TRAINING MANUAL

for Ambulance and Pre-Hospital Response in Risk Situations

HEALTH CARE IN DANGER

IT'S A MATTER OF LIFE & DEATH

Norwegian **Red Cross**

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Front cover A row of helmets at the Lebanese Red Cross.
Photo by Olav A. Saltbones /Norwegian Red Cross

Note on links and references
This manual supports the trainer with detailed content for the training, as well as extra thematic material to strengthen the delivery of the training. You will find references for all mentioned material in the Resources section on pages 132–148. For all boxes like the one below, there will be a full reference with access links.

Reference box
Throughout the manual, these boxes provide the title and short descriptions of additional material to support learning.

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FOREWORD

Violence and threatening behaviour towards healthcare constitute a worrying global trend. They occur not only where there is armed conflict, but also in countries at peace. Every day, ambulance providers and other health personnel are exposed to violence as they carry out their duties. They might be verbally threatened or physically assaulted, even murdered. When emergency services are impeded, citizens, including children, can be deprived of vital emergency care.

The main focus for health workers is always to save lives. Many may feel a sense of contradiction between this duty and putting their own safety first. However, preparing for situations where your team is under threat or attack should be a priority; and awareness that they will enter situations where they may not have a full overview of the risks will help them to meet challenges as safely and effectively as possible.

This training manual is designed to be easily used, and relevant for health workers in operational services worldwide. This version of the manual is a reviewed product from the original pilot version, incorporating the feedback provided by over 35 people who were directly engaged in the pilot trainings. It should be implemented based on an assessment of the context in which the health service operates and of the current standard operating procedures that the service follows to mitigate risk. It focuses on individual protective behaviour and highlights the active role health workers can play in reducing the incidence and/or impact of violence and threats. At the same time, it encourages managers and decision-makers to support protective measures. Health personnel are expected to make contributions, according to their experiences and knowledge, while using the training manual.

The overall goals of this training manual are to:

- Equip health workers with practical skills to improve their security and mitigate the impact of violence.
- Provide a starting point for organisations delivering health services to develop, review and strengthen their emergency preparedness and security management procedures.

One thing is certain: violence against healthcare is unacceptable.

ACRONYMS AND ABBREVIATIONS

EMS	Emergency Medical Services
HCiD	Health Care in Danger
ICRC	International Committee of the Red Cross
RCRC Movement	International Red Cross and Red Crescent Movement
IHL	International Humanitarian Law
IHRL	International Human Rights Law
ISO	International Organization for Standardization
NS	National Society
SAF	Safer Access Framework
SOP	Standard Operating Procedure
WHO	World Health Organisation

TERMS AND DEFINITIONS

The following definitions are necessary for understanding this document

Attacks on healthcare Defined by the World Health Organization (WHO) to be "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. Types of attacks vary across contexts and can range from violence with heavy weapons to psychosocial threats and intimidation."

Definition of "Attacks on healthcare"
Website of the World Health Organization

Emergency Medical Services (EMS) refers to a system of coordinated response, involving multiple people and agencies, that provides emergency medical care. Once activated, the focus of EMS is emergency medical care of the patient(s). An EMS system comprises a range of components, including highly trained professionals such as volunteer and career ambulance and pre-hospital personnel. EMS providers respond to all kinds of emergencies and all kinds of dangers, often working side by side with the police, fire services and public-safety colleagues in law enforcement.

Definition of "Emergency Medical Services"
International website dedicated to informing about Emergency Medical Services

Violence can include threats, harassment, intimidation, robbery, injury, killing and kidnapping. It hinders health personnel from performing their medical duties. Violence can have both physical and psychological impacts. WHO defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."

Definition of "Violence"
Website of the World Health Organization

Healthcare personnel includes all those working in the area of healthcare. For example:

- Those with professional healthcare qualifications, including paramedics, nurses, doctors and pharmacists;
- Those who work in hospitals, ambulance stations, communal health facilities and administrative functions associated with health;
- Medical personnel of armed forces;
- Staff and volunteers of the International Red Cross and Red Crescent Movement (RCRC Movement) involved in the delivery of healthcare;
- Personnel of health-oriented international and non-governmental organisations;
- First-aiders.

Definition of "Healthcare personnel"
Booklet by the International Committee of the Red Cross (ICRC), about the Health Care in Danger Initiative

Hazard or danger, and hazardous or dangerous situations are situations or events with the potential to compromise the health and safety of health personnel, or delivery of services and/or the operational continuity of an organisation or service.

- **Risk** can be defined as the probability of violence and its consequences, such as threats, abuse, harm and suffering.
- **Safer behaviour** is a behaviour that gives a person or an organisation better protection from recognised hazards that are likely to cause harm.
- **A security incident** is a dangerous incident that leads to or may lead to an accident. An accident is an undesired event that results in harm. In this manual, only incidents and accidents relating to the provision of health services, ambulance and pre-hospital and mobile health services will be dealt with.

Definition of "Hazard, risk, safer behaviour and security incident"
ICRC's publication about Weapon Contamination

INTRODUCTION

Why do we need this training?

Physical assaults, verbal abuse, denial of access to those in need of assistance, and threats of violence are just a few examples of how violence affects health workers, including EMS and ambulance providers worldwide. Whether they operate in a zone affected by armed conflict or in a country at peace, the reality is that health workers and ambulance providers are working in high-risk environments. The risks and their consequences vary from context to context, but the better prepared the providers of emergency assistance are, the more securely they will be able to fulfil their duties.

The purpose of this training manual is to help health workers to reflect on how to mitigate risk. This includes how to prepare for dealing with occurrences and consequences of threats and violence.

This training manual is about prevention and mitigation. It focuses on risk awareness and on the role of health personnel in preventing or reducing security incidents before, during and after the delivery of health services. Through the process described in the training, participants will develop a basic set of informed and contextual recommendations services more safely.

BACKGROUND

The idea of developing this training manual is linked to the work of the Community of Action for Ambulance and Pre-Hospital Care Providers (CoA), established in 2016 under the auspices of the Health Care in Danger Initiative (HCiD). The CoA is a network of ambulance providers who discuss challenges and share best practices, with the overall objective of improving the security of their services. In 2016 and 2017, the CoA held online exercises for operational staff to facilitate mapping of the types of violence occurring in different contexts. Case studies developed in the framework of these workshops also revealed gaps in the prevailing response to violence against EMS. This led to the development of this training manual, which is intended to complement existing approaches and tools, such as *Ambulance and Pre-Hospital Services in Risk Situations*, *Best Practice for Ambulance Services in Risk Situations*, *Training Manual on Interpersonal Violence Prevention and Stress Management in Health Facilities* and *the Safer Access Framework*.

Ambulance and Pre-Hospital Services in Risk Situations

This publication identifies a set of contextualised challenges facing healthcare professionals and provides a number of recommendations to improve security and make access safer for ambulance and pre-hospital services in high-risk situations.

Training Manual on Interpersonal Violence Prevention and Stress Management in Health Facilities

This manual focuses on individual protective behaviours, challenging personnel in healthcare facilities to recognise their responsibilities and roles in situations of interpersonal tension and conflict.

Best Practice for Ambulance Services in Risk Situations

This report gives practical recommendations focused on best practice for volunteers and staff conducting ambulance and pre-hospital operations.

The Safer Access Framework

Contains a set of actions and measures that when applied in a context-specific and structured way in tandem with the Fundamental Principles, have been shown to increase acceptance of National Societies, their security, and access to people and communities in need.

WHO SHOULD USE THE TRAINING MANUAL?

This training manual is designed to be used by health workers and/or trainers in health or security programmes, with some aspects requiring a broader engagement from the whole organisation providing the services. The manual is designed to be a 'toolkit' to help deliver training that is appropriate for a given context. It is not a 'one size fits all' solution, so it may be that users will adapt certain sections to strengthen their existing training or choose to use meaningful sections content as a standalone discussion on security risk management[1].

1 There are more adequate, comprehensive trainings with focus on community engagement, non-violent communication, psychological first-aid or mental health support. Please note that the core subject of this training is security risk management for ambulance, pre-hospital and mobile health services.

The trainer should ideally be someone with prior training experience, experience in the topic of security management and be cultural awareness of the working environment of the trainees. Moreover, they should consider prior capacitation in Psychological First-Aid (PFA) and in the training on Interpersonal Violence prevention and stress management in Health Facilities (see further in the Resources section).

HOW TO USE THE TRAINING MANUAL

The training manual provides an overall conceptual and methodological approach to help health workers to increase their resilience in the face of risks encountered as they work. Rather than a prescriptive how-to guide, the training manual offers general guidance, with a dedicated annex where various examples are provided to support the exercises. This can be applied to a broad variety of contexts and scenarios and can be adapted according to local practices.

Part 2 of the training manual is designed to actively involve participants in the learning process, to develop practical recommendations for context-specific situations. The participants will be guided through points of reflection, discussions and group work. The participatory approach is a key element in ensuring contextualisation and ownership of the recommendations developed.

This training will result in a set of recommendations to help safeguard health workers in their daily practice. These recommendations should then be presented to operational management for implementation, representing the key effects of the training in regards to risk management, increasing resilience and capacity to respond to scenarios with varied risk.

It is recognised that the entire manual represents a relatively large amount of training time, which may not be possible in all settings. It is left up to those using the manual to decide who should receive the training, and how much of the content they want to deliver based on the resources they have available. Nonetheless, based on the feedback received after the pilot trainings, it is suggested that the training should take at least three full days, to allow time for a minimal overarching approach. Ideally, the training may be held through a week of work (5 days), enabling in-depth discussions and practical exercises. A full table with suggested time distribution is available in this manual.

There may be elements that are suitable for initial training for all providers, but the manual is designed primarily as ongoing education for health workers with some operational experience.

The manual is designed to be used electronically, but also contains QR Code links in the section titled "Resources" so that the material mentioned here is easily accessible.

STRUCTURE OF THE TRAINING MANUAL

The training manual isdivided into two parts. Part 1 introduces participants to the HCiD initiative of the International Red Cross and Red Crescent Movement, which aims to address violence against healthcare. Then it gives an overview of the legal framework around the protection of healthcare in situations of armed conflict, other emergencies and situations of peace. Finally, the reader is presented with a risk-management approach that can be used to address challenges that health personnel face in their day-to-day operations. As a trainer, this first part will give you key insights and theoretical content to prepare for the training.

Part 2 of the manual is a set of sessions intended to support the implementation of the proposed methodology and identify relevant context-specific measures for risk mitigation. This process is largely informed by the Best Practice for Ambulance Services in Risk Situations report, which is a collection of lessons learnt from twelve National Societies with extensive operational experience in the ambulance and pre-hospital sector. These modules will help you as a trainer to deliver the proposed sessions and better understand how to address the challenges that the training may pose.

FIRST STEPS TOWARDS THE TRAINING

Once the need and relevance of the training have been identified, it is important to follow the steps outlined below. Putting the training together might take several months and the trainer should dedicate time for studying and preparation of the sessions.

1) Carefully read and study this manual for trainers.
2) Ensure key decision-makers and managers in the health service understand the objectives of the training, and that they agree to support further the needed measures that will be implemented as a result of TARRS.
3) Define with key decision-makers in the health service: the right audience, the best time for the trainings, and the sustainability of the work in safety and security
4) Define, as a trainer or with the group of trainers, the material and distribution of contents, according to the availability of time, the space and resources provided and the audience (See details in Part 2 of this manual)
5) Start documenting the implementation of the training by including the needed information in the evaluation framework, already before the training.

A successful training starts weeks before meeting the participants!
Do not hesitate to engage the management and the decision-makers at the service to ensure the training is delivered to the right people, in a concerted sustainable effort: this is not a one-off activity, but one that triggers new measures and reflection about protection and security.

Important! Always make an agreement with management before initiating this training. This is to ensure organisational support and secure the willingness to implement change. You may want to have a letter of commitment or a dedicated project plan that engages the service beyond the delivery of the training.

HEALTHCARE IN DANGER

Why should we learn about Health Care in Danger?

UNDERSTANDING THE CONCEPT OF VIOLENCE AGAINST HEALTHCARE

Violence against healthcare occurs in conflict and non-conflict zones, and may take many forms, depending on the context and circumstances. It affects all layers of healthcare systems, including patients and their families, all types of healthcare personnel including ambulance providers, and medical facilities. EMS are often a first point of contact for those in need, hence their increased exposure to violence and security incidents. Numbers of reported incidents show only the tip of the iceberg as in most contexts it is difficult, even impossible, to track all the incidents and those affected.

> Between 2015 and 2017, the ICRC recorded more than 1,200 incidents of violence against healthcare in 16 countries where it operates, with destruction of or damage to medical transport or medical facilities among the most frequent acts. With 25 per cent of incidents occurring at checkpoints, border crossings or in public places where both patients and healthcare personnel are more vulnerable, the importance of undertaking measures to improve acceptance of and respect for ambulance providers is clear. (Adapted from Gathering Evidence-Based Data on Violence Against Health Care, see below.)

Violence against healthcare precludes access to life-saving assistance when it is most needed. There is a knock-on effect on the entire health system, hindering the provision of preventive and curative health for patients suffering from chronic diseases or accessing public-health services such as vaccination, maternal or neonatal care. For example, damage inflicted on medical transport or health facilities may render them inoperative or may seriously limit their capacity. What has been developed over years can be destroyed in seconds. In a similar vein, the impact of attacks against health workers should be measured in terms not only of how many have been killed or wounded but also how many leave their places of work to seek refuge in safer areas. Some may choose to abandon their profession, given the traumas experienced. As a result, not only patients and their families, but other individuals and entire communities may be deprived of access to healthcare services. Re-creating these capacities takes years.

Gathering evidence-based data on violence against health care

Report with review of scientific studies and operational data from the International Committee of the Red Cross, presenting recent data on violence against healthcare.

Given the multifaceted nature of violence against healthcare, any attempt to tackle its causes and consequences necessarily requires the involvement of different actors and actions. For

example, states must ensure the protection of health services by adopting relevant legislation; weapon bearers need to respect healthcare and comply with relevant legal provisions; healthcare personnel, medical transport and health facilities can implement preventive measures to increase their security and preparedness to withstand the consequences of violence.

The problem of violence against healthcare has been raised by the RCRC Movement via the Health Care in Danger initiative. This initiative sheds light on the prevalence of violence affecting healthcare providers, and promotes the implementation of practical measures to improve their security at local, regional and national levels. In bringing together states, weapon bearers, the healthcare community, humanitarian agencies and anyone else concerned with the issue, the HCiD initiative emphasises that everyone has a role to play in preventing such violence and ensuring safer delivery of and access to healthcare. Bringing in experts and practitioners from the aforementioned constituencies, the initiative aims to map and identify measures that can be implemented to ensure safe access to and protection of health services.

Health Care in Danger (HCiD) Website

More information about the HCiD initiative and the various resources available.

VIOLENCE AGAINST HEALTHCARE

Increasing security around ambulance and pre-hospital services is one of the main workstreams under the HCiD initiative. To map the challenges and identify possible solutions, global consultations were organised with practitioners from ambulance and pre-hospital services both within and outside the RCRC Movement. A workshop organised in Toluca, Mexico, in 2013 provided a basis for the report Ambulance and Pre-Hospital Services in Risk Situations.[2] The report includes a number of recommendations and measures to improve the preparedness and security of these services. The Norwegian Red Cross then worked with twelve National Societies in the Americas and in the Middle East and North Africa region to translate the recommendations into more practical measures based on operational experiences. These are now available in the report Best Practice for Ambulance Services in Risk Situations.[3]

It is important to mention that while ambulance services usually have policies relating to scene safety, many providers still respond in situations of high risk to themselves based on a moral decision. Especially in situations of conflict and violence, ambulance providers will respond during air strikes, rocket attacks and active gunfire despite the imminent risk to their lives. This dilemma between 'safety first' and the 'duty of care' is both very prevalent and very difficult to manage in high-risk contexts.

2 See report available via the Resources section, page 134
3 See report available via the Resources section, page134

Extra resources for sensitization

HCiD: Making the Case
Brief report available in various languages, presenting the issue of violence against healthcare.

Video: The Human Cost
14-minute video that can be used during this session to address the problem of violence against health personnel.

THE LEGAL FRAMEWORK

Its importance for health workers

The rights and responsibilities of health personnel are anchored in international and domestic law and will vary according to whether the response takes place in a conflict zone, another emergency or a peaceful environment. Rights and responsibilities will also differ for military and civilian healthcare.[4] It is important to remember that the responsibilities determined by medical ethics are always valid.

International humanitarian law is the specialised legal framework for armed conflict (either international or non-international) and provides rules that are binding on the parties to a conflict. International human rights law and domestic law apply in all situations (except in few ad-hoc circumstances) and regulate the relationship between the state and its citizens or between citizens.

International humanitarian law seeks to minimise the suffering and loss of dignity caused by being wounded or falling sick during an armed conflict, in other emergencies or in peacetime by protecting the provision of impartial and effective healthcare. Therefore, healthcare personnel, medical facilities and transports are afforded special rights and protections. It should be noted that these rights and protections are not fixed; they can vary according to the circumstances and applicable legal framework. They are also accompanied by a set of responsibilities. Ambulance providers should have a sound grasp of these rights and responsibilities, and should understand how they may change in the context of an armed conflict.

This part of the training manual covers the ways in which international law protects health personnel, both during armed conflict and in peacetime. It will identify relevant international and national laws regulating and protecting medical vehicles and health personnel, and give a basic understanding of the domestic legal framework.

Rights and responsibilities of healthcare personnel

E-learning: The rights and responsibilities of healthcare personnel working in armed conflicts and other emergencies.

4 An international armed conflict exists where there is armed force between two or more states; non-international armed conflict exists in cases of protracted armed confrontations between state armed forces and the forces of one or more armed groups or between such groups if they occur on the territory of a state party to the Geneva Conventions of 1949. Other emergencies are situations that fall short of the threshold for armed conflict but are still characterised by high levels of violence and instability during which security measures or incidents can result in serious consequences for people.

INTERNATIONAL LEGAL FRAMEWORK

Protection offered by the international framework can be divided roughly into three main elements: (1) protection of the wounded and sick; (2) protection of healthcare personnel, facilities and medical transports; and (3) the use of the distinctive emblems (red cross/red crescent/red crystal).

	INTERNATIONAL HUMANITARIAN LAW	INTERNATIONAL HUMAN RIGHTS LAW
The wounded and sick	Have a right to adequate medical treatment without discrimination, which corresponds to an obligation for healthcare personnel to provide such treatment where possible. The parties to the conflict must facilitate access and may not order healthcare personnel to give priority to any person except on medical grounds.[5]	Have similar rights: access to healthcare services of sufficient quality, information, and in absence of discrimination, enshrined under the right to health.
Healthcare personnel	Shall be respected and protected and shall not be the object of attack. Under no circumstances shall medical units be used to shield military objectives from attack. May not be required to give priority to any person except on medical ground and decide, in accordance with medical ethics, which patient receives priority. Shall not be hindered in the performance of their exclusively medical tasks. Parties to a conflict shall not harass or punish healthcare personnel for performing activities compatible with healthcare ethics, nor shall they compel them to perform activities contrary to healthcare ethics or to refrain from performing acts required by healthcare ethics. Should not be compelled, unless required to do so by the law, to give information concerning the wounded and sick who are or have been under their care, if this information would prove harmful to the patients or their families. Duties: healthcare personnel must protect the confidentiality of patient information. Limits on the protection afforded: Medical transports cease to be protected when they are used, outside their humanitarian function, to commit acts harmful to the enemy.[6]	Have the right to undertake their duties to provide healthcare without undue interference from the authorities, and in line with healthcare ethics. The right to health imposes an obligation on authorities to respect and protect the provision of healthcare and address any imbalances in it.[7] Healthcare personnel who overstep their medical functions may be subject to penal, administrative and disciplinary sanctions in accordance with relevant domestic law.

	INTERNATIONAL HUMANITARIAN LAW	INTERNATIONAL HUMAN RIGHTS LAW
Emblem	Healthcare personnel, medical units and transports may be authorised to carry the emblem (see links below) for protective use. Those entitled to make protective use of the emblem in times of armed conflict include various actors providing medical and healthcare services, including medical services of armed forces and Red Cross and Red Crescent Societies. Healthcare personnel, buildings, material, medical units and transports used to deliver healthcare and displaying the distinctive emblems shall not be the object of an attack. Any use of the emblem not prescribed by International Humanitarian Law (IHL) is considered to be improper. Perfidious use of the emblem, for example to protect or hide combatants, constitutes a war crime when it results in death or serious injury. As a general rule, the protective emblem should mainly be used in times of armed con flict. Use of the protective emblem without due authorisation from national authorities is illegal and sanctioned in domestic law. The components of the RCRC Movement are authorised to use the emblems in an indicative manner; small in size and unambiguously displayed.	

Common ethical principles of healthcare in conflict and other emergencies

Document co-signed by various health-based international organizations, stating the ethical principles that should be respected by all health personnel.

Health Care in Danger: the legal framework

Report describing the legal framework and recommendations for implementation of legislation protective of healthcare.

5 Denial of medical treatment without justified cause may constitute cruel or inhumane treatment, an outrage upon human dignity (particularly in cases of humiliating and degrading treatment), or even torture if the necessary criteria are met.

6 Examples of "acts harmful to the enemy" include, inter alia, transport of troops that are not wounded or sick, arms or munitions, as well as the collection or transmission of military intelligence. Even if acts harmful to the enemy are committed, a warning must be given, setting, whenever appropriate, a reasonable time limit for compliance. Healthcare personnel, units and transports lose their protection only when such a warning remains unheeded and an attack is launched against them.

7 It should be noted, however, that the extent to which this right is upheld varies.

Video: What's the difference between the red cross, red crescent and red crystal?

1:44-minute video explaining the emblems that protect healthcare.

Figure 1: The red cross, red crescent and red crystal

IMPROPER USE

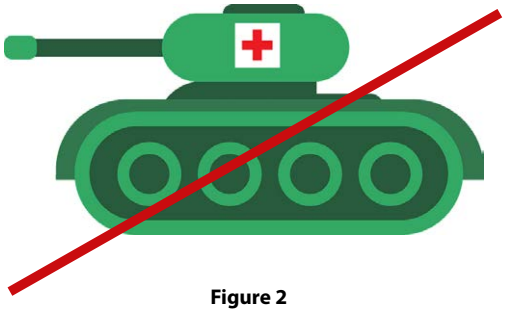


Figure 2

"Improper use refers to any use other than that for which the distinctive emblems were intended, namely the identification of medical and religious personnel, medical units and medical transports, as well as personnel and property of the components of the International Movement of the Red Cross and Red Crescent." (Customary IHL, Rule 59. Improper Use of the Distinctive Emblems of the Geneva Conventions (icrc.org)).

EXAMPLE OF LEGAL AND CORRECT USE DURING ARMED CONFLICT

Figure 3

It is vital to be aware of the importance of using the emblems correctly at all times.

The emblems:

- Are recognised by States;
- Are free from any religious, cultural or political meanings, and offer protection;
- Should be used to clearly mark medical units and transport;
- Health workers should carry identity cards displaying the emblem.

YOUR RIGHTS AND RESPONSIBILITIES AS A HEALTHCARE PROVIDER IN NATIONAL LEGISLATION

TIP
Familiarise yourself with relevant national legislation.

Domestic law will have integrated provisions that reflect international law, including IHL and International Human Rights Law (IHRL), to varying degrees. Health providers should familiarise themselves with the relevant national legislation in order to ensure that they act in accordance with the legal environment within which they operate. This will allow them to make use of protection afforded by the law, and also avoid undertaking any action that may be contrary to the law.

The rights and obligations set forth in the international framework should be incorporated into each national legal framework, normally in the legislation relating to the healthcare system. Additionally, relevant provisions can be found in legislation pertaining to the working environment, as well as public welfare and insurance legislation. Breaches of rights and obligations are normally regulated in the penal code or in applicable administrative or disciplinary regulations.

It is important to be familiar with the roles, rights and responsibilities assigned to healthcare personnel in the national legal framework, including who is defined as protected healthcare personnel in times of peace, disaster, crisis and armed conflict situations, as these may vary.

In addition, a reflection on relevant domestic laws should include an overview of the ethical principles for healthcare services, as these also constitute rules that health workers need to follow.

Below are suggestions for discussing applicable rights and responsibilities for health providers.

- What provisions exist to protect patients/the wounded and sick in the relevant context?
- What provisions exist for the protection of health personnel?
- Are the rights and obligations of health personnel clearly spelt out in your national legislation, and what are they?
- Does the national legislation contain provisions on the protection of health personnel and unhindered access to the wounded and the sick?
- Are there any elements relating to the security of the service specified in the law or agreement?

- What national legal protection is afforded by the red cross or red crescent emblem and/or other logos used by health services?
- Does the national legislation contain provisions on authorisation to use the protective emblem?

SUMMARY OF RIGHTS AND OBLIGATIONS OF HEALTHCARE PERSONNEL

Healthcare personnel are given certain protections in international and domestic legislative frameworks to ensure that the wounded and sick are given access to necessary treatment. The rights afforded to healthcare personnel are accompanied by a number of obligations set out both in legislation and in medical ethics, which may involve actions (e.g. caring for the wounded and the sick humanely, effectively and impartially) and/or abstentions (including from experimenting on people, supporting illegal interrogatory techniques that may amount to torture or transporting weapons).[8]

Extra – Resources on IHL, IHRL and healthcare

HCiD: The responsibilities of healthcare personnel working in armed conflicts and other emergencies

A guide to help healthcare personnel adapt their working methods to the urgent demand of armed conflicts and other emergencies.

Factsheet: Protecting healthcare in armed conflicts not covered by international humanitarian law

Factsheet by ICRC's legal advisory service, providing information about the legal framework protecting healthcare in conflict and in situations not covered by IHL.

Article: A human rights approach to healthcare in conflict

Scientific article that provides further insight into protection of healthcare, beyond IHL and using a human rights approach.

8 See the HCiD booklet on the rights and responsibilities of healthcare personnel, via the resource section, page 135.

Extra – Resources on IHL

Video: Rules of war (in a nutshell)
4:44-minute animated video summarizing key principles and rules in IHL that should be respected by combatants in war.

Podcast: Pushed to the Limit: Healthcare in Conflict
Episode of Intercross podcast (24 minutes), interviewing ICRC's Head of Health in 2017.

THE HUMANITARIAN PRINCIPLES

Derived from the Fundamental Principles of the International Red Cross and Red Crescent Movement and enshrined in international humanitarian law. They are to form the basis for all humanitarian action in both conflict situations and natural disasters, as set out in UN General Assembly resolutions 46/182 and 58/114. The four principles are:

HUMANITY

Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.

NEUTRALITY

Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.

IMPARTIALITY

Humanitarian action must make no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions.

OPERATIONAL INDEPENDENCE

Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.

THE RISK-MANAGEMENT APPROACH

This training manual is intended to improve the way risks related to the provision of health services are assessed and addressed. The methodology supports the processes of identifying and ranking existing risks, and of designating adequate applicable mitigation measures to address them.

The methodology is based on a recognised International Organization for Standardisation[9] (ISO) risk-management approach to mitigating risks. The aim of this approach is to make sure that risk assessments are done systematically and objectively so that interventions effectively address the most prominent risks, allowing health services to continue, and communities to be safely assisted as required.

The ISO risk-management model is a typical programme-management cycle model that needs to be continuously applied to provide the full scope of benefits for the organisation.

Figure 4: The ISO risk-management process

A proper analysis of the context in which one organisation or one specific service operates allows for the implementation of a full risk-assessment process to take place, in which all the stakeholders contribute to identifying the most prominent hazards and the situations in which health services are likely to be confronted with them. Context analysis also allows for the identification of the most effective and appropriate risk-mitigation measures in light of the resources available, and for processes to mobilise said resources

9 International Organization for Standardization, ISO 31000:2018 Risk management – Guidelines, available at: https://www.iso.org/standard/65694.html

by involving the relevant stakeholders within and outside the organisation. Such a cycle requires all the different steps, decisions and actions planned and undertaken to be recorded and reported, monitored, and reviewed in order to constantly adapt to changing situations and foster learning from past experience.

This chapter provides the theoretical elements that will allow practitioners to understand and apply the methodology.

Risk management is already applied by many organisations, in one way or another, to aid decision-making at different levels. The RCRC Movement has developed a series of tools, such as the different dashboards that are used in many conflict settings, aiming to identify, monitor, and mitigate risks faced by the organisation itself (such as financial or logistical risks), as well as its staff and volunteers. Those tools support the decision-making process.

SAFER ACCESS FRAMEWORK

One of the most common tools integrating the risk-management approach within the RCRC Movement is the Safer Access Framework (SAF).

The SAF is an approach developed by ICRC and more than 50 National Societies, which aims to increase acceptance, security and access to people and communities in need, especially in sensitive and insecure contexts. It is made up of eight sections (elements) containing actions and measures that can be integrated into operational work according to context-specific priorities. The eight elements of the SAF are like links in a chain: interlinked and interdependent.

Safer Access Framework: Resource centre

Visit the SAF page to find various resources, including a methodology for applying the framework, and videos from risk assessment to reinforcing the eight elements of SAF.

