The physical safety of health facilities

HOW RECOMMENDATIONS PROPOSED FOR CONFLICT AND OTHER EMERGENCIES CAN BE USEFUL IN PEACETIME

This report was produced by two Master in International Affairs candidates for the fulfilment of an Applied Research Seminar project at the Graduate Institute of International and Development Studies, Geneva.

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Executive Summary

This report examines how key recommendations for the safety of health-care facilities in times of conflict, produced by the ICRC’s Health Care in Danger project (HCiD), can be useful for health-care facilities in times of peace. Drawing on qualitative sources including primary interviews and secondary media data from two country case studies, Brazil and Serbia, we reveal areas in which the HCiD recommendations have relevance in peacetime contexts. In particular we find that recommendations focused on management and health system issues are relevant but that peacetime contexts differ in several ways including differences in the characteristics and motivations of perpetrators of violence in health care settings. Particular attention and recommendations in peacetime might additionally include managing patients that are intoxicated or suffering mental illness.

General Findings:

- The research did not identify any violent incident with the deliberate aim of disrupting the delivery of health-care itself.
- The majority of threats identified are internal to the facility – including physical and verbal violence – as opposed to external threats such as armed entries.
- Violent incidents caused by intoxicated or mentally ill patients are frequent.
- Lack of clear tasks, inefficient time management, lack of medical supplies and unrepresentative staff composition are some of the management issues identified that contribute to the frequency of outbursts of violence.
- Negative portrayals of health-care personnel in the media indirectly contribute to the occurrence of violent incidents by a population who was seen to distrust health-care personnel.
- In Brazilian health-care facilities, all instances of armed entry were perpetuated by individual outsiders targeting a specific patient.
- In Serbia, triggers for violent incidents are sometimes marked by corruptive practices in the health-care system and by ethical, national or minority disputes.
• The study found that corruptive practices arise in the form of public procurements, individual business contracts, and in a relationship between the patient and the doctor.
• In Serbia, national, ethical or religious minorities perceive a lack of medical supplies or long triage as a sign of discrimination.
• Subcontracted police officers are employed as unarmed guards in Brazilian facilities to control the flow of patients and manage violent incidents. Only one tertiary clinic in Serbia was found to make use of guards, who were armed.
• Serbian interviewees reported the need for unarmed security guards, regular security risk assessments, and regular incident reporting and defended increased penalties for offences against health-care personnel.
• The study stressed the importance of treating and recognizing post-traumatic stress disorder (PTSD) in post-conflict societies, especially in preventing violent outbursts.

Salient conclusions derived from findings and Health Care in Danger reports:
• Clarity of job responsibilities, time management and clear staff expectations are vital to successfully administrating health-care personnel, patients and relatives.
• Psychological first aid, emergency preparedness and personal training consisting of good communication skills of each individual health-care provider remain essential during stressful times.
• It is important to strengthen planning with other stakeholders and have back-up resources of medical supplies.
• Provisions on how to manage mentally ill or intoxicated patients should be directly addressed in recommendations for times of peace.
• Recommendations involving the threat of armed violence against health-care facilities in peacetime should be tailored to the threat of individual, as opposed to collective, armed violence.
• Hospital guards need be trained and prepared to manage pressures and tensions from patients and relatives, with consideration for how the informal roles played by guards (e.g. point of information about the service) should be managed.
• The case of Serbia showed the need for a strong ethical code that is sensitive to ethnic and national differences, and the need for recruitment of staff reflective of those differences.
• The case of Brazil illustrates the need to have special recommendations for convicts as patients, since they represent a potential threat to health-care personnel, patients and relatives.
• Recommendations should specifically address corruption in the health-care system, as illustrated in the case of Serbia.
• Training on ethical code and education on accountability for both medical and nonmedical staff could be used as means for tackling corruptive practices.
• Engagement with the media needs to be proactive to maintain a good image of health-care personnel.
• There is a need for a coordinated and integrated response from various private, governmental and non-governmental institutions in addressing violence in the health-care.
• Given that the research found no incidents critically compromising the functioning of a facility, recommendations related to “creating temporary safe solutions” for peacetime should focus on how to address temporary disruptions within specific sectors of a facility.
• Given some of issues faced in each case differed substantially, the HCiD project should continue issuing in-depth qualitative research that explores the specific issues faced by different countries.
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Preliminary definitions

Health care
Prevention, diagnosis, treatment or control of diseases, injuries or disabilities, as well as measures to safeguard the health of mothers and young children. The term encompasses all activities that ensure, or provide support for, access for the wounded and sick to these health-care services, including searching for, collecting or transporting the wounded and sick, or the management of health-care facilities.

Health-care personnel or staff
All people with professional health-care qualifications, e.g. doctors, nurses, paramedics, physiotherapists, pharmacists; people working in hospitals, clinics and first-aid posts; ambulance drivers; administrators at hospitals; personnel working in the community in their professional capacity; staff and volunteers of the International Red Cross and Red Crescent Movement involved in delivering health care; medical personnel of armed forces; medical personnel of armed groups; and personnel of health-oriented international and non-governmental organizations.

