

# SECURITY RISK MANAGEMENT FOR HEALTH CARE SERVICES

Handbook for Addressing the Risks of  
Violence against Health Care in Insecure  
and Conflict-affected Settings



The security risk management for health care (SR4H) cycle

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- [!\[\]\(33b18af9a4b997eb52666cfeb3c44157\_img.jpg\) \*\*Module 2:\*\* Generating awareness and communicating to create violence-free environments](#)
- [!\[\]\(262b158440b847a82f89a14cab8644ec\_img.jpg\) \*\*Module 3:\*\* Assessing the risks of violence and increasing preparedness to better prevent and cope with it](#)
- [!\[\]\(f51929fecf7b0dc947ac13f4c4835e8f\_img.jpg\) \*\*Module 4:\*\* Responding to violent incidents](#)
- [!\[\]\(dfbf0e54bcca114319aa65c906feb8d0\_img.jpg\) \*\*Module 5:\*\* The aftermath of incidents, and working towards sustainable access to health care](#)
- [!\[\]\(64792950f1b7ee883a860b5f0af110c3\_img.jpg\) \*\*Module 6:\*\* Annex 1: Aide-memoire to support the risk assessment and context analysis and Annex 2: Examples of context analyses, risk assessments and contingency plans](#)

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# Foreword

Health care needs to be protected from violence. In insecure and conflict-affected settings, health care facilities and workers come under attack and patients are denied access to health care. This handbook offers guidance for health care providers on how to protect staff and maintain health services when insecurity and violence threaten health care infrastructure and workers, and people's access to care when they need it. Administrators and coordinators of health services can put in place practical measures that protect infrastructure and, most importantly, save lives. The handbook aims to support people responsible for running health care programmes in implementing best risk management practices, in light of the fundamental principle that health care service providers have a duty of care towards both staff and patients.

The contents of this handbook are based on a decade of monitoring incidents of violence against health care for the Safeguarding Health in Conflict Coalition and incorporates insights on the consequences of this violence collected by the Researching the Impact of Attacks on Healthcare (RIAH) project. The proposed approach has been informed by principles supported by the operational work of the Humanitarian Action Support (H2H) Network. The proposed solutions are based on a review of existing guidance and good practices of the NGO and humanitarian sector with decades of experience of working in conflict-affected environments.

The handbook offers operational and pragmatic solutions that are informed by reported patterns of violence, individual health worker's experiences, and studies of how violence disrupted the provision of services. It covers awareness of the risks of violence against health care, responses to violent acts, and the development of long-term sustainable changes that ensure greater protection for health care personnel, services, and infrastructure. The handbook proposes a framework that balances the rights and responsibilities of health workers and patients and the communities they come from. The aim is to promote safe working environments for health care professionals and efforts to ensure the continuation of health care during conflict.

The handbook has been written for health care providers working in conflict-affected areas. The suggested approach can be applied by health care providers during a humanitarian response, by health care providers working for national health service structures, and by voluntary health care initiatives. Funding bodies that support the provision of health care during conflict can use this handbook to identify support that their local implementing partner or partners may need to put better protection measures in place. Existing practice will vary between countries and health programmes, and as such requires locally adapted approaches to implementing best practice during emergencies and crises.

The handbook provides guidance on how to create awareness of the risks that health services may face during conflict, to prepare and train personnel to respond effectively to such risks, and to learn from tragic incidents how to develop and implement sustainable best practice. Awareness, preparedness, appropriate response, and sustainability are key building blocks of efforts to address violence against health care. To protect health care, the competent authorities also need to hold the perpetrators of such violence accountable.

We hope that the practical solutions proposed in this handbook provide helpful advice and actionable suggestions for how to better protect health workers, patients and access to care during conflict.

Christina Wille  
Director of Insecurity Insight

# Acknowledgements

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For suggestions for improvement, training or any other feedback please write to us at [info@insecurityinsight.org](mailto:info@insecurityinsight.org)

# Glossary

**Acceptance:** The strategy of serving a population not through imposing the presence of a new facility and teams, but by building trust and being accepted in that space as a positive contributor to the well-being of the population.

**Armed actors:** Soldiers, policemen, members of militias, members of armed groups, and any other persons who carry weapons, whether legally or not.

**Community:** A group of people joined together by a common interest, characteristic or experience such as geographic location, ethnic composition, age, faith or health care need.

**Contingency plan:** A series of planned actions to be carried out when an undesired event occurs.

**Disinformation:** False information that is deliberately intended to mislead or manipulate people.

**Ethical dilemma:** A complex situation in which a health care worker must balance different principles of health care ethics to find the best decision to implement and action to take.

**Impartiality:** The ethical duty of providing care without any discrimination, beyond the medical needs of patients.

**International humanitarian law (IHL):** A set of internationally agreed laws that are valid in times of war (armed conflict), and that grant special protection to teams providing health care in an impartial and neutral manner.

**International human rights law (IHRL):** A set of internationally agreed rights that are valid at all times, and that grant people fundamental rights such as the right to benefit from quality health care in a timely manner, and the right not to be the subject of violence.

**Medical neutrality:** The responsibility to refrain from engaging in hostilities in any way and the right to be protected while impartially providing health care.

**Misinformation:** Incorrect or misleading information. Misinformation does not necessarily have a specific malicious intent (disinformation is different in that it is deliberately designed to deceive people – see definition above). Misinformation can include inaccurate, incomplete, misleading, or false information, as well as selective or half-truths.

**Parties to a war or conflict:** Groups that are fighting each other, regardless of whether they are part of a state structure or not.

**Reactive behaviour:** Behaviour that is immediate, not the result of conscious thought, and not intended to cause harm, but is triggered by intense suffering and powerful emotions, such as when one receives news of the death of a loved person.

**Security forces:** Agents connected to a state-run structure (e.g. police, armed forces) that are in principle part of the various state structures designed to maintain law and order.

# Introduction

## About this handbook

This handbook **provides guidance on addressing violence against health care. It was developed to assist health services in middle- and low-income contexts affected by situations of insecurity, violence or war/conflict.** It provides advice on how to implement a range of actions intended to promote respectful and violence-free environments, and prepare individuals or organisations to face and respond appropriately to violent events/incidents and deal with the aftermath of such events/incidents.

The handbook has been written for administrators, managers and coordinators of health care programmes, and focuses on the duty of care and the responsibility to provide a safe environment for health care workers and patients. Health professionals have a medical duty of care towards their patients, which they can only fulfil if managers are able to ensure a safe working environment. The competent authorities (e.g. senior administrators and coordinators) have a responsibility to empower health programme managers with the knowledge and skills they need by providing them with appropriate frameworks to guide and govern their work and by holding perpetrators of violence against health services accountable.

The handbook recognises that few health care managers receive formal guidance or training on to respond to violence of some kind and ensure that health services they manage continue to function when violence erupts. Humanitarian organisations have developed security risk management practices over the past decades, and many humanitarian health care providers employ professional security risk managers to ensure that appropriate, effective risk management practices guide health care programmes when they are faced with violent events. In some high-income settings, manuals providing such guidance have been developed for hospital and ambulance personnel. This handbook brings together some of the best practice based on such existing guidance and proposes a framework adapted for health care providers working with limited resources in conflict-affected settings where appropriate risk management practices are not consistently implemented.

The implementation of the proposed guidance can be challenging if there are no dedicated personnel tasked with ensuring appropriate security guidance and risk management, no dedicated budget, and no contingency plans for responding to violence and ensuring security. The handbook therefore includes references to further guidance and reading materials that may help those responsible to develop the necessary infrastructure and human resource capacity to implement best risk management practices.

The objective of this handbook is to promote an approach that considers the safety and security of health professionals while ensuring patients' access to care. The aim is to enable the provision of health care during periods of insecurity or war. In essence, this means that health workers and the health infrastructure should be properly protected. Patients depend on health workers and properly functioning health care facilities, and they need to be able to access health care when they need care.

Many health workers live and work in areas affected by insecurity, violence, and war/conflict. In their efforts to deliver care even under the most difficult circumstances, they are often exposed to violence. In these challenging contexts, health care facilities strive to sustain the adequate delivery of services, and frequently have to deal with criminality, blockages or obstacles of some kind that limit their capacity to fulfil their mandate, and a fragile relationship with armed actors.

During conflict, demands on the health service change. Frequently, demands increase as more people suffer injuries or health impacts from the conflict, including malnutrition. Insecurity and the damaging or destruction of infrastructure make access to health care for those in need difficult, which often contributes to mortality during conflict.

The handbook considers ways to ensure the safety and well-being of health care workers and the safety and security of health facilities, medical supplies (equipment, medications), and medical transport, as well as the ability of people in need to access health services during periods of insecurity or conflict.

Security risk management practices that focus on context assessment, mitigation measures, and how critical<sup>1</sup> to the provision of health care particular programmes can help to protect staff, health care facilities and infrastructure, and access to health care.

In essence, therefore, the handbook has been written for health programme managers with the responsibility to enable effective programme delivery and manage any risks that may prevent this.

## Structure of the handbook

The SR4H handbook starts with a short description of the various forms of violence against health care that it addresses. The main part of the handbook is structured in four chapters that cover the key factors that need to be in place to ensure the appropriate management of risks that threaten health care. This is summed up in the following diagram:

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<sup>1</sup> The security risk management procedures proposed in the handbook do not treat all health services the same, but may give different weight to more critically needed services, such as an emergency department in a health care facility and ambulance networks.

Figure 1: The security risk management for health care (SR4H) cycle



**Awareness:** Generating awareness of possible threats facing health and communicating ways of managing these threats to ensure as far as possible a violence-free environment in which health care services can function properly.

**Preparedness:** Assessing the risks and putting systems and procedures in to better prevent and cope with violence before it occurs.

**Response:** How to respond if a violent incident occurs.

**Sustainability:** Dealing with the aftermath of violent incidents and working towards sustainable health care provision and access to health care.

Each chapter has three main sections:



**Elements that need to be put in place to prepare for action**



**Implementing activities, measures and other significant interventions to each step of the cycle**



**Particular sensitivities and points of attention that should be considered in that step**

The content is visually represented as a rolling cycle of activities, highlighting that all measures are part of the wider structure in which health care programmes are rolled out, and that their implementation requires continuous improvements and adaptation as part of the larger system. Entry points for implementation can be found at any stage of the cycle, and the guidance in this handbook does not have to be implemented step-by-step in the order in which it appears in the handbook. Many programme managers seek guidance on how to address violence following adverse experiences when they have attempted to respond to an incident, or because of the limitations imposed by their organisation's workplans or budget allocations.

The implementation of all the proposed solutions would require a substantial allocation of resources that are frequently not available and require an awareness of the importance of the proposed risk management measures within the wider health care system. This handbook can also be used to identify activities for workplans or project proposals as the starting point for efforts to design and implement safer practices.

The chapters also include boxes with tips, reminders and other important elements, and each chapter contains resources for further reading on a particular chapter's topic.

## How to use this handbook

The guidance given in this handbook is designed to provide support for those seeking to address violence against health care in a comprehensive manner, ranging from preventive to response measures, including actions to reinforce preparedness, enhance coordination and enable trust. In particular, the handbook has been written to guide health services working outside the humanitarian system that may face severe resource limitations, including no dedicated personnel responsible for security guidance or management, no dedicated risk management budget, and no ready-made contingency plans for dealing with violence and ensuring security. All chapters include references to existing guidance for further information on how to build internal systems to better protect staff and services during conflict.

The security risk management approach presented in this handbook is based on the **SR4H cycle of components** presented in Figure 1. The cyclical nature of the proposed steps determines that actions are not final until all steps have been implemented. However, implementation will never be fully and completely finalised, because an ever-changing threat environment and new experiences of threats to health care will always inform the four steps of the cycle, and each step will always need updating and improving. Therefore, the handbook and the guidance it gives provide a **sustainable and dynamic approach to continuously improving security risk management** and better protecting health care from violence.

The chapters follow the components of the SR4H cycle given in Figure 1 (and repeated throughout), which outlines the handbook's approach to the problem of risk management for health care, but this **does not mean that the order in which the steps are implemented must necessarily follow the order in which the handbook discusses them**, and different steps can be implemented at appropriate moments **in response to the specific threats faced at any particular time**. For example, a health service might start implementing "groundwork" activities for all steps of the cycle, before looking into the "action" section of a particular step. Alternatively, implementation

can start with response to an incident before addressing awareness or communication. At the same time, it is important to see all the individual measures as part of a comprehensive, interactive whole that contributes to a better system for ensuring the security of health care during conflict.

### **Recommendations for health care managers:**

- Start with the most relevant and appropriate actions given in the various chapters of this handbook.
- Propose or lead the implementation of individual steps that improve security management in your health service.
- Envisage a comprehensive security risk management approach to deal with possible threats, but focus one by one on individually achievable steps.
- Select the most relevant and feasible steps from anywhere in the full risk management cycle and try to get budget and staff time allocated to implement these steps.
- Discuss relevant ideas, define the specific steps that will be taken, delegate appropriate tasks, lead the development and implementation of the safety and security measures that are developed, and actively participate in their implementation.
- Explore the extra guidance material provided in this handbook according to the needs of your health service, guide your colleagues through the reading of the material and lessons learned from it, and ensure a person-centred approach to all measures.
- Mobilise state authorities and other stakeholders for support. In terms of possible support measures ranging from financial sponsorship to technical advisory support, much can be done in partnership with other areas of public services (firefighters, education services, civil protection), humanitarian organisations, academics and, when appropriate, state security agents.