THE EIGHT ELEMENTS OF THE SAFER ACCESS FRAMEWORK		
I	**Context and risk assessment**	National Societies have a clear understanding of the interlinked political, social, cultural and economic aspects of the evolving operational environment and the inherent risks, which forms the basis for preventing and managing those risks.
II	**Legal and policy base**	National Societies have sound legal and statutory instruments and develop policies that provide a basis from which to carry out their humanitarian mandate and roles in conformity with Movement policies, international humanitarian law and domestic legislation.
III	**Acceptance of the organisation**	National Societies have attained a high degree of acceptance among key stakeholders by providing relevant, context-sensitive humanitarian assistance and protection for people and communities in a manner consistent with the Fundamental Principles and other Movement policies.
IV	**Acceptance of the individual**	Staff and volunteers have attained a high degree of acceptance among key stakeholders by working in a manner consistent with the Fundamental Principles and other Movement policies.
V	**Identification**	National Societies take all necessary steps to protect and promote the organisation's visual identity and that of its staff and volunteers.
VI	**Internal communication and coordination**	National Societies implement well-developed internal communication and coordination strategies and mechanisms, which enhance coordination with other Movement components.
VII	**External communication and coordination**	National Societies implement well-developed external communication and coordination strategies and mechanisms, which enhance coordination with external actors.
VIII	**Operational security risk management**	National Societies assume responsibility and accountability for the safety and security of staff and volunteers by developing and implementing an operational security risk-management system, and structure.

Figure 5: Elements of the Safer Access Framework

Actions taken or not taken in connection with one element may often have an impact on the others. A chain is only as strong as each of its links; should one be weak or break, it would have a negative effect on the chain.

The Framework is underpinned by the **Safer Access Cycle** – access, perception, acceptance, security – and reinforced through use of the **Fundamental Principles** to guide operational communication, practice, thinking processes and decisions. These are key pillars for security risk management, and this training manual will delve into more specific actions in this realm.

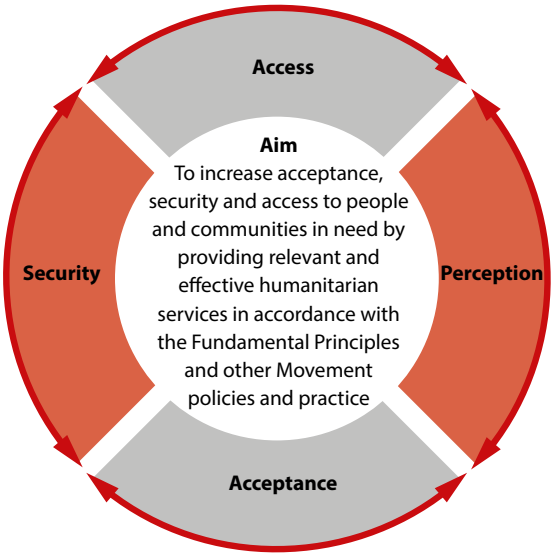


Figure 6: The Safer Access Cycle

RISK ASSESSMENT

Once a series of hazards has been identified, via consultation with the relevant stakeholders, around the planning, managing and delivery of health services, the associated risks must be given grades. The higher the grade, the more acute the risk, and the higher the priority of managing it.

A full procedure for conducting a risk assessment for ambulance and pre-hospital services can be found on page 151 in Annex 1.

The risk-assessment guidelines provided in this document apply only to hazards associated with the delivery of health services. They do not apply to any other hazards or threats posed to the organisation, which may be included in a broader, organisation-wide security-risk assessment.

Risks associated with a hazardous or dangerous situation depend on a combination of the following elements:

- The SEVERITY of harm that can result from the danger in question;
- The LIKELIHOOD of a harmful event, referred to in the table below as the "probability of occurrence", which is a function of: a hazardous event occurring, exposure to the hazardous or dangerous situation and possible ways of avoiding or limiting the harm.

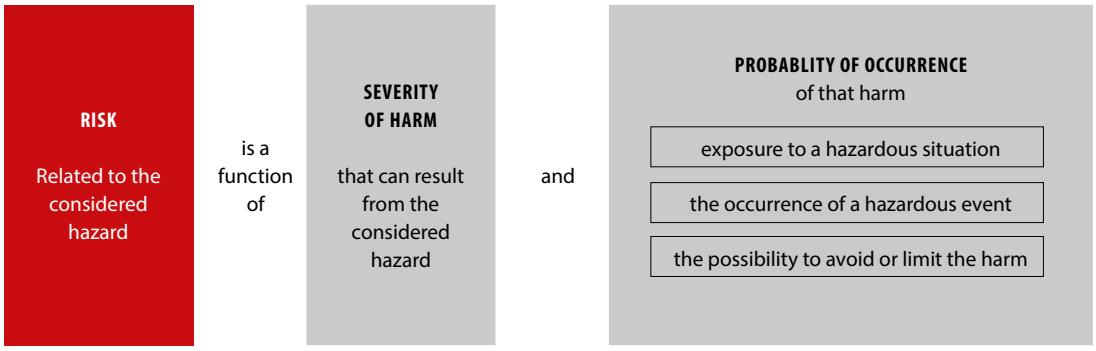


Figure 7: The elements of risk[10]

Assessing risks associated with the delivery of health services involves:

- Identifying the hazard and the potential severity of an incident's impact on health workers and/or delivery of the service;
- Assessing the likelihood of an incident given the frequency of previous occurrences, the vulnerability of the health team and services to the risk, and their ability to limit or reduce any resulting harm.

In terms of managing risks related to the delivery of health services, the likelihood and severity of a given impact are determined by:

- The type of danger in question;
- The frequency of incidents[11] caused by the danger in question;
- The vulnerability of the health team to the potential impact of the danger (including their level of exposure to the danger, their capacity to reduce or limit their exposure, and the harm that the hazard may cause).

Using predefined scoring criteria, the likelihood and severity of an incident are plotted onto a risk matrix, illustrating the risk associated with each identified hazard that may impede the delivery of health services.

The risk matrix allows you to see and show the risk associated with one hazard at a certain moment. Using such a matrix supports the decision-making process linked to identifying appropriate mitigation measures. It shows the evolution of risk associated with one hazard over time, in relation to the impact of internal and external factors.

10 International Committee of the Red Cross, Increasing Resilience to Weapon Contamination through Behaviour Change, available at: www.icrc.org/en/publication/4381-increasing-resilience-weapon-contamination-through-behaviour-change

11 An incident is a hazardous event that leads or could lead to an accident. An accident is an undesired event that results in harm

RISK TO MOVEMENT STAFF AND VOLUNTEERS			LIKELIHOOD				
			Very unlikely	Unlikely	Possible	Likely	Very likely
SEVERITY OF IMPACT (CONSEQUENCES)	**Catastrophic**	Life-changing injuries, or fatalities	**5A**	**5B**	**5C**	**5D**	**5E**
	Severe	Injuries requiring immediate pre-hospital and long-term clinical care	**4A**	**4B**	**4C**	**4D**	**4E**
	Significant	Injuries requiring immediate pre-hospital and clinical care	**3A**	**3B**	**3C**	**3D**	**3E**
	Moderate	Injuries requiring clinical care	**2A**	**2B**	**2C**	**2D**	**2E**
	Negligible	Minor injuries requiring no medical assistance	**1A**	**1B**	**1C**	**1D**	**1E**

Figure 8: Model of a risk matrix assessing the risk of weapon contamination on the civilian population
Note: indicators regarding severity of impact are only examples and must be defined by the organisation

Once a risk associated with a specific hazard is mapped, discussion within the organisation should then lead to a decision on whether the risk level, as mapped, is acceptable or not. If the organisation is satisfied with a certain risk level, no further action needs to be taken. If the risk level is deemed unacceptable, or has become unacceptable over time due to a change of situation, measures must be implemented to address the situation, with the objective of bringing the risk level down to an acceptable level.

Deciding what indicators to use should be a collective endeavour, with consultations involving all stakeholders, and results widely communicated internally. It is important for health workers to understand and accept the risk-assessment process and its outcome, and essential for them to directly involved in the delivery of health services.

Situations can evolve, resulting in a change of risk level, either due to external factors (such as an increase in the level of armed violence or a change in how the organisation is perceived) or internal factors (such as a policy change relating to acceptable risk or a change of equipment/procedure that reduces the impact or likelihood of a hazard). Internal factors often equate to risk-mitigation measures.

The risk-assessment process will inform the development of measures aimed at mitigating risks deemed to be at an unacceptable level.

Acceptable risk

All human activity involves risk in one way or another. It is not possible to achieve absolute safety in the face of all dangers. This said, the risk of injury during the provision of healthcare should be kept as low as possible, or at a level that is pre-defined as acceptable.

It is not easy to gauge acceptable risk levels. These depend on what the health personnel, the organisation, society and politicians consider to be normal. Utility value and cost are two factors that always tend to come into play when looking at the degree of risk from a societal perspective.

The concept of acceptable risk refers to a level of risk that is tolerable for the majority. This could be in terms of reputation, financial or material loss or even the risk of loss of life. The notion of acceptable risk, the parameters within which an organisation feels safe to operate, will greatly vary from one organisation to another, and within one organisation with respect to changing external factors. A drastic example of this is when a conflict suddenly erupts in a given region. The extent of what is deemed acceptable risk will be greatly influenced by the context.

It is important that any organisation undertake the process of clearly defining and internally communicating the thresholds of acceptable risks, before using the data to correctly plot each identified situation in the risk matrix.

An example of a risk-assessment protocol can be found on page 157 in Annex 2

RISK MITIGATION

Once every relevant hazard is identified, and associated risk plotted in the risk matrix, the next stage is to identify, prioritise and plan activities to deal with the risks that are deemed unacceptable so they can eventually be moved to a lower category in the risk matrix, until they are at a level where the organisation feels safe enough to operate.

Using a graphic matrix that integrates the most relevant hazards and associated risks will help to illustrate the consolidated situation, and facilitate decisions about which risks to address first.

Once a risk has been assessed, a risk-treatment option should be chosen. The ISO defines the following risk-treatment measures:

- Avoiding the risk by not starting, or by stopping, an activity that gives rise to the risk;
- Accepting the risk in order to pursue an important activity;
- Removing the risk source;
- Changing the likelihood associated with the risk;
- Changing the consequence associated with the risk;
- Sharing the risk with another party or other parties (through collaborative projects, for instance).[12]

In most environments in which health service providers (such as ambulance services) operate, it is usually not feasible to remove all risk sources (i.e. checkpoints, traffic-related problems, hostile population, etc. nor is it standard practice to transfer the risk, although it may be shared through collaboration with other actors. Accepting the risk may be an option in some instances, after careful consideration and in agreement with the organisation's management as to which risks are acceptable. Avoiding the risk means not engaging in or ending operations in certain circumstances; this may be an option in the event of heavy shelling or other situations where the threat to health workers cannot be mitigated. Removing the risk source is the most effective risk-reduction measure, but it is often not a realistic option.

Traditionally, mitigation measures that an organisation can implement are a mixture of the following:

- Adapted standard operating procedures (SOP) around planning and delivery of health services (including contingency plans in case of incidents);
- Adapted equipment supporting the above;
- Training (and retraining) on the implementation of procedures and use of equipment.

In Part 2 and in Annex 3, you will find a series of examples of mitigation measures that have been identified by peer practitioners to be relevant in the frame of your activity.

Examples of risk mitigation measures can be found on page 159 in Annex 3

12 International Organization for Standardization, ISO Guide 73:2009, Risk Management – Vocabulary, ISO, Geneva, 2009–11.

MONITORING AND REVIEWING RISK

Risks evolve and in order to manage them over time, ensuring that the organisation deploys its limited resources to address the most pressing risks, they must be regularly assessed.

Monitoring risk involves:

- Re-evaluating the environment and potential severity of impact;
- Assessing changes that may affect the vulnerability of the health team and/or the likelihood of an incident.

Health workers can revise entries to the risk-assessment matrix if necessary and confirm that risk-mitigation measures still address the highest-priority risks.

It is worth noting that downgrading a risk category on the risk assessment matrix may demonstrate that mitigation measures are working, or the improvement may be the result of other non-attributable factors, such as the cessation of hostilities.

PART 2:
WORKSHOP SESSIONS

SESSION 0:
SETTING THE SCENE

This training manual is designed to be used by health teams, including ambulance and pre-hospital providers, although some aspects require engagement from the wider organisation. It is a toolkit to help deliver training that is relevant to any given context, so you might incorporate a few sections into your existing training, or you might choose to use the whole content.

Part 2 presents a training programme for contextualising risk management and safer behaviour. It uses a wide range of training methods, including reflections, active discussions, role-play, individual and group activities.

Together with the information presented in Part 1, these resources are background material that should be studied by the facilitator and the participants in preparation for the training.

Use your judgement as a trainer to adapt the training to the needs of the participants and the situations they work in. We recommend that you vary the methods to accommodate all types of participants and to keep the training interesting.

The suggested training programme below shows the sessions and activities in Part 2, and gives an indication of time management for the sessions. It does not include breaks, meals or energisers. Create your own schedule and plan the programme to suit your local needs.

SUGGESTED TRAINING PROGRAMME			
	SESSIONS	**ACTIVITIES**	**PROPOSED TIME**
0	**Setting the scene and building the group dynamic**	• Introduction of trainers and participants • Set a safe learning space • Expectations and aims • Basic rules • Introduction to the workshop	45 mins
CONTEXTUALISING RISK MANAGEMENT			
1	**Violence against healthcare**	• Violence against healthcare • Different perceptions • Impact of violence	3 hours

	SESSIONS	ACTIVITIES	PROPOSED TIME
CONTEXTUALISING RISK MANAGEMENT			
2	**Using risk methodology**	• Familiarising with the concepts of risk • Managing the risks • Incident reporting/template	4 hours 15 mins
CONTEXTUALISING SAFER BEHAVIOUR			
3	**Security and behaviour**	• Safer Access Framework • Code of Conduct • Uniforms and other means of identification • Who are we communicating with? • Situational awareness • Culture, religion, tradition	6 hours 45mins
4	**Managing aggression and interpersonal violence**	• Contextualising why aggressions occur • Human needs and the basic emotions • Vital space • Contextualising good communication • Active listening • Non-violent communication • Escalating and de-escalating reactions	6 hours
5	**Stress and psychosocial wellbeing**	• Contextualising stress factors • Contextualising stress management	3 hours 45 mins
6	**Recommendations and action cards**	• Consolidating learning from all the previous sessions • Recommendations for management • Action cards for pockets • Evaluation and closure	5 hours
PROPOSED TIME IN TOTAL (WITHOUT BREAKS)			**29,5 HOURS**

The sessions described in the timetable above can be easily distributed across 5 days of training, the ideal period suggested by this manual. This includes sufficient time for breaks, practical exercises and group discussions. Should there be any need to reduce the timing or shorten the training time, you may consider:

- The amount of previous training the trainee group has had with the Safer Access Framework or with Health Care in Danger (this could reduce the need to spend time on some of the modules in "Contextualizing Risk Management" or the Safer Access part in "Contextualizing Safer Behaviour")

- The skillset and other parallel trainings that may have been already offered to the group regarding mental health and psychosocial support, community engagement and/or non-violent communication (this could reduce time spent on the parts related to culture, religion and tradition in communication, some elements of the module "Managing Aggression and Interpersonal Violence" as well as the module "Stress and psychosocial wellbeing").

The occurrence of previous trainings does not exclude the need for reminders and potential new content, while it may be understood a higher degree of adaptation and shortening of certain aspects of the session.

Regardless of the adaptations, it is not recommended to carry out the training in shorter time than 3 days (around 20 hours of work). This might impair the discussions related to risk awareness, risk management and safer behaviour, creating actionable recommendations that may not be the most adequate or effective ones.

PREPARATIONS FOR THE FACILITATOR

Venue

- Access to the premises, including bus or train stations nearby, and parking
- Appropriate temperature and lighting in the room
- Familiarise yourself with evacuation and safety procedures

Prepare the facilities

- Consider how to set up the room to encourage participation and comfort
- Make sure there is enough space for group discussions and role play
- Ensure that seating is in line with the desired effect of the activities, e.g. behind a desk, in a row, in a circle
- Prioritise infection prevention and control (IP&C)
- Access to internet if available
- Access to technical devices if needed and available
- Have a plan B in case the technology goes wrong

Materials

- Registration form for the participants to list their contact information
- Printed copies of Participants' handbooks, as needed
- Pens and pencils
- Notepaper and post-its
- Whiteboard or flipcharts with stand
- Markers
- Feedback forms
- Pre- and post-training tests

Other

- Become acquainted with the reading material offered, as well as various resource materials that may come in useful
- Ensure examples and scenarios used in the training will be aligned to the reality experienced by the audience of trainees, and ensure the learning outcomes can be triggered by the use of these scenarios (see the Special Annex for a long list of ideas)
- Prepare the daily agenda including breaks. (Please note that this is a set of tools to help you develop a workshop that suits your context. The proposed agenda for the session is only a suggestion. It is recommended that you tailor the structure to your needs and your context. You need to design your own timetable.)
- Prepare yourself to continue the reporting on the training based on the TARRS evaluation framework
- Utensils and beverages
- Plan snacks, water, tea and coffee or meals if these will be provided
- Consider if you require a co-trainer or someone to support you with time management, mealtimes, or to write down key points from discussion groups on the board or flipchart
- Determine whether someone is available to provide psychosocial support should there be adverse reactions to some of the content of the workshop (see Annex 5 on page 171), an example of how to manage difficult reactions and disclosures)
- Determine whether it is possible to have a co-facilitator with MHPSS or PSS background

Know your participants:

- What skills, motivation and experience do they have?
- Your teaching must be adapted in form and content to the participants as this often varies from course to course and between different courses' implementations
- Have they been in a serious situation of violence/aggression in the last 6 months?

The role of the instructor is very important – as an organisation ambassador, a facilitator and a role model. You are responsible for creating the conditions for good learning to take place, within the given framework.

Method is about how you teach to achieve the learning objectives and which resources you use; it should be characterised by involvement, practice, reflection and interaction.

You can work on the feedback loop before, during and after the training to develop and adapt the course content and teaching styles. A feedback form is provided as a suggestion in Annex 7 of this manual.

WELCOME AND SETTING THE SCENE

- Registration of participants
- Introduction:
  - The facilitators introduce themselves
  - Briefly describe your background
  - Present practicalities such as available facilities, fire safety, etc.
- Daily agenda – a brief introduction to the training and its objectives

TIPS:

- The introduction of participants can be skipped if the group members already know each other.
- In general, the content of each activity matches the dedicated time for the session; some discussions might need to be shortened.

NOTE TO THE TRAINER:
It is essential to highlight that the topic being covered and the discussions surrounding it may be emotionally triggering for some participants. While this may be relevant and appropriate in the context of the training, the trainer must be adequately prepared to address any emotional reactions or discomfort that may arise. The trainer should be skilled in managing sensitive situations and create a safe and supportive environment for all participants. Additionally, the trainer should have information readily available about psychological support mechanisms within the National Society (NS) and ensure that participants are aware of how to access these resources, both during and after the session. Providing guidance on where participants can seek support, including any available services for psychological first aid (PFA), is crucial to ensure participants feel supported and safe throughout the training.

TIPS FOR GIVING FEEDBACK
- Stick to facts
- Be specific
- Keep your tone professional
- Make it a two-way conversation e.g. 'How do you think that went, what would you do differently'

TIPS FOR RECEIVING FEEDBACK
- Listen, openly and without judgement
- Be aware of your response (how does your body feel, how is your tone of voice)
- Ask clarifying questions to be sure you understand the feedback
- Allow yourself time for reflection (you don't need to respond immediately!)
- Follow up

ACTIVITY 1: EXPECTATIONS AND AIMS

Ask the participants to introduce themselves and to mention what they hope to gain from this workshop. The expectations should be written down on a flipchart or a white-board for the group to re-visit in session 6.

Spend two or three minutes going through the objectives of the training:
- To equip the health personnel with simple practical skills to improve their security and mitigate the impact of violence
- To offer a starting point for organisations delivering health services to develop, review and strengthen their emergency preparedness and security management procedures.

TIP For help managing difficult reactions and disclosures in the group, see *Training in Psychological First Aid – Support to Teams* p. 64[13].

BASICS RULES OF THE WORKING AGREEMENT

- The working agreement is a set of rules that members of the workshop develop together and commit to. Ask the participants: What rules do we need in order to create a safe environment where everybody can learn comfortably and actively?
- Write down the suggested rules on a flipchart or project them on a screen so that everyone can read them and suggest adaptations where necessary. Display the list of basic rules where everyone can see it clearly during the workshop

13 Training on Psychological First-Aid for Red Cross and Red Crescent Societies, Module 4, available at: https://pscentre.org/wp-content/uploads/2019/05/PFA-Module-4-Group.pdfe

Examples of useful considerations for the group:

- Create a safe environment and decide together to maintain confidentiality
- Consider following the Chatham House Rule, whereby you can share information but never reveal the source, to create a trusting environment for discussing potentially sensitive issues
- Be mindful of each other and be constructive in your comments
- Everybody is invited to share their point of view, but nobody should be pressured to speak
- Make sure that all the participants have equal chances to speak and express themselves
- Personal concerns and boundaries should be respected
- Remember that people might have different reactions to the discussions and scenarios of practice. Nonetheless, this should remain a supportive environment for learning and mutual care, not for shaming or mocking
- All participants have the right to withdraw from the session should they feel overwhelmed
- Remember that this workshop is not to assess your competence as professionals, but to gain additional skills
- Participate and listen actively
- Encourage questions
- Turn off phones or have them face down on the table as a commitment to being present in the session
- Leave the room to make or receive calls if they are necessary
- Be on time for the sessions

The Chatham House Rule

The Chatham House Rule helps create a trusting environment to understand and resolve complex problems, by stating that nothing said in the room will be attached, in the record, to the person who said it.

Emphasise the importance of understanding and accepting that everyone is different and has different experiences. This room should be a safe place, and if someone, for whatever reason, needs to leave the room, they should feel free to do so.

See page 138 for a list of resources and further reading for this session

CONTEXTUALISING RISK MANAGEMENT

SESSION 1:
VIOLENCE AGAINST HEALTHCARE

LEARNING OBJECTIVES

By the end of this session the participants will:

- have an understanding of what violence against healthcare is and how it affects health personnel
- have reflected on the impact of violence on healthcare and any potential gaps in their current response

SUGGESTED SESSION OUTLINE		
ACTIVITIES	**METHODS**	**PROPOSED TIME MANAGEMENT**
Introduction to the training	Presentation of the rationale for this session and how it's relevant to participants' contexts	15 mins
1: Violence against healthcare Outline the key terms and concepts used Identify different types of violence	• Facilitator-led discussion on the issue of violence • Group work to map threats and violent incidents • Categorising violent incidents (group presentations)	1 hour
2. Different perceptions Why does violence happen?	• Plenary discussion to consolidate different perceptions among health workers, patient, relatives, etc • Individual and group work to develop understanding of our perceptions, and look at why threats and violence arise	1 hour
3: Impact of violence	• Group work to discuss the consequences of violence and its impact on healthcare • Plenary presentations from each group	30 mins
4: Wrap-up Common understanding of violence against healthcare	Short summary from the facilitator and participants in the plenary	15 mins
PROPOSED SESSION TIME		**3 HOURS**

PREPARATIONS FOR THE FACILITATOR:

- Make a plan for this session
- Familiarise yourself with Part 1 of the training manual, with particular focus on the 'Healthcare in Danger' chapter, p.14–17. Acquaint yourself with the additional resources highlighted in the boxes, and also use the dedicated annex for further examples, if needed
- Find information on how threats and violence are defined by your organisation. If available, please obtain your organisation's SOP
- Pinpoint what the threshold of acceptable risk is for the organisation (pp. 32–33 in Part 1)
- Perform a basic desktop review of common incidents of threats and violence against health workers that may occur in your context
- Obtain information about the national laws on the provision of health services (pp. 18–25 in Part 1)
  - Who are the health workers? How have we defined them for the purpose of this session? What types are there in their context and around the world?
  - Who is entitled to provide health services?
  - What are the rights and obligations of health personnel?
  - How are they identified?
  - What sanctions exist for the acts of violence against health personnel?
- Review if there are any specific regulations at the level of the employer/organisation
  - Are there any institutions or organisations collecting data on violence against healthcare, including ambulance providers, at a national level?
- If available, and with the consent of management, obtain information from the organisation on reported incidents of threats and violence

INTRODUCTION TO THIS SESSION

The facilitator informs the participants that this session aims to build on the awareness of violence against healthcare acquired through Part 1. It should deepen our understanding of how threats and violence affect us as professionals and the impact this may have on us and our work.

Through the exercises, the participants will gain a better understanding of the types of abuse, verbal or physical, that often occur in their context. What are the potential gaps in their current response and how can they better prepare to respond to this violence?

The mapping of incidents of violence will be useful for the risk matrix activity in section 2 ('Managing the risks').

The facilitator goes through the session outline.

ACTIVITY 1: VIOLENCE AGAINST HEALTH WORKERS

Main issues to be highlighted: One is not alone in having experienced threats and violence. The reasons behind such acts vary greatly.

Introduction: The facilitator introduces the topic based on information provided in part 1 related to this topic, and the information below.

DEFINITION OF VIOLENCE:

The World Health Organization (WHO)

The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."

Workplace violence is violence associated with work. It can include physical and/or psychological violence that occurs in the health facility, in the medical vehicle, or the incident location.

Violence against healthcare is usually not an isolated, individual problem, but a structural, strategic problem embedded in economic, social, organisational, and cultural factor[14]. Recognising risks is important in order to determine appropriate courses of action before incidents occur. It is also important to distinguish between the origins of the violence. These may include interpersonal aggression, perhaps family members or neighbours attacking health workers; a sense of frustration within communities; organised violence (such as gang-related violence); being caught up in armed conflict; being in situations where health providers are specifically targeted.

Obstructions are also an example of violence. Retaining ambulances at checkpoints or roadblocks while a critical patient is waiting to be transferred is a violent act according to WHO's definition, and also gravely traumatising to the team.

Physical violence in the health services is widely acknowledged, while psychological violence is underestimated. Psychological violence is often perpetrated through relatively

14 International Labour Office, International Council of Nurses, World Health Organization, Public Services International, Framework Guidelines for Addressing Workplace Violence in the Health Sector, available at: www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/normativeinstrument/wcms_160908.pdf

small, repeated behaviours which cumulatively become a significant form of violence. Although a single incident may be sufficient, it is often these repeated, unwelcome and imposed actions that can have a devastating effect on the health professional[15]. Psychological violence should also be a priority concern in the workplace.

Definition of psychological violence: any intentional conduct that seriously impairs another person's psychological wellbeing through coercion or threats[16]

Plenary discussion: The facilitator leads a plenary reflection on how threats and violence are understood.

Participants are asked to raise their hands if they:
- Have ever felt unsafe while providing medical assistance
- Have ever experienced threats or been verbally abused at work or when providing medical assistance
- Have ever been physically attacked while giving medical assistance
- Have ever been prevented from performing their duties by third parties

The facilitator then may choose to ask some of the below questions to the group as a whole or ask participants to volunteer to share their experience.

Suggested questions to help the discussion:
- What were the circumstances of the incident that took place?
- Who were the perpetrators?
- Do you believe it was intentional or unintentional? Why?
- Has you ever been denied access to those that needed assistance? If yes, why?
- What factors can increase the risk of exposure to violence (age, sex, ethnicity, religion, experience)

Emphasise the importance of understanding and accepting that everyone is different and has different experiences. Exposure to threats and violence can be difficult to talk about or even think about. For that reason, if someone does not want to talk, wants to leave the room, or needs a private conversation, they should be given the opportunity along with the assurance that this is okay. Also remind the participants they should only share experiences they are comfortable discussing.

15 International Labour Office, International Council of Nurses, World Health Organization, Public Services International, Framework Guidelines for Addressing Workplace Violence in the Health Sector, available at: www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/normativeinstrument/wcms_160908.pdf

16 European Institute for Gender Equality (europa.eu), Glossary definition for "psychological violence" https://eige.europa.eu/publications-resources/thesaurus/terms/1241

- Statement for discussion: women experience higher levels of verbal aggression and sexual abuse, while men experience more overt threats and physical assaults. Does it matter if you are a male or female ambulance provider?

Group work: The participants are divided into small groups and asked to consolidate any threats and violence they have experienced, witnessed or heard of. They can use post-it notes to write them down. This is to focus attention and increase understanding of what threats and violence are.

One person from each group will place the post-its under the following categories on a flipchart or equivalent, marked with 'psychological harm', 'physical bodily harm' and 'material damage':

PSYCHOLOGICAL HARM	PHYSICAL HARM	MATERIAL DAMAGE
Examples: • Threats: verbal or non-verbal (e.g. sexual, abusive, threatening behaviour) • Ganging up • Harassment/ persecution (e.g. telephone calls, letters) • Stalking • Intimidation • Bullying	Examples: • Attacks/assaults • Blockages of the work of the health team • Incidents which cause major injury • Incidents which require medical assistance or first aid • Sexual assaults • Homicide	Examples: • Hitting or kicking a wall, door or other physical object • Throwing things around to intimidate or in anger • Attacks to the ambulance or the medical room interior • Stealing the ambulance or medical equipment

Each group will have five minutes to present their work.

The facilitator should end the exercise by commenting on the results, including whether verbal or physical violence seems the greater threat for these participants. The facilitator could ask the participants which types of violence have the greatest impact on them personally and how that might affect their work environment. We recommend that if this triggers discomfort or heavy feelings, that should not be interpreted as a problem and the facilitator should invite participants to seek support.