Health-care facilities
Hospitals, laboratories, clinics, first-aid posts, blood transfusion centres and the medical and pharmaceutical stores of those facilities. The term includes but goes beyond the different categories of “medical units” that are specifically protected under IHL and entitled to use the red cross, red crescent or red crystal emblems for protective purposes.

Violence
Intentional or accidental use of physical force or power, threatened or actual, against oneself, against another person or against a group or community that results in or is likely to result in injury or death, psychological harm or deprivation. Forceful obstruction of health care is also included.

Violent incident against health care
A violent incident against health care may consist of one or several acts or threats of violence that hinder or adversely affect the provision of and/or access to health care.

Introduction

This paper is a contribution to the Health Care in Danger (HCiD) project of the Red Cross and Red Crescent Movement. Launched in 2011, HCiD has addressed the issue of violence against health-care in the context of conflict and other emergencies. Building from an initial 16-country study and subsequent reports, the project culminated over the years in twelve thematic expert workshops that produced a series of recommendations. Themes include “military practice national legislation, the safety of health-care facilities, ambulance and pre-hospital services, health-care ethics, the rights and responsibilities of health-care personnel, the role of civil society and the role of the National Societies”. This paper is concerned specifically with the topic of “the safety of health-care facilities”, and what factors and contexts need to be considered to make HCiD recommendations for facilities in times of peace. This will be done by examining the cases of Brazil and Serbia.

In different armed conflicts around the world, the delivery of health-care, as well as the lives of medical workers, patients, and relatives have been endangered and sometimes subject to deliberate attacks. As enshrined in international humanitarian law (IHL), the provision of health-care to the victims of conflict is an establishment that must be protected and respected by all parties involved in the fighting at all times. Nonetheless, health-care facilities, health-care workers, patients and relatives have been put in danger in a variety of contexts across the world. In extreme cases, conflicts such as the Syrian civil war have been marked by the deliberate targeting of health facilities.
Among the reasons for attacks to health-care facilities in times of conflict, are the targeting of facilities for political or military gain; the targeting of persons within facilities from specific ethnicities or connected with rival factions; and the use of health facilities for military purposes such as storing weapons\(^5\). A HCiD report of violent incidents from 2012 to 2014 found that most incidents against health-care in conflict “occurred against, inside or within the perimeter of health-care facilities”\(^6\).

Two expert workshops addressed the theme of safety of health-care facilities, Ottawa (2013) and Pretoria (2014). Both workshops discussed four main themes: “Ensuring the functioning of health facilities during armed conflict and other emergencies”; “Managing stress and human resources”; “Physical security of health-care infrastructure”; and “Creating temporary safe solutions”\(^7\). Some of the overarching concerns raised throughout the discussions were ensuring the impartial delivery of services, achieving a balance between protective safety measures and perception in communities, and the need for context-sensitivity when implementing measures.

While these themes and areas of concern were thought of and discussed for conflict settings, it is possible to see them as having applicability in times of peace. This paper will use a working definition of ‘times of peace’, or peacetime, as a prolonged period of stability and absence of conflict, which is seen to exclude situations of peacekeeping, transition from conflict to peace or humanitarian emergencies. However, the authors recognize the difficulty in defining the term, which can be seen not only in the negative sense as the absence of conflict, but also in the positive sense as a social order that is generally accepted as just\(^8\).

Types of incidents, triggers, prevention and incident management depend on context. In the case of the United Kingdom, for instance, it has been suggested that hospitals are

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6 ICRC, 2015, p. 1


vulnerable to mass-casualty and disruptive terrorist attacks, as the hospital provides one of the core functions of cities. In Brazil, urban violence appears in some communities as a source of danger against health-care, constraining the access to services. Given that some incidents in peacetime bear resemblance with incidents in conflict settings, there is room to inquire into which HCiD recommendations can be applied. This research paper therefore aims to contribute to that exercise, in the hope that future outcomes may be used in different contexts to tackle violence against health-care. For that end, it looks specifically at the cases of Brazil and Serbia.

The first section of the project will include an introduction to the topic of violence against healthcare in conflict by drawing from existing research. This will include an overview of the four main themes in the Pretoria and Ottawa workshops: “Ensuring the functioning of health facilities during armed conflict and other emergencies”; “Managing stress and human resources”; “Physical security of health-care infrastructure”; and “Creating temporary safe solutions”. Additionally, this introduction will outline the importance of domestic legal frameworks for the safety of health care staff, as well as current examples of violence against health care.