### **Recommendations for donors, INGOs, governments and the relevant authorities:**

- *INGOs* (International non-governmental organisations) can use this handbook to start a conversation with their local implementing partner or partners to verify the extent to which they are prepared to respond to violence and to identify possible areas of support to give to them if they are operating in violent settings.
- *Donors, INGOs, governments and relevant authorities* can consider options for providing direct support, whether providing financial and technical support or training, or through partnerships with front line health care services.
- *INGOs, governments and relevant authorities* can implement the following actions:
  - Include data about violence against health care in the regular monitoring of programmes. This should include data on violence against staff and facilities, and the violent obstruction of access to health care. The objectives would be to better understand how violence reduces the effectiveness of health care programmes and then take appropriate measures to prevent this.

- Use mechanisms to identify the needs of staff and patients affected by violence and implement support for affected health workers. These processes should be based on the recognition that health workers are central to the quality of any health care system and that workers suffering from poor mental health and burnout are unable to deliver their mandated health services.
- Allocate budget for security training and actions related to security risk management adapted to health care providers.
- Include criteria for security risk management in the reference documents of health programmes, provide technical and financial support for their implementation.
- Insist on the implementation of a comprehensive security risk management approach even in peaceful areas to prepare facilities and personnel for potential changes in the context in which they operate by using a person-centred approach and avoiding the unnecessary securitisation or militarisation of health care.
- *Donors and INGOs* can support partner health services with continued sponsorship in the face of insecurity and violence. They should recognise that halting a programme in the aftermath of an attack has devastating consequences for access to health care in violence- and crisis-affected areas.

# Addressing violence against health care: Introduction

## Violence against health care

According to the World Health Organization (WHO), an attack on or violence against health care is **“any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access and delivery of curative and/or preventive health services during emergencies”**. Violence or harassment that happens outside of emergency settings, but within the context of the provision of care, is considered occupational violence under the WHO and International Labour Organization (ILO) framework.

This definition includes violent acts that might be against a person (i.e. a health care worker,<sup>2</sup> a patient, a family member accompanying a patient, or a community member who is present in a health care facility); against a structure (a health clinic, a first-aid post or mobile clinic, a hospital, a medical laboratory, a drug storage facility, etc.); or against transport vehicles (ambulances or any other official transport vehicle used to transport sick or wounded people). Violence might also be used to prevent access to health care. In this case, the most common are actions that block or obstruct the provision of health care in some way (denial of care, denial of passage for people seeking care, arrest of health care personnel, denial of the transport of medical goods, etc.).<sup>3</sup>

Violence against health care is a reality that occurs in war-affected countries or areas, during political and organised criminal violence, and during public health emergencies around the globe. Violence against health care may also occur in environments affected by violence, and even in peaceful areas, when a disaster or emergency is followed by an emergency response.

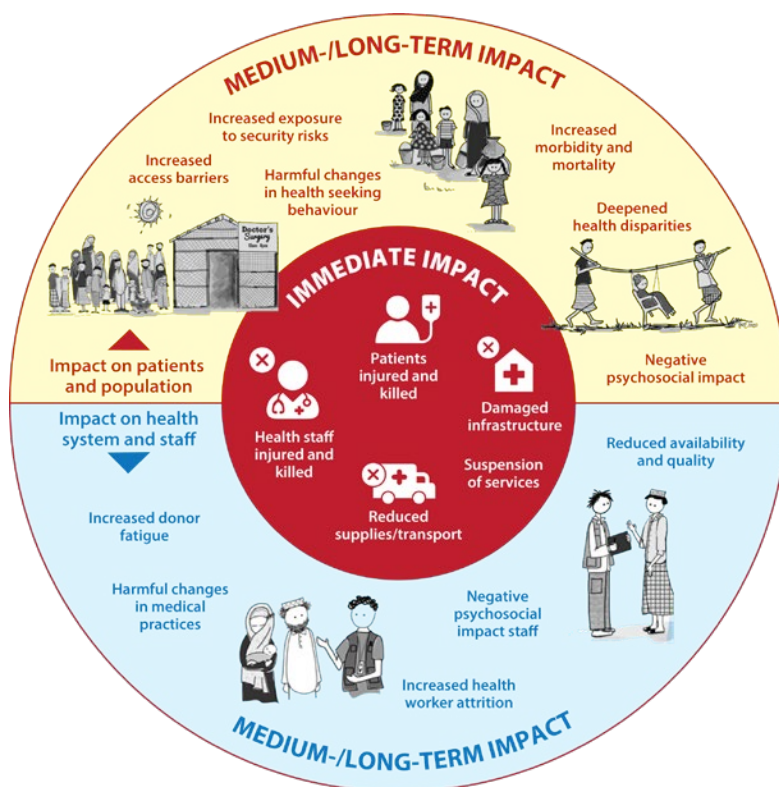
Addressing violence against health care is not only important to protect life when violent actions or attacks occur. It is essential to prevent the cascading consequences of such violence that weaken the health care system and the quality of care that follow from repeated attacks and the normalisation of violence. Violence against health care leads to the loss of health personnel, wastes resources, and forces closures of services, which in turn lead to an increase in morbidity and mortality among the population reliant on these services. Because of the wide range of these impacts, addressing violence through security risk management is a complex task that requires putting access to health care and the people affected by violence at the centre of policies.

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<sup>2</sup> For the definition of health care worker, please see page vi of the WHO-ILO guidance document.

<sup>3</sup> In Annex 1 you will see a comprehensive list of acts of violence given according to Insecurity Insight’s glossary.

Figure 2: The impact of violence against health care



## Balancing access to health care and the protection of health workers: cross-cutting elements of security risk management

### Managing security risks with access to healthcare at the center of decision-making

- Effective measures should **balance sustaining access to health care and protecting health workers from harm**. While the objective of every health service is to guarantee access to health services for all people in need of health care, it is necessary to protect the health personnel and patients from harm and avoid unnecessary exposure to risks. If decision-makers are facing the issues of whether to authorise an ambulance to move or to reopen a health service after a violent incident, they should first make sure that all possible prevention and mitigation measures are put in place to protect both staff and patients. Decisions to halt health programmes and health care services need to consider the direct and indirect consequences of such decisions for patients and public health.
- **The provision of health care should not be securitised:** The provision of care should always be carried out in respectful and dignified manner. Health care settings need to be open to the public and should not feel like restricted or unwelcoming places. Security measures should not cause fear or trigger tensions between users and workers in a health service. Any links between security forces and health services should not be perceived as collaboration: health personnel are not police agents.

- **Transparent communication and proactive reputation management help to build and maintain trust:** Effective health care requires patients and funding bodies to trust the quality and efficiency of the service. Avoiding false statements about the aim of security measures is important in security risk management. Some measures might entail a preventive component, but the expected results of the measures should not be exaggerated.<sup>4</sup> According to the same logic, preparedness can prevent certain attacks, but because perpetrators are not under the control of the health service, violence can still occur. Implementing actions to manage security risks should not generate or exacerbate fear among patients, staff or funding bodies (conversations about security can trigger fear). Transparency regarding the reasons why and procedures under which security is being addressed is important in order to create constructive and empowering environments instead of sparking fear and doubts.

## Respecting and balancing rights and responsibilities<sup>5</sup>

- **Rights and responsibilities of health care workers:** Health workers must practise health care in accordance with accepted medical ethics (see Box 1), always prioritising the safe and timely delivery of care by qualified personnel. They must also refrain from engaging in hostilities or acting in ways that militarily favour one or the other side involved in the conflict. Health workers have the right not to be attacked, persecuted or detained for carrying out their duties in accordance with medical ethics. The elements listed so far refer to what is often called “medical neutrality”. Health workers might also be covered by certain protective rights as workers according to responsibilities typically called “duty of care” that must be fulfilled by their employer. These duties will depend on the context, but often entail the right to work in a safe and dignified working space, to be properly remunerated (sometimes with additional hazard pay), to be covered by medical insurance, and to have the option of taking leave of absence under certain circumstances.
- **Rights and responsibilities of community members:** Every person has the right to receive health care that is available, accessible, acceptable and of good quality.<sup>6</sup> It should be provided to all people in need without discrimination. Community members should respect the provision of health care by not acting in ways that prevent it from being delivered or that harm others. Acts of violence by the community against health care workers, vehicles or a health facility should not be permitted in any circumstances.
- **Rights and responsibilities of armed actors:** Soldiers, policemen, members of militias and armed groups, and others who carry weapons have clear responsibilities to respect and protect health care from harm, and to actively contribute to the continuity of the provision of care, even amid fighting. In general, armed actors should not disturb the provision of health care or act in ways that prevent it from being provided, because this would be hindering every person’s right to receive health care, as previously stated. Armed actors also have the right to receive care like every other person does whenever it is needed.

<sup>4</sup> For example, if a security measure changing the structure of a facility can deter an armed entry by giving people extra time to hide in safe areas, this should not be presented as “preventing armed entries”.

<sup>5</sup> Although some of the responsibilities are not legally binding in all contexts, they are based on the principles of IHRL and respect for the lives, dignity, and well-being of others.

<sup>6</sup> This is also a basic right under IHRL.

## Box 1: Respect for medical ethics

The management of security risks must not violate medical ethics. Measures designed to reduce risk or prevent violence must be respectful of ethical principles such as providing impartial and dignified treatment, respecting the confidentiality of medical information, and providing the best possible care in every health-related situation. Medical ethics are applicable at all times when health care is being provided, and its principles are non-negotiable. The key principles of medical ethics are:

- **Patient autonomy:** The decisions of patients regarding their health and treatment must be respected.
- **Beneficence:** Health care activities should strive to offer the greatest benefit possible to the person receiving such care.
- **Non-maleficence:** Health care activities should not cause harm.
- **Justice:** The distribution of resources should be fair for all members of the population being served.
- **Impartiality of care:** Decisions affecting care are made solely based on health needs and available resources, and no other factors (e.g. religion, ethnicity, political affiliation, military affiliation, etc.) may be used to deny health care services or prevent people from receiving health care.

Further guidance on medical ethics can be found in the following resources:

- [WMA International Code of Medical Ethics – World Medical Association](#)
- [The ICN Code of Ethics for Nurses – International Council of Nurses \(ICN\)](#)
- [Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies](#)
- [Booklet entitled “Health Care in Danger” – International Committee of the Red Cross \(ICRC\)](#)

- **Respect for legal obligations:** Some countries have legal obligations that employers must fulfil to ensure the well-being of their employees. In addition, health workers might be bound by certain legal obligations, such as cases of mandatory reporting or the use of protective personal equipment. These obligations must be respected at all times and balanced with the need to increase or manage measures to ensure security.

Figure 3: Health care-related rights and responsibilities



## Understanding local challenges and responding with context-adapted measures

- Participation of the whole health care system in security risk management:** Most activities included in a comprehensive security risk management strategy for the health sector have to be implemented by those tasked with the responsibility to manage health care programmes. However, a comprehensive approach requires (1) the active participation of all health workers, support staff, and health authorities in designing responses and respecting protocols, and (2) the provision of active support by funding bodies and partners to enable the implementation of and generate respect for such measures among patients, their families and armed actors.
- Adapting measures to manage security risks to the context in which health care services are provided:** Practical security risk management measures need to be affordable, practical, legal, and safe for any context and health care provider. Some available health care security management manuals are designed to be used in high-income settings that can afford to pay for dedicated risk management staff and high-tech security solutions. Humanitarian security risk management is based on the concept of health care providers' work being accepted by local communities, authorities and armed actors. Guided by humanitarian principles, humanitarian security risk management may seek contact and negotiations with armed groups to ensure the independent and ethical provision of health services in ways that are not a feasible option for other health programmes. A comprehensive security risk management strategy for health care identifies the most appropriate needs of each context and adapts its provisions accordingly.

- **Implementing prevention and preparedness measures:** While it might not always be possible to implement exactly the same measure that are proposed in guides and case studies, adapting these measures to local realities will make them most effective. Locally available resources for related sectors and discussions with health workers and communities may help to identify alternative appropriate actions and mobilise support from authorities and other organisations such as humanitarian partners or funding bodies/donors.

# Generating awareness and communicating to create violence-free environments

## Objectives of this chapter



### Groundwork

Define key messages that can be transmitted to relevant stakeholders when advocating for a violence-free environment for health care.



### Action

Carry out activities that are appropriate in the local environment to build acceptance and establish transparent and constructive communication between health care personnel, communities, and other stakeholders.



### Challenges

Working with the community in violence-affected areas; respecting medical ethics; and listening to feedback from service users, even when talking about triggers of violence.



## Groundwork

### Acceptance, trust, respect and transparent communication

Awareness is a key building block of any plans and procedures to address violence against health care. The objective is to make health personnel, the community, external partners and others, such as armed actors, aware of how violence has negative consequences for everyone involved in a health care service, and that even in the most extraordinary circumstances, it is important to maintain a violence-free environment to ensure access to care and the quality of the care provided to those in need. By building consensus around the need to protect health care from violence, all stakeholders – but particularly armed actors – can be encouraged to behave in a way that respects the importance of health care services to those in need.

To achieve these goals, transparent communication and honest dialogue are imperative. Any communication or dialogue should be appropriate to the unique culture of the particular community being provided with health care, which will enhance trust levels between health care personnel and that community. Effective communication/dialogue helps to identify where and

how the health care service needs to adjust its practices to the community's need, while staff and patients need be aware of both their rights and responsibilities.