TIP To support managing difficult reactions and disclosures in the group, visit the Training in Psychological First Aid – Support to Teams p. 64[17]

17 Training on Psychological First-Aid for Red Cross and Red Crescent Societies, Module 4, available at https://pscentre.org/wp-content/uploads/2019/05/PFA-Module-4-Group.pdf

This story is available in case the group is not willing to share from their experience

In their own words: from an ambulance provider

FIGHT BETWEEN TWO GROUPS

The incident

One night, we responded to a call from a dangerous location where the local police need to keep watch. A fight broke out in the neighbourhood, with knives involved and several casualties.

When we got there, the police were nowhere to be found. One casualty was in a critical condition, with a knife in his back, so the team immediately headed to him. The area was not safe, and two groups were still fighting. Our focus was on the most critically injured, which upset one of the two groups. They accused us of not being impartial and pushed members of the team, which restarted the fight.

The situation was chaotic. The driver of the ambulance called the police, but there was no of them. We decided to treat the casualty inside the ambulance and evacuate quickly.

People started to block the road in front of our ambulance, demanding that we take all the casualties, which wasn't possible. We were now unable to drive the ambulance thought we wouldn't be able to leave safely and get to hospital.

Just as the people outside began to open the door of the ambulance, the police car finally appeared and gave us chance to leave. We stopped away from the scene and treated the casualty, who had lost a significant amount of blood. Then we finally headed for the hospital.

Analysis

We completed the operation successfully and the casualty was transported to hospital after receiving emergency care. But to be honest, we were lucky. We were on the verge of a disaster caused by a lack of awareness about the principle of impartiality. People need to know about this principle and its role in our work.

Another mistake was not confirming that police had arrived. This almost caused more injuries. Interfering in a struggle between two groups requires intense focus, local knowledge of the circumstances surrounding the incident, and a handle on security measures.

We were lucky that the police showed up, albeit late, and we may not be so lucky next time. In the future, we need to confirm we have accurate and sufficient information from dispatch. We also need to implement stronger security measures, to help de-escalate potentially violent situations.

As a medical officer, I am surprised that society has so little awareness that all those enrolled in the Red Cross and Red Crescent are volunteers and impartial, that we do not distinguish between victims, and that our goal is simply to preserve life and dignity. We need to raise awareness to prevent people from blocking ambulances and stopping us from doing our work.

ACTIVITY 2: DIFFERENT PERCEPTIONS

Main issue to be highlighted: One can consciously focus one's attention, and thus influence what information the brain will absorb, but since our consciousness is affected by emotions, experiences and unconscious processes, we must first become aware of these.

This section might be especially relevant when most of the violence is related to reduced trust or acceptance challenges with the local communities.

Introduction: The facilitator introduces the activity by linking the previous discussion to the information below.

By being aware of how we and others see a situation, we may be better equipped to de-escalate that situation. Everyone interprets events differently based on experience, knowledge and intuition.

Much of our interpretation happens without us thinking about it. We do not think we interpret signals when we see a traffic sign, a police officer or an ambulance. Most of the information the brain receives goes straight into the unconscious, so our behaviour is often affected by things we aren't aware of.

Perception is about how we experience the world through our five senses – sight, hearing, smell, taste and touch – and can be understood through three sub-processes:

- Sensation
- Interpretation
- Behaviour

From the moment we get up to the moment we go to bed, we are constantly busy with three things:

- Receiving external stimuli
- Thinking and comparing external stimuli with the information stored in our own brain
- Drawing conclusions, making decisions or taking action

Perception involves two steps:

1) That one or more sensory organs are stimulated
2) That this stimulation is interpreted and results in an experience

The second step depends on our own assumptions and expectations[18]. Perception is our recognition of physical objects or social situations based on our individual sensory impressions here and now. It is fair to say that perception is very subjective.

18 Definition of "perception" in Wikipedia: en.wikipedia.org/wiki/Perception



Plenary discussion: The facilitator shows three pictures, one at a time. The participants are asked to share what they see.

> It is the totality of the image that makes sense to us, not only the individual elements. The whole is more than the sum of its parts.

Pair discussion: The facilitator invites participants to sit in silence for one minute and think of a work experience containing a misunderstanding or in which the situation turned out to be very different from what they had first thought, in a positive or negative way.

After one minute the facilitator asks the participants to turn to the person next to them and describe the situation they were thinking of. Discuss the below question:

- Could you have done anything different in this particular situation to change the outcome (positive or negative)?

Group work: The facilitator divides the participants into groups of three or four people and asks them to discuss the following question:

- Are there any contexts that might trigger feelings of insecurity or fear? If so, why?

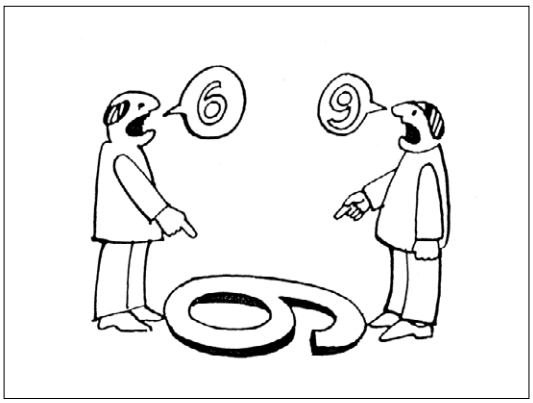
After 10 minutes, the facilitator asks the groups to list the different threats associated with various contexts. They must also try to explain why they believe that the perpetrators might be acting in such frightening ways. The more examples given, the better. The goal is for the participants to reflect on different perspectives and perceptions. One designated person from each group writes down their main findings on a flipchart.

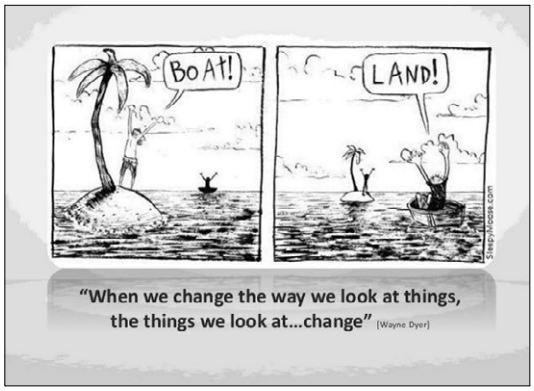
Suggested questions to help the discussion:

- Who are the perpetrators?
- What can be the motivations or reasons for perpetrated threats or attacks?
- What are the circumstances?
- How are the health services perceived by these people?
- Have there been previous incidents?

The facilitator refers to the images below to make the point that the angle from which we see things, from which position we perceive a situation, can determine how the experience is understood.

ACTIVITY 3: IMPACT OF VIOLENCE





Main issue to be highlighted: Threats and violence have an impact on us as health workers and our organisation more generally and should therefore not be accepted as just 'part of the job'[19].

Introduction: The facilitator introduces the topic.

Group work: The facilitator divides the participants into groups of three or four and asks them to discuss the impact violence has on the provision of healthcare. Participants should reflect on:

- How violence impacts them as healthcare providers, both in the short and long term
- Why threats and violence should not be accepted as just 'part of the job'

Plenary discussion: Each group reports back in the plenary and a consolidated list is developed and kept as a resource by the facilitator to contextualise other activities in the coming sessions.

19 See various mentions in the studies listed in the report "Gathering evidence-based data", available via the Resources section, page 134

In their own words: from an ambulance provider

DEALING WITH VIOLENCE BY NON-PHYSICAL MEANS

The incident

Based on the below information, we dispatched to the call. We had just dealt with a similar call, so we were quite relaxed and not expecting anything extraordinary. The fact that 'community patrol' was on-scene and had requested an ambulance also suggested there was little reason for concern.

Time:	~02.30 am
Week day:	Weekend
Location:	Main Road
Dispatch call:	"Alcohol intoxication, drunk, community patrol reqests ambulance"
Type of call:	"Urgent" (speed lights and siren)
Drive time:	4 minutes (to given address)
Shift:	23:00 – 07:00
Team:	2 personnel – 1 x EMT1 (medic) + 1 x EMT2 (senior medic/driver)
Previous call:	"Suspected alcohol intake, fatigue, blurre vision"

While driving on the main road, we saw the orange flashing lights of community patrol, as well as blue police lights (missed clue #1).

When we got there, we saw one vehicle had driven into the back of another at a red light. A policeman told us only one person needed assistance – the driver of the vehicle that had collided with the stationary car.

A quick visual assessment of occupants from the other vehicles verified that there were no other injuries. The policeman who briefed us said that the driver was "totally drunk", "smells of alcohol" and "was walking around cursing before he noticed the police, then got back into the driver's seat to sleep" (missed clue #2).

The driver did not react to his name but did react to pain which was met with slurred curses. We transferred the driver to the ambulance to check vitals since there were no visual injuries. The driver was clearly bothered by the ambulance team's attention and said he wanted to sleep.

Since the police suspected drunk-driving, a policeman was to escort us and the driver in the ambulance to the hospital. When the driver saw the policeman, he got violent, lashed out and tried to leave.

We managed to restrain the driver without sustaining any blows or injuries by pinning him down on the stretcher with our weight. We explained the consequences of attacking a policeman and ambulance team member. The driver agreed not to be violent, so we didn't use handcuffs or triangular bandages. The drive to the hospital went ahead without further incident.

Analysis

Anyone who has ever dealt with security or safety issues knows to be wary of thinking a situation is 'routine'.

Seek information. If anything doesn't make sense, no matter how seemingly insignificant, probe it. We are all aware that there are communication gaps between callers, dispatchers and emergency teams: the information can be misinterpreted, forgotten, misrepresented.

While many emergency calls might follow a type of pattern, every call has the potential to develop into something totally unexpected. I feel that the drunk call we attended before this one dulled our senses.

Reassess all the time. Once we saw the blue police lights, we should have connected the dots and realised there was a drunk driver. Had my partner or I reassessed or voiced this idea, I am quite sure we would have been more alert and ready for potential dangers.

What If? In this case, had I asked myself, "What if the drunken driver is not asleep?", a lot of the drama might have been avoided. I have no doubt that the policeman who briefed our team was convinced that the driver really was asleep, but we did not question it and we should have. The driver was drowsy-drunk but definitely not asleep. He was trying to avoid police questioning by pretending to be asleep (missed clue #2).

Minimise confrontation. I am fairly convinced that the drama that ensued might have been avoided if both the policeman and ambulance crew had been trained to try and keep confrontation to a minimum.

Moral dilemmas

Judgement: I found myself judging the driver for drunken driving (unverified, of course, at the time of interaction), but also for being a serious threat to others. It would be dishonest to say that I didn't judge him and I remember thinking that I was glad that the police were on-scene to deal with it. I had to be conscious that I had to represent my organisation honourably and act appropriately.

Anger: When the driver turned violent, I had flashes of this person hurting my children. I felt anger building, even though I didn't act it out.

Lessons learned

I am fairly convinced that the drama that ensued might have been avoided if both the policeman and ambulance crew had been trained to try and keep confrontation to a minimum.

In this case, since the drunk driver was relatively drowsy, it would have been wiser that the policeman either sat next to the driver or in the paramedic seat after getting into the ambulance via the ambulance's side door, thus avoiding eye contact and full-frontal presence.

I often play through different scenarios of the same incident and wonder how I could better manage future incidents. There is no one right answer and only through discussion, debate and listening to the experiences of others can one adequately prepare for incidents of this nature. Every situation – the circumstances and events, the organisations and populations – is different and you have to be confident in your approach, your organisation and your support mechanisms. This is definitely a topic for discussion which I did not receive during my training.

WRAP-UP

Plenary discussion: The facilitator asks the participants to summarise the main takeaways from this session and provide an opportunity for the participants to jointly reflect on what they have learned. A wrap-up can be done in several ways, and one suggestion is simply: What did I learn today?[20]

Purpose

- Evaluation
- Summing up

TIP Make sure everyone has one minute to think. Some finish quickly and others need more time.

How

Participants sit in a circle. Give each participant the task of expressing with one sentence what they have learned from session 1. They are given one minute to think and put together a sentence, and then they share it with the group. For example:

"I have learned that the way things look to me can be very different to another person's perspective."

See page 141 for a list of resources and further reading for this session

20 See more ideas for group wrap-ups in the manual for the training on prevention of interpersonal violence, available via the Resources section, page 134

SESSION 2:
USING RISK METHODOLOGY

LEARNING OBJECTIVES

By the end of this session the participants will:

- have knowledge of the key elements of risk management
- have considered how these can be applied to the health services
- think about how these may be relevant to their own organisation
- have identified the risks in their practice and how these might be managed
- recognise how important it is to report incidents, and know the key elements that should be reported

SUGGESTED SESSION OUTLINE		
ACTIVITIES	**METHODS**	**PROPOSED TIME MANAGEMENT**
Introduction to the training	Presentation of the rationale for this session and how it's relevant to participants' contexts	15 mins
1: Familiarising with the concepts of risk	Group work followed by a plenary discussion	45 mins
2: Managing the risks	• Facilitator presentation • Group work • Matrix – the already defined list of threats and violence from the previous session will be placed in the matrix	1 hour 15 mins
3: Incident reporting The importance of reporting and monitoring security incidents	Facilitator presentation followed by plenary discussions and discussions in pairs	45 mins
4: Reporting template	• Group work • Plenary discussions	1 hour
Wrap-up	Short summary from the facilitator and participants in the plenary	15 mins
PROPOSED SESSION TIME		**4 HOURS 15 MINS**

PREPARATIONS FOR THE FACILITATOR

- Ensure that management are aware of the topics that will be discussed and that they welcome the initiative; it is important to have their support and for participants to know they can speak freely
- Make a plan for this session
- Familiarise yourself with the section on the risk management approach (pages 26–35 of Part 1)
- If available, become acquainted with the organisation's risk management plan related to violence against health teams, and make it accessible to the participants
- Familiarise yourself with the organisation's risk assessment matrix, if there is one, and use this as a basis for further work in this session
- Prepare handouts of the risk matrix for activity 2
- Familiarise yourself with the organisation's incident reporting system and prepare handouts of procedure(s) if available

INTRODUCTION TO THIS SECTION

The facilitator explains that this session provides practical tools to support the risk management approach for assessing and mitigating risks associated with the delivery of healthcare, as well as an exercise to practise risk assessment. The session will also highlight the importance of incident reporting and risk register.

Useful reading material for participants. For full text see Annexes 1 (page 151)**,** 2 (page 157) **and** 3 (page 159)

- The 'Procedure for conducting a risk assessment' demonstrates step-by-step what needs to be done in a risk assessment
- The 'Example of a risk-assessment protocol' provides suggestions of how to make a risk assessment in an organisation
- The 'Example of a risk mitigation measure' illustrates how to reduce the impact or the likelihood of incidents once an assessment has been made. The example used includes the presence of manned checkpoints

TIP We are all responsible for making risk assessments, and we all do it in our daily lives, even if we do not always notice it.

ACTIVITY 1: FAMILIARISING WITH THE CONCEPTS OF RISK

Main issue to be highlighted: The difference between personal and organisational risk. Everyone in the organisation has some degree of responsibility in identifying and managing risks.

INTRODUCTION: WHAT IS RISK?

Health services, as well as ambulance and mobile health services, take place in environments where there are many unknowns and where it is not possible to control all the elements, so we must undertake dynamic risk assessments regularly when attending incidents. This means constant assessment and reassessment of the risks to the health personnel, the patient and others. These risks may be related to the treatment being provided, but more often they are related to the surrounding environment.

Extra - Risk management: Guidelines

ISO 31000: Guidelines, principles, framework and a process for managing risk.

In their own words: from an ambulance provider

UNSAFE FIELD WORK

The incident

Before this field mission, we'd been in contact with local authorities and had their approval to be there. When we parked up two men with weapons appeared and began shouting at us. They asked who we were and who had told us there were mines in the area and said that we were suspicious. They told us they had to check all the cars, including the ambulance. I explained that we are humanitarian workers and as medical staff we only had medical equipment on board. One of us could understand the local language, which was lucky: the armed men were talking about killing us and stealing our things. When we heard that, we shared the information with the team and left the area. That same day, other humanitarian workers were attacked and one person was killed. There was no government or police force nearby. The area was declared unsafe, humanitarian operations were stopped and we had to move to another region where working conditions were more stable.

Analysis
This happened because we were not in contact with all the various armed groups. This contact should have been maintained through local authorities, to raise awareness among those various groups and among the general population so that they know we are an impartial, neutral and humanitarian organisation. All this requires transparency, trust and clear communication systems. A strong safety assessment must be introduced, and security training is necessary too.

Who is responsible?
Part of the ambulance providers' service is to identify and manage risks, including wider organisational risks. The formal responsibility for risk management usually sits with the leadership team, but everyone within an organisation has some degree of responsibility for identifying and reporting risks, as well as dealing with them in an operational context.

Group work: The participants are divided into groups. Depending on the number of participants, decide whether each group should answer all the questions or share the questions between the groups.

- What is risk?
- What might be examples of risks in your work context?
- How do you see your responsibility in identifying and managing risks?
- Which risks are acceptable to you, and which are not?
- Which risks are acceptable in your organisation, and which are not?
- What do you think are the biggest risks for health workers in your context?

Plenary discussion: Following group discussions, the facilitator asks the participants to share with the whole group some of the risks they have discussed and how they might manage them as a team.

Presentation of terms and concepts. Opportunity to discuss if required:

Hazard – anything with the potential to cause harm
Psychosocial risks – risks that affect mental health and social well-being, often as a result of exposure to stressful, traumatic, or high-risk environments
Risk – the likelihood that a hazard will cause harm
Risk management – a system for identification, reduction and, where possible, elimination of risks
Risk appetite – amount of risk that an individual or organisation is willing to accept or be exposed to at a given time
Risk identification – any means by which a risk is recognised and this information is passed to an appropriate person
Residual risk – level of risk deemed acceptable after risk reduction measures have been applied
Risk register – the system used to record risks that have been identified, their rating score and what measures have been applied

ACTIVITY 2: MANAGING THE RISKS

Main issue to be highlighted: The purpose is to gain insight and knowledge about the risk assessment matrix and its use.

Important! The results of the exercise must not be considered the actual risk assessment of the organisation as this needs to be led and approved by operational management.

Facilitator presentation: The facilitator presents the 'Procedure for conducting a risk assessment' (p.151 in Annex 1) with particular focus on points 5 and 6

You will find additional resources and examples when preparing for this session in 'Example of risk-assessment protocol' (p. 157 in Annex 2) and 'Example of a risk mitigation measure' (p. 159 in Annex 3), as well as triggering scenarios that can be used from the dedicated annex Make sure you use situations that are adequate and contextualized to the reality of the people you are training.

Group work: The facilitator asks the participants to provide a relevant risk using the list of threats and violence developed in session 1 ('Violence against healthcare') as a reference.

The facilitator then asks the participants to get into small groups and provides them with handouts of the risk matrix (Annex 6, p. 173). Each participant should first reflect on how they would score the risk and discuss this within their group. The facilitator should guide

the participants step by step, giving them instructions on how to use the risk assessment matrix. Participants should be able to ask questions at any point throughout this process.

ASSESSING THE RISK

RISK TO HEALTH PROVIDERS			LIKELIHOOD				
			Very unlikely	Unlikely	Possible	Likely	Very likely
SEVERITY	**Catastrophic**	Life-changing injuries, or fatalities	**5**	**10**	**15**	**20**	**25**
	Severe	Injuries requiring immediate pre-hospital and long-term clinical care	**4**	**8**	**12**	**16**	**20**
	Significant	Injuries requiring immediate pre-hospital and clinical care	**3**	**6**	**9**	**12**	**15**
	Moderate	Injuries requiring clinical care	**2**	**4**	**6**	**8**	**10**
	Negligible	Minor injuries requiring no medical assistance	**1**	**2**	**3**	**4**	**5**

Figure 9: Model of risk assessment matrix

Step 1: The participant should identify criteria to define each level of severity and come up with indicators. Refer to point 5 of the 'Procedure for conducting a risk assessment' (p. 151 in Annex 1).

Step 2: Based on the previous exercise, the participant should in their context identify which hazards are the most relevant for them as health workers.

Step 3: The participant should assess the potential severity and likelihood of the hazard causing harm[21]. They should then plot each hazard into the risk assessment matrix (figure 9). In assessing the severity of an incident, participants will need to refer to the criteria defining each level of severity and the agreed upon indicators. In assessing the likelihood, participants will need to consider the elements provided in point 6 of the 'Procedure for conducting a risk assessment' (p. 151 in Annex 1).

Plenary discussion: The facilitator asks for volunteers to share their risk assessment, plotting them on a common matrix (either projected or drawn on a flipchart). They are also encouraged to explain how they came to these conclusions by making reference to criteria, indicators, likelihood and severity.

21 Remember: an incident includes those hazardous events that could have caused harm as well as those which did cause harm.

Participants are likely to have different results, which can generate interesting discussions and reflections. However, the facilitator should wrap the exercise up with the remark that it is the process itself that is the focus here, not finding the correct place to plot a hazard. That would require more dedicated time, a wider consultation and the direct involvement of operational management. Any general consensus around risks and where in the matrix they belong could be of interest to management and should, if the group agrees, be shared along with the takeaways collected throughout the workshop.

The facilitator should also point out the importance of understanding the motives behind perpetrator actions when trying to determine mitigating measures.

> Assessing risks that may impede the safe delivery of healthcare is a continuous process and should be regularly renewed. Defining the appropriate frequency of new assessments is the role of the organisation's management.

ACTIVITY 3: INCIDENT REPORTING

Main issue to be highlighted: It is important to have an updated understanding of risks and incident reporting as an important tool in this regard.

Introduction: The facilitator introduces the topic based on the information below, then makes reference to the previous activity that has provided an understanding of the contextual risks. Participants are asked whether this picture will be relevant next week, next month and next year.

Incident reporting is not about getting people into trouble. It is an essential tool for identifying and reducing the risks of recurring incidents.

Security incidents can occur at any time and in any work environment. Health providers operating in unsafe environments and in crisis situations may be at risk of experiencing a security incident. Research shows that violence against healthcare workers is "an under-reported, ubiquitous, and persistent problem that has been tolerated and largely ignored"[22]. Established procedures for reporting and monitoring security episodes should be in place and well known to all in the health team, and mechanisms for responding to such cases must be available. All incidents should be reported, including threats, violence or crime that can have lasting physical and emotional effects on everyone involved. Each organisation has a duty to protect, respond and support its employees before, during and after an incident occurs[23].

22 James Phillips, "Workplace violence against health care workers in the United States", The New England Journal of Medicine, vol. 374, n. 17, 2016.

23 Please consult the SIIM Mobile Guide available via the Resources section, page 142.

There are periodic reviews of such incident reports to help improve safety measures in the workplace. This responsibility usually lies with organisational management rather than individual providers.

THE IMPORTANCE OF REPORTING AND MONITORING SECURITY INCIDENTS

Insight into the situations where health workers can be exposed to threats and violence requires a reporting system. Management will then receive information on which areas require increased competence and/or implement measures to reduce or eliminate the risk. Violence of any kind is not acceptable, and your organisation can only act if they know about the incidents. There must be a culture in the organisation that promotes incident reporting without fear of reprisals or criticism[24].

Safety and Security Incident Information Management (SIIM) for Staff

Learn how to report a safety and security incident to your organisation.

Discussion in pairs: Participants are asked to turn to the person sitting next to them and discuss the following two topics:

1) The importance of reporting and monitoring incidents of violence against healthcare
2) The different types of threats and violence to be reported, using examples

Plenary discussion: The facilitator leads a discussion to find out if there is general agreement on the topic.

The facilitator may use the questions below to guide the discussion:

- Are incidents reported in your organisation? How? Is there a dedicated protocol or focal point?
- What experience, if any, have you had of reporting incidents?
- What happened next? Did you get any feedback or see any changes as a result?
- If not, did this deter you from reporting again?

24 International Labour Office, International Council of Nurses, World Health Organization, Public Services International, Framework Guidelines for Addressing Workplace Violence in the Health Sector, available at: www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/normativeinstrument/wcms_160908.pdf

ACTIVITY 4: REPORTING TEMPLATE

Main issue to be highlighted: There are different reporting systems and routines, and each organisation must determine which is the best and most effective for itself and its employees. If reporting systems are in place, there should be "clear guidelines on how to report an incident and set expectations on how they will use the information in the report to take next steps"[25].

Preventing and protecting against attacks
Questions and answers regarding the Attacks on Health Care initiative.

WHO: Surveillance System for Attacks on Health Care (SSA)
Live dashboard of attack types, including statistics and locations.

Option 1:

FOR PARTICIPANTS FROM ORGANISATIONS WITH WELL-FUNCTIONING REPORTING SYSTEMS IN PLACE

Group work: With management's approval, the facilitator distributes the organisation's existing reporting procedures. In small groups, the participants go through the procedures and discuss the content. The following questions can be used as a starting point:

- Is the system easy to use and easily accessible?
- Have you been taught how to use the reporting system?
- Do you use the system?
- If you are not using it, what might encourage you to?
- Are there any elements you would add to the reporting system?
- How might you be better at reporting security incidents involving threats and violence?
- Do you trust how the system is managing sensitive information and the routines for ensuring data protection?

Personal data may be considered 'sensitive' and subject to specific processing conditions.

25 Please consult the SIIM Mobile Guide available via the Resources section, page 142

Which personal data is considered sensitive?

An official European Union checklist of data considered sensitive, which is subject to specific processing conditions.

TIP Prepare to explain the link between confidential info and medical ethics.[26]

- Personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs
- Trade union membership
- Genetic data, biometric data processed solely to identify a human being
- Health-related data
- Data concerning a person's sex life or sexual orientation
- Other sensitive topics

Plenary discussion: The groups briefly present their answers from the previous activity (two or three minutes each). The facilitator asks the below questions and consolidates suggestions.

- What can you do to improve your reporting activity?
- What can your organisation do to facilitate increased reporting activity?

Option 2:

THIS SECTION IS MAINLY RELEVANT FOR ORGANISATIONS THAT SO FAR HAVE NO OR LIMITED INCIDENT REPORTING PROCEDURES AND TEMPLATES IN PLACE

Use the time given to reflect on whether the already existing reporting tool is good enough or needs an adjustment. Is there a need for a new procedure and template?

Group work: The facilitator divides the participants into small groups and presents or hands out examples of reporting templates.

An example of how to design a reporting template: The Health Care in Danger 'Guiding note on incident reporting for health care providers' can be found on p.164 in Annex 4.

TIP Give the participants the opportunity to look at the checklist on p. 6 in *Safety and Security Incident Information Management (SIIM) for Staff.*

26 See the HCiD booklet on the rights and responsibilities of healthcare personnel, on page 136

Discuss and write down what the reporting template for your organisation should contain. Reflect on why it should or should not include certain information. Important aspects to consider may include:

- Place, date, time of the incident
- Details of victim. Who was involved?
- Circumstances around the incident. What happened?
- Consequences (injuries, sick leave, termination of work, etc.)
- Information on measures. What actions have been taken up to now?

Highlight: Reporting mechanisms should not become police documents, otherwise the link between health and security services can cause perception issues for the health teams and the health services.

In addition to creating a reporting template for later completion, it is important to report on:

- Lessons identified/learned
- Suggestions to prevent a similar incident from happening

TIP Remember only to include relevant information. This helps reduce the risk of details being misused later.

Continue in the same groups and now discuss:

- How long should the template be?
- When to report: immediately or later?
- Who should do the reporting?
- Who is collecting the information?
- What is going to be done with the information?
  - Educational tools
  - Analysed data (e.g. to identify trends that help to formulate injury reduction)
- What happens to the report once it is submitted?
- If I provide my contact information, how will it be used?
- Do I have to give my name when I submit a report?
- Who will have access to my report?
- How is my identity protected when I submit a report?
- How is the confidentiality of the report going to be sustained?

Plenary discussion: The facilitator asks each group to present their responses, followed by a plenary discussion. The outcome should be a consolidated list of agreed-upon recommendations that can be presented to the operational management.

WRAP-UP

Plenary discussion: The facilitator asks the participants to summarise the main takeaways from this session and write them down to bring to session 6. This provides an opportunity for the participants to jointly reflect on what they have learned.

A wrap-up can be done in several ways, and one suggestion is the 'cabbage ball'[27] activity.

TIP If IP&C is a concern, each may be given a question separately.

