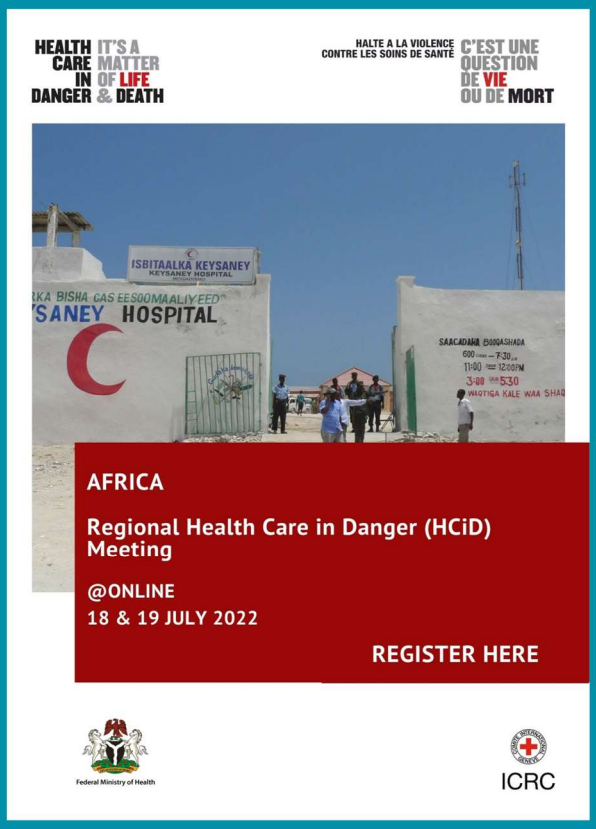
SECOND AFRICA REGIONAL HEALTH CARE IN DANGER MEETING, 18–19 JULY 2022



FINAL REPORT

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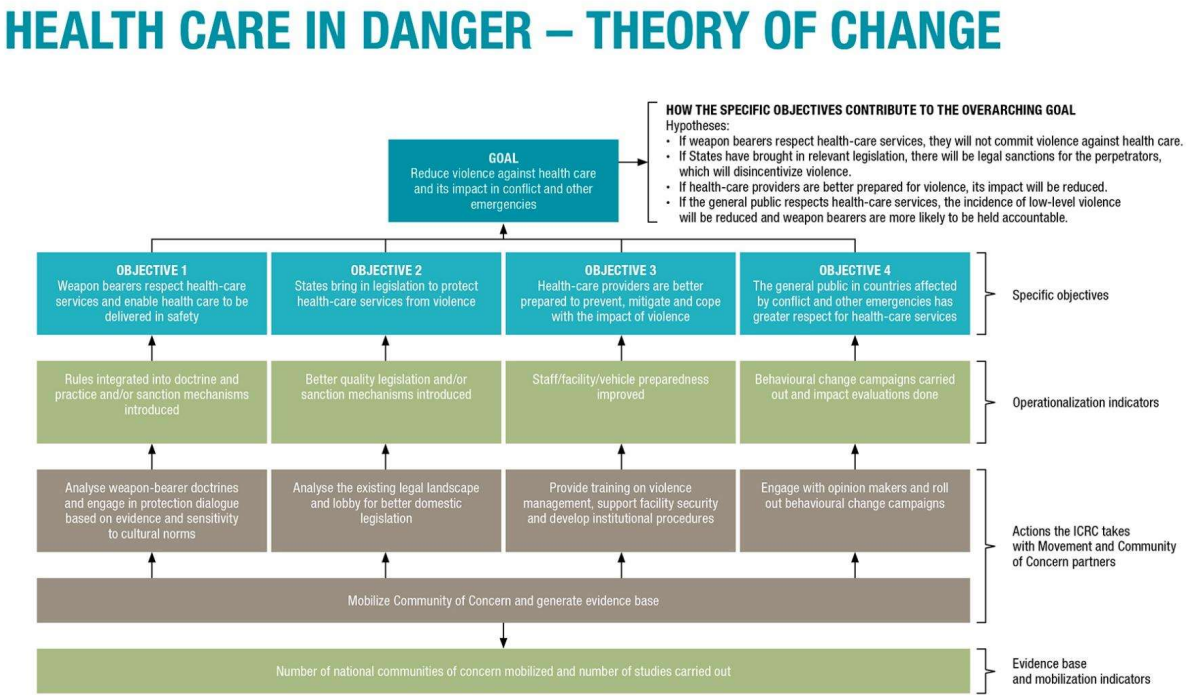
The Health Care in Danger Initiative

Ensuring the safe delivery of health care and affording special protections to medical personnel, facilities and vehicles have been at the heart of the International Red Cross and Red Crescent Movement's work since the beginning. Over the past ten years, the International Committee of the Red Cross (ICRC) and the Movement have placed special emphasis on ensuring safe access to medical services through the Health Care in Danger initiative.

The initiative was formally established when the Health Care in Danger resolution was passed at the 31st International Conference of the Red Cross and Red Crescent in 2011. Advocacy by the ICRC and our partners led to significant mobilization around protecting health care, resulting in several resolutions at the World Health Assembly and the 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 rallied partners within and outside the Movement, bringing together global experts to highlight Health Care in Danger-related issues.



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

ICRC

Health Care in Danger Strategy 2020–22

The Health Care in Danger Strategy 2020–22 is built around the Theory of Change methodology and has four objectives and three axes of engagement:

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 work together with partners along three axes of engagement:

1. **operationalization**
2. **evidence-base generation**
3. **influencing and coalition building**.

Regional Meetings

The strategy emphasizes the implementation of concrete measures at the local and national level. In parallel, the Health Care in Danger initiative has transitioned from holding meetings of stakeholders at the global to the regional level. The regional focus allows stakeholders to share experiences on operations and approaches, and to develop and strengthen local and national partnerships, creating a Community of Concern to prevent and address violence against health care. The partnership with the Community of Concern is a central pillar of advancing our common agenda.

The Health Care in Danger initiative aims to better understand regional dynamics to support actions on the ground. It is mobilizing key actors through regional forums, working with regional institutions to support appropriate national legislation and encouraging Movement partners to explore avenues of collaboration and peer-to-peer support.

Regional meetings took place in 2019 for the Asia–Pacific Region in Manila and the Near Asia and Middle East Region in Beirut. Participants appreciated the opportunity to discuss similar experiences, dynamics and cultural issues with stakeholders from neighbouring countries.

