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# VIOLENCE AGAINST HEALTH CARE:

Current practices to prevent,  
reduce or mitigate violence  
against health care



International Council of Nurses  
*The global voice of nursing*



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# I. Executive summary

Violence against health personnel and facilities has been documented more often in recent years, affecting all regions of the world both in war and in peacetime, undermining the very foundations of health systems, impeding the right to health and impacting critically on outcomes achievable by health systems. In war, it also constitutes a severe infringement of international humanitarian law – which prohibits targeted attacks on medical facilities, health personnel and medical transport – and of international human rights law. With the health emergency linked to the coronavirus pandemic, a worrying upward global trend in reported incidents has emerged.

From May to July 2021, the International Council of Nurses, the International Committee of the Red Cross, the International Hospital Federation and the World Medical Association – four international umbrella organizations which are members of the global Community of Concern of the [Health Care in Danger](#) initiative – carried out a joint survey to evaluate the perceptions of violence against health care during the early stages of the pandemic and to identify good practices implemented to prevent, reduce or mitigate incidents according to country's circumstances and health personnel's perspectives.

The members of the four partner organizations replied to the survey voluntarily, based on their specific knowledge of the location. The analysis proposed in this report focused on qualitative data around good practices shared by the members across countries with differing Human Development Index values.

Results demonstrate the persistence of violence against health personnel in all responders' locations, with a higher frequency of incidents after the coronavirus pandemic started. The incidents also impacted negatively on a wide range of health care services, from emergency care to programmatic preventive activities. It documents practical solutions initiated by health entities to tackle violence at community level in the areas of security, promote safer work environments, care for staff's mental health and well-being, and address gaps in communication and coordination.

We hope that the good practices presented in this report will spur the global health community to take action, to share further positive experiences and to advocate for meaningful strategies to protect health personnel and address the scourge of violence against health care.

## II. Introduction

### 1. The issue of violence against health care

Violence against health care has been a recurrent problem over the years across the globe. The coronavirus (COVID-19) pandemic has appeared to worsen the situation, with a documented increase of incidents in many countries. Health personnel and their patients are persistently subject to acts of violence in all regions of the world.

The World Health Organization (WHO) defines attacks against health care as “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”. [1]

Besides attacks on health care in emergency settings, violence against health care can also happen in times of peace, during times of regular work in health care systems with significant variations depending on the geographical locations and types of attacks. Violence targets health personnel [2] or patients, health facilities [3] or health transport. [4]

Violence against health care may happen amidst war and in other violent scenarios and may include violent acts – such as intentional or reckless violent behaviour towards, or wielding weapons against, health care personnel and assets – or blockages or denial of care. Outside of these exceptional scenarios, violence against health care may derive from tensions at the workplace, from a lack of socially or culturally adequate health responses or even from criminal acts, such as robbery and intentional damage to health material. Coercion and threats to compel health personnel to work against ethical principles are considered a form of violence against health care, as well as any act intended to prevent care from being provided. In addition, the situation has evolved since the start of the COVID-19 pandemic. Some countries have reported violence and aggression against health care driven by the pandemic, for example, health care personnel being discriminated against, harassed and targeted for violence. The pandemic has added further pressure and risk to the already overwhelmed health care workforce.

Since 2011, the [Health Care in Danger](#) (HCiD) initiative from the International Committee of the Red Cross (ICRC) has shed light on the problem and offers resources to raise awareness and promote action to change this reality. The International Council of Nurses (ICN), the International Hospital Federation (IHF) and the World Medical Association (WMA) have been members of the global Community of Concern of the HCiD initiative since its beginning, advocating for the safety of health personnel and protection of health care around the globe with strong and sustainable actions by decision makers.

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[1] WHO, “Stopping attacks on health care”, WHO, Geneva, 2022: <https://www.who.int/activities/stopping-attacks-on-health-care>, all links accessed 11 June 2022.

[2] Health care encompasses activities that aim to preserve or restore health through the prevention, diagnosis, treatment, cure, recovery and/or rehabilitation of any physical and/or mental health condition. The term might also refer to the organized system through which these activities are carried out. “Health care service” refers to the provision of care at various levels and within particular scopes (such as a pre-hospital health care service, a primary health care service or a rehabilitation service), while a health care provider is the agent responsible for that activity – a medical or a non-medical agent, which can be either an individual or a group.

[3] Health facilities include hospitals, laboratories, clinics, first-aid posts, blood-transfusion centres, forensic medical facilities, and the medical and pharmaceutical stores of these facilities. Health personnel include doctors, nurses, paramedic staff, first-aiders, forensic medical staff and support staff assigned to medical functions. The term also encompasses the administrative staff of health care facilities and ambulance personnel.

[4] Health vehicles include ambulances, medical ships and aircraft, whether military or civilian, and any other vehicles transporting medical supplies or equipment.

## 2. Why conduct this survey?

Considering the need to protect all people from violence within the health care context, the ICN, the ICRC, the IHF and the WMA carried out a joint collaborative survey from May to July 2021 to understand the perceptions of violence against health care during the first year of the COVID-19 pandemic and to identify good practices implemented to prevent, reduce or mitigate violence, with a focus on (but not limited to) those measures implemented during the early stage of the pandemic.

An invitation was sent to a focal point in each member organization of the ICN, ICRC, IHF and WMA to participate in the survey about their perception of levels and types of violence surrounding their work in health care, and the practices implemented at the organizational and national level to counter the violence. The goal of the survey was to collect experiences from member organizations – giving consideration to their specific location while facing different types of violence – to highlight the negative impact of violence and to share this knowledge with a broader community, compiling meaningful suggestions for action in order to support replication, adaptation or expansion of such measures and protect health care from harm.

## 3. Methodology and limitations

The survey was shaped to collect the perceptions and experiences of health personnel in various categories and was circulated within the membership base of the four partner organizations. Responses to the survey were voluntary. It consisted of 31 questions and was purposely designed with multiple-choice answers and parallel open questions to capture qualitative data. Participants were free to answer the questions they desired. To ensure consistency in the responses and avoid duplication, only one representative answered the survey on behalf of each member organization. The survey was translated into three languages (English, French and Spanish) and the responses were collected through an online platform.

A sample of over 120 responses was received. The survey responses were reviewed for consistency, completeness and data entry errors. Responses with missing information, such as the organization's name or contact details, and blank or duplicated responses were removed from the analysis. [5]

The main limitations of the study are due to its voluntary approach: some questionnaires were only partially answered, and a low number of members engaged in the effort. The complexity of the situation around the pandemic surely impacted member organizations' ability to respond to the survey. Those limitations reduced the survey's capacity to present quantitative information and make generalizations. To counterbalance this fact, we propose a qualitative analysis, linked to suggestions for action that come from a broader list of recommended material, to complement the great examples that surfaced in the good practices submitted.

The final sample of responders is distributed geographically (Figure 1) and across the Human Development Index (HDI) [6] (Figure 2). Categorizing responses based on HDI allows a fuller picture of the responders' national level of human development, and the analysis showed that

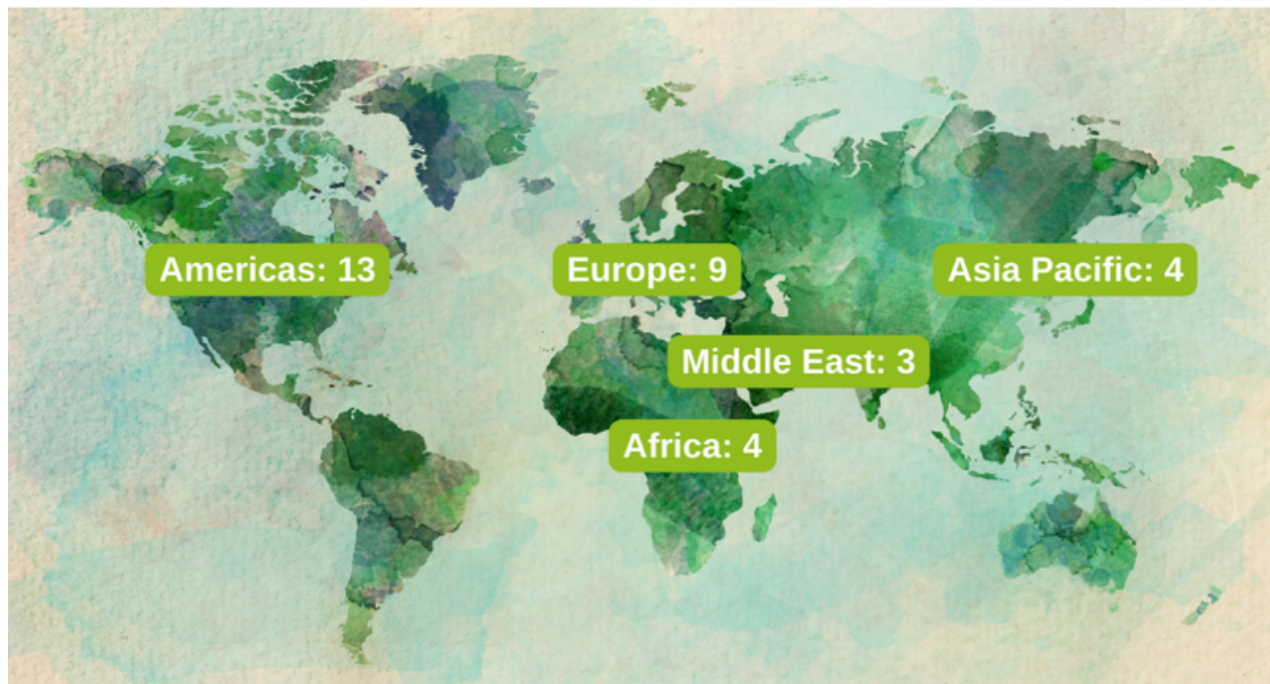
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[5] Please refer to the annex for the detailed explanation of the number of responses and validation process.