Purpose

- Evaluation
- Summing up

Preparations for the facilitator

- Count the number of participants. You are recommended to prepare one review question for each participant
- Refer to the topic and main learning points to create your questions
- Write a single review question on each piece of paper
- Crumple the paper into a ball
- Write a new single question on a single sheet of paper. Cover the first crumpled ball with this second paper
- Continue writing one review question on a new sheet of paper each time
- Add each sheet to the ball
- When you have finished, you will have a small ball or 'cabbage' with layers of questions

How

- Ask participants to stand and form a circle
- Gently toss the cabbage ball to a participant
- Ask the participant to peel the top sheet from the cabbage ball and read the question out loud. If the participant can answer the question, they should do so. If the participant is not able to answer the question, they can ask the group
- Once the question is answered, ask the participant to toss the cabbage ball to a new participant who has not yet answered a question. The participant receiving the cabbage ball will peel off the top sheet, read the question out loud, and answer it to the best of their ability

27 See Training Manual on Interpersonal Violence Prevention and Stress Management in Health Care Facilities, available via the Resources section, page 134

- Continue until all review questions have been answered
- Congratulate everyone for their participation and round off the session

See page 142 for a list of resources and further reading for this session

CONTEXTUALISING SAFER BEHAVIOUR

SESSION 3:
SECURITY AND BEHAVIOUR

LEARNING OBJECTIVES

By the end of this session the participants will:

- understand how a code of conduct can help improve perception, acceptance, security and access for health services
- understand how identification and uniforms can improve security
- know the principles of safe communication
- know how to improve situational awareness
- understand how cultural, religious and traditional norms can influence attitudes towards health workers and healthcare in general

SUGGESTED SESSION OUTLINE		
ACTIVITIES	**METHODS**	**PROPOSED TIME MANAGEMENT**
Introduction to the training	Present the thinking behind this session, how it's relevant and how the participants will be involved	15 mins
1: Safer Access Framework (SAF)	A plenary discussion on how our behaviour can affect each element of the SAF-cycle	45 mins
2: Behaviour and Code of Conduct (CoC)	• Discussion on what the 'ideal' CoC is • Look at how this CoC would mitigate the risks identified in previous sessions • Group work to review the organisation's CoC and the actual practices • Groups present recommendations	2 hours
3: Uniforms and other means of identification	• Case discussion in pairs and feedback in the plenary • Group discussion on the uniform(s) used by the participants' service • Sharing of findings in the plenary	1 hour
4: Who are we communicating with?	• Discuss experiences of poor and effective communications • Individual exercise • Plenary discussion • Collection of final recommendations	45 mins

SUGGESTED SESSION OUTLINE		
ACTIVITIES	**METHODS**	**PROPOSED TIME MANAGEMENT**
5: Situational awareness	• Plenary exercise: video • Presentation about being in a risk situation • Individual exercise on awareness • Facilitator presents the topic and gives information for the outdoor exercise • Plenary discussion on being aware of surroundings • Wrap-up	1 hours
6: Culture, Religion, Tradition (CRT)	• The facilitator frames the discussion • Role-play • Plenary exercise with the observers presenting what they witnessed • Discussion on CRT competence • Recommendations	45 mins
7: Wrap-up	• Key take-away messages	15 mins
PROPOSED SESSION TIME		**8 HOURS 45 MINS**

PREPARATIONS FOR THE FACILITATOR:

- Make a plan/agenda for this session
- Familiarise yourself again with the risks, gaps and needs collected during sessions 1 and 2
- Become acquainted with the Safer Access Framework (p. 28 in Part 1), and ask management if the participants have already received the Safer Access Framework training, in which case "Activity 1" of this session may be a shorter summary
- Consult with your organisation and, if possible, collect: an existing Code of Conduct or other relevant documents regulating professional behaviour; visibility and identification policies (uniform policy); any guidelines that relate to operational communication
- Revisit the section on the emblems in the chapter 'The Legal Framework' in Part 1, pages 18–25, as key background information for activity 3 on uniforms and other means of identification
- Perform a basic desktop review of common cultural, religious and traditional customs and ask the management to help you identify some of the potential challenges these may present for health services in the given context
- Ask management if it's possible and appropriate to invite an experienced responder to the session. They can talk to participants and share their first-hand experience of being in a dangerous situation

INTRODUCTION TO THIS SESSION

This session will help participants develop tactics for safer access. The activities will be a starting point for recognising how one's behaviour can reduce risks. This section will end with recommendations on how to work towards better procedures and practices.

ACTIVITY 1: THE SAFER ACCESS FRAMEWORK (SAF)

Main issues to be highlighted: The behaviour of the individual health worker can influence the acceptance of the health service and increase the security of colleagues.

Introduction: The facilitator introduces and displays the SAF cycle (Part 1, p. 30).

Group work: Divide participants into four groups with each group focusing on one element of the SAF cycle: Perception, Acceptance, Security and Access. Ask the groups to brainstorm about the different factors that influence each of these elements, based on their experiences.

Plenary discussion: Participants briefly present the factors they discussed (suggested maximum of three elements from each group) and then the facilitator asks the participants to explain how the four elements of the cycle relate to each other: Perception, Acceptance, Security, Access. Participants are asked: How can our behaviour affect each element of the cycle, both positively and negatively?

Suggestion for wrap-up: It is important to deliver quality healthcare, manage expectations, earn the trust of the people we aim to assist and protect, and create a culture in which everyone feels safe. Appropriate behaviour can help provide safer access, while inappropriate behaviour from just one health worker can seriously affect their security, as well as the safety of team members, patients and bystanders, and the reputation of the EMS as a whole.

Safe access is gained over time:

- Acceptance and perception are built through services that healthcare workers deliver in peaceful contexts (e.g. people recognise the emblem and the uniform and associate them with a specific behaviour)
- In risk situations, there is usually a need for additional engagement to gain access and build acceptance

Website: Safer Access Framework

Resource centre: the Safer Access Framework in a nutshell.

In their own words: from an ambulance provider

DEALING WITH ALCOHOL AND VIOLENCE

The incident

In general, our city is peaceful. Most conflicts happen because someone is drunk. One constant issue is that we often arrive at the scene before the police, so there's no crowd control and no one to stop us being verbally or physically assaulted.

One evening, the office received a call about a motorbike accident. Our team arrived on-scene approximately four minutes from the emergency operations centre. It was chaos. Several bystanders seemed to be drunk, and the unconscious patient had been moved from his original position. Bystanders were shouting and saying we had been too slow. They wanted us to drive the patient to hospital immediately. As team leader, I explained that we were there to provide proper care before taking the patient to hospital. A number of bystanders refused to listen. The argument continued and a drunk bystander pushed one of the ambulance crew. He said he was a 'village official' and threatened to sue us if we didn't do what he said. The team continued to treat the patient but, with the ongoing commotion and accusations, we lost our composure and there was nearly a fight. The police arrived just in time. The team calmed down and went back to their work.

Analysis

We should never have reacted – and pretended not to hear the bystander. We are trained and prepared for these types of scenarios, but we are also human. Sometimes we react badly to a situation. This incident has highlighted several things for me. Our country does not have an established EMS law to protect ambulance providers – instead we are working with the guidance of disaster risk reduction. A lot of people have misconceptions about our work. This can mean that they become a threat to us – especially if they are drunk.

Lessons learned

We are strengthening our security through multiagency coordination and by establishing a crowd-control unit. Our office has engaged a number of trainers on Mental Health and Psychosocial Support (MHPSS) to provide us with a support team after traumatic events. The office also runs community-based disaster risk

reduction and management (CBDRRM) to help tackle misconceptions about our job. We have also established links to the Department of Health's Violence and Injury Protection Program (VIPP) to address our existing problems on violence.

ACTIVITY 2: BEHAVIOUR AND A CODE OF CONDUCT

Main issues to be highlighted: A Code of Conduct (CoC) is not a document to sign and put away; it is a vital tool to help health workers deliver a safer response.

TIP Safety may also include behaviours that make sure operational procedures are followed carefully – for example, a basic vehicle check (tyres, fuel, spares).

Introduction: The facilitator introduces the topic based on a selection of the below information.

Important! This training evaluates the organisation's existing practices and procedures and generates recommendations on how to strengthen these where there are gaps. You must keep management informed before and after the session. For example: have they given consent for the CoC or other relevant documents to be assessed by the participants?

Highlight: If a CoC already exists, it should not be challenged, but the understanding of its importance should be reinforced.

A CoC is a framework for ethical decision-making which health workers commit to when joining the health services. It is a written collection of rules, values, principles and behaviours that the organisation believes in and will put into practice. The CoC also communicates an overall picture of the organisation to the public. When each health worker agrees to the CoC, the risk of large variations in the work of different members of the team is reduced[28]. Breach of CoC is taken seriously and will have consequences for the individual.

Emergency responders and ambulance providers often work in situations of high tension, and our behaviour can escalate or reduce that tension. Thus a context-specific CoC is an important part of mitigating risks.

28 See the report Best Practice for Ambulance Services in Risk Situations, available via the Resources section, page 134

BRAINSTORMING ON A CODE OF CONDUCT

Group reflection: Participants are asked to brainstorm keywords that the CoC should contain. The keyword should be written down on post-it notes.

Plenary discussion: Each group reports to the plenary and places the elements they identified on a flipchart or screen. Based on the feedback from the groups, participants will collectively design an 'ideal CoC'. Facilitators then provide feedback based on format (Is it clear? Is it too long?) and content (Is it relevant? Is it realistic?).

Plenary discussion: Participants review the risks identified during the risk mapping in sessions 1 and 2, picking out those that relate to the behaviour of health workers. Then they review the 'ideal CoC' to see if it tackles those risks.

GROUP WORK

Important! Make sure that management is well-informed and open to review the CoC based on the feedback received. If not, all groups can focus on the group 2 activity.

TIP To avoid too many people in a group, divide into several groups, and distribute the questions equally.

GROUP 1: Review the organisation's CoC; discuss what is good; recommend up to three changes. If the organisation doesn't yet have a CoC, this can be discussed as a potential draft or a model robust CoC from another organisation may be used for discussion.

GROUP 2: Review current practice for familiarising health personnel with their CoC; recommend three measures to increase knowledge and use of CoC.

(Examples for facilitators: signing, training, refreshers, inclusion in evaluations, referred to in other trainings, displayed in key areas of the station, reporting on violations.)

Plenary discussion: Both groups present their recommendations, and the other participants are given the opportunity to comment.

Closing: The facilitator leads the participants to agree on a set of recommendations on how to strengthen the CoC and/or its implementation.

ACTIVITY 3: UNIFORMS AND OTHER MEANS OF IDENTIFICATION

Main issues to be highlighted: The use of uniforms and other means of identification foster unity. When the health service has a good reputation within the local community, an identifiable uniform helps protect health providers and makes access easier.

Introduction: The facilitator introduces the topic and the case, based on the information below.

TIP Ensure case examples suit the cultural and social context you are working in.

Uniforms and other means of identification ensure visibility and unity. Ambulance providers must wear uniform that reflects their skills and service. This way, the community knows what to expect from them. When the ambulance or prehospital service has a strong reputation within the local community, uniforms make it easier to identify and access responders.

Video: Health care should never be in danger

7:10-minute video which looks at practical solutions to protect healthcare workers and facilities around the world, and shows that there are actions we can take to prevent violence against health workers.

Other means of identification may include:
- Personal identification – e.g. ID card, passport
- Protective emblems as described in Part 1 'The Legal Framework', pages 18–25
- Vehicles, their light and sound alarms

Case: An ambulance provider arrives at the scene where someone has been shot. They are wearing a beige uniform and they run towards the victim. As they approach, they open the small black emergency first-aid kit on their belt to save time. A couple of seconds later, security forces shoot at the ambulance provider.

Plenary discussion: The facilitator asks the participants to discuss in pairs for two minutes: What could have caused this? Feedback in the plenary.

By the end of the short discussion the participants should all be aware of the link between security and the colour and format of uniform; in this case, a beige uniform can be confused with that of an armed group and the black first-aid kit could look like a gun holster. In high-risk situations, good visibility of health personnel may be key to their access and

security. This includes displaying the Red Cross or Red Crescent emblem (for National Societies) or the organisational logo.

Group work: With management approval, the facilitator distributes or projects images of the uniform(s) used in the participants' service. Participants are divided into groups and asked to reflect on how safe the choice of the service uniform is. The facilitator can offer guiding questions, such as

- Is the uniform standardised across the service or are there many different types?
- Are there other organisations, departments, parties or groups with similar uniforms?
- How can this affect perception and safer access?
- How visible is the organisation's logo on their uniform?

Plenary discussion: The groups share their findings. If there are elements of their identification or uniforms that they would like their management to consider, these should also be collected. These will form part of the last session on recommendations to management.

ACTIVITY 4: WHO ARE WE COMMUNICATING WITH?

Main issues to be highlighted: Good communication improves the safety of health workers. There are differences between internal and external communications. Effective ways to communicate are largely defined by context.

Introduction: The facilitator introduces the topic and the case, based on the below information. For this activity, it may be interesting to revisit session 1 ('Violence against healthcare) and activity 2 ('Different perceptions').

The access and security of health personnel can be affected by their internal and external communication. How the team communicates with dispatch; how they communicate with patients, community and bystanders; who ensures communication flow within the team; who communicates with the authorities and other agencies. These are all elements to be considered in the service's SOPs.

Group work: Participants are divided into three groups and asked to:

- Provide examples of when communication affected how they were perceived by the community, positively or negatively
- Provide examples where internal communication has negatively or positively impacted a given operation
- Provide examples of how communications with dispatch have positively or negatively impacted risk mitigation

In their own words: from an ambulance provider

GUN INCIDENT ON A CALL-OUT

The incident

Our unit answered a low-priority call to the outskirts of town at 4am: dispatch told us there was a man with pain in his knee. As we got to the address, my supervisor remembered that he had been to the same address just a few weeks ago because someone accidentally shot himself while drunk. The ambulance was parked about 20m away from the apartment. As we went in, I made the lock on the front door stick out so that it could not be pulled shut. The apartment was very poorly lit. According to our operating procedure (+1 rule) we checked all the rooms for extra people.

As I interviewed the patient, I noticed a rifle on the wall which was out of the immediate reach of the patient behind the sofa he was sitting on. I pointed it out to my supervisor with my flashlight and made him aware of it. As I continued interviewing, it became apparent that there wasn't really anything to treat and that the patient wanted opioids. I explained that there wasn't anything we could do as he was too intoxicated. When he realised he wasn't getting what he wanted he asked us, "What if I had a gun?" We saw that he had a pistol next to him on the sofa. My supervisor made a silent alarm through our Tetra radio. To our surprise, the radio gave a dial tone. This alerted the patient and he asked, "Why did you do that?" Then, dispatch on the radio asked us if we were okay (something they shouldn't do). My supervisor, trying not to provoke the patient, told dispatch we were okay and ready to leave. Dispatch shut the emergency line.

The patient grabbed the gun and aimed at us. My supervisor tapped me in the back and said, "Run!" I ran out of the apartment, my supervisor behind me and our colleague behind him. We got out and continued on foot as the ambulance was too close to the front door. We discovered later that the pistol had been deactivated and the patient couldn't have shot us with it.

Analysis

I was surprised at how calm and rational our team was. Our organisation doesn't have any specific instructions for these situations other than 'avoid and escape', and things developed so quickly that we had to improvise. Because the perpetrator was in the same room, we could only communicate through body language. We had to rely on that and intuition. We had really good situational awareness about the rest of the apartment and we weren't distracted by others because the patient was the only one there. We did a good job securing a way out and maintaining it throughout the situation. Running was the only move we could make in our situation, but we failed to do the initial surround check with flashlights when we entered the room. That might have given us the chance to flee the scene right away.

Lesson learned

We did many things right and as we were trained to do. For example, we secured the escape route and checked the space for extra people. But things can go wrong however you prepare. I realised that we lacked clear CoC for environmental safety during call- outs: it should be standard procedure to make a quick risk assessment on each mission. The problematic part was the communication between teammates during a stressful situation where you couldn't speak freely to each other. I think we need simple models for how to act when these situations arise, so that we can act as a team without having to communicate first.

We also didn't know there are two ways to make an emergency call through the panic button. Just pushing the button on the radio makes a normal emergency call with a dial tone. To make a silent call, you push two buttons in sequence.

The second serious mistake was when dispatch spoke to us on the radio. According to our guidelines they should listen for at least one minute to determine if there is a threat or violent situation going on. Only if it's clear that this isn't the case should they try to contact us. Afterwards, we were upset with how dispatch handled things. There was some discussion with the dispatch centre as the dispatcher clearly hadn't followed procedures on how to handle emergency calls through the Tetra radio. Dispatch promised to put more resources in training and ensure emergency calls would be handled according to official instructions in the future.

Our employer held a debriefing meeting in the next shift after the situation. This was done according to our guidelines and is a standard procedure after a serious situation. It helps prevent psychological trauma from developing. We talked through the situation and reflected on our actions and feelings during and after the situation. None of us felt the need for further psychological support.

The legal outcome was a disappointment for us. The district attorney made a decision not to press charges, as he believed it was not clear that the patient was threatening us. He argued that the patient probably posed a greater threat to his own life.

Despite a very large number of firearms in our country, it is extremely rare for ambulance personnel to be threatened with weapons. But if anything, that makes it even more important to have simple models for how we should act, because otherwise we rely on luck.

Plenary discussion: Participants share some of the examples. The facilitator follows up by asking participants how any of these individual incidents could have longer term effects on Perception, Acceptance, Security and Access.

Instructions for the exercise: If time and technology allow, prepare a survey in advance (using Kahoot, for example[28]), otherwise ask the participants to score the below statements and then discuss and compare scores. The facilitator presents each statement one by one and leaves them all up for everyone to see. Then the below instructions for the individual exercise are shared.

Individual work: Score the following good practices according to how important you believe they are. How do these good practices relate to their context, and how would you adapt them?

Plenary discussion: The facilitator calculates the full score for each as the voting takes place. At the end, participants explain the thinking behind their votes.

Examples of good practices to include:

- Upon arriving at the scene or in coordination with dispatch/radio room, explain what services will be provided to manage expectations and prevent possible misunderstanding or disappointment
- Refrain from inappropriate behaviour or language at all times
- Show respect for the patient's cultural and religious customs. Familiarise yourself with the traditions of the communities you work with. For example, in the event of a death, responders should know the appropriate way to handle the body before, during and after transport in the ambulance
- Adapt language and tone of voice depending on the situation. In a chaotic environment with many people, it can be more effective to speak loudly and assertively, while empathy must be shown and use a softer tone if the situation is calm and only a few relatives are present
- If assistance is being provided in communities where you do not speak the language, try to make sure someone on the team speaks the language. Healthcare should not be restricted because you do not understand the patient or their community
- All ambulance providers operating in areas with checkpoints or roadblocks should be trained and tested on the relevant dos and don'ts. See examples of these in 'Best practice for ambulance services'[29]. Also, see Annex 3 (on p.159) and the example of a risk mitigation measure

28 Ideas of learning games and live-interaction options available at: kahoot.com

29 See the report Best Practice for Ambulance Services in Risk Situations, available via the Resources section, page 134

ACTIVITY 5: SITUATIONAL AWARENESS

Main issue to be highlighted: It is difficult to ensure situational awareness at all times when dealing with a patient in need of urgent help. Given the importance of a safer response, health personnel should proactively develop and maintain a relationship with the community.

Introduction: The facilitator introduces the topic and the case based on the information below.

Health personnel must be able to reflect on how a situation affects their behaviour, and vice versa. It is important that they are aware of their personal limits, the limits of the team and the limits of the service. Role playing, simulations, on-the-job coaching and mentor programmes can help with this. While classroom lectures should be kept to a minimum, this session seeks to generate a basic understanding of the concept of situational awareness and to generate some recommendations for further work on this crucial capacity.

Plenary discussion: An experienced staff or volunteer member explains how it was to experience a specific security incident or risky situation. The purpose is to highlight real contextual dilemmas, including how difficult it can be to follow previously learned rules and absorb important environmental clues in chaotic situations. The experienced volunteer can explain what measures they took, and what was successful or not successful. Participants are encouraged to ask questions.

TIP You can also choose one of the cases provided to facilitate discussion.

In their own words: from an ambulance provider

SITUATIONAL AWARENESS

We were responding to a fairly routine, vague call one night – man down at a train station, no details given. We parked and arrived at the scene on foot. There was little light and no one was around except the patient and the cousin. He said the patient had drunk too much and had to go to hospital. The patient was lying on a bench with alcohol bottles next to him.

After completing the initial assessment, we asked about the events of the evening and about the patient's medical history. The patient was too drunk to answer, and the cousin did not like the questions. He became angry and verbally

threatening before approaching my colleague and trying to punch him in the head. My colleague managed to block the attack with his arms, trying to calm down and push back, but it developed into a wrestling match.

I radioed to ask for help. We overpowered the cousin, and the patient remained lying on the bench. A few minutes later, several police cars arrived and the officers took the cousin into custody. When they searched him, they found a large knife tucked into the back of his pants.

Plenary activity: All participants are blindfolded and asked to describe the room they sit in: colour of the ceiling, walls, floor, wall decorations, objects, number of chairs or anything else. The facilitator can ask questions about particular aspects of the room. Blindfolds are removed and participants discuss how much they are aware, or not, of their surroundings.

Plenary discussion: To contextualise the problem, the facilitator leads a discussion on:

- How participants maintain situational awareness at work
- What has taken them by surprise

Facilitator presentation: Introduce the topic and the case based on the below information.

Slide 1 (Introduction): We can train the brain to develop muscle memory just like any other muscle in the body. By practising situational awareness and how to respond, we can put our cognitive awareness skills to use more instinctively in a crisis.

Time-critical reactions are even more crucial when seconds matter; late decisions could mean the difference between life and death.

Health workers can hone their skills through everyday exercises that train the brain to be constantly aware of surroundings.

Slide 2 (OODA Loop): Fighter pilot John Boyd created a system for rapid identification of threats and decision-making called the OODA Loop. OODA stands for Observe, Orient, Decide and Act.

While the last two steps involve how to respond to an observed threat, the first two steps relate directly to situational awareness. By observing our surroundings, we can orient what we should be looking for, put that information into context and know what to do with the observations.

Responders can build better situational awareness skills using simple games.

Slide 3 (Practical exercises): The following are cognitive situational training exercises described by Van Horne and Riley.[30] These help develop the mental skills necessary to keep responders safe when abroad.

1) "A" game: A is for awareness. You can play this game with a team member after any regular day-to-day encounter. When entering a place (bus, subway, shop), make note of certain items such as the number of exits, number of people working there, colour of the clothes of people in line etc. Once you leave, ask your team member questions like: How many people were in line?; What colour shirts did the employees have on? The more you and your teammates play this game, the better you will get at observing your surroundings.
2) The "What if" Game: This is done alone, and you can play it any time. It involves simply playing out a scenario in your head. Just ask yourself something like: What would I do if a group of angry men/women suddenly stormed into the room? The more you do this, the better you'll get at real-time decision-making. You can always have a follow-up discussion with a colleague from the team to see what their reaction would be.
3) Peripheral vision: Try to get better at noticing your peripheral vision by observing things occurring outside of your direct focus. For example, when you're talking to a colleague in front of you, make note of the movements of someone across the room or at the edge of your vision.

Group work: The facilitator asks the participants to go outside in pairs or groups of three and test their preferred exercise. After each participant has taken a turn, the participants share quick feedback of their impressions in the plenary.

Plenary discussion: The facilitator introduces the next discussion based on the following information:

Every environment we enter has a baseline of what is normal. It will change constantly depending on where we are. Once we have our baseline, we can observe abnormalities, based on the things that do not happen and should, or things that do happen and should not.

Video: Protecting healthcare during a medical emergency

Produced by ICRC and the Lebanese Red Cross, this 1:54-minute video shows that people may be violent and use weapons to perpetrate violence during moments of high stress and when receiving negative news.

The facilitator asks the participants which traits might suggest potential abnormal behaviours that would give away someone's intention of doing something bad. Point out the importance of avoiding negative stereotypes.

30 Van Horne and Riley (2014), Left of Bang.

The facilitator can complement their answers with the following:

- Always notice what is in someone's hands as they approach, or simply what they are doing with their hands. When trying to conceal a weapon such as a gun or a knife, a person will subconsciously pat or touch the part of the body concealing it. Clenched fists often mean one is preparing for a physical confrontation
- If someone with bad intentions is trying to blend into a surrounding, they will often try to 'act natural'. This is very hard to do. Those attempting to 'act natural' will often over or under exaggerate their movements
- People with bad intentions may regularly look behind them. People do this subconsciously when uncomfortable or when they are about to do something abnormal. Be aware that this may also be a result of insecurity

Important! Remember that some people will show no signs, so the absence of any of these indicators does not mean that there is no likelihood of violence.

Closing: The facilitator shows the video above and concludes: the key to developing good situational awareness is practice, practice, practice.

The facilitator then asks participants to share recommendations they may have in terms of how situational awareness could be improved among the teams in their service.

In their own words: from an ambulance provider

ROADBLOCK ATTACK

The incident

Spontaneous mass protests had broken out up and down the country because of the huge increase in fuel prices. This was the largest and most widespread general strike in the country's history.

Thousands of people were gathering daily in cities and protesters marched and set up barricades. Young people played football on the road and organised music, dancing and food, all of which made vehicle movement difficult. At barricades, union vehicles and cars with flags were attacked, showing the extent of the public's distrust towards the government.

On the first day of the protest, I was appointed to lead a group of Red Cross members at the local branch. While I was driving others around to give first-aid, we came to a certain barricade point in the zone. We were taunted, and as the driver, I was pulled out of the car.

The mob tried to take off everything I was wearing. My team members shielded me, and it took their intervention to get rid of the mob and save my life so we could carry on. My car was dented, and the handset was missing. My heart skipped a beat and I was scared to the bone. I could not forget this incident afterwards.

Analysis
One of our team was absent the following day and decided to give up volunteering. We had to work really hard to convince her to stay. A lot of work was put into creating awareness of the services provided by aid workers and we organised first-aid training for the transporters. And because training is key, volunteers were also trained in managing threats and the risk of violence. Refresher training is organised regularly, and we also include negotiation skills in our programmes now, too.

Lessons learned
I learned that we have to be prepared for hostility in crowds, even at the point of dispatch. I now know that we need to involve local trained personnel when we're out on the road, whether volunteering or providing first-aid – especially where there are protests, elections or other situations.

ACTIVITY 6: CULTURE, RELIGION AND TRADITION (CRT)

Main issues to be highlighted: Everyone has personal assumptions about different cultures, religions and traditions. This includes health teams and the communities they respond to. While traditional norms are per definition relatively static, the way in which traditions are interpreted changes over time and may vary from one place to another.

The main point here is the importance of acknowledging such personal assumptions and cultural diversity, especially in emergency medical settings. The facilitator should offer examples specific to the relevant health service, to keep the conversation relevant and focused, avoid a shift into trainees' personal lives. It would be helpful to also highlight the evolving nature of traditions and norms to foster understanding and reduce biases in diverse contexts.

Presentation: The facilitator frames the discussion based on the below information. This will help ensure that the discussion on these big concepts remains focused. Where applicable, the facilitator may provide examples of how these may relate to the health service in question (for example dead body management, pressing a wound in first aid, male responders treating female patients).

CRT and scene safety

Points to be considered by facilitator when leading discussions on CRT:

- Consider the fact that while people speaking the same language may seem uncomplicated, the real challenge is when people do speak the same language, but still present deep cultural/religious/traditional differences
- Always consider components that include vital space and personal distance, body language, touch, eye contact, tone and pitch, etc. What in some cultures will be considered completely normal may be perceived as aggressive and frightening in other cultures
- How we express our feelings varies from person to person, but there are also different customs in different cultures. It is important to know and be open to the different reactions of people in crisis as well as the specific culture's accepted way of behaving and expressing themselves in given situations
- There may be different approaches to questions concerning diseases (such as cancer, HIV/AIDS, infectious diseases, etc.) along with perceptions and reactions regarding the end of life. This can be a source of tension and create unsafe situations for health personnel. Feel free to spend some time discussing this topic
- Gender and medical response, as some groups might have social rules on how genders may interact.
- Reflect on what and how you as a health worker think and feel when dealing with situations such as not being allowed to treat someone of the opposite sex or that, for instance, a male relative or patient does not want to talk to the female health worker

How can reflection on these themes make the scene safer for you as an ambulance provider?

CULTURE

Culture or civilisation includes common customs, values, social rules of conduct, beliefs, rituals and traditions, perceptions of human nature and natural events. It makes us a member of society. Different countries have different cultures and different communities. Even families may adopt different cultural practices. Culture affects many aspects of life – from how we communicate and celebrate to how we perceive the world around us and how we are perceived. There are many things that shape our personal culture, and we all hear and see our surroundings in different ways.[31]

31 Tylor, Edward. 1871. Primitive Culture: Research into the Development of Mythology, Philosophy, Religion, Art, and Custom. London: John Murray. Volume 1, page 1.

Understanding how we present ourselves to others can open the possibility for others to share who they are. Thus, we will all be able to function more effectively in the context of cultural differences.

Cultural competence is related to having and showing respect for others and accepting that there are many ways of viewing the world. This does not mean that you must be an expert on all cultures or share views and values with the person or people you are treating, but more that care is given free from predetermined assumptions. Having cultural competence helps us to ask the right questions, in the right way, so that we get the right information and can provide the right treatment.[32] By doing so, we can assume that the tolerance for us as medical assistants increases and consequently the risk of being harmed is reduced.