Owing to COVID-19-related restrictions, a two-day webinar format was adopted. The first meeting for the Africa Region was held in June 2020. The success of this format led to a second meeting for the Africa Region meeting, held on 18–19 July 2022. The agenda and four sessions of the Africa meeting were broadly organized in line with the four workstreams of the Theory of Change.

Disclaimer

This report provides a summary of the Health Care in Danger Initiative Africa Regional Meeting, held online on 18–19 July 2022. The views expressed in it are those of the participants concerned and do not necessarily reflect the views of the organizations they represent.

ICRC

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

Federal Ministry of Health

THE ICRC WOULD LIKE TO THANK NIGERIA'S FEDERAL MINISTRY OF HEALTH FOR ITS EXEMPLARY COLLABORATION IN CO-HOSTING THE AFRICA REGIONAL HEALTH CARE IN DANGER MEETING.

Executive Summary

1. The first session discussed **tools and approaches that are used to prevent violence against health care and mitigate its impact**. Dr Shaheem de Vries, medical director of the Western Cape Government Health Emergency Medical Services in South Africa, described the technological and people-centric approaches used to engage with the affected communities. Ms Andohery Andrianarinony, the ICRC deputy protection coordinator in charge of the Protection of the Civilian Population in Mali, spoke about the conflict in the Sahel, emphasizing a confidential and bilateral approach taken. Mr Harouna Kadio, director-general, National Agency for Primary Health Care Management in Burkina Faso, spoke on disseminating ethical principles to ambulance drivers relating to providing health care in a conflict situation.

2. The second session focused on **enhancing health-care protection through policy, legal measures and education**. Mr Alcídio Sitoe, ICRC legal adviser for Mozambique and Angola, spoke about the Mozambique legal framework to protect health-care facilities and personnel and ICRC efforts to spread knowledge of IHL. Ms Isam Elhag Mahmoud Abrar, ICRC legal adviser in Sudan, presented changes in legislation in Sudan that have allowed health-care services to operate without the need for prior administrative procedures. Prof. Alphonsus Rukevwe Isara, president, Association of Public Health Physicians of Nigeria, spoke about the collaborative work with the ICRC that focused on introducing health-care protection into the curriculum of medical schools and promoting the rights and responsibilities of health workers.

3. The third session discussed the **latest research on violence against health care in Africa**. Dr Ghislain Bisimwa Balaluka, director of the School of Public Health of the Catholic University of Bukavu in the Democratic Republic of the Congo, spoke about a study that identified different aspects of the violence suffered by health workers during COVID-19 and Ebola pandemics in North Kivu and South Kivu. Dr Dare Godiya Ishaya, the president of the Nigerian Association of Resident Doctors, presented his study's findings that despite the enactment of the Compulsory Treatment and Care of Victims of Gunshot Act 2017, police and health workers were still largely unaware of the changes. Prof. Martha M. Bradley, associate professor in the Department of Public Law at the University of Pretoria in South Africa, spoke about the legal framework for protecting medical and humanitarian personnel during the COVID-19 response and in non-international armed conflict.

4. The fourth session focused on the **role of diplomacy and regional platforms in the protection of health care**. H.E. Mohamed Gad, ambassador of the Arab Republic of Egypt to Ethiopia and Permanent Representative to the African Union, highlighted regional initiatives on protecting health-care workers and facilities and presented a series of crucial recommendations on protecting health care. Ms Pelagie

Manzan Dekou, ICRC legal adviser for Côte d'Ivoire, explained the ICRC's collaboration with the Economic Community of West African States to carry out a plan to protect health care and international humanitarian law. Imam Ibrahim Moussa, the grand imam of Ouallam, Niger, spoke about the violence against health-care workers and facilities in the Tillabéri Region and the importance of collaboration with local stakeholders.

5. The final session focused on **Nigeria**. Dr Datonye Dennis Alesia, editor of the Nigerian Medical Journal, Nigerian Medical Association, spoke about the joint health and security sector coordination supported by the ICRC to protect health care. Dr Manir H. Jega, head of Health and Care in the Nigerian Red Cross Society, presented a grassroots mobilization campaign using volunteers. Mr Aliyu Agwai, head of National Health Information Management Systems at the Nigerian Federal Ministry of Health, presented the integration of indicators on violence against health care in the national Community Health Information Management System. Dr Osahon Enabulele, president-elect of the World Medical Association, closed the regional meeting stressing the importance of health personnel and exemplifying actions to mitigate violence against them.

Day 1, Opening Session: Welcome & Opening Remarks

Moderator: **Juliet Kelechi Unubi,** Humanitarian Affairs Adviser, ICRC Nigeria

Panellists: **Professor Sydney Ibeanusi,** Director, Department of Hospital Services, Federal Ministry of Health, Federal Republic of Nigeria

Patrick Youssef, Regional Director for Africa, ICRC

Ms Juliet Kelechi Unubi set the scene, delivering a summary of the meeting's context, objectives and ground rules, and handled the introductions to the two distinguished panellists, who delivered opening remarks**. Mr Patrick Youssef** welcomed all the virtual participants, acknowledging the presence of a representative of Nigeria's Federal Ministry of Health, co-organizers of the Second Africa Regional Health Care in Danger Meeting, by recalling that Nigeria has been a giant in the protection of health care. Mr Youssef explained that Africa's overlapping humanitarian crisis, worsened by the COVID-19 pandemic and misinformation, hindered civilians' access to health services, making Health Care in Danger, now ten years old, more relevant than ever. By stating that one of the challenges is the invisibility of the violence against health workers, he commended the ongoing work with the Ministry of Health and other partners as vital to seeing the unseen. He recalled that the continent has deep roots in Health Care in Danger, evidenced, for example, by hosting four expert meetings in Pretoria, Abuja, Dakar and Cairo in the early years of the project. Mr Youssef concluded by expressing his hopes that this meeting could be a space and a platform to launch further reflection on health diplomacy's role in informing and influencing the policy environment to tackle this critical and enduring issue.

Prof. Sydney Ibeanusi, speaking on behalf of the health minister, Dr Osagie Ehanire, stressed the importance of the Health Care in Danger initiative in Nigeria and the region. Stating the common goals of Nigeria's Ministry of Health and the ICRC to provide safe access to health-care services during times of crisis, he said that the topic was of interest to the government of Nigeria, as evidenced by the organization of two national workshops recently.