## Key messages

All communication needs to be context specific. Table 1 suggests some general messages that should be communicated, the possible content of such messages, and possible audiences. These suggestions can be used to develop the most appropriate communication strategy for each situation. This is not an exhaustive list, and the best and most appropriate messages should be identified in group discussions that consider multiple and diverse perspectives on the unique context that a health service is operating in. Key messages should be tested with the intended audience before any information campaign is rolled out. Specific contexts, such as a disease outbreak or changes in the health programme, may require a communication strategy to explain the reason for any new approach to health care.

**Table 1: Key messages**

Possible messages and their content	Possible audiences
<p><b>Violence is never acceptable.</b> Describe incidents of violence against health care and its consequences, with a focus on the local community's realities and experiences. Draw a parallel between the occurrence of violence and the reduction of health services' availability that will impact the whole of society.</p>	<ul style="list-style-type: none"> <li>• Community members and users of the service</li> <li>• Authorities</li> <li>• Armed actors</li> <li>• Health care personnel, including support staff</li> </ul>
<p><b>Violence is not just attacks using heavy weapons.</b> Violence can happen in different ways, but it is always negatively disruptive, reducing the capacity of a health service to provide care. Even violent reactive behaviour such as anger or accusations may contribute to undermining trust and undervaluing health care. It also heavily impacts health care personnel's well-being.</p>	<ul style="list-style-type: none"> <li>• Health care personnel</li> <li>• Community members and users of the service</li> <li>• Partners or sponsors of the health service</li> </ul>
<p><b>Health care must be protected from attacks.</b> While carefully taking context into account, focus on the key message that in fragile and conflict-affected scenarios, health care should be especially protected because this is when it is needed most. Besides the fact that health care is protected by international humanitarian law, parties to a conflict (and weapons bearers in general) should avoid putting health care in danger. At the community level, everyone has a role to play in ensuring that health care is protected. Authorities and sponsors must ensure that adequate measures are in place to prevent acts of violence against health care and punish those who commit such acts.</p>	<ul style="list-style-type: none"> <li>• Armed actors</li> <li>• Community members and users of the service</li> <li>• Authorities</li> <li>• Health care personnel</li> <li>• Partners or sponsors of the health service</li> </ul>

<p><b>The presence of weapons in health facilities has negative consequences.</b></p> <p>Emphasise risks related to the presence of weapons, such as the killing of patients, the accidental discharge of weapons, attempts at theft in the health care setting, and threats against people. Advocate for no-weapons spaces in all health care facilities. If applicable, focus on the risks posed by weapons to groups such as children, the elderly, people living with disabilities or pregnant women, who might be particularly in danger (children might be curious about weapons, while the others might have reduced mobility to shelter in time if a weapon is used).</p>	<ul style="list-style-type: none"> <li>• Community members and users of the service</li> <li>• Armed actors</li> <li>• Authorities</li> <li>• Health care personnel</li> </ul>
<p><b>Access to health care is a right.</b></p> <p>Emphasise the locally relevant barriers to accessing health care, including curfews, checkpoints, and a general lack of safety that hamper people’s ability to go to health facilities. Discuss solutions with authorities and weapons bearers, including ways to obtain permission to go to health facilities in case of medical emergencies.</p>	<ul style="list-style-type: none"> <li>• Community members and users of the service</li> <li>• Armed actors</li> <li>• Authorities</li> <li>• Health care personnel</li> </ul>
<p><b>The community needs to trust and accept the health service and its personnel, just as much as the health personnel and service must cater to the community’s needs and rights.</b></p> <p>Subjects like the level of trust between health personnel and the community, or the community’s satisfaction with the services can also be discussed in the conversation, because they might also relate to internal tensions affecting the health service.</p>	<ul style="list-style-type: none"> <li>• Community members and users of the service</li> <li>• Authorities</li> <li>• Healthcare personnel</li> <li>• Partners or sponsors of the health service</li> </ul>

### Data and information on violence against health care

Insecurity Insight, the World Health Organization and the Safeguarding Health in Conflict Coalition provide open-source information on the nature and patterns of violence against health care. The Health Care in Danger Initiative of the Red Cross and Red Crescent Movement and many professional associations have also published material on this subject. Please note that different organisations refer differently to the problem, and you may find that different terms are used to refer to it, such as “attacks on health care”, “violence against health care” or “occupational violence in the health care sector”.



## Action

### Communication from the health team – who should deliver key messages?

- Various health workers can participate, but the health workers who are most trusted or most respected by the community and the users of the health service are the best messengers for leading the conversation.
- Managerial staff and health authorities are usually best placed to communicate concerns to peer authorities and funding bodies.
- Community health workers can amplify key messages and incorporate some of them in their daily activities and the networks they manage within communities.
- Education services, community leaders, academics, and humanitarians can be important partners to advocate on behalf of the health service and health workers.

## Engaging audiences to communicate key messages

Messages that call for the protection of health care can be communicated in many different ways. Targeted communication campaigns can create widespread awareness, while specific concerns can be included in dialogue with interlocutors. Not all pertinent messages need to be communicated in one single activity. It can be more effective to concentrate on one or two messages at a time that are designed to be clearly understood and accepted by a specific audience.

### Communities

Communities can play an important role in protecting health care. A community refers to a group of people joined together by a common interest, characteristic or experience such as geographic location, ethnic composition, age, faith or health needs.

Communities are best engaged through participatory activities both in the identification and spreading of messages.

These could include:

- developing and sharing key messages using **posters or parts of structures (e.g. blank walls) on which messages can be written;**
- developing and carrying out **cultural activities** such as painting (e.g. decorating external walls with no-violence messages and visuals), music or theatre;
- developing and recording **communication content** (e.g. radio or social media spots, interviews to be shared online, or videos about the importance of respect for health services);
- **awareness-raising sessions** in waiting areas in the health care facility; and
- **round-table discussions** involving health personnel, the community, health care leaders, and any other stakeholders.

Communities need to be engaged through **honest conversations** about fears and risks. Communities may have concerns about health programmes, and these need to be understood.

**Communication around public health measures** such as vaccination campaigns or responses to disease outbreaks are best addressed through dialogue between communities and health care providers that promotes a positive and respectful environment in which health care can be effectively delivered.

Feedback mechanisms about health programmes in the form of “hotlines” or a book in which patients can express their gratitude or complaints can be ways to engage the community. This will ensure that fears, dissatisfaction, and questions are quickly addressed to reinforce the trusting relationship between health personnel and the community.

Social media channels can be used to disseminate negative messages or misinformation and disinformation about health care services and campaigns. Health services should therefore monitor social media, which can provide an understanding of the dominant themes affecting community members’ attitudes to services and programmes. Health services can also use appropriate social media strategies to disseminate relevant information about their work.

### Box 2: Social media and awareness of violence against health care

Misconceptions about the purpose and motives of health programmes are often spread on social media platforms. This can create negative sentiments towards public health initiatives that can even turn into hate speech and incitement to violence, putting health care programmes at risk.

Examples of such misconceptions on social media include the following:

- A belief circulated in Uganda that the public health measures taken against Ebola in the country in 2022 were motivated by the intention to displace people from their land in order to gain access to natural resources, which put outreach workers at risk. See: <https://bit.ly/UGAEbolaNov2022>
- A lack of knowledge about the medical ethics requirement to treat people according to their needs and not military affiliation triggered outbursts of hatred towards health care providers in Burkina Faso in 2023 when people heard on social media that health workers had assisted wounded members of the conflict party that they (the social media users) did not support, putting life-saving health care services at risk. See: <https://bit.ly/MSFBurkinaSMMMMar2023>
- Principles of neutrality prevented doctors in Sudan in 2023 and 2024 from naming the conflict party that had attacked multiple hospitals in statements that called for the protection of health care led to aggressive criticism online and accusations that health workers were fuelling the conflict through their perceived support for perpetrators of atrocities against civilians. See: <https://bit.ly/SDNMSFCriticisedSep2023>

The widespread use of social media is changing conflict awareness. Today, every person with a smart phone in a conflict zone has become a war observer – and possibly a war reporter. The horror of experiencing war is shared with millions who see and hear about real-life experiences from people they can relate to. Health services’ failure to engage with communities can contribute to misinformation and disinformation that increases suspicion of the intentions behind health care activities.

### **Discussing traumatic experiences can be difficult and can trigger very strong or painful emotional reactions**

Awareness-raising events may cause difficult emotions among conflict-affected communities. It is important to consider the need for follow-up action to provide additional psychosocial support if people react very emotionally during such events or the atmosphere becomes tense.

Prior to the activity or event, provide guidance to the leading team on how to identify signs of emotional distress and discuss what can be done if these signs are present. Ensure that the teams are aware of the relevant government or humanitarian mental health and psychosocial support (MHPSS) referral mechanisms that can be activated if people need immediate support.

### **Managing authorities, funding bodies and partners**

Managing authorities, funding bodies and partners are instrumental in creating the framework within which health care is provided. Managing authorities often create the legal and administrative rules, while funding bodies determine budgets and priorities. Partners can support training and capacity development in health services.

Authorities, funding bodies and partners are the best stakeholders to approach when the aim is to develop concrete risk management proposals and workplans. **Round-table discussions, briefing sessions or technical meetings** are useful ways of creating awareness and requesting support. In some instances, private and confidential dialogue with trusted partners can help to develop the right kind of support.

### **Health workers**

Health workers have a right to a dignified and safe working environment that allows them to focus on the provision of care. They also have the responsibility to uphold ethical principles and always to act with respect towards the community. Health workers also have a duty to support the health programme and facility managers in implementing security management activities by communicating concerns and respecting protocols.

Health programme managers can organise learning sessions for health care personnel about their rights and responsibilities, and the importance of ethical, non-discriminatory and respectful behaviour among people both working in and using the service. During health emergencies and conflict-affected settings, ethical conduct and acceptance by the community are part of any safety and security strategy.

Internal discussions can be held to discuss how frontline health workers perceive the problem of risk management, and this can be important to ensure internal support for the relevant strategies and programmes. Such discussions can also be organised for specific groups such as community outreach workers, female staff or staff members from specific ethnic groups who may experience unique vulnerabilities and may not feel able to express their concerns during a wider discussion.

Such discussions need to be conducted in a climate in which health workers feel that there will be no risk that voicing their fears and concerns will lead to negative repercussions.

### **Weapons bearers, state forces, non-state armed groups, and war/conflict parties**

State security forces may have the capacity to protect health care providers working in a particular country or region. In other situations, the actions of both state security forces and other weapons bearers and armed groups can put health care providers at risks.

The context will determine when and how communication may be addressed to state or non-state forces to ask that they respect health care. In some contexts, direct contact may be possible to discuss specific incidents or concerns. In other cases, health care providers can seek support from partners such as humanitarian organisations to advocate on their behalf. Health care providers can also seek advocacy support for their situation from the international community.

### **Monitoring changes and impact**

The monitoring of changes to the relationships between health care providers and the community or weapons bearers following communication efforts provides important lessons to inform further messaging. Communication to promote respect for health care should be a regular activity to maintain awareness and ensure new members in the various stakeholder groups are also sensitised to the issue. Continuous communication will improve trust and positive perceptions.

If a communication effort has not generated positive results, the message and dialogue strategy need to be reviewed and revised.

#### **Remember, community members are allies!**

Developing a positive and respectful relationship with the community using the health service is not only useful for security, but will ensure access to and the quality of health care. Community members are an essential part of any health service and should not be treated as a threat. If there is tension between the community and the health service, remember to evaluate whether and how the health service has been operating, because the triggers of the tension might be in the service, not in the community!



## **Challenges**

### **Selecting the right approach and appropriate messages**

Selecting the right and most effective messages is a difficult process that requires high levels of sensitivity towards concerns in violence-affected environments. In each context, careful consideration of different perspectives, concerns and fears among the various stakeholders need to be tested against each other. Feedback on whether the proposed messages are appropriate or will work can only be provided in an environment characterised by trust.

*Examples:* A video or song played in an area where patients wait for a consultation may be more appropriate to engage community members than graphs with statistics about the extent of violence against health care in the community, region or country. Carefully compiled data will be key in any conversation with a donor or an official from the country's ministry of health.

## **Ethical challenges of providing care in fragile contexts**

The provision of health care in emergencies or fragile violence-affected contexts can be very complex and poses many ethical dilemmas. Prioritising how limited medical resources will be utilised can be challenging when medical needs are increasing and violence is growing worse. Providing impartial care can be difficult when certain groups are seen to be “the enemy”. Medical ethics are very complex. Health personnel should be well trained and ready to explain their ethical duties to interlocutors (community members, armed actors, social media users, etc.). Ethical principles governing the provision of health care should be communicated and presented transparently to avoid tensions and violence that may arise if people misunderstanding these principles.

## **Addressing the causes of violence**

Violence against health care occurs in specific contexts. Communities and health workers often fear the perpetrators of violence, and identifying specific perpetrators often creates fear and tension. Communication needs to occur in an environment of trust, and the risk of retaliation caused by particular messages needs to be addressed.

In some instances, scarce resources and low quality of care may be a cause of violence, and if this is the case these issues need to be addressed by raising the concern with superiors or other health authorities who can contribute to efforts to correct this problem as soon as possible.