The two following sections will be dedicated to the case studies of Brazil and Serbia, exploring themes that are relevant to each. Here the findings from interviews and secondary data will be analyzed matched with relevant recommendations from the HCiD workshops. Finally, the concluding section will identify common and differing recommendations for similar challenges and, in case they are found, explain why certain recommendations were identified in one case but not the other. This section will also provide suggestions for how communities can be part of the solution for violence against healthcare in peacetime.

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10 Borge, Dorian; Cano, Ignacio; Cabral, Cristiane; Pinto, Alessandra, 2014, “O impacto da violência no acesso à saúde nas comunidades de baixa renda”, Humanitarian Action in Situations Other than War (HASOW), Discussion Paper 13
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International Law

The last decade, marked by outbursts of violent civil war around the world, has highlighted that respect for health-care facilities during civil war or other forms of violence cannot be guaranteed without the observance of IHL and international human rights law. Customary IHL, in the view of the ICRC, guarantees the protection of health-care facilities in all circumstances during international and non-international armed conflict. In order to ensure compliance of that rule, there must be adequate training for armed groups as well as severe consequences and high penalties for those who breach international law. These measures aimed at ensuring safety of healthcare services during armed conflict should not be applied only to armed forces but to healthcare personnel as well. The medical staff needs to be well educated about how healthcare services are to be “delivered, respected and facilitated” during wartime, and in what ways their work ethics intertwines with their safety.

The UN General Assembly has several times addressed the need to secure safe and equitable access to healthcare in war zones. The resolution called “Global health and foreign policy” directly addresses the need for protection and more in sync state policies with regards to protection of healthcare personnel during armed conflict. The resolution acknowledges that “attacks upon medical and health personnel result in long-lasting impacts… weaken the ability of health systems to deliver essential life-saving services and produce setbacks for health development.” Most importantly, the resolution underscores that each member state is responsible for constructing resilient healthcare facilities and expanding national capacities when it comes to professional delivery of healthcare, financing, acquisition of medical

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supplies as well as providing equitable healthcare coverage to the disadvantaged communities.13

**Domestic legal frameworks**

The last point is important because “one of the ways to ensure that healthcare is protected in wartime is to implement, and enforce, policies in peacetime.”14 One HCiD report entitled “Domestic normative frameworks for the protection of healthcare” illustrates different techniques by which states can translate their international obligations into domestic policies.15 The report gave rise to a set of recommendations, clustered into three themes: legislative measures concerning implementation of the existing legal framework; dissemination of information, education and training; and coordination among different stakeholders.16 It further highlights the need for contextualized national frameworks based on the nature and causes of violence against health-care in the country.17 Next, states need to set up a national system for data collection on violence and any interference with the delivery of healthcare.18 Subsequently, domestic legislation must sanction and impose dire consequences on “all kinds of undue interference” within the healthcare system during armed conflicts or other forms of violence, “including threats against healthcare personnel and other undue obstacles to the provision of healthcare services.” Lastly, in all the reports produced by the ICRC HCiD project, the protection of the Red Cross, Red Crescent and Red Crystal emblems is particularly emphasized. All reports recommend that the improper domestic legislation during peacetime diminishes the emblems’ protective power during wartime, thus it is crucial

14 Wells, 2015
15 Ibid
17 Ibid, p. 37
18 Ibid, p. 38
that the misuse of the Red Cross, Red Crescent and Red Crystal emblems is disciplined long before conflict arises.

**Pretoria and Ottawa workshops**

The Pretoria and Ottawa workshops outline the existing difficulties medical workers face during armed conflicts and other types of violence, as well as offer recommendations for ensuring the proper functioning of health care facilities, managing stress under pressure, enduring physical security of medical facilities, and creating temporary safe solutions for the health-care personnel. Most of the proposed recommendations focus on setting up the right priorities when dealing with imminent threats, as well as addressing possible constraints when confronted with violent outbursts. Discussions were oriented around four broad themes.

The first theme is “ensuring the functioning of health-care facilities”. During armed conflict and other situations of violence, medical facilities experience higher risk of damage, and disruption of health care provision due to consequences of violent acts. In such situations, “networking, coordination and sharing of plans” among healthcare workers is seen as indispensible. Furthermore, staff preparedness, comprised of clarity of job tasks and individual expectations, and combined with mock exercises is represented as crucial for contingency planning. Additionally, staff composition needs to represent a well-balanced and representative workforce as means toward “bridging frictions in communities.” Next the media is seen as having a positive role in boosting acceptance, trust and knowledge of the healthcare personnel. A *no weapons policy* is seen as more appealing since having armed guards could ruin the perception of the healthcare facility. Non-armed guards on the other hand are seen as having a “vital function” in controlling entrance to the facility.