Prof. Ibeanusi added that different measures were taken to address this issue, such as the incorporation of health-care personnel responsibility in the curricula of Nigeria's medical schools, health and security coordination and the capture of data from incidents of violence against health-care personnel in their national health-care information system. He recalled that the rights of health workers were well established in Nigeria's patients' bill of rights. Beyond this, they had been coordinating with different state health commissioners to integrate health-care protection into their programme and create a platform to coordinate with different actors. They were working with other government ministers to position violence against health care as a national concern. Regionally, they

would like to propose a meeting on the protection of health care on subregional and regional bodies, Economic Community of West African States (ECOWAS) and the African Union respectively, and to seek regional collaboration to address the issue in the Lake Chad region. Prof. Ibeanusi concluded by saying that they hoped the ICRC would continue supporting the efforts of the Ministry of Health that regularly brought together stakeholders to take action to reduce violence against health care in Nigeria and elsewhere, and to discuss and share good practices. Prof. Ibeanusi then declared the session opened.

Day 1, Session 1: Experiences with Tools and Approaches in Preventing Violence Against Health Care and Mitigating its Impact

Moderator: **Theresia Mohere,** Programme Manager, Aga Khan Health Service, Tanzania

Panellists: **Dr Shaheem de Vries,** Medical Director, Western Cape Government Health Emergency Medical Services, South Africa

Ms Andohery Andrianarinony, Deputy Protection Coordinator, in charge of the Protection of the Civilian Population, ICRC Mali

Mr Harouna Kadio, Director-General, National Agency for Primary Health Care Management (AGSP), Burkina Faso

The first session aimed to share experiences of tools and approaches that prevented violence against health care and mitigated its impact. Highlighting the importance of working in partnership, and the importance of evaluating progress and the impact of the measures to prevent violence, **Theresia Mohere** took the floor to introduce **Dr Shaheem de Vries**. Dr de Vries began his presentation by saying that the creation of protocols implemented in red zones requiring ambulances to be escorted by police failed to provide an effective response to communities affected by violence. This resulted in delays in medical treatment. The unsustainability of this approach led to a solid push to limit the number of red zones and to shift how they worked to mitigate the risk to staff. A few solutions were envisaged: first, cameras, police officers and neighbourhood watchers were placed in strategic spots to gather information; they mobilized some of their dispatch centres to exchange crucial information, enabling them to mitigate the threat of violence. In addition, leadership on emergency medical services and staff-supported efforts were vital to finding solutions. Nonetheless, the most crucial solution embraced the issue of community engagement implicating different stakeholders in the problem. Finally, when it comes to communication, they used documentaries to showcase the importance of safety when delivering health-care services.

The chairperson introduced **Ms Andohery Andrianarinony,** who discussed Health Care in Danger experiences in Mali. She started by saying that Mali was not spared from the conflict affecting the Sahel. This conflict had affected the civilian population and health-care staff for several years. The ICRC's protection department had documented more than 70 incidents involving health workers in central and northern Mali. As an incident may include several violations, this amounted to 130 violations of Malian, international and humanitarian law since 2020.

Ms Andrianarinony explained that health care suffers considerably from the presence of armed personnel in health facilities, often accompanied by threats to health staff and damage to health facilities, raising fears among the population seeking treatment. The ICRC, with the agreement of the personnel concerned, had also documented health-service movement restrictions, such as kidnappings, arrests, robberies, theft and a small percentage of direct attacks targeting health structures. The ICRC had addressed these violations in confidential and bilateral dialogue with the perpetrators. Regarding the general public, campaigns and radio broadcasts were organized to raise awareness about the issue's importance. At the same time, community leaders were mobilized to convey the importance of protecting health-care facilities and staff.

In closing, Ms Andrianarinony briefly gave the floor to Dr Yssouf Al Moustapha Touré, director of Gao Hospital and Mr Sidibé Hamidou, supervisor at Sévaré Hospital. Both confirmed the many constraints they faced regarding the security of their facilities and patients, saying they benefited enormously from the training seminar carried out by the ICRC on Health Care in Danger.

Ms Mohere then presented **Mr Harouna Kadio**. Mr Kadio spoke about the dissemination of ethical principles relating to providing health care in a conflict situation in Burkina Faso.

According to Mr Kadio, Burkina Faso had gone through a difficult period – with more than 60 per cent of the country facing conflict since 2016 – and a growing number of security events for health workers. This situation had generated a humanitarian crisis characterized by the loss of livelihoods and the displacement of populations, obviously also affecting health-care facilities and workers. According to a Burkina Faso health ministry report published in 2022, 539 health facilities had been affected by insecurity, of which 185 were closed, and 354 were working at minimum capacity, depriving more than two million inhabitants of access to health care. Mr Kadio, noting the incident when an ambulance struck an improvised explosive device, killing its six occupants in May 2021, mentioned that the kidnapping and killing of health workers and ambulance kidnapping constituted a large part of the incidents they faced.

Thus, to address this issue, ambulance driver training was organized with the support of the ICRC and the Burkinabe Red Cross Society. This training contributed to strengthening the capacities and skills of ambulance drivers, also improving the protection of medical transport, the referral of patients and access to health care for the populations of areas affected by the conflict. One hundred and thirty ambulance drivers were trained in seven regions, allowing these professionals to adopt behaviours in line with medical ethics and regulations. In his concluding remarks, he added that the ICRC was a prominent protagonist for the health ministry to try to curtail problems affecting the safe delivery of health care and the effects on the population. He then gave the floor to Mr Sidou, who briefly shared

that he had been working with the ICRC since 2012. Mr Sidou believed that it was of the utmost importance that the ICRC continued to carry out some awareness-raising work with different actors to protect health workers.

In the Q&A, someone asked which community resilience initiative the emergency health department wanted to revisit. Dr de Vries said they had learned that security in the community was not only related to access to health care. For example, in a community, there were areas of safe passage that members used to go shopping or visit their families. Rather than imposing a general decision on green corridors, it was important to understand which security practices were being carried out by the community itself. Therefore, there was a way to actively engage with people living in a specific area, hearing about their abstract ideas and concrete mechanisms to manage physical security in the neighbourhood. So, they had to start working with the communities on this point.

The second question was directed to Ms Andrianarinony, asking whether the ICRC shared their evaluations with the security services. She replied that the ICRC did not share evaluations with the security services. With the agreement of health-care personnel, the ICRC might engage in a confidential and bilateral dialogue with the alleged perpetrator to try to afford protection and prevent the recurrence of incidents.

