GLOBAL PROTECTION FORUM 2023

Coming Up…

GLOBAL PROTECTION FORUM 2023

Beginning in…

02:00

Child Protection AoR
Global Protection Cluster

Gender Based Violence AoR
Global Protection Cluster

Global Protection Cluster

Housing land and Property AoR
Global Protection Cluster

Mine Action AoR
Global Protection Cluster

INTERPRETATION

This room will have translation enabled for Spanish, French and Arabic speakers

Esta sala tendrá habilitada la traducción para los hablantes de Español, Francés y Árabe

Cette salle sera équipée de traduction pour les orateurs espagnols, français et arabes

يوجد ترجمة باللغات العربية و الانجليزية و الفرنسية و ايضا الاسبانية

AGREEMENTS

- Please note that this session will be recorded and streamed live on LinkedIn
- We invite and encourage you to have your video on if your bandwidth will allow
- If you have any questions for presenters throughout this year's forum, please put then into the Zoom Q&A, rather than the chat box
- Please note that the chat function will only allow participants to send messages to the host and/or co-hosts, not everyone in the meeting
- Please reach out to the technical team (Look for the word Producer in their name in the participant list) for any questions on interpretation or other IT issues

AGENDA

- Setting the Scene
- Sharing Best Practices from South Sudan, Yemen and Colombia
- Gathering your views
- Panel discussion: what else can and should be done?
- Closing remarks

SPEAKERS

Jane Mogeni, IRC Protection and Rule of Law Senior Technical Advisor, UK
Samira Tika, Whole of Syria Protection Cluster Co-Lead, Syria
Dr. Mukeshkumar Prajapati, Health Cluster Coordinator, South Sudan
Shehu Nanfwang Dasigit, IRC, Health Technical Coordinator, South Sudan
James Keah UNIDOR, Executive Director, South Sudan
Dr. Jose Antonio Bastos Amigo, ICRC Health Coordinator, Colombia
Dr. Osan Ghazi Ismail, WHO Public Health Officer, Yemen

Best Practices and Lessons Learned

GLOBAL PROTECTION FORUM 2023

South Sudan Health Cluster
24 October 2023

Background

- South Sudan is facing a **worsening humanitarian crisis** due to years of conflict, sub-national violence, food insecurity, climate crisis, and public health challenges.
- An estimated **9.4 million people (76 %)**, including 2.2 million women, 4.9 million children, and 337,000 refugees, are projected to need humanitarian assistance and protection services in 2023
- **The Humanitarian Response Plan (HRP) 2023** requests **$1.7 billion** to assist **6.8 million people** with life-saving and life-sustaining assistance and protection. **55 % of the total population** and **72 % of the People in Need**
- Aims to provide lifesaving essential health services to people in need, especially women, children, the elderly, persons with disabilities and chronic diseases, and survivors of violence.

Response Strategy

- Provision of life-saving basic **essential health services** in line with national and international humanitarian standards and is based on the epidemiological profile of disease outbreaks, seasonality, and trauma-related emergency requirements.
- Continue prevention, preparedness, and response activities **addressing outbreak-prone diseases** including COVID-19 and Ebola Virus Disease (EVD).
- Prevention, preparedness, response, and mitigation measures with special attention to **vulnerable groups including** women, children, and persons with disabilities.
- Strengthening **the cluster coordination mechanism at all levels**;
- Streamlining **referral pathways** for MHPSS, GBV survivors, and MCH emergencies; supporting **Community Health Systems**
- Targets 3.6 million people with health interventions in 2023, with a funding requirement of **$128.6 million**

Attack on health care: Scenarios

- About 24 incidents or more of violence against or obstruction of Health Care in South Sudan were reported, Safeguarding Health in Conflict Coalition SHCC report 2023)
- At least 20 health workers were kidnapped and 10 killed in these incidents, impacting health care providers' ability to maintain safe staffing levels to effectively meet patient needs.

