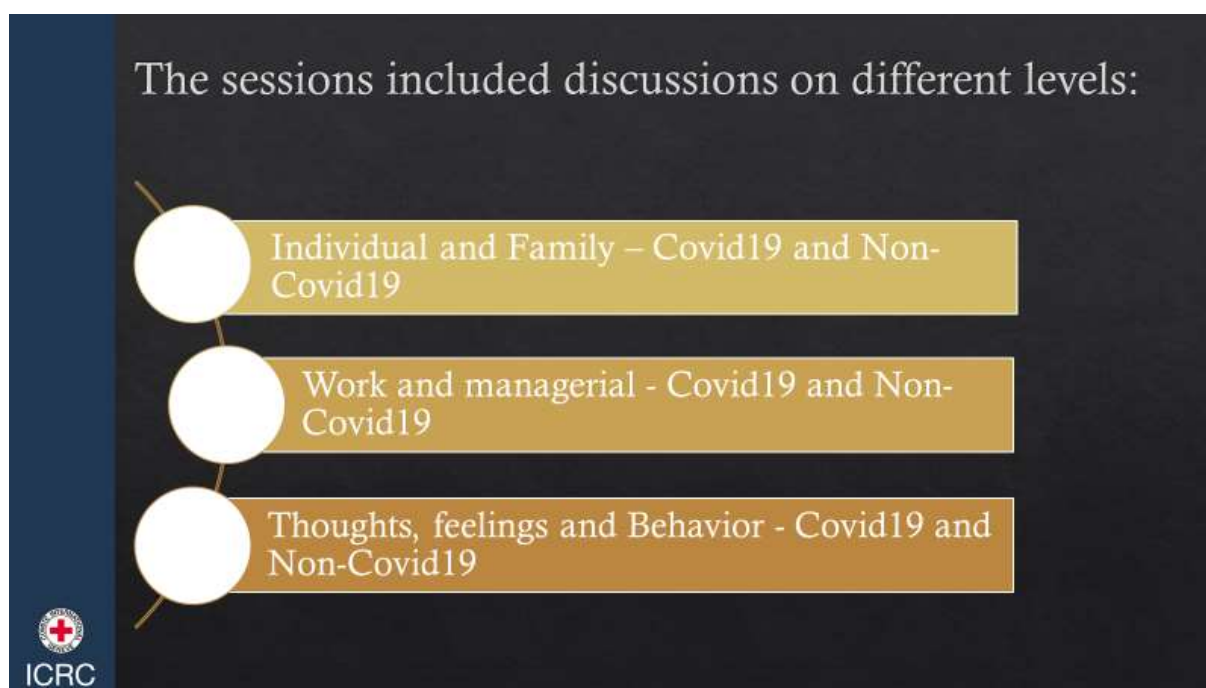
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The government's response was to carry out the survey in 2019 and to produce the training materials in 2020. In 2021, the government adopted a policy to formulate a corporate response manual for dealing with harassment from customers in 2022. Ms Moriuchi concluded by expressing the willingness of the JNA to further promote these measures, as well as to consider how much these measures effectively contribute to preventing and reducing harassment and violence.

Dr Lubna Baig noted the striking similarities in findings between Japan and Pakistan before introducing the second speaker, Mr Sherzod Musrifshoev, who is a psychologist by profession and a mental health and psychosocial delegate working with the ICRC in the Philippines. Mr Musrifshoev took the floor explaining that his presentation will shed light on the implementation of the Help the Helpers programme during the COVID-19 pandemic. After sharing a short video, Mr Musrifshoev noted that there were two million confirmed cases of COVID-19 when the Help the Helpers programme was launched in the Philippines. While responding, health-care workers have been preparing for a massive surge in the number of cases.

The focus of the Help the Helpers (HtH) programme is to enhance resilience and provide basic mental health and psychosocial support (MHPSS) to health care workers¹. It promotes self-care for front-line health-care workers and provides a safe space where sharing can take place. The programme supports doctors and nurses coming from local health facilities and from the ICRC, and who are providing care to COVID-19 patients and supporting the response. The programme is made up of support sessions for staff of health facilities – some face to face and some online, reaching 207 participants to date.

The discussions are structured at three levels around individual and family, work and managerial, and thoughts, feelings and behaviour.



The sessions conducted were mainly designed to give space to participants so they could share their concerns openly and feel understood. Discussing with colleagues allows them to create a new psychological family and find those who are ready to listen. It allows them to openly share their concerns and be understood, and to provide the kind of listening that is required. The programme consists of eight or nine sessions of 1.5 hours each, with two sessions per week, and focuses on self-

¹ For further information see <https://shop.icrc.org/guidelines-on-mental-health-and-psychosocial-support-print-en.html>

care and basic communication skills. Participants can better track negative thoughts, learn adaptive behaviour and increase their ability to deal with uncertainty.

The discussions and activities have given rise to a number of sources of anxiety and stress. These included complications with returning home, out of fear that they may catch and spread the virus to their family despite taking precautions, and not being able to care for relatives. Many were having trouble managing their workload and struggling to deal with lockdowns and being stuck in quarantine. Many were also grappling with uncertainty and negative thoughts.

Some contours of the coping mechanisms were shared. It was noted that groups formed spontaneously as trust built. Those who were single reported better coping in comparison to those with families, who frequently were not able to reunite with them owing to quarantine restrictions.

Two psychometric tools (DASS21 and PRoQOL) were administered to better understand the impact of the programme. The assessment results of the HtH programme indicated that it positively contributed to the self-management of health-care workers. The results for handling stress, anxiety and depression were positive, especially considering that the conditions were worsening over the period. The results suggest that concern for health-care workers were related not only to anxiety over getting the virus, but also to stigma, workload, requests from management and travelling back to home.

During this time, a number of complementary activities have been delivered. The ICRC has also been broadcasting messages about how to deal with anxiety during the COVID-19 pandemic, has produced leaflets about self-care and has carried out live online discussions related to mental health.

In closing, Mr Musrifshoev noted that, according to the WHO, as many as 38 per cent of health-care workers are subjected to violence in their professional life – particularly those who are directly involved in patient care, and most notably nurses. He then went to outline recommendations around mental health and underscored the importance of carrying out psychoeducation and support-group sessions. These sessions should be culturally adapted, multidimensional and supported and enhanced by the health system, notably the hospital administration. Such sessions also give rise to other systemic issues beyond MHPSS but that could be addressed in parallel: proper time management, scheduling, and salary and other benefits.

Dr Lubna Baig then introduced Dr Jugal Kishore, a celebrated public health expert and Director Professor and Head of Department in Community Medicine at Vardham Mahavir Medical College and Safdarjung Hospital in New Delhi.

Dr Kishore opened his presentation noting the degradation of broad respect for the health-care profession that must be re-established. He asked how this respectable profession is losing respect and noted that the general public has high expectations of health-care professionals. He shared examples of news reports that have tainted the perception of doctors and contributed to stress and violence against health-care providers, particularly at the hands of patients and their families. One of the issues is the mindset of health-care professionals, who are seen in heroic terms, which reinforces unrealistic expectations. Doctors are also taking to the streets to protest against violence in a climate of mutual blame.

Legal measures have been taken to reinforce the protection of doctors and nurses by increasing the severity of punitive measures. The Epidemic Diseases Act was amended in 2020 to punish those who destroy the property of a doctor or impede the services of a doctor or nurse.

The legislation on assaulting doctors in the Telangana Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act 2008 has been made an unbailable criminal offence with a fine and jail term of up to three years. Dr Kishore sees this in a positive light,

Factors influencing the quality of medical services



| Category | Themes |
|----------------------------------|--|
| Patient related factors | Patient socio-demographic variables |
| | Patient cooperation |
| | Patient illness |
| Physician related factors | Physician socio-demographic variables |
| | Physician competency |
| | Physician motivation and satisfaction |
| Environmental factors | Healthcare system |
| | Resources and facilities |
| | Collaboration and partnership development |

especially during the COVID-19 pandemic, where doctors are perceived as bearing a heavy degree of responsibility. It is positive that the institution takes this up and that violence is not normalized. He cited a research study entitled *A Study of Workplace Violence Experienced by Doctors and Associated Risk Factors in a Tertiary Care Hospital of South Delhi, India*, which indicated that 47.02 per cent participants experienced violence. The highest percentage was among male doctors.²

At the hospital where Dr Kishore works, they have 25–40 incidents per day; more than one per hour. He cited a study that found that interns and new doctors lack the critical foundational skills necessary for the exercise of the profession. Insufficient skills can lead to burnout due to an inability to deliver quality services, thereby feeding the cycle of violence against health care.