Mr Kadio was then asked if he had a specific approach to preventing violence in immunization activities. Mr Kadio replied that vaccination campaigns were carried out across the country. There was no uniform approach because each area had its specificity. But, in general, he always advised his staff to stick to the code of ethics and the Hippocratic oath to avoid risky and compromising behaviour.

Day 1, Session 2: Enhancing the Protection of Health Care through Policy, Legal Measures and Education

Moderator: **Dr Paola Forgione**, Legal Adviser, ICRC

Panellists: **Professor Alphonsus Rukevwe Isara**, President, Association of Public Health Physicians of Nigeria

Alcídio Sitoe, Legal Adviser for Mozambique and Angola, ICRC Mozambique
Theme: Legal protection of health care in Mozambique

Isam Elhag Mahmoud Abrar, Legal Adviser, ICRC Sudan
Theme: Towards enhancing legal protection for health care in Sudan

Dr Paola Forgione introduced the session on how to enhance the protection of health care through policy, legal measures and education. She then gave the floor to **Mr Alcídio Sitoe**. Mr Sitoe took the floor to speak about the legal protection of health care in Mozambique. To do so, he gave a short description of the recent Mozambican armed conflict history: its colonial liberation movement, two consecutive civil wars and since 2017, a new conflict in the north. While presenting, he noted the impact of armed conflicts on health care, evidenced by the lack of access to health services for victims of armed conflict, destruction of hospitals and attacks on health professionals.

Mr Sitoe stressed that the Mozambican Constitution provided a generic right to health. However, he added that there was no specific provision for protecting health care during armed conflicts. There was no specific legislation on the legal protection of health personnel, beyond the general provisions in several domestic laws. So, attacks on health-care personnel were considered a military crime. National repression existed, but no specific framework or provision to protect staff during conflict or admissibility mechanisms. When it came to medical ethics and confidentiality, there was a prohibition for health personnel to refuse to perform their duties, except if the refusal was related to moral and humanitarian objections, or in contradiction with the Code of Ethics of the Medical Association, but never in case of emergencies. Mozambican law allowed the use of the emblem for health and paramedical personnel, units, goods and health transportation. The transport of the wounded and seriously ill was free in ambulances. The lack of a specific legal framework for medical assistance during armed conflicts or any provisions to protect health professionals and health infrastructure during armed conflicts or emergencies was being seen as an opportunity for the authorities to start the process of drafting one. This file was now being led by the recently established National Commission of Human Rights and International Humanitarian Law.

Finally, Mozambique found itself in a situation where knowledge of international humanitarian law (IHL) needed to be improved. There was a lot of discussion and training on IHL for the executive, the parliament and the judiciary. There were also IHL events with academics. Some tried their best to make things better, and Mozambique worked to grow the community of those who could do something – the ICRC was spreading knowledge of IHL, building the Community of Concern around the issue and engaging actors to develop solutions. Mozambique had recently established the National Commission of Human Rights and International Humanitarian Law with a specific mandate to advise the authorities on the implementation of IHL, being one of the files on the table, the drafting of a legal framework for protection of health care and those who did not participate in the conflict.

Ms Forgione gave the floor to the second panellist, **Ms Isam Elhag Mahmoud Abrar**, who gave a presentation on improving legal protection in Sudan. She started by explaining that in the past, doctors had to fill out a police form (called police form no. 8) when patients were exposed to criminal harm – the obligation to fill this form led to most cases of violence against doctors. They were afraid of being held criminally accountable if they treated patients arriving in a critical condition without satisfying this prerequisite.

In 2016, a group of registrars were accused of murder after a citizen received treatment. The justice ministry later cancelled the obligation to fill out the form. Following the 2019 revolution, the transitional government enacted the Protection of Doctors, Health Cadres and Health Facilities Act 2020 to address this issue. Although there were problems because police stations were still unaware that the new law was in force, this innovative piece of legislation conferred immunity on doctors so that they were not exposed to legal proceedings that would conflict with their mission. In addition, the new law also determined the civil responsibility of doctors who harmed their patients and prescribed severe penalties for assaulting health-care personnel at work. Assaults, work disturbances, destruction of material and dissemination of misleading information became offences punishable by the law.

Then Dr Forgione introduced the last speaker of the session, **Prof. Alphonsus Rukevwe Isara**, who opened the discussion on the Health Care in Danger module in Nigerian universities by saying that the Association of Public Health Physicians of Nigeria (APHPN) was the largest body of public health physicians in Africa. It comprised members in academia, all three tiers of health-care delivery in Nigeria, international agencies and non-governmental organizations.

He explained that the collaboration between the APHPN and the ICRC commenced in 2017 in a round-table meeting focusing on the introduction of protection of health care into the curriculum of medical schools and the promotion of the rights and responsibilities of health workers. The APHPN attended 2019 and 2021 round tables and other meetings and launched a Health Care in Danger module for

medical students and health workers in 2020. The training of medical students and health workers on Health Care in Danger was held in many critical medical centres and universities across the country. A multi-centre study to assess the prevalence and patterns of violence against health care in Nigeria was on the way.

Prof. Isara concluded by saying that scaling up the Health Care in Danger module in Nigeria's medical schools was a priority for the APHPN. Therefore, a working group was established within the APHPN to coordinate the implementation (monitoring and evaluation) of this module. The working group had members in all Nigerian states. To promote the Health Care in Danger module's implementation and evaluate the extent of assimilation by medical students, there would be a Health Care in Danger competition among medical students of implementing universities.

In the Q&A, someone asked why there was no legal framework for health-care protection in Mozambique. In addition, someone asked if it would not be possible for the ICRC to propose a framework. Mr Sitoe replied that the absence of specific IHL domestic legislation might be due to the reduced level of knowledge of IHL. The ICRC helped authorities develop IHL knowledge and implement it, including supporting the drafting of legislation. The Mozambican authorities also sought advice from the ICRC to understand the issue. Therefore, many state actors now understood Health Care in Danger as a relevant issue and were eager to ensure the country had a proper legal framework, particularly establishing the national commission on IHL.

A question was raised on the role of the ICRC regarding cancellation of form no. 8 and the establishment of the Protection of Doctors, Health Cadres and Health Facilities Act. Ms Abrar answered that the ICRC worked on the file, but not particularly on that police form. The ICRC carried out dissemination sessions with different actors about the topic but did not advocate for a legal change.