Some key scenarios

- A health worker was severely injured among other key staff, The Same Year, health facility staff murdered by knife
- A medical staff member was murdered by unidentified individuals
- Several other attacks have been reported on either individual HCWs, health facilities characterized by lootings/vandalization of supplies or direct attacks on communities/beneficiaries, road ambushes on vehicles with HCWs, supplies

Attack on health care: Consequences

- Suspension/closure of humanitarian services
- Closure of facilities
- Staff incur physical injuries and have to be evacuated for medical attention
- Staff subjected to psychological torture
- Significant reduction in health service consumption; subsequent increase in deliveries at home
- Disruption in the supply chain for critical medical Supplies

Attack on Health Care: Recommendations

- Organizations/Partners
  - Improve physical infrastructure including perimeter fencing
  - Use Early warning mechanisms: Community, Government, Interagency
  - Friendly and non-violent feedback mechanisms for patients and their relatives on healthcare services
  - Use existing monitoring and reporting mechanisms of attacks on healthcare to strengthen accountability efforts (such as WHO SSA, OCHA reporting mechanisms)
- Donors
  - Support with sufficient funding to meet identified health needs according to the Humanitarian Response Framework
  - Advocacy on safety and security of humanitarian assets, workers, and systems.
- Governments
  - Accountability and legal framework in place to protect Health care workers, assets, and systems
  - Stakeholders' consultation and sensitization on responsibility and accountability

Lessons Learned

- Government Leadership, and Ownership

- Active sustained partnerships (NNGOs, INGOs, UN Agencies, MSF, ICRC, SSRC, IFRC, and others)

- Localization of services: Partnerships between INGO and NNGOs can limit suspensions of services, as NNGO likely to be able to continue to deliver in the face of insecurity.

- Constant engagement (communication) with stakeholders including communities and donors;

- Clusters' integration and mainstreaming (internal, external, across) with learning from existing practices.