Next, the discussions considered the different sources of stress in times of conflict affecting health-care personnel under the theme “managing stress under pressure”. As emphasized in HCiD Pretoria report, health-care personnel is often subjected to killings,

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20 Ibid, p. 9
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kidnappings and intimidation.\textsuperscript{21} The effects of the attacks on the health-care personnel can have grave consequences on the recovery and treatment of patients, but more importantly frequent episodes of attacks on medical facilities lead to dislocation of medical personnel to other unaffected areas, which disrupts the provision of medical care. Additionally, stress can come from many other sources, such as organizational glitches, lack of resources, ethical issues due to governmental prioritization, etc. As emphasized by the HCiD report, a couple of aspects could help reduce the effects and gravity of stress. Such as, awareness training, arranging safe transportation to affected areas, financial motivation, provision of basic services (water, sanitation, food, accommodation), a good dialogue with patients and relatives, and a psychosocial support.\textsuperscript{22}

Thirdly, the two workshops addressed the theme of “physical safety of health-care infrastructure”. The occurrence of armed conflicts and other situations of violence has significant consequences on the physical security of health-care facilities. As indicated by the HCiD, most of the damages to health-care facilities are caused by explosive weapons, and by state armed forces. Besides the use of explosive weapons, second most occurring type of attack on health-care personnel is armed entry, followed by material damage, and forced use of health-care services. Thus, as suggested by the HCiD report, further efforts should be made in ensuring visibility of health-care facilities, as well as increasing respect for IHL and sanctity of the healthcare facilities by the warring parties. Furthermore, a number of measures can be taken about improving the resilience of health-care facilities, which goes hand in hand with available resources and funding.\textsuperscript{23} Additionally, healthcare facilities need to undergo a safety assessment and a physical inspection in order to mitigate weaknesses and implement measures increasing its resilience. Overall, it is of great importance to disseminate information about the neutrality and independence of health-care facilities during conflict. Such information must be communicated at all times, in order to avoid violence aimed at medical facilities as well as stigmatization about the provision of medical care.\textsuperscript{24}

\textsuperscript{21} Ibid, p. 9 \\
\textsuperscript{22} HCiD, 2013, pp. 12-13 \\
\textsuperscript{23} Ibid, pp. 15-17 \\
\textsuperscript{24} HCiD, 2014 pp. 12-19
The final theme addressed was “creating temporary safe solutions”. Due to various issues that affect provision of health-care during armed conflict and other situations of violence, health-care personnel may find it necessary to adopt temporary solutions, such as having prepackaged medical kit of equipment in case of emergency, or temporarily moving health-care facility to other safer area (mobile clinics). The HCiD Ottawa report emphasized the need for “necessary support to the health-care personnel during relocation,” as well as identifying vulnerable individuals and groups during allocation, so as to assure proper and immediate medical care.\textsuperscript{25} Furthermore, the Ottawa report emphasized that relocation is the last resort, and as such it entails that some services can be suspended. Thus “essential services” must be better defined through consultations with local governments in order to ensure contextualized and coordinated delivery of healthcare.\textsuperscript{26}

Some of the questions addressed in Ottawa and Pretoria workshops are: how can a hospital continue providing medical care in a war zone? What can be done to ensure patients safely reach the hospital? Or, how do you ensure safe and sufficient chain of supply of medical material, as well as basic needs such as water and electricity in a war zone?\textsuperscript{27} All of these questions revolve around an extremely pertinent problem, which is how to establish an assessment of the context and the conflict, as well as collect data and statistics, which will provide policy makers with a baseline and a well-founded starting point when formulating policies. The nature of the topic is such that data is limited, and subjected to domestic, governmental prioritization. As exemplified by the Ottawa and Pretoria workshops, although the humanitarian organizations are motivated, and willing to operate in conflict areas, challenges they encounter are far greater, and thus they must be addressed not only by the international community but also with the help of domestic authorities.

\textbf{Violence against health-care in peacetime}

\textsuperscript{25} Ibid, p. 22  
\textsuperscript{26} HCiD, 2014, p. 14  
\textsuperscript{27} HCiD, 2013, p. 8, HCiD 2014, p. 4
Although the consequences for healthcare personnel are much broader during wartime, peacetime also poses serious threats to safety of healthcare personnel. As seen in many examples across the globe - starting with the US and Australia, even though some countries are considered peaceful, they too experience violent outbursts aimed at healthcare workers. The US in particular has been under spotlight due to an “epidemic of violence” against its healthcare workers.28 Last year, a video surfaced showing a 69-year-old patient, attacking a group of nurses with a pipe pulled by his bed, resulting in two hospitalized nurses, and one with a collapsed lung.29 A study done by the Journal of Nursing Administration states that more than 50% of respondents in their study reported physical violence such as being “spit on, hit, pushed/shoved, scratched, and kicked.” Consequently, more than 70% of respondents reported being victims of verbal abuse, by being “yelled/cursed at, intimidated, and harassed with sexual language/innuendo.” One of the biggest barriers, as addressed by the study is the lack of reported incidents. Most hospitals lack reporting policies, and in most cases the healthcare staff is discouraged from reporting incidents because they may be viewed as “poor job performance”, “negligence at work”, and most often as being “a part of their job.”31 This culture of acceptance, as noted by the Emergency Nurses Association, is the main problem since it is instilled not just in the individuals performing the medical assistance but in the judicial and enforcement system as well.32

31 Ibid, p. 340
Thus, better prevention plans in both wartime and peacetime are necessary in order to mitigate violence in the healthcare. This includes staff preparedness, personal management, information sharing and incident reporting. As emphasized above, in order to provide effective medical assistance during armed conflicts, each country needs to adopt contextualized policies during peacetime that will educate, train and diminish general disregard of healthcare safety during wartime.