Day 1, Session 3: The Latest Research on Violence Against Health Care from the Region

Moderator: **Mutsa Mugangavari,** Deputy Head of Regional Delegation, ICRC South Africa

Panellists: **Dr Ghislain Bisimwa Balaluka,** Director of the School of Public Health, Catholic University of Bukavu, Democratic Republic of Congo

Dr Dare Godiya Ishaya, President, Nigerian Association of Resident Doctors

Professor Martha M. Bradley, Associate Professor, Department of Public Law, University of Pretoria, South Africa

The aim of the session was to present the latest research on violence against health care from the region. After being introduced by **Ms Mugangavari**, **Dr Ghislain Bisimwa Balaluka**, Director of the School of Public Health of the Catholic University of Bukavu in the Democratic Republic of the Congo, spoke on a cross-study of violence against health workers in eastern Democratic Republic of the Congo (DRC). He opened his presentation by stating that even though a protracted conflict had plagued DRC for over 30 years, no incident data collection system was implemented, and little data were available. The only data available came from the Munzembo study in Katanga (prevalence of 80%) and a report by the United Nations Office for the Coordination of Humanitarian Affairs that spoke of 121 cases of armed group attacks in 2021 in six eastern provinces.

Highlighting that the study was comprised of qualitative and quantitative data collected from about 600 health workers through interviews and a survey carried out during the period of Ebola and COVID-19 pandemics in eastern DRC (North Kivu and South Kivu), he noted that almost 50 per cent of the respondents had been subjected to violence. While most cases were of verbal aggression, the remaining ones were comprised of physical aggression, sometimes with weapons. In addition, when it came to the profile of those who committed these acts, most cases of aggression involved the patient's family, followed by violence from the patient, the community and armed groups. Mr Bisimwa recalled, however, that the aggressors could have several profiles at the same time; for example, they could be family members and still belong to an armed group. Most interviewees stated that they had witnessed aggression against a colleague, confirming the data already presented. Still, just a small percentage had officially complained to authorities.

Then, he explained the reasons behind the violence against health care personnel found in his study, such as the perception of medical negligence, the community's knowledge of the pandemic and their resistance to awareness-raising campaigns, disputes about staff recruitment and disputes with patients around billing. Amongst the mechanisms to reduce aggression mentioned, Mr Bisimwa

quoted awareness-raising campaigns, the construction of local health-care facilities, and security personnel training. Finally, he recommended that hospitals and other health facilities should put in place strategies to ensure that these facts were reported and punished, and that strategies be in place to prevent these problems. Lastly, establishing a National Observatory could consolidate the health system in monitoring violence against health personnel.

Ms Mugangavari introduced the second speaker, **Dr Dare Godiya Ishaya**, who took the floor to present his mixed baseline study on the evaluation of the level of implementation of the Compulsory Treatment and Care for Victims of Gunshot Act 2017 (CTCVG Act 2017) amongst health workers and the Nigerian police force. He explained that gunshot injuries were rare before the Nigerian Civil War of 1967–1970. However, subsequently, they had become increasingly rampant. Therefore, new policies were imposed to control access to health care for gunshot victims, leading to hospitals demanding police clearance before treating patients with gunshot wounds. Although attempts to address this situation with the enactment of the CTCVG Act 2017 were taken, the awareness of the new act among health-care professionals, security forces and the public was a concern. So, this study showed how the law was applied in practice by health workers and by the police to allow wounded patients to have proper treatment access.

The study demonstrated that despite the enactment of the CTCVG Act 2017 five years ago, awareness of the act was not yet optimal among key stakeholders, such as police and health workers. Similarly, operational understanding of critical components of the CTCVG Act 2017 was lacking. Therefore, there was a need to enhance awareness among these groups of stakeholders through training, workshops, radio/television and social media spots. In addition, there was a need for more qualitative studies to identify areas not covered by the CTCVG Act 2017 and more interaction between health workers and police to improve understanding of the act. Finally, funding should be established to cover the treatment costs of gunshot victims, and the CTCVG Act 2017 may need to be amended to cover grey areas.

Ms Mugangavari thanked the presenter and stressed the importance of facilitating dialogue within the various community groups to ensure everyone was on the same page. Then, she gave the floor to **Prof Martha M Bradley**, who spoke about IHL in the context of armed conflict and COVID-19. She started by saying that non-international armed conflicts were part of the African reality; therefore, she decided to focus on this aspect. She then reminded us that Article 3 common to the four Geneva Conventions applied to all non-international armed conflicts and that Additional Protocol II gave more content on the protection of medical personnel if the non-international armed conflict satisfied the scope of its application under Article 11, when the armed group's level of organization reflected its territorial control. The latter gave more content on the protection of medical personnel.

Prof. Bradley focused on three dimensions of IHL and the safeguards it offered in the fight against COVID-19: first, the protection of the treatment of the sick. The second is the safety of medical personnel, facilities and vehicles, and the third is the protection of humanitarian personnel. When it came to the first dimension, she explained that common Article 3 required that the wounded, sick and shipwrecked be collected and cared for, saying that was irrelevant if the medical condition predated the conflict or was not caused by it. Therefore, it did not matter if someone who got sick from COVID-19 was part of the armed forces or a civilian. They needed to be cared for. In addition, rule 110 of the ICRC IHL study, applicable to both non-national and national armed conflict, stated that the wounded and sick had, to the fullest extent practicable and with the least possible delay, provide the medical care and attention required for their condition. Of course, this applied to any pandemic, not only COVID-19.

Regarding the protection of medical personnel, facilities and vehicles, rules 25 and 29 of the ICRC IHL study (considered implicit in common Article 3) required that medical transportation and personnel assigned exclusively to medical transportation and duties be protected in all circumstances. There was a link between being collected and caring for and protecting medical personnel, facilities, and vehicles because if medical personnel were not protected, it would be impossible to care for the wounded and sick. Finally, talking about humanitarian assistance, common Article 3 had no explicit reference to humanitarian assistance, but rule 55 and 56 of the ICRC IHL study stated that the parties to the conflict had to allow and facilitate rapid passage of humanitarian relief for civilians in need and ensure the freedom of movement of authorized relief personnel.

In the Q&A someone asked if, in the study on violence against health workers in eastern DRC, the definition of armed groups included armed forces or authorities. Dr Bisimwa replied that the study covered all weapon bearers, including regular armed forces – even in the qualitative survey, as he thought that the people interviewed would not make the distinction.