HEALTH CLUSTER

Thank you

ATTACKS ON HEALTH CARE
Prevent · Protect · Provide

ATTACKS ON HEALTH CARE
Prevent · Protect · Provide

Contingency Planning: An Experience from Yemen

World Health Organization

Implementation context

23
Governorates

333
Districts

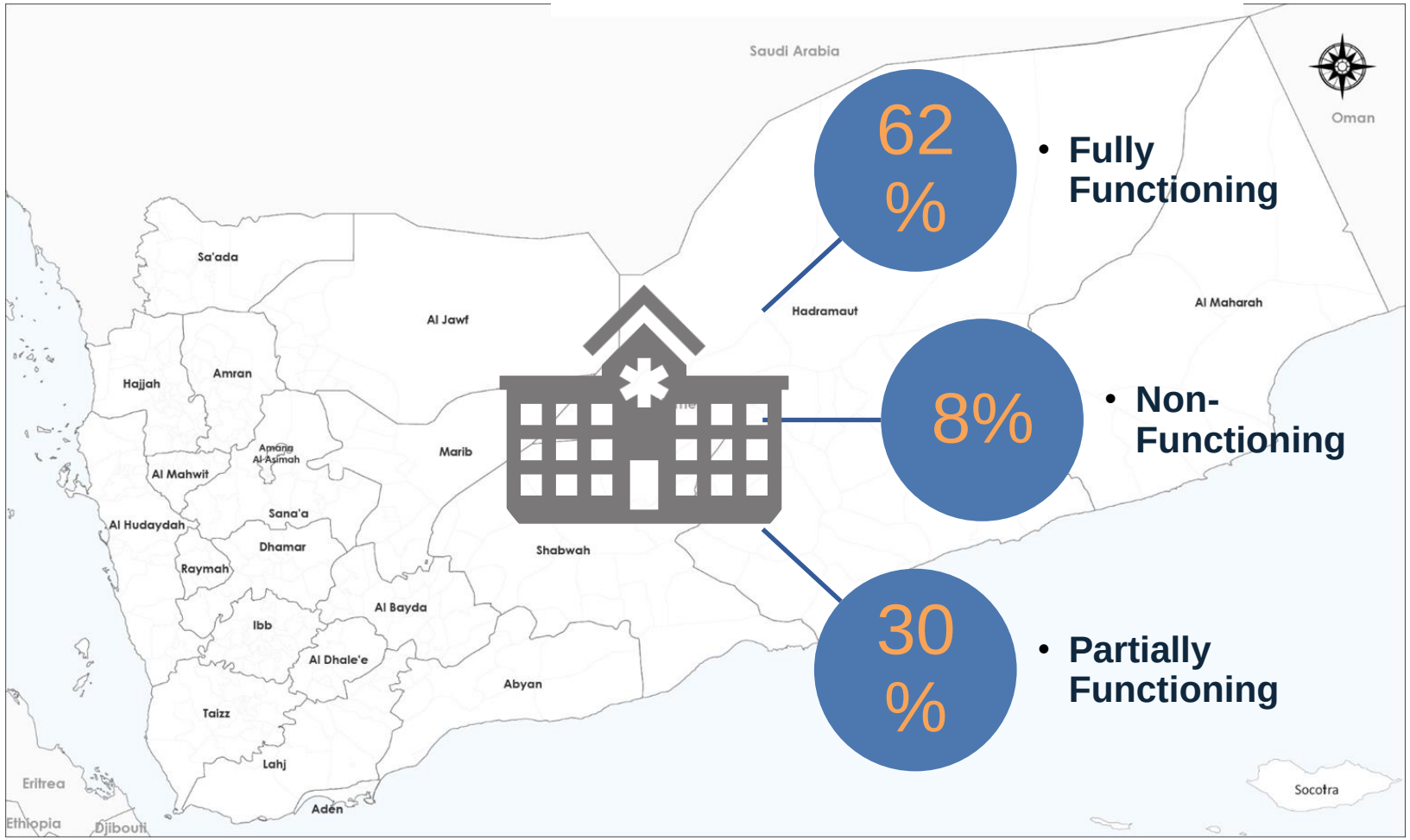
5539
Health Facilities

20.3M
PEOPLE IN NEED

3.1M
IDPs

11.7K
Deaths in Conflict area

73.5K
Injuries in Conflict area



WHO’s mandate & Surveillance System for Attacks on Health Care

Based on World Health Assembly Resolution WHA 65.20
Paragraph 2(8) calls on the Director-General "to provide **leadership** at the global level in developing methods for systematic **collection and dissemination of data on attacks** on health facilities, health workers, health transports, and patients in complex humanitarian emergencies

- WHO’s Attacks on Health Care initiative launched in response
  - —ensuring access to essential health services to emergency-affected populations unhindered by any form of violence of obstruction
- WHO’s Surveillance System for Attacks on Health Care (SSA) launched in 2017
  - —primary (but not the only) data collection system for attacks
- 19 countries/territories have reported attacks since

World Health Organization

Attacks on Health Care in Yemen

Dec-2017-Sep-2023

Status: All

Year, Month: Multiple selecti...