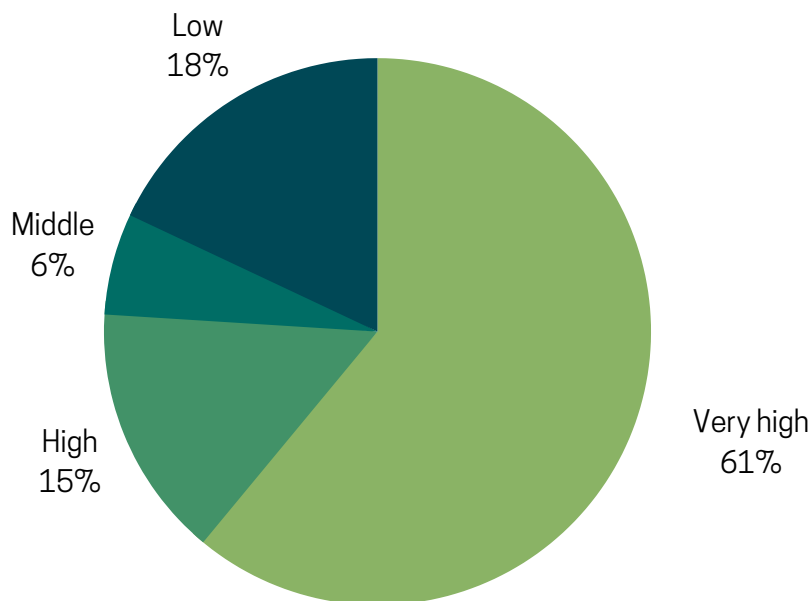
[6] The HDI is a composite index of three dimension indexes: life expectancy, education (mean years of schooling completed and expected years of schooling for children of school-entering age) and gross national income per capita. (Source: United Nations Development Programme, "Human Development Index (HDI)", United Nations Development Programme, New York, 2022: <https://hdr.undp.org/data-center/human-development-index#/indicies/HDI>.)

there was diverse representation from responders and geographic locations. The higher response rate coming from very high-HDI countries might be related to their available resources to respond to diverse institutional needs during the pandemic.

**Figure 1. Geographic distribution of responders**



**Figure 2. Distribution of countries according to Human Development Index (HDI)**



#### 4. Introductory findings

Only answers reporting events of violence (33 responses) have been selected for analysis. [7] In most cases, violence against health personnel was reported to already occur before the pandemic and close to 10% of the organizations received reports of attacks related to the COVID-19 pandemic. In addition, such attacks have continued to escalate and close to 60% of the responders

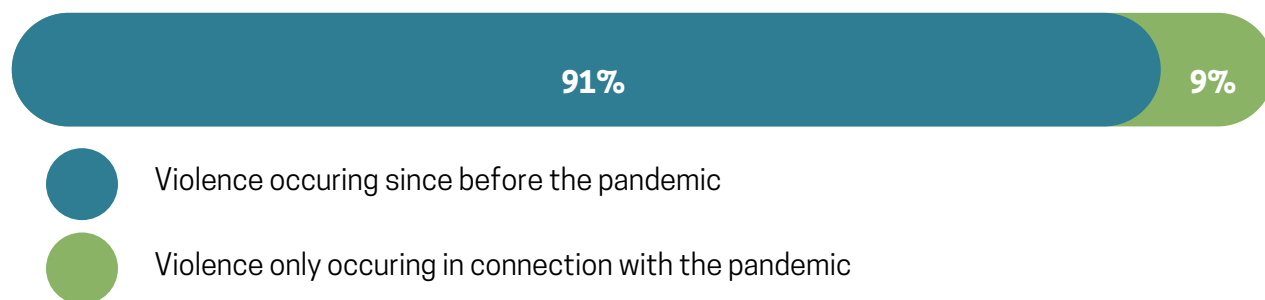
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[7] See Annex 2, "Methodology".

perceived an increase in reported cases of violence against health care since the beginning of the pandemic. The survey shows that violence against health care affects all responding organizations, regardless of their countries' economic and security situations.

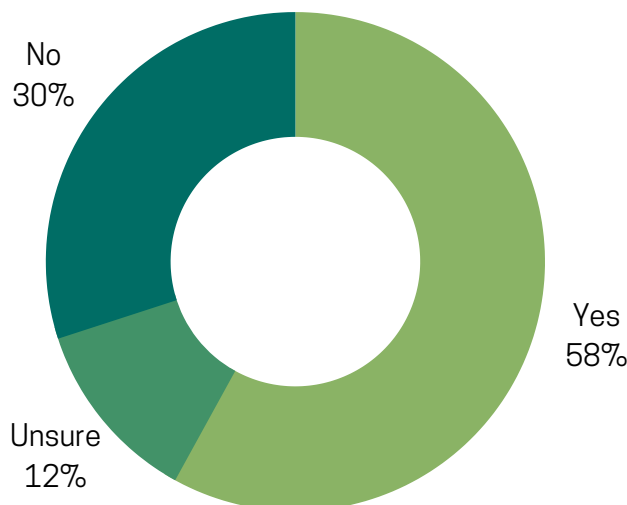
### **Occurrence of reported cases of violence against health care personnel, patients or facilities**

**Figure 3. Occurrence of reported cases of violence against health care before and during the pandemic**



### **Perceived increase in reported cases after the pandemic started**

**Figure 4. Perceived increase in reported cases**

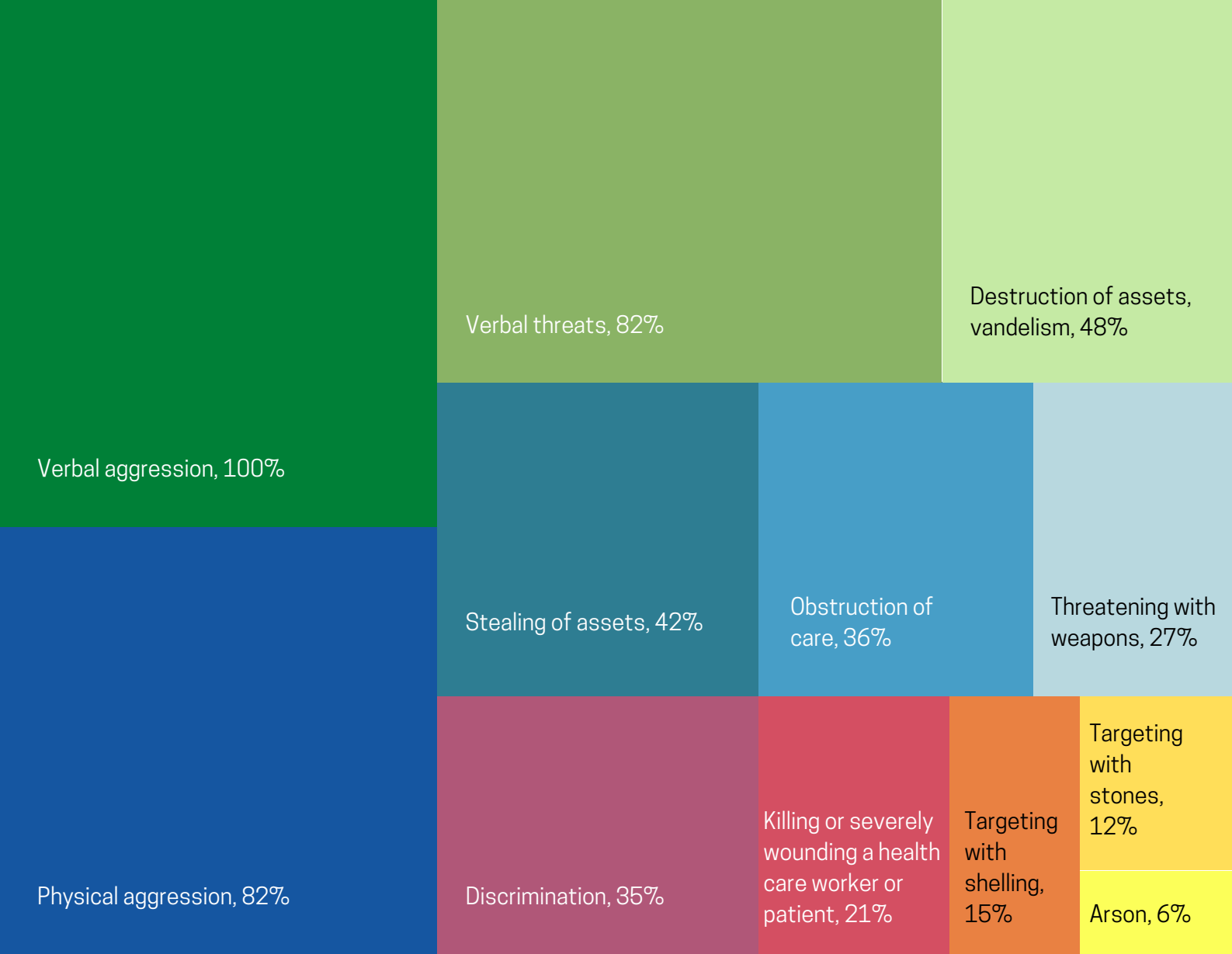


### **Forms of violence perceived by responders**

In this report, violence is classified in four main categories: verbal aggression, physical aggression, damage or loss (e.g. destruction or theft) of assets, and obstruction of care. All answers mentioned the occurrence of verbal aggression. Threats were mentioned by 82% of the organizations, and the same percentage mentioned physical aggression.

