HEALTH CARE IN DANGER
A MATTER OF LIFE & DEATH

Royal Military School, Brussels, 5 December 2013

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ICRC Brussels
Health care in danger: the issue

At the start:
A report based on statistical study on how armed violence affects health care
Health Care in Danger - the issue

VIOLENCE against:

- **Attacks**: bombing, shelling, looting, etc.
- **Personnel**
  - Harassment, threats, intimidation, and robbery; and arresting people for performing their medical duties
- **Voluntary discrimination**
- **Facilities**
- **Obstructions**
- **Wounded & Sick**
  - Killing, injuring, harassing and intimidating patients or those trying to access health care, etc.
- **Vehicles**
  - Attacks upon, theft of and interference with medical vehicles
- **General insecurity**
Report: Violent incidents affecting health care

- January to December 2012
- 921 incidents recorded
- Identification of main patterns
Health-care providers affected by category

- Local health-care providers and national NGOs: 14%
- National Red Cross and Red Crescent Societies: 6%
- ICRC/International Federation*: 2%
- International NGOs or UN agencies: 1%
- No information: 1%

Total number of incidents by category of health-care provider affected - 1366
Victims by category

- Medical personnel*: 1000
- Patients: 345
- Drivers: 68
- Bystanders and relatives of patients: 46
- Security guards: 41
- Others**: 35

Total number of victims - 1535
Types of violence that affected at least one person

Total number of acts or threats of violence that affected at least one person - 1108

- **Killed**: 118 (Personnel: 118, Patients: 79, Bystanders: 10, Drivers: 16, Security Guards: 2, Others*: 3)
- **Wounded**: 113 (Personnel: 113, Patients: 36, Bystanders: 73, Drivers: 11)
- **Beaten**: 94 (Personnel: 94, Patients: 15, Bystanders: 27, Drivers: 12, Security Guards: 1)
- **Kidnapped**: 82 (Personnel: 82, Patients: 8, Bystanders: 17, Drivers: 7, Security Guards: 4)
- **Arrested**: 81 (Personnel: 81, Patients: 40, Bystanders: 10, Drivers: 9, Security Guards: 7)
- **Passage denied**: 86 (Personnel: 86, Patients: 109, Bystanders: 13, Drivers: 141)
- **Unable to get treatment**: 46 (Personnel: 46, Patients: 1, Bystanders: 1, Drivers: 1, Security Guards: 1)
- **Robbed**: 75 (Personnel: 75, Patients: 10, Bystanders: 1)
- **Other types of violence**: 29 (Personnel: 29, Patients: 10, Bystanders: 11, Others*: 3)
Health care in danger: the issue

The knock-on effect

- One single incident can affect entire communities
- Weakening of health-care system while it should be reinforced
HCiD: The project

Authorities
Health-care community
ICRC delegations
RCRC National Societies
NGOs
Arms carriers

Encouraging concrete measures

2015
RCRC International Conference

2014
Intergovernmental conferences

2012-2014
Thematic expert workshops

2011
RCRC International Conference

Communication Campaign
HCiD process

International Conference 2011

16 Country Study

Data Collection on Incidents 22 countries

Field Level Multidisciplinary strategies

Expert Consultations Establishing Recommendations

Consultations with States 2014-5

Final Report & Tools for Professionals

International Conference 2015
Mobilization at Global Level

- World Medical Association
- MSF / Medical NGOs
- Red Cross / Red Crescent Movement (Workshops in Oslo, Teheran, Mexico; Movement reference group created)
Mobilization at Global Level

Other key actors being mobilized 2013-4

- World Health Organization
- The International Committee of Military Medicine (ICMM)
- International Hospital Federation
- Medical Academic World
- OHCHR -Right to Health-
## Mobilization at global level: Consultations

<table>
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<tr>
<th>Issues for global consultations</th>
<th>Location</th>
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<tbody>
<tr>
<td>1. Military practice: from training to operational orders</td>
<td>Sydney (December 2013)</td>
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<td>2. National Societies’ response to HCiD (PNS and ONS)</td>
<td>Oslo (December 2012), Teheran (February 2013)</td>
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<td>3. Ambulances and pre-hospital services</td>
<td>Mexico (May 2013)</td>
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<tr>
<td>4. Responsibilities and rights of health-care personnel</td>
<td>London (April 2012), Cairo (December 2012)</td>
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<td>5. The physical safety of health facilities</td>
<td>Pretoria (April 2014), Ottawa (September 2013)</td>
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<td>7. Civil society: mobilizing opinion &amp; religious leaders</td>
<td>Dakar (April 2013)</td>
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Rights and obligations of health-care personnel

