



EVENT REPORT

HEALTH CARE IN DANGER – FROM CONSULTATION TO IMPLEMENTATION

- Date:** 3rd December 2013
- Venue:** Royal Society of Medicine
- Partners:** International Committee of the Red Cross (ICRC), the British Red Cross Society and the Conflict and Catastrophes Forum of the Royal Society of Medicine
- Background:** The ICRC's Health Care in Danger project, seeks to address the problem of violence affecting healthcare in armed conflict and other emergencies.

This conference followed a series of workshops and meetings with experts across the world which developed recommendations and discovered best practices in the field of healthcare, armed forces operational practice, national legislation and protective measures that can be taken to reduce the impact of war and violence on healthcare.

On 3rd December the participants in London were asked to look at three areas related to the protection of healthcare and to discuss examples of best practice and recommendations as to how to better understand the problem of violence against healthcare. They were then asked to evaluate these and discuss how they may be replicated or implemented in situations of war and violence across the world.

These three areas were: collating data on the problem, the protection and safety of healthcare workers themselves, and finally security measures that can be taken to make ambulances and hospitals safe.

This event aimed to benefit from the feedback of an expert audience. It also wanted to prompt the self-analysis of practitioners and experts as to how they as individuals or groups provide or support healthcare provision in conflict.

EVENT SUMMARY

Introductions

President-Elect of the Royal Society of Medicine, Mr Babulal Sethia welcomed participants to the event before handing over to President of the World Medical Association, Margaret Mungherera. President Mungherera gave an account of her own experience of violence against healthcare in Uganda and said that it is important to sustain the provision of healthcare during times of armed conflict because the health consequences of sustained violence are massive and health workers play an essential role in minimising trauma and alleviating suffering. She confirmed that the diversion of

health resources to deal with the long term effects of conflict adversely affects health services, including preventive medicine, across the board. Finally she said that national medical associations have a responsibility to document and report incidents of violence, provide training in ethics to their members, and lobby for protection of healthcare services and healthcare workers in partnership with national Red Cross societies and human rights organisations.

Deputy Director of Operations of the ICRC, Christophe Martin, spoke on behalf of the Health Care in Danger project, to provide an update on the work the ICRC is doing to address the problem of violence against healthcare, including through two recent publications: [The responsibilities of health-care personnel working in armed conflicts and other emergencies](#) and [Ambulance and pre-hospital services in risk situations](#). He said that the conflict in Syria will be remembered for the lack of respect for healthcare and concluded by asking the audience to reflect on how their own activities can be improved or made more effective by the best practice to be highlighted during the conference.

Panel 1: Data Gathering – The Challenge

The first panel was chaired by Professor Sir Andy Haines, Professor of Public Health and Primary Care at the London School of Hygiene and Tropical Medicine. It began with a presentation by ICRC Medical Advisor, Dr Bruce Eshaya-Chauvin, as to the importance of data - how it allows groups to intervene with decision makers, how difficult it can be to collect and what are the criteria to focus on when gathering information. He emphasised that it will be impossible to comprehensively record the problem of violence against healthcare, but that qualitative analysis can help further understanding of the issues involved. Bruce also pointed out that those killed/wounded as a result of violence against healthcare are the tip of an iceberg, composed lower down of those affected by increased risk of mortality, mental health problems, the aggravation of existing vulnerabilities and risks placed on healthcare structures themselves. Lastly he explained that data analysis must be contextual – violence against healthcare in one country is difficult to compare with the situation in another.

Mr Henry Dowlen, President of the Conflict and Catastrophes Forum, next presented the work of [NHS Protect](#) - the government body in the UK that monitors violence against healthcare and has the responsibility for protecting National Health Service workers. The biggest cause of violence against healthcare in the UK according to NHS Protect data, is mental health-related, which is on the rise, however Henry commented that it isn't fully known whether this rise is down to improved reporting and collation of events. Overall violence against health workers in the UK increased by 6% from 2011-12 to 2012-13. One of the problems the NHS faces is that the only recourse to action by health staff in the face of potential violence is to try to de-escalate tensions through "relational security", meaning recourse to non-violent means of calming an agitated person down.