Three sets of factors are influencing the quality of medical services. Dr Kishore is focusing on the physician- and environment-related factors, mainly through the physicians, given the difficulty of influencing the patients themselves. Communication skills are the critical ingredient that must be reinforced.

Expert inputs and a literature review are being used to develop a workshop on communication skills. The workshop comprises sessions on the doctor-patient relationship, stress management, conflict management and prescription-writing.

Session feedback revealed that participants believed the content was beneficial in terms of increasing knowledge and developing applicable skills. The sessions reinforced listening skills, non-verbal communication and expressing empathy. Participants appreciated techniques of conflict management. For example, simply being able to apologize at times can facilitate a receptive response. They also helped them focus on prescribing generic drugs and writing legible prescriptions. These sessions have also catalysed broader change in the hospital management and administration.

The way forward in Safdarjung Hospital is to continue to train interns and to expand this training to other categories like nurses, health-care workers and security guards. Refreshers should be offered from time to time and should be underpinned by policy – the hospital is currently finalizing theirs. This

² See [\(PDF\) A Study of Workplace Violence Experienced by Doctors and Associated Risk Factors in a Tertiary Care Hospital of South Delhi, India \(researchgate.net\)](#).

should also be complemented by a mentorship programme for students of medicine, nursing and pharmacy.³

During the Q&A, Ms Moriuchi stated that, in Japan, measures against workplace harassment had been legislated for employers in 2020 and that, at the time, six categories of harassment were indicated. When asked about how to handle severely depressed participants, Mr Musrifshoev said that they need to be referred to specialized care.

Dr Kishore responded to a question about barriers to implementation of laws to protect health care by saying that the existence of the law is the first step, even if implementation is poor. Policing to prevent violence against health care is a challenge even when you have laws making violence an offence. For long-term change, the behaviour of doctors must change and they must improve their communication skills. Doctors used to be worshipped and they have a strong feeling that they should be listened to, but the perception of them has changed and they, too, have to listen.

On the changes as a result of COVID-19, Dr Kishore noted that this period has been characterized by heightened aggression, anxiety and stress. Patients and their families have been fighting with health-care providers owing to the unavailability of beds. That said, there is a tendency not to seek legal redress and, when asked, Dr Kishore agreed that there were parallels between India and Pakistan around trends including stigmatization.

Ms Moriuchi responded to a question noting the risk that, in the face of persistently elevated levels of violence and harassment, health-care professionals will be inclined to retire or quit. This will feed a vicious cycle as it will also negatively affect the quality of overall care.

³ Dr. Kishore made reference to several other articles: [Effective Communication and Conflict Management Workshop for Nursing Interns: Experience at a Tertiary Care Hospital of Delhi, India | International Journal of Healthcare Education & Medical Informatics \(ISSN: 2455-9199\) \(medicaljournalshouse.com\)](#), [\(PDF\) Identifying Competencies in Community Medicine: An Explorative Study in a Medical College in Delhi \(researchgate.net\)](#), [Communication Skills for Interns: Evolution and Assessment of a Training Workshop in a Medical College of New Delhi | International Journal of Healthcare Education & Medical Informatics \(ISSN: 2455-9199\) \(medicaljournalshouse.com\)](#).

POLICY & LEGAL MEASURES TO PROTECT HEALTH CARE

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| Moderator | Farhana Faruqi Stocker, Regional Representative Asia Regional Office, Norwegian Red Cross |
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| Theme | MITIGATING VIOLENCE AGAINST HEALTH CARE: A TAILORED LEGAL APPROACH |
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| Panellist | Sahar Haroon, Regional Legal Adviser, Indonesia delegation, ICRC |
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| Theme | PROTECTING HEALTH CARE THROUGH POLICY: THE AFGHAN EXAMPLE |
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| Panellist | Ioanna Voudouri, Legal Adviser, Afghanistan delegation, ICRC |
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| Theme | SAFEGUARDING HEALTH CARE THROUGH LEGAL INTERVENTIONS: THE KHYBER PAKHTUNKHWA EXPERIENCE |
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| Panellist | Dr Farooq Jamil, Special Secretary Health, Khyber Pakhtunkhwa Health Department, Pakistan |
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Ms Farhana Faruqi Stocker, Regional Representative of the Asia Regional Office of the Norwegian Red Cross, opened the second session, outlined the topic and introduced the first panellist, Ms Sahar Haroon.

Ms Haroon introduced her presentation by asking participants different questions about how armed conflict or other situations of violence impact health-care services, and about the adverse consequences of such acts.

Feedback taken from participants included:

- a lack of access to health care
- attacks on ambulances
- impeding direct access health care.

The presenter then shared examples of possible direct or indirect consequences:



In times of conflict, when health-care facilities are most needed, they are rendered least accessible, underscoring the need for their respect and protection. The impact is felt not only by health-care personnel, but also by thousands of health-care beneficiaries. Further, this impact is not a one-time effect, but rather has lasting repercussions.

Incidents do not only occur during times of conflict, as similar incidents also take place in other emergencies and, unfortunately, during times of peace. Hence, health care is in danger in many different contexts, which underscores the need to mitigate violence and to protect health-care workers through all possible avenues.

One way to prevent violence against health care is by drafting comprehensive legislation and taking policy measures. For legislation to be effective, lawmakers must first be aware of how health care functions and is impacted by violence. For example, ambulances and paramedics may be most vulnerable in one context, while in other context it might be nurses. Similarly, in one situation, health-care personnel might be more at risk of reactive violence or interpersonal violence, and in another situation, the context might be directly related to conflict. Therefore, legislation needs to be tailored to the needs.

Ms Haroon presented the ICRC's publication *Legislative Checklist: Protecting Health Care from Violence*⁴ as a tool to support the review of legislative frameworks. The purpose of a review is to identify gaps in domestic legislation and regulation in order to assess their humanitarian consequences and to propose recommendations.

The Structure of the Checklist

- Introduction
- Methodology
- The 2014 Brussels Report and the Guidance Tool
- Main Challenges related to the Protection of health Care in Armed Conflicts and Other Emergencies
- Preliminary Questions
- Substantive Questions

This checklist compliments previous HCD documents, including the 2014 Brussels Report,⁵ as well as its findings compiled in form of the Guidance Tool on the HCD website. Other chapters of the study discuss the main challenges related to the protection of health care in armed conflicts and other emergencies. It also puts forward guiding questions to support the legislation review.

Section IV identifies two main challenges that arise in relation with health care:

- a lack of adequate protection for health-care personnel, patients, staff, facilities and transport against direct attacks and other forms of violence
- a lack of respect for key medical ethics, which poses a dilemma for health-care personnel.

⁴ https://healthcareindanger.org/wp-content/uploads/2021/05/legislative_checklis_on_protecting-health-care-from_-violence_web-1.pdf

⁵ Link to the Brussels Report: [New Report - Domestic Normative Frameworks for the Protection of Health Care | International Committee of the Red Cross \(icrc.org\)](#)

Section IV then delves into the humanitarian consequences of each challenge and the subsequent six key areas users of the checklist will be reviewing in order to identify gaps in domestic legislation. These are:

- legal and regulatory protection
- medical ethics
- protection against all forms of violence including interpersonal violence
- use of distinctive emblems and other signs
- role of armed and security forces and law enforcement agencies (LEAs)
- effective data collection to ensure coordination.

