Q&A: 'HEALTH CARE IN DANGER'

In conversation with Pierre Gentile

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In 2011, the International Red Cross and Red Crescent Movement launched the Health Care in Danger project, a global initiative with an ambitious objective: to improve the security of health-care delivery in armed conflicts and other emergencies. Two years later, Pierre Gentile, the ICRC's Head of Project, speaks about the achievements, the challenges and the way forward to make this intention a reality.

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What is the Health Care in Danger project about?

The Health Care in Danger project started with a sad realisation: that violence against patients and health-care personnel, facilities, and transport is even more present now than in the past. We are all following it in the news – from a hijacked ambulance in the Middle East to a looted health-care centre in the Central African Republic, this violence is not invisible in the international media.

Yet, even if the International Committee of the Red Cross (ICRC), the Red Cross and Red Crescent National Societies, and many others had often been direct witnesses to these events or had been even tragically affected by them, we had tackled the problem not as a thematic issue but rather as a sum of single, unrelated incidents. The same was true for the international community at large. After doing a study in the field, we realised that there are common patterns of violence, independently of the contexts in which it occurs. We then launched the Health Care in Danger project, starting with raising awareness about the problem and about the humanitarian consequences of this phenomenon, which probably affects millions of people around the world. We are mobilising a wide range of actors such as health-care professionals, national authorities, and ministries of health. With their

help, the project team is working to define good practices and recommendations that can help secure health-care delivery in the field.

Health Care in Danger is an evidence-based project. What does this mean concretely?

In this issue of the *Review*, you will find an article by ICRC Medical Adviser Robin Coupland which provides an overview of what we called the Sixteen-Country Study – the first exercise we did on gathering and analysing violent incidents affecting health care between 2008 and 2010. The study helped us better understand the phenomena and served as a basis for the project. Yet we did not stop here – the methodology evolved, and we have been continuing to collect information from a broader number of countries. For all incidents reported, a data quality check is performed first at the level of the relevant ICRC field delegation. Data is then centralised and entered systematically in Geneva to ensure that the interpretation of the different cases is coherent across the different countries participating in the data collection. In 2013, the ICRC published a new report based on a full year of data collection from across twenty-two countries affected by armed violence. On this basis, we were able to analyse more than 900 incidents.

These data are just the tip of the iceberg in terms of the reality they portray. We have no pretence of giving an exhaustive account of the number of incidents that occur; we can only be aware of a small part of them, and this is therefore not an exact image of the reality on the ground. Nonetheless, we do think the methodology we use enables us to have an understanding of the main trends. We plan to continue regular data gathering and to publish annual reports on it. We hope to see that, over time, the situation in the field evolves positively.

What are the main findings of the Health Care in Danger project so far?

The main trends we have observed can be summarised in the following three findings.

First, the vast majority of the affected health-care workers are local health-care providers (international providers become victims in only 7 per cent of the incidents) – a reality which is very different from the perception that is generally created by media. Even this figure is probably an overestimation. Simply put, we are more aware of incidents affecting international actors than of incidents affecting local health-care providers, especially when these happen in remote areas. So the real percentage of local health-care providers who do become victims of incidents is probably closer to a 95–97 percentile.

This trend is essential to understand, in order for us not to assume that 'health care in danger' and protecting the delivery of health care is only about international organisations lacking access to remote areas; the problem is essentially one of local health-care systems being able to function or be strengthened if need be, in order to confront a higher demand in times of emergencies and crises.

The second finding is the nature of the violence itself. Violence against health care can take different forms and often has tragic consequences, such as health-care providers or patients being killed, wounded, or kidnapped, but the biggest proportion of incidents involve health-care personnel being threatened. The threats recorded in the ICRC study are serious threats to which people have had to react, either by changing their work patterns or sometimes even by leaving their work. Although such threats do not directly affect the physical integrity of the health-care personnel, they can have serious consequences for the entire population in need of health care. From the perspective of the population, if you live in a remote area and the nurse or the doctor does not come any more because he or she was threatened and chose to leave, at the end of the day you do not get the health services you used to get. This is one aspect to take into account. Beyond the number of people directly affected, there are a number of people indirectly affected, such as by a population's health services decreasing or becoming more difficult to access. This usually occurs in situations of armed conflict or emergency, in which the needs tend to increase. This preoccupation is today at the core of the Health Care in Danger project.

