Ministers of Health Meeting on Protection of Health Care from Violence

23 May 2022

Report

Overview

The Ministers of Health Meeting on Protection of Health Care from Violence took place on 23 May 2022 at the headquarters of the International Committee of the Red Cross (ICRC) in Geneva, Switzerland. The organizing committee was made up of representatives from the Red Cross and Red Crescent Movement (the ICRC[1] and the International Federation of Red Cross and Red Crescent Societies), the Swiss Government and the Safeguarding Health in Conflict Coalition.

Six years ago, the UN Security Council approved Resolution 2286,[2] with the UN Secretary-General then issuing recommendations on its implementation.[3] However, progress in implementing the resolution has been slow and fresh momentum was needed, which is why this meeting was set up. The aim was to bring Ministers of Health and ministerial representatives together to engage on the issue, since it is an area in which Ministers of Health have a legitimate leadership role, but their engagement has been under-leveraged. Ministerial participants from a total of five countries met to discuss the challenges they faced and share good practices in the domestic implementation of measures to protect and prevent violence against health-care facilities and personnel.

The event provided a non-politicized environment in which participants could work towards the meeting aims, which were to: foster dialogue and connections among representatives of ministries of health and lay the foundations for participating ministries to continue to build on this work at the regional and global levels.

The meeting was held under the Chatham House Rule.[4] As a result, this document provides a summary of the discussion but does not indicate which meeting participants expressed particular views. Instead, the topics discussed have been grouped by theme. This summary therefore does not reflect a consensus view but rather is intended to serve as a refresher for those who took part in the meeting and to provide a general overview of the outcomes for interested stakeholders.

Background

UN Security Council Resolution 2286 focuses on preventing and addressing violence against health care in armed conflict. Yet the measures set out in the resolution are not meant to be implemented only if a country is engaged in an armed conflict. Implementing measures to increase the safety and security of health systems in peacetime helps to secure access to health care, increase preparedness, enhance the well-being of health workers and ensure that everyone respects health-care workers and facilities.

Ministers of health have shown increasing interest in strengthening the preparedness of health systems in situations of violence, and in several countries, have championed actions that increase protection and security. With this in mind, the meeting was an opportunity to better understand, encourage and leverage the leading role that Ministers of Health can play as ambassadors of health-care protection domestically, regionally and globally.

The meeting was particularly timely given the recent experience of the COVID-19 pandemic and the burden it had placed on health workers. Furthermore, 2022 marked the 10th anniversary of the World Health Assembly resolution that gave the World Health Organization a leading role in protecting health care.

[1] See also, https://healthcareindanger.org/hcid-project/
[2] Resolution 2286 (2016) / adopted by the Security Council at its 7685th meeting, on 3 May 2016, S/RES/2286. Available at: https://digitallibrary.un.org/record/827916?ln=
[3] Recommendations of the UN Secretary General, submitted pursuant to para 13 of SC resolution 2286 (2016), S/2016/722. Available at: https://reliefweb.int/report/world/recommendations-un-sg-submitted-pursuant-para-13-sc-resolution-2286-2016-measures
[4] The Chatham House Rule: 'When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.'

Structure of the discussion

The opening and closing remarks were made by representatives of the co-hosting organizations, with the meeting moderated by an ICRC representative. The opening remarks focused on how violence against health care in all instances and in all forms profoundly hampers the delivery of effective, humane and comprehensive health services, and how attacks on medical services are a violation of international humanitarian law *and* a major concern for the overall health sector – affecting individuals at every level and requiring a globally shared responsibility to implement existing rules. A short overview was also provided of the kind of work that Ministers of Health have been doing in this area, providing the backdrop for participants to share their own experiences.

Participants were sent two rounds of questions to prepare in advance and responded to them in the statements they gave at the meeting. Those questions were:

First: **What have been the current challenges your Ministry has faced in the protection of health care and prevention of violence against health care? Describe some of the work and best practices your Ministry is doing in this area**; and

Second: **How can Ministers of Health lead in protecting the medical mission by using their role to expand these practices, influence others and share this experience across regional and global platforms? What supports should exist for further work together on the issue?**

The responses given were cross-cutting and, in some cases, combined into one statement. But they can nevertheless be broken down into the following four interconnected themes:

1) Identifying key stakeholders, defining the issue and understanding its challenges
2) Collecting data and sharing knowledge
3) Championing a multi-factorial approach driven by ministerial leadership
4) Ongoing engagement on implementation

Discussion topics

Identifying key stakeholders, defining the issue and understanding its challenges

People are at the core of health systems. This does not only include health-care providers and recipients, but also volunteers, drivers, cleaning staff, administrative workers, other stakeholders such as traditional and religious leaders who facilitate community engagement, people providing counselling and referral services, and the governing bodies that support and regulate health systems, including ministries of health, magistrates, law enforcement, and, in some cases, the military and even non-state entities.