Section V helps practitioners review the legislation and identify gaps by posing questions focused on the following areas:

- the right to health and whether it is a constitutional right; this is an excellent entry point for advocacy with national authorities to devise appropriate mechanisms for the protection of health-care personnel and services
- the definitions of key terms regarding protection of health care; for example, how domestic legislation defines the protection of health-care personnel
- the existence of domestic legislation
- the existence of national professional associations
- whether the protection of health care is integrated into military manuals.

These questions help when advocating with national authorities for better protection of health care.

Section VI builds on the key areas identified in Section IV of the checklist.

Section VI: Substantive Questions

- Legal and Regulatory Measures:
 - Medical Ethics
 - Interpersonal Violence
- Use of Distinctive Emblems
- Criminal Sanctions
- Roles of Security Forces and LEAs in protection
- Data Collection
- Coordination Mechanism

These questions help identify the root causes of violence against health care and serve as a foundation. Checklist users can do further analysis to make their review comprehensive and to tailor their legal approach. This should be complemented by engagement with expert stakeholders and partners in order to foster understanding, build ownership of the process and tackle the protection of health care through a multidisciplinary lens.

Once the normative gaps needing corrective action have been identified, a strategy is needed with clear priorities. While drafting the report, consider the audience, the report's promotion, whether it will be published and how it will be disseminated. It should serve as the basis for consultations with stakeholders in order to facilitate its implementation.

After being introduced, Ms Ioanna Voudouri, Legal Adviser at the Afghanistan delegation of the ICRC, outlined her presentation looking at protecting health care through policy, with a focus on Afghanistan. In order to understand why a policy is needed, the problems addressed in the policy should be considered first. In Afghanistan, conflict has continued for decades and has taken a toll on those not participating in hostilities, including the medical mission, and on the provision of health care. The situation has been further exacerbated by the COVID-19 pandemic.

The issues documented by the ICRC and various other organizations include the following characteristics:

- The sick and wounded are unable to access health care in a safe and timely manner.
- Medical facilities and personnel are directly targeted, sometimes owing to the misuse of the facilities (used for military purposes).
- Access is impeded for medical care owing to an increased number of check points and hostilities.
- Medical providers are at risk of being directly targeted or being killed, arrested or kidnapped for providing medical care to wounded fighters.
- Medical evacuations are delayed or cannot be carried out.
- There is exposure to residual risks such as weapon contamination, which are widespread in Afghanistan and create an additional risk.

IHL foresees that:

- medical personnel, units and transport exclusively assigned to medical duties must be respected and protected under all circumstances
- punishment for performing medical duties in accordance with medical ethics is prohibited, as is compelling a person engaged in medical activities to perform acts contrary to medical ethics.
- attacks directed against medical personnel and objects displaying the distinctive emblems are prohibited
- the wounded and sick must receive the best possible medical care with the least possible delay, solely based upon medical criteria; whenever circumstances permit, parties to the conflict must care for the wounded and sick.

Moving from the international to the national, how does Afghan law protect? The ICRC examined existing Afghan laws and how health care is being protected. The research showed that there is no specific legislation protecting health care – even less so during armed conflict. However, there are various provisions in existing domestic laws including the 2009 Public Health Law, the 2008 Forensic Law, the Constitution and the Penal Code. These laws include provisions that provide protection of health care, even though they do not make specific references to armed conflict. The research, however, showed that Afghan law and military doctrine lack provisions on the protection of medical personnel, units and transport, and a Ministry of Defence (MoD) policy was identified as one way to partially fill this lacuna.

In 2018, the ICRC offered technical support to develop a Ministry of Defence policy on the protection of the medical mission. The ICRC prepared:

- a framework document shared with the legal directorate
- a document with practical measures that the MoD can draw inspiration from when developing the policy.

Currently, the final draft of the policy needs to be finalized and validated by the Minister of Defence. All the concerned actors in the government have agreed to the content of this policy, and the policy is one step away from being validated. The reasons for this delay are the multiple priorities of the government of Afghanistan and the prevailing circumstances, which do not allow for the validation process to take place.

The content of the policy includes:

- specific measures to guarantee the exceptional nature of health-care facility searches. These searches are largely unregulated and not specifically addressed by the domestic laws.
- explicit protection of medical personnel, i.e. this policy highlights the particular nature of health-care facilities and medical personnel in times of conflict. It also foresees measures to enhance understanding of the operational environment, saying that it is not enough to recognize the protection of those persons and locations, but also that those who need to act in a respective and protective way need to understand where they are operating (including better training before the operations and implementation).
- coordination measures with health-care professionals to minimize the impact of search operations. If security and military forces need to carry out such search operations, they should coordinate with the medical professionals to minimize the impact on them. To avoid unnecessary delays to medical transport, security checks should be as quick as possible.
- mapping of health-care providers, relevant NGOs and others providing for the evacuation.

Ms Voudouri explained that the policy lays out ground rules based on what IHL provides, and that is how health care should be protected during armed conflict. These points go beyond and are tailored to the Afghan context, to the gaps that were observed and to what the policy should address. With points like those mentioned above, the content of the policy was kept realistic.

Ms Voudouri concluded her presentation by saying that, although the policy has not been implemented, the delegation sees its added value. The policy includes comprehensive definitions, particularly for lawyers. When saying medical personnel, transport or facilities, who do they mean? We need to offer definitions that specifically define the units and people to be protected, and this policy offers that. She further added that the biggest added value of the policy is the clarification it offers in cases of misunderstandings around the protection offered to medical activities – where offering medical services, even sometimes according to the law, could be construed as meaning offering some sort of indirect assistance to the enemy. Another part of the law explicitly states that medical personnel must never deny medical services to someone in need, which, for the Afghan

delegation, is the substance and the value that the law needs to protect. This policy offers clarification, dispels misunderstandings and makes provisions for training tailored to the Afghan context.

Beyond getting this policy validated, the delegation are looking to promote similar policies to other ministries, to other security and defence forces operating in Afghanistan and, ideally, to other fighting parties/armed groups.

Dr Farooq Jamil, Special Secretary Health at the Khyber Pakhtunkhwa Health Department, opened his presentation by stating that violence against health care is a global predicament, and that Pakistan and the province of Khyber Pakhtunkhwa are also victims of this menace. Health-care workers regularly approach the department of health requesting legal interventions to prevent violence.

Various studies were conducted, the first of which took place in Karachi a few years ago, which showed that almost 66 per cent of health-care workers had experienced and/or witnessed some form of violence in the previous year. These studies showed that violence affects health-care workers not only physically but also psychologically.

From these studies, the Khyber Pakhtunkhwa Health Department identified two major areas of need: a systematic analysis of the problem to guide policies and decisions, and a review of the legal framework to identify the existing legal protections of health care and gaps.

The Department joined Khyber Medical University and the ICRC to conduct a baseline study in Peshawar. The research study done in Peshawar explored the magnitude, determinants and dynamics of violence against health care. It found that 51 per cent of health-care workers had experienced or witnessed some form of violence while working at their health-care facilities.

The study showed that the perpetrators of violence in health-care facilities were relatives/attendants of the patients (44%), patients (20%) and the general public (14%). VIP escorts were responsible for 8 per cent of the violence, while the health-care staff (7%) and security personnel of a facility (5%) also contributed to incidents of violence inside health-care facilities.

A review of the legal framework of Khyber Pakhtunkhwa was jointly conducted by the Department of Health and the ICRC. This consisted of a desk review of existing laws, semi-structured interviews and consultations with key stakeholders. The objectives of this review were:

1. to understand the situation on ground
2. to determine the factors that contribute towards violence against health care, and

3. to provide legal solutions to those factors.

Dr Farooq Jamil acknowledged the ICRC for holding various consultations with stakeholders, including doctors, nurses, paramedics, legal experts and civil society, so that all the stakeholders have ownership of the design of legal strategies or laws.

Findings of the legal review showed that the legal regime applicable to Khyber Pakhtunkhwa for preventing violence against health care could be divided into five broad themes:

- preparedness
- training for health-care personnel
- a mechanism to monitor violence against health care
- reinforcement of respect for health-care services
- protection of health care – comprehensive legislation.