**“ It can [happen] in different places (hospitals, practices), it can be done by patients or those close to them. Verbal or physical aggression is not always predictable. ”**





**Figure 5. Type of violence reported**

### ***Perceived frequency of violence against health care***

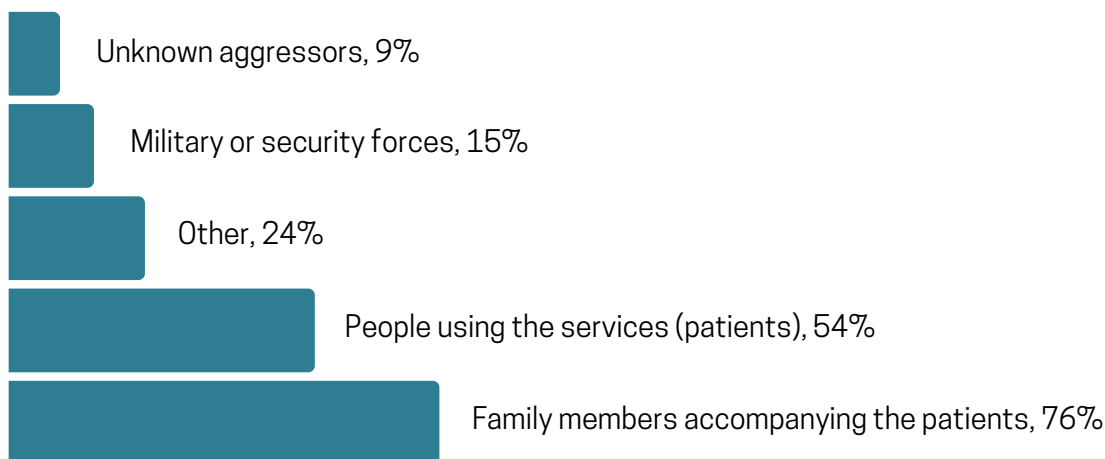
Responders were asked to indicate how often they perceived violence occurring, and their answers seem to vary across the categories, as shown in Figure 6. Attacks carried out with guns and other means of physical or destructive violence are perceived as occurring much less frequently than violence perpetrated verbally. [8] Differing frequencies of violent incidents against health care were mentioned. In most answers, events were perceived as occurring at least once a month.

### ***Perceived aggressors***

Violence against health staff can be perpetrated by different actors. Patients and family members were often perceived as the main source of violence.

[8] An important limitation of the study is that responders who are more affected by violence could have felt more compelled to answer. As the focus of this survey is on the practices generated by members to counter violence, please refer to the following report for a discussion of the prevalence of violence: ICRC, Gathering Evidence-Based Data on Violence Against Health Care, ICRC, Geneva, 2020: [https://healthcareindanger.org/wp-content/uploads/2021/03/4513\\_002-ebook.pdf](https://healthcareindanger.org/wp-content/uploads/2021/03/4513_002-ebook.pdf).

**Figure 6. Percieved aggressors**

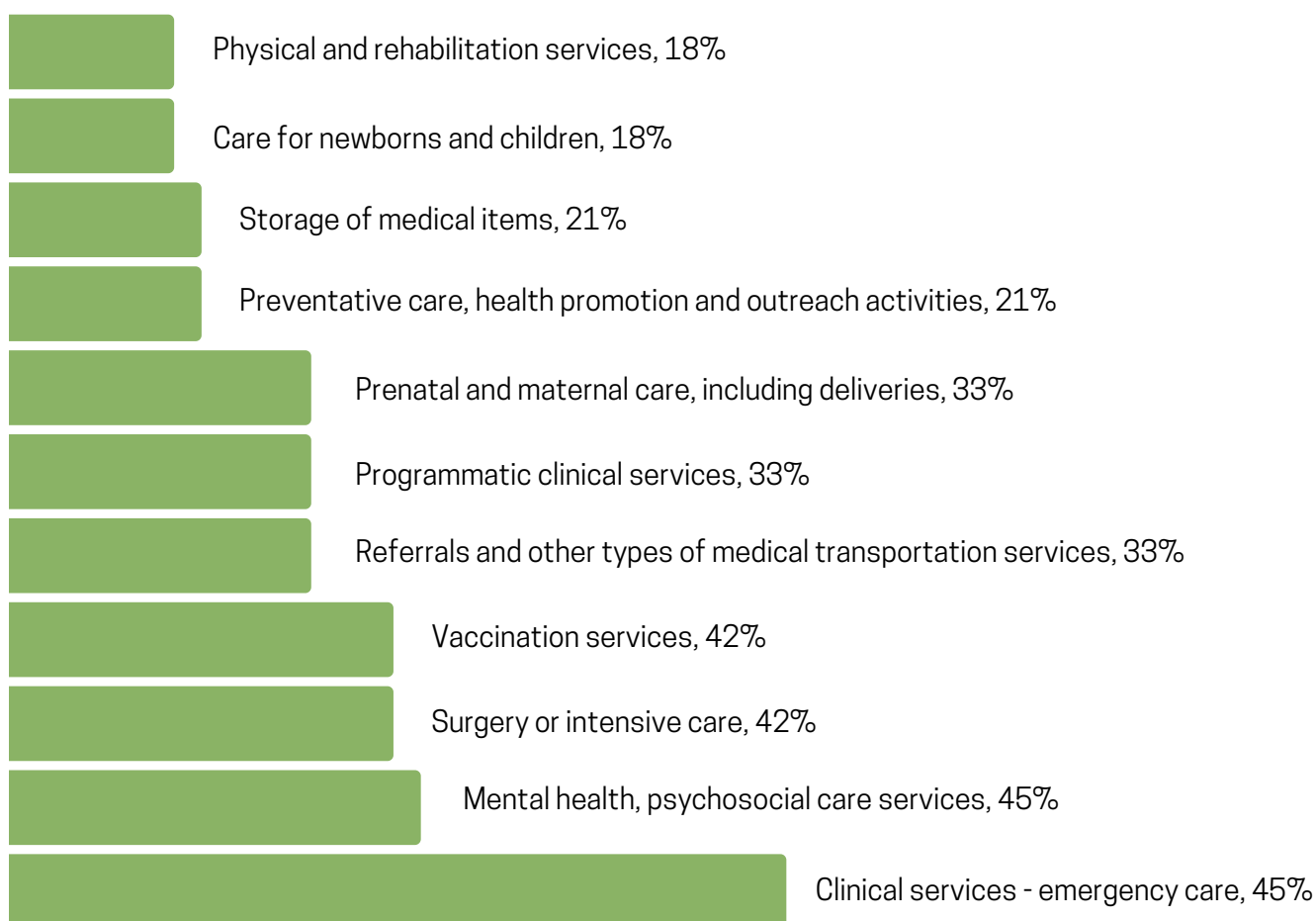


### Services affected

As shown in Figure 7, emergency care is by far perceived as the service most affected by violence. Surgery or intensive care, vaccination services (especially during a pandemic), and mental health and psychosocial support services are also widely perceived as being affected.

“**When there is a health worker who is wounded or arrested, clinical services will be disrupted, as well as the continuity of care**”

**Figure 7. Services affected**



### III. Main findings

#### 1. Overview of the responses – measures to counter violence against health care

The data collected makes it possible to draw up a list of five main themes in line with the practices and/or measures reported countering the occurrence of violence: **security, work environment, mental health and well-being, communication** and **coordination**.

A distribution for each topic was developed according to the frequency of references in open answers. [9] The following points regarding HDI were observed with this thematic analysis:

- **Communication, security** and **work environment** were referred to the most frequently across all levels of HDI.
- **Security** and **work environment** seem to be more frequently referenced for countries with lower HDI values.
- **Mental health support** and **communication** are less frequently mentioned in low-HDI countries.

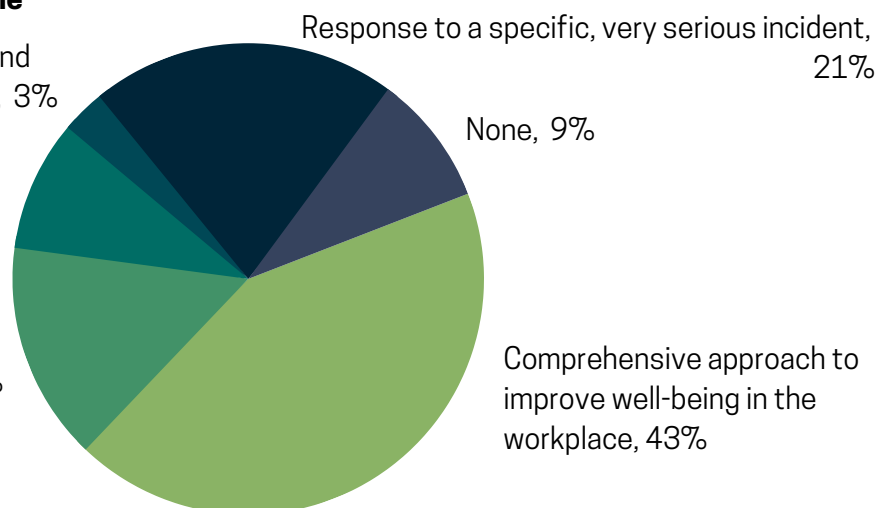
#### *Decision to intervene on the issue of violence against health care*

**Figure 8. Decision to intervene**

Both pressure from the staff and response to a serious incident, 3%

Pressure from the staff, 9%

Initiative from the management, 15%



In more than half of the responses, the decision to intervene was made either through a holistic approach related to well-being or a specific initiative from management. The reasons mentioned for not implementing measures were: 1) a low reported number of violent incidents against health personnel; 2) lack of time to implement measures; and 3) the current political and security situation in the country.