In view of the need for a contextualized approach to ensuring the safety of health-care facilities in peacetime, the following section explores findings from data collected about Serbia and Brazil, respectively. Each section will explore different themes that reflect country context and the types of violence against health-care facilities that occur in each case.

**Methodology and Sources**

Recommendations from the HCiD project had their applicability verified in two case studies: Serbia and Brazil. In choosing these countries, the researchers expect to account for incidents connected to ethnicity (Serbia), urban violence (Brazil), and personal motivations (both). The native languages, nationalities and cultural familiarity of each researcher in relation to the chosen countries were expected to allow for a greater openness and access to potential interviewees. Given that each country case presented different types of attacks against health facilities, conclusions about recommendations were expected to differ.

In this paper, case studies are seen as the focused analysis of one or a small number of examples of an issue, providing context-specific analysis. Furthermore, the authors sought to provide an in-depth qualitative angle to the topic, which until then had been predominantly addressed in quantitative terms in previous HCiD reports. In doing so, the authors hope to contribute to a deeper and context-specific understanding of the problem.

Conducted interviews were semi-structured. A standard set of interview questions was produced to identify the types of attacks experienced by interviewees, as well as existing

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34 See Annex 1.
mechanisms to manage incidents and areas that need improvement. Interviewees were contacted via phone, email, or by third person recommendation. In the case of Serbia, participants were asked whether the attacks invoked ethical, national or minority tensions. Interviewees in this case had experiences with health-care during the civil wars, when some of them migrated to Serbia: two participants are from Kosovo and one is from Bosnia. A list of interviewed persons can be seen in Annex 2 and standard interview questions in Annex 1. This is the project’s source of primary data.

For the Brazil case, the report will also make use of secondary data from incidents reported in the media to complement two interviews conducted. While information contained in these reports is limited and may not be representative of the problem of violence against health-care in Brazil, they will be used to illustrate some of the most acute types of incidents. This is based on the assumption that the media will tend to report on critical incidents that catch the attention of the public.

While using case studies, one potential limitation that could be pointed is that, due to the small number of samples examined, the conclusions of the research would have limited applicability to the issue of safety of health facilities on a global level. As it has been pointed on literature on case studies, however, the strategic choice of cases that have special importance to the problem can allow for the generalization of conclusions to other cases. In other words, since each are an important representation of attacks related to urban violence and ethnicity, their conclusions could potentially hold valid for other countries facing similar attacks. Furthermore, by using a combination of interviews and case studies, the researchers expect to gather more specific recommendations and best practice than those identified in the Ottawa and Pretoria workshops, which were conceived of as general guidelines.

Finally, considering that the topic of the project may have been sensitive to interviewees, their consent for recording, transcription, and inclusion in the final report was sought prior to interviews. In addition, all individuals were anonymized and statements mentioned in the final report have been appropriately worded in order to maintain that anonymity.

35 Ibid, 229
Case study: Serbia

This case study examines interviews with eight Serbian health-care professionals, coming from primary, secondary and tertiary medical care, with a goal of finding what motivates violence in the health-care system. What is common in all cases of attacks on health-care workers, as exemplified by the interviewees, is that they were all characterized as a consequence of the dysfunctional health-care system and as a reflection of the grave situation in the society. All eight interviewees testified that medical workers are almost daily exposed to verbal violence, with occasional incidents of physical violence.

The next section will, before going into more detail about the interviews and the findings, depict specificities of Serbia’s health-care system and the effects of conflict onto the health-care system in Serbia. Since the position of health-care workers within a society is highly susceptible to political influence, adding context and social framework to the study, in order to understand why violence against health-care occurs - is extremely important.