Based on the above findings, the following recommendations were made:

- Create specific offences for “violence against health care”, including the obstruction of services. Although a domestic law exists, specific protection for the health-care workers was lacking.
- Provide protection to all categories of health-care workers, health-care facilities and medical transport, as ambulances have been damaged by mobs.
- Ensure the existence of a functioning mechanism for monitoring violence against health care.
- Clarify the responsibilities of health-care providers and mandate disciplinary action for violation, for example, when a facility staff member is involved in harassment of a patient or co-worker.
- Consider the adoption of a protective symbol to be used uniformly by all health-care services.

After consultations with relevant stakeholders and the ICRC, the government of the province of Khyber Pakhtunkhwa drafted a bill. This bill was reviewed by the legal and health departments of the province, recommendations were provided by stakeholders and the bill was vetted by the law department before being approved by the provincial cabinet. The bill was then presented at the provincial legislature for debate and approval. After the final consent of the governor of Khyber Pakhtunkhwa, the bill has been approved as law, known as the Khyber Pakhtunkhwa Healthcare Service Providers and Facilities (Prevention of Violence and Damage to Property) Act 2020.

The act not only prohibits violence against health care but also provides protection to patients and their attendants. The act prohibits damaging health-care facilities and equipment and broadens the relevant legal definitions to offer protection to health-care workers across various categories and health-care settings (in hospitals as well as outdoor settings providing health-care services). It prohibits the obstruction and disruption of health-care services and prohibits the entry of weapons inside health-care facilities. At the same time, the law sets out the responsibilities of health-care workers and facilities to protect the rights of patients and their attendants, as it has been observed that violence occurring inside health-care facilities is also perpetrated by health-care workers on patients or their attendants. The act spells out detailed punishments for offences and violations of the law.

Now that the law has been passed, the focus is on implementation. The Department is working in collaboration with the ICRC to disseminate the law to the wider community, including health-care providers. For this purpose, the Department has provided approval and support to the ICRC for the use of its logo during the dissemination campaign. It is also important to establish an incident reporting mechanism to record any incidents of violence across the province so that prompt action can be taken against the perpetrators. A monitoring mechanism to strengthen the implementation of the law must also exist because laws will not achieve their desired objectives without implementation.

Passing the act is a significant achievement that reinforces the protection of health-care against violence in the province of Khyber Pakhtunkhwa, including the merged districts (erstwhile FATA). Dr Jamil then presented a chapter-by-chapter overview of the law, before thanking those present for attention and ending his presentation.

Ms Stocker thanked Dr Farooq Jamil for his presentation and opened the Q&A. In answer to a question about how violence affects neonatal and maternal health services, Ms Haroon referred to the relevance of the checklist to identify the specific causes of violence and the consequences of that violence in any given context. With this, one can examine the impact on neonatal and maternal care and whether domestic legislation exists to protect those affected or not. The other panellists noted the importance of the implementation of any laws and the enforcement of the law.

The next question asked whether, in a world where international and domestic laws are often violated in conflict-affected and poorly governed countries, policy and legal changes have the potential to improve the security of health-care workers in the short and medium terms, particularly in a country like Afghanistan. Ms Voudouri noted that the second part of the question was addressed in her

presentation and, for the first part, that rules are not systematically enforced in all aspects of our lives, although this is the goal. The better the rules, the greater the likelihood of robust protection. In Afghanistan, the parties to the conflict and the communities that live under their control refer to the rules, which are essential to determine what can and cannot be done. When violations take place, it is important to be clear that they are violations and that violations should not take place. Without proper laws and policies, a culture of respect will not be created. The investigation of violations is also critical when they take place.

When asked about how to introduce a mechanism to monitor violence across all the health-care facilities in the province, Dr Farooq Jamil answered that the department wants to have a reporting desk in every health-care facility – something that already exists in certain tertiary health-care facilities. Incidents of violence are reported at these desks and prompt action is taken in response. In rural areas, clusters of health-care facilities report these incidents to a single monitoring cell.

In answer to a question about coordination, Dr Farooq Jamil responded that a Community of Concern Working Group exists under his chairmanship, which works for the prevention of violence against health care in the province of Khyber Pakhtunkhwa. This working group's membership includes academics, health-care authorities, representatives from law enforcement agencies and legal experts, who meet regularly and provide suggestions for interventions to protect health care.

In response to a separate question, Ms Voudouri shed light on the coordination between the military and the health sector in Afghanistan. In relation to the policy that she spoke about earlier, it was an easy process as their direct interlocutor was the Ministry of Defence, which would then communicate the policy to all the security and defence forces. The challenge now would be the implementation and dissemination of this policy to various other actors. On the Ministry of Public Health, Ms Voudouri explained that they have dialogue, and that a round table co-organized by the ICRC and the Ministry of Public Health to discuss the various issues regarding the protection of the medical mission in Afghanistan is pending. It was decided that one of the four main points of discussion would be the formation and adaptation of policy that would go beyond what was mentioned earlier about the Ministry of Defence and other actions that the ministry could undertake.

In answer to a question about insurance coverage for health-care providers, Ms Haroon noted that while it was difficult to say whether such a requirement was in place for all categories of health-care

providers at all times, it is a mandatory requirement for those working in the Movement and delivering humanitarian assistance in conflict settings.

Ms Stocker thanked all the panellists for sharing their enriching reflections and experiences, provided a summary of the presentations and ended the session by thanking the participants.

PROMOTING RESPECT FOR HEALTH-CARE SERVICES AMONG WEAPON BEARERS & ENSURING SAFE SERVICE DELIVERY

Moderator [Dorsa Nazemi Salman](#), Deputy Head of Delegation, Philippines ICRC

Theme PROMOTING RESPECT FOR HEALTH CARE WITH WEAPON BEARERS

Panellist [Ruben Stewart](#), Military and Armed Forces Adviser, ICRC

Theme RESPECT FROM WEAPON BEARERS IN ISLAM

Panellist [Abdul Haq Haqani](#), Professor & Vice Chancellor, Afghan Institute of Higher Education, Afghanistan

Spotlight Session: ENHANCING PROTECTION FOR HEALTH CARE: PROGRESS IN PAKISTAN

[Dr Seemin Jamali](#), Executive Director, Jinnah Postgraduate Medical Centre

[Dr Rehan Ali](#), Assistant Director Media & Communication, Pakistan Red Crescent Society

[Dr Mirwais Khan](#), Head of HCiD Project, Pakistan delegation ICRC

Ms Salman introduced the session and outlined its objectives before introducing Mr Ruben Stewart, Military and Armed Forces Adviser at the ICRC. Mr Stewart opened the floor by stating that the term “arms carriers”, when used within the ICRC, refers to engaging a wide range of actors such as law enforcement agencies, state armed forces, non-state armed groups and private security companies.

Three key issues have been identified as problematic during the ICRC’s engagement with weapon bearers. The first key problematic area identified is ground evacuations of the wounded and sick, including the delay and denial of medical transport, the evacuation of sick and wounded, and the movement of health providers, especially through checkpoints. The second problematic area identified was military search operations in hospitals and other health-care facilities. The last key issue is the harm to health-care personnel, transport and facilities caused by the presence of military objectives either inside or close to health-care facilities. Any military operation with those objectives may jeopardize those health-care facilities. These factors identified most likely impede patient access to health care and have a negative impact on the delivery of health care.

The first phase towards a solution is engagement with weapon bearers. In 2021, members of the ICRC’s Unit for Relations with Arms Carriers conducted over 950 dissemination and promotion activities with over 60,000 participants from 124 different nationalities. This may seem like a large number, but it is a 48 per cent reduction in comparison to 2019 owing to the COVID-19 pandemic. The sessions were conducted with the weapon bearers mentioned earlier, as well as with multinational forces such as peacekeeping missions. The focus was on IHL, particularly the conduct of hostilities. The emphasis was also on sexual violence, child protection, access to education, the environment and health care in danger.