Although workplace violence has a universal understanding, its perception and understanding may still vary between different cultures. This cultural difference should be considered:

- By using appropriate terminology that reflects the common language of a particular culture
- With particular emphasis on forms of violence in the workplace that have a special relevance in a particular culture
- With a special effort to identify and detect situations of violence in the workplace that are difficult to detect and accept as a reality due to specific cultural background.[33]

RELIGION AND SPIRITUALITY

Religion and spirituality may include different perceptions and cultural patterns of action that presuppose reality as more than the physical, measurable world. These are personal sets or institutionalised systems of religious attitudes, beliefs, and practices. Religions often present answers to human existential wonder. This distinguishes religion from beliefs that do not necessarily imply a belief in something non-physical.[34]

32 For more information and examples of activities, see the Washington Health Department's manual on Multicultural Awareness for prehospital EMS professionals: tinyurl.com/2p8caxjm

33 International Labour Office, International Council of Nurses, World Health Organization, Public Services International, Framework Guidelines for Addressing Workplace Violence in the Health Sector, available at: tinyurl.com/ssj2rj4p

34 Definition of "religion": www.merriam-webster.com/dictionary/religion

TRADITION

Tradition is a form of social practice or perception that is passed on, e.g. from generation to generation, in a society or group. The task of tradition is to tie together the old and the new to create a historical continuity for a group or the members of a society. The content of the tradition is often linked to cultural elements that are believed to be particularly valuable because they form an essential part of a society or group's social heritage.[35]

Plenary activity: The facilitator gives a number to each participant from 1–6 and assigns questions for reflection accordingly. Everyone is given five minutes to reflect on their question privately. Anyone who wants to share may of course do so, but it should be clear that this is optional (given the inherent private sensitivities).

- What are your personal assumptions about people who are different from you?
- What values do you stand for?
- How do you react when someone says something against your faith or traditions?
- Have you or others you know experienced being stereotyped based on religion or beliefs? Try and put words to how that feels
- Why do you think spirituality, faith, and religion are important to people?
- How is your reaction to a negative coping strategy based on religion/tradition/local customs that can hinder the effective provision of healthcare?
- Do you know what medical ethics says in terms of respect to patients and impartiality of care? [36,37]

SCENARIOS FOR REFLECTION

Burial attacks in Sierra Leone

A report of healthcare personnel attacked for conducting burials against the customary rules of the local communities in Sierra Leone.

Massacre in Guinea

A report of healthcare personnel attacked for conducting burials against the customary rules of the local communities in Guinea.

35 Definition of "tradition": en.wikipedia.org/wiki/Tradition

36 See more in the training on Medical Ethics by the World Medical Association, available at https://elearning.icrc.org/healthcareindanger/wp-content/uploads/2018/12/medical_ethics.pdf

37 See the HciD booklet on the rights and responsibilities of healthcare personnel, via the resource section on page 136

In their own words: from an ambulance provider

ALCOHOL AND VERBAL VIOLENCE

The incident

I was in a small rural city for a three-night shift. On my second night, we received a priority 2 call (meaning urgent and possibly life-threatening). It was in a remote native settlement, about a 40-minute drive away.

Once we got there, we took our equipment and walked a distance to get to the patient. Our dispatch centre had told us that we were dealing with a woman with a head injury.

A lady showed us the way to the patient. Her English wasn't great, and I couldn't understand her. The patient had a head wound and severe bleeding. She mixed her native language with some English. It turned out that she had been hit with something on her head by her partner. The lady was drunk.

It was dark so I used my torch to help with the assessment. More and people from the village showed up at the scene. Many were drunk. The patient's accusations against her partner became louder. We soon realised he was one of the bystanders. We persuaded the patient to walk with us to the ambulance. I thought about running to the ambulance to switch on the outside lights but didn't want to leave my partner alone.

While walking to the ambulance, the patient fell to the ground twice and started crying and shouting. At one point, she refused to carry on, but her friend convinced her to let us treat her.

At the ambulance, some drunk men (most likely friends of the potential perpetrator) were standing in our way. They started to verbally attack us and our patient. It was barely possible to calm them down as I did not speak or understand their native language.

Once again, we had to convince the patient to trust us. Eventually, we managed to get her inside the ambulance.

I accompanied my partner inside the back of the ambulance to help with the examination and we soon realised we had to get her to hospital.

People tried to open the ambulance door while we examined the patient. As I stepped outside to get to the front of the ambulance, I was once again verbally attacked. One guy spat at my feet but was held back by other bystanders.

Eventually, we made it to the hospital and were able to hand over the patient safely. We were not physically attacked or harmed, but the situation could have deteriorated at any time.

Analysis

Normally, volunteer ambulance officers have a good reputation at all levels of society. I was surprised that the people in this settlement were so aggressive towards us. We wanted to help.

My partner was very calm and concentrated on the patient while keeping a close eye on the surroundings at the same time. He did not interact with aggressors unless necessary. He did not accuse or blame anybody. And he was careful not to mention the police. It was good fortune that he had the role of the clinician for this case. We have distress buttons on our mobile radio that can immediately alarm the police, but this seemed unnecessary. I felt it would cause more problems because the police aren't well respected there.

Besides, any type of backup from the police would have required the same 40-minute drive. And as the only ambulance crew, more ambulance backup would have (a) left another rural community without coverage and (b) required at least an hour's driving time to reach us.

Looking back, we should have illuminated our outside working light right from the start. I shouldn't have joined my partner in the back of the ambulance, and we should have taken off immediately. We could have stopped a distance away from the settlement and crowd.

I am more aware of cultural and language problems now. I inform myself of what kind of area we are going to and what I should expect to find. Further steps have already been taken to implement a zero-tolerance strategy. In the future, I will ask for backup if possible.

Role play: The facilitator asks for nine volunteers and separates them into a group of six and a group of three.

How to facilitate for active role play
Encourage participants to imagine that they are experiencing a situation in real life and showing the reactions in their own way, so that they can act as realistically as possible. Don't make the situation too complicated as this can be frustrating and disrupt learning. If needed, you can prepare using this manual: tinyurl.com/yc46zxbf Role play guidance for facilitators of MHPSS trainings, MHPSS Hub

Instructions for group of six: This group should play out a response to a car accident. The different roles are: one unconscious patient, three health workers and two bystanders that are trying to involve themselves and are in the way.

Instructions for group of three: This group is going to play three relatives of the patient who are scared, angry and aggressive. They speak a local language and do not understand the health workers well. They do not want the patient to be handled by someone of the opposite sex nor to die in hospital where they believe people are immediately cremated after death. Others are not aware of these instructions.

Instructions for the observers: Observers will be taking notes on what they see during this emergency situation. They are asked to pay particular attention to elements related to culture, religion, tradition, and professional jargon.

Plenary activity: The observers present what they have seen, followed by the group of six sharing what they experienced when the three relatives entered the scene. Finally, the participants who played the relatives share the instructions they were provided before the role play.

The facilitator then guides the group to discuss how cultural competence plays a role within the context in which they operate. They should discuss how a lack of cultural competence can adversely affect the safer access cycle's four elements, both in the short and the longer term.

Closing: If the group has any specific recommendations related to CRT on how ambulance providers can further reduce the risk in their context, these are collected by the facilitator

TAKEAWAYS

Individual work: The facilitator asks participants to individually write down one or two follow-up measures from each activity. What do participants think are the most important measures for reducing threats and violence against health personnel in their organisation (CoC, uniforms and other means of identification, communication, situational awareness and CRT)? Participants should present and discuss all the suggestions in the plenary.

Plenary agreement: Agree and consolidate the key points from this session. These are collected by the facilitator to bring to session 6.

WRAP-UP

One wrap-up approach is the confirmation pyramid, in which everyone stands together in a circle. The facilitator begins by describing the group using a positive word. Another participant follows on from this, firstly describing the group using a positive term and then bringing up a positive experience from this session. Continue until everyone has had their turn. The facilitator then closes the session.

See page 144 for a list of resources and further reading for this session

SESSION 4:
MANAGING AGGRESSION AND INTERPERSONAL VIOLENCE

LEARNING OBJECTIVES

By the end of this session participants will:

- have explored different scenarios where aggression and violence may occur
- understand the connection between reactions, emotions and needs
- be aware of how to contribute to de-escalation of aggression and interpersonal violence
- have become familiar with practical skills in non-violent communication and conflict management

SUGGESTED SESSION OUTLINE		
ACTIVITIES	**METHODS**	**PROPOSED TIME MANAGEMENT**
Introduction to the training	Presentation of the rationale for this session, the involvement of the participants and how it's relevant	5 mins
1: Contextualising why aggressions occur	• Plenary discussion on potential reasons for interpersonal aggression • Contextualising in groups	30 mins
2: Human needs and basic emotions	• Individual work / brainstorming on the connection between stress and feelings • Plenary discussions on self-awareness of emotions and behaviour	40 mins
3: Vital space	Plenary activities to inform about the principle of the vital space as a form of sphere	10 mins
4: Contextualising good communication	• Discuss experiences of poor and effective communications • Individual exercise • Plenary discussion • Collection of final recommendations	45 mins
5: Active listening	Plenary and in-pair discussions on active listening	30 mins
6: Non-violent communication	Facilitator presentation followed by plenary discussion, activity and group work on non-violent communication as a tool	1hour 30mins

SUGGESTED SESSION OUTLINE		
ACTIVITIES	**METHODS**	**PROPOSED TIME MANAGEMENT**
7: Escalating and de-escalating reactions	Group work to explore different ways of responding to scale down a potential conflict	1 hour 30 mins
8: Takeaways	Plenary consolidation of takeaways from the sections	20 mins
PROPOSED SESSION TIME		**6 HOURS**

PREPARATIONS FOR THE FACILITATOR

Make a plan/agenda for this session

- Familiarise yourself with the theory provided in this session
- Become acquainted with the 'Training Manual on Interpersonal Violence Prevention and Stress Management in Health Care Facilities' see QR-code on p. 134 in the Resources Section

INTRODUCTION AND AIM[38]

This section provides the participants with a basic understanding of how violence and the threat of violence can affect health workers. It aims to develop relevant interpersonal communication skills to de-escalate and prevent conflictual situations. The use of examples and role-play is the starting point for participants to learn how to identify the essential human emotions that can trigger violent behaviour.

Highlight: The facilitator should clarify that the soft skills that will be trained in this session are not sufficient in situations of extreme danger such as armed attack or structural sexual violence. The skills provided by this training do not aim to equip participants to deal with such extreme situations; rather, they focus on lower levels of aggression and interpersonal violence that can be addressed using basic interpersonal skills.

38 This module is largely inspired by module 3 of the Training Manual on Interpersonal Violence Prevention and Stress Management in Health Care Facilities. The training manual is, in turn, largely based on the Norwegian Red Cross manual for street mediation. Norwegian Red Cross can provide you with this street mediation manual, as well as training if this is of interest.

ACTIVITY 1: CONTEXTUALISING WHY AGGRESSIONS OCCUR

Main issues to be highlighted: When met with aggressive behaviour, health workers can influence the situation by the way they react and behave. This requires the capacity to be aware of and control one's own emotions in such a situation.

Introduction: The facilitator sets the scene stating that in crisis or other stressful situations, strong emotions and reactions can easily arise. These are usually normal reactions to an abnormal situation. As health workers, it can be stressful and frustrating that someone reacts in an aggressive manner, especially if you are trying to help that person or someone they care about.

Plenary discussion: The facilitator asks the participants why they think interpersonal aggression can take place. Answers can be supplemented with the following points:

- Aggression may occur when a person is insecure, frustrated or angry, feels powerless or lacks information
- Aggression can help the person to regain control in the short term in confusing situations
- Aggression can be observed both in people who are still thinking logically, and in people who are in such a crisis that logical arguments do not materialise

Group work: Divide participants into groups of three to four and provide them with paper and pens. Ask participants to share situations where they experienced aggressive behaviour or violence while on duty. Remind participants that they are in a safe space and emotional reactions may occur – they are normal. Also, situations of extreme danger such as armed attack or sexual violence will not be the focus of this section.

TIP If someone discloses an incident of sexual or gender based violence to you:

- Note that providing information is an essential part of helping
- Check if the participant wants to continue their story
- Listen carefully, do not doubt, do not judge
- Be informed of the services available inside and outside the organisation (such as a hotline or a referral system)
- Share this critical information. Do not give advice you are not trained to give
- Remember consent
- Keep any disclosure confidential

In the plenary, each of the groups share two or three of the situations they have discussed. The facilitator notes down key words for the types of situations on a flip chart (for example: "worried relatives" or "checkpoint aggression").

Plenary activity: Participants are asked to suggest ways in which these situations can be defused.

Examples may include:
- Remain calm and be polite
- Speak slowly and calmly
- Ask what the person needs and try to help with this, rather than reacting to anger
- Provide information about:
  - What is happening?
  - What is your task?
  - Who else can provide help?

This may look easy on paper, but as many of the participants already know, when you are in the middle of a situation it can be much more confusing and difficult.

In their own words: from an ambulance provider

LACK OF UNDERSTANDING FROM BYSTANDERS

The incident

I witnessed a car accident involving a large bus on a remote route. This community there has experienced many traffic accidents because of the mountainous terrain and steep roads. My family and I were driving directly behind the bus when it happened.

I started to provide first aid, responding without a team of responders. I was able to get about seven more people to help me treat and evacuate the injured. Some of the casualties went to the nearest Government hospital, a two-hour drive away. Others went to a cottage hospital in the same community. Unfortunately, the staff were on strike there.

I did my best, including performing chest compressions on someone who I already knew, deep down, was dead. Her companion would not let me stop.

I was exhausted and tried to explain that I needed to help others, especially the bleeding casualties and someone with a suspected spinal cord injury. The companion said I was a "bad nurse" and told me I had to do my job and keep her sister alive. This person pulled at me and dragged me around until someone intervened.

Analysis

I imagine this violent incident occurred because of the following factors:
- Frustration at being unable to get a professional health response
- A poor health system with no contingency plans or emergency response system on the highway
- Non-functioning health facilities

- Lack of awareness of first-aid and the Red Cross within the affected population
- If there had been a team of rescuers who were skilled in first aid at the time of the incident, it might have resolved the tensions.

The situation could also have been mitigated if there had been more knowledge about the presence or existence of first-aiders as well as the emblems of the society in question.

Adequate infrastructure and health facilities with the right staff and hospital supplies would have alleviated the situation. If there had been proper, rapid continuity in the care of the wounded, the spectators and relatives would have acted differently.

Also, people need to be aware that health professionals, no matter what capacity they serve, should never be exposed to any form of violence. Awareness must be created in this case.

Lessons learned

I've learned that emergency responses have limitations, and one person cannot do everything. It is important to step back if you feel overwhelmed and don't feel safe to continue. Engaging other actors, especially bystanders, is important. This might mitigate and control negative reactions.

If I did this again, I would take more control of my emotions. I'd calm everyone down, then introduce myself properly as a skilled first-aider. I would also give spectators specific roles such as helping with evacuation, or taking care of victims in the best possible way.

ACTIVITY 2: HUMAN NEEDS AND THE BASIC EMOTIONS

Main issues to be highlighted: Stressing the importance of understanding the relationship between the unmet needs of a person, emotions and his/her aggressive behaviour. If we are able to identify the unmet needs of the person in front of us, we can try to de-escalate the situation by meeting them in the best way possible.

Introduction: The facilitator explains that emotions and needs are closely connected. In difficult and stressful circumstances, physical or psychological aggression and violence is produced by high emotions, which in turn appear because of some unmet needs. Emotions may be hard to identify, as well as the unmet needs behind them. This is why it is so important to practice self-awareness and to explore these issues.

Activity: The facilitator asks the participants to reflect on the different emotions that arise when our needs are met and how we react to them. These reactions should then be written down on post-its.

Plenary discussion: The facilitator writes the four basic human emotions as titles on four separate flipcharts and asks the participants to stick their post-its under the core emotion to which they relate.

1) ANGER
2) FEAR
3) SADNESS
4) HAPPINESS

Depending on the size of the group, the facilitator may ask between two and four volunteers to share their experiences. The facilitator leads the participants in a plenary discussion focussed on highlighting that anger is usually a secondary emotion. It means that anger seldom arrives alone; it is rather an expression of another deeper emotion such as fear or sadness. For example: fear can be expressed by a person becoming angry and confrontational. As these emotions are closely interrelated, it can be confusing both for the person who experiences it and for the people around.

The facilitator asks participants the following questions (if the time allows for it, the two questions could be first responded to while working in pairs before discussing as a group):

- Can you think of a situation during your work where the manifested anger most likely was an expression of other feelings or fears?
- Follow up by asking: Why is this understanding important in defining how we react to a person facing us with anger?

Closing: When we meet people who are angry or aggressive it can often be more effective to try to identify their underlying emotions and meet their underlying needs, rather than to react to the anger itself. Thinking in this way may also help you to keep your own calm, rather than to inherit the feelings and reactions of the other party.

In their own words: from an ambulance provider

COMMUNITY FEAR AND ATTITUDE TO AMBULANCE PROVIDERS

The incident

I was leading a team of nine in a difficult-to-access community. Our volunteers told us that sick people were showing signs of EVD (Ebola Virus Disease) but their family members refused to take them for treatment or call an ambulance.

I called an ambulance myself and went to convince the family members to let me take their sick family members to the emergency treatment unit (ETU). They refused and would not even allow us near the house.

When the ambulance arrived a few hours later, the community members were furious and threatened to burn the ambulance. It was one of the scariest moments

in my fight against Ebola. The people were supposed to be under quarantine but broke all regulations, including wanting to touch us, which would expose us to the virus. There were so many life-threatening complications for me and my team. We just wanted to save the lives of the sick and take them to the ETU.

Analysis

We were later told that two of our local volunteers went to the town manager to explain the incident. They also left someone with us on the spot who spoke the local dialect, asking to let us transport the sick to the treatment centre. The mayor came and intervened, and the families agreed that their loved ones could be transported on the condition that we update them on the prognosis of their loved ones. We quickly accepted and delegated responsibilities. As the Ebola coordinator, I was responsible for providing the follow-ups, which we did through through the mayor. It was a perfect arrangement and helped to improve the relationship we had with the members of the community. It also built further trust in the Red Cross work.

Lessons learned

Community: The community didn't know much about the Ebola virus – transmission pattern, prevention or dangers. They had a myth that health professionals spread the virus, so they shouldn't go to healthcare facilities with their loved ones. They were angry because previously when people had been taken to ETU, they heard nothing from them. They believed that when sick people were taken to ETU, they were sprayed with a toxic solution that would kill them.

There was a lack of trust in the system, with no feedback mechanism from the treatment unit to the community members regarding the progress of the patient's condition. The dead body management team, which is run by the Red Cross, was also faster than the ambulance run by the authorities. Members of the community couldn't tell the difference between them. The community's fear and mistrust may have been rooted in a lack of information and previous negative experiences. The intervention of local volunteers and the mayor helped provide reassurance by offering updates on patients' conditions, addressing emotional needs, and building trust. This highlights the importance of communication and feedback mechanisms in managing psychosocial stress during health crises. Ensuring the community feels heard and informed is essential to reducing fear and strengthening the response.

Response: There were many disruptions among humanitarian workers and major partners, including the government through the Ministry of Health. We did not respond in time due to many factors that were beyond our control (unfortunate road networks, rainy season with flooded bridges, poor network connection and so on).

ACTIVITY 3: VITAL SPACE

Main issues to be highlighted: Not everyone is comfortable with the same proximity to other people. Standing very close to another person can unintentionally communicate some sort of provocation.

Introduction: The facilitator introduces the topic based on a selection of the below information.

The aim of this section is to understand the principle of the vital space as a sort of sphere around us. This sphere may change size according to our mood and who we are interacting with. The intrusion into our vital space can be perceived as an interference, a violation or a lack of respect.

Plenary activity: The facilitator asks all participants to freely move in the room and let them find the place where they feel most comfortable. Some are then asked individually why they specifically chose this place. The goal is to make them realise that we tend to position ourselves at a comfortable distance from other people and in a way that provides us with a better overview.

Plenary activity: One participant stands still, and another is asked to slowly walk towards him or her, starting from about 5–10 meters away. The one walking should stop at the limit of his or her comfort zone and explain the decision to stop by providing details about the feelings involved. The facilitator will define this border or threshold as the limits of this participant's vital space. The other participant, who was standing still, provides an account of how he or she experienced it and whether his or her vital space is the same, larger or smaller than that of the colleague.

ACTIVITY 4: CONTEXTUALISING GOOD COMMUNICATION

Main issues to be highlighted: As individuals we take on different roles in different situations. If we understand this, we are better able to control the role we take and how we communicate, rather than letting our emotions drive us in that situation.

Pair discussion: The facilitator asks all the participants to find four words that answer the question: What are the most important elements of good communication? The participants have three minutes to write each of the four words on different post-it notes. Participants partner up and agree on which of their combined eight words they believe are the most important, ending up with a new set of four prioritised words. No new words can be added, and participants are not allowed to change the words or put two words together. This should also take three minutes.

The process continues in the same manner with each pair joining another pair to make groups of four. Together they spend three minutes finding a new combination of four words from these two lists. The groups of four then join in groups of eight to make a new list of four words. The process continues until the whole group has made a priority of all the lists, ending with one list of four words common for all participants.

The facilitator observes the groups during the exercise. How do the different participants react? What role do they take in the process? Some will be leading, others will pull back, some will seek to clarify, and others may dominate.

Plenary discussion: In the plenary, participants share what kind of role they felt they took and the facilitator comments.

- Was it difficult to come to agreement with the others?
- Did this change as the number of participants in the groups increased?
- Did the participants feel like the others heard and saw them during the whole process?
- Is everyone happy with the end result? Does everyone agree?
- Did they use the four elements of good communication that they had identified in this process?
- How did it feel having to let go of their own words that they thought were important?
- What were the consequences of the allocated time being so short?
- Do they think that the end result would have been different if they had been given more time?
- What did the participants learn about communication during this exercise?

ACTIVITY 5: ACTIVE LISTENING

Main issues to be highlighted: While we are relatively aware of our verbal communication, the nonverbal signals that we display when another person is talking to us are usually less deliberate. It is important to understand that these non-verbal signals may affect the person who is talking to us and facilitate (or hinder) the communication of a certain message.

Introduction: The facilitator introduces the topic based on a selection of the below information:

Active listening is a communication skill that is about being present in the conversation and giving full attention to the person who is talking by showing openness, interest and respect. The ability to actively listen can help to strengthen relations by creating understanding, trust, improving cooperation and reducing conflicts. Active listening is important in all communication and especially in stressed and conflictual situations. Fortunately, it is a skill that can be improved with training.

Plenary discussion: The facilitator asks the participants: What is active listening? What do or don't we do when we are listening actively? The facilitator encourages participants to describe behaviours they might perform when they demonstrate attention and care and disclose whether that changes from one group to another (based on gender, age, etc).

The key points are written down and the facilitator adds to the list if any of the following actions are missing, according to locally-appropriate non-verbal communication:

- Seek eye contact, if this is locally appropriate
- Be aware of body language (e.g. nodding, facial expressions, posture, sitting position)
- Make noises and give feedback (e.g. "mmm", "oh", "exactly", "oh really?", "how interesting")
- Think about vocalisation and tone of voice
- Be aware of our own judgments, prejudices and interpretations
- Avoid interruptions or criticisms
- Ask questions about things you might not have understood, or simply to have the speaker go into greater detail about the topic

Pair discussion: Participants are divided into pairs. They take turns in telling each other about something that is important to them (goals in life, principles they try to live by, something they feel they need to improve, etc.) The other participant will start by acting as an active listener, but after about a minute, switch to being a poor listener.

Closing: The facilitator concludes the activity based on the following information:

When interacting with others, we often do not listen properly. Perhaps we are distracted by our own thoughts or by something else that is happening in the room (e.g. TV, mobile phone, other patients). We sometimes start sharing our own thoughts, interpretations, conclusions and suggestions for solutions, before the other person has had time to finish telling their story. Alternatively, we 'steal' the story by starting to talk about something similar that has happened to us – we think that our story is bigger, worse or more significant.

How the listener listens may have a large effect on how well the speaker talks. The person who is listening gives both verbal and nonverbal signals that affect the person who is talking and even the message that is conveyed. The attitude, the way we stand or sit, our gaze, facial expressions, gestures, touch and physical distance, are all involved in signalling to others how we feel and how much attention we are giving to what is being said. This nonverbal communication often takes place unconsciously.

ACTIVITY 6: NON-VIOLENT COMMUNICATION

Main issues to be highlighted: Language choices have a huge impact on how effective your communication is. Our use or abuse of words in daily conversation can be transformative or destructive.

Introduction: The facilitator introduces the topic based on a selection of the below information. (It is recommended that the facilitator write down key words on a flip chart while describing the You-language and I-language, to help clarify the differences.)

While you may not consider anything you have ever said to be violent, some words are considered more violent than others in that they make people feel threatened or attacked, which in turn makes people defend themselves and often attack back. Words that make us defensive are generalisations like "always" and "never", as well as demands such as "you have to" or "you cannot".

Non-violent communication is designed to strip away the narrative people automatically build in their heads – that big looming cloud of supposition you might be carrying around about a person or situation.

Non-violent communication can similarly be an effective tool for meeting people that are experiencing strong emotions, like fear, anger or sadness to be able to identify and meet their needs.

Marshall Rosenberg distinguishes between two characteristic ways of speaking that can affect the development of a conflict either towards an escalation or a de-escalation:

You-language contributes to the conflict escalating. When using You-language we blame the other person. When we use it, our focus is on how you (the other person) reacts, handles the situation, manages a task. In other words, it is your fault. As a result, the recipient often becomes defensive and naturally enough starts a counterattack.

I-Language contributes to de-escalate conflicts and can facilitate an understanding and closeness that increases the chance of a common solution. When we use it our focus is on how I see a situation, how it affects me and my needs. I take responsibility for my own emotions and reactions, rather than demand actions from others, the disagreement does not harm the relationship but instead generates empathy.

Plenary discussion: The facilitator introduces the key message below and asks participants what the implications are for healthcare providers.

Key message: In stressful situations we are often unable to have an overview of what is

happening before we feel that we have been heard and understood. If we find that the other person has heard or understood what we need, then we can calm down and hear what is being communicated to us as well.

The facilitator can use the following example as an explanation:

In a conflict in which one person is more upset than the other (for example, the father with an injured son, who thinks that the nurse is not doing his or her job properly), the most effective method can be to first listen and allow the upset individual to feel that she is being understood. This person will then often calm down enough for a dialogue to be possible.

Plenary activity: The facilitator draws a person and explains the four steps in Rosenberg's model of non-violent communication, focusing on constructing a sentence in the following structure: *"When I see/hear that ..., then I get/feel/become..., because I need..., therefore I would like that..."*

1) **Observations**: What you see or hear, without evaluating, interpreting or criticising. The observation should be as specific as possible.
   For example: *"When I see/hear that ... "*

2) **Emotions**: How this situation makes you feel, how it affects you personally.
   For example: *"...I get/feel/become... "*

3) **Needs**: What your underlying needs, values or desires are that cause these emotions.
   For example: *"...because I need..."*

2) **Wishes**: Specific actions you would like the other person to take that would help you get your needs met. It is important that this is a wish and not a requirement, so that one is not angry with the other person if the wish is not granted.
   For example: "*Therefore I would like that..."*

Participants take turns in constructing examples of statements that take into account the four above elements. After each statement, other participants are invited to provide feedback to the statement before the facilitator does.

Group work: Rosenberg connects feelings and needs, identifying that a person's feelings are a reflection of that person's unmet needs. So, while I may be tempted to say that I am frustrated because you are not doing your job properly, this method helps me see and

communicate that I am frustrated because I need information, I need to feel safe, or I need to feel control in the situation.

Bearing this in mind, when we talk to someone who is very upset, it is useful to try to identify what the underlying feelings and needs are. We should try to meet these, rather than confront the anger.

The participants are divided into groups of three or four and asked to:

- Identify a realistic scenario during health operations in which this approach could practically be implemented
- Under each of the four steps, identify questions that could be asked to help people identify their needs or formulate their wishes

The groups share their reflections in the plenary. The other groups and the facilitator complement where relevant, highlighting the potential such questions can have in de-escalating a situation.

Key questions could include:

Observations:

- What happened?

Feelings:

- How did you experience the situation?
- How is it now?
- Confirming emotions: I understand that you are frustrated. I can see that you are upset, and that is understandable.

Needs:

- What do you need?

Wishes:

- What can be done to make the situation better?

TIP Some participants may find the *I-language* to be a naive approach to take in a situation where someone behaves aggressively. This approach is indeed not infallible, and it will be implemented with varying degrees of success based on their individual capacities. Already staying focussed on avoiding *You-language* will reduce the chances of further escalation. But rather than defending the approach, the facilitator should let the rest of the group explore the topic by asking: Does anyone have other thoughts or ideas about this?

ACTIVITY 7: ESCALATING AND DE-ESCALATING REACTIONS

Main issues to be highlighted: Our immediate reactions in a tense situation are usually emotional. With continuous awareness raising and training we are increasingly able to manage our emotional reaction and implement de-escalation techniques.

The facilitator briefly introduces this activity by stating that, unless we are experts in non-violent communication, our immediate reactions in a tense situation are often emotional. We may give a reaction in what we say, through a gesture, an eye movement or many other ways. This activity seeks to capture some of those behavioural details from the participants' own context and reflect on how they may escalate or de-escalate a given situation.

Group work: In this exercise, the participants will be exploring different methods of reacting in difficult situations.

1) The facilitator asks the participants to spend three minutes to reflect upon a conflict or tense situation they have been part of and that they felt they did not handle in a good way. The situation should preferably be related to a work situation, but can also have happened at home, among friends or in a social situation.

2) The participants are then divided into smaller groups of three or four. They are given 15 minutes to tell each other briefly about the situations, using the lead questions: how did they feel at that moment? Were they aware of their emotions?

3) Each group then chooses one of the stories for further work. They spend the next 10 minutes exploring the following alternatives:
   - What is the most likely way to react in this situation?
   - What could be the most escalating way to act in this situation?
   - How could you act in this situation in order to de-escalate the conflict?