#### *Response to violence in the organizations*

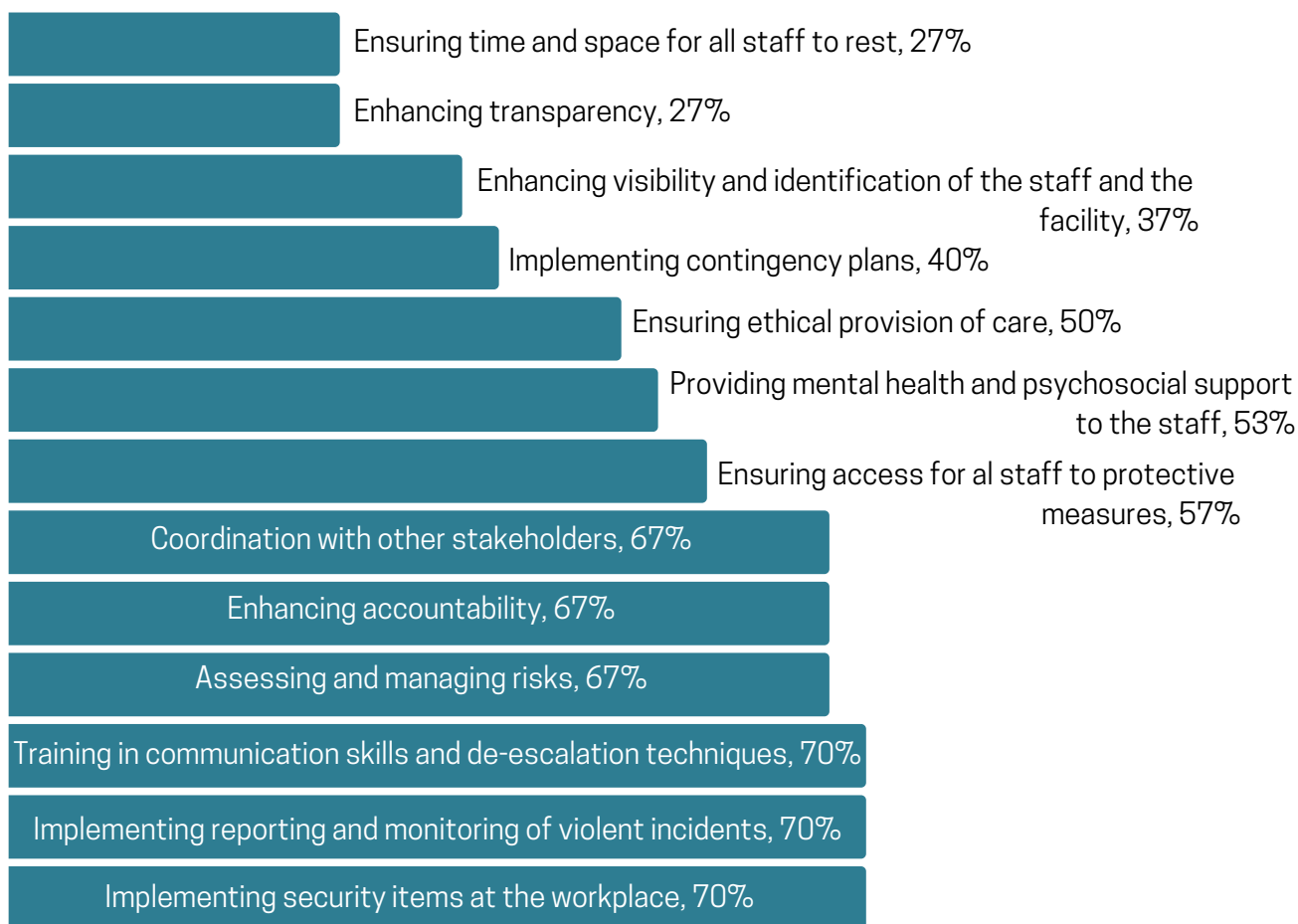
Communication skills, reporting, risk assessments, enhanced accountability protocols, coordination with other stakeholders and the further development of security items at the workplace are mentioned in 60% of the answers. [10] Development of new legislation has also been mentioned, albeit less frequently.

The responses were mostly multidimensional, with seven different types of measures cited on average, and eight responses composed of at least ten measures. The full frequency of mentions can be seen in Figure 9.

[9] See Annex 2 for the methodology of the qualitative analysis.

[10] See question 15 in the questionnaire (Annex 3).

**Figure 9. Types of interventions**

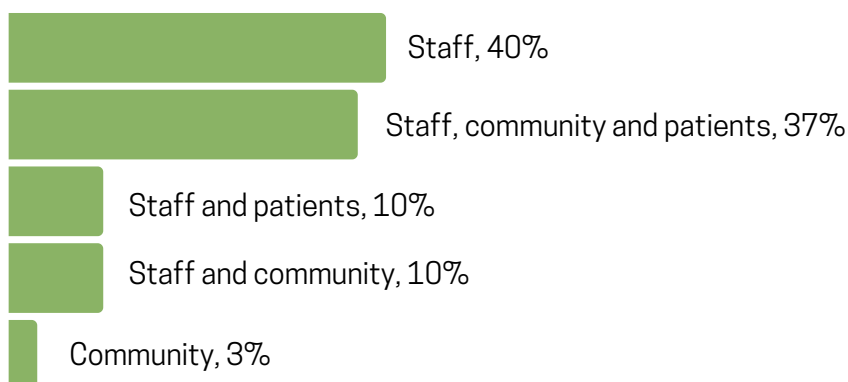


**Target population of the measures to prevent violence**

Measures to prevent violence against health care usually target staff, as mentioned in nearly all responses. However, the patients and the community are mentioned in around half of the answers. This finding also aligns with the question about perceived aggressors of violent incidents. Close to 80% of reported violence against health care is perpetrated by family members accompanying the patients, which explains why the responders also consider the community and patients as targets of the measures. Around one-third of responses focus on all three presented categories, and another third exclusively on the staff.

Armed groups were mentioned only once as a specific target of the response.

**Figure 10. Target population**



The following sections address the content of the answers provided in each thematic category, with suggestions for action at the end of each topic.

## 2. Security

### General security-related measures

The deployment of efficient security staff is suggested as a requirement to improve security. In addition, new recruitment of security staff and changes to the current organization have been mentioned.

The security staff need to be responsive and easily reachable in case of a problem, the speed of its intervention being of the utmost importance.

57% of responses included  
“Protocols to ensure access of all staff to  
protective measures”

The engagement of security focal points within the health facility is very important to ensure a quick reaction to incidents. Security agents outside the facility, in a nearby neighbourhood, can also intervene if needed to provide in-house security.

Finally, clear identification of health personnel inside the facility (with, for example, new dedicated jackets) and signage on the facility itself (such as a “no weapons allowed” sign) could deter potential aggressors from performing aggressive acts against health personnel. Many examples also displayed the good results from existing tools and the integration of the results in a training session.

37% of responses included  
“Procedures to enhance  
visibility and identification of  
the staff and the facility”

67% of responses included  
“Procedures to assess and  
manage risks”

### Suggestions for action

- Identify security focal points in the staff

Train specific or health personnel in each team on the issue of security, including on the necessary steps to be performed to de-escalate violence or trigger a contingency plan, with protocols always enabling communication with the security service.

- Employ responsive security staff

The security staff should be trained to be responsive, as the speed of their intervention is an important factor.

- Use clear protocols for communication at the organizational level and between the focal points in case of emergency

Such protocols should be put in place through official means for the whole security process (walkie-talkies, official applications for chatting in groups).

- Clearly identify the health personnel

In countries with a higher level of violence, use distinguishable items to identify the staff, such as bright jackets, specific ID cards or other elements that cannot be easily copied.

“ **Identification of most affected areas, perpetrators of the events, and type of events - thanks to the detailed and systematic documentation system** ”

“ **After the installation of the walls, a reduction of armed people entering the facility was noted, as well as a reduction of verbal aggression (...) between users and staff** ”

### **Measures on passive security and/or equipment**

Security equipment items in the workplace entail a reinforcement of general security in and around the facility. This can range from building security walls or reinforcing fences to secure high-risk areas and provide the possibility to lock down an area. The use of technology, such as installation of cameras, can also strengthen general security by ensuring better access control. It was also mentioned that risk assessments can provide pertinent solutions.

70% of responses included “Security items at the workplace”

### **Suggestions for action**

- **Secure the high-risk areas with access control**  
Using adapted means – either with technology to control access and limit it to patients and the needed staff (e.g. ID badge management, camera) or without such technology (simple ID cards, human checks) – ensure that entry and exit areas, as well as restricted circulation areas, are properly marked and that staff are always identifiable.
- **Secure the space around the facility**  
Elevate external walls, ensure lighting around the health facility and remove blind spots, patrol the area around the health facility and coordinate with local security authorities.
- **Assess the risks**  
Perform a risk assessment in and around the health facility, with the involvement of the various segments of staff and users of the service. Implement measures to limit the risks, including topersonnel, be it at the workplace or during transport (e.g. ambulance, referral).
- **Analyse the reported cases of violence against health personnel**  
Maintaining compliance with personal data protection rules, provide protocols to document the cases, enabling the collection of relevant information about the violent event and its consequences.
- **Train the staff**  
Share protective information with staff through informative and participative training sessions.