Serbia’s health-care system

After Yugoslavia broke apart in 1990, Serbia inherited its health-care system based on the Bismarck model. This particular health insurance model consists of universal coverage coming from the Serbian National Health Insurance Fund (NHIF). The NHIF supervises and manages all health-care services in Serbia. Its goal is to provide universal health coverage to all its citizens, regardless of their status. The NHIF covers most of the health-care services, such as “treatment by specialists, hospitalization, prescriptions, pregnancy, childbirth and rehabilitation through health centers,” and most of its expenses, in fact 69.48% come from people’s income and 29.01% comes from the pension plan. Thus, NHIF services are highly vulnerable to unemployment and low income. Private health insurance is also a choice. It
provides faster access to health-care, and gives more treatment options.\textsuperscript{36} However, having in mind that an average salary per person in Serbia is 372 euros, one cannot afford private health insurance.\textsuperscript{37}

Furthermore, the NHIF is also responsible for purchasing medical supplies, such as drugs, and medical equipment. In 2012 the Serbian Ministry of Interior Affairs implemented a law on public procurement in all public institutions, which regulates the flow of goods and services in the public sector, with the aim of increasing market competition, diminishing fraud, waste and protectionism.\textsuperscript{38} Thus, in order to obtain medical supplies for public health institutions across Serbia, the NHIF would announce a tender, which is a process by which different governmental bodies invite different stakeholders to bid for large projects that need to be completed by a certain deadline.\textsuperscript{39} Therefore, whenever a hospital or a pharmacy experiences a lack in medical supplies, the NHIF calls for tenders, and through a competitive process obtains best prices for medical supplies. Besides providing health insurance and medical supplies, the NHIF along with the Ministry of Health is responsible for providing funds to public health institutions, which consists of salaries, and expenses such as hospital maintenance.

The users of health insurance in Serbia can be divided into two groups. The first group are people who earn income and pay obligatory contributions, and the second group are those people without income, and whose insurance is covered by the Republic of Serbia.\textsuperscript{40} Health-care in Serbia is provided through different levels of primary, secondary and tertiary health-care. The primary level is characterized by state-owned health centers, emergencies and pharmacies. The secondary level is comprised of hospitals. In cases where a primary


health-care provider is unable to deliver appropriate health-care, the patient is referred to hospital care. Tertiary level is the highest level, comprised of specialty clinics. In cases where a patient is unable to receive proper medical care, due to severity of illness or due to technical difficulties, a doctor in primary or secondary health-care, along with a signature from the NHIF is entitled to refer him/her to a medical professional in tertiary health-care.\textsuperscript{41}

**Effects of a decade of conflict on Serbia’s health-care system**

Throughout a decade of conflict in 1990s in the Balkans, which resulted in dissolution of Yugoslavia, the health-care system in Serbia has significantly deteriorated. During this period, mass migrations, political and socioeconomic instability followed by sanctions, embargoes and a structural devastation by NATO air campaign, further crippled already weakened health-care system in Serbia.\textsuperscript{42}

While a new transitional democratic government marked the beginning of the 2000s, the remnants of the past have left the economy collapsing with high unemployment (27-49\%), low wages and “an increased demand on the strained health-care system.”\textsuperscript{43} Thus, the viability of the health-care system was affected by a reduction in the resources. Additionally, the national health-care plan was no longer sustainable, since health-care insurance contributions decreased, and consequently left millions of people uninsured.\textsuperscript{44} The internal tensions followed by political pressure and economic instability have caused severe underfunding, low wages, as well as lack of investment in the infrastructure of health-care facilitates. This severe decline in the quality of health-care was attributable to a lack of


\textsuperscript{43} Ibid, p. 7

“medicines and medical material, bribery and corruption, transfer of patients and a part of equipment from the state to the private health sector.”

A study done by the European Agency for Reconstruction in 2002, found that “only a third of hospitals had functioning sterilization equipment” and that “75% of the medical equipment in health facilities was more than 10 years old.” The same study found that the average salary in 2000 in Serbia’s health-care was €130 a month. Thus, in order to compensate for low income, health-care personnel supplemented it with informal payments. Consequently, due to a lack of medical supplies, patients themselves had to buy medical supplies in order to get treated.

Since 2002, the government of Serbia has implemented several reforms to tackle long-lasting issues in the health-care sector. Most of the reforms aimed at providing universal level health-care, “with varying levels of co-payments, supplemented by private insurance for services that are not part of the compulsory scheme.” Nonetheless, much progress is still needed. Working conditions as well as wages have improved, however the Yugoslav cultural heritage still lingers. Since the financial crisis in 2008, the NHIF has been struggling with revenue collection, because the economic crisis has increased unemployment, thus impacting taxation.

Since 2006 the National Health Accounts organization (NHA), has monitored the flow of funds in the Serbian health-care system. The main challenges NHA has encountered within Serbian health-care are lack of transparency of financial flows in the public and private sector, especially informal or side payments to the health-care personnel. The NHA concluded that private spending on health includes bribes, therefore making official statistical data on corruption in the Serbian health-care inconclusive.
All of the illustrations above expose difficulties people of Serbia face after several unsuccessful attempts to recover and reform its society. The health-care system in Serbia has been marginalized in a way that demoralizes health-care workers through very high perception of corruption in the health-care system, low wages, and an extremely high number of young health-care professionals continually leaving the country. Therefore, the downgrading of medical professionals allows for many kinds of exploitations, mistreatment and abuse continually circulating between the doctor and the patient.