## **Further resources**

### **Additional guidance and information to generate awareness of the problem**

Annual reports on violence against healthcare – [Safeguarding Health in Conflict Coalition website](#)

Videos for campaigns and other advocacy material – [Health Care in Danger, ICRC website](#)

[WHO and ILO official guidance on occupational health for the health sector](#)

Developing acceptance of the health service – ECHO: <https://acceptanceresearch.wordpress.com/wp-content/uploads/2010/10/dg-echo-security-training-manual-module-5-image-and-acceptance.pdf>

The Acceptance Toolkit – USAID and Save the Children: <https://acceptanceresearch.wordpress.com/wp-content/uploads/2012/01/acceptance-toolkit-final-for-print-with-notes.pdf>

### **Examples of Good practices on generating awareness on the problem**

[Prevention and protection against attacks on healthcare: good practices](#) – WHO (Chapter 3)

[Ministers of Health Meeting on Protection of Health Care from Violence](#) – ICRC report

[Impact of COVID and Violence against Healthcare](#) – ICN, ICRC, IHF and WMA report (Chapter 4)

\* [Experiences of the International Red Cross/Red Crescent Movement](#)

## Take-aways

- Promoting respectful interactions between health workers, the community, service users and other stakeholders helps to ensure that everyone understands that in all circumstances violence is an undesired event.
- Violence is never acceptable, and it will always have negative consequences for the capacity of health care systems or facilities and the quality of the care that they provide.
- There are several ways of engaging in discussions and campaigns to keep the health service free from violence – so be creative and adjust the type of activity you use to the needs of your service!
- It is important to discuss their rights and responsibilities with health workers and the need to always respect medical ethics. In insecure and conflict-affected contexts, it is necessary to ensure medical neutrality – i.e. not to engage in any action that might be interpreted as being part of the hostilities or supporting one side against the other.
- Authorities, partners, and sponsors should be made aware of the problem of violence against health care and should support measures to address this issue.

# Assessing the risks of violence and increasing preparedness to better prevent and cope with it

## Objectives of this chapter



### Groundwork

Gather information about the context, carry out a risk assessment and identify the vulnerabilities of the health service.



### Action

Implement measures to address the identified risks and reduce or mitigate them to enhance the health service's preparedness to cope with the issue of violence against health care.



### Challenges

Implementing measures that are feasible, efficient, and sustainable and do not hinder or block the access to health care of people in need.



## Groundwork

### Context analysis and risk assessment

Context analysis and risk assessment create an understanding of the environment in which health care programmes are delivered. Context analysis identifies the underlying political, social and cultural factors that can influence how these programmes are perceived. This requires understanding who may be fighting whom, and where, why and how these dynamics may affect health care providers. Risk assessments consider the likelihood of health care infrastructure and workers being attacked, as well as the vulnerabilities of key parts of the health system and their capacity to protect staff and programmes during crises caused by violence.

Context analysis and risk assessments start by gathering information about the realities of the environment surrounding the health service and the health care that it offers.

#### Understanding the health service and its environment

How long has the health service operated in the area?

Which health care services are provided?

What are the health needs of the population?

What are the community dynamics (leaders, religious groups, ethnic groups, clans, etc.)?

What are the typical patterns of criminality and insecurity in the surrounding area?

### **Understanding patterns of violence against health care**

If possible, try to understand the known violent events that have directly affected health care in the local environment and obtain detailed information about these events beyond simple statistics for how often they happen. Key questions include:

- What type of violence has occurred?
- What time of day and where did these incidents happen?
- Who were the main victims?
- Which components of the health service or its personnel were attacked or affected by the attacks?
- Who were the alleged (or known) perpetrators?
- What was the motivation for the attacks?
- Were these one-off incidents or part of a pattern?

Information about the triggers of violence and the relationships between the health workers, the community and other actors (e.g. weapons bearers or civil authorities) is equally important.

#### **Ensure a sensitive approach when gathering information about the context.**

Be aware that mentioning personal names or identifying victims and perpetrators in public might bring additional risks. Make sure that you determine whether certain information would be kept confidential, and what type of information can be shared with others for mobilisation or information purposes.

### **Understanding the consequences of violence against health care for the provision of health care**

- How does the violence affect health services (personnel, facilities, transport, supplies, etc.)?
- Which services are interrupted or stopped?
- What are the consequences for patients?
- How quickly can the service be reopened and are there alternative health services that those in need can access?
- Which patients are most affected by the interruption of services?

#### **A context analysis and risk assessment are needed even in contexts where there is no history of violence against health care.**

It is important to make sure whether the absence of reports of violence means “lack of reporting” or “the absence of incidents”. If there is no previous history of violence, but the general context is one of fragility (war, violent or insecure neighbourhoods, ongoing social protests or public health emergencies), it is still useful to carry out an assessment of possible risks and design related measures to deal with them. This is particularly important in a deteriorating security context where circumstances may be changing rapidly. At the same time, **it is important that assessments do not cause fear and contribute to increased feelings of insecurity.**

### Who should participate in the context analysis?

The best context analysis is carried out by using a participative process. Diverse perspectives from different staff members, health authorities and community members provide nuance and details. Proactive contributions help to identify wide-ranging concerns, therefore

- include different views on the same risks; and
- use as many different sources of information as possible.

Be aware that different people may experience the same situation differently. For example, a man might not be afraid to walk in the neighbourhood of the health facility, but a woman might feel uncomfortable or in danger. Similarly, a receptionist at the entrance to a health facility may feel more vulnerable than a doctor or laboratory technician working further away from the entrance. It is therefore important to listen to and incorporate all contributions to the risk assessment.

After gathering sufficient information about the context, the risk assessment should follow the steps described below.

### How to decide whether a violent incident will affect health care

Annex 1 contains a long (although not exhaustive) list of possible events that might be considered to be violence against health care, and that may impact people (health personnel, patients or other community members), structures or assets (the health facility, medical transport vehicles, medical storage facilities), or access in general (intentional blockages/obstacles and actions that prevent health care from being delivered and those in need from accessing care).

To help decide what is relevant to the risk management strategy of a particular health service, consider whether the event will have a negative effect on the delivery of health care services, e.g. verbal abuse of the receptionist will make it difficult for them to work effectively and will hamper the ability of the facility to run smoothly. Therefore, this can be considered a violent event.

- 1. List violent events** that may occur near a health service, rate each one according to the **likelihood that it will occur** and estimate its **impact**. Do not consider only major disruptions such as the damaging or destruction of infrastructure and the closure of services. Consider also the impact of a particular violent incident on the availability of health personnel, the loss of the health service's access to a certain area or population, the loss of the ability of those in need to access health care, the loss of material and medical goods, the loss of personal items, and the psychological impact on people (personnel and patients).
- 2. Assess the vulnerabilities** of the health service, especially those that arise from the risks you have identified. There is a comprehensive list of possible vulnerabilities in Annex 1 of this handbook.

A vulnerability assessment helps to identify the areas that need particular attention in order to mitigate specific risks.

Examples of vulnerabilities:

- The health facility has no available means of communication; only staff members' personal mobile phones are available.
- The doors and windows of the health facility cannot be securely locked.
- A group of displaced people are living close to the health facility, and the local community does not welcome this new group.
- To reach the health facility, people in need of health care must go through a checkpoint controlled by armed actors that often charge money for passage.

Table 2 gives some examples of possible violent events and vulnerabilities that can be identified.

**Table 2: Examples of possible violent events and vulnerabilities**

Possible violent incidents	Probability of occurrence	Impact	What and who are vulnerable?
Looting of the drug storage facility	Very likely	Moderate (loss of materials that can be replaced) OR High (loss of materials that will result in the withdrawal of services)	Drug storage area; medication  Patients who depend on the drugs
Armed assault on a patient	Moderately unlikely	Severe (loss of life; psychosocial harm) Reduced ability of health staff to care for patients	Patients; health care personnel; areas close to the entrance of the facility  Long-term impact on mental health of the wider health work force
Sexual assault on a nurse	Unlikely in the health facility Moderately likely on way to and from work	Severe (physical and psychosocial harm; the health worker might leave the service)	Health care personnel (specify if a group is particularly affected, e.g. women)
Interpersonal violence (physical assault) because of lack of trust between health workers and community members	Very likely	Minor, if on staff (low-level physical harm; psychosocial harm) BUT Severe for community (reduced provision of a particular health service to the community)	All persons circulating and working in the facility; areas where closer interaction occurs between patients and health personnel (consultation rooms or wards)  Patients requiring the service that was attacked

3. Arrange the gathered information (likelihood and impact) in a matrix, like this example:

Table 3: Risk assessment matrix

Impact	Negligible	Minor	Moderate	Severe	Critical
	<ul style="list-style-type: none"> <li>No serious injuries</li> <li>Minimal loss or damage to assets</li> <li>No delays to programmes</li> </ul>	<ul style="list-style-type: none"> <li>Minor injuries</li> <li>Some loss or damage to assets</li> <li>Some delays to programmes</li> </ul>	<ul style="list-style-type: none"> <li>Non-life-threatening injuries</li> <li>High stress</li> <li>Loss of or damage to assets</li> <li>Some delays to programmes</li> </ul>	<ul style="list-style-type: none"> <li>Serious injuries</li> <li>Major destruction of assets</li> <li>Severe disruption to programmes</li> </ul>	<ul style="list-style-type: none"> <li>Death or severe injury</li> <li>Complete destruction or total loss of assets</li> <li>Loss of programmes and projects</li> </ul>
Probability					
Very likely Daily	Low	Medium	High	Very high	Very high
Likely Once per year	Low	Medium	High	High	Very high
Moderately unlikely Every year	Very low	Low	Medium	High	High
Unlikely Every 2-3 years	Very low	Low	Low	Medium	Medium
Very unlikely Every 4+ years	Very low	Very low	Very low	Low	Low

By using the colour codes, it is possible to work out the degree of risk and identify what threats might be potentially more worrying for local health care personnel, patients, and health structures and facilities.

By using the risk assessment matrix and identifying threats and vulnerabilities, it is possible to determine what the priority areas are for improving security risk management, whether to focus on specific facilities or personnel, and whether to take steps to reduce or mitigate the likelihood of specific events or reduce their impact.



## Increasing preparedness by designing and implementing measures to manage, reduce, or mitigate risks and their impact

Preparedness refers to the health service putting in place procedures to manage security risks and ensure better coping mechanisms and responses to any violent incidents **before they occur**.

After the context analysis, risk assessment and identification of the vulnerabilities of a health service, the measures to increase preparedness can be designed and implemented.

### **Who should lead the design and implementation of appropriate measures?**

- Managers are well placed to have an overview of what is needed to manage the risks facing the health care service after the context analysis and risk assessment have been completed and preparedness measures have been designed and put in place, and so will be well placed to lead implementation, but the actual measures will most likely be implemented by specific team members.
- A group of representatives of the service may need to be involved in the process, and health authorities need to be duly informed about, assist with and, if needed, sponsor the security risk management actions, thus providing a supportive environment for their design and implementation.
- Partnerships with other stakeholders can provide technical guidance and financial support. Make sure that your needs are discussed with possible partners: the humanitarian community, civilian authorities, civil protection or firefighting services, funding bodies or, when needed and possible, security forces.

### **Security incidents affecting health care and police services**

In most countries that are not at war or affected by conflict, the police force is the authority responsible for ensuring security. However, even in peaceful circumstances, community members might perceive the police or other state security agents as being hostile and threatening.

A health service's involvement with the police needs to be carefully managed to avoid perceptions that the health service is collaborating with state security agents – possibly against the community. It may even be an unfortunate reality that police may have strong links to a particular group, which may then limit the ability of others to access the service.

Other armed actors such as the military and members of non-state armed groups who might control or simply live in the area in which a health service operates need to be considered as part of a risk assessment.

Health services do not carry out security work, which means that no confidential medical information should ever be shared with security authorities without due process. Weapons bearer should not normally be allowed to enter a health facility.

Table 4, below, lists possible preparedness interventions designed to reduce risk. All measures should be adapted to any particular context and service. It is unlikely that all measures can be implemented at once. But a single measure has limited impact, so several measures should be implemented that (1) are most appropriate for a particular context, and (2) can be realistically implemented with the resources available to the health service. A priority plan will then be needed to build the health service's capacity to implement the measures for as long as they are needed.

**Table 4: Interventions to increase preparedness and reduce risk**

Categories	Possible measures	Possible supporting stakeholders
A health facility's physical structure	<ul style="list-style-type: none"> <li>• Reinforce passive security (expand the perimeter of the facility, reinforce doors/windows, create safe areas, identify and protect critical zones, etc.)</li> <li>• Include barriers or "labyrinths"<sup>7</sup> to control the circulation of people or vehicles and prevent the exposure of areas to open view, and consider using locally accepted material to do so (plant pots, murals painted by the community, etc.)</li> <li>• Reinforce the structure of key areas and assets in the facility (e.g. water and electricity supply systems)</li> <li>• Create safe areas to mitigate specific risks (biological contamination, groups with reduced mobility or special needs, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Firefighters</li> <li>• Civil protection teams</li> <li>• Humanitarian organisations in general</li> <li>• Humanitarian security organisations</li> <li>• Police or military, if community members do not perceive them as a threat</li> </ul>
Management	<ul style="list-style-type: none"> <li>• Implement mechanisms for reporting incidents of violence</li> <li>• Regularly repeat the risk assessments and adjust plans according to circumstances. Consider doing this at fixed intervals, but reviews should occur after incidents</li> <li>• Include security and awareness training for on-boarding (i.e. newly appointed) staff, and regular drills and training to practise and correct the application of contingency plans</li> <li>• Include security management actions in referral and medevac procedures</li> <li>• Add security as a standing item on the agenda of regular meetings (e.g. monthly for all staff, weekly for management)</li> </ul>	<ul style="list-style-type: none"> <li>• Civil or health authorities</li> <li>• Humanitarian organisations in general</li> <li>• Humanitarian security organisations</li> <li>• Partners or sponsors of health services</li> </ul>

<sup>7</sup> In this context, a labyrinth is a series of barriers that make it impossible to walk straight into a health facility. The way the barriers are arranged must allow people to access the facility, but should require them to take several turns back and forth when they do so. Barriers to manage vehicles work on the same principle of preventing easy and direct access.