Dr Ishaya was asked if there was a difference in the treatment of a gunshot wound in times of peace and war in Nigeria. He answered that the treatment of gunshot victims was different in peacetime as the law obliged health workers to provide information that could lead to the apprehension of criminals, even if they were receiving treatment in a health-care facility.

Finally, someone asked Prof. Bradley if medical and humanitarian personnel were defined separately in IHL. She replied that there was uncertainty regarding the difference between medical personnel and relief personnel and the extension of their protection. What could be said was that, essentially, rules stressed the need to protect both medical and relief personnel.

Day 2, Session 4: The Role of Diplomacy and Regional Platforms in the Protection of Health Care

Moderator:	**H.E Churchill Ewumbue-Monono,** Ambassador of the Republic of Cameroon to Ethiopia and Permanent Representative to the African Union
Panellists:	**H.E. Mohamed Gad,** Ambassador of the Arab Republic of Egypt to Ethiopia and Permanent Representative to the African Union
	Pelagie Manzan Dekou, Regional Legal Adviser, ICRC Ivory Coast
	Imam Ibrahim Moussa, the Grand Imam of Ouallam, Niger

The fourth session was chaired by **H.E. Churchill Ewumbue-Monono**, who welcomed the participants to the second day of meetings, this time devoted to the role of diplomacy and regional platforms in the protection of health care. He emphasized that the African Union (AU) had been strengthening the new African health public order with the operationalization of the Africa Centres for Disease Control and Prevention and the African Medicines Agency. He explained that this last session also aimed to highlight the relevance of regional initiatives to contextualize and understand how regional policies had been implemented and, to take further steps. H.E. Ewumbue-Monono stressed that Egypt had been a front runner when it came to Health Care in Danger, pushing the issue on the agenda in the UN Security Council under its presidency to enact Resolution S2286/2016 and recently, within the AU Peace and Security Council, for instance, with Egypt chairing the 2018 Peace and Security Council's 775th meeting. While giving the floor to H.E. Ambassador Gad, he recalled that on the 5th of November 2021, H.E. Mohamed Gad chaired the AU Peace and Security Council and put the issue of the protection of the medical facilities and personnel on the agenda.

H.E. Mohamed Gad, opened by saying that the African continent is disproportionately affected by attacks and threats to health-care workers and facilities, affecting the lives of civilians in need of medical care and humanitarian assistance. The Geneva Conventions clearly state that medical personnel and facilities should be respected and protected at all times. UN Security Council Resolution 2286, adopted under the Egyptian presidency, is a robust commitment to protecting health systems in armed conflict.

The Egyptian ambassador saw with concern the increasing pattern of violence against health-care facilities, erasing decades-long, hard-fought efforts to reduce child mortality and improve maternal health and hampering efforts to fight diseases. He stated that between January 2016 and December

2020, the ICRC documented over 3,780 incidents affecting health-care delivery in 49 African countries. This situation had worsened with the COVID-19 pandemic. Again, between February and December 2020. The ICRC recorded 848 violent incidents against health workers associated with COVID-19.

He concluded by saying that there was a need to advocate to scale up efforts to protect medical facilities and personnel in armed conflicts while affirming the goals of Security Council Resolution 2286 and, in more general terms, upholding the principles of IHL. Therefore, he recommended first that African countries considered entrenching humanitarian law doctrines in the domestic curricula to train military and police staff, especially those participating in peacekeeping and supporting missions; second, that they review the draft guidelines for protecting civilians in AU peace and support operations; third, that they include the protection of health care and humanitarian-assistance providers as an indicator of the monitoring and evaluation mechanism of the AU master roadmap of practical steps at silencing the guns initiative by 2030 in Africa; fourth, that the AU Peace and Security Council should hold regular sessions on protecting health-care facilities to promote awareness and persistently put health-care safety on the union's agenda; lastly, that African countries should consider leading a campaign or declaration on protecting medical personnel and facilities.

After summarizing the main points of H.E. Mohamed Gad's speech, H.E Churchill Ewumbue-Monono gave the floor to **Ms Pelagie Manzan Dekou**. Ms Dekou explained that health-care protection was a major humanitarian issue for ECOWAS. The latter signed a Memorandum of Understanding with the ICRC in 2001 to frame its action around a seminar held annually by its 15 members and awareness-raising and advocacy sessions. On this occasion, states exchanged their expertise and good practices on issues related to humanitarian action and the implementation of IHL at the national level. In a meeting held in 2018, ECOWAS also decided to adopt a 2019–2023 action plan with a whole section devoted to protecting health care and the red cross and red crescent emblems. In addition, ECOWAS states made a joint commitment at the 33rd International Conference of the Red Cross and Red Crescent in 2019 on the promotion and integration of IHL, which included a component relating to health-care protection. Regarding awareness-raising, in 2022, ECOWAS held meetings in Togo and Ghana to promote the Kampala convention, advancing the protection of health care for internally displaced people.

ECOWAS parliament also held a meeting focusing on the region's health care for internally displaced people and refugees. The parliament considered the protection of health care as a priority issue and commissioned a study on access to health care following a mission that the parliament had carried out in displaced people’s camps to take stock of the existing legislation and policies to formulate a recommendation. This study was carried out by the ICRC and would be presented to parliament soon.

H.E. Churchill Ewumbue-Monono then called participants' attention to the main points of Ms Pelagie's speech. He added that the AU was concerned with its coordination with regional communities, stressing that in Lusaka it launched a knowledge exchange platform between the AU Peace and Security Council and the peace and security organs of the various Regional Economic Communities for further coordination.

Imam Ibrahim Moussa took the floor explaining that he had been involved in the humanitarian movement for more than two decades, first alongside the International Federation of Red Cross and Red Crescent Societies in 1996 and later as a community leader working to attenuate the effects of the conflict on the civil population in his region. Although many acts of violence against health facilities were not reported, the statistics collected were alarming. The department of Ouallam in the Tillabéri Region alone recorded four incidents over the past three years, and at least five health facilities were closed today because of security issues. He also said that the existing legal framework was insufficient to meet the challenges of protecting the region's health-care facilities and personnel, for which collaboration with local actors affected by a conflict in the Sahel was necessary. For example, as part of cooperation efforts with different stakeholders, a symposium resulted in 2020 in a fatwa, a religious legal opinion according to sharia, on protecting humanitarian organizations.

H.E. Churchill Ewumbue-Monono thanked the three presenters before taking questions, first, on which guidance could be given to help implementation of measures to protect health care, and, second, if there was a model law for the protection of health care in armed conflict.