Organizational issues

As exemplified by the interviewees, the lack of personnel, along with a lack of medical supplies, long waiting times and a lack of security procedures is a direct consequence of inefficient facility organization. As such, these organizational vulnerabilities trigger verbal or physical violence aimed at health-care personnel.

a) Lack of personnel

All the interviewees agreed that a lack of personnel was an extremely debilitating issue. Two of the interviewees who work as emergency doctors complained that emergency rooms get overcrowded, and a lack of health-care workers contributes to patients’ anxiety, and in many cases provoke a verbal or physical response. Interviewee #5 said that she is one of the two main emergency doctors who work 12-hour shifts. The health-care protocol commands that after two 12-hour working days, a health-care worker must take a day off. However, as the interviewee #5 pointed out, “if I do not come to work, there will be no doctor in charge of the patients.”

Next, as the interviewees testified, last year the government of Serbia implemented a new socioeconomic reform aimed at reducing government’s deficit through cutting wages by 10% of all people hired in the public sector. Additionally, the government of Serbia decided to reduce the number of employees working in the health-care sector by 6%. Thus putting a
quota on the amount of health-care staffs working in the medical facilities. Therefore, the employment of health-care workers is directly correlated with the changes in the socioeconomic structure.

Interviewee #2, who is currently a deputy director in a tertiary clinic, pointed out that there are often enough of employed medical staff, but many of them are not on duty. Some take maternity leave, others annual leave hence causing a shortage of health-care personnel on duty. Health-care workers as other public employees are entitled to a certain amount of free days, and in many cases they tend to take all the free days at once. The interviewee indicated that being in this field requires ones constant presence, which is why he is currently working on implementing a regulation that will limit the number of free days a health-care worker can have on one occasion. The stress caused by the lack of personnel, can easily be managed with a regulation modifying the annual leave. Additionally, as several interviewees pointed out, the time spent in a hospital should be restructured so as to diminish “irrational use of capacity.” A doctor should use his time in the health clinic as effective as possible. That implies working 8h shifts; 6 out of 8 hours are spent treating patients, and 2 hours are spent managing paperwork or visiting patients in care. Hence, the organization among the health-care workers needs to be impeccable.

Measures such as staff preparedness, which consists of clarity of job tasks and individual staff expectations are found to be vital in the HCiD report (Recommendation 6.1). The ICRC acknowledges that a lot of stress comes from a lack of health-care personnel, and thus it needs to be addressed by recruiting experienced personnel, training health-care personnel how to cope with a lack of personnel in stressful situations, and ensuring that the health-care personnel is motivated (Recommendation 6). Thus good organization of roles coupled with incentives can help mitigate some stress caused by the lack of personnel, in cases were additional recruitment is not attainable.
b) Long waiting times

The violent incidents caused by long waiting time can in many cases be traced to patients complaining about compiling tons of paperwork. Only a small number of hospitals in the capital city of Belgrade, have switched to Heliant system, which enables health-care facilities to reduce the paperwork, schedule appointments, write referrals and prescriptions online. However, hundreds of other health-care facilities outside the capital are still using tons of unnecessary paperwork, which puts nurses working at the reception counter desks at a higher risk of violent incidents.

The interviewee #1 recounted an incident that happened during one of his shifts, where a patient attacked the nurse, punching through the glass that separated the nurse and the patient. The patient was a previously identified drug addict also diagnosed with AIDS, who demanded certain pharmaceuticals from the nurse. After being politely asked to wait in the waiting area, the patient became disgruntled and broke the glass causing widespread panic. This particular incident can also be ascribed to patient’s drug abuse and possible mental illness, which will be discussed later in the paper.

Another interviewee working in an emergency room reported being slapped by a patient’s relative, pulled by her hair and hit with a cellphone. As recognized by the participants, such incidents occur due to inability to service everybody equally, and due to patients lack of understanding how triage works. The participants noted that many violent episodes could have been prevented through more careful handling of the irritated patients. Carefully explaining how prioritization works, or having nurses approach the patients while they are waiting and inquiring them about the assistance they need, has in many situations been proven as comforting and soothing the patients.
The most vulnerable group of patients, as noted by the interviewee #7, are children. Distressed parents instigate a lot of incidents. Most of the time they do not sleep all night, they are restless, and demand immediate assistance.

In congruence with above-mentioned techniques on how to deal with the tension caused by long waiting times and triage, the HCiD also suggests that the health-care providers need to ensure that patients feel respected while at the same time being “sensitive to the risks that some patients can bring to the infrastructure”\textsuperscript{50} (Recommendation 7). Next, the ICRC recommends that the health-care providers must provide a “welcoming and cooperative environment” for patients’ relatives, with an understanding of the sensitive situation they are in, in order to reduce potential tensions by “absorbing their outburst” and by being “humble”\textsuperscript{51} (Recommendation 8).