The last important finding is linked to the emerging trends of violence against health care. Among others, we have identified a pattern of attacks against health-care workers during vaccination campaigns in several countries. This type of violence affects the capacity to prevent epidemics across large areas. In the same line, we have also recorded several incidents of what we call 'follow-up attacks' – situations in which a first explosion is launched and while first responders struggle to help the victims, a second explosion follows, affecting both the wounded and the health-care personnel. In those cases, there is an apparent intention to target, among others, people who come to rescue the wounded. The result is that emergency health-care delivery becomes even more difficult. First responders face a dilemma: either to act and potentially risk their own lives, or not to intervene and to leave people behind who could have survived. This dilemma was echoed in many of the consultations we had with ambulance services, as it has a very negative impact on their operational procedures and local perception. This is of course extremely worrying, as the wounded have a right to be attended to on time, and emergency services have a right to access people in need of medical assistance.[1]

The Health Care in Danger project convenes experts to work on recommendations that would improve the security of health care. Could you tell us a bit more about these consultations?

At the beginning of the project, we identified a few thematic areas on which we can work to improve the security of health-care delivery. We then organised workshops

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1   For a detailed account of the rights of the sick and wounded, see Alexandre Breitegger, 'The legal framework applicable to the protection of the provision of health care in armed conflicts and other emergencies', in this issue.

around each of these thematic areas, inviting a variety of experts to share their experiences and recommend solutions going forward.

For instance, one of the workshops, which took place in Ottawa in 2013, focused on the security of health-care infrastructures. Practically speaking, the discussion revolved around questions such as how to make sure that a medical facility can continue to function for several days when the electricity grid, the Internet, or the water system on which it usually depends are disrupted. Or, how to ensure that a hospital has the capacity to manage its staff, even when the team is under pressure and when some health-care workers might even not be able to reach their workplace. In a situation of risk, there will be lack of resources, more demands, and possibly also pressure from armed men, from the media, or from the families of the patients. As an example, one of the objectives of the consultations with experts on this topic was to understand how to best manage a situation of stress.

Other workshops address, for instance, the question of how ambulance services can be efficient in a situation of risk. We are now working on another, very different topic – what practices armies and security forces can put in place to guarantee that the delivery of health care is respected and protected. This includes issues such as search and arrest operations in hospitals or the management of checkpoints on roads where ambulances and sometimes even private cars transport the wounded and sick. The dilemma of the arms bearers would be the right balance between humanitarian considerations and security constraints. What we want to do is to build on the practices of the military, and that's why, in addition to the workshops, we are conducting bilateral consultations with representatives of different armies.

What is the field of expertise of the different workshop participants?

Depending on the thematic area in question, we are mobilising experts from different fields. As I just mentioned, if we work on military practices, for example, the experts will be members of state armies, both from military medical services and from operational units. If we discuss national legislation, the experts will be mostly legislators or members of international humanitarian law (IHL) committees, but also people working in the field of medical ethics.

For workshops on measures that health-care providers can take on their own, the experts will mostly be coming from the medical field, from various humanitarian organisations or organisations of health-care professionals. This will also depend on whom the recommendation is directed towards; we do involve, as much as possible, those stakeholders who would be directly applying the recommendations. For instance, if health-care professionals are recommending an action to be taken by national authorities, we try to integrate an expert from a health ministry.

What are the recommendations that have surfaced until now?

At this stage, we can say that some recommendations are already clearly formulated, while for others, we can see the direction they might take. For example, a recommendation that came out from the workshop on ambulance services addresses the necessity to pay special attention to ambulance drivers, who are often among the first contact people at checkpoints on the road. Ambulance drivers often have a key role to play when it comes to assessing road security, and they therefore need to be fully integrated in all capacity-building activities targeting ambulance personnel. Another possible measure making first responders more efficient would be to include more systematically psychological support, reinforcing the team's ability to function under pressure. There is a need for a mechanism allowing the team to detect if a staff member needs to take a break when the emotional charge becomes too strong.

During some of the workshops, there was a debate about the use of personal protective equipment (PPE) – such as helmets, bulletproof jackets, and gas masks – by ambulance teams. There are always pros and cons to the use of such equipment, hence the consultation with experts. In this case the recommendation is not about using or not using PPE. Instead, experts came out with criteria that we would recommend to apply in order to better assess the environment and decide if this type of equipment is necessary or not. The situation will vary from one context to another. The recommendation will be thus more about understanding the surrounding environment and its difficulties, as well as about having the right criteria to enable people on the ground to make the best decision.