4) The facilitator informs the groups that they should now make a role play for each of the three alternatives and gives them 15 minutes to practice performing the role plays. Make it clear that whoever told the story to the group should not play himself in the role-play. The role play should be shorter than three minutes in total.

TIP It may be good to have a back-up scenario prepared in case the group scenarios do not meet the objectives of the exercise.

5) The role-plays are then performed for the wider group. If time is limited, the facilitator selects one or two that seem most valuable to the group (for example, scenarios set within health services or other relevant contexts).

6) The facilitator then leads the wider group in a reflection around the following questions after the role plays:
   - What do you think is the objective of this activity?
   - What can we learn from seeing three alternative ways of reacting in one situation?
   - What worked in the different situations, and why?
   - For those who experienced the situations that were acted out, was it familiar or strange to see the situation played out and why?

7) In closing, the facilitator asks the participants to use one minute to think about one skill, technique or strategy that they will remember from this exercise. They write them down on a piece of paper with their name on it, before sharing their one take away with the rest of the group. The facilitator collects the papers in order to include this statement on the back side of their individualised certificates of completion.

ACTIVITY 8: TAKEAWAYS

The objective of this activity is to summarise the main takeaways from this session and provide an opportunity for the participants to jointly reflect and write down what they have learned.

Group work: The facilitator asks the participants to individually write down one recommendation that they think is the most important from each of the activities. Next, discuss these recommendations in small groups and present to the whole group a listing of the agreed takeaways.

Plenary agreement: Agree and consolidate the key elements to be retrieved from this session. These are collected by the facilitator to bring to the last session on recommendations to management and supportive action cards.

WRAP-UP

In the plenary: Conduct a brief summary from the facilitator and participants about how the day has been.

TIP Positive attention and recognition both develop people's self-respect and make them feel good. In addition, they increase the likelihood of participants keeping up the good work. Positive feedback has the following effects:

- Participants learn best through recognition, encouragement and specific feedback
- Consistent encouragement directs attention from defeat to mastery
- Skills training through encouragement and recognition promotes mastery and self-confidence
- Learning through encouragement and recognition has no negative side effects

See page 146 for a list of resources and further reading for this session

SESSION 5:
STRESS AND PSYCHOSOCIAL WELLBEING

LEARNING OBJECTIVES

By the end of this session the participants will:

- better understand how events experienced during their service can affect psychosocial wellbeing
- have a better awareness of the possible signs of stress and distress, including after overwhelming situations or security incidents
- be familiar with actions that can be taken to mitigate the risks of stress

SUGGESTED SESSION OUTLINE		
ACTIVITIES	**METHODS**	**PROPOSED TIME MANAGEMENT**
Introduction to the training	Presentation of the rationale for this session, the involvement of the participants and why it's relevant	10 mins
1: Contextualising stress factors	Plenary discussions and group work on factors that may cause stress, post-traumatic stress injuries and potential signs of it	1 hour 20 mins
2: Contextualising stress management	• Group work exploring measures in stress management • Plenary presentation and discussion of discoveries	1 hour 40 mins
3: Takeaways	Plenary consolidation of takeaways from the sections	30 mins
Wrap-up	Brief summary of the session in the plenary	5 mins
PROPOSED SESSION TIME		**3 HOURS 45 MINS**

PREPARATIONS FOR THE FACILITATOR

- Make a plan/agenda for this session
- Familiarise yourself again with the risks, gaps and needs collected during sessions 1 and 2
- Together with the employer/management, map existing procedures and practices for the prevention and management of stress and post-traumatic stress injuries (PTSIs). Identify gaps in order to tailor the training
- Be aware of the support systems that exist within the organisation for staff and volunteers to seek.
- Gain a basic understanding of how the culture is related to discussing psychosocial health and care in the context where the training will be implemented
- If culturally appropriate, an experienced health worker should be identified to describe an incident that affected his/her psychosocial wellbeing
- If you wish, contact a mental health professional who can answer questions and support you in your preparation

TIP The facilitator can describe his or her own experience, as there may be reluctance to talk about this topic. It can be very powerful if the facilitator is prepared to open up, as this can encourage others to do the same.

- Get acquainted with Annex 5: Managing difficult reactions and disclosures[39]

Important! Keep the information confidential and private. Preferably agree to this at the beginning of the meeting. Everyone should be advised not to share things in the meeting that they may feel uncomfortable with others knowing afterwards. Also, people should not feel like this session is about "diagnosing" colleagues with certain mental health conditions. It is important to reinforce this is a session to gain awareness and practice self-care, not to point fingers.

No pressure to talk. Respect people's wishes if they choose not to share. If someone is not ready to talk, they can still experience and appreciate the presence of a supportive fellow human being with a caring attitude. It is important to never press for details, ask about the worst things that have been experienced, or to investigate unpleasant thoughts or feelings. This can distort or even damage the natural healing process

Listen actively, with respect and empathy[40]

39 Training on Psychological First-Aid for Red Cross and Red Crescent Societies, Module 4, available at: pscentre.org/wp-content/uploads/2019/05/PFA-Module-4-Group.pdf

40 Psychosocial Centre, International Federation of the Red Cross and Red Crescent Societies, "Guidelines for Caring for Staff and Volunteers in Crises", available at: pscentre.org/wp-content/uploads/2020/01/Guidelines-for-supporting-volunteers-2.pdf

INTRODUCTION

The facilitator introduces the topic based on a selection of the information below.

This section provides participants with a basic understanding of how events experienced during their service can affect psychosocial well-being, to become more aware of the possible signs of stress and distress reactions.

The section should encourage the adoption of actions that can mitigate stress and support mental health, ending with recommendations on how to work towards better procedures and practice on this within the health services.

> Post-traumatic stress injury (PTSI) is a **non-clinical** term that encompasses a range of mental health injuries, including some operational stress injuries (OSI), anxiety and depression. PTSI can have a lasting impact on a person's ability to do their job, as well as affect their overall mental health and wellbeing.

Why is this particularly important for health personnel? They are the most valuable resource that the health services have in their effort to reach and help people in need. In order for health teams to be able to carry out their work and care for others to the best of their abilities, their own basic physiological and safety needs must be met.

Health workers may respond in challenging situations, and often they put aside their own needs. At the end of the day, they often feel inadequately equipped to help patients with the tragedy they are facing. They can also be members of affected communities and work close to home. They may experience the same losses and grief in their families and communities as the recipients they support.[41]

PTSIs should be prevented where possible and managed when they occur. Given the scope of this workshop, however, the focus will be on mitigating measures that can reduce both effects of stress and the prevalence of traumatic stress.

41 Training on Psychological First-Aid for Red Cross and Red Crescent Societies, Module 4, available at: pscentre.org/wp-content/uploads/2019/05/PFA-Module-4-Group.pdf

What is psychosocial wellbeing?
From Psychosocial Centre | IFRC: Psychosocial wellbeing[42]

The term psychosocial reflects the dynamic relationship between psychological and social processes. Psychological processes are internal: they include thoughts, feelings, emotions, understanding and perception. Social processes are external and include social networks, community, family and environment. It is important to remember that what happens in one of these areas will affect aspects of the others. How we feel internally affects how we relate to the environment around us. Similarly, our traditions, customs, and community affect how we feel.

Psychosocial wellbeing depends on many factors: social, spiritual, cultural, emotional, cognitive and physical. The overlapping circles suggest that individual and collective wellbeing depends on what happens in a variety of areas and these are interrelated.

Social: Social wellbeing refers to a sense of connectedness to others and feelings of belonging. Human beings are social by nature and a denial of access to social activities and social interaction can increase a person's distress levels. For example, friends, family, relatives, social activities, sports and leisure groups and clubs, as well as support groups all contribute to social wellbeing.

Spiritual: Spiritual wellbeing refers to people's feeling of connectedness and purpose in life. For example, following a religion often gives people a sense of meaning and connectedness to others who follow the same religion.

Cultural: Culture involves learned patterns of belief, thought and behaviour. Culture makes life more predictable. It influences the tools, types of shelter, transportation, and other physical items that are needed for psychosocial wellbeing. It influences our perception of what behaviour is considered normal or abnormal. It also influences standards of beauty, both of things and of people, and prescribes acceptable and unacceptable ways to express emotion. Culture evolves and changes over time. An example of how culture affects our wellbeing is in the simple act of how we greet one another, which makes us feel comfortable and safe as it is a mutual understanding of behaviour that connects us.

Emotional: This refers to how we feel and what we call our moods. Family and friends are part of creating the social structures that provide emotional wellbeing.

42 Training on Psychological First-Aid for Red Cross and Red Crescent Societies, Module 4, available at: pscentre.org/wp-content/uploads/2019/05/PFA-Module-4-Group.pdf

Examples of emotions that lead to wellbeing are typically positive emotions such as happiness and hope.

Cognitive: Cognitive aspects concern functions of the mind, which include thinking, learning how to learn, how to acquire information, and how to use this information. Examples of cognitive wellbeing are when we are able to understand and analyse problems and find solutions to challenges.

Biological: This refers to physical and mental health and the absence of disease and disorders. Examples of biological wellbeing are when we feel strong and rested.

Foundations for experiencing wellbeing:

Safety refers to being out of immediate danger and feeling safe in one's physical environment and with the people in this environment. It also refers to basic needs such as food, shelter and water, as it is not possible to focus on emotional, social and other needs if these are not fulfilled first.

Participation refers to being able to participate in ongoing daily activities. It also refers to feeling that one has choice and some sense of control over one's life.

Development refers to the belief that tomorrow will be better than today. It is closely connected to hope. In order to feel a positive sense of wellbeing, it is important to know and believe that life can and will be better in the future. This can be experienced, for example, by seeing positive changes such as rebuilding after an emergency, reunification of families if separated, re-opening of schools, communities coming together after terrorist attacks etc.

The facilitator goes through the session outline.

ACTIVITY 1: CONTEXTUALISING STRESSORS

Main issue to be highlighted: Not everyone who is exposed to stressors or a potentially traumatic event develops psychological trauma, but it is important for the individual's wellbeing that there is a culture where difficult experiences can be talked about without stigma. Team members should be aware of how they receive such information when it is shared with them.

It is vital to recognise that major events are not the only cause of psychosocial trauma. Health workers are exposed to so-called minor stressors daily, such as patient deaths, accidents, domestic violence, etc. The sum of these can potentially also lead to unhealthy stress.

The facilitator should emphasise that an acute stress reaction may be response after an abnormal event. If the symptoms do not subside with time, this is a sign that the individuals will need help in dealing with the situation, and that doing so can lead to a progression into a mental health condition. Understanding this can encourage people to talk about their normal response and accept it themselves.

Psychosocial Centre | IFRC: Risks to staff and volunteer wellbeing[43]

Personal risks

- Idealistic or unrealistic expectations of what they can do to help others
- Feelings of guilt in realising limitations, or if someone dies, or from prioritising their own needs for rest or support
- Moral or ethical dilemmas when having to choose who to help first

Interpersonal risks

- Feeling unsupported by colleagues or supervisors
- Experiencing difficult dynamics within a team
- Working with team members who are stressed or burned out

Risks related to working conditions

- Having to perform physically difficult, exhausting and sometimes dangerous tasks
- Being expected (or expecting themselves) to work long hours in difficult circumstances
- Feeling detached from their own family and home life because they cannot share the details of their experiences at home
- Feeling they did not deal with their tasks well enough or that they were not adequately prepared
- Witnessing traumatic events or hearing survivors' stories of trauma and loss

Risks related to organisational issues

- Having an unclear or non-existent job description or an unclear role in the team
- Lack of information sharing
- Being poorly prepared or briefed for tasks
- Lacking boundaries between work and rest
- Working in a context where wellbeing is not valued, and efforts are not acknowledged or appreciated

43 Training on Psychological First-Aid for Red Cross and Red Crescent Societies, Module 4, available at: https://pscentre.org/wp-content/uploads/2019/05/PFA-Module-4-Group.pdf

Plenary discussion: The facilitator writes the following definition of stress on a flip chart and asks participants who recognise this feeling to raise their hands:

Stress can be defined as a state of worry or mental tension caused by a difficult situation. Stress is a natural human response that prompts us to address challenges and threats in our lives. Everyone experiences stress to some degree. The way we respond to stress, however, makes a big difference to our overall well-being.[44]

The facilitator emphasises the importance of understanding and accepting that everyone is different and has different experiences. The experience of stress and remembering traumatic episodes can be difficult to talk about or even think about. For that reason, if someone does not want to talk, wants to leave the room or needs a private conversation, they should be given the opportunity along with the assurance that this is okay. Also highlight that participants should not share anything they might regret later.

The facilitator explains the difference between daily stress and posttraumatic stress injuries (PTSIs), but also the message that cumulative daily stress may result in PTSIs over time.

Normal stress activates our sympathetic system in a way that allows us to optimise our energy use; *eustress* is positive stress, when challenge and resources are in balance; distress is negative stress, when the challenge overwhelms our resources.

Posttraumatic stress injuries (PTSIs) occur in situations when life or body integrity are at stake and we do not have enough resources to cope. In these situations, stress reactions become so extreme that the connections between our frontal lobe (responsible for problem solving), our amygdala (responsible for evaluating stressors as potentially life threatening) and our brain stem (responsible for instinctive fight, flight, freeze reactions and for automatic routines) are partially or completely cut.

That's why, in stressful situations, we react automatically (if well trained) or instinctively (fight, flight, freeze). Afterwards, we often ask ourselves repeatedly why we reacted the way we did and if we acted correctly.

> Trauma is a vital discrepancy between situational threat and one's own coping abilities[45] which can lead to shattered assumptions about the world and the self.

44 World Health Organization, see at: www.who.int/news-room/questions-and-answers/item/stress#

45 To learn more about trauma, you can watch this video: mhpsshub.org/resource/what-is-trauma/

ACUTE REACTIONS

- Being overwhelmed, feeling helpless, unable to set priorities and plan ahead
- Cognitive impairment; stick to first idea and not able to see alternatives
- Hyperactivity
- Not feeling hunger
- Exaggerated feelings of thirst, or no thirst at all
- Pains
- Dissociation
- The sensation of perceiving reality as strange/as if in a film
- Time appearing in slow motion
- Amnesia
- Shock
- Perceiving the self from outside the body

As an example, situations of physical violence are often experienced as traumatic and therefore activate traumatic stress reactions.

Reasons for Potentially psychologically traumatic events (PPTE):[46]
One may have been subjected to death, threatened with death, actual or threatened serious injury, or actual or threatened sexual violence and so on resulting from:

- Direct exposure
- Witnessed, personally
- Indirectly, by learning that a close relative or close friend was exposed to trauma. If the incident involved actual or threatened death, it must have been violent or unintentional
- Repeated or extremely indirect exposure to conflicting details about the incident(s), usually during professional duties (e.g. ambulance providers assembling body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, films or images

The facilitator asks the participants to name examples of PPTEs. Examples for the facilitator to suggest given the contextual realities:

- Exposure to gun fire or explosions
- Experiencing something terrible happening to someone you know or who looks like someone you know
- Witnessing a lot of suffering and damage
- Failing to rescue someone

46 See definition in the Glossary organized by the Public Health Agency of Canada: tinyurl.com/2zv44t45

- Constantly feeling like you are not able to do enough
- Exposure to intense workload, tension and pressure over longer periods of time
- Having near death or perceived near death experiences

PSS IFRC | Guidelines for Caring for Staff and Volunteers in Crises

Guidelines outlining different ways of giving recognition and psychosocial support through various types of support meetings.

Participant presentation: If appropriate, an experienced participant describes an incident that affected him/her, what effects this experience had psychologically and how this manifested itself physically or through altered behaviour. This can help promote openness around a potentially stigmatised subject, while contextualising the issue.

Group work: The facilitator divides the participants into groups of three to four people and asks them to discuss the following question: What are the main causes of stress in your specific working environment?

After 15 minutes, the facilitator asks the groups to list the stress signs that they are aware of, or more broadly: How can stress be detected?

The list of signs of stress does not need to be exhaustive, but the more examples that are provided, the better. The aim is for participants to connect the experience of stress in their working environment with the effects it has on their body and mind.

In their own words: from an ambulance provider

EXPLOSION IN FRONT OF A PRIMARY SCHOOL

The incident

I work in a city at war and witness violence on a daily basis. Healthcare personnel are at risk of attack. There are no security personnel or guards at the hospital to prevent attacks or assaults, which makes things worse.

The scariest, most difficult incident I have ever witnessed happened when I was the resident doctor in the Emergency Department (ED) of a hospital next to a primary school. When children were leaving school, a car parked in front of it blew up. Shrapnel scattered in all directions. The area around the schools is closed off with concrete barricades so it's hard for ambulances to get in.

One terrorist attack usually follows another – often when people gather around the casualties to offer assistance. This is exactly what happened. A man was calling

out to gather frightened children to show them the way out. When they did so, he blew himself up. It all happened in front of me and it was difficult to work out what to do. Should I start helping the children while everyone, myself included, was yelling: "Watch out for a second explosion"?

Do I wait in the ED to help whoever comes in, knowing how hard it would be to reach the children and bring them there?

Do I run away and leave because the second explosion might happen in front of me?

Ultimately, the hardest part was deciding who to help first, especially since the paramedics and surgeons took 45 minutes to arrive.

How were risks mitigated?

After the shock, I mustered up strength and tried to get the hospital workers to assemble in a nominally safe zone.

Meanwhile, I asked the people in charge of the warehouses to bring me the biggest quantity of bandages and IV fluids possible.

I divided tasks according to the number of workers in the hospital. One of the most important things was to give someone the task of identifying the names of the children.

As I said, it was almost impossible to work out the right thing to do. We are ready for casualties, but in all my years of experience, I have never been exposed to more than 30 casualties at once. Explosions and blasts are the most difficult incidents to deal with, especially when hundreds of children are involved. I guessed we would receive all the casualties because we were so close to the attack.

We were organised and fast. But when the parents came, they were confused and some became violent. This hampered our work to begin with.

I asked parents whose children were ok to help by calming down frightened kids and putting on plasters. They took less serious cases to less-crowded hospitals. We admitted a number of patients to prepare them for surgery before the surgeons arrived. No measures were taken to prevent psychological trauma for employees. We all returned to work the next day and are still shaken by what happened. Some of us cry as soon as the incident is brought up.

I still keep the list with the names of the children on it. I visited some of them at home. A lot of them have disabilities now.

In training, we learned how to handle similar incidents, but I wasn't prepared to see so much violence and so many casualties.

Lessons learned

The delay was caused by the security barricades, which were originally put in place to prevent such blasts.

Future consequences
After the incident, I wanted to know what the correct procedures would be in a situation like this. I have been deeply affected by this incident. I've suffered sleepless nights, a lack of focus and nightmares because of it. It is still difficult for me to think about.

PSS | IFRC: a guide to psychological first aid[47]

LOOK for

- Information on what has happened and is happening
- Who needs help
- Safety and security risks
- Physical injuries
- Immediate basic and practical needs
- Emotional reactions

LISTEN refers to how the helper

- Approaches someone
- Introduces oneself
- Pays attention and listens actively
- Accepts others' feelings
- Calms the person in distress
- Asks about needs and concerns
- Helps the person(s) in distress find solutions to their immediate needs and problems

LINK is helping people

- Access information
- Connect with loved ones and social support
- Tackle practical problems
- Access services and other help

Plenary discussion: One group shares the identified causes of PPTEs and another shares the identified signs of PTSIs. These are written down on a flip chart and the remaining groups are given the opportunity to comment with additional causes and signs.

The facilitator may suggest some of the signs listed in the box below if they are not mentioned.

47 Psychosocial Centre, International Federation of Red Cross and Red Crescent Societies, "A guide to Psychological First-Aid", available at: pscentre.org/wp-content/uploads/2018/12/12007_psc_pfa_guide_T2_samlet_low.pdf

These symptoms may occur in a light, mild or severe way:

PSS | IFRC: Signs & Symptoms of Distress[48]
PHYSICAL
Problems with sleeping Stomach problems like diarrhoea or nausea Rapid heart rate Feeling very tired Muscle tremors and tension Back and neck pain due to muscle tension Headaches Inability to relax and rest Being frightened very easily
MENTAL
Poor concentration Feeling confused Disorganised thoughts Forgetting things quickly Difficulty making decisions Dreams or nightmares Intrusive and involuntary thoughts
SPIRITUAL
Feelings of emptiness Loss of meaning Feeling discouraged and loss of hope Increasingly negative about life Doubt Anger at God Alienation and loss of sense of connection

48 Psychosocial Centre, International Federation of the Red Cross and Red Crescent Societies, "Guidelines for Caring for Staff and Volunteers in Crises", available at: https://pscentre.org/wp-content/uploads/2020/01/Guidelines-for-supporting-volunteers-2.pdf

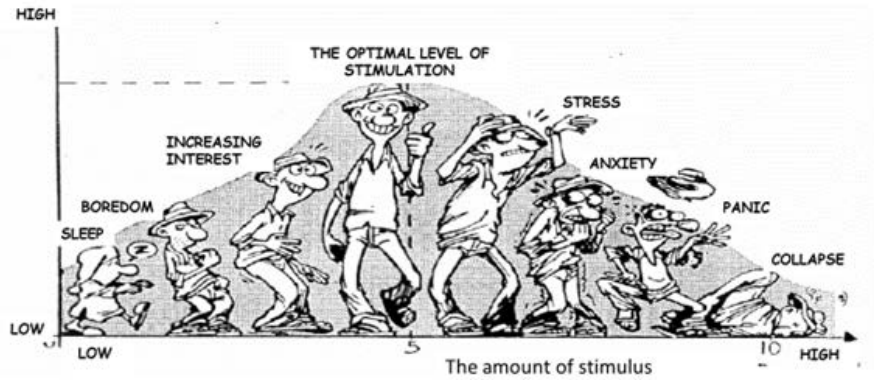
PSS | IFRC: Signs & Symptoms of Distress
BEHAVIOURAL
Risk-taking e.g. driving recklessly Overeating or undereating Increased smoking Having no energy at all Hyper-alertness Aggression and verbal outbursts Alcohol or drug use Compulsive behaviour, e.g. nervous tics and pacing Withdrawal and isolation

ACTIVITY 2: CONTEXTUALISING STRESS MANAGEMENT

Main issue to be highlighted: Stress does not need to be something we simply experience; it can be something that we manage. This implies taking measures to ensure some level of control over the experience of stress and to try to prevent or mitigate the development of PTSIs.

Introduction: The facilitator emphasises that there are different strategies for preventing and reducing stress. The organisation should identify and tailor training that can mitigate the psychological impact of PTSIs based on the needs of the health staff.

Intervention principles:
- Enhance internal and external safety
- Strengthen coping mechanisms and resources



The facilitator guides the participants in a discussion around the following question: Bearing in mind the effects of stress just discussed, how can your stress levels negatively affect your safety, that of your team and that of the patient?

Group work: The facilitator divides the participants into three groups, each tasked with discussing a different question:

Group 1: Identify what you as an individual can do to manage your own stress
Group 2: Identify what you as a team member can do to reduce stress at your workplace
Group 3: Identify what measures can be implemented in your work environment to reduce stress levels among the ambulance providers

Plenary discussion: Each group presents their conclusions in the plenary. The facilitator suggests additional measures from the three adjacent boxes. Tell participants that, in the upcoming discussion, they will be asked to score the measures with regards to their impact and relevance in context.

Suggested measures that an individual may take to manage stress:
Not all of these may be applicable in every emergency context or cultural setting and are provided as examples only. See more measures in tinyurl.com/5t36azct –The Well-being Cards, MHPSS Hub

- Take care of yourself, feed yourself and exercise
- Limit your alcohol and tobacco intake
- Share your feelings with colleagues, supervisor or other trusted people after disturbing incidents or after each work shift
- Continue to perform routine tasks that give you a sense of routine and self-care, such as going to work, cooking, showering, and spending time with family and friends
- Find a healthy way to vent that works for you, for example through exercising or expressing yourself through writing
- Seek professional advice when you feel like your own self-care is not being sufficient to restore your psychosocial wellbeing
- Do not withdraw socially
- Do not self-medicate
- Seek professional healthcare advice and support
- Take a break (if possible) when you feel your tolerance levels are dropping

Emergency services, such as ambulance and pre-hospital services, often run on 'heroes' who continue shift after shift, especially in emergencies.

Suggested measures that team members can take to reduce stress in their work unit: There are many benefits to developing peer support systems. Early-stage peer support can prevent major problems by helping people develop personal coping skills. This is an active process where you create time and space to talk to each other about how you are feeling, the challenges you all face, and your different coping mechanisms. Peers are people who have something in common and by forming support groups, peers gather their knowledge, perspectives and experiences to benefit each other.

Not all of these may be applicable in every emergency context or cultural setting and are provided as examples only.

Peer support can provide:

- Informal support both during and after work
- A formal framework for discussing work and solving problems together
- Space to talk. If culturally acceptable, you can share your feelings and thoughts with someone you feel comfortable with
- Support when you're both out in the field, with someone to check in on how things are going
- An opportunity to listen to others and share knowledge
- An opportunity to encourage and support your peers and be available in a non-intrusive way
- Confidentiality as a cornerstone for this support
- Non-intrusive follow-ups to professional care, for instance when the support received does not restore well-being, when very disturbing behaviour or strong signs of trauma arise

Important! Referrals should not be a "last resort" to help a colleague or a staff or volunteer that you manage, but make sure that the referral is qualified! If you don't know what to look for, or how to assess the situation, ask for support of a trained MHPSS colleague or focal point.

Suggested measures that can be implemented in your service to reduce stress levels among health personnel:

Before attending a call:

- Prepare the health teams for tasks with adequate training and resources
- Explain all the details of the mission so that all team members know what to expect and if they will be able to handle it
- Support less experienced colleagues, and do not expect them to undertake roles better performed by senior colleagues such as breaking news of a death
- Establish buddy systems to ensure that everyone has at least one colleague that looks after them

During the incidents:

- Team members who show worrying signs should be cared for by a more experienced team member
- Team leaders should preferably have received at least basic training in how to identify and handle such situations
- Establish rotations and shifts that enable sufficient rest, feeding, drinking

After the incidents:

- Facilitate time for health personnel to recover, reflect and assess how they can improve future responses
- Health personnel should have access to follow-up after traumatic and stressful experiences. They should be able to access support systems anonymously if they wish
- Follow up with any referrals to psychosocial support professionals for further assistance

In general:

- The service can organise regular retreats or opportunities for colleagues to participate in social activities. Smaller teams can organise these themselves
- PPTEs and PTSIs can be included as central topics in meetings, with the aim of removing the stigma that is sometimes associated with such conditions. Sessions should seek to represent potentially psychologically traumatic events as a normal reaction to abnormal situations

Plenary discussion: Participants are asked to score the measures that they believe to be most impactful and relevant in their contexts. Those with the highest score are recorded by the facilitator, to be shared with management as recommendations for improving procedures and practice that would mitigate risks of PPTEs and PTSIs.

ACTIVITY 3: TAKEAWAYS

The objective of this activity is to summarise the main takeaways from this session and provide an opportunity for the participants to jointly reflect and write down what they have learned.

Group work: The facilitator asks the participants to individually write down a couple of recommendations that they think are the most important from each of the activities. Next, discuss these recommendations in small groups and present to the whole group a listing of the agreed takeaways.

Plenary agreement: Agree and consolidate the key elements to be retrieved from this session. These are collected by the facilitator to bring to the last session on recommendations to management.

If available, this is the moment for the trainer to present available options for mental health and psychosocial support in the organisation, or in the community where they live. These should be accessible services for anyone who wishes, and it should be explained whether the services depend on referral or not.

WRAP-UP

In the plenary: A brief summary from the facilitator and participants about how the day has been.

TIP Round of recognition: end the section with a round where everyone briefly speaks about a specific situation where another person in the group has made a difference for themselves or said something interesting and instructive. Such a round sharpens the attention to all the little things that contribute to the feeling of safety and community.

See page 146 for a list of resources and further reading for this session

SESSION 6:
RECOMMENDATIONS AND ACTION CARDS

LEARNING OBJECTIVES

By the end of this session the participants will:

- have compiled a set of recommendations for operational management
- have made contextualised action cards in pocket format

SUGGESTED SESSION OUTLINE		
ACTIVITIES	**METHODS**	**PROPOSED TIME MANAGEMENT**
Introduction	Presentation of the rationale for this session, and how participants will be involved	5 mins
1: Consolidating what has been learned through all the previous sessions **Recommendations for management**	Group work and plenary agreement on takeaways to be included in the recommendations to management	1 hour 25 mins for group work and 40 mins for plenary
2: Action cards for pockets	Group work and plenary agreement on content (including suggestions for design and layout)	2 hours
Evaluation and closure	Closing the training, distribution and filling out of feedback form of the training and sharing ways forward	40 mins
PROPOSED SESSION TIME		**4 HOURS, 50 MINUTES**

PREPARATIONS FOR THE FACILITATOR

- Make a plan/agenda for this session
- Collect and assemble all takeaways from the completed sessions. Make them available for the participants as handouts or equivalent

Important! Revisit the agreement with management before starting this session. Make sure that you are within the framework of what is agreed, in order to maintain commitment and support for the follow up of the training.

INTRODUCTION TO THIS SESSION

Throughout a response, health personnel should be asking themselves: *Is this scene safe enough?* Since the scene is rarely safe, reasonable precautions should be taken to mitigate risks to the patient, ourselves and the bystanders.