Gaining an understanding of the relationships between these groups and the infrastructure that supports them can make it easier to produce clearer working definitions of what violence against health care is and to ensure that those definitions reflect different realities and legal frameworks, i.e. workplace violence, violence from criminality, violence amidst conflict, etc. Many of the participating countries agreed that having better definitions of what constitutes violence against health care across different contexts was crucial to developing a multi-factorial approach to protecting health care from violence. Here are some of the comments from the countries taking part:

- We should scrutinize violence and not take certain categories for granted: violence may or may not be conflict-related; it can be domestic or international; it may be instigated by civilians (e.g. patients or relatives of patients); it can be physical, psychological or emotional; and it could be against facilities or workers.
- It is important to look at conflict *and* non-conflict-related violence, since aggressors can vary depending on the scenario. Anyone can be a perpetrator or a victim.
- Most of the measures discussed in relation to violence and attacks on health systems are not only applicable to conflict situations or even situations of violence but can, for instance, be part of general emergency preparedness and response efforts.
- It is important to be aware of the potential for negligence, harm or insensitivity by the health workforce towards patients.

Some of the overall challenges and responsibilities that participants spoke about in protecting health care from violence centred on:

- Providing support to victims of violence and implementing safeguarding mechanisms
- Fostering community engagement and dialogue with a range of stakeholders to generate respect for health care

- Evaluating risks and vulnerabilities, at facility level and at regional level, to identify vulnerable areas and ensure effective responses for those most affected
- Improving the security of clinics and hospitals
- Acting as a liaison with the country's security forces
- Engaging in dialogue with armed groups and non-state entities
- Collecting data to improve monitoring of violence, as well as of response and surveillance efforts
- Providing training and guidance to health workers on ethics and respectful and safe behaviour
- Designing and implementing emergency preparedness protocols, including for emergencies, that include the prevention of violence against health care
- Launching media and other awareness campaigns with non-governmental organizations (NGOs) and other groups.

A few Ministers and ministerial representatives shared examples of the violence committed against the health services in their country. They mentioned the toll that decades of violence and conflict had taken; direct attacks on health workers and infrastructure; hundreds of destroyed facilities; attacks that stoked religious tensions; and public misconceptions that health-care workers are not there to help but to harm.

Looking beyond conflict situations, they also all said that the scope of and response to the COVID-19 pandemic had raised new challenges, including the lack of information and resources, increased harassment and attacks, and new types of stress related to working conditions (e.g. doctors who were not allowed to go home to families and communities during lockdown periods).

Collecting data and sharing knowledge

Many meeting participants identified data collection as a critical baseline tool to help protect health care from violence in their countries, with one minister noting that the pandemic had provided the necessary momentum to shift from a decentralized health and data collection process to a unified system. One representative, from a country with a data collection system in place to record cases of violence against health care, stressed the urgent need for more anonymous, consolidated data to give countries a bigger and more accurate picture of what is going on.

Participants gave examples of data collection process and opportunities for knowledge sharing at the national, regional, international and peer-to-peer levels. Examples included:

- A unified data collection system that uses data to identify the country's most vulnerable areas and where enhanced security is needed.
- A roundtable held in the state's capital, at which the Minister of Health worked with the minister of the interior, the minister of justice, the minister of defence, the security forces and other top officials to create plans for pandemic response and related protection measures.
- A longitudinal data collection system that logs all individual cases of attacks against the health-care system with the aim of determining, for example, if a case is related to armed conflict or another cause (e.g. a quarter of that country's reported cases in 2021 related to tensions caused by the pandemic, while the majority related to armed violence).
- Early plans for a national consultation on the protection of health care that would allow key stakeholders in the country (ministry of health, NGOs, justice department, law enforcement and others) to take stock of present standards, encourage cross-team collaboration and create an implementation plan.
- A large regional meeting with neighbouring countries' Ministers of Health to share best practices and ensure buy-in within and among governments.
- Continued collaboration with humanitarian organizations such as the International Red Cross and Red Crescent Movement, which several states mentioned as having offered critical support and cooperation in expanding services, including COVID-19 vaccinations.

Here, the focus was on the need for Ministers of Health to work with colleagues across disciplines and at all levels as part of a multilateral effort to protect health care. This, in turn, pointed to the need for a multi-factorial approach.

Championing a multi-factorial approach driven by ministerial leadership

Some meeting participants noted that a specific methodological approach was needed to ensure continued collaboration and good practices – whether nationally or across ministries. As one of the co-hosts recalled, a Minister of Health had once recommended that addressing violence against health care should in fact become a discipline within health management, one for which a systematic approach was taken and in which Ministers of Health played a key role.

As violence against health care stems from multiple factors, a multi-factorial approach must be taken to address it. To this end, meeting participants brought up the importance of context – being aware, for example, of local realities in different countries, while also acknowledging that there are some integral components of any working approach

to protecting health care from violence. Good practices identified by the participating ministries based on their experiences and results included the following:[5]

- Provide social support to victims of violence and general support for all health workers
    - Some states have granted special legal protection to health workers (similar to that afforded to journalists or human rights activists).
    - There should be safeguard mechanisms for victims and their families, with ministries of health and states being responsible for prevention, and, as one state mentioned, some kind of life insurance should be provided to a health worker's family should something happen to them.
    - Emergency care should be provided free of charge. One state spoke of ministry of health-led legislation that ensured that no accident victim paid for health services, including transportation and hospitalization, for the first 48 hours.