Another example of a recommendation I would like to bring forward refers to the security of medical infrastructure. During the workshop in Ottawa, we discussed different preparedness measures that could be undertaken by health-care facilities. Many local health-care providers emphasised the need to incorporate in contingency plans measures that can help maintain the supply chain, including uninterrupted provision of water, electricity, drugs, and so forth. When elaborating preparedness measures, health-care professionals need to make sure that the contracts they have with key suppliers incorporate the obligation to continue the service, even in a situation of emergency. In a normal setting, most contracts will have a clause announcing that, in case of emergency, services can be suspended. However, in a crisis situation, the hospital would typically need these services all the more, as the flow of patients is likely to increase. Health-care professionals need to make sure that contracts clarify what is expected in case of an emergency and that suppliers themselves have a contingency plan that will allow them to continue their work during an emergency.

Do you think most of these recommendations will be applicable cross-culturally?

Once we finalise all recommendations, we aim to share them with ICRC's delegations and National Societies working in operational contexts, but also with

all actors that can apply them at a local or international level. We are currently running a communication campaign that has, as one of its objectives, the promotion of recommendations to all relevant stakeholders. It will then be up to each of them to decide how far every single recommendation suits their context, needs, and capacities. So, it is not only about being culturally appropriate; in some cases, a recommendation can simply not be relevant.

There is no single solution to the complex issue of lack of safe access to health care. My team and I are not working to identify the best five recommendations to be applied worldwide; instead, we are trying to identify ten to fifteen measures for each of the seven thematic areas on which we work. That makes a list of around 100 recommendations. Of course, we do not expect that this list will be applied as such in every country. Rather, our goal is that in every context concerned by the problem, there be discussion among the relevant actors on which of these recommendations are relevant and useful for making health-care delivery safer.

Violence against health care cannot be solved with one type of action undertaken by one actor across the globe. Different actors have to take different actions in different contexts, so that the cumulative effect at the end of the day will hopefully have an impact.

The Health Care in Danger project works with several partners. What are their roles and how is the Red Cross and Red Crescent Movement involved?

Indeed, the project is based on the idea that the issue is of concern to many actors. We therefore need to be sure that all concerned actors join forces to improve the situation on the ground. To do so, it is essential that attacks on health care are seen as a priority not only by the ICRC, but also by many other organisations within and beyond the humanitarian sector.

Making sure that the issue of health-care security is a priority for humanitarians and for the international community in general was at the core of the first stage of the project. We focused a lot on sensitising and mobilising different actors. Some of them have even developed their own projects with similar objectives to the Health Care in Danger project.[2] This is the case with *Médecins sans Frontières* (MSF), for example, who launched the Medical Care under Fire project. Others joined efforts within Health Care in Danger. We have developed a strong partnership with several professional organisations such as the World Medical Association, the International Council of Nurses, and the International Military Medical Association. They are part of the expert consultations, but they also play an important role in bringing the recommendations closer to their members.

Last but not least, we have developed a very strong partnership with many National Societies, as the project is primarily a Red Cross and Red Crescent

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2   See www.msf-ureph.ch/en/thematique/medical-care-under-fire-0 and www.msf.org/topics/medical-care-under-fire. All internet links were last visited in November 2013.

Movement project. National Societies are at the forefront, not only in terms of taking the risks while evacuating the wounded and sick in emergencies, but also in participating in many of the expert consultations. We have a reference group of some twenty National Societies, who made pledges during the 31st International Red Cross and Red Crescent Conference in 2011 and who are following the project very closely. Many of them have dedicated resources to achieving some of the objectives of the project at national level or to supporting it internationally.

You mentioned MSF's Medical Care under Fire project. Several other NGOs have launched a similar initiative called the Safeguarding Health in Conflict Coalition.³ How does your team make sure that there is no lack of coordination between all these similar projects and initiatives in the humanitarian world?

Those are separate but parallel and complementary initiatives. As I mentioned, one of the aims of the Health Care in Danger project was to mobilise key actors around the issue, in the hope that they would develop their own projects or at least have the issue included in their own strategies. That is exactly what MSF, for instance, did. MSF has slightly different objectives then us, more oriented towards the security of its own staff and operations, but we all look for the same result in the end – security for the delivery of health care. We also try to include in the consultation process all the different actors that are already working on that. To go back to the example of MSF, it is already part of some of the workshops and we have a very good operational partnership.

In fact, in order to boost the cooperation and the exchange of best practices amongst all the different organisations and individuals that are working actively to find solutions, we extended and remodelled the official Health Care in Danger website and launched the Health Care in Danger Network, an online community of concern where all interested members can share resources, ideas, and information about upcoming events and thus capitalise on their engagement.[4]

What about the ICRC's independence? Can the organisation stay independent while cooperating and even partnering with other organisations and states?