102 Attacks

36 Deaths

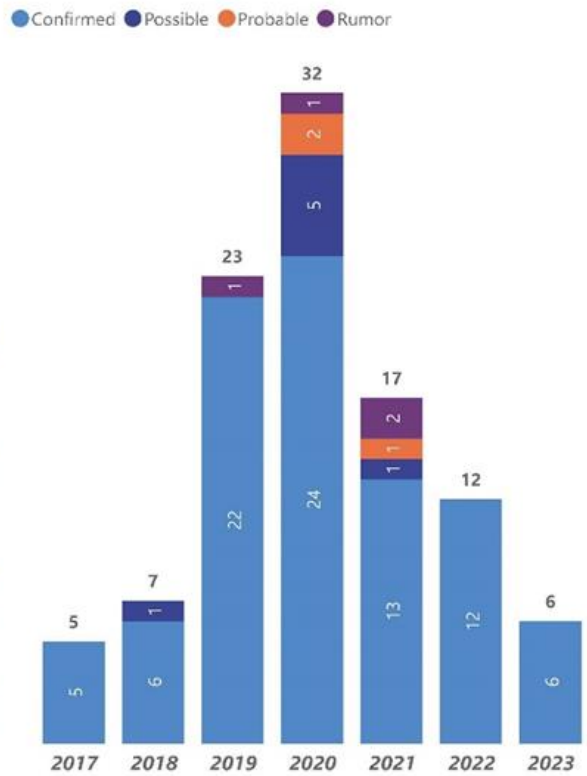
47 Injuries

7 attacks impacted **patients**

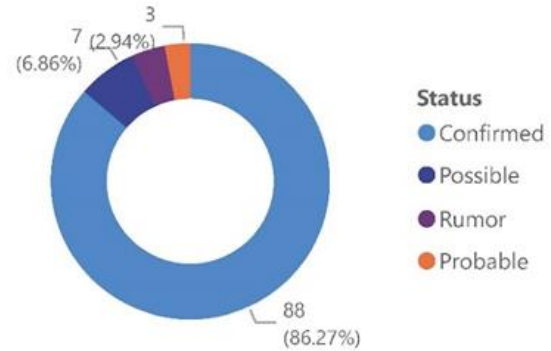
36 attacks impacted **health care personnel**

94 attacks impacted **health care facilities**

14 attacks impacted **health care transport**



Certainty Level



*CERTAINTY LEVEL THAT THE ATTACK ON HEALTH CARE ACCURRED BASED ON SOURCE INFORMATION

Types of attacks

Violence with individual weapons	23
Violence with heavy weapons	44
Obstruction to health care delivery	7
Threat or psychological violence	7
Assault	7
Removal of health care assets	9
Armed or violent search	4
Abduction/arrest/detention	8
Arson	1
Militarization of health care asset	3

Contingency Planning in Yemen: aim, implementation

Aim: Protecting access to health care services during conflict (in case the frontline health facilities were attacked and/or medical staff fled).

Implementation:

- “Frontline” hospitals: 2 hospitals in Hajjah and 1 hospital in Hodeida.
- “second line” hospitals: 3 hospitals in Hajjah.

Contingency Planning in Yemen: aim, implementation

Done by WHO:

- Effective coordination with health partners.
- Supplemented the stocks with trauma kits A&B, surgical supply kits, single blood bags, and IV fluids.
- Fuel, water and oxygen supply.
- Deployed surgical teams.
- Ambulances.

Criteria used to identify frontline & second line hospitals:

- Geographic (proximity to frontline).
- Hospital capacity.
- Onsite stock levels.

Contingency Planning in Yemen: Results

- The three second line hospitals are ready and continue to be on standby in case frontline hospitals become exposed to any type of attack or security threat.
- Sustained health service delivery in Hajjah and Hodeida despite armed conflict.
- Health contingency planning became a widespread practice in Yemen based on scenarios.

Challenges, lessons learned, applicability elsewhere

Challenges:

- Difficult to find qualified health workers for the facilities included in the contingency plan.
- Shortage in funding will affect availability of stocks for a contingency set-up.

Lessons learned:

- Contingency planning should be based on close understanding of the local conflict dynamics.
- Coordination with health partners is critical for success.

Applicability elsewhere:

- Anywhere with an escalation in conflict or shifting frontlines.

Next steps

- Collaboration between protection cluster and health cluster at national level will improve efforts to mitigate attacks and uphold the practice of healthcare amidst conflict.

PROTECTION OF HEALTH CARE IN COLOMBIA

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

ICRC

Child Protection AoR Global Protection Cluster

Gender Based Violence AoR Global Protection Cluster

Global Protection Cluster

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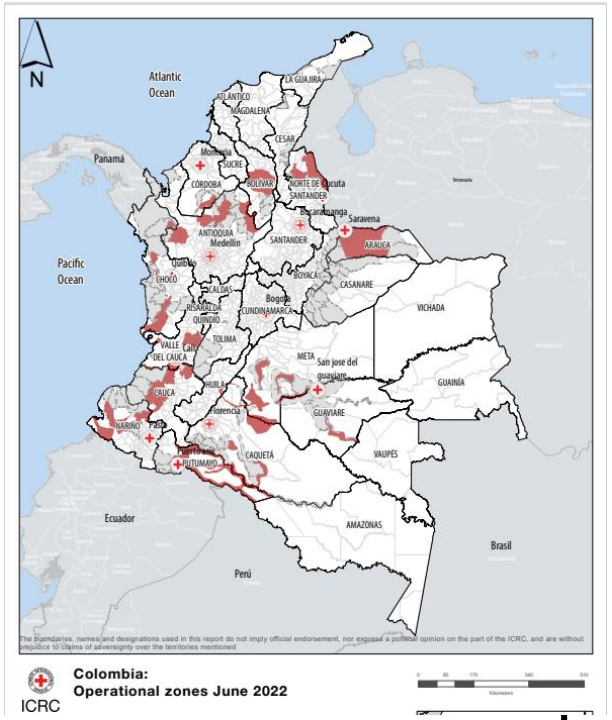
Jose A Bastos
ICRC - Colombia