- Provide psychological support services to health workers
    - One state's ministry of health representative said their ministry is now responsible for providing psychological support services to health workers after violent incidents (e.g. if a family member is killed).

- Provide training on the protection of health care and related topics for the health workforce
    - Provide safety training in case of attacks
    - Educate workers on their rights and responsibilities
    - Set up a uniform process for workers to document any physical or non-physical violence against them
    - Promote non-violent interactions in health-care settings and interactions with patients (e.g. patient handling and courtesy).

- Engage with all kinds of stakeholders whose cooperation is necessary to protect health care
    - Religious, spiritual and traditional community leaders play a key role in fostering active community engagement in health-care systems.
    - The media can play a role in education efforts.
    - Open lines of communication with non-state entities can ensure that they are involved in the debate, for the purposes of both health and peace.
    - Education campaigns should focus on raising awareness, norms and behaviour change.
    - Social media can be harnessed to raise the profile of and respect for the health workforce.

- Increase the security for health workers and infrastructure
    - Military personnel can give cover to medical workers in the field.
    - Workplace risks regarding violence against health care should be identified.
    - It is important to engage in direct dialogue to create protocols with security forces (police) for enhanced surveillance in the most vulnerable areas.

- Strengthen existing legislation and consider new regulations and accountability frameworks where helpful
    - Ensure that the law is implemented, criminalize violence and ensuring the necessary reporting and accountability mechanisms are in place
    - Make sure that workers and other stakeholders are aware of the sanctions in the event of an error or wrongdoing at all levels of the health system, from the highest political level to a hospital's human resources, and clarify those sanctions
    - Ensure that there is a mechanism for auditing regulations that leads to the judiciary
    - Draft bills that take into account multiple stakeholders (e.g. both health workers and health-care recipients).

- Build public trust in health-care systems
    - Ensure that health and other front-line workers are present in communities before a problem arises, so that they can establish a rapport and open lines of communication
    - Use specific emblems[6] to identify health-care facilities, transport and workers, based on domestic standards
    - Encourage the Minister of Health to be visible and impartial

[5] The bulleted items under the sub-headings below are not meant to be exhaustive or explanatory, but rather indicate some key points made by meeting participants.
[6] Examples shared in the meeting on the topic of dedicated indicative emblems were not exclusive to conflict but noted the effectiveness of peacetime usage.

    - Have feedback and adjustment mechanisms in place to address local needs and concerns during an emergency – slight adjustments in protocol can go a long way in reassuring people.

- Capacity-building and strengthening infrastructure
    - Ensure better transportation systems, especially ambulance and emergency services
    - Leverage new and existing technology (e.g. to explore telemedicine solutions with a view to optimizing processes).

Towards the end of the meeting, representatives from two countries provided further details of concrete ways to implement some of these measures. One suggested developing an evidence-based action plan with advocacy packages, while another had brought with them a long-standing manual on protecting health care promoted by their ministry. The manual includes the emblem displayed on medical buildings, vehicles and workers in the country and sets out, among other things, the roles and categories of medical personnel as well as the regulatory frameworks and accountability mechanisms used to make sure that the rules are implemented. The ministerial representatives said that the manual was part of more than two decades of intersectoral collaboration within the government, and especially the ministry of health. Each month, there is a gathering of stakeholders across government institutions under the aegis of the ministry of health to coordinate their strategies to protect medical services.

Ongoing engagement on implementation

Implementing a multi-factorial approach takes time and resources. One participant said that "It's not just something you can do now and get a result; it's something you invest in over years before you see changes." In particular, it was noted that bringing about change in deep-rooted behaviours requires a lot of advocacy work. Investing in the training, safety and well-being of the global health workforce is a way of supporting some of our greatest assets – the people who make up the backbone of our health systems. Moreover, protecting health systems against violence is a cornerstone of health systems strengthening overall.

Going forward, cross-team collaboration and leadership, increased resources and support, and continued multilateral engagement are needed to ensure collective progress towards implementing UN Security Council Resolution 2286.

Some participants noted a need for better funding for data collection and analysis, campaigns and promotion work, anticipatory and preventive measures and strengthened infrastructure. The protection of health care should be systematically integrated into ministry of health agendas; this approach has great potential, particularly if Ministers of Health continue to come together and share experiences in order to expand and replicate good practices. In the medium term, the safety and protection of health workers should become a regular feature of WHO meetings, boosting policymaking, awareness and the implementation of such measures.

Participants left the meeting with the understanding that peer-to-peer, and perhaps regionally focused, exchanges with other ministries of health and agencies were the next step in continuing the conversation and momentum in protecting health care from violence. One minister said that more exchanges with countries experienced in the protection of health care would be beneficial. There was also mention of the potential for a declaration of engagement to be discussed at a later date.

#End of Report#