Categories	Possible measures	Possible supporting stakeholders
Norms and protocols	<ul style="list-style-type: none"> <li>• Implement a no-weapons policy in health care facilities, and put up clear signage to communicate it</li> <li>• Advocate for sanctions on crimes and violations against health care</li> <li>• Develop ethical protocols and support committees that follow up on misconduct</li> <li>• Develop and implement norms for using identification symbols for the health facility and medical vehicles, and to identify staff, so that they can be easily differentiated from other non-medical facilities, vehicles and people</li> </ul>	<ul style="list-style-type: none"> <li>• Civil or health authorities</li> <li>• Community leaders</li> <li>• Academics with expertise in health care or human rights</li> <li>• Health care professional associations</li> <li>• Police, if community members do not perceive them as a threat</li> <li>• Humanitarian organisations in general</li> <li>• Partners or sponsors of health services</li> </ul>
Coordination	<ul style="list-style-type: none"> <li>• Define when and how health teams would coordinate with security forces, and establish clear responsibilities for both sides</li> <li>• Define when and how inter-facility coordination is expected to happen, and prioritise the adoption of safe procedures (safe routes, safe exchanges of information)</li> <li>• Design standard procedures for communicating with family members of patients or peer health care personnel to break bad news or provide reliable information in an emergency scenario</li> <li>• Inform relevant stakeholders about, support the development of, and promote operational protocols to prevent delays or discriminatory behaviour against people (patients or health personnel) at checkpoints and other barriers</li> </ul>	<ul style="list-style-type: none"> <li>• Police, military, and other armed actors as needed and if possible</li> <li>• Civil or health authorities</li> <li>• Humanitarian organisations in general</li> <li>• Humanitarian security organisations</li> <li>• Partners or sponsors of health services</li> </ul>
Engagement with community	<ul style="list-style-type: none"> <li>• Implement mechanisms for making complaints and asking questions to reinforce local accountability</li> </ul>	<ul style="list-style-type: none"> <li>• Civil or health authorities</li> <li>• Community leaders</li> </ul>

Categories	Possible measures	Possible supporting stakeholders
	<ul style="list-style-type: none"> <li>• Reinforce transparency in all communications about services, functioning hours and criteria for access to health facilities and programmes</li> <li>• Implement codes of conduct for staff and patients</li> <li>• Encourage training to improve the communication skills of staff members</li> <li>• Carry out regular surveillance of social media platforms to identify potential threats and negative perceptions associated with the health service and health workers</li> </ul>	<ul style="list-style-type: none"> <li>• Humanitarian organisations in general</li> <li>• Partners or sponsors of health services</li> </ul>
Care and support	<ul style="list-style-type: none"> <li>• Ensure respectful working conditions for all staff</li> <li>• Implement policies and services to provide psychosocial support for staff</li> <li>• Implement mechanisms for addressing conduct violations and other tension points among staff and with patients</li> <li>• Develop referral procedures for providing specialised support to workers who are victims of violence for both their physical and mental health needs as required</li> </ul>	<ul style="list-style-type: none"> <li>• Civil or health authorities</li> <li>• Community leaders</li> <li>• Health care professional associations</li> <li>• Humanitarian organisations in general</li> <li>• Partners or sponsors of health services</li> </ul>
Contingency plans	<ul style="list-style-type: none"> <li>• Develop and implement ways to continue providing services during and after emergencies, and criteria for when these measures should be implemented</li> <li>• Implement measures to prevent the total disruption of services if violent incidents occur (instal generators, obtain extra supplies of drugs and water, adapt routes used to access and exit the health facility, etc.)</li> <li>• Use locks to isolate critical areas, such as operating rooms and places where medications are stored</li> <li>• Develop and implement specific procedures (depending on risk!) to:</li> </ul>	<ul style="list-style-type: none"> <li>• Civil or health authorities</li> <li>• Humanitarian organisations in general</li> <li>• Humanitarian security organisations</li> <li>• Civil protection teams</li> <li>• Partners or sponsors of health services</li> <li>• Police, military as needed and if possible</li> </ul>

Categories	Possible measures	Possible supporting stakeholders
	<ul style="list-style-type: none"> <li>• de-escalate tense situations</li> <li>• deal with violent threats or armed entries</li> <li>• deal with hostage-taking situations</li> <li>• mitigate the adverse consequences of a lack of access to basic resources (water, electricity, communication systems)</li> </ul>	
Safe access	<ul style="list-style-type: none"> <li>• Map out access routes to health facilities and instal clear and distinctive signs on these routes</li> <li>• Obtain authorisations and put procedures in place to facilitate the movements of medical vehicles and people seeking health care</li> <li>• Develop risk management protocols to assess daily risks and impose “red zones” when needed</li> <li>• Disseminate rules for the safe behaviour of people moving into and out of the health service</li> </ul>	<ul style="list-style-type: none"> <li>• Civil or health authorities</li> <li>• Community leaders</li> <li>• Humanitarian organisations in general</li> <li>• Humanitarian security organisations</li> <li>• Partners or sponsors of health services</li> <li>• Police, military or other armed actors as needed and if possible</li> </ul>

Staff need to be properly trained and response measures need to be regularly practised.

Annex 2 contains examples of the entire process of managing risk, including how measures were selected based on a context analysis and risk assessment, and then implemented at particular times and according to the degree of urgency of each.

## Challenges

### Identifying feasible, efficient and sustainable measures that protect staff and do not hinder or prevent access to health care

The best way to decide which measures should be prioritised is to consider whether they are feasible (it must be realistically possible to implement them), and what their likely impact would be on staff, communities, and access to care. Questions that should be asked include the following:

#### Is this measure feasible, efficient and sustainable?

- How is this measure expected to reduce any of the risks previously identified and assessed?
- Is this measure adequate and is it adapted to local realities and security needs?

- Will this measure help the health service to better cope with a violent incident, should one occur?
- Does this measure require constant renewed financial investment? Are repair, adjustment or recovery costs within the health service's budget?
- Does this measure require a great deal of training and/or specialised personnel?

**Does this measure ensure patient access to health care and respect the ethical principles of health care?**

- Will this measure harm the relationship between health personnel and the community, or create negative perceptions of the health service and the health care team?
- Will the community feel scared, disrespected or mistreated if this measure is implemented?
- Will this measure make it easier or more difficult for communities and individuals to access the health service?
- Will health workers be asked to carry out activities or procedures that might negatively affect the quality of their work?
- Will this measure create any form of discriminatory practice within the health service?
- Will the measure create any risks that the confidentiality of medical data will be compromised?

*Table 5: Solutions and related issues that should be taken into account/considered*

Proposed solution	Consideration
Purchase and install security cameras	<ul style="list-style-type: none"> <li>• Do the security cameras require a consistent supply of electricity? Can this be guaranteed?</li> <li>• Are personnel available to monitor the images on the security cameras and manage suspicious or dangerous behaviour?</li> <li>• Is there a risk that key stakeholders might misinterpret the purpose of the cameras?</li> <li>• Would patients feel threatened or violated by the cameras?</li> <li>• Is there a risk that the cameras may become the target of an attack?</li> </ul>
Copy the contingency plan of a health care provider in another location	<ul style="list-style-type: none"> <li>• Is the contingency plan aligned with the realities of violence in the local environment? - How do the risk and vulnerabilities assessments of the plan you are copying compare to those of your own health service?</li> <li>• Are the action points in the plan realistic for the local context?</li> <li>• Is the copied contingency plan proposing actions that might be problematic for your local context, such as calling the security forces to intervene during violent incidents?</li> </ul>
Employing security guards	<ul style="list-style-type: none"> <li>• Would the presence of security guards (armed or not) give the impression that the health facility is aligned with any groups of armed actors?</li> <li>• Would the checking of bags and/or searching people at the entrance of the facility be perceived as too invasive by the community?</li> </ul>

## Key points

- **Be creative**
- **Respect medical ethics**
- **Balance access and security**

## Ideas

- Use colour-coded bracelets to identify health personnel and patients and distinguish them from other people circulating in the area.
- Use plants to create a natural perimeter wall without over-securing the health care facility.

## Further resources

### Additional guidance on developing a risk assessment and managing security

Security Risk Management Toolkit: Assessments – [GISF](#)

Toolkit: Evidence that Protects Health Care – [CPHHR](#), [IRC](#), [Insecurity Insight](#), [PHR](#), [SHCC](#)

Security and Safety Manual for Humanitarian Personnel – [ICRC \(Chapter 3\)](#)

Operational Security Management in Violent Environments – [Humanitarian Practice Network](#)

Guidance on using private security guards – [GISF Security to Go Module](#)

### Additional guidance on developing measures for enhanced security preparedness

[Checklist for patient safety \(all levels of security\)](#) – [WHO Red Book](#) (see pages 72 and 73)

[WHO Guidelines on Occupational Safety during Emergencies](#) (see Chapter 8)

[Security Challenge: Mob Attacks](#), quick sheet on protecting a medical facility against a mob attack – [Insecurity Insight](#)

[Security Challenge, preparedness guidance for different scenarios](#) – [Insecurity Insight](#)

[Prevention of Entry of Weapons into Health Facilities: A Toolkit](#) – [Health Care in Danger](#), [ICRC](#)

[Vaccination in Emergency Settings](#) – [ICRC](#), [IFRC](#), and [WHO Joint Note](#)

[Enhancing passive security for health care facilities](#) – [Health Care in Danger](#), [ICRC](#)

[SAFE: Security and Safety Manual for Humanitarian Personnel](#) – [ICRC](#)

[Training Manual for Ambulance and Pre-Hospital Response in Risk Situations](#) – [Norwegian Red Cross](#)

[Safer COVID-19 Response: Checklist for Health-Care Services](#) – [ICRC](#) (this can serve as a model for responding to other emergencies)

[Security Risk Management: A Basic Guide for Smaller NGOs](#) – [GISF](#)

## Trainings

Emergency Healthcare in Insecure Settings – Disaster Ready and Insecurity Insight (please register at [www.disasterready.org](http://www.disasterready.org) to access the online course)

De-escalating Violence in Health-Care Settings – Health Care in Danger, ICRC

Stay Safe – International Federation of the Red Cross and Red Crescent Societies

Personal Safety and Security Certificate – Disaster Ready (free online training)

## Examples of good practices in improving/increasing preparedness

Stopping Attacks on Health Care – WHO (Section 4.3)

Violence against Health Care: Current Practices to Prevent, Reduce or Mitigate Violence against Health Care – ICRC, ICN, IHF and WMA

Best Practices for Ambulance Services in Risk Situations – Norwegian Red Cross

Preventing Violence Against Health Workers – WHO (a collection of cases)

## Take-aways:

- Risk assessments are essential for proper preparedness.
- Participatory risk assessments provide broader insights by including many stakeholders.
- Risk assessments need to be updated.
- Prioritising action should be based on good risk assessments.
- Measures can be implemented with the support of outside stakeholders such as local authorities, humanitarian organisations, partners or sponsors of the health programme.
- It is essential to balance reducing risks and simultaneously ensuring that people needing health care can access the health service.
- Transparent and clear communications support the implementation of appropriate risk management measures.
- Training is essential if risk management measures are to be properly implemented.
- Security risk management is not a separate activity, but should be part of planning and service provision.
- Good security risk management measures help to keep staff safe, but risks remain.

# Responding to violent incidents

## Objectives of this chapter



### Groundwork

Develop contingency plans and train health care personnel to respond efficiently and effectively if a violent incident occurs.



### Action

Deploy the actions outlined in the contingency plans as needed, apply safe behaviour principles and coordinate with other stakeholders to ensure a rapid resolution of the incident.



### Challenges

Respecting and caring for individual emotional reactions to violence; allocating due time for training personnel to implement the contingency plans; asking security forces for help.



## Groundwork

### Remaining alert and ready to respond when violence remains a risk

Violent incidents may possibly occur even when all preventive measures are in place. Preparedness measures are designed to reduce the likelihood of violent incidents occurring, to reduce the impact of these incidents, and to strengthen the capacity of the health service and its personnel to respond to a violent incident.

Preparedness to respond to an incident depends on its type. For example, the theft of personal items in the health facility requires a different response to one responding to an armed attack. During a violent incident, priorities need to be clear and would usually focus on the safety of health care personnel and patients and the protection of the lives and dignity of all people affected.

All health services should have a **response plan** that indicates what needs to be done if particular incidents occur and who will be responsible for specific actions. These plans need to be specific for each type of violence and realistic for the environment in which they are used. They need to

be disseminated to everyone who might be involved, and training needs to be implemented to ensure that everyone knows what to do in an emergency.