### 3. Work environment

 **[The issue of violence] was discussed in weekly and monthly meetings** 

#### **Managerial measures**

Strong management protocols were mentioned in the survey as critical to preventing, responding to and reporting on acts of violence. These protocols include measures through which direct actions may be triggered when violence occurs and when staff are trained in a previously defined contingency safety plan. Dedicated staff can monitor the post-incident situation to avoid possible retaliation against the personnel in their daily life. Frequent reminders and training sessions are incentives for all to follow a procedure, including ethical standards and national norms. In emergencies a clear definition of roles and responsibilities frequently is missing or fails, which increases the overall pressure on health personnel.

To reduce workplace violence, solutions mentioned ranged from the existence of a workplace-violence prevention committee to the recruitment of dedicated staff monitoring the situation.

The respect of health care's ethical principles is key to building a culture of trust with patients and their family members. Not respecting those norms will only worsen the situation. Some responses also mentioned including the staff in discussions, to make them agents in their own safety.

50% of all responses included  
“Protocols to ensure ethical  
provision of care”

40% included “Development and  
training of contingency plans”

#### **Suggestions for action**

- **Develop a contingency plan**

Establish clear responsibilities through a contingency plan for situations of violence, with frequent reminders to the staff. The plan should be intersectoral, with the involvement of local authorities if possible. It should also consider different levels of violence or types of threats.

- **Train the staff on procedure and norms**

The procedures and norms can be evolving or changing with time. Regular updates should be proposed.

- **Strengthen internal communication**

Organize frequent meetings between the direction and the staff and involve the staff in decisions concerning their security.

#### **Technical measures - reporting, monitoring and references**

Beyond the lack of awareness of violence against health personnel, the main reason for not reporting incidents might be the absence of a unified system for collecting occurrences of violence (mentioned by five different countries). Some answers mentioned reporting a case directly to the management of the facility, but most of the time information seems to be kept locally. Having a national database with thorough procedures to ensure transparency, and limit intermediaries between the moment of complaint and its resolution, was said to facilitate and guarantee the communication of violent incidents to decision makers and prevent under-reporting.

Guidelines from the ministry of health are sometimes provided to the staff, but the means to implement them can be lacking. The distance between the law and the reality in the field may also be explained by the lack of regional procedures.

70% of all responses included  
“Procedures to report and monitor the occurrence  
of violence in the health care setting”

### **Suggestions for action**

- **Develop national procedures and systems of reporting**  
Advocate with the national authorities to create a specific mechanism for reporting violent incidents against health personnel, accompanied by clear procedures and training courses in this system in all health facilities. Documentation and analysis should be performed whenever possible.
- **Link with the justice department**  
The justice department should be included in these procedures to ensure a direct action or simplified procedure for health personnel to complain formally about violent incidents.
- **Adapt the guidelines to the reality in the field**  
Provide various levels of guidelines for better and concrete implementation, with detailed methods and solutions according to the location.

### **Working conditions**



**Sometimes, the health staff is not aware that violence against health care should be addressed as a problem, so creating awareness also makes the reporting rise**



The lack of awareness of the issues of violence against health personnel is not only a social problem; it concerns the staff itself. Many answers display the need for awareness sessions on violence for both the staff and, separately, the community. A healthy working environment should be inclusive and team-friendly.

However, a few cases of violence between health personnel themselves have been reported. Respondents often mentioned the need for legal support provided by the management to staff members exposed to violence, including with the intention of accompanying the person through the complaint system. Setting up a mechanism enabling direct reporting to the prosecutor's office was mentioned. The legal implications of aggression towards health personnel can be dissuasive to some of the aggressors. The support offered to health personnel who are victims of violence can include mental health support, counselling as well as legal advice and incentives to report incidents.

### **Suggestions for action**

- **Hold awareness sessions on violence against health personnel for both staff and the community**  
Organize both internal and public sessions to raise awareness on the matter. Display information at the entrance of the health facility. Encourage reporting of violent events.
- **Provide complete support to victims of violence**  
The support must include legal help for an official complaint, counselling on how to cope with the situation and mental health and psychosocial support.



## 4. Mental health and well-being

### **The losses for those who suffer an attack are not only material issues (...) these attacks generated fear of being attacked**

Mental health support presents a double challenge, as it concerns both health personnel and some patients suffering from the situation. The responses to the survey suggest that countries with a low HDI reported fewer mental health and psychosocial support (MHPSS) measures when compared to the others.

Psychosocial support to health personnel is often a neglected theme, even in difficult situations such as the pandemic. Staff might feel exhausted mentally, if not physically, sometimes resulting in necessary breaks from work. The same is even more true in conflicts, as the long-term exposure to violence will only increase the need for MHPSS. Solutions reported range from establishing psychosocial teams (when none previously existed) to the creation of a hotline available at any time and moderated by professionals specifically trained in the subject.

When the internet connection is reliable, support can consist of virtual sessions with specialized teams. If physical meetings are prioritized, collaboration with other organizations with the necessary capacities was mentioned as another possible solution.

53% of all responses mentioned  
“Protocols to provide MHPSS to the  
staff are available”

27% of all responses included  
“Protocols to ensure resting time and  
space for all staff”

#### **Suggestions for action**

- **Ensure time and space for all staff to rest**  
Shifts not only need to be scheduled in ways that allow for sufficient rest, but the workplace should also provide space for short breaks and private areas where people can get away from the working atmosphere.
- **Create MHPSS teams or collaborate with other organizations that can provide MHPSS expertise**  
Hire and train professionals in mental health to provide the needed support. If that is not possible, collaborate with organizations and foundations that can provide support in the workplace.
- **Create and train a remote team of professionals on MHPSS**  
The team should be accessible through virtual tools and/or a hotline. They should be trained specifically in violence against health care and in the advantages and drawbacks of online consultations.
- **Provide free access and sessions for all the staff**  
All staff should have access to this support through free sessions. It is important also to give access to staff’s family members or others who might suffer indirectly from the situation.
- **Encourage team-building and peer support**  
To strengthen awareness and build team spirit, group activities based on realistic scenarios could feature in a practical way the challenges that the team could face during an event.

## 5. Communication

### *With the community*



**Acknowledgement that there's a need to publicly communicate in the protocols (what is new in the response to the pandemic), key message on stigma and discrimination against health workers**



The survey pointed out an expectation from the civilian authorities to communicate widely on violence against health care and raise awareness in the community, while encouraging respect towards health personnel and informing of the legal consequences of violence. Some respondents reported cases where civilian authorities on the contrary provoked miscommunication during the pandemic. The need for a good communication strategy targeting the right groups, including arms bearers, is essential.

It was suggested to launch official media campaigns at the national level (which should not prevent initiatives at the local level) in order to guarantee wide-reaching communication to the population. This can be done through posters and flyers, meeting with journalists or social media.

67% of all responses included  
“Procedures to enhance accountability  
towards the public, including patients  
and family members”

### **Suggestions for action**

- **Communicate through media campaigns**

Communication campaigns should be planned – targeting the right group (community, vulnerable groups, youth, religious leaders, etc.) and using the right media (radio, SMS, newspapers, social platforms, etc.) – and have a clear objective of preventing and reducing the violence.

- **Disseminate information through the civilian authorities**

Reach out to civilian authorities to promote the large-scale dissemination of key messages on respect for health personnel and to raise awareness of the legal consequences for those attacking them.

### **With patients and family members**

Communication with patients and their family members, often perceived as the main aggressors, has been prioritized by many organizations in their response to the violence.

The main solution suggested is training staff in de-escalation methods, to keep the situation under control. Informational items handed over to the patients, including on their legal responsibilities, were also mentioned.

Finally, the patient feedback form, while a tool used mainly for accountability to the public, enables better communication between the staff and the patients by promoting learning from past situations.

It was mentioned that, during the pandemic, some people have insisted on access to vaccines while not belonging to the target groups. Better communication would be helpful in this type of situation.

## Accountability to the users of the service

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Tools have been developed to enhance accountability, such as patient feedback forms, performance appraisals and attendance and punctuality records. They are meant to exhibit effective work interactions and improve communication and transparency. It is also important to establish protocols and accountability mechanisms for ethical questions that might be triggering violence and/or overburdening carers in their daily duties.

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27% of all responses included  
“Procedures to enhance  
transparency regarding  
provision of care”

70% of all responses included  
“Development of  
communication skills and de-  
escalation training”

### Suggestions for action

- **Provide staff with training in communicating with patients**  
Train all the staff with frequent interactions with patients or their family members in communication skills, such as de-escalation methods and non-violent communication. Train all staff in violence prevention.
- **Communicate priority groups for triage or specific health interventions at the entrance of the facility**  
Print posters displaying the current rule. Appoint dedicated staff to remind visitors of the rules, answer questions and ensure application of the protocols.
- **Improve transparency and accountability**  
Create a patient feedback form or any other tool allowing the patients or their family members to either report their frustration in a peaceful way or to propose ideas to improve the overall relation between staff and patients.
- **Educate staff continuously**  
Education should be developed through a variety of means (i.e. through initial studies, on-the-spot training, continuous education) to include reminders about the ethical principles of health care and norms, in order to ensure better transparency and accountability.

## Training

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De-escalation training has been part of the response more often than not. It has not been implemented in the same way throughout the world, and countries with a lower HDI mentioned a low rate of training.