In order to better integrate IHL into doctrine, structures and processes, other influencers were utilized by the ICRC. These influencers can be external, for example, from the community and family. These influencers were both formal and informal in nature: religious and spiritual channels (formal) and customs and values (informal). For example, in 2014 in the Gaza Strip, a meeting was held with Islamic religious leaders to discuss how Sharia law relates to health care in danger. The ICRC is also working to identify norms from other religions including Buddhism to see how the dissemination of IHL can be complemented.

A virtual reality tool (VRT) has been developed, with a series of VRTs including a decision-making scenario for weapon bearers to help soldiers and commanders improve situational decision-making.

The purpose of this integration is to make these key IHL issues an integral part of how the military operates. The purpose is to shape four key areas: doctrine, education, training and equipment, and sanctions. Doctrine is all the directives, policies, procedures, codes of conduct and reference manuals that shape the training and tactics used during operations.

The education of that doctrine comprises the classroom activity, where they learn about obligations. The third key area is training, where the most effective technique is practical exercise. This includes field exercises, tabletop exercises and command post exercises. The last component is a regime of sanctions – predictable and visible sanctions are the most effective.

Resource materials are available and shared with the military,⁶ including [*Protecting Health Care: Guidance for the Armed Forces*](#), which was released this year with the support of the government of Sweden. To develop this document, inputs were gathered from a number of state forces and international organizations such as NATO, UN Peacekeeping and the Collective Security Treaty Organization (CSTO). It is a guide focusing on integration that enable forces to better protect health care. The document is available in English, Spanish, French and Arabic and very soon will be available in Russian and Portuguese.

The approach to non-state armed groups can be significantly different from the approach to state armed forces. For example, a similar exercise was conducted with non-state armed groups such as in Ein el-Helweh in Lebanon, the biggest Palestinian camp in the country. It covers one square kilometre but is home to 70,000 refugees, with security duties shared by 15 different factions with different interests. In some cases, the armed groups have entered the hospitals and clinics. In 2014, the ICRC started a three-phase process to integrate the Health Care in Danger Initiative into the processes that the armed groups employ. The first phase was engagement and consultation during first aid training sessions. This deepened engagement with the ICRC and helped them understand the nature of the ICRC's work. Phase two was the consolidation and approval phase, in which the ICRC drafted a

⁶ “Promoting military operational practice that ensures safe access to and delivery of health care” and “Safeguarding the Provision of Health Care: Operational Practices and Relevant International Humanitarian Law concerning Armed Groups” are other relevant examples

unilateral model declaration containing a set of principles for the protection of health care. Inputs were gathered from the leaders of the groups and consultations were carried out with religious leaders and health-care workers. The declaration was signed by the leaders in front of the community and health-care workers. Phase three was the implementation through a formal ceremony at which members from all 15 groups signed the declaration in front of their community, including health-care workers and civil society. The declaration made a real difference on the ground and shifted behaviours positively over time; monitoring took place and the ICRC provided support where required.

The next panellist, Prof. Abdul Haq Haqani, Professor and Vice Chancellor at the Afghan Institute of Higher Education in Kabul, took the floor describing the difference between Sharia and law. Prof. Abdul Haq Haqani explained that Sharia is the law of God that comes from divine revelations, whereas the law is the product of the human mind. The law and obeying the law are very important for life on earth. The law might differ from tribe to tribe, whereas Sharia is the same for all. Sharia does not allow the use of weapons for pride or as a joke. Sharia does not permit the killing of innocents, patients or those who are not part of the war. Weapons can only be used in a legal war and for hunting under conditions described by jurisprudence.

Islam gives special immunity to the wounded and sick, including exemptions from fasting, and, for example, an exemption from the use of water for ablution if water is harmful for patients. Sharia also commands not to kill or target those who are neutral and not participating in the war. Islam requires respect for medical staff as they are the last hope for the wounded.

Article 5 of the Afghan public health law provides for the provision of preventive medicine and environmental health services for employees in government and non-government offices. Article 13 makes it an obligation for government and non-government departments to cooperate with medical staff in performing their specific duties.

The Second, Third and Fourth Geneva Conventions provide immunity to persons not participating in war, those armed forces who have laid down their weapons, the wounded and sick, and persons in detention. They must be treated humanely without any adverse distinction based on race, colour, religion, belief, gender, birth, wealth or any other similar criteria. Sharia similarly provides the same immunity to the groups of persons mentioned in the Geneva Conventions.

However, ICRC research and data show that these rules are infringed across the globe. Some 3,780 attacks were recorded between 2016 and 2020, mainly in Afghanistan, Democratic Republic of the

Congo, Israel and the occupied Palestinian territory, and Syria. Given the difficulty in collecting such data, these numbers are an underestimate of the total attacks taking place.

According to Prof. Abdul Haq Haqani, there is a need to create awareness among the public, as well as among the parties to the conflict, through the dissemination of these rules. The parties to the conflict, whether state or non-state, are required to implement the rules. There is also a need for an impartial committee or organization such as the ICRC to provide humanitarian services during wars.

In reply to a question about the particular challenges in Afghanistan and what needs to be done to tackle them, Prof. Abdul Haq Haqani stressed the importance of dissemination of the rules of war to religious scholars and clerics. In Afghanistan, people listen to religious scholars and clerics, so increasing awareness through religious scholars can be effective. The role of neutral and impartial organizations such as the ICRC is also crucial in such situations.

Ms Salman then opened the Q&A and Mr Stewart responded to a question about protecting medical staff during evacuations. The guidance produced by the ICRC is tailored with heavy weapons in populated areas in mind, including improvised explosive devices (IEDs), as well as direct and indirect weapon systems such as mortars, artillery and rockets. It asks the military and other weapon bearers to apply and ensure the principle of distinction when they are employing explosive weapons. This might involve placing observers on the ground to ensure that the situation has not changed, or ensuring that an ambulance does not pass the area where the operation will be taking place. The ICRC is focusing on how state armed forces and non-state actors conduct urban warfare, and on ensuring that the principle of distinction is applied and maintained. This can be done through simple processes such as mapping of the medical facilities. The publication provides guidance to the military and armed groups on how the operations can be conducted in or around health-care facilities.

Ms Salman responded to a question about the percentage of attacks on health care and civilians and whether the parties causing such attacks were brought to justice, noting that the prevalence of such attacks cannot be estimated as most are not reported. The figure mentioned by Prof. Abdul Haq Haqani in his presentation is an underestimate of the actual situation. Mr Stewart replied that it is not possible for him to answer the question as to whether the perpetrators were brought to justice as this is very much a state issue.

Replying to a question about how low-resource militaries can implement the comprehensive measures presented and whether this is feasible, Mr Stewart indicated that most of the measures presented are

not particularly resource-intensive. The two generic measures that the ICRC frequently asks militaries to look at are enhancing understanding of the operational environment and coordination measures with health-care providers. Neither is resource intensive. Understanding the operational environment refers to understanding the location and capacity of health-care facilities and the markings on vehicles and health-care staff. The military's coordination with health-care stakeholders is particularly related to search operations inside health-care facilities. This does not require any fancy devices or equipment. It relates to establishing points of contact and communication (especially the sharing of information) and requires intent and willingness from the military. These two measures are the bare minimum and are not resource intensive.

This session then transitioned into a spotlight session tracking progress in Pakistan.

Dr Mirwais, Head of the HCiD Initiative at the ICRC in Pakistan, started the presentation by mentioning that the ICRC in Pakistan has been working to be an agent of change since 2014. It employs a multidisciplinary approach to tackle the factors causing violence in health-care settings. The Initiative is working in four distinct yet connected areas:

- evidence base generation
- interventions based on the findings of the evidence
- legal and policy changes at the systemic level in order to have a broader and sustainable impact
- advocacy with relevant authorities, mobilizing stakeholders and raising awareness in the general community to effect behavioural change.