Ms Dekou replied that the Geneva Convention of 1949 and its protocols have provisions prohibiting attacks on health-care facilities and medical personnel. States had to enact legislation at the national level to end attacks on their health-care facilities and personnel, treating it as a war crime. States could also adopt legislation protecting the emblems displayed at hospitals and health centres. The ICRC could accompany these efforts by providing technical advice to create conditions for the best protection of affected populations and health care in conflict situations. For instance, the ICRC had a model law to protect the emblem, which could always be made available to states.

H.E. Mohamed Gad recalled previous engagement from humanitarian actors and civil society before the adoption of the UN Security Council Resolution 2286/2016, calling the participants' attention to the importance of proactively engaging and lobbying in the AU. Recalling Ambassador Churchill's Regional Economic Communities platform adopted in Lusaka, he invited the participants to engage with the African peace and security architecture. He added that Commissioner Bankoli and the Political Affairs, Peace and Security Department was undertaking a lot of work, including launching an early dialogue with the research community that could be considered an entry point. He added that the

ICRC's presence in Addis Ababa along with other African humanitarian actors, could be a suitable vehicle, to further strengthen the protection of Health Care in Danger. The Egyptian mission would be happy to support this initiative.

He said that the draft guidelines for protecting civilians in the AU peace support operations could be modified. Furthermore, this should be brought into the discussion on the silencing gun initiative, which should be fertilized with ideas and elements of protecting health-care facilities and personnel during armed conflict. He also affirmed that it was time to have an AU declaration on Health Care in Danger as a starting point.

Day 2, Session 5: Spotlight Session on Nigeria

Moderator:	**Leonard Blazeby,** Deputy Head of Delegation, ICRC Nigeria
Panellists:	**Dr Datonye Dennis Alesia,** Editor Nigerian Medical Journal National
	Officers Committee, Nigerian Medical Association
	Dr Manir H. Jega, Head of Health and Care, Nigerian Red Cross Society
	Mr Aliyu Agwai, Head of National Health information Management Systems, Federal Ministry of Health

Mr Leonard Blazeby took the floor to moderate the fifth and last session on Nigeria. He explained that protection of health care was an important part of the ICRC's work in Nigeria, encompassing different activities involving the Nigerian government, security forces, health-care workers, medical associations and the Nigerian Red Cross Society (NRCS), among others.

Mr Blazeby explained that the success of these protection activities in Nigeria is due to stakeholders' sense of ownership. There was an understanding that newly trained doctors could be posted anywhere, including in a conflict area. The Federal Ministry of Health and several state ministries saw the value of protecting health care in this situation, which was reflected in the partnership with the Federal Ministry, demonstrated by the minister's presentation at the World Health Assembly side event and the co-hosting of this event.

Dr Datonye Dennis Alesia spoke about the joint health and security sector coordination for the protection of health care during movement restrictions in Nigeria. He started by saying that due to the challenges when delivering health care during movement restrictions (election days restrictions, sanitation curfews and other forms of community-imposed restrictions), the ICRC and the NRCS held a multi-sector round table in Abuja in 2017. The round table made 15 recommendations, and one of them dealt with challenges to access to health care during emergencies.

During the COVID-19 lockdown, issues like the denial of access at checkpoints, physical assaults and harassment, and detention of health-care personnel and patients were brought to the public attention as some of these restrictions affected the quality of access to health care. So, the ICRC decided to facilitate a joint sector workshop in 2021 and a follow-up meeting in 2022 between these two sectors to address the negative impact of the movement restrictions. One of the critical agreements taken at the time was to provide an adequate means of identifying health-care personnel and vehicles. Another outcome was the development of a standard operating procedure which would facilitate communication between these two sectors, whose participants agreed on the follow-up meeting a

year later. These standard operating procedures would be launched and implemented soon, which would likely improve access to health care during movement restrictions in Nigeria. Dr Alesia concluded by stating that he hoped this model could be replicated in other countries with similar situations as, for them, the key learning point from the Nigerian action plan was the importance of the cooperation and coordination of multi-stakeholders in resolving these issues.

Dr Manir H Jega took the floor to present the grassroots mobilization campaign on Health Care in Danger in Nigeria. He identified the refusal to treat victims of gunshots, verbal and physical assault, kidnapping of health workers and the destruction of health facilities as the most common forms of violence against health care in Nigeria.

As the NRCS was an auxiliary aid society to the Nigerian federal government with branches in different states, he stressed that it gave autonomy to its 36 branches to plan according to their context based on available resources. Each branch developed a home-based strategy to tackle violence against health workers. For instance, when carrying out a stakeholder mapping exercise, they realized that community leaders' influence varied. In some communities, they needed to work with religious leaders, while in others, with the security personnel and health workers.

Everybody was important: government departments, unions, media, young people (often the major perpetrators in an uprising), and communities while carrying out our awareness-raising activities, distributing material and marking health facilities. Many health workers did not know that their behaviour helped determine what would happen in the event of an uprising. Therefore, the NRCS carried out capacity-building activities with health workers and managers, supporting service quality as key to their security, not to mention developing their interpersonal skills to build trust within the communities.

In addition, the NRCS had a group of volunteers within the communities who were passionate about supporting their area's health-care facilities. They provided a lot of support in terms of human resources and listening to the challenges of the staff in health facilities in their communities. The NRCS was building community structures around the health facilities and, of course, within these community structures. The NRCS had involved all the stakeholders in the dissemination of, for instance, the 2017 Compulsory Treatment and Care for Victims of Gunshot Act.

Mr Jega said that it was challenging to measure the impact of what the NRCS was doing. There had been an uprising in certain areas, but because of what they did, they had a health facility spared while other government structures were destroyed and looted. Raising awareness of the 2017 act was something the NRCS still needed to look at, as well as inadequate reporting of Health Care in Danger events, and activities and limited funding to implement different branches' plans of action fully.

Therefore, he recommended sustaining this partnership and continuing stakeholder engagement to scale up this grassroots mobilization and fully implement Health Care in Danger legislation.

Then, after commending the work done by the NRCS. Mr Blazeby gave the floor to **Mr Aliyu Agwai**, who started his presentation on the integration of violence-against-health-care indicators in the national Community Health Management Information System (CHMIS) in Nigeria by regretting Nigeria's lack of data to understand the attacks on health workers, identified as an issue. Hence, the government recognized the need to integrate violence-against-health-care questions in its CHMIS. This system was implemented to manage data from the services delivered at the community level of primary health care. It effectively linked all community stakeholders, namely health providers, volunteers, clients and researchers. Mr Agwai added that the CHMIS would be connected to the national system and hosted on the global District Health Information (DHIS2) platform. Therefore, the CHMIS constituted an entry point as a national data collection system, remaining essential to understand the nature and extent of the violence against health workers in different contexts to design intervention programmes that better responded to existing challenges and prevented future attacks.