## Contingency plans for responding to violence against health care

There is no standard, “ready-made” procedure that can determine what to do in each violent scenario that might happen. In general terms, five elements need to be considered in any plans drawn up to respond to a violent incident:

- **Protecting people’s lives and dignity:** Always prioritise actions that ensure the safety of any people who may be affected by a violent incident (health personnel, patients, and others such as family members of patients and community members who might also be present). Only after ensuring that all such people are safe should personnel focus on protecting material goods or keeping infrastructure and assets intact.
- **Ensuring that communication lines are available to ask for support:** A person should be clearly assigned to be responsible for external communications and asking for help, and other personnel should not make similar calls and other communication efforts, and should rather focus on protecting lives, including their own. This will avoid confusion, ensure that calls for assistance are clear and efficient, and keep communication flowing in the best possible way.
- **Coordinating with external stakeholders for support, as planned:** In some cases it might be necessary to ask for the intervention of external stakeholders such as humanitarian organisations or security personnel. This should be done in strict alignment with the context analysis and mitigation measures developed in the preparedness activities, and the external stakeholders who will be contacted should be informed that this might occur during an emergency. The person responsible for contacting external stakeholders should also be identified in the plan.
- **Applying contingency measures to limit the impact of the incident:** It might be necessary to direct people to safe areas or shelters, lock up certain spaces or cupboards, use fire extinguishers, and evacuate some zones of the facility, among other actions to prevent further consequences from the attack. The type of attack covered by the contingency plan should be clearly described in the document, with specific action to be taken, and aligned with connected actions taken in the preparedness activities, e.g. the installation of signage guiding people to emergency exits or designating critical areas. In other words, people should know what to do and how it should be done.
- **Keeping contact numbers and key information about the health service up to date:** Important contact numbers, such as those of security managers and health personnel in the service, should be constantly updated, and should be saved with clear descriptions of the roles each person should play so they can be quickly identified and found when needed. Other documents might also need to be kept up to date and instantly accessible in an emergency, such as a list of staff with their contact numbers, a list of supported sites and other relevant information about the health service. Decide where this information is stored, who needs access to it, and whether it can be accessed out of normal office/working hours. It should also be stored off-site in case the facility experiencing the emergency is not accessible.



## Action

### Who should be in charge of the response to a violent incident?

- The incident contingency plan should clearly indicate who is responsible for each step of the response.
- All communication and coordination responsibilities should have been previously established and communicated, and the relevant personnel properly trained. These responsibilities should be carried out according to the plan.
- The potential support of humanitarians, security agents or representatives of other health services should also be planned for.

Table 6: Good practices when responding to an emergency

De-escalation and safe behaviour	<p>Violent incidents often trigger fear and a sense of being out of control.</p> <p>Proper training before any incident occurs will allow personnel to make sound decisions when they are responding to an incident.</p> <p><b>Key questions to ask:</b></p> <p>Are you injured? Is there an exit? Are people in the vicinity? Can you call for support? Who could harm you? Where are they?</p> <p><b>If a person is behaving violently:</b></p> <ul style="list-style-type: none"> <li>• Keep as much distance as possible from the person, try to remain close to an exit point, and don't raise your voice.</li> <li>• Check the environment to see if the person is alone and who else is around.</li> <li>• Ask questions <b>as calmly as possible:</b> What does the person want? Who would the person like to speak to? What could you do to help?</li> <li>• Invite the person to go to an isolated area for a conversation, and try to prevent others from being exposed to danger.</li> <li>• Invite the person to sit down, because it is more difficult to be aggressive when seated.</li> <li>• Use mirror techniques<sup>8</sup> to check if you understand the person's needs and demands correctly.</li> </ul>
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<sup>8</sup> These are ways of showing that you are listening to and understand what the person is saying. You could say "I understand" when they make demands to show that you are listening to them, or repeat their demands to show that you understand what they are saying, e.g. "So you want your wife/child/brother/friend to be treated immediately".

	<p><b>If a person is armed:</b></p> <ul style="list-style-type: none"> <li>• Lift your hands to demonstrate you are not armed and that you want to cooperate, but do not make sudden moves.</li> <li>• Try to remain calm and move towards an exit, but avoid exposing others to danger.</li> </ul> <p><b>If there is shelling outside:</b></p> <ul style="list-style-type: none"> <li>• Stay away from windows, doors or any other structure through which shells, glass or debris could come.</li> <li>• Hide behind masonry or concrete walls, but if this is not possible, lie flat on the floor.</li> <li>• Close and/or reinforce doors and, if possible, close and cover windows.</li> <li>• Do not expose yourself immediately after the shelling seems to have stopped. Wait a little longer before leaving the place where you have sheltered and try to contact someone outside the facility to confirm it has stopped.</li> </ul> <p><b>If there is an arrest or abduction:</b></p> <ul style="list-style-type: none"> <li>• Do not try to escape or fight back, because cooperation usually leads to less physical harm and establishes a better rapport with the captors.</li> <li>• Remain observant and gather as much information as it is safe to do.</li> </ul>
Response actions	<ul style="list-style-type: none"> <li>• Check on people: Is everyone accounted for? Are people behaving in a safe way? (if not, guide them).</li> <li>• Help people to find shelter by following the plans made in the preparedness phase: are people present who would find it difficult to move to a shelter? (elderly or people with reduced mobility). Are unaccompanied children present?</li> <li>• Check if critical areas are isolated and out of harm's way.</li> <li>• Lock up or barricade doors and windows that may increase the facility's exposure to violence, or take steps to control how people enter or leave the facility (whichever is more appropriate at the time).</li> <li>• Isolate areas that can shelter people.</li> <li>• Take steps to control fires and prevent electricity cuts or short circuits.</li> </ul>

<p>Coordination procedures</p>	<ul style="list-style-type: none"> <li>• Call for help as soon as it is safe to do so – the contact person and the flow of support should have been previously defined in the preparedness phase.</li> <li>• Remember to focus on essential information in order to explain the emergency as quickly and clearly as possible. Provide information that answers the following questions: What is happening? Where is it happening? How many people are involved in the situation? Are the perpetrators still there? Is there any further immediate risk (fire, electrical cuts or short circuits, damage to the facility's structure)? Is it possible to communicate information about what is happening or needed, and if so, when? (Think of the key questions: What? Where? Who (health personnel/perpetrators)? What next? When?)</li> <li>• Call for medical evacuations if injured people need to be transferred. How many injured people need to be transferred?</li> <li>• If needed and possible, ask for people to be evacuated and essential materials/equipment to be relocated to safer places. Find out whether other health care facilities can take over some or all of the people and material/equipment.</li> </ul>
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## Adapting contingency plans to a wide range of possible scenarios

Perpetrators of incidents of violence against health care may not always use weapons. For example, the contingency plan for incidents where ambulances are stopped at checkpoints may prioritise rapid and effective communication and coordination actions to ensure that passage is granted to the ambulance team.

Response plans may also need to take into account the impact of an incident on health workers or patients. For example, some types of incidents may leave health workers or patients in a highly emotional and distressed state, and contingency plans need to include appropriate procedures to deal with this.

Contingency plans can identify responses to warning signals such as shootings in the neighbourhood or agitated behaviour among weapons bearers in the area.

Personnel need to know about and be trained to implement all contingency plans. Key elements require regular practice, such as evacuation, lockdown or communication procedures.

Contingency plans need to include plans to communicate with people who will not have received training, such as patients and their family members.



## Challenges

### Reactions of survivors to violent incidents

Violent incidents of any kind might trigger strong emotional reactions in some people. This can include crying, shouting, laughing, trying to escape in dangerous ways and/or freezing. These are all normal reactions, even in response to non-critical incidents. Reactions should not be judged, mocked, or stigmatised, and people should not be blamed for reacting in the way that they do.

Preparedness, including training, team discussions to identify fears, and well-developed supportive strategies, helps to reduce stress and limit behaviour that may put individuals at greater risk during an incident.

Some people may require specialised mental health support if signs of distress are persistent over time. A specialist should assess this.

Contingency plans also need to be designed to support people who were not trained to respond to violent incidents, such as patients or their family members.

### Training

Training personnel and regularly practising the key actions laid down in the contingency plan are essential to ensure that it can be implemented when required.

### Asking security forces for help

In many contexts, security forces might be associated with or directly implicated in violent incidents affecting health care. Asking for their support in such circumstances may expose health services to greater risks, and humanitarian organisations may be better able to provide support during a crisis.

Some health services may decide to rely on private security personnel when they are operating in areas where heavy criminality is present. These private security personnel are usually tasked with protecting entry/exit points and managing low-level interpersonal violence, so they are not expected to confront people who are carrying weapons.

Ensure that the need for contacting security forces and asking for their support is evaluated in the risk and vulnerabilities assessment phase of the risk management cycle, and that the contingency plans specify the scenarios when support will be asked for and the specific individuals or security forces units that will be contacted to ask for help.

## Further resources

### Additional guidance on safe behaviour and response actions

Poster with reminders on techniques for de-escalating violent behaviour – [Defusing Violent Behaviour in Health-care Settings](#)

SAFE: Security and Safety Manual for Humanitarian Personnel – ICRC (especially Chapter 11)

Safe behaviour and passive security – [Staying Alive](#) (especially Chapters 4, 7 and 8)

General security guidance for safe behaviour and security of premises – [Stay Safe: The International Federation's Guide to a Safer Mission](#) – IFRC (especially Chapters 2, 4 and 5)

Closing an office – <https://www.gisf.ngo/resource/office-closure/>

Managing sexual violence – <https://www.gisf.ngo/resource/managing-sexual-violence-against-aid-workers/>

Managing an abduction – <https://www.gisf.ngo/resource/abduction-and-kidnap-risk-management-guide/>

### Example of good practices in managing violent incidents

Prevention and protection against attacks on healthcare: good practices – WHO (Chapter 5)

Coordination and evacuation practices – [MSF report of attack](#) (see page 7)

Dialogue with community to unblock access – [Frontline Negotiations](#) (pages 10-12)

## Take-aways:

- ➔ The impact of an incident can be greatly reduced when contingency plans have been prepared and effectively disseminated, and personnel are properly trained to implement them in an emergency.
- ➔ When responding to an incident of violence against health care, the priority is to save the lives and ensure the dignity of people affected by the incident.
- ➔ Several types of safe behaviour and response actions may be used to de-escalate or mitigate the impact of a violent incident.
- ➔ All staff working in the health facility should be trained to respond to violent incidents and take appropriate action. They need to know their roles and expected behaviour should an incident occur.

# The aftermath of incidents, and working towards sustainable access to health care

## Objectives of this chapter



### Groundwork

Develop policies to care for survivors (health service employees, patients and their families), define criteria to ensure that services continue after an incident has occurred, and design a system for documenting incidents of violence against health care.



### Action

Provide immediate and long-term care for survivors of incidents; document the incident; implement the needed recovery actions; and ensure that the lessons learned from the experience are used to inform the updating of the security risk management cycle.



### Challenges

Striking a balance between ensuring sustainable access to health care and mitigating security risks in the health service; and continuously learning from an experience and adjusting preventive measures accordingly throughout the security risk management cycle.



## Groundwork

### Reducing negative impacts in the aftermath of a violent incident

Violence against health care is always a tragedy and will have many adverse consequences for staff, the health programme, patients and people's access to health care. The level and extent of this impact does not only depend on the perpetrator/s of acts of violence, but also on the way in which the service responds to an incident and succeeds in restoring the health service's ability to function properly. Better and faster mitigation measures prevent violence against health care from having lasting and serious consequences for health outcomes. Responses in the aftermath of a violent incident are more effective when they are planned and agreed on before a crisis occurs.

## Supporting health programme employees who have survived violence

Providing support for health programme employees who have survived violence is a priority. The benefits that survivors are entitled to and how the programme will deliver support to staff need to be specified before a violent incident occurs. Employees who survive violent incidents risk being even more traumatised if they have to struggle to obtain support due to a lack of policies or an adequate response from their employer.

Policies to support survivors who are health service employees:

- Define policies and procedures to provide health care for both mental and physical health needs.
- Carefully consider appropriate language and ways of communication that can be used to contact and speak to survivors and their families in a humane and dignified manner, in particular when communicating sad or disappointing news. If health service personnel have been killed in an incident, ensure that when their families are informed, the lives and work of their loved ones are honoured.
- Clarify entitlements related to the provision of financial support to survivors in order to avoid further distress, particularly when expensive rehabilitation is needed.
- Clarify entitlements related to the provision of financial support to health care workers' dependents if workers have been killed or are unable to work.

## Supporting patients and communities

Community members and patients directly affected by violence targeting health care also need support. Identify the health service's responsibilities towards the communities in the aftermath of an incident. Decide on mechanisms to monitor the impact of violence against health care on community members' health-care-seeking behaviour.

Table 7 presents some actions that can be implemented to care for survivors of a violent incident.

**Table 7: Caring for survivors of a violent incident**

Supportive action	Group who may benefit from the intervention
Immediate psychological first aid and first aid for physical wounds or injuries	<ul style="list-style-type: none"> <li>• Staff working in the health facility</li> <li>• Patients and family members</li> <li>• Community members near the incident</li> </ul>
Direct access to curative or rehabilitation services according to policy, as needed	<ul style="list-style-type: none"> <li>• Staff working in the health facility</li> <li>• Patients</li> </ul>
Direct access to mental health support and specialised care, as needed	<ul style="list-style-type: none"> <li>• Health care personnel</li> <li>• Patients</li> </ul>
Support to families of dead or severely wounded people	<ul style="list-style-type: none"> <li>• Health care personnel and their families</li> </ul>

## Reporting violent incidents

The WHO and ILO state that every health care service should have an **internal mechanism for reporting violent incidents**. The systematic documentation and reporting of incidents will allow health service managers to become aware of the patterns of violence that the service faces, which will in turn allow them to draw up more appropriate contingency plans to deal with such violence and then update these plans in light of any new circumstances that have been reported.

Health programme managers should set up reporting mechanisms and should encourage the reporting of incidents. Health workers should **not normalise incidents of violence** (i.e. they should not be allowed to think that violence is a normal part of their work experience), even if such incidents happen frequently.

When reporting incidents, the following information should be included:

- Who was involved in the incident
- What happened
- Where the incident occurred
- When the incident occurred
- What has been done about the incident and if help is still needed.