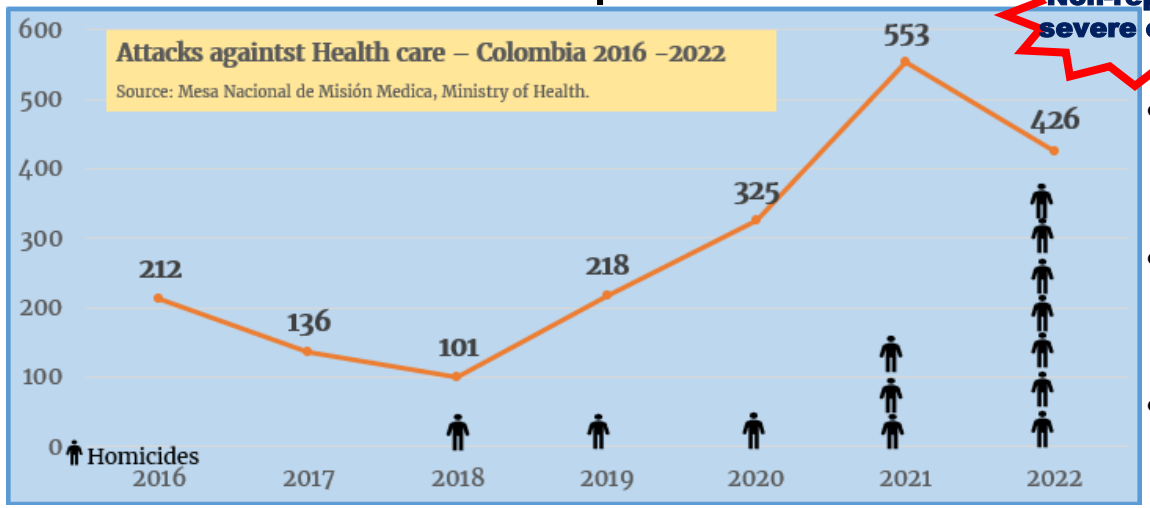
CONTEXT COLOMBIA

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



- Lower-Middle Income Country: GDP per cápita 6,131 USD. **High inequality** (GINI index 54,2; 7th worse)
- "Interpersonal violence" is 2nd/3rd cause of mortality
- "Hybrid" **dysfunctional health system**
- "Civil War" since 1964, "La Violencia" 1948-1958.), 2023: 7 NIAC (ICRC IHL Classification)
- 2009-2019: Colombia 1st / 2nd in reported landmine victims;2021: Colombia 3rd in conflict- related IDPs
- **Highly developed normative for the protection of health care (Mison Medica), with own emblem for identification.**

MISION MEDICA



Non-reported severe events

- **Sustained increase Violence Against Health Care (VAHC)** : 2018: 101 events; 2022: 426 events. With increased severity (homicides).
- In conflict areas NSAGs, State Security Forces, criminal/urban violence, communities and individuals, all are responsible for VAHC.
- In some conflict areas: decreased or no access to health care due to VAHC

ICRC Colombia, PROTECTION OF HEALTH CARE

1. ENGAGEMENT WITH "ARMS BEARERS"

(SSF and NSAGS):

- **Confidential Dialog, follow up of events.**
- **Disemination /Training on Protection of Health Care**
- ***Acces to health care for war wounded arms bearers***