Additionally, the HCiD Ottawa and Pretoria report suggest that the best way for health-care providers to ensure viable working conditions in stressful situations, such as frustration caused by waiting time, is to provide training for both medical and non-medical staff on how to cope with high security risk situations (Recommendation 5). Training components such as communication skills, psychological first aid and self-care should be included in the curriculum for medical students.

Lastly, in the case of Serbia, one of the possible solutions of frustration caused by waiting time would be an introduction of Heliant system in the rest of health-care facilities across the country. However, such measures are constrained by the lack of funds. Thus, until such changes occur, the implementation of the mentioned HCiD recommendations is indispensable.

\textsuperscript{50} HCiD, 2014, p. 19
\textsuperscript{51} Ibid
c) Lack of medical supplies

There is a chronic shortage of medical supplies in Serbian public health-care facilities. Each one of the participants acknowledged that NHIF along with the local government inefficiently manages the funds. The lack of medical supplies aggravates the patients since they need to buy medicine such as aminophylline, mannitol or simple medical supplies such as syringes, bandages, or adhesive tape.

As noted by the two interviewees who work as emergency doctors, most of the problems with medical supplies happen over night. During the day, in case of a shortage of medical supply a patient can go to a pharmacy and buy necessary drugs. However, during the night, pharmacies are closed and the health-care personnel need to find creative ways to handle a patient in need.

Purchasing medical supplies goes through public procurements established by NHIF. These public procurements, although having a deadline, can take up to two years to get processed, leaving many health-care facilities around Serbia experiencing a shortage of most basic medical supplies. Serbian minister of health has recently spoken up about the controversies surrounding mishandling of medical supply by the NHIF, and he proclaimed that the law of public procurement would have to be either revised or changed completely.⁵²

"The most difficult is treating children. We have some of fever reducing syrups that we can provide as first aid, but when a child has an allergic reaction we do not have a medicine supply to treat it. Understandably, parents are nervous, as I would be if it were my child. In situations like this, we would call a person we know works in a pharmacy, to open it, and provide us with the necessary medicine." (Interviewee #5)

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The equitable and continuous provision of medical supplies is essential for a proper functioning of a health-care facility. The HCiD suggests establishing a minimum of health-care critical supply, such as emergency health-care kits in case of a crisis (Recommendation 4).

Next, as mentioned in the text, sometimes there is a need for planning with other health-care providers, such as with the example of a pharmacy delivering medicines after hours. Thus it is important to strengthen planning with other health-care facilities, and have back-up resources and specialized medicine supplies.

The HCiD Ottawa and Pretoria report also suggests extending the list of suppliers and reducing the reliance on a single source of medical supply (Recommendation 10.3). However, in the case of Serbia that is not possible since law regulates the provision of medical supplies to public hospitals. Thus, other supplementary and more contextualized recommendations are needed to tackle the core issues causing the lack of medical supplies in Serbia.

d) Lack of security procedures

As pointed out by all the interviewees, lack of security procedures has a profound effect on the safety of health-care personnel. None of the primary and secondary medical personnel I interviewed had guards at the entrance of the hospital, except for the tertiary clinic. The two interviewees working in a tertiary clinic in the capital of Serbia stated having armed guards at the entrance of the hospital. This particular tertiary clinic has experienced violent incidents including mob violence and shootings outside of the clinic. Therefore, this particular clinic is an exception to other health-care facilities I examined. Outside of this
particular example, the interviewees reported having many violent intrusions inside the health-care facility, such as violence triggered by intoxication, gun violence and robberies. One interviewee reported Roma community stealing the engines of the ambulance cars during night and thus disabling health-care workers going on their morning visits.

Besides agreeing that having unarmed guards is a necessary deterrent, the interviewees pointed out that training on psychosocial and personal management or crisis communication, could be a beneficial skill, not only as a guiding tool through a security crisis, but as a help with cue recognition. Many health-care personnel is inexperienced, and thus lacking the ability to recognize dangerous situations. Training in cue recognition, and different ways to manage stressful and threatening situations, could be a helpful preemptive skill as pointed out by the interviewees.

Hiring unarmed security guards, or having psychosocial training is a fiscal and organizational issue highly dependent on the chief of hospital. After having a verbal confrontation with a patient, who threatened a physician by saying, “you better have your husband take you home tonight,” the interviewee turned to her chief of hospital, informing him of this grave event, while in turn he told her to write her complaints in “the book of unwanted events.” This infamous book is similar to a guest book, where guests can write their complaints that are rarely acted upon. Therefore, the lack of recording incidents is a serious impediment to health-care safety, since it leads to a culture of acceptance.53

Additionally, the HCiD Pretoria and Ottawa reports recommend evaluating facility’s structural resilience in order to identify measures for protection (Recommendation 1 and 13.1). Conflict zones differ significantly from peacetime, hence peacetime does not require a strategic organization or strengthening of health-care infrastructure with plastic filming on the windows for glass explosions; but it does require certain protection, such as unarmed guards or video surveillance.

Besides carrying out a security assessment