Mr Agwai, while showing the tools to record violence against health workers, said that a pilot had started in the field, and an awareness-raising campaign was being carried out. CHMIS would be vital for assessing the humanitarian situation relating to the violence against health workers and improving the quality of health services. Nigeria's government was promoting community ownership of health interventions and helping to monitor progress; it could easily be accessed online by communities anywhere in the world, informing better health programming and resource allocation. Overall, health managers at different levels could access the data for planning and monitoring.

The main challenges constituted the delay in the rollout of the tool (due to the need for continuous consultation of different stakeholders at every stage of the implementation) and the need to strengthen government ownership/coordination efforts. Finally, Mr Agway recommended that the Federal Ministry of Health should continue collaborating with various departments within the ministry and partners, like the ICRC, to provide expertise and support for smoothly running an integrated data collection system in the country. He recognized the need to strengthen government ownership and for coordination efforts to establish CHMIS; scale up the CHMIS pilot to cover all geo-political zones; stakeholder validation of CHMIS tools to pilot outcomes and the finalization of its tools and standard operating procedures; a sustainable funding mechanism and its approval by data governance structure; training of volunteers and activation of the CHMIS module on DHIS2.

Mr Blazeby thanked the speaker for his overview and opened the floor for questions. In the Q&A, someone asked if there were mechanisms to identify sick persons trying to access health-care facilities

who were not using ambulances but private vehicles. Dr Alesia said there were cases of armed robbers pretending to transport a sick person. Even though they should be more in favour of promoting access to health care than any other consideration, in this case, the general opinion was that security personnel were allowed to use their discretion. Having suitable referral mechanisms from one level to another might help as well.

The second question was on the Federal Ministry of Health's plans to link data collection with follow-up, where specific violence issues were identified and who specifically reported the incidents in the system. Mr Agwai replied that the plan to link the data was on its way. For now, they had already started piloting the community tools, including on violence against health workers in three states. Community volunteers collected the data and would link it to a facility in an area. Then the facility manager uploaded it to the DHIS2. So the Federal Ministry knew someone was responsible for sending data and where the data were coming from. It would start sending the data monthly to the DHIS2 server.

Another question was raised on the role of National Societies in coordinating effective action. Dr Jega replied that the NRCS does not take any stakeholder for granted. It sought a dialogue with every stakeholder to ensure everybody was carried along and, again, allowed the community to take the lead. At any level, they were encouraged to come out with their initiatives and decide which measures they could put in place to protect health facilities. The military and the paramilitary were essential in some hotspots, while in other places, the association of commercial motorcycle riders was essential.

Day 2: Closing Session

Moderator: **Maciej Polkowski,** Head of Health Care in Danger initiative, ICRC

Closing Remarks: **Dr Osahon Enabulele,** President-elect, World Medical Association

Leonard Blazeby, Deputy Head of Delegation, ICRC Nigeria

Maciej Polkowski took the floor and seized the opportunity to thank all participants for their engagement with the discussions. Mr Polkowski praised Nigeria for co-hosting the meeting, stressing that Prof. Ibeanusi was representing not only the Ministry of Health but the entire Nigerian government in their commitment to improve health-care protection, showing their regional and international leadership on the issue.

In addition, he stressed how Prof. Ibeanusi outlined the different elements of progress achieved in Nigeria with round tables, technical meetings and measures. He also mentioned that Prof. Ibeanusi regarded ECOWAS and the AU as valuable platforms, recalling that Prof. Ibeanusi stated that it presented a valuable opportunity to foster better regional collaboration on all issues pertaining to health-care protection. Then Mr Polkowski summarized the main points discussed, highlighting the main issues in every speech.

Dr Osahon Enabulele closed the regional meeting by thanking the organizers, Nigeria's Federal Ministry of Health and the ICRC, for their choice of topics presented at the meeting. He explained that the World Medical Association (WMA) encompassed 10 million physicians and 110 medical associations who firmly believed in medical neutrality in armed conflict and violence. The WMA had been seeking to de-escalate violence against health-care personnel through statements, by enacting an international code of medical ethics and through the WMA regulations of armed conflict and other situations of violence. Dr Enabulele said that if there was anyone still in doubt about the critical roles of health-care personnel, the COVID-19 pandemic had convinced them otherwise. However, as seen in the presentations, acts of violence against health care personnel still abounded across the African continent and globally. Therefore, concrete efforts had to be made to mitigate violence against health personnel, including intense advocacy; public enlightenment and awareness-raising through training, national domestication and enforcement of humanitarian law alongside good governance and leadership; and strengthening health-care systems with the capacity to prevent and manage acts of violence. He ended his speech by stating the support of WMA in this task.

Mr Leonard Blazeby thanked the Federal Ministry of Health for co-hosting the meeting and praised the support of the Honourable Minister Dr Ehanire. He also expressed his pleasure in closing the meeting alongside Dr Enabulele.

Mr Blazeby reviewed how participants performed against the meeting objectives, expressing pleasure that participants had successfully shared experiences, forged links and strengthened partnerships across the continent. He also noted how showcasing health workers' work and furthering the links in a network could help inspire greater action and provide recognition for those who were currently active. Finally, he insisted that making clear the approach currently being undertaken in such a public event could also attract further interest from stakeholders and the general public to raise the profile and generate new interest in health-care protection.

Regarding the content of the meeting, he emphasized three points: congratulating the Nigerian government for its work, underscoring the importance of research to understand the nature of the problem of violence against health care, and finally the centrality of meaningful collaboration and partnerships, underscoring the importance of local and national partners. Mr Blazeby thanked the local medical associations and the NRCS for their collaboration.

Moving forward, he underscored the need for an unwavering focus on practical measures. Participants should keep their feet on the ground and remain rooted in the local and national context where they worked to achieve this objective.

When it came to the ICRC in Nigeria, Mr Blazeby restated the organization's commitment to advance measures currently being undertaken and to deepen collaboration, engaging with partners in Nigeria while taking on ideas and good practices regionally and globally. He closed the meeting by thanking all the participants.