Rudi Coninx, Coordinator for the Policy, Practice & Evaluation Unit at the [World Health Organisation](#) (WHO), finished the first panel discussion by introducing the engagement and mandate of the WHO with respect to violence against healthcare, including its role to collect data on such violence. He then illustrated challenges to collecting data, including in relation to double counting, confidentiality, who does the reporting, and how far to document consequences of attacks including indirect health consequences (such as high rates of caesarean sections being performed in Syria). There is a problem, he said, with chronic under-estimating of the extent of the problem, including the effects of

obstruction to preventive medicine, such as polio vaccines in Syria. How long, he asked, until there is a case of polio in London as a result?

Panel 1: Discussion

Key points made in the discussion on data gathering included:

- What are the alternatives to working with Health Ministries to collect data?
- Syria is the best example for understanding the problem of violence against healthcare, but the worst place to find solutions
- How can the validity of data be assured? Does it have to be accredited, or does WHO/ICRC use a sampling methodology?
- Data is only important if you do something with it, and the purpose of data collection should be clear in advance
- The lack of reliable data means that interested parties can distort analysis for political or partisan reasons, which may adversely affect a humanitarian response
- If data cannot be collected, this can mean that a response cannot be provided because agencies are not present to undertake either
- Data should be used for advocacy purposes - what does it say about the adherence of parties to the conflict?
- There needs to be a baseline to understand data collected on this issue - the level of degradation in a given context is more significant than one set of statistics
- There must be an emphasis on ambulance drivers and their exposure to violence

Panel 2: The Protection and Safety of Healthcare Workers

The second panel was chaired by Mike Adamson, Managing Director of Operations for the British Red Cross. Head of Programmes at [Médecins Sans Frontières UK](#), Andre Heller Perache, began the second panel by explaining the way that MSF responds to risks to its staff in connection with violence against healthcare in a given context. He explained that the organisation's approach is flexible and context specific, meaning that there may be different concerns and action taken for different roles performed by MSF staff, as well as taking into consideration the country and community in which MSF is working. MSF analyses possible threats to its healthcare workers and adapts its security plans to reduce its exposure in various ways. Safety is best ensured, he said, through practical decisions such as being aware of the times of day when roads are most dangerous, but is always also derived from the utility and necessity of emergency medical aid in time of crisis. Close proximity to and understanding of local communities and working with prominent leaders/figures in society is also crucial. Lastly, communication is key to security, including explaining to all actors what it is to be an impartial aid actor.

Brigadier Martin Bricknell, Head of Medical Operations and Capability at Joint Forces Command for the [Ministry of Defence](#), next presented the UK armed forces' position on the protection of healthcare workers. He praised the work of the ICRC and the organisation's guidance document: [Health Care in Danger: The responsibilities of health-care personnel working in armed conflicts and other emergencies](#). He also described as helpful the ICRC's focus with regards to violence against healthcare in other emergencies, including the subsequent discussions the organisation has had with armed actors on adherence to and respect of international human rights law. From the UK's

perspective he said it is essential that armed forces abide by the law and appropriate codes of conduct. He welcomed the British Medical Association's [Armed forces: ethical decision making](#) toolkit and explained the approach of the UK's military medics as 1) protection of self, 2) protection of patients and 3) advocating for compliance with International Humanitarian Law.

Lastly Professor Vivienne Nathanson, Director of Professional Activities at the [British Medical Association](#) spoke about ethics and safety in conflict and disaster situations for medical personnel. She spoke of the tensions between the duties of healthcare workers to patients, society and personal safety. The strength of ethics in such a context, however, is that it takes a humanist model and allows respect for people and cultures - it has, she said, an international currency. Turning to the military, she said that it is important military medics conduct their duty according to the ethical standards of civilian practitioners formed on the basis of fairness and trust. Lastly she said that for a health professional to cooperate with torture, or cruel, inhuman and degrading treatment is so obviously wrong, however this message needs to be constantly re-asserted because it continues to happen.