This training has provided some examples and resources related to how health personnel can prepare for a safer response by improving their Code of Conduct, training on situational awareness, de-escalating tense situations at the scene and in other ways. Given how much the specific context influences how the health workers should respond, including the ambulance and pre-hospital services own specific capacities, it is important that the participants themselves flag what in this training was of particular relevance to them.

In addition, a prioritised set of recommendations will be shared with operational management after the training. The extent to which these recommendations can and will be followed up will vary from one context to another, so it is worth reminding the participants that even if this follow up takes time, they are left with valuable knowledge on how to mitigate risks and make the scene safer.

The facilitator reminds the participants of the objectives of the training:

- To equip health workers with simple, practical skills to improve their security and mitigate the impact of threats and violence
- To offer a starting point for organisations that provide ambulance, pre-hospital and mobile health services who want to review and reinforce their existing procedures in terms of preparedness and security management

TIP For reflection/discussion prior to carrying out the final activities, ask the class: What can you as a person, you as a team and your organisation do to make your workplace safer? (For example: emergency plans, protection measures, clear statements from the organisation, etc.) Think about strategies that can be developed on each of these levels.

ACTIVITY 1: CONSOLIDATING WHAT HAS BEEN LEARNED THROUGH ALL THE PREVIOUS SESSIONS

To ensure concrete results that can contribute to a safer delivery of healthcare, the facilitator has been collecting key takeaways and recommendations produced by the participants throughout the training. There should be key takeaways and recommendations from all the sessions conducted in the training.

Introduction: The facilitator presents and distributes the list of the key takeaways to the participants.

Group work: The facilitator divides the participants into groups of three or four. From the list provided, the groups discuss which recommendations they want to bring to their operational management and why. There may be many recommendations collected, but selecting too many may be counterproductive as it may be difficult for management to dedicate sufficient time and resources in following all of them up.

TIP The list should not be too long. It can also be categorised or ranked in order of priority.

Plenary discussion: Based on the previous group discussion, the participants should all agree on the recommendations that they believe to be the most important. They must also ensure that these are realistic and as specific as possible.

The facilitator will compile these key recommendations and integrate them into the training report that will be shared with operational management.

ACTIVITY 2: ACTION CARDS FOR POCKETS

An action card is a support tool that helps a member of the health team to implement necessary measures in the right order and can help raise awareness about what factors make the scene unsafe. It is an operationalisation of the contingency plan. The purpose is to ensure that all necessary measures are carried out regardless of the type of incident you are facing.

Important! Ensure close collaboration with the management in the development of the action card(s). The proposals produced in this group must be reviewed and revised by operational management. It is important that the action cards are quality assured, in line with existing or planned SOPs. This is to avoid developing parallel practices that are potentially harmful and so that the action cards can be used by the entire organisation if deemed relevant.

Event-specific, or in general?
While part of the exercises in this training are meant to encourage the implementation of event-specific risk management measures, it is recommended that the card is general, i.e. that it describes work tasks to be performed regardless of the type of event in question. There are several reasons for this. The card must be updated, and this happens continuously in connection with organisational development and contextual changes. A general card is easier to update than a card specified for each conceivable type of event.

TIP Simple language: write concisely, almost in the form of keywords, and be specific.

Individual work: The facilitator asks the participants to reflect on what information the action card should include and how it should look. Participants are tasked to write down at least three ideas each about what is important to include on the action card(s). If comfortable, participants can share their points in the plenary.

Group work: The facilitator divides the participants in groups of three or four to discuss the ideas for inclusion and how they see the end result. Each group will present a suggestion of how they think the action card should look and what it should include.

Plenary discussion and agreement: The facilitator leads the discussion based on the previous group presentations. The outcome should be a consensus on which key actions the action card(s) should contain and how it should be structured and formatted.

The facilitator presents the agreed proposal to the operational management for review and audit. As previously mentioned, management must always decide the content and appearance of the action card(s) to ensure that the information is in line with current procedures and can be used for health workers throughout the organisation. The action cards should ideally be made in pocket format and in solid material (e.g. laminated).

EVALUATION AND CLOSURE

Evaluation is about measuring the effect of the training. Have the participants achieved their goals?

TIP For an example of an evaluation template, see Annex 7 on p.175

You can do evaluations before, during and after the training, both for the programme itself, but also to evaluate your own role and efforts. Is there anything you want to change for the next workshop in terms of your facilitation, your preparations or anything else related to your role as a facilitator?

EVALUATION DIAGONAL[49]

The facilitator presents the expectations collected in the first session of the workshop and reviews which were met, and which were not met.

PURPOSE

- Feedback
- Examine the participants' assessment of what they have learned and what this might mean to them

HOW

- Ask participants to imagine a line running diagonally through the room, from one corner to the other. The endpoints of this line are the corners
- The facilitator gives a statement, such as:
  - "I believe that what I learned about conflict management will change the way I interact with patients"
  - "I believe I can actively contribute to reducing the stress level at work"
- One corner represents denial of this statement ("not at all") while the other corner represents confirmation of the statement ("totally agree")
- The participants position themselves at the point along the line that reflects the extent to which they agree or disagree with the statement
- The participants are encouraged to speak with each other to find out if they are placed correctly in relation to each other, what makes them stand where they do and so on
- When all the participants have found their place, the facilitator asks some of the participants questions to hear more about what they think about the position they have found on the evaluation diagonal. The dialogue with each of them can trigger further reflection

If there is time, repeat the activity with more statements, such as:

- "I think my life will change after this workshop"
- "My interaction with patients and their relatives will improve as I now know better how to read their needs and understand their reactions"
- "This course has taught me a lot about risk management"
- "After this workshop, I will deal with threatening situations and conflicts better"

The facilitator provides participants with a training evaluation template, Annex 6, and asks them to complete it. When everyone has finished, collect the forms.

WHAT'S NEXT?

The facilitator informs the participants of the next steps that will be taken from their side.

After sharing a reflection about the group and the implementation of the training, the facilitator thanks everyone for their participation and says goodbye.

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49 See Training Manual on Interpersonal Violence Prevention and Stress Management in Health Care Facilities, available via the Resources section, page 134

RESOURCES

TERMS AND DEFINITIONS

Definition of "Attacks on healthcare"
Website of the World Health Organization

tinyurl.com/5a5fwe53

Definition of "Emergency Medical Services"
International website dedicated to informing about Emergency Medical Services

tinyurl.com/59cz4eba

Definition of "Violence"
Website of the World Health Organization

tinyurl.com/mr3vn5th

Definition of healthcare personnel
Booklet by the ICRC, of the Health Care in Danger Initiative

tinyurl.com/24du7jpj

Definition of hazard, risk, safer behaviour and security incident
ICRC's publication of Weapon Contamination

tinyurl.com/bdedwjrh

PART 1

Ambulance and pre-hospital services in risk situations
Report from the Health Care in Danger Initiative with challenges and recommendations for the work of ambulance and pre-hospital services in risk situations.

tinyurl.com/kpwnr958

Best Practice for Ambulance Services in Risk Situations
Report based on experiences of the Red Cross and Red Crescent National Societies, provides a set of examples of best practices for EMS.

tinyurl.com/chrb5yeh

Interpersonal Violence Prevention and Stress Management in Health Care Facilities
A training manual for Red Cross and Red Crescent facilitators to teach and sensitise personnel in health care facilities.

tinyurl.com/36uvpf7m

Safer Access for all National Societies
Website for the Safer Access: Increasing acceptance, security and access to people and communities in need.

tinyurl.com/yk4uytsj

Gathering evidence-based data on violence against health care
Report with review of scientific studies and operational data from the International Committee of the Red Cross, presenting recent data on violence against healthcare.

tinyurl.com/344w9hey

PART 1

Health Care in Danger (HCiD)
Website of the initiative by the International Red Cross and Red Crescent Movement, aimed at addressing the issue of violence against patients, health workers, facilities and vehicles, and ensuring safe access to and delivery of healthcare in armed conflict and other emergencies. healthcareindanger.org

Health Care in Danger: making the case
Brief report available in various languages, presenting the issue of violence against healthcare.

tinyurl.com/2zmpm389

Video: The Human Cost
14-minute video that can be used during this session to address the problem of violence against health personnel.

tinyurl.com/yckjb253

Video: Protecting healthcare together
2:42-minute video about engaging stakeholders to better protect healthcare from violence.

tinyurl.com/4522v5m7

E-learning: Rights and responsibilities
Free online course about rights and responsibilities of health personnel working in armed conflict and other emergencies.

tinyurl.com/4zycujja

PART 1

Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies
Document co-signed by various health-based international organizations, stating the ethical principles that should be respected by all health personnel.
tinyurl.com/2zbh2hkj

Legal Framework for Protection of Healthcare
Report describing the legal framework and recommendations for implementation of legislation protective of healthcare.
https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-

https://tinyurl.com/3h73edtf

Video: What's the difference between red cross, red crescent and red crystal?
1:44-minute video explaining the emblems that protect healthcare.

tinyurl.com/4fuzbtkj

ICRC: International Humanitarian Law (IHL) app
Find the most recent legal documents on this app, available on iOS and Android.

Health Care in Danger: The responsibilities of healthcare personnel working in armed conflicts and other emergencies
A guide to help healthcare personnel adapt their working methods to the urgent demand of armed conflicts and other emergencies.

tinyurl.com/24du7jpj

PART 1

Protecting healthcare in armed conflicts and other situations
Factsheet by ICRC's legal advisory service, providing information about the legal framework protecting healthcare in conflict and in situations not covered by IHL.

https://tinyurl.com/mw2fsaxr

Article: A human rights approach to health care in conflict
Scientific article that provides further insight into protection of healthcare, beyond IHL and using a human rights approach.

tinyurl.com/zrbbf2df

Video: Rules of war
4:44-minute animated video summarizing key principles and rules in IHL that should be respected by combatants in war.

tinyurl.com/5f7hnz9u

Podcast: Pushed to the limit – Healthcare in conflict
Episode of Intercross podcast (24 minutes), interviewing ICRC's Head of Health in 2017.

tinyurl.com/39zsrmch

Video: Victory by any means
1-minute video about respect to IHL in war

tinyurl.com/45s3uj54

PART 2 – BY SESSION

SESSION 0

What is the Chatham House rule?
The Chatham House Rule helps create a trusted environment to understand and resolve complex problems.

tinyurl.com/465by2j2

Website: Health Care in Danger (HCiD)
As presented in the resources for Part 1 (see page 135)

healthcareindanger.org

Security Risk Management for Health Care
Learn how to implement appropriate security risk management measures to protect healthcare workers and communities, available in various languages.

tinyurl.com/msbwrdkr

Protection: An ALNAP Guide for Humanitarian Agencies
Published by the Overseas Development Institute in 2005, this report provides important advice and insights to humanitarian practitioners involved in providing safety and protecting vulnerable people in war and disaster. It gives practical advice on how to think through the various elements of protection-focused programming in four clear steps: assessment; programme design; implementation; monitoring and evaluation.

tinyurl.com/2p9b7na3

SESSION 0

The Sphere Training Package
Produced by The Sphere Project (2004), this contains useful information on The Humanitarian Charter and includes training materials on refugee, human rights, and international humanitarian law.

tinyurl.com/b7z9tvz5

IFRC: Stay Safe
This booklet features checklists and tips to help you conduct site security assessment for residential and office sites, and describes the IFRC minimum security requirements that apply.

tinyurl.com/yp3j5vsx

Insecurity insight: Attacks on Healthcare
Website that presents updated data on attacks on healthcare workers and health facilities are in different areas of the world. Insecurity Insight monitors open sources for information on events that interfere with healthcare delivery.
insecurityinsight.org

Increasing Resilience to Weapon Contamination through Behaviour Change
This document covers developing and conducting risk awareness and safer behaviour interventions to reduce the likelihood of casualties among staff, volunteers and the civilian population.
tinyurl.com/bdedwjrh

Action Against Small Arms: A Resource and Training Handbook
Handbook produced by International Alert, Oxfam GB, and Saferworld, this contains useful materials on developing an advocacy strategy and managing risk.

tinyurl.com/yeytnkfh

SESSION 0

The Oxfam Gender Training Manual
This manual contains many useful exercises and materials, including materials specifically focusing on sexual and gender-based violence.

tinyurl.com/2p9cb7t7

Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action
Guidelines for reducing risk, promoting resilience and aiding recovery.

gbvguidelines.org/en

First Aid in Armed Conflicts and Other Situations of Violence
A practical manual presenting the specific knowledge, skills and practices that first aiders should have to act safely and effectively when caring for people caught up in armed conflicts and other situations of violence, such as internal disturbances and tensions.
tinyurl.com/bdzy8kt3

SESSION 1

World Health Organization (WHO) – Attacks on Healthcare
As presented in the resources for Terms and Definitions
(see page 133)

tinyurl.com/5a5fwe53

Gathering evidence-based data on violence against health care
As presented in the resources for Part 1 (see page 134)

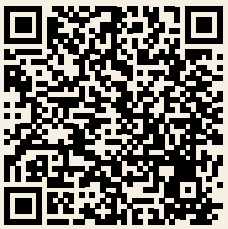
tinyurl.com/344w9hey

Video: The Human Cost
As presented in the resources for Part 1 (see page 135)

tinyurl.com/yckjb253

Psychological First Aid Training (module 4)
A group training module offering support for Red Cross and Red Crescent societies.

tinyurl.com/3bfptcw5



Interpersonal Violence Prevention and Stress Management in Health Care Facilities
As presented in the resources for Part 1 (see page 134)

tinyurl.com/36uvpf7m

SESSION 2

Risk management – guidelines
ISO 31000: Guidelines, principles, framework and a process for managing risk.

tinyurl.com/yefu7ns6

Safety and Security Incident Information Management (SIIM) for Staff
Learn how to report a safety and security incident to your organisation.

tinyurl.com/2p9ne6xh

WHO: Preventing & protecting against attacks
A section on question and answers regarding the Attacks on Health Care initiative.

tinyurl.com/49jhesu5

WHO: surveillance system for attacks on healthcare (SSA)
Live dashboard of attack types, including statistics and locations.

tinyurl.com/2frjb7ay

Which personal data is considered sensitive?
A checklist provided by the European Commission.

tinyurl.com/yc6c6bnj

SESSION 2

Best Practice for Ambulance Services in Risk Situations
As presented in the resources for Part 1 (see page 134), specially in the topics of reporting and monitoring security incidents (pages 39–40 of the report) and the concept of acceptable risk (pages 14–15 of the report).
tinyurl.com/chrb5yeh

Interpersonal Violence Prevention and Stress Management in Health Care Facilities
As presented in the resources for Part 1 (see page 134)

tinyurl.com/36uvpf7m

Increasing Resilience to Weapon Contamination through Behaviour Change
As presented in the resources for Part 2, session 0 (page 139)

tinyurl.com/yvzv68hc

NAEMT: Violence against EMS practitioners
2019 National Survey on Violence Against EMS Practitioners. See pages 12–14.

tinyurl.com/83nkuayx

Medical Ethics Manual
A comprehensive manual provided by the World Medical Association.

tinyurl.com/mryckfmf

SESSION 3

Safer Access for all National Societies
As presented in the resources for Part 1 (see page 134).

tinyurl.com/yk4uytsj

Video: Healthcare should never be in danger
7:10-minute video which looks at practical solutions to protect healthcare workers and facilities around the world, and which shows that there are actions we can take to prevent violence against health workers.
tinyurl.com/2p8jmcsd

Video: Protecting healthcare during a medical emergency
Produced by ICRC and the Lebanese Red Cross, it shows that people may be violent and use weapons to perpetrate violence during moments of high stress and when receiving negative news.

tinyurl.com/2ku5tkrc

Scenarios for reflection: Burial attacks in Sierra Leone
A video report of healthcare personnel attacked for conducting burials against the customary rules of the local communities in Sierra Leone (0:44).

tinyurl.com/2h438cb4

Scenarios for reflection: Massacre in Guinea
Video: A report of healthcare personnel attacked for conducting burials against the customary rules of the local communities in Guinea (3:12).

tinyurl.com/yc35mvev

SESSION 3

Interpersonal Violence Prevention and Stress Management in Health Care Facilities
As presented in the resources for Part 1 (see page 134)

tinyurl.com/36uvpf7m

Multicultural Awareness for Prehospital EMS Professionals
A manual provided by Washington Health Department.

tinyurl.com/2p8caxjm

Increasing Resilience to Weapon Contamination through Behaviour Change
As presented in the resources for Part 2, session 0 (page 139)

tinyurl.com/yvzv68hc

SESSION 4

Interpersonal Violence Prevention and Stress Management in Health Care Facilities
As presented in the resources for Part 1 (see page134)

tinyurl.com/36uvpf7m

Training on de-escalation of violence in health-care settings
Page from the Healthcare in Danger initiative, with different material (including a printable poster) to help health workers to de-escalate violence.

tinyurl.com/2s3f9jbs

The Center for Nonviolent Communication
Website of the global organisation helping people peacefully and effectively resolve conflicts in personal, organisational, and political settings.

cnvc.org

SESSION 5

Caring for Staff and Volunteers in Crises
Guidelines outlining different ways of giving recognition and psychosocial support to staff and volunteers deeply affected by crises they are responding to.

tinyurl.com/bfcyrmte

A Guide to Psychological First Aid
Developed for staff and volunteers working in situations where psychological first aid (PFA) may be relevant.

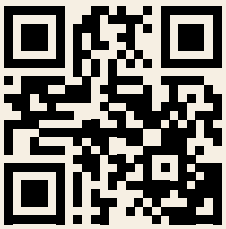
tinyurl.com/ffzm9k4h

Interpersonal Violence Prevention and Stress Management in Health Care Facilities
As presented in the resources for Part 1 (see page 134)

tinyurl.com/36uvpf7m

IFRC Reference Centre for Psychosocial Support
Website and resources on psychosocial support from the PS Centre.

pscentre.org



Canadian Institute for Public Safety Research and Treatment
A useful glossary of terms, for experts and the general public, which help to describe Psychologically Traumatic Event, Psychologically Traumatic Stress and Psychologically Traumatic Stressor.

tinyurl.com/2hmtc747

SESSION 5

Training in Psychological First Aid
Three-day training to introduce participants to PFA in Groups – Support to Teams.

tinyurl.com/329vr58h

Supporting grieving family members and friends
Guide on how to support those who are experiencing loss and grief during disasters.

tinyurl.com/5eeazvk3

Five essential elements of immediate and mid-term mass trauma intervention
An article informing on empirically supported intervention principles that should be used to intervene at early to mid-term stages of mass trauma.
tinyurl.com/ms5nc83

ANNEXES

ANNEX 1:
PROCEDURE FOR CONDUCTING A RISK ASSESSMENT

The objective of conducting a risk assessment is to evaluate the level of risk posed by identified hazards or hazardous situations to health workers. It should facilitate the identification of specific hazards and their level of risk and enable appropriate prioritisation of risk-mitigation measures.

1: UNDERSTAND THE ELEMENTS OF RISK ASSOCIATED WITH THE DELIVERY OF A HEALTH SERVICE

To begin with, it is important to understand the elements that comprise the concept of risk. The risk associated with a particular hazard depends on two primary factors

- The severity of harm that could result from the hazard
- The likelihood of this harm occurring

In addition, this likelihood is a function of:

- Exposure to the hazard
- Occurrence of a hazardous event
- The possibilities of avoiding or limiting the harm

The elements of risk are illustrated in figure 10.

Figure 10: The elements of risk (same as figure 7, Part 1, p. 31)

Assessing risks associated with the delivery of healthcare therefore involves two stages:

- Identifying a given hazard and assessing its potential severity of harm or impact on the delivery of health services, in terms of both the safety of health personnel and operational continuity perspectives
- Assessing the likelihood of harm occurring from a hazardous incident, in terms of the exposure to the hazard, the frequency of such hazardous events and the possibility to avoid or limit the harm from such an event

Risk = Severity x Likelihood

The assessment is best done in collaboration with colleagues and stakeholders to ensure that all known factors have been taken into consideration, thereby ensuring the assessment is as accurate as possible.

2: IDENTIFY THE SCOPE OF THE RISK ASSESSMENT

Risk management can be applied at different levels within an organisation: at the strategic level, operational level, programme level, project level, or for specific activities. It is necessary to clarify the scope of the risk assessment before the process begins. For example, in an organisation involved in the delivery of ambulance and pre-hospital healthcare, the assessment of strategic and operational risk to the organisation will normally be dealt with by the senior management, whereas the risk around specific activities will often be dealt with by those responsible for the activity.

The assessment procedure can be applied generically (i.e. for all ambulance providers) or specifically for each team or operation (depending on specific areas that are covered by different teams). It is advisable to conduct a generic risk assessment for all health teams in the organisation (or branch), as well as specific risk assessments for those personnel and operations deploying to areas or conducting activities where exposure to specific hazards is likely.

3: ENSURE THAT YOU UNDERSTAND THE CONTEXT

Before conducting the risk assessment there must be a proper understanding of the internal and external context in which the organisation operates. This includes the specific environment of the activity to which the risk-management process is being applied. This means that it needs to be done by or in collaboration with people who fully understand the organisation's context (including the legal framework in which it operates) and its dynamics. This usually involves several people within the organisation.

4: DEFINE THE ASSESSMENT CRITERIA

The criteria for identifying and evaluating risks must be defined and agreed before the risk assessment begins. Clear criteria are essential to support informed decision-making.

For example, when referring to the severity of impact or consequence of an incident, define what is meant by a severe, a moderate or a negligible consequence. Likewise, when referring to the likelihood of a harmful incident occurring, defining what is meant by very likely, likely, etc. Activities 5 and 6 provide examples of criteria.

5: ASSESS THE POTENTIAL SEVERITY OF THE IMPACT OF AN INCIDENT

The assessment of impact severity is based on the nature of the hazard itself. It can be defined according to a predefined scoring criterion, ranging from negligible to catastrophic. See figure 11 for an example.

SCORE	1 NEGLIGIBLE	2 MODERATE	3 SIGNIFICANT	4 SEVERE	5 CATASTROPHIC
Health personnel	Minor injury requiring no medical assistance	Injuries requiring clinical care	Injuries requiring immediate pre-hospital and clinical care	Injuries requiring immediate pre-hospital and long-term clinical care	Life changing injury/ies or fatality/ies
Ambulance and pre-hospital service operations	No impact on operations	Operations continue with further consideration of risk; mitigation measures required	Operations and health personnel limited to essential only	Operations cannot continue; all movement stopped	Stop operations and evacuate health teams

Figure 11: Example of predefined criteria for the severity of impact of an incident

6: ASSESS THE LIKELIHOOD OF AN INCIDENT

Once the potential severity of hazards has been assessed, the likelihood of harm should be judged. The likelihood of a given incident can be categorised as very unlikely, likely, possible, likely or very likely. The assessment of such probabilities will be based on:

- Exposure to the hazard (e.g. are there hostilities or regular or current armed violence, is the presence of checkpoints confirmed, or is the patient to be recovered located in a known hostile community?)
- Frequency of incidence of the hazard in question (e.g. are there any confirmed incidents or casualties in the area of focus for the risk assessment?)
- The possibility of avoiding or limiting the harm (i.e. what is the health workers level of knowledge of risks and safe behaviour, have they had safer-behaviour training, what is their attitude to a given risk, what is their actual behaviour in hazardous environments, and are they able to avoid or limit harm through proactive risk- mitigation measures, such as getting a green light to operate from formal or informal authorities or finding alternative routes?)

The information for assessing likelihood should be gathered during the assessment stage, and include evidence of levels of exposure to the hazards, as well as data regarding frequency of occurrence of incidents, and formal and informal input on existing knowledge, attitudes and behaviour in relation to the hazards.

The likelihood of an incident occurring can be scored 1–5, ranging from very unlikely to very likely, using pre-defined criteria such as those below.

SCORE	1	2	3	4	5
Level of exposure	Not ever likely to be exposed	Not likely to be exposed in current circumstances	Possibility of exposure in certain circumstances	Exposed occasionally (e.g. weekly or monthly)	Exposed regularly (daily basis)
Number of incidents	None heard of or confirmed	Few heard of but none confirmed	A few incidents but none recently	Recent incidents occasionally reported	Recent incidents often reported
Ability to avoid /limit harm	Self and others aware of risk and behaving safely (social norm)	Report self-aware of risk and behaving safely but others not	Report aware of risk and usually behave safely	Aware of risk but not practising safe behaviour	Not aware of the risk or how to behave safely
Average score is to be plotted on the risk matrix for the likelihood score where 1 = very unlikely, 2 = unlikely, 3 = possible, 4 = likely, 5 = very unlikely					
Total divided by 3 = average score					

Figure 12: Example of predefined criteria for assessing the likelihood of an incident

It is advisable for the scoring to be done in conjunction with colleagues and stakeholders who have participated in the assessment process.

7: ASSIGN A RISK SCORE AND CATEGORY

The previous two steps have assessed the likelihood and severity of a given risk. These can be brought together to establish a risk score, which is the likelihood score multiplied by the severity score. The score can then be plotted onto a matrix, which shows the risk category for each person, team or group from high risk to low risk.

By evaluating these groups separately, giving them a risk score and plotting them all onto the risk matrix, those most at risk can be clearly and quickly identified and prioritised for risk awareness and safer behaviour activities and other risk-mitigation measures.

As examples, the matrices below show the results of an assessment of the risks associated with conventional weapons for ICRC staff and their operations.

RISK TO ICRC STAFF			LIKELIHOOD				
			Very unlikely	Unlikely	Possible	Likely	Very likely
CONSEQUENCE	**Catastrophic**	Life-changing injuries, or fatalities	**5**	**10**	**15**	**20**	**25**
	Severe	Injuries requiring immediate pre-hospital and long-term clinical care	**4**	**8**	**12**	**16**	**20**
	Significant	Injuries requiring immediate pre-hospital and clinical care	**3**	**6**	**9**	**12**	**15**
	Moderate	Injuries requiring clinical care	**2**	**4**	**6**	**8**	**10**
	Negligible	Minor injuries requiring no medical assistance	**1**	**2**	**3**	**4**	**5**

Figure 13: Risk assessment matrix 1 – Assessing the risk of weapon contamination to ICRC staff

RISK TO ICRC OPERATIONS			LIKELIHOOD				
			Very unlikely	Unlikely	Possible	Likely	Very likely
CONSEQUENCE	**Catastrophic**	Stop operations and evacuate staff	**5**	**10**	**15**	**20**	**25**
	Severe	Operations cannot continue; all movement stopped	**4**	**8**	**12**	**16**	**20**
	Significant	Operations and staff limited to essential only	**3**	**6**	**9**	**12**	**15**
	Moderate	Operations continue with further risk mitigation measures	**2**	**4**	**6**	**8**	**10**
	Negligible	No impact on operations	**1**	**2**	**3**	**4**	**5**

Figure 14: Risk assessment matrix 1 – Assessing the risk of weapon contamination to ICRC operations

8: CONSULT WITH OTHER STAKEHOLDERS TO AGREE THE RISK CATEGORY AND IDENTIFY PRIORITY TARGET AUDIENCES

With all the information collected during the assessment, it is advisable to discuss and agree the risk categorisation on the risk assessment matrix as well as the priority target audiences and priority activities to be carried out to treat the risk with informed but impartial colleagues and/or other stakeholders. This is especially important if other risk

mitigation activities to facilitate safer behaviour involve the mobilisation of a number of other departments or organisations (notably those in charge of purchasing equipment and providing training).

This is the risk assessment completed. It should always be recorded with references or evidence for the risk scores that have been awarded.

9: Risk mitigation activities
The next stage is to identify, prioritise and plan the activities to mitigate the risk, i.e. to reduce the likelihood and/or the severity of an incident. The aim is that the target groups at risk will eventually be moved into a lower risk category on the risk assessment matrix.

10: Monitor the risk using the same risk assessment process
The risk assessment can be conducted again during and after the intervention as part of the monitoring process to see if the risk has changed. A reduction in the risk score can be an indicator of success.

ANNEX 2:
EXAMPLE OF RISK-ASSESSMENT PROTOCOL

1. HOW TO IDENTIFY THE MOST RELEVANT HAZARDS THAT MAY IMPEDE THE SAFE DELIVERY HEALTHCARE

The idea here is to put in place a system that allows an internal consultation to take place, with the participation of all stakeholders within the organisation, and possibly also relevant external actors. The participants must be able to contribute, and either have their contribution integrated or, if not, be given an explanation as to why.

The system can be administered by one person or a group. The process must be transparent and documented, with outcomes communicated to participants in due course. Documentation should be available for consultation at the end of the process.

How formal the process is will depend on the size of your organisation, the numbers of stakeholders to involve (basically, anyone who has an informed opinion on the issue) and the organisation's existing culture.

A simple and effective way to proceed is to organise a series of workshops. The first could be explanatory and gather a first round of suggestions. After that, stakeholders should be given enough time to reflect on the subject, based on their own experiences. They will then need a channel that lets them offer their feedback easily, possibly anonymously, before a clearly communicated deadline.

Once this first stage of consultation is over, the individual or group leading the process must consolidate and analyse the data, so the most relevant input is identified. It is essential that this part of the process is conducted in a transparent manner, and its outcome explained to participants.