A tool for all health-care personnel confronted to armed violence

The responsibilities of Health Care Personnel working in armed conflicts and other emergencies:

- International law
- Medical ethics
- Data protection & health records
- Dead body management and issue of missing persons
- Taking into account vulnerabilities
- Witnessing abuses
Recommendations from the consultations on the role of National Societies

- aspects of safer access;
- incident data collection and research;
- ambulance drivers;
- safety and security of health-care personnel— (issue of follow-up attacks and use of PPE);
- health and/or life insurance;
- dialogue with authorities - national multi-stakeholder forums;
- advocacy
Recommendations & best practices

**Specific:**
- Coordination Mechanisms in place between service providers and authorities (preparedness, legal basis)
- Alternative Communication Equipment (facing the risk of breakdown of communication system)
- Psychological support (incl. in insurances)

**Re-affirmed:**
- Recognized & accepted by communities
- Personal Protective Equipment
- Key role of ambulance drivers
- FOLLOW UP ATTACK DILEMMA
Safety of Health Facilities
Ottawa Workshop, September 2013

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<th>Themes</th>
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<td><strong>Ensure Functioning of Health Facilities</strong></td>
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<td>❖ contingency/emergency response planning including reserve of essential supplies for several days;</td>
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<td>❖ contract with suppliers to ensure repair or delivery during emergencies</td>
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<td><strong>Managing Stress and Pressure</strong></td>
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<td>❖ psychological support to the staff and relatives</td>
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<td><strong>Physical Security of Health Infrastructures</strong></td>
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<td>❖ external protection and secure access to hospital, (controlling the flow of people entering the facility)</td>
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<td>❖ clear marking</td>
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<td><strong>Temporary solutions</strong></td>
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<td>❖ discharging patient for recovery outside the infrastructure (private houses)</td>
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<td>❖ re-location in a safer zone;</td>
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<td>❖ security through community acceptance</td>
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Military Operational Practice
Consultations

Focus in 4 areas, namely:

- **Ground evacuation** of wounded and sick across territory controlled by different parties to a conflict (including the issue of **checkpoints**)

- **Search operations** in health-care facilities

- **Fighting in proximity of medical infrastructure**: precautions in the attack and defense at either the planning or conduct of operations stages, in order to avoid or minimize potential dangers medical workers, vehicles and facilities

- **Use of the protective emblems** by health-care workers, medical vehicles and health-care **facilities**
Military Operational Practice
Results out of 26 consultations

- **Ground evacuation (checkpoints)**

  **Doctrine**
  - NO: 46%
  - YES: 35%
  - OTHERS: 19%

- **Education/Training**
  - NO: 27%
  - YES: 69%
  - OTHERS: 4%

- **SOPs**
  - NO: 35%
  - YES: 50%
  - OTHERS: 15%

- **Search operations in health-care facilities**

- **Doctrine or SOPs**
  - OTHERS: 19%
  - YES: 39%
  - NO: 42%

- **Use of the protective emblems**
  1. Widespread use
  2. Restrictions for tactical/security reasons
  3. Interchangeability of the 3 protective emblems
  4. No doctrine offering guidance on use/non-use
Domestic normative frameworks for the protection of the provision of health
Consultations with 35 countries

Main findings

Scope of application

• Few States have developed legal frameworks specific for armed conflicts and other emergencies
• The protection of the medical mission is enacted through national legislation on the protection of the distinctive emblems
Key elements

• Integrate victims of armed conflicts and other emergencies into national scheme ensuring access to health.
• Contextual definition of Health care providers, transports and infrastructure; what about traditional medicine?
• Need to ensure protection of Red Cross/Red Crescent emblem; in addition possibility of creating a national emblem for the medical mission as in Colombia.
• Importance of criminal, administrative and disciplinary sanctions.
• Preserving medical ethics and confidentiality when regulating possible disclosure of medical information.
Moving to concrete action

- Progress report
- Workshop
- Village display
- External event
Best Practice

Colombia:

• Government decree
• Data collection
• Medical mission
• Communication campaign
• Training for health professionals
Yemen: receiving a strong governmental commitment to protect health-care
Communication Campaign

The **public face** of the project.

**Raise awareness** on the issue of safe access to health care and **advocating practical solutions**.

**Wide range of audiences** in contexts where the lack of safe access to health care is an operational concern and in countries with a global and regional influence

**Support the implementation** of the operational and diplomatic tracks at key moments
HCiD Publications
A Specific Website

www.healthcareindanger.org
Dank U....

Merci....

Thank you....

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