2. WORK WITH INSTITUTIONAL SYSTEM:

- **National MoH: advisory role (Mesa Nacional de MM), advice on normative.**
- **Regional Health Authorities: technical and operational support).**

3. DIRECT SUPORT TO VICTIMS (Health Care Staff) :

- **Identification, support and follow up of events**
- **Awareness and training (rights and responsiblities)**
- **Mental Health Program ("Helping the Helpers")**
- **Security Management for Health Care Staff**
- **De-Escalation of Violence**

4. COMMUNITIES

- **Dissemination sessions, social media**
- ***"Friends of Health Care"***

ICRC

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

ICRC Colombia, ARMS BEARERS

1 Confidential DIALOGUE

2 Dissemination and training

3 Access to health care for wounded combatants

3.1 Coordination SSF / MoH for care of SSF WW in civilian health facilities

ICRC

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

ICRC Colombia, RECOMMENDATIONS

Colombian context and response to violence against health care are quite unique. **Response to violence against health care should be adapted to each context. "Good practices" are inspirational, rarely a blueprint.**

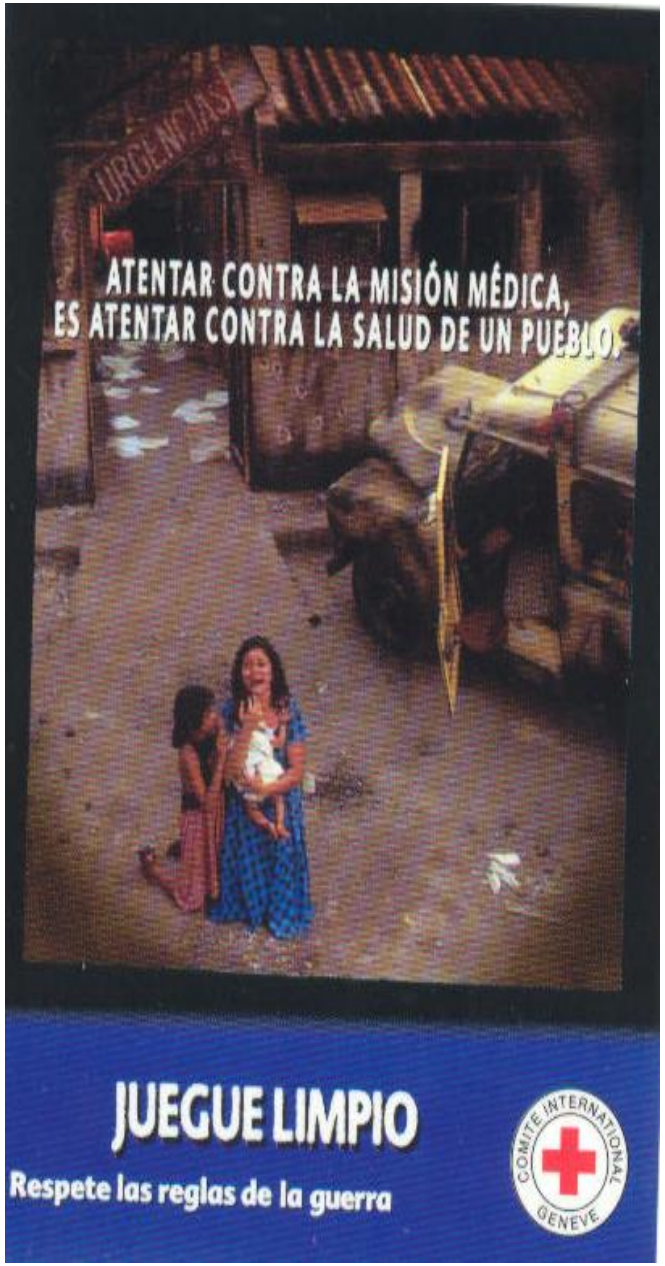
In functional States (not failed states), responsibility of the state in protection of health care should be advocated for, fostered and supported.

As in the case of Colombia, **developing a structured state response to violence against health care takes long time. Why not starting soon?**

Arms bearers (SSF and NSAGs) have a major role in violence against health care. Engaging with them can go beyond reminding them of their IHL obligations.