The system for reporting can be very simple, using paper forms or basic spreadsheets, or more complex methods can be used involving digital technologies.

Designate a person to be responsible for systematically reporting violent incidents in line with established practice. Ways to protect data must be specified according to good practice and legal requirements, and personally identifiable information should always be kept confidential. Mechanisms need to be in place to ensure that only people who need to know have access to sensitive information.

The sharing of information on incidents through trusted networks can support wider context and risk assessments and build a community of support for health services working in conflict-affected environments. Information about incidents can also be shared with those advocating for the proper protection of health care during conflict. It is important to reflect upon and describe in detail processes for information sharing experiences in dedicated protocols or agreements.

Publicly acknowledging that violent incidents have occurred can be important for transparency, to build trust among communities, and prevent misinformation and disinformation. Humanitarian organisations' communication departments may need guidance on how, when and what to publicly communicate following an incident.

### Reporting the consequences of violence

Better awareness of the consequences of violence against health care provides key information needed to design the best mitigation measures and will improve programming and budget allocation for better protection practices.

Reporting the consequences of a violent incident should cover the following points:

- Were health services interrupted or closed because of the incident? If so, which services and for how long?
- Who was affected by the interruption of services?
- What data is available to document the impact of a violent incident?
- How many patients have used the service after the incident, compared to before it occurred.
- How has the incident affected health workers' ability to provide the best possible care?
- Have you lost trained staff? Are there increased staff absences? Is it difficult to recruit staff? Is there a change in who works in the health programme?
- Which utilities, infrastructure and medication were affected?
- Which drugs were lost and what has been the impact?
- Which medical equipment malfunctioned or was lost and what was the impact?

### **Near misses and best practice**

Because the objective is to ensure that the worst impacts of a violent incident can be prevented, it is important to report near misses, and when an incident occurred but was partly dealt with and even worse consequences were avoided. This helps to document best protection practices.

Reporting near misses should seek to answer the following questions:

- Which factors prevent an attack from causing more harm than it did?
- What should be in place to ensure that the lessons learned from this incident are systematically applied?

### **Deciding whether a health service should continue to operate or not**

Difficult decisions have to be taken in the aftermath of a violent incident. One of the most difficult is whether to continue operations or not. Such a decision should not be taken lightly, but the possibility of closure needs to be confronted and prepared for.

Therefore, as part of the contingency plans for dealing with a violent incident, criteria need to be defined that will enable the health service's management to decide whether the health care programme can continue as usual or not.

Such a decision is not taken lightly, and must be taken only after carefully considering the further danger to personnel and the health service that may occur if services are continued, and the threats to community members' health and well-being if operations are closed even for a short time.

### **Ensuring that services continue after an incident**

It is to be hoped that health services will continue to be offered after a violent incident has occurred.

As part of the preparedness phase of the risk management cycle, the manager of the health care service, supervisors, and other health care authorities need to predefine criteria that can be used to assess how critical a health programme is, ways to protect staff and assets, and medical needs. These criteria should be discussed and defined before incidents occur to give managers the confidence to make difficult decisions during a crisis. Sign-off procedures that apply during an emergency need to be clear.

Ensure that mitigation procedures are identified and in place that will in most cases allow the health service to continue its operations. This could include, for example, the following:

- Ensuring that generators and fuel to run them are available or can be replaced
- Designing procedures to replace solar panels
- Designing procedures to replace stolen or lost medication
- Designing options to move or refer patients to other health care providers in the area

In the preparedness phase of the risk management cycle, plan the replacement of items that could be lost in an emergency, including generators, extra beds, and consumable medical items such as gloves, masks and gowns, trays, and diagnostic kits. In the aftermath of an incident, implement these plans if necessary.



## Action

### Who in the health team takes the lead in the aftermath activities?

- **Caring for people:** Staff members with clinical capacity or first-aid skills lead on providing immediate care to patients and potentially injured colleagues; all staff with appropriate training may provide immediate psychosocial support.
- **Documenting the incident:** The manager leads on documenting the incident and sharing relevant information with key partners, as agreed in the protocols.
- **Balancing access security and access to care:** Managers and supervisors lead decision-making to ensure that the service's work continues and an assessment of current or new risks is updated in light of the events that have occurred.

These activities can be implemented in partnership with other health services or humanitarians. Especially during recovery efforts, the support of local authorities, humanitarians and other funding bodies might be needed.

## Caring for people

In the aftermath of an incident, the manager of the incident response should **ensure that everyone affected by the incident has been accounted for and that staff, patients, and their family members are safe and receiving care.**

Focus the response on the **well-being of people affected by an incident**. Ensure that people are not retraumatized by the response to the incident or exposed to judgement and blame.

Ensure that people providing evidence about the incident are protected from retaliation.

## **Documenting the incident according to the pre-planned procedures**

Information about the incident needs to be reported and stored according to the pre-planned procedures. The final incident report should include perspectives from the various people involved before, during and after the incident.

Use the information in the report to learn from the incident and prevent further incidents. Information can be used to:

- generate consolidated data (monthly, quarterly, yearly, etc.)
- carry out trend analysis
- request **accountability-seeking activities** from local security actors, other humanitarian agencies, protection mechanisms, and advocacy organisations
- address structural problems with authorities
- where feasible or possible, engage with perpetrators

## **Implementing recovery measures needed to ensure that services continue**

Implement the service recovery plan as soon as it is safe to do so in order to reopen services and replace lost supplies, equipment and infrastructure. The recovery measures should be adapted to the medical needs of the population and to the capacity to care for patients and ensure the safety and security of patients, health workers and the facility. Any response should support the existing capacities and efforts and not undermine them. Remember that staff absences may make the provision of specific care difficult unless additional staff are recruited. Assess the risks that replacing staff may trigger repeat attacks.

## **Learning from the incident and improving access to health care**

If they are properly responded to, tragedies can help a health service to do better in future. Learning from an incident means understanding its causes and contexts, and should not involve blaming individuals and circumstances. Most tragedies are the result of a particular combination of problems, people, and needs that combine in an unpredictable way in an unpredictable situation. Often small process failures can combine to cause the devastating impact of a particular incident. The objective of the learning review is to identify the small failures within a best practice system and find ways to correct them.

The learning exercise should focus on measures that need to be adjusted or implemented to prevent violence from affecting health care and health workers in tragic ways. The learning exercise should identify what needs to be renewed or reinforced in the health service's awareness and preparedness activities.

**Discussions in the aftermath of a violent incident** can provide key answers to improve results in the preventive part of the risk management cycle. Leaders need to create and reinforce a culture

that counteracts the blame game and makes people feel both comfortable with and responsible for recovering and learning from the tragedy. As part of this process, it is important to avoid simplistic conclusions like simply advocating for more physical security measures. What is needed may well be steps to strengthen the community's acceptance of the health service and increase community engagement, instead of higher walls around the facility.

### **Some key questions to consider after an incident of violence against health care:**

- What triggered the violence?
- Could the incident have been foreseen or prevented?
- How was the contingency plan implemented?
- What worked well?
- What was missing?
- Have the security policy and measures been reviewed?
- Is a full reassessment of risks needed?
- Is it necessary to change the contingency plan?
- Is there any other preventive or risk-reducing action that should be included in the contingency plan?
- What do affected staff or patients think and feel?
- Have their priorities and needs been addressed?

### **Reviewing the impact of violence on the health programme:**

The purpose of a health programme is to deliver health care, therefore the impact of violent incidents has to be assessed in relation to how this affected the provision of care.

### **Key questions to ask in the aftermath of an attack:**

- Is the health service functioning as it is expected to?
- Are people still coming to the service and seeking health care?
- Are health care workers coming to work normally?
- Are people afraid of something similar happening again?

**The security risk management approach demands that the post-incident learning process should be used to reassess and adjust the other steps of the risk management cycle.**

The efforts to learn from the response to an incident and the actions taken in its aftermath do not stop immediately after an incident has been assessed! The findings from this learning process should be used to inform the restarting of the risk management cycle, any adjustments that need to be made to preventive measures, any steps that need to be taken to strengthen certain activities, and efforts to hold dialogues with the community and others. **Remember that the cycle of security risk management requires the constant re-evaluation of what is working and what needs to be reinforced or changed.**



## Challenges

### **Striking a balance between sustaining access to health care and protecting health personnel and patients from risk**

After an incident of violence against health care, quickly reopening a service that is still under severe risk of attack may expose health care workers and patients to further risks. Health programme managers need to balance maintaining access to health care (i.e. offering a service to people in need and providing high-quality care to them) and avoiding putting staff and patients in undue danger. Further attacks on the health facility or patients travelling to reach it may occur. The closure of a service (partially or entirely) for a certain period might save lives because it avoids unnecessary exposure to further violence. At the same time, it may cost lives if no alternative health care services are available. The longer the service remains closed, e.g. because it has not been properly prepared to manage the aftermath of an incident, the more people in need of health care will be deprived of their right to it.

For services that operate under a high degree of volatility that may result in violent incidents, such as ambulance services, it might be necessary to constantly reassess risks as they arise, in an almost real-time decision-making process. For fixed health facilities such as hospitals or clinics, the key element might be identifying whether damage to the facility itself or to routes that people use to access it poses danger to the people circulating in the area. Whatever the case, the criteria used to define what is considered to be safe must be relevant to the local context and circumstances, and health authorities should delegate the power to on-site health service managers to quickly gather the necessary information and assess the best course of action in these particular circumstances.

### **Continuously applying the full security risk management cycle**

Addressing violence against health care requires all stakeholders to continuously implement and reassess the full cycle of security risk management discussed in this handbook. Isolated actions do not prevent violence from impacting health care. Good practice requires a continuous cycle of learning, making adjustments, and developing better practice to increase awareness and preparedness and respond to and learn from incidents.

### **Further resources**

#### **Additional guidance on supporting people after a violent incident**

Supporting the staff – [Occupational Violence and Aggression Post-incident Support](#) – Victoria State Government Health and Human Services Department, Australia

Supporting the staff – [Creating Safer Work Places](#) – American Hospital Association, page 7

[Psychological First Aid: Guide for Field Workers](#) – WHO

[On-line Training of Trainers in Psychological First Aid](#) – IFRC

## **Additional guidance on documenting a violent incident**

Documenting an incident – [Security Incident Information Management](#) – Insecurity Insight  
Data collection, Incident Reporting Form, [Toolkit: Evidence that Protects Health Care](#) – IRC,  
Insecurity Insight, PHR, SHCC and JHU

## **Examples of good practices in aftermath care and documentation**

[Prevention and Protection against Attacks on Health Care: Good Practices](#) – WHO (Chapters 2 and 6)  
[Using data to improve action to prevent violence inside hospitals](#) – [American Hospital Association](#)

## **Take-aways:**

- ➔ After a violent incident, the first and most important action is to care for the survivors to the extent possible. Other steps can be taken to provide immediate and long-term health care in response to the physical and mental needs of people who were affected by an incident.
- ➔ In the aftermath of a violent incident, the impact on health care delivery should be assessed, including both the impact of the incident itself and the measures that were taken after the incident.
- ➔ The incident must be reported to ensure that the factors affecting the severity of the incident will not go unnoticed and lessons are learned. The proper reporting of incidents allows a systematic approach to the issue, including understanding the incident itself and the trends it might show, and using the information contained in the report to assess accountability and advocate for stronger preventive measures.
- ➔ Any corrective or recovery measures to respond to the consequences of the incident must be taken in parallel with a review of the risks and current realities affecting the health service. Reviews of protocols and measures should not be done to blame people, but to learn from what happened.
- ➔ Lessons should be learned and implemented, and the relevant security risk management policies and procedures should be continuously updated accordingly.

# Annex 1:

## Aide-memoire to support the risk assessment and context analysis

### Violent incidents that could affect health care

**Remember: incidents may impact people, structures, or vehicles, or may block or hinder access to and the delivery of care!**

#### Interpersonal or reactive violence (no use of weapons)

- Verbal abuse
- Physical assault
- Coercing, intimidating or threatening health care personnel
- Sexual assaults against health personnel, patients, or people in a health facility or medical transport vehicle

#### General criminality

- Theft or robbery of personal items within a health facility
- Theft or robbery of medical goods, equipment and transport vehicles
- Looting of health facilities, medical storage facilities or medical transport vehicles
- Destruction of health facilities, medical storage facilities or medical transport vehicles (this includes arson)

#### Violence using weapons

- Shelling, bombing, or setting fire to a health facility or medical transport vehicle, even if there are no victims (deaths or injuries)
- Shooting at a person (health personnel or patients), health facility or medical transport vehicle, even if there are no victims
- Armed entry into a health facility, with hostile behaviour towards people
- Shooting at a medical transport vehicle while it is moving
- Killing medical personnel or patients
- Injuring health personnel or patients
- Coercing, intimidating or threatening health personnel

#### Blocking or hindering health care in some way

- Kidnapping health personnel or patients
- Intentionally blocking health personnel from reaching people in need of care

- Intentionally blocking patients from reaching a health care facility
- Misinformation or disinformation campaigns to prevent health services from being delivered
- Arresting health personnel for carrying out their duties in line with medical ethics
- Arresting or abducting health personnel to intentionally reduce or compromise the delivery of care
- Denying or deliberately failing to provide assistance to people in need of health care
- Discriminating against people in need of health care
- Forcibly interfering with the functioning of a health facility or medical transport vehicle (e.g. depriving them of electricity, water, fuel, etc.)