Much of the HCiD work in Pakistan is partnership driven. Partnerships have been built with emergency medical services, medical academia, medical universities, health-care authorities and civil-society actors. Apart from the partners mentioned, an informal community of concern has been instrumental in contributing towards the protection of health care. A formal community of concern has also been established in one of the provinces of Pakistan, Khyber Pakhtunkhwa, in order to monitor and implement the ways to protect health care from violence.

The first phase of the initiative in Pakistan comprised exploring and understanding the dynamics of violence against health care. The factors responsible for violence against health care were identified and interventions were developed with our partners based on the findings. The focus now is on consolidating and scaling up the impact of the tools and recommendations.

The Karachi baseline study was the first step towards evidence generation. In the absence of an institutional incident reporting mechanism, it provided a sense of the magnitude, trends and determinants of violence against health care. It also generated an understanding of the consequences of violence among health-care workers and patients, as well as for access and provision of medical services. Broad categories of perpetrators were identified with the help of this cross-sectional study, which was later replicated in Peshawar. Both studies showed that the magnitude of the problem is immense. A study using a similar methodology was later replicated in 16 cities in Pakistan in order to study the determinants and magnitude of violence in urban, semi-urban and rural settings. Later, with the emergence of COVID-19, incidents of stigmatization and violence were reported alongside an outpouring of positive statements that would appear to indicate respect for health-care workers. To better understand this trend and to develop measures that could counter violence and stigma experienced by health-care workers in a COVID-19 unit, a study was carried out with three universities in three cities in the country.

Evidence generation helps to evaluate the impact of the interventions, to foster awareness and to mobilize the community of concern. These cross-sectional studies were instrumental in this regard. Violence against health care is a multi-factorial phenomenon whose causes are behavioural, institutional and socio-political, and which calls for a multidisciplinary response.

The initial exploratory studies identified areas for interventions and where the ICRC and partners are operating. These areas are training, the development of manuals, support mechanisms, safer access tools, community engagement, the design and promotion of curricula of safer behaviour for medical colleges, the reform of laws, media campaigns, engagement with law enforcement agencies and physical safety of facilities.

Speaking of the interventions, violence in health-care settings was normalized owing to its high prevalence and because health-care workers were never trained to manage situations of violence in health-care settings. The ICRC, together with its partners, developed an interactive training programme that focuses on developing the communication skills of health-care workers to prevent and better manage violence in health-care settings.

In addition, security surveys of hospitals were conducted, and a contextual security policy framework was developed. A panic alarm and passive surveillance system was piloted in a tertiary care hospital, paving the way for incident reporting and response. Training manuals for ambulance staff – on safety

and security in the field and on medical ethics – have been developed. HCiD in Pakistan has been able to implement community- and hospital-based interventions for the protection of health care.

There was a need to focus and work on community perceptions of violence against health-care workers. The impact of these interventions was assessed in terms of how they reduced violence against health care.

On the legal and policy track, the evidence from the study indicated that there was little recourse to legal protection for health-care workers. One of the problems identified was a lack of awareness of the current legal framework among health-care workers and the general community. A detailed analysis of the legal frameworks of Khyber Pakhtunkhwa and Sindh were carried out and, based on this analysis, the need for legal intervention was identified in some areas. It was discovered that there was no law on giving way to ambulances in one province. Amendments were made possible in the Sindh motor vehicle ordinance, ensuring the right of way for ambulances. Based on the analysis of the Khyber Pakhtunkhwa law, a law was passed by the provincial legislature for the protection of health care. In the province of Sindh, the same law was approved by the government and will soon be presented in the provincial legislature for approval.

Dr Rehan Ali, Assistant Director for Media and Communication at the Pakistan Red Crescent Society, then took to the floor and focused on the community-focused awareness-raising campaigns around the protection of health care. In 2016, the first campaign, named “Rasta Dien” (which means “give way to ambulance”) was launched. The campaign was designed to bring about a change in the behaviour of motorists towards ambulances. A behavioural change of almost 16 per cent was recorded after the campaign. Initially, the campaign focused on the city of Karachi but later, in 2017, it was scaled up to the nationwide level and renamed “Pehlay Zindagi” (or “life first”). The campaign had print, social media, television and radio elements, and volunteers sensitized the general community. Pledges were made by people from different walks of life, including media and sports figures, lawyers, teachers and religious clerics. An app was also developed for the public to sign the pledge.

In 2019, another campaign by the name of “Bharosa Karien” (which means “trust the health-care workers”) was launched. This campaign aimed at increasing the general public’s awareness of the need to respect health care. PRCS sensitized and mobilized its volunteers to do outreach. The effectiveness of the campaign was assessed, and the results were significant and encouraging. In 2020, the campaign was repeated in the context of the COVID-19 outbreak. The focus was on sensitization of the public

towards respect for health care amid stigma and rumours related to COVID-19. It was done through digital and social media platforms by engaging religious leaders and other influencers. A video related to the campaign was presented to the audience.⁷

Dr Seemin Jamali, Executive Director at the Jinnah Postgraduate Medical Centre, talked about the impact of the initiative in the country in her presentation. She appreciated the efforts of the ICRC to change people's behaviour and to bring the issue into the limelight. The approach is systematic and not just about protecting health-care workers with arms or increasing the security of health-care facilities. Now, a discussion has been generated in academic circles about how and why medical students and doctors are not taught how to manage situations of violence and how to communicate effectively in such situations.

There is progress on the legislative front as well. A law has been passed in the province of Khyber Pakhtunkhwa and another law is in process in the province of Sindh. The media campaign, with simple messaging, proved effective, and low-cost interventions were piloted in a country like Pakistan where the focus is on cost-effectiveness of the interventions. The COVID-19 pandemic coincided with a spike in violence and an absence of information for the public. This is the time to say "no" to violence in health-care settings. There is a need to protect lives by protecting health care.

Moving to the Q&A, Dr Seemin Jamali responded to a question about successful ingredients by stressing the importance of bringing everybody on board – to engage all segments of society, as well as all categories of health-care personnel, including the security staff of health-care facilities. There is a need to improve communication skills and to show empathy to patients and attendants. Small gestures such as holding a hand or calming somebody down when they are experiencing pain make a huge difference.

In response to a question, Dr Mirwais said that the solution was not issuing licences for arms to health-care workers, since this would in a way place the onus of responsibility for safety on the health-care workers themselves. In a context like Pakistan, partnerships and co-creation of relevant solutions are key to success.

⁷<https://healthcareindanger.org/wp-content/uploads/2021/07/Untitled-1-2.mp4>

CREATING A CLIMATE OF RESPECT & FREE FROM VIOLENCE FOR HEALTH-CARE WORKERS

Moderator **Dr Khizir Hayat Khan**, Director, Social Islami Bank Foundation Hospital & former Director of Islamic Foundation, Bangladesh

Theme **WELL-BEING OF HEALTH-CARE WORKERS: THE ROLE OF THE COMMUNITY**
Dr Vinya S. Ariyaratne, President, Sarvodaya Shramadana Movement, Sri Lanka

Theme **CREATING A SAFER CLIMATE FOR HEALTH CARE DURING THE PANDEMIC: THE EXPERIENCE IN INDONESIA**
Panellist: **Dr Corona Rintawan**, Emergency Doctor, Muhammadiyah Disaster Management Center, Indonesia

Theme **THE COVID-19 RESPONSE: THE SUPPORT OF THE CHURCH TO HEALTH-CARE WORKERS**
Panellist **Jeanie Curiano**, Head of Humanitarian Programmes, National Secretariat for Social Action – Caritas Philippines

The Moderator, Dr Khizir Hayat Khan, Director of the Social Islami Bank Foundation Hospital in Bangladesh, opened the session and introduced the subject. Dr Khizir introduced Dr Vinya Ariyaratne, the President of the Sarvodaya Shramadana Movement in Sri Lanka. Dr Vinya is a specialist in community medicine and co-chair of the UN Humanitarian Country Team.

Dr Vinya explained that his presentation would illustrate challenges and provide recommendations building on three groups of experiences in Sri Lanka: the past conflict and ethnic violence, natural disasters, and the COVID-19 pandemic.