ICRC

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



LA MISIÓN MÉDICA SALVA VIDAS, PODRÍA SER LA TUYA ¡RESPÉTALA!

ES UNA CUESTIÓN DE VIDA O MUERTE

LA MISIÓN MÉDICA: ¿QUÉ ES Y QUIÉNES LA COMPONEN?

LA MISIÓN MÉDICA SALVA VIDAS, PODRÍA SER LA TUYA

ES UNA CUESTIÓN DE VIDA O MUERTE

La salud es de todos | Minsalud

Cruz Roja Noruega | Cruz Roja Colombiana | CICR

2019.1182COD 06/2019 5.000

FOLLETO

CLOSING STATEMENT (1/2)

- **IMPACT:** This session, and the recent attacks in crises such as Gaza and Ukraine, really bring home what happens when health care is under attack in armed conflict. The health personnel risk their lives to be able to provide support, often at a high cost to their mental health. Patients are often injured and killed during such attacks, and cannot access the lifesaving health care they need when affected services are suspended. Communities are deprived of access to health care: can no longer trust that they can safely go to hospital, safely give birth, safely bring their children for vaccinations

- **THIS MATTER IS OF GLOBAL IMPORTANCE:** Most of those attacks against health care take place beyond the headlines: at least 35 health workers were kidnapped in Cameroon last year. In the DRC, more than 20 hospitals were burned down in just 12 months. In Myanmar, as many direct attacks as in Ukraine were recorded since February 2021.

- **WHOSE RESPONSIBILITY IS THIS?**: It is the responsibility of Governments to provide safe and prompt access to health care. And to ensure the protection of health care. Non-state actors are also responsible to provide safe access to health care for the communities under their control. All parties to the conflict must ensure protection and safe access to health care. Almost all countries in the world have endorsed the right to health. That means that Governments are responsible for bringing health care in safe reach for all sections of the population, including persons with disabilities and other vulnerable groups. More than 7 years ago, the UN Security Council unanimously adopted Resolution 2286, which calls for greater protection for healthcare in armed conflict. It is time for States to re-affirm these commitments with practical action. Even in armed conflict, all conflict parties are to uphold international humanitarian law and international human rights laws, which dictates that health personnel, patients, medical vehicles and health facilities are protected.

CLOSING STATEMENT (2/2)

- **SO WHAT IS THE ROLE HUMANITARIAN ACTORS?**: It is clear that not all Governments and armed actors are able, or willing to comply with IHL & IHR law. In several situations, the communities have played a significant role to ensure the protection of health care, as do civil society networks and local actors. Where there are gaps, humanitarian and development actors have stepped up in support of the local and national capacities. The World Health Organization, through its ***WHO Attacks on Health Care Initiative***, has set up a system to monitor and respond to attacks, as Dr. Osan in Yemen has shown us. The Health Cluster coordinates local level response and advocacy with frontline health and human rights actors, as illustrated by the health cluster team in South Sudan. The Safeguarding Health Care in Conflict coalition brings together civil society actors to share data, provide analysis and advocate for change. Health humanitarian organizations such as IRC negotiate on a daily basis with communities and non-state actors to grant safe access to communities to healthcare. But this is not always sufficient.

- **COLLABORATION:** This cannot be addressed by just one actor alone. It requires strong collaboration between health and protection teams. The Joint Operational Framework established by the Health and Protection Cluster is an example of an initiative that can be used for such collaboration. Today, we've heard some good examples from South Sudan, Yemen, and Colombia. However, the different speakers also clearly highlighted the challenges, and what needs to be done urgently to address these issues:
  - Joint analysis by health and protection actors to understand the issues.
  - Exchanges between health and protection actors, to increase awareness of common objectives
  - Collaboration between health and protection for joint action and response to help to reduce violence and the impact of violence
  - Increased resources to end violence, and implement interventions to reduce such violence.

Attacks on health care is a protection concern that requires action at all levels from local to global, across sectors. We hope that this session has brought us one step closer to working better together to protect civilians. Thank you all for taking the time, we are looking forward to continuing the conversation.

THANK YOU FOR JOINING US