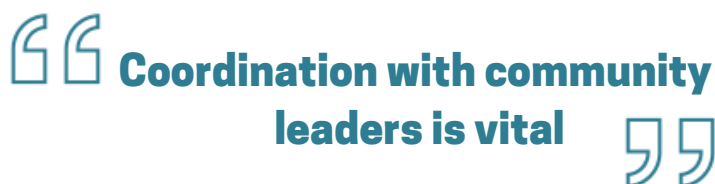
In conflict-affected countries, several solutions have been implemented, e.g. training medical students, awareness sessions with the staff and community, training in national norms and programmes to teach ethical standards in providing care.

A few specified examples of de-escalation techniques used are non-violent communication methods, crisis training and specific programmes about care-team support. A proactive method has been the inclusion of a violence-management course in continuing medical education and through group sessions or webinars with staff.

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### 6. Coordination with others

#### **Civilian authorities**



Coordination with civilian authorities, from local partners to the ministry of health is often seen as an important measure to reduce the problem of violence against health personnel. Support to improve dialogue may be needed in some cases, while in others, authorities will readily help spread the message within the community.

Finally, two different approaches regarding how coordination should be realized were reported. In one case with a conflict between two belligerents, coordination is mentioned as being always confidential. In the second case, the creation of a task force including several entities, such as health authorities, non-governmental organizations and security forces, allowed for a unified message and the dissemination of better practices.

67% of all responses included  
“Coordination with other stakeholders, such  
as the police, EMT teams, firefighters or  
other health care organizations”

#### **Suggestions for action**

- Engage in dialogue with local authorities to ensure safe provision of care  
Prioritize what is necessary in each scenario and ask for support when needed. The safe passage of ambulances should, for example, be respected by all parties.
- Coordinate in special situations, especially when a contingency plan is activated  
Foster cooperation between the various parties, including health organizations. If they do not agree to communicate with each other, coordinate bilaterally to ensure safety within the health facility and of health personnel.

## **Military or security forces**

The analysis of the answers showed that in countries with low and medium HDI values, unknown aggressors and military and security forces are perceived as more common aggressors when compared to the other categories.

Responders indicated that coordinating with military forces can be a difficult process, with potential conflicting interests that can threaten the respect of medical impartiality when providing care. Ensuring timely and adequate access to all by implementing suitable procedures throughout the military hierarchy was suggested as a way to help solve these difficulties.

A strong and respectful relationship with the police, through focal points, has helped in resolving some situations. It has led to positive results, such as officers leaving weapons outside the facility when they enter for security operations. The double security-focal-point system, in which both trained health personnel and local security forces cooperate, can also create a better relationship and prevent such operations.

## **Suggestions for action**

- **Establish focal points within the security forces**

The security forces should be connected to the focal points inside the health teams to ensure quick intervention.

- **Implement a no-weapons policy at the health facility**

Ensure that the health facility and health transport are free of weapons, to avoid direct targeting but also accidental discharge of weapons and coercive behaviour.

- **Speak with all weapon bearers**

It is important to discuss the issue with all weapon bearers, even informally, to achieve safety for all health personnel.

## IV. Case studies

### Bulgarian Medical Association

#### CONTEXT

Violence against health care is systemic in Bulgaria, and, although the pandemic does not seem to have worsened deeply an already-complicated situation, more than a case of violence per week is still reported.

The violence is of multiple kinds and mid-level intensity and includes verbal threats, physical aggression, obstruction of care and destruction of assets.

Specific services have been affected: emergency care, surgery or intensive care, vaccination services and maternal health care. Staff availability has also suffered from the situation. The main perceived aggressors against health personnel are patients and family members but also the media.

The initiative included security items at the workplace and procedures to report and monitor the occurrence of violence in the health care setting in coordination with the ministry of health and the prosecutor's office.

**All signals and complaints received or found by the Bulgarian Medical Association and the ministry of health are forwarded to the head of the cabinet of the prosecutor's office and are acted upon immediately**

#### GOOD PRACTICES

- Strengthen relations with the justice department with a functioning workflow of identification and analysis of violent incidents against health personnel. Identify the various target groups and a suitable strategy.
- Use TV campaigns with a recognized actor for older populations (identify an actor who is keen to participate in charity events). For younger groups, streaming live on social media such as Facebook and YouTube will be more engaging.

#### FOCUS - COORDINATION

The Bulgarian Medical Association, the ministry of health and the prosecutor's office concluded an agreement with the aim to cooperate on prevention, detection and investigation of violence against health personnel in the course of, or in connection with, the performance of their duties.

All signals and complaints received or found by the Bulgarian Medical Association and ministry of health are forwarded to the head of the cabinet of the prosecutor's office and are acted upon immediately.

#### FOCUS - 2019 MEDIA CAMPAIGN

The need for a media campaign has long been noted (since 2002). The Bulgarian Medical Association launched the campaign "Good words heal" in 2019 in order to keep public attention focused on the issue of violence, raise awareness among health personnel and ultimately reduce these acts of violence.

The association recruited a famous Bulgarian actor and photographer, Vladimir Karamazov, to promote the campaign. The actor had already participated in other charity initiatives, with UNICEF for example.

## ICRC Colombia

### CONTEXT

Violence against health care is systemic in Colombia. It has grown in parallel with the increase in recent years in the intensity of the conflict and its consequences, and it has worsened since the beginning of the pandemic.

The violence includes various types of incidents, from verbal threats to physical aggression, retention of health care staff to be taken away to care for members of non-state armed groups, attempts to kill wounded patients in hospitals and ambulances, wounding of staff and destruction of assets.

There have been times when violence has led to mass resignations by staff in some health care facilities, and repeated exposure to attacks surely imposes a severe burden on well-being and mental health, especially in those areas affected most by armed conflict. Violence has affected health care in a range of ways, reducing the provision of life-saving or time-sensitive services and hindering preventive and clinical health care, staff availability and drug storage.

While mainstream patients and family members are the most frequently identified aggressors against health personnel, according to the official register from the ministry of health, the armed groups, and less frequently the security forces, have also been identified as perpetrators of violence.

### GOOD PRACTICES

- Empower and help the ministry of health to develop, sustain and improve a comprehensive system for protecting health care.
- Advocate for, and support, the implementation of a normative framework to protect health care (through domestic legislation and policies).
- Collaborate with all stakeholders, as they all have a role to play in the protection of and respect for health care.
- Support coordination to develop and implement intersectoral plans of action to protect health care.
- Engage in separate dialogues if stakeholders can't coordinate together. This may include confidential dialogue to respect each stakeholder's needs and respect medical confidentiality.
- Develop a risk assessment based on robust data analysis, systematic case documentation and qualitative analysis.

### APPROACH

The ICRC addresses the problem using a comprehensive, multidimensional approach targeting all stakeholders, in close coordination with the highly developed national health ministry system and the high-performing Colombian Red Cross. The aims are to:

- spread the relevant information on protecting health care from violence, targeting the general public (via campaigns and social media), specific communities, security forces, armed groups and health care staff
- increase accountability to the public with specific staff training in the national norms on protecting health care
- provide psychosocial and mental health support to the staff (both as crisis interventions and through a structural Help the Helpers programme)
- enhance the visibility and identification of staff and facilities, making them clearly identifiable to all
- report, monitor and analyse the violence through a well-structured documentation system led by the health ministry and complemented by ICRC documentation of confidential cases
- engage in dialogue with all stakeholders, including armed groups, to ensure respect for health care and support health services and the provision of health care, particularly for communities affected by violence.

## ICRC Colombia continued

### FOCUS – COORDINATION

The dialogue with the various stakeholders in Colombia can be challenging. The ICRC has therefore divided its actions accordingly, focusing on what can realistically be achieved with each of them. This includes:

- support to, and coordination with, the robust normative framework and documentation system from the ministry of health on protecting health care, in cooperation with the Colombian Red Cross
- communication on protecting health care and how to ensure safe provision of care; support and coordination between health authorities
- communication with armed groups on protecting health care; confidential dialogue with armed groups in response to specific incidents of violence
- coordination with stakeholders on real-time interventions to enable safer passage of ambulances, mobile vaccination teams or health care teams.

### OUTCOMES

The community is more respectful of health workers, and both the armed groups and the security forces officially accept the importance of protecting health personnel, even if the reality can pose challenges to maintaining the respect and protection needed.

Health care staff understand better what the problem is and cooperate with the measures taken, improving both their own security and the capacity to cope with the violence. Finally, an analysis of the frequency and nature of violent events allowed for a description of the most affected areas and the type of incidents as well as improved responses or planning of interventions.

### FOCUS – MONITORING AND ANALYSIS

To develop an effective risk analysis and improve daily operations, the detailed documentation of events is compiled in the comprehensive documentation system, which identifies high-risk areas, the type of violence suffered by the staff and its consequences.

This monitoring tool is run by the local health ministry, with technical support from the ICRC.

The quantitative analysis of the data from the documentation system is complemented by a qualitative analysis taking into account the severity and impact of the attacks, as well as the number of unreported events (due to fear) of which the ICRC has knowledge through confidential dialogue with health care staff and communities.

 **Collaborate with all stakeholders, as they all have a role to play in the protection of and respect for health care** 



## Italian Nurses Association

### CONTEXT

Violence against health care was happening in Italy before the pandemic and the current high frequency of events is not perceived to have worsened with the pandemic. According to the survey, the source of violence is mainly family members accompanying patients and, to a lesser degree, patients themselves. Reported incidents mostly include verbal threats, stealing or destruction of assets, with some cases of physical aggression. Emergency care, mental health and psychological care, and outreach services were highlighted as negatively impacted by episodes of violence.

Interventions and initiatives were developed after specific incidents reported intensively by the media, especially on a few cases of gender-based and physical aggression. Most measures are targeted at training staff in communication skills, mental health and psychosocial support, as well as protocols to ensure ethical provision of care and security in the workplace. Additionally, new legislation was implemented to target patients and communities.