There is no threat to our independence or neutrality when it comes to working with other organisations on this thematic issue in order to find pragmatic and applicable solutions ahead. The project is not about a particular country; it is about an issue

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3   See www.safeguardinghealth.org.
4   For the official website, visit: www.healthcareindanger.org. For the Health Care in Danger Network website, visit: www.healthcareindanger.ning.com. To join the Network website, please contact the platform administrator (czanette@icrc.org).

that we unfortunately witness in many countries around the world experiencing armed conflict or other emergencies. There is therefore a need to find a common interest with many organisations in order to create recommendations that will allow secure health-care delivery. In the end, it is all about the very nature of humanitarian action – helping the wounded and sick, based on the urgency of their case and independently of who they are and where they are. In that sense, finding recommendations that are mostly of a preventive nature – measures that various state institutions, armed forces, health-care providers, and other actors can take to reduce the risk to health-care delivery in conflict-affected areas or other emergencies – is not as such an activity that goes against our neutrality or independence.

Would it be accurate to say that the Health Care in Danger project is also a learning experience for the ICRC from a more institutional perspective?

Absolutely, and there are of course many internal challenges. The first one lies in the fact that the project is of a transversal nature. It brings together the different disciplines within the ICRC: protection work, medical assistance, cooperation within the Movement, communication and outreach, legal expertise, and so on. All these different specialists are working together on the project. This is the strength of the project, but it also has a cost in terms of energy and time put into internal coordination, and in creating an understanding around common short- and long-term objectives.

Moreover, precisely because the project is not ICRC-centric, but rather seeks to engage an array of actors around a humanitarian problem, there is an internal challenge when it comes to the decision-making process, especially around the allocation of time and resources, as the partners we are engaging with are not directly participating in those internal processes. So to maintain an understanding of common goals, the project team needs to be able to constantly highlight the bridges and the positive synergies that the project creates between the ICRC and other stakeholders.

You are now halfway through the project. From your point of view, how do you assess the success of the project and of the consultations more specifically?

At this stage, we can say that we have been able to raise awareness and mobilise a large number of stakeholders, ranging from medical associations such as the World Medical Association and the International Council of Nurses to humanitarian organisations such as MSF, a series of states, and also many Red Cross and Red Crescent National Societies. We were therefore able to create a tipping point where the issue is being discussed in many different fora. We hope that this trend will not only continue but will be amplified in 2014. So far, we are satisfied with the way

many of the stakeholders have understood the opportunity the project could give them to address an issue which is a priority for many health-care providers around the world.

We see that today many National Societies start to develop their own activities, be it advocacy in their respective countries, reflecting on measures to be taken in their own operations, or working on some of the recommendations that came out of the expert workshops and putting them into practice. This is extremely important. The project is a Movement project and we need National Societies to have ownership of it.

Another important aspect is the series of expert workshops and the recommendations that come out of them. We still have three consultations to be completed and there is a lot to learn with the experts involved. We already have a publication on the role and responsibilities of health-care personnel and a publication on ambulance services in crises situations with very concrete examples from the field. We will share via different publications the outcome of the workshop on national legislation, military practices, and medical infrastructures. These publications will be the support for the work to be carried out in 2014–2015 in promoting the recommendations. We hope that they will then be implemented by national authorities, ministries of health, health-care providers, NGOs, international organisations, or military and security services, depending on whom the recommendations concern.

The Health Care in Danger project will end in 2015. What are the priorities and the challenges you see for the coming years?

A particular challenge comes from the fact that the project is short-lived. The project was elaborated around the idea of mobilising support from different actors to elaborate practical solutions and then promoting the outcomes of the expert workshops. However, the issue will not disappear when the project is over and we already know that by 2015, it will unfortunately be too early to see a significant change in the field.

We need to think about how to ensure that enough stakeholders have developed their own plans of action and strategies to address the problem, so that once the project ends, a sustainable dynamic is maintained.

While some recommendations can be relatively quickly put in place, it will take a few years for most recommendations to be fully implemented and to bring lasting changes on the ground for the security of health-care providers.

The challenge ahead will therefore be to be able to keep the mobilisation around the issue beyond 2015, both within the Red Cross and Red Crescent Movement and with all the different partners that came together around the project.

Although we were able to mobilise and sensitise many key actors around the issue, even when the expert workshops are well under way and recommendations are being elaborated, we do realise that the real challenges lie ahead of us and concern the implementation of those recommendations

in 2014–2015. This is of course the key issue, because it is only once the recommendations are being applied on the ground that we will hopefully see a difference for the patients. Our energy should therefore be geared towards promoting the implementation of the recommendations by different stakeholders.