Panel 2: Discussion

Key points made in the discussion on the protection and safety of healthcare workers included:

- International aid staff are able to leave a dangerous place, whereas national staff normally cannot – agencies must recognise the limits of the latter but provide the same support and protection
- It isn't about the size of an agency that means it is able to distance itself from belligerents and armed forces to ensure its neutrality - small as well as big organisations are able to, and should, do this
- Healthcare workers need educating to understand that they can have political views, but professionally they cannot take sides in a conflict in the service they provide
- Military medics are not impartial, however they have an obligation to do no harm, including to others providing healthcare. International armed forces must in addition focus on supporting local security forces to protect local health structures
- Delivering what you say you are going to, by aid agencies, builds trust. Organisations also have a responsibility to make the world aware of horrific acts, such as use of chemical weapons.
- The ethical position of healthcare workers cut off in exceptionally difficult circumstances (such as in besieged areas in Syria) is to do your best. The responsibilities of others who know this is happening, is to lobby on their behalf

Panel 3: Physical Safety for Hospitals and Ambulances

The third panel was chaired by Sir Thomas Hughes Hallett, Executive Chair, Institute of Global Health Innovation, Imperial College London. Sharonya Sekhar, Policy Advisor, at the [Canadian Red Cross](#) (CRC) kicked off this last panel and presented the findings from the conference she had led on behalf of the CRC in Ottawa. This conference had examined ways to ensure the physical protection and security of health facilities and made detailed recommendations on how to best protect health structures such as hospitals and clinics to ensure the safe delivery of health care during conflicts and emergencies. She emphasised that a key finding in Canada had been that context specific solutions should be sought. In depth and systematic analysis should be done to gain an overall understanding

of the context as well as to identify the types of threats to the healthcare facility. Solutions should be designed accordingly, including whether to mark hospitals, or keep them hidden. Dialogue with parties to the conflict should be collaborative and continuous – as perceptions, she explained, are key.

Dr Mohammad Awadeh, Primary Health Care Director for the [Palestine Red Crescent](#) Society (PRCS), next presented the work of the PRCS Ambulance teams in the Occupied Palestinian Territory (West Bank, Gaza and East Jerusalem) which have developed their own best practice in the past decade, working in often very difficult and violent situations where acceptance of their work is not always guaranteed. Dr Awadeh went through the specific, contextual challenges that the PRCS faces, including direct attacks on its ambulances, premises, staff and volunteers, collateral damage and problems of perception. He then explained the ways in which PRCS has overcome these risks to enable the organisation to deliver healthcare, including by travelling during the day and coordinating with the ICRC to secure safe access for medical teams and ambulances.

Finally Mr David Nott, Consultant General Surgeon at Chelsea and Westminster, Royal Marsden and St Marys Hospitals as well as former MSF, British Red Cross and ICRC delegate, reflected on his own experiences of violence against healthcare and how in particular this has affected ambulances and hospitals. David showed images from Sarajevo, Chad, Darfur, Libya and Syria of times when healthcare has not been respected and spoke movingly about the work he undertook in summer 2013 for the organisation [Hand in Hand for Syria](#) in Aleppo.

Panel 3: Discussion

Key points made in the discussion on the physical safety for hospitals and ambulances included:

- Does the nature of the threat to hospitals and ambulances affect the way in which healthcare workers respond, -ie. criminality vs conflict?
- No - what matters is the weapons being used and emphasising the legal protection that exists for healthcare in either situations of conflict or emergency
- The changing role of healthcare workers in conflict was emphasised by Margaret Mungherera – she gave the example of a specific healthcare worker affiliated to an armed opposition group providing healthcare to all sides, who may be perceived as a “liberator”, but who may eventually become Minister of Health
- Super-charged physical protection is not the answer to protect healthcare during conflict and violence as the technology would be either stolen, perceived as connected to an armed force and/or make healthcare workers even more of a target to armed actors
- Is now the time for health organisations to make a statement against President Assad as a doctor committing violations against IHL and healthcare?
- Misuse of ambulances is a violation of IHL - in some cases, it is an example of perfidy, which is a grave breach of IHL that constitutes a war crime.

Conclusions

Dr Margaret Mungherera and Geoff Loane, Head of Mission for the ICRC in the UK and Ireland, both provided closing comments to the conference, thanking the participants and speakers for their time

and engagement and emphasising once more that this is a problem that requires action, communication and concern.