### FOCUS - WORKING CONDITIONS

Training courses focusing on how to manage difficult or violent situations were added to continuing education for health professionals. The need for more support for staff who are victims of violent episodes has been documented widely. A national approach is in development to resolve the issue of under-notification of violent events. Particular attention should be paid to all professionals who work in the community. They visit clients and patients at home, putting them at high risk, as they are often alone and without any support from colleagues or security staff.

This has led to the development of a number of support and counselling services led by local non-profit organizations aimed at meeting health and social care professionals' need for mental health support to cope with the impact of these events.

### FOCUS - NEW LEGISLATION



In September 2020, the Italian parliament approved a new law to address violence against health professionals. This law includes the constitution of a National Observatory on the Safety of the Health and Socio-Health Professions under the ministry of health, which promotes studies for reducing health professionals' exposure to risk factors, monitors the implementation of safety measures, including video-surveillance tools, and promotes best practices and specific training for health professionals.

Furthermore, the legal consequences and implications for people aggressing health personnel verbally or physically have been strengthened. The law extended prison sentences (from 4 to 16 years) for individuals who cause serious or very serious personal injuries to health personnel, including in emergency settings. Also, it increased the administrative penalty (from €500 to €5,000) for an action that, short of constituting a crime, involves violence, abuse, offence or harassment towards health care workers.

The law also enjoins the ministry of health to promote knowledge of the importance of respecting health professionals. In addition, a National Day of Education and Prevention of Violence against Health Personnel (12 March) was created to raise awareness on the subject.

### GOOD PRACTICES

- Create or update a specific law on violence against health personnel with dissuasive legal implications.
- Establish good and functioning working environments.
- Provide continuous training and support to minimize the frequency of the events and their possible impact.

 **This law shows that it is necessary to take care of and defend from violence the health and well-being of those professionals who spend their lives protecting and taking care of others' health in every setting, such as family and home care.** 

## Taiwan Nurses Association

### CONTEXT

Violence against health care occurred before the pandemic but only infrequently, with the estimation of one reported case per month. The aggressors are mostly the patients and their family members. Workplace violence has also been reported among health personnel.

Reported incidents include verbal threats, physical aggression and targeting of assets, with damage to both the isolation room and equipment such as chairs, doors or computer screens. Various services have been affected including life-saving or emergency services, activities outside health facilities, vaccination, and mental health services.

### FOCUS – SECURITY

To ensure medical personnel's safety, the prevention of violence against health care has been included in the hospital accreditation process. Medical institutions first performed a detailed risk assessment by establishing criteria to identify high-risk sites, such as the emergency departments. They then tightened access to these areas. Security was strengthened by installing monitors and facilitating communication with the police through a common procedure.

### OUTCOME

In addition to the existing health violence prevention and occupational disaster-management procedures, the new measures strengthen the protection of health personnel providing care in an epidemic.

### GOOD PRACTICES

- Encourage reporting and develop standard procedures to facilitate it.
- Include all possible information in the risk assessment, analyse the results and include them in the training sessions.

### FOCUS – WORK ENVIRONMENT

A reporting mechanism for violent incidents in hospitals has been established. Regular collection of incidents targeting health personnel in and out of the hospital facilitates robust analysis, which, after review, can be incorporated into safety-management practices and staff education and training.

The Medical Care Act was announced in 2014 and amended in 2017. It stipulates that “no person shall use violence, coercion, intimidation or other illegal methods to disrupt the order of a medical institution or to obstruct the execution of medical care practice”. The revision added public insults to the list of legally actionable offences against providers of medical services, making verbal abuse against medical personnel by members of the public punishable by a fine of NT\$ 30,000–50,000 (about USD 1,000–1,700). Additionally, this revision enjoined the national governing authority to establish a formal reporting mechanism and to issue regular public announcements regarding the content and prosecution results of related cases. The revision also includes emergency health personnel as a protected category, ensuring their rights while on duty.

In addition, the Ministry of Health and Welfare has developed: standard procedures for reporting and managing disturbances to medical order or obstruction of medical practice in hospitals; guidelines for response procedures, education and training; and standards for response evaluation.

Management also provides appropriate psychological support, counselling, and support for related legal claims or other assistance to employees who have been injured.

🗨️ **Some people had a fight owing to personal disagreements in the process of seeking medical treatments in a medical institution. The health care workers were violently attacked in the process of handling the dispute.** 🗨️

## Portuguese Association for Hospital Development

### CONTEXT

Violence against health care is a recurrent problem in Portugal, happening since before the pandemic and with very frequent occurrences, with more than a case per week. However, the frequency of events has been reduced from 9 to 4 cases per 1.000 workers in the year since the beginning of the pandemic compared to the prior one. These specific values are collected thanks to an online reporting system used for the last 14 years. Violence is mainly produced by patients and their family members, and ranges from verbal threats to physical aggression and from discrimination to the destruction of assets.

Mental Health, emergency care, and other programmatic clinical services have all been affected by the absence of the staff suffering violence. The comprehensive approach developed targeted the staff, the patients, and the community. It included various measures: security protocols, management, support to the staff, communication towards the public, trainings, coordination, etc.

### FOCUS - MENTAL HEALTH & WELL-BEING

Occupational safety and health measures are implemented to promote well-being and prevent violence as an occupational risk. Directives to create a safe and healthy environment in the Health Sector in terms of interpersonal relationships, structures, work organization, equipment, and circuits have been developed.

The support to health professionals who are victims of violence has been conceived through the creation of optimized circuits in the legal, clinical, and psychological support areas, where an improved interconnection with the justice sector is still ongoing.

Finally, a dedicated telephone support service was set up, with psychologists specifically trained to act in cases of violence against health professionals for crisis intervention and follow-up at national level. The service is available 24 hours a day, every day of the year.

### FOCUS - SECURITY

To overview the assessment and management of security conditions to reduce violence against health care, a security office was set up at the Ministry of Health, with a hierarchical organization comprising more than 200 focal points appointed in the different structures of the national health service: regional focal and institutional focal points in hospitals, local health units and health centre groups – at least one for each institution. At the same time, points of contact in the security forces have been identified to support these focal points. A collaborative network was created with all the actors mentioned above to strengthen the procedures and clarify the objectives.

To discern and investigate the phenomenon of violence in the health sector and promote the identification, notification, and analysis of cases of violence, the organization conducted a security survey of all the national health institutions (INQSEG2020), with quantitative and qualitative research methodologies to highlight the main findings that were shared broadly. It also defined a template for the risk assessment and organized security visits in order to implement the recommendations.

The national online platform for reporting cases of violence on health professionals (Notific@) was used to analyse the episodes of violence. Based on the conclusions of the analysis, the security literacy in the health sector was strengthened.

Pilot projects with innovative solutions for the prevention and mitigation of violence in the health sector have been encouraged through training of personnel. Results of some of the projects were already presented.

The Action Plan for the Prevention of Violence in the Health Plan for the Prevention of Violence in the Health Sector was reinforced in 2022 with a Resolution of the Council of Ministers of Portugal (No. 1/2022 of January 5) which places measures related to violence on health professionals as one of the priorities for investment and improves the coordination of cross-sectoral work and between ministries.

## Portuguese Association for Hospital Development continued

### OUTCOME

With a consolidated system and workflow in place, the number of recorded violent episodes has fallen, even though there is a strong incentive to report them. It also allows everyone concerned to develop ideas on how to keep improving with the already mentioned innovative pilot project, changes to the online registered system or coordination with even more actors.

### GOOD PRACTICES

- Create a remote system (hotline, video calls) available 24/7 with trained specialist to support the staff.
- Identify a security focal point in the staff to coordinate with security officers, while ensuring they are first and foremost following the ethical principles of health care.



**“We thought that having a clearer governance model now (the current one has been in place for about a year), optimized circuits and training will provide the necessary guidance to achieve better results.”**



## V. Conclusion

This survey focused on qualitative data, and the responses display very consistent answers. Answers show that violence against health care has long been present and the COVID-19 pandemic has worsened the situation, with a higher frequency of violent events.

Despite the persistent presence of this violence, it is clear that practical solutions to prevent it do exist: from raising awareness in communities about violence against health personnel, to the development of new legislation to protect them, the survey shows that much can be done. The frequent under-reporting of incidents of violence documented in the study indicates that awareness-raising does also concern the health personnel themselves. A better and more robust system for reporting, monitoring and analysing data is required to allow for a better understanding of the magnitude of this phenomenon and to take appropriate decisions.

The survey also shows the importance of improving relations between health personnel and patients and their family members, who are perceived as the main aggressors. The display of ethical and accountable behaviour was mentioned as a suggested response; however the most mentioned measure was training health personnel in communication skills for de-escalating potentially violent situations.

This survey has presented the perception of many complementary points of view and has collected operational strategies to cope with critical situations, emphasizing the need for guidelines in order to prevent, reduce and manage the violence against health personnel. Strategies should be as comprehensive as needed to engage at all stages of the process: from prevention to mitigation of the consequences of violence. At the same time, proper evaluation of the interventions might support pinpointing those that are the most effective in specific contexts, or to respond to particular problems. Such evaluations are largely missing.

The authors of this report strongly hope that the good practices presented here will encourage all those concerned to take action to prevent and mitigate violence against health care, and to share further positive experiences with those facing similar issues.

The HCiD initiative recommends additional good practices related to the pandemic, [11] legal support [12] and health-facility security assessment. [13]

Ethical Principles of Health Care, [14] endorsed in June 2015 by civilian and military health care organizations, aims to guide health personnel when providing health care to patients.