On the role of health-care workers to provide preventive and curative health care in an organized manner, the approach must be inclusive, respect the “do no harm principle” and approach the protection of health-care workers as a two-way process: health-care workers expect that no harm should come to themselves but must also be subject to the same expectation. The context is multi-cultural and multi-ethnic and the dynamics had changed even before the COVID-19 pandemic. The epidemiological pattern has changed, as has the character of conflict and violence, and a strong contextual understanding is critical.

Tracing back to the internal conflict between 1983 and 2009 and the Easter Sunday attacks (2019), while the exact number of people killed in the conflict is not known, the numbers were significant. The war ended through military means and the conflict had a significant impact on the health sector. The initial impact on hospitals was significant even if, for most of the conflict, hospitals or health-care workers were not directly attacked. Both sectors generally respected the right of the health sector to function. Nonetheless, health-care workers were displaced and some left the country during this time.

In terms of natural disasters, there are hydro-meteorological disasters including floods and landslides and also the tsunami in 2004, which was a huge challenge for health-care workers. Although it was a major disaster with over 45,000 people killed and 500,000 displaced, the tsunami was confined to a specific area and services from other parts of the country continued to function and were able to respond effectively.

The Easter Sunday attack in 2019 on a church and some tourist hotels, orchestrated allegedly by an Islamic extremist group, killed 269 people and injured hundreds. This resulted in a backlash against the local Muslim community, including health-care workers and other professionals, even though they were not involved. The event led to the reinforcement of pre-existing prejudices against this whole community. To mitigate this situation, community leaders of high stature, including religious leaders, came together from all the four faiths to fight discrimination.



Finally, Sri Lanka has been faced with an unprecedented challenge during the COVID-19 pandemic, where health-care workers themselves have faced threats and have needed to take specific preventive measures.

Sri Lanka has created a robust and equitable health-care system, providing a high level of coverage across the country and reaching all communities. This was a determining factor in the strong response in the first two waves. Sri Lanka is now in the third wave. Around 300 health-care workers have been infected and three have died.

While the numbers are still relatively low, the cracks in the health-care system are becoming visible. More needs to be done to protect health-care workers not only from physical harm but also from

psychological strain. They and their families must be protected. This includes being vaccinated. Health-care workers in most cases received their first dose but, since that time, there has been a vaccine shortage as India, the major supplier of vaccines, has dealt with its own crisis. As a result, the second dose has generally not been available for fuller protection.

Looking at the three types of challenges, and the direct impact including attacks against health care, some took place at the end of the conflict in Sri Lanka. The lingering impacts include injury and psychological impacts, including post-traumatic stress disorder (PTSD). The government has recognized this issue, support has been provided and, in many cases, those affected have returned to normal service.

In terms of indirect impacts, based on Dr Vinya's personal experience, the deprivation of certain key services is a major issue. Not having running water, access to nutritious food or access to communication (to stay in touch with family) are also critical needs. There is a tendency to ignore social and cultural needs, which have a strong impact on the individual. The impact is quite high, including the economic impact, which stems from a general lack of social support. This impact also extends to families themselves. For example, during COVID-19 times health-care workers could not support their children's education satisfactorily.

Sri Lanka has had a strong community response and there has been a mass of compassion towards health-care workers to ensure that their specific needs are met. Religion has played a strong role, from Buddhists, Hindus, Christians and Muslims alike. Religious leaders and institutions have delivered organized support to communities. They have been supporting public health and social measures, addressing stigma and discrimination, and countering disinformation and misinformation. This has been done by using innovative messaging through religious teachings and scripts, and by documenting real-life stories and disseminating them for advocacy purposes. Religious leaders have also undergone training and mobilized to create a safe environment for health-care workers and the community. They have reinforced public health measures by, for example, communicating religious messages through religious leaders in order to create space markings and to have washing stations around religious sites.

They similarly mobilized to create community resilience through village leaders and created "a COVID-19-ready village" concept. A manual was prepared, and leaders and representatives were trained in the relevant measures to be taken. Finally, special measures were taken to support care workers

themselves through concrete support, with some of these staff being unable to return home for months at a time.

In order to address these risks, there are four simple recommendations: to recognize and understand the context in which you operate, to assess the need, to work with the community as you respond, and to keep learning and capturing best practices and then work to institutionalize them.

Moving to the next panellist, Dr Khizir introduced Dr Corona Rintawan, a medical doctor working as the Head of the Emergency Department in Lamongan Muhammadiyah Hospital in Indonesia. Dr Corona is also an educator and trainer at the Muhammadiyah Disaster Management Center and serves as Operational Coordinator with the International Muhammadiyah Emergency Medical Team.

Dr Corona Rintawan shared an experience of Indonesia and opened by contrasting the situation before the pandemic with the situation during the pandemic. Before the pandemic, there were issues with the police around riots and relating to the misuse of ambulances, some examples of which appeared in the news. Since the pandemic, there have been issues between health-care workers and the community, as many people do not believe in the existence of COVID-19 in an environment where disinformation is rife. Issues around the handling of the dead have, at times, turned the community against health-care workers.

Numerous organizations are involved in the response to COVID-19, and this presentation will pay particular attention to the role of the Indonesian Red Cross and Muhammadiyah. A broad initiative is underway to try to improve the understanding of community of the issue. Many organizations, including Muhammadiyah, Nahdlatul Ulama, the Indonesian Red Cross and the ICRC, are working to establish an informal communication forum between health-care organizations. Workshops, training sessions and webinars are being held, and Muhammadiyah is also involved in providing legal aid for victims.

The Indonesian Red Cross has implemented activities and, in 2019, held a workshop with first responders in emergencies on the protection of health care. This led to the creation of a WhatsApp group that shares information between organizations on the safety and security of health-care workers. This list was active before and during the pandemic. The Indonesian Red Cross also has an education component in its community programmes. It has disseminated information over social media.

Muhammadiyah formed a taskforce for the COVID-19 response and created a command centre with a specific role to support the government's response to, and management of, the COVID-19 pandemic. This support includes TV and radio programming, interviews with volunteers and monthly press conferences. Muhammadiyah has also conducted webinars and produced videos on COVID-19 prevention, and developed a call centre for religious, health and psychological services.

One of the practical lessons that can be learned from experience is the negative perception of families of the handling of COVID-19 with respect to dead bodies. Some families do not believe in COVID-19 and are upset about health protocols that do not allow them to be present at the washing of the dead body of their loved one or the burial site, and to do "shalat jenazah". They are also not happy to deal with a burial official who is fully covered and looks like an astronaut.

WHAT CAUSE OF NEGATIVE STIGMA FOR DEAD BODIES OF COVID19 ?

- The family doesn't believe this pandemic
- the body is not bathed properly,
- if it is bathed, the family cannot see the process of the dead body being bathed, cleaned and wrapped
- family cannot be present at the burial site
- Family can't do "shalat jenazah"
- The community afraid to see burial officer wearing cover all uniform

As a result of this negative perception, several adaptations have been put in place, allowing:

- the procedures to take place after the body has been decontaminated
- the body to be wrapped in plastic before the cloth and put in a coffin
- one less-vulnerable family member to be present as a witness, in order to limit exposure
- "shalat jenazah" to take place, but at a safe distance (two metres)
- specific people to be present who are less vulnerable and with some protection (i.e. coveralls)
- burial officers to wear only gloves and a surgical mask rather than the full suit (after conducting strict procedures for the body and making sure it has been decontaminated).

These measures allow the family to feel more positive about the management of their loved one's dead body. Burial officials are also provided with regular health checkups. The procedures in place have been successful and, so far, there have been no instances of the infection spreading through the handling of dead bodies. Data have been collected on the rejection of procedures and the numbers of rejections went down from 75 per cent to around 10 per cent as a result of the work carried out in the first six months of the pandemic. Since that time, there have been no cases of rejection.

The moderator introduced Ms Jeanie Guzman Curiano, the Head of Humanitarian Programmes at the National Secretariat for Social Action of Caritas Philippines. Ms Curiano opened her presentation on the role of the Catholic Church in supporting workers and volunteers in the COVID-19 health response in the Philippines.