## **Elements that may play a role in a context analysis by increasing risks or exposing the health facility, a transport vehicle, the health team and patients to danger**

### **Possible scenarios**

- Ongoing hostilities causing overwhelming health needs or reducing the availability of care
- Proximity to front lines during hostilities
- Weapons freely circulating in the area (regardless of whether they are legally owned or not)
- Social protests or civil unrest
- The provision of health care services during a state of siege or in encircled, divided or occupied territories
- High levels of criminality in the area
- Areas frequented by military personnel or near military bases
- Restrictive cultural environment (e.g. affecting behaviour, personal relations, etc.)
- History of violence against health care in the area
- Presence of armed groups restricting normal access to health care or health goods
- Existence of legislation or security practices that restrict access of certain groups to health care
- Existence of legislation or security practices that criminalise care for certain groups
- Interference with health services or the dissemination of negative information about such services for political gain (e.g. vaccination programmes, Ebola interventions, etc.)
- Aggressive social media campaigns

### **Possible triggers of health care response/intervention**

- Mass-casualty event (especially those involving violence, like a terrorist attack)
- Public health emergency
- Newly discovered pathogen or treatment

- Violent incident (e.g. domestic violence or the need to treat war-related wounds)
- Negative community response a new service that was previously not available and that people may not understand
- Closure of services in the surrounding area or closure of a particular service in the facility
- Lack of acknowledgement of the service by armed actors, community members or other influential stakeholders

## **Nature of the services provided**

- Provision of emergency services (including by, but not restricted to, emergency departments)
- Mental health services
- Provision of sexual and reproductive health services
- Mobile health services (e.g. ambulances, vaccinations)
- Epidemic or pandemic response
- Provision of services to marginalised, discriminated against or specifically vulnerable populations (e.g. people living with disabilities, detainees, displaced people)

## **Structure of the facility**

- Lack of or inadequate waiting areas for people accompanying patients
- Lack of the ability to control people circulating within the health facility
- Lack of control over people's entry to and exit from the health facility
- Lack of division between different areas in a health facility
- Lack of private space for health care personnel to rest
- Makeshift or temporary structures (less able to resist if attacked because usually made of plastic or other flimsy materials)
- The presence of dormitories or other spaces for longer-stay patients or people attending to/ accompanying patients, which may lead to various forms of co-living and tensions

## **Personnel**

- Team working for long periods without rest or working under continuous stress
- Team predominantly composed of less experienced members
- Team predominantly composed of members with a high degree of resistance to change or with a "I want to be a hero" attitude
- International team, or team coming from a different part of the country
- Team members who do not speak the local language
- Team members with poorly developed communication skills for a particular context
- Team members with previous exposure to violence and/or who normalise the violent events

# Annex 2: Examples of context analyses, risk assessments and contingency plans

## Example 1

*A drug storage facility was looted in the night, and the health service manager triggered appropriate responses when he arrived at the facility next morning.*

### Example of a possible context analysis

- This is a primary health care facility in a rural village with a catchment population of 15,000 people from the same ethnic group and religion.
- Gangs are present in the area and some criminal acts have occurred, while police are sometimes hostile towards the population, which they see as being “aligned” with the gangs.
- Team: two nurses, one doctor, two health care assistants. A doctor is the team lead, and a supervisor from the district office visits once a month.
- Incidents that occurred in the past year: two incidents of looting (including the one in the night that triggered the response to address this violence), three threats against health workers (two by gang members, one by the police), one incident of shooting in the area surrounding the facility (between gang members and the police).

### Example of a possible risk assessment using the risk assessment matrix (see Table 3 on page 33)

Violent incident/ event	Likelihood	Impact	Vulnerable person or object (what/where/who?)
Threats against health workers	Likely	Moderate	Health personnel
Looting of medical drugs	Somewhat likely	Severe	Drug storage facility/area, availability of supplies
Assault on health workers	Unlikely	Severe	Health personnel
Intentional denial of care to a person in need (e.g. if the person is seen as a criminal)	Likely	Severe	Patients, people in need of care
Shootings in the surroundings of the health facility	Unlikely	Minor	Health facility structural integrity, people circulating in and out of the health facility
Hostile armed entry into the health facility	Somewhat likely	Moderate	People circulating in the health facility
Theft of personal items in the health facility	Unlikely	Minor	Personal objects of people circulating in the health facility

*Other issues that might be identified that increase exposure to risks:* doors are in bad condition, making it very easy to break in; police and gang members believe that the health service is passing information to the “other side”; health care assistants and one of the nurses have only just started working in the community; health care services are often unavailable for gang members because they are scared to come to the health facility.

**Plans to increase the facility’s preparedness – and when they should be implemented:**

- *Mitigate or prevent threats against health workers:* create radio spots to talk about the importance of respect for and trustful relations with health workers; discuss with the community the importance of medical confidentiality; ensure training in medical ethics for all health personnel (especially the new members) – **in the next months.**
- *Prevent looting of medical drugs:* reinforce security around the drug storage area with stronger doors or locks, and evaluate if it is possible to install an alarm system to sound an alert if someone breaks in – **URGENT.**
- *Prevent the intentional denial of care:* hold discussions with the security forces (police) to talk about the ethical duties of health workers and the need to provide care to all, without distinction; request support from the health authorities to define the protocols that should be followed if security forces are searching for a member of an armed group, in order to avoid creating negative perceptions for the health team – **as soon as possible.**
- *Assault on health workers:* define safe behaviour and how to take shelter (hide) if a hostile person is in the health facility; define coordination mechanisms to request external help to control the hostile person (ideally, by working with community members) – **URGENT.**
- *Hostile armed entry to the health facility:* paint and hang posters forbidding people from bringing weapons into the health facility, and ask the community to support the initiative and obey this rule; train health team members to adopt safe behaviour if there is an armed threat – **in the next months.**
- *Shootings in the health facility’s surroundings:* discuss with the team the need for safe behaviour and train them to carry out contingency actions, such as closing and blocking windows and doors – **if and when possible.**
- *Theft of personal items:* remind people circulating in the facility to keep their personal items safe, and carry out community-level activities to reinforce the need to respect the environment of the health care facility – **URGENT.**

## Example 2

*A health service is coping with an outbreak of infectious disease in a conflict-affected context. They assess the risks they face in this context and decide to integrate actions into their daily work to address tensions with the local community and other types of insecurity.*

### Example of a possible context analysis

- This is a primary health care facility in a rural village with a catchment population of 20,000 people; the facility works mostly through outreach activities.
- Team: two nurses, six community health workers. A doctor supervises the work and visits the clinic twice per week, but does not participate in the outreach activities.
- Outreach activities are planned and carried out with the support of community leaders. The team is identified with blue vests donated by the regional department of health.
- Currently there is an ongoing outbreak of a known infectious disease affecting mainly children who have missed or skipped vaccinations. The community understands the need to vaccinate, but they do not like to be pressured or feel that the health team is invading their daily lives.
- Incidents that occurred in the past year: one theft of the personal items of a community health worker during an outreach activity, two threats by community members who did not want to be home-visited, one situation of verbal aggression between the doctor and a community leader who disagreed on the prioritisation of actions to assist the community.

### Example of a possible risk assessment using the risk assessment matrix (see Table 3 on page 33)

Violent incident/ event	Likelihood	Impact	Vulnerable person or object (what/where/who?)
Threats against health workers	Somewhat likely	Moderate	Health personnel
Assault on health workers	Very unlikely	Severe	Health personnel
Verbal aggression between community members and health personnel	Somewhat likely	Moderate	Reduced trust, less coordination for outreach activities
Theft of personal items during outreach activity	Somewhat likely	Minor	Personal objects of people circulating in the health facility

*Other issues that can be identified that increase exposure to risks:* the outbreak response has not been discussed with community leaders, but simply mandated from the regional office of the department of health; only four out of six team members have phones that can be used in an emergency (the other ones only work if there is sufficient airtime credit); the issue of the tension between the doctor and the community leader has never been addressed.

### **Plans to increase the facility's preparedness – and when they should be implemented:**

- *Mitigate or prevent threats against health workers:* develop community forums where people can come and present their views about the health service and what it offers; discuss with the community the importance of containing an infectious disease outbreak and the means to do it – **URGENT**.
- *Assaults on health workers:* define safe behaviour and the coordination mechanisms to request external help in case the team is working away from the facility; help all health personnel to keep minimal airtime credit in their phones for emergency scenarios; define the team protocols and codes used to indicate that the environment is unsafe and that they should pack their equipment and leave – **URGENT**.
- *Verbal aggressions between community members and health personnel:* paint and hang posters encouraging respectful behaviour; train the team to adopt specific de-escalating behaviour in cases of aggressive interactions, but also make them self-aware of their own behaviour – **as soon as possible**.
- *Theft of personal items:* remind health personnel to keep their private belongings safe during outreach activities; carry out community-level activities to reinforce the need for community members to respect the safe delivery of all health care activities – **URGENT**.

### **Example 3**

*A community is experiencing mounting pressure from violence, the growing presence of armed actors, and increased fighting in the surroundings that threaten the health service working in the area.*

#### **Example of a possible context analysis**

- This is a secondary-level facility in a small town with a catchment population of 50,000 people, and with 20 beds capacity. It typically receives cases of complicated births, household injuries, road accidents (the most important trauma cases), and people with severe complications due to chronic or infectious diseases.
- Team: two nurses, six assistant nurses, two doctors, one midwife. One of the doctors is also the director of the hospital.
- The town is being increasingly surrounded by armed actors fighting a regional conflict, and the small hospital is receiving almost daily trauma cases resulting from the fighting. This increases the health care needs and results in a lack of capacity to cope with surges in patient admissions. The hospital director is worried that the hospital might get caught in the fighting as the front line approaches.
- Incidents that occurred in the past year: one theft of a doctor's personal items, two threats from community members who wanted their family members to receive priority care, two reported cases in the past few weeks of patients who had died at home because it was unsafe to go out and seek care at the hospital because of shooting in the area.

**Example of a possible risk assessment using the risk assessment matrix (see Table 3 on page 33)**

<b>Violent incident/ event</b>	<b>Likelihood</b>	<b>Impact</b>	<b>Vulnerable person or object (what/where/who?)</b>
Assault of health workers	Somewhat likely	Severe	Health personnel
People unable to come to the hospital due to insecurity	Very unlikely	Severe	People in need of care and access to health care
Shootings in the hospital surroundings	Very likely	Moderate	Health facility structural integrity, people circulating in and out of the health facility
Hostile armed entry to the health facility	Somewhat likely	Moderate to severe	People circulating in the health facility
Theft of personal items during outreach activity	Somewhat likely	Minor	Personal possessions of people circulating in the health facility

*Other issues that can be identified that increase exposure to risks:* the entry and exit points of the hospital compound are not well controlled and the gate is open most of the time; there is currently no coordination mechanism between the ambulance service and the hospital (the ambulance just arrives whenever it picks up a patient, but there is no previous warning or communication between the services); local people know that the compound is a hospital, but there are no proper external markings or means of identification that can inform strangers entering the area that the building is a hospital; there are no identified safe areas within the small hospital building.

**Plan to increase the facility’s preparedness – and when it should be implemented:**

- *Assault on health workers:* define safe behaviour and the coordination mechanisms used to request external help in case the team is assaulted; make means of communication available to be used in emergencies; implement policies to safeguard and support survivors – **URGENT**.
- *People unable to come to the hospital due to insecurity:* develop and implement a coordination mechanism with the ambulance service so that ambulances can be on standby for cases in need of urgent transport; remind the ambulance service to also operate according to a risk management protocol designed to prevent further casualties and injuries; communicate externally (via radio or other public information channels) about the importance of allowing people in need of care to make their way safely to a hospital; as far as possible, establish channels for remote support for urgent cases (e.g. hotlines over which people can receive advice through the phone) – **URGENT**.
- *Shootings in the health facility’s surroundings:* discuss with the team the need for safe behaviour and train them to carry out contingency procedures such as closing and blocking windows and doors, moving patients to areas with less exposure to external walls, and ensuring that the hospital’s external perimeter is adequately identified with hospital signs; request the relevant authorities to issue public statements and directly

communicate with conflict parties to encourage them take due precautions when fighting in the vicinity of a health facility – **URGENT**.

- *Hostile armed entry to the health facility*: paint and hang posters forbidding people from bringing weapons into the health facility; train the team to adopt safe behaviour practices to deal with an armed threat; reduce the number of entry and exit points to the compound and the building and control these exit/entry points properly; define coordination mechanisms to request external support to deal with an immediate threat and/or violence – **URGENT**.
- *Theft of personal items*: remind health personnel to keep their private belongings safe during outreach activities, and carry out community-level activities to reinforce the need to respect the safe delivery of health care activities – **if and when possible**.



**Insecurity  
Insight**

Data on People in Danger

The SR4H handbook provides guidance on how to implement a range of actions intended to promote respectful and violence-free environments and prepare individuals or organisations to face and respond appropriately to violent incidents, also dealing with the aftermath of such events. It was developed to assist health services in middle- and low-income contexts affected by situations of insecurity or war. This handbook brings together some of the best practices on security risk management and proposes a framework adapted for health care providers working with limited resources. The objective of this handbook is to promote an approach that considers the safety and security of health professionals while ensuring patients' access to care.

Insecurity Insight is a humanitarian to humanitarian (h2h) organisation which delivers data products and services to humanitarian and aid organisations, advocacy groups and researchers. By offering innovation ideas, tools, data and methodologies, Insecurity Insight enables other organisations to assist and protect people affected by disaster and conflict. Insecurity Insight is committed to the humanitarian principles.

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