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[11] ICRC, Safer COVID-19 Response: Checklist for Health-Care Services, ICRC, Geneva, 2020: [https://healthcareindanger.org/wp-content/uploads/2020/05/4469\\_002\\_Safer\\_COVID-19\\_Response-Checklist\\_for\\_Health-care\\_Services-Lr\\_1.pdf](https://healthcareindanger.org/wp-content/uploads/2020/05/4469_002_Safer_COVID-19_Response-Checklist_for_Health-care_Services-Lr_1.pdf).

[12] ICRC, Security Survey for Health Facilities, ICRC, Geneva, 2020: <https://www.icrc.org/en/publication/4315-security-survey-health-facilities>.

[13] ICRC, Protecting Health Care from Violence: Legislative Checklist, ICRC, Geneva, 2021: <https://healthcareindanger.org/wp-content/uploads/2021/05/legislative-checklist-on-protecting-health-care-from-violence-web-1.pdf>.

[14] WMA et al., Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies, WMA, Ferney-Voltaire, France, 2015: [https://www.wma.net/wp-content/uploads/2016/11/4245\\_002\\_Ethical\\_principles\\_web.pdf](https://www.wma.net/wp-content/uploads/2016/11/4245_002_Ethical_principles_web.pdf).

## VI. Annexes

### 1. About the organizations



The [International Council of Nurses](#) (ICN) is a federation of more than 130 national nurses' associations, representing more than 27 million nurses worldwide. Founded in 1899, ICN is the world's first and widest-reaching international organization for health professionals. Operated by nurses and leading nurses internationally, ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge and the worldwide presence of a respected nursing profession and a competent and satisfied nursing workforce.

The [International Committee of the Red Cross](#) (ICRC) is an independent, neutral organization ensuring humanitarian protection and assistance for victims of armed conflict and other violence. It takes action in response to emergencies and at the same time promotes respect for international humanitarian law and its implementation in national law.



Established in 1929, the [International Hospital Federation](#) (IHF) is a global not-for-profit, non-governmental membership organization. Headquartered in Geneva, Switzerland, the IHF is the global voice of hospitals and health systems. The IHF provides its members with a platform for knowledge exchange and networking with different actors in the health sector, to improve the standard, quality and level of service delivery.

The [World Medical Association](#) (WMA) is a global federation of 115 national medical associations, representing millions of physicians worldwide. Acting on behalf of patients and physicians, the WMA promotes the highest possible standards of medical care, ethics, education and health-related human rights for all. The WMA has a long-standing commitment to protecting health care, in line with the principles of humanity and impartiality and international humanitarian and human rights law.



## 2. Methodology

The survey was carried out from May to July 2021.

The responses analysed in this report have been selected from the overall list of responses, according to the following criteria: Responses which provided incomplete information (such as the absence of the organization's title or contact details and/or data-entry errors) were not retained for the study. Only one representative answered the survey on behalf of each member organization, except multiple responses submitted by the hospitals in the Philippines.

Owing to a limited number of answers, most of the numbers are not disaggregated in the report to prevent challenges associated with statistical tests at this scale.

From a total number of 129 responses collected, 11 were removed due to either duplication or missing values. An additional 55 responses were either incomplete or duplicated entries from the hospitals in the Philippines. These responses have been removed from the analysis.

For some of the remaining responses, the missing organization name was able to be recovered using the official email address of the respondent or other means. The final sample is composed of 63 answers, separated into four groups:

- global (33)
- global but only to analyse qualitative answer (1)
- Philippines health facilities (22)
- Philippines but only to analyse qualitative answers (10).

The global sample is the one used for all numbers in this report.

### **Topics classification**

For open answers, the method used detection of some initial keywords for each topic (e.g. "media" or "journalist" for communication to the public), finding new related keywords ("campaign"). It then defined a value for each word related to a topic. For example, the detection of the word "equipment" in a sentence cannot be related directly to the "security equipment" subtopic, or to "destruction of material equipment". Manual validation was performed in the end to ensure coherence in the categories.

Every quantitative answer has been linked to a topic and graded according to the level of relevance, using a score from zero to two. For example: "How often did you perceive this violence as happening?" would get a higher grade depending on the frequency, from zero for "In very few moments over the past 12 months" up to two for "More than once a week".

As the available number of points for every topic was different, the categories have been normalized to achieve a denominator of 100, permitting simple percentages, e.g. a score of 14 in the topic "mental health" (out of 18 available points) becomes 78%, while a score of 14 in "security" (out of 48) is only 29%.

### 3. Survey questions

	<b>Question</b>	<b>Response type</b>
<b>Identification</b>	Name of the organization	Open
	Country where the organization is based	Open
<b>Description</b>	Have your members reported cases of violence against health care personnel, patients or of facilities and ambulances being a target of violence in any way?	No / Yes, and it has occurred since before the pandemic / Yes, but this is only connected to the pandemic response
	Does your organization or association perceive there has been an increase in reported cases of violence against health care since the start of the pandemic?	Yes / No / Unsure - Unknown
	What type of violence has occurred? (check all that apply)	Verbal aggressions / verbal threats / physical aggressions / threatening with weapons / obstruction of care / destruction of assets (vandalism) / stealing of assets / targeting people, the facility or the vehicle with stones / targeting people, the facility or the vehicle with shelling / arson-burning / killing or severely wounding a health care worker or patient / discrimination / other (describe)



Question	Response type
Who are the aggressors? – Family members accompanying the patients	1 (most frequent) to 5 (least frequent)
Who are the aggressors? – Persons using the services (patients)	1 (most frequent) to 5 (least frequent)
Who are the aggressors? – Unknown aggressors	1 (most frequent) to 5 (least frequent)
Who are the aggressors? – Military or security forces	1 (most frequent) to 5 (least frequent)
Who are the aggressors? – Other	1 (most frequent) to 5 (least frequent)
If you selected Other, please specify here	Open
How often did you perceive this violence as happening?	More than once a week /Once a week /More than once a month /Once a month /Less than once a month, sporadically / In very few moments over the past 12 months
Share, if possible, an approximate number of cases reported per month:	Open

Question	Response type
<p>What were the services negatively impacted by the episodes of violence? (check all that apply)</p>	<p>Clinical services – programmatic / clinical services – emergency care/clinical services – pre-natal and maternal health care, including facility-assisted deliveries/ surgery or intensive unit care/preventive care and health promotion - outreach activities outside a health facility /preventive and clinical care – activities targeting newborn and child care/ referrals and other types of medical transportation services /mental health and psychosocial care services /physical rehabilitation services/ vaccination services/storage of drugs and other medical equipment/human resources – availability of health care workers</p>
<p>If you wish, you can use the box to further describe the impact – for example, you can tell us more if a service was fully interrupted or suspended for some hours, if there was damage to infrastructure, etc.</p>	<p>Open</p>

Response	Question	Response type
	Was there any intervention to respond to the situation of violence?	Yes/No
	How was the decision to intervene on that violence taken?	It came as a pressure from the staff / It was an initiative from the management / It was a response after a specific very serious incident /It was part of a comprehensive approach to generate well-being at the workplace
	If you wish, you can use the box for further explanations	Open

Question	Response type
<p>What does the measure(s) to protect health care from violence entail? (check all that apply)</p>	<p>Development and training of communication skills and de-escalation techniques / security items at the workplace / procedures to assess and manage risks / protocols to ensure ethical provision of care / procedures to enhance accountability towards the public, including patients and family members / protocols to ensure resting time and space for all staff / protocols to ensure access of all staff to protective measures / procedures to report and monitor the occurrence of violence at the health care setting / procedures to enhance transparency regarding provision of care / procedures to enhance visibility and identification of the staff and the facility / development and training of contingency plans / protocols to coordinate with other stakeholders, such as the police, the EMT teams, firefighters or other health care organization / protocols to provide mental health and psychosocial support to the staff</p>
<p>If you wish, you can share further explanations on the measures taken</p>	<p>Open</p>
<p>Who was the target population of the new measure(s)? (check all that apply)</p>	<p>The staff / the patients / the community as a whole / other</p>
<p>Can you describe in more detail the new measure(s) and its implementation?</p>	<p>Yes/No</p>

Question	Response type
Please comment on the new measure(s) and its implementation	Open
Do you have any perceived or measured outcome from the new measure(s)?	Yes/No
Please comment on the perceive or measured outcome from the new measure(s)	Open
In your opinion, what was the main reason to not develop measures to respond to the issue of violence?	Lack of guidance on what to do / lack of financial resources / lack of dedicated staff / lack of time / other
If you wish, you can use the box for further information	Open
Did you feel like you had all the information you needed to design and implement the measure(s) to respond to violence against health care?	Yes/No
Please comment on the information you needed to design and implement the measure(s) to respond to violence against health care	Open

<b>Resources</b>	<b>Question</b>	<b>Response type</b>
	Do you have a public report, a news article or other public document that has presented the events of violence you have mentioned in this survey?	Yes/No
	If you wish, you can use this box to add links of public report, news article or other public documents to be sent to survey coordinators.	Open
	Has your organization or association published any resources or guidance materials on violence against health care that can be shared with us?	Yes/No
	If you wish, you can use this box to add links of resources or guidance materials on violence against health care to be sent to survey coordinators.	Open
	How would you like to hear back from the results of this survey? (check all that apply)	Dissemination of the report through newsletters and the websites from the participating organizations / webinar to discuss the results / recommendations or guidance publication

## VII. Acknowledgements

This report is the result of the collective work of:

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