Once a series of hazards is identified for the organisation to focus on, a second workshop (or any other form of public consultation) should be organised to present the results and gain validation and ownership. As mentioned, it is essential that participants, as well as others that may have an interest in the process, have the opportunity to view the records produced throughout the consultation phase. These could take the form of minutes issued after each workshop, and a summary of the input gathered.

2. HOW TO IDENTIFY THE RISK LEVEL OF PROMINENT HAZARDS

Each organisation is likely to have a different estimation of what constitutes a catastrophic or moderate impact, and what is likely to happen or possible. Again, consultation is key during this phase, which allows the organisation to agree on categorisation of risks. The same principles apply: integration of the stakeholder contributions, transparency and accountability.

Assessing risks associated with the delivery of healthcare involves:

- Identifying the hazard and the potential severity of the impact (consequences) of an incident on health personnel and or delivery of healthcare
- Assessing the likelihood of an incident, given the frequency of previous occurrences, the vulnerability of health personnel to the risk, and their ability to limit or reduce any resulting harm

To achieve this, the organisation must agree on the criteria for evaluating the severity of the impact of an identified hazard, and a system for assessing the likelihood of each hazard. The objective here is to collectively reach a consensus on what indicators to use for each category. The impact scale ranges from "negligible" to "catastrophic". Your consultations should allow you to fill the table (matrix) in figure 15 on page 173.

The score for likelihood combines several indicators: one for the level of exposure, one for the number of incidents and one for the capacity to avoid or limit harm.

> Assessing risks that may impede the safe delivery of health services is a continuous process and should be regularly renewed. Defining the appropriate frequency of new assessments is the role of the organisation's management.

ANNEX 3:
EXAMPLE OF RISK MITIGATION MEASURE

In order to illustrate the risk mitigation process, we are going to use a made-up example and go through the process of addressing the risk associated with a hazardous situation. To this end, we will simulate a situation where ambulances are either slowed up or prevented from conducting their operations due to the presence of checkpoints in the area of operations. At the end of this chapter, you will find other examples of risk mitigation measures that can be used to support the discussions.

Full example:

CHECKPOINTS

Following a risk assessment, you identify the presence of checkpoints as hazards that can significantly hamper either the physical integrity of the ambulance providers, or the conduct of your operations.

As a result of internal consultations, you have rated the risk related to checkpoints 4E on the risk matrix as a VERY LIKELY hazard with a SEVERE impact (you and your organisation will need to have agreed *ahead of the risk assessment process* with clear indicators of SEVERITY). You have decided that you need to mitigate this risk to a lower, more acceptable level, so that your operations can be undertaken in a safer manner.

We have seen earlier that risks can be mitigated either by reducing the LIKELIHOOD of an event, or its SEVERITY. The risk treatment measures you will choose to implement will need to address either or both of those dimensions.

The most effective way to deal with checkpoints is to avoid them! In other words, reduce the likelihood of having to go through one. Having said this, you must consider the risk to the patient who is waiting for treatment. Furthermore, if the ambulance reaches a checkpoint and then decides to turn around and drive off, the risk of being targeted and fired upon increases.

How can one reduce the *likelihood* of encountering a checkpoint when responding to an emergency call?

- By using alternative routes

This is easier said than done and implies an information management system is put in place that allows for gathering, storing, updating and sharing updated information. It

also implies that this information is systematically used to choose a route to and from the incident location that is free from checkpoints.

- By having a checkpoint lifted ahead of your intervention

This can be achieved by developing a trust relation with the group(s) in command of the checkpoint, and gaining the confidence that the leaders will be able to contact the people manning the checkpoint in time so that it is lifted by the time you reach it

Can you think of more procedures that could contribute to decreasing the likelihood of encountering a checkpoint?

Unfortunately, it is not always possible to avoid having to go through a checkpoint. In such cases, it is important that you develop your own protocol aimed at reducing the severity of such encounters.

How can one reduce the *severity* of encountering a checkpoint when responding to an emergency call?

There are many protocols that have been developed over time by different organisations that provide guidance on handling checkpoint situations. General considerations include:

- Which documents are needed to pass a checkpoint?
- What information can be shared and what is protected?
- Who can be in the car?
- What would be considered irregular?
- How can the severity of the case being transported be explained to ensure agility when needed?

TIP Where the ambulance service has an established dialogue with arms carriers, it could be interesting to undertake a joint simulation and highlight security challenges at checkpoints from a wider perspective.

The people manning the checkpoint may have been at the checkpoint for hours in a hot or cold climate with no air conditioning or heating. They may have had no food or water. You may be the first people they have seen today.

They may have been drinking, taking drugs or may even be children who have been taken from their families and also under the influence of drugs or alcohol. They can be very dangerous and volatile.

The checkpoint may be in an area where security forces are being targeted and therefore those manning it may be jumpy and afraid for their lives. Ensure you do nothing to give them the impression that you are a threat to them.

Your behaviour may directly influence your situation. Always be polite but alert. Avoid confrontation. You may be under time pressure, but they are not. Do not pressurise them just because you have a deadline. It should be established ahead of the mission who will be communicating with the people manning the checkpoint.

- Keep the vehicle windows up, doors locked. Do not get out unless ordered to do so. Wind down the window to speak just enough to be able to look them in the eye
- Show them that you are not a threat. Keep your hands in sight and do not make any rash, quick movements. They may think you are going for a weapon

When approaching an unknown checkpoint:
- The lead vehicle should warn the remainder of convoy
- Appraise the situation
- Turn off any music or other distractions within the vehicle
- Agree on who is going to speak to those manning the checkpoint
- Remove your sunglasses
- Slow down (to first gear, reduce speed as much as possible)
- Be prepared to stop, turn off the engine and pull on the hand brake

Approaching a legal checkpoint, the soldiers or police may do the following:
- Check ID cards or passports
- Visual security check of the interior (take your sunglasses off to confirm ID)
- Search the glove compartment
- Search the vehicle
- Conduct an underneath mirror search of the vehicle
- Open the bonnet/hood and search the engine area
- Increase the search level if he/she is suspicious
- If the search is conducted using a dog, the driver should remain in the car and the vehicle doors must be kept closed

If you need to get away quickly and *remember this comes with a huge risk*:
- Turn around early
- If you can't turn around early, drive through
- If you can't drive through, reverse out
- If you can't reverse out, run away

OTHER POSSIBLE MITIGATION MEASURES

(outside of the proposed scenario)

These suggested actions may be further detailed during the discussion, or used as examples if the group needs support. They are simply examples, and the list is non-exhaustive, as many other mitigation actions could be creatively and effectively implemented depending on the risk assessment and the context.

- Adopt standard operating procedures to quickly alert colleagues in the team and the base for escalating risks
- Adopt distinctive uniform to be easily visible and distinguished from other stakeholders in emergency responses
- Adopt special visibility personal equipment for scenarios in which general visibility might be compromised, such as places with smoke, reduced illumination or when operating in crowded spaces
- Adopt special protective equipment for scenarios in which there may be risk of direct or indirect targeting
- Implement, adapt or adjust the use of luminous or sound alert for the vehicles
- Implement, adapt or adjust the operational protocols for checkpoints: documentation needed, coordination with checkpoint controllers, coordination with base/dispatch
- Implement, adapt or adjust the use of communication during response to ensure positive perception from community members and other actors at site, while maintaining clear bridge with base/dispatch
- Adopt verbal and non-verbal de-escalating behavior
- Adopt behavioral protocols for checkpoints (who can talk, what to do, what not to do) or other challenging scenarios (e.g. if the ambulance is stopped by the police or by protesters)
- Implement and/or establish secondary means of communications
- Implement and/or adjust protocols for communications between base/dispatch and the vehicle
- Implement and/or adjust protocols for circulation in risk areas (e.g. with use of tracking devices, real-time communication or monitoring, interactive maps or other resources that may help active and quick adjustments to risk)
- Implement and/or adjust protocols for risk assessments and planning for circulation in new areas, areas affected by disaster, conflict, protests or any other factor that might hinder circulation
- Encourage and inform measures to coordinate with security agents, while keeping distinction and independence
- Implement and/or adjust protocols to demand support for security agents, in situations of threats and violence
- Encourage and inform communication and awareness-raising campaigns on the scope and capacity of the ambulance service
- Encourage and inform communication and awareness-raising campaigns on respect to healthcare providers

- Encourage, inform and participate in actions to disseminate information about the need for safe access and clear passage for ambulance and pre-hospital teams, as well as mobile health services
- Encourage and engage in feedback mechanisms to strengthen trust with community

By implementing these measures, you will be able to reduce the risks associated with the presence of checkpoints. In order to be effective, these measures should be implemented in a systematic way. They should be widely spread throughout the organisation, health personnel should be trained on their implementation, and regular refreshers should be conducted internally.

ANNEX 4:
GUIDING NOTE ON INCIDENT REPORTING FOR HEALTH CARE PROVIDERS

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

GUIDING NOTE ON INCIDENT REPORTING FOR HEALTH CARE PROVIDERS

The purpose of this document is to provide guidance for reporting and monitoring incidents of violence against healthcare. The collection and analysis of such data is crucial to develop evidence-based and adequate responses, including improving the security of health care personnel.

CAUTION: Given the potential sensitivity linked to collecting and managing data on violence against healthcare in the context of armed conflict and other emergencies, it is imperative to conduct a thorough risk analysis and ensure that adequate data protection mechanisms and data management system for processing such data within a given organisation are in place in line with the norms and guidelines provided in the ICRC's Handbook on Data Protection in Humanitarian Action and in the Professional Standards for Protection Work.[50] Data protection standards should be maintained at each step of information gathering and management processes. Attention should be given to the basic principles of data protection, data processing, data retention and security, applicable law and legal obligations, and mitigation of risks to individuals. Conducting a Data Protection Impact Assessment (DPIA) is recommended to identify the risks for individuals, groups and organisations.[51]

This sample template could be adapted to the different contexts; it is recommended to test it with a few employees/volunteers before its full implementation to modify the definitions according to the cultural norms. Prior to rolling out the use of this template, it

50 The *Handbook* seeks to help humanitarian organisations comply with personal data protection standards, by raising awareness and providing specific guidance on the interpretation of data protection principles in the context of humanitarian action, particularly when new technologies are employed. Handbook on Data Protection in Humanitarian Action (ICRC and Brussels Privacy Hub): tinyurl.com/mrxthyra. Professional Standards, accepted broadly within the humanitarian sector, provide a set of minimum but essential standards to ensure that protection work is conducted safely and effectively. Chapter 6 of the Standards focuses in particular on the issue of data collection. See Professional Standards for Protection Work.

51 See the *Handbook on Data Protection in Humanitarian Action*.

is imperative to establish adequate internal systems and provide training to staff and volunteers to guide the process of collecting and reporting information about the incidents of violence.

According to the *Professional Standards for Protection Work*, the following norms should be respected when handling any type of data or information:

- Data on incidents of violence against health care must be collected only by trained staff/volunteers (standard 6.1)
- Information about incidents should be used only to inform adequate responses and enhance security of health care providers (standard 6.3)
- When collecting information, measures should be taken to avoid unnecessary burdens and risk for persons affected and/or witnesses (standard 6.4)
- Information should be gathered and processed in an impartial manner to minimise the risk of bias and discrimination (standard 6.5)

In addition, when dealing with *sensitive personal data and/or sensitive protection data and information, additional protections should be applied* to satisfy the following principles: legitimate basis and fair processing, limited purpose, confidentiality, data minimisation, limitation of data retention, data accuracy and data security (standards 6.9-6.15). Sharing, transferring and publishing of such data should also be subject to stringent procedures (standard 6.16).

The following template was developed as a sample reference to monitor violence against health care by means of quantifying the magnitude of incidents of violence against health care and identifying the most prominent types of violence against health care in a given context. This information should be used to prioritise the response, the necessary corrective/preventive measures and their subsequent monitoring and evaluation.

DEFINITIONS

The ICRC has identified the following forms of violence:[52]

Violence (physical or psychological[53]) against the wounded and the sick

Violence includes killing, injuring, extortion, sexual violence, harassing and intimidating patients or those trying to access health care; blocking or interfering with timely access to care; deliberate failure to provide or denial of assistance; discrimination in access to and quality of care; and interruption of medical care, among others.

The wounded and the sick include all persons, whether military or civilian, who are in need of medical assistance and who refrain from any act of hostility. This includes maternity cases, newborns and the infirm.

Violence (physical or psychological) against health care personnel

Violence includes killing, injuring, kidnapping, harassing, threatening, intimidating and robbing health care personnel; arresting anyone for performing their medical duties, including the impediment and arrest of forensic professionals while performing their forensic medical duties.

Health care personnel include doctors, nurses, paramedic staff, first-aiders, forensic medical staff and support staff assigned to medical functions; the administrative staff of health care facilities; and ambulance personnel.

Violence against health care facilities

Violence includes bombing, shelling, looting, forced entry, burning, shooting into, forced closure, takeover of the facility, encircling or other forceful interference with the running of health care facilities (such as depriving them of electricity and water).

Health care facilities include hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, forensic medical facilities, and the medical and pharmaceutical stores of these facilities.

52 International Committee of the Red Cross. Health Care in Danger: Making the Case, available at: https://shop.icrc.org/health-care-in-danger-making-the-case.html

53 The Joint Programme on Workplace Violence in the Health Sector, defines physical violence as the use of physical force against another person or group that results in physical, sexual or psychological harm. Includes assault/attack (intentional behavior that harms another person physically, including sexual assault/rape), beating, kicking, slapping, stabbing, shooting, pushing, biting, and pinching, among others. Psychological violence/emotional abuse (here referred as verbal violence) is defined as the intentional use of power, including threat of physical force, against another person or group that can result in harm to physical, mental, spiritual, moral or social development. Includes verbal abuse, bullying/mobbing, harassment, and threats. Joint Programme on Workplace Violence in the Health Sector (2003). Workplace Violence in the Health Sector, Country Case Studies Research Instruments Survey Questionnaire: tinyurl.com/2p9fvdpa

Violence against medical transport

Violence includes bombing, shelling, looting, burning, shooting into, takeover, and interference with the movement of medical transport.

Medical transport includes ambulances, medical ships or aircraft, whether military or civilian, and any other vehicles transporting medical supplies or equipment.

INCIDENT REPORTING FORM TEMPLATE – VIOLENCE AGAINST HEALTH CARE

GENERAL / ADMINISTRATIVE INFORMATION	
DATE OF REPORTING:	LOCATION (e.g. city):
NAME OF THE HEALTH CARE FACILITY/SERVICE PROVIDER (e.g. where the person who reports works) : ENSURE THAT NO PERSONAL NAMES ARE INCLUDED	
INCIDENT-RELATED INFORMATION	
DATE OF INCIDENT:	TIME OF INCIDENT:

Site of occurrence

☐ Ambulance station
☐ Blood transfusion centre
☐ Clinic
☐ First aid post
☐ Forensic centre
☐ Hospital
☐ Medical warehouse
☐ Mobile unit (including vaccination mobile unit)
☐ National society branch
☐ Pharmacy
☐ Public space (e.g. street, road)

IF OTHER, PLEASE DESCRIBE _____

INCIDENTS AGAINST HEALTH CARE PERSONNEL OR THE WOUNDED AND THE SICK

Type of incident

☐ Abduction/kidnapping
☐ Access denied (to personnel/to the wounded and sick)
☐ Arrest/detention of personnel for performing their duties
☐ Extortion/arbitrary taxation/blackmail
☐ Forced interruption of medical care
☐ Killing
☐ Physical violence (injuring, beating, kicking, slapping, stabbing, etc.)
☐ Protests/strikes affecting the delivery of care
☐ Harassment (including sexual harassment or other forced acts of sexual nature)
☐ Shooting
☐ Theft/robbery
☐ Threats/intimidation (or other types of verbal violence)

IF OTHER, PLEASE DESCRIBE _____

Victim(s):

DESCRIPTION OF VICTIM(S) DESIGNATION	NUMBER OF VICTIMS (IF MULTIPLE)
☐ Ambulance personnel: driver ☐ Ambulance personnel: EMT ☐ Ambulance personnel: other ☐ Health care personnel: doctor ☐ Health care personnel: forensic specialist ☐ Health care personnel: nurse ☐ Health care personnel: pharmacist ☐ Auxiliary staff: security guard, other ☐ Patient/client (wounded or sick) ☐ Patient's relative IF OTHER, PLEASE DESCRIBE _____ DO NOT INCLUDE PERSONAL NAMES	

WERE THE PERSONNEL APPROPRIATELY IDENTIFIED?

☐ Yes
☐ No
☐ Don't know

INCIDENTS AGAINST HEALTH CARE FACILITIES OR MEDICAL TRANSPORT

Affected/targeted structure:

☐ Ambulance
☐ Health care facility
☐ Medicines
☐ Other medical transport

IF OTHER, PLEASE DESCRIBE _____
DO NOT INCLUDE PERSONAL NAMES

Type of incident

☐ Airstrike/bombing/shelling (use of weapon/explosives)
☐ Destruction/damage of health care facility or medical transport (i.e. burning, vandalism)
☐ Forced closure of health care facility
☐ Forced interference in health care facility (including arm entry)
☐ Misuse of distinctive emblems, signs, and signals
☐ Misuse of medical transport (including perfidy)
☐ Obstruction of passage (including at checkpoints, protests/strikes)
☐ Shooting at facility or medical transport
☐ Takeover of health care facility
☐ Theft/robbery

IF OTHER, PLEASE DESCRIBE _____
DO NOT INCLUDE PERSONAL NAMES

Perpetrator

☐ Patient/client
☐ Patient's relative
☐ General public (aggressive crowds)
☐ Patient's armed guards
☐ Armed group

IF OTHER, PLEASE DESCRIBE _____
DO NOT INCLUDE PERSONAL NAMES

INCIDENTS AGAINST HEALTH CARE FACILITIES OR MEDICAL TRANSPORT

WERE THE HEALTH CARE FACILITIES OR MEDICAL TRANSPORT APPROPRIATELY AND CLEARLY IDENTIFIED WITH EMBLEMS OR SIGNS?

☐ Yes
☐ No
☐ Don't know

DESCRIPTION OF INCIDENT

State in simple words the facts that constitute the act of violence, specifying if possible the probable causes of the incident (e.g. long wait times, refusal of care) Note: ensure that no personal names are included

ANNEX 5:
PSYCHOSOCIAL SUPPORT (PSS) | IFRC MANAGING DIFFICULT REACTIONS AND DISCLOSURES

1 – RISK: If someone becomes agitated, the reaction may affect the group dynamics or increase the distress in others.

Response: The first thing a psychological first-aid (PFA) facilitator can do is to normalise the situation and show understanding by expressing calmly that he or she understands this is difficult for the group member. If the person seems unable to focus on the present, the PFA facilitator can quietly instruct them to focus on something they can see or hear to help make them feel calmer. He or she may ask the group member to sit on a chair or stand on the floor and to focus on what it feels like and to describe what they feel.

2 – RISK: If someone withdraws, they will not benefit from the psycho-education and peer support.

Response: The PFA facilitator can highlight that they would like to hear a little from everyone and that the group is a safe place for everyone to share, without calling too much attention to the person who is withdrawing. If the person continues to exclude him or herself, the facilitator can invite them by name to share directly, for example by saying, "Jim – would you like to share anything?" or by talking with the person privately after the meeting to hear what is troubling them.

3 – RISK: If someone becomes very angry and a conflict arises between two group members, this may lead to others feeling unsafe and heighten their feelings of distress. Peer support may then not function well in the group.

Response: The PFA facilitator needs to stop the argument, acknowledge the feelings the individuals are having, but explain that this is not the appropriate time or place to continue with the argument.

4 – RISK: If someone starts to cry uncontrollably, it may lead others to feel heightened distress.

Response: If appropriate, comfort the person by touching them, for example, by putting a hand on their shoulder or holding their hand. Invite them to tell you what is making them upset and give individual PFA. Allow expressions of grief and use this as an opportunity for psycho-education and invite others to share ideas of positive coping methods.

5 – RISK: If someone discloses something very sensitive, this may make the person vulnerable and lead them to feel uncomfortable.

Response: There are different options on how to handle sensitive disclosures depending on the context. It is important not to let the person become more vulnerable, as this may make them feel unsafe and they may later regret sharing. If they disclose something very personal that is better discussed in private, the PFA facilitator should ask the person to stop sharing and instead invite them for an individual support session afterwards.

6 – RISK: If someone dominates a PFA and support meeting by talking a lot and not letting other participants share, or talks over the top of others and rejects other group members' opinions, this can lead to others feeling inhibited and uncomfortable and discourages peer support.

Response: The PFA facilitator can first try within the group itself to deal with a dominant group member by using basic helping skills. They can thank the person for their contribution and then invite others to share. For example, you can say:

> "Thank you, (name). What you are saying is very interesting, but I'd also like to hear from others in the group. Has anyone else had a similar or different experience?"

If the person does not respond in the group setting, then it may be necessary to speak to them on their own during a break or at the end of the meeting. Explain that it is important that everyone has a chance to talk and the opportunity to share and participate in the group. Be careful not to start by saying something negative to the person, as they may not listen to your suggestion. For example, you can say:

> "You have been very engaged in the discussions today, which is good. However, I want others to have the opportunity to be as engaged as you are. Let's also hear from others about their experiences."

ANNEX 6: THE RISK ASSESSMENT MATRIX

ASSESSING THE RISK TO HEALTH PROVIDERS			LIKELIHOOD				
			Very unlikely	Unlikely	Possible	Likely	Very likely
SEVERITY	**Catastrophic**	Life-changing injuries, or fatalities	**5**	**10**	**15**	**20**	**25**
	Severe	Injuries requiring immediate pre-hospital and long-term clinical care	**4**	**8**	**12**	**16**	**20**
	Significant	Injuries requiring immediate pre-hospital and clinical care	**3**	**6**	**9**	**12**	**15**
	Moderate	Injuries requiring clinical care	**2**	**4**	**6**	**8**	**10**
	Negligible	Minor injuries requiring no medical assistance	**1**	**2**	**3**	**4**	**5**

Figure 15: Risk matrix assessing the risk of weapon contamination on the civilian population.

ANNEX 7:
EVALUATION TEMPLATE

OVERALL, HOW WOULD YOU RATE THE CONTENT OF THE TRAINING?	VERY POOR	POOR	AVERAGE	GOOD	EXCELLENT
COMMENTS:					

OVERALL COMMENTS Please indicate how much you agree with the following statements	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
The content was interesting and engaging				
The training met the training objectives				
KNOWLEDGE AND SKILLS: **Please indicate how much you agree with the following statements**	**STRONGLY DISAGREE**	**DISAGREE**	**AGREE**	**STRONGLY AGREE**
Session 1: I have gained an understanding of what violence against healthcare workers is and what impact this has on provision of care				
COMMENTS:				
Session 2: I have now increased knowledge of the key elements in risk management and the importance of incident reporting				
COMMENTS:				

KNOWLEDGE AND SKILLS: Please indicate how much you agree with the following statements	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
Session 3: I have obtained new insight into how my behaviour can affect my operational security				
COMMENTS:				
Session 4: I have become aware of how I can deal with aggression and interpersonal threats and violence				
Session 5: I have learned more about how to reduce the risk of stress and increase psycho-social wellbeing				
COMMENTS:				

THE FOLLOWING HELPED MY UNDERSTANDING	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
Group work				
Plenary discussions				
Role play				
Power points				
Background material				

COMMENTS:				
THE FACILITATOR	**STRONGLY DISAGREE**	**DISAGREE**	**AGREE**	**STRONGLY AGREE**
The facilitator was knowledgeable about the topic				
The facilitator had good facilitation skills				
The facilitator was good at engaging the participants				
COMMENTS:				
THE TRAINING AS A WHOLE	**STRONGLY DISAGREE**	**DISAGREE**	**AGREE**	**STRONGLY AGREE**
I have gained a better understanding of how to improve my security and mitigate the impact of threats and violence				
The learning environment was safe and inclusive				
The overall length of the course was appropriate				
COMMENTS:				

HOW DID YOU PREPARE FOR THIS WORKSHOP?							
I read Part 1		I read through the resources provided in Part 2		I read through the resources provided in Part 1 and Part 2		No preparations	

EXPLAIN IN MORE DETAIL HOW THIS INFLUENCED YOUR LEARNING, POSITIVELY OR NEGATIVELY:		
DID YOU GET THE NECESSARY INFORMATION YOU NEEDED:		
IN PART 1?	**YES**	**NO**
FROM THE EXTRA RESOURCES OFFERED THROUGH THE TRAINING MANUAL	**YES**	**NO**
PLEASE GIVE DETAILS ON WHAT YOU FOUND USEFUL/NOT USEFUL IN PART 1:		
PLEASE GIVE DETAILS ON WHAT YOU FOUND USEFUL/NOT USEFUL IN PART 2:		

WHAT WENT WELL IN THE TRAINING?
WHAT DID NOT GO WELL IN THE TRAINING?
THANK YOU!

SPECIAL ANNEX:
LIST OF CASES THAT MAY BE USED IN THE TRAINING

CONTEXT	SCENARIO
Criminality and hostile behavior from arms-bearers	The ambulance was already dispatched, and you get a message on your phone from friends, saying the area you are currently working in is currently unsafe The ambulance is responding in a high criminality area, and armed people stop the vehicle, demanding people to descend from the car The dispatch service is concerned that there are rising incidents of criminality in an area covered by the ambulance service. The colleagues are trying to define new criteria to clear the deployment of ambulances The ambulance is stopped and taken over by armed men who end up using it for criminal purposes While transporting a patient, gangs start fighting and the ambulance may be hit by stray bullets if it continues moving. The first-aid team is blocked from entering an area under the control of an armed group Local armed groups are found to be using vehicles "disguised" as medical vehicles to move around the territory In a certain area, the lights and sound-alarm installed in the ambulance cars are the same as the ones used by police vehicles The ambulance is stopped and armed men rob the personal and medical goods carried by the team members A gang member is being transported to the hospital. The medical vehicle is stopped by enemy fighters, and they kill the patient inside the car After undergoing an armed attack from unknown men, the team is afraid to be redeployed until the security protocols are revised The ambulance is picking up a gunshot victim, but the team is unsure of whether the area is currently clear of potential arms-bearers who might still be active

CONTEXT	SCENARIO
Responding to/during protests and manifestations	While responding to a call during social protests, the ambulance finds itself blocked with no space to move or access the wounded While the ambulance is trying to move a wounded person during a protest, the crowd gets aggressive towards the moving vehicle and the team is afraid of continuing ahead The team is dispatched to an area that they don't know well, to respond to wounded persons in a protest. They are not sure about the exit routes and which areas have been blocked by the protesters The ambulance is transporting a person against who people are manifesting. The crowd learns that and becomes aggressive towards the vehicle While moving to pick up a patient, the ambulance team is blocked by the police due to the occurrence of a social manifestation in that area
Responding to disasters	When responding to a disaster (fire, flooding, mudslide, etc), the ambulance is blocked by community members desperately looking for information about their loved ones The ambulance is moving to a complex area in the disaster response, but the COM system failed The pre-hospital service is asked to stop all movements as the pick-up scene is currently insecure, but community members threaten the team as they see the ambulances parked
Conflict settings	An ambulance from the service was stolen over night, and there is concern that this car will be used by the local non-state armed groups for military purposes The ambulance has to cross several checkpoints when operating in the area of coverage, and the agents controlling those checkpoints are not always friendly The ambulance service is operating in an area that now crosses lines of control between different fighting parties. The protocols for operating in this challenging scenario must be redefined There was a call for support in a zone know for still being contaminated by explosive weapons. The ambulance service must define whether to respond to the call, and the protocols to do so The medical vehicle is shelled when moving a wounded person to the point of care When carrying patients, the ambulance is hijacked by armed people who demand that the team takes able combatants in the vehicle Armed men demand that the pre-hospital team NOT provide care for a wounded person

CONTEXT	SCENARIO
Conflict settings	People controlling a checkpoint arrest a patient that was being transported The medical vehicles are travelling in a convoy and one of the cars is hit by an explosive weapon The team checks the ambulance after returning to the base, and find that the previous patient had left a bag of ammunition inside the vehicle
Situations with family and community members	While the team responds to a call, a family member of the patient shows very agitated behaviour and wants to come in the ambulance with the patient When responding to a call regarding care for a high-profile person, the team members realize the patient is dead. There is a risk that the community might become aggressive and frustrated if the patient is simply declared dead at site. The ambulance was called to a home, but the team realizes the request is related to out-of-scope issues, such as domestic violence Community members threaten the ambulance team, telling them to not come back to that area Community members are fearful of outsiders, and the ambulance team is seen as a group of people from outside of their territory The composition of the pre-hospital team (ethnicity, religion, or any other element of background) triggers tensions with the local community, who doesn't want to accept that team caring for their people A team member, without authorization, requested a sum of money to transport a patient, and that was reported to the service An ambulance team of the same organisation had a prior negative incident with a community, and now the team is fearful of going back and suffering violence A young, new team member entered a physical fight with a family member of the patient, who was shouting at him An all-male team needs to take a pregnant woman to the hospital, but the husband refuses to authorize it, and threatens the team The organisation to which the pre-hospital service is affiliated is going through a reputational crisis (malpractice, corruption, etc) and this is affecting the perception and acceptance of the team during deployments The family member wants to choose where the patient will be cared for, and is threatening the ambulance team to take a different route

HEALTH CARE IN DANGER

IT'S A MATTER OF LIFE & DEATH

Norwegian **Red Cross**