The Philippines has 103,000,000 inhabitants, the majority of whom are Catholic (83%). Today, as of June 2021, there are over 1.3 million cases in the country, with the total number of cases increasing steadily. According to the World Health Organization, health-care workers have accounted for 120,000 cases and 76 deaths. Based on 2013 data, there are around 30,000 health-care facilities in the country, including public, private and community health centres. "Front-liners" must include support staff, for example, security guards at facilities. The role of "barangay" – or community/village health workers (BHW), who are often volunteers – is indispensable as they deliver primary health care and the response in the community from house to house, including doing contact tracing.

The village health structure often suffers from inadequate resourcing and the COVID-19 pandemic has been testing as these structures struggle to keep the numbers of infected under control. Health-care workers have experienced high levels of discrimination and stigma from their neighbours and the community during the COVID-19 pandemic. Some have been blocked from going home and forced to be accommodated in the health-care facilities where they work. At times, they may be able to accommodate staff, but they are not intended for such a purpose and have limited amenities, if any at all. The Department of Health has intervened when health-care workers have been denied accommodation or transport because they are perceived to be a risk. Health-care workers have also protested and appealed for salary increases and improved hazard benefits, given that they are risking their lives in the exercise of their function. In this context, the church has provided support to health-care workers and other affected non-medical personnel.



NASSA, or the National Secretariat for the Social Action of the Catholic Bishops' Conference of the Philippines, is the humanitarian and development advocacy arm of the Catholic Bishops' Conference of the Philippines (CBCP). It serves as the national secretariat for 85 dioceses and represents the Philippines in the global confederation, along with the other Catholic charities that make up Caritas International. When the government declared the community quarantine on 13 March 2020, NASSA was also affected and many workers were stuck at home. Some of the work could be moved onto online platforms, but not all. The Church's desire is to help not only the poorest of the poor, but also those rendered most vulnerable by the pandemic, notably health workers.

In March 2020, the CBCP distributed a memo to clergy encouraging a day of prayer and calling for the community to follow public health regulations, including those recommending quarantine. It also noted the challenge that health-care workers are facing with respect to being able to travel home, to be with family, and to access and maintain stable accommodation. It appealed to the community to provide places to stay for health-care workers. Local communities took up the call and provided accommodation and other forms of support where possible, including constructing accommodation with washing facilities and preparing food on site. Fundraising is ongoing to sustain this campaign and priests are using social media platforms such as TikTok to draw attention to the needs.

The local government has also collaborated with the Church to support initiatives through close coordination and through sharing resources to cover gaps. Besides temporary shelters, free dedicated transport was also provided where public transport was no longer operating. Other initiatives include providing regular free food from the Church to health-care facilities. Some dioceses also distributed PPE when there was a shortage. Finally, for spiritual nourishment, Cardinal Chito Tagle offered dedicated sermons not only for the public but also for health-care workers, specifically taking into account their needs. In the course of carrying out their duties, a number of priests and bishops have passed away from COVID-19, and the CBCP has distributed a number of memos on the pandemic. The Church has supported vaccination efforts and worked to prevent churches from becoming vectors for the spread of infection.

To sum up, the religious community has mobilized in response to the COVID-19 pandemic and provided critical support. Challenges persist, including the sustainability of resourcing for the emergency response, the vulnerability of church workers themselves, and increasing case numbers. However, with adherence to prevention guidelines and the arrival of the vaccine, this crisis will hopefully pass. In closing, coordination, collaboration and partnership are critical to the pandemic response.

In the Q&A, Dr Vinya was asked about further steps that could be taken to address the direct and indirect impacts of the COVID-19 pandemic on health-care workers beyond those already mentioned. He responded with two further points. Firstly, professional associations and trade unions of health-care workers (e.g. nurses' associations) should do assessments of their membership in order to better understand the key issues they are facing. Based upon this feedback, they should identify a tailored response so that the community can meet those needs. Secondly, there is a need for greater awareness of the difficulties that health-care workers and their families face, in order that the community can be mobilized to provide more organized support. The government can also provide additional allowances

or support, such as in the form of counselling and psychological support. In answer to a follow-up question focused on social media, Dr Vinya mentioned that, in his community, they have used public display units to spread health messages and context-specific messaging, including interviews and animations. In terms of the mainstream media – on radio, on TV and in the print media – it is also important to relay key messages, but this costs money as these media are usually not available free of charge.

Dr Corona was asked how he had developed the modified procedures mentioned and how feedback from communities can be successfully deployed. He explained that, in the early stage of the COVID-19 pandemic, there were doubts about the needs expressed by the community. There was confusion as to why procedures were being rejected when the result would be an increase in the risk of infection. However, through intensive communication with the community members, the reason for the rejection of the procedures was better understood. A task force was formed inside the hospital to discuss the scientific implications of modifying the formal procedures. This allowed for procedures to be put in place that were accepted by the community while not putting people at risk. Dr Khizir mentioned, as an addition, that the coronavirus is what is called a droplet infection – hence the importance of social distancing – and then asked about the wrapping procedure employed for dead bodies as a follow-up. Dr Corona shared that the national policy on dead body management states that the bodies of those who have died from COVID-19 must be wrapped in plastic to prevent transmission.

A common question noted that the COVID-19 pandemic has generated admiration for the health-care workforce but, at the same time, has led to stigmatization, and asked about the long-term impact and strategies that should be employed. In response, Dr Vinya contrasted general stigmatization and stigmatization directed at health-care workers specifically, noting that at the outset there was stigmatization of people of certain faiths who were felt to be more prone to infection owing to their religious and hygiene practices and were seen as “super-spreaders”. There was a lot of hate speech on social media, but the situation changed as everyone was infected equally. This was also supported by a media campaign stating that everyone is susceptible to infection.

Health-care workers have been affected. For example, landlords have on occasion feared the risk of transmission and not extended rental agreements. The lesson can be to ensure that health-care workers have healthy living spaces and are provided with safe transport, which can be a problem. These sorts of issues can also be improved through better awareness as a long-term answer.

The next question, addressed to Ms Jeanie Curiano, asked what kind of collaboration between the Church and state she would consider a good practice in her context. She highlighted the importance of strong partnership between these actors, as well as with actors beyond the local government. Local coordination is key and should involve the sharing of resources and the fostering of a climate of synergy, not competition. One actor cannot stand alone. A second question highlighted the great support of the Church but sought to know more about whether providing dedicated accommodation could entail the risk of singling out health-care workers. The diocese coordinated with the department of health, which maintains preventive guidelines to ensure that certain criteria are fulfilled before any facility can be opened. With respect to feedback from health-care workers on the facilities, an assessment has not yet been completed, but most of those involved have already returned to their homes. The provision of vaccines has helped to mitigate the situation but, with the passage of time, the sustainability of such arrangements is a challenge to the Church and local government.

Finally, in answer to a question about managing stress and a heavy workload, Dr Corona said that debriefings after shifts are critical as a time to speak. This allows health-care workers to unburden themselves around some of the issues they face and express themselves. It is important to acknowledge and resolve problems without delay. Lighter activities and laughing are also critical.

Another question focused on the risk of infection COVID-19 from dead bodies and how this relates to Islam, in which the handling of dead bodies is very sensitive and respect for the dead is critical. Dr Khizir mentioned that, during the first wave of the pandemic, no one wanted to touch the body in Bangladesh, including family members. Dr Khizir indicated that the virus is spread through breathing, coughing and sneezing and, therefore, a dead body cannot easily spread the virus, but that it took time to generate this understanding and cited the guidelines on managing dead bodies from the ICRC that were published in Bengali and served as a great informational support.

In closing, Dr Khizir shared the importance of respecting and protecting health-care workers across all faiths. Religious and community leaders have a specific role to play in ensuring this respect and protection and in highlighting the key work that health-care workers are doing, and the real sacrifice they are making, for the benefit of the community. Concrete steps should be taken to provide support and to create a climate free from violence, harassment and stigma for those who are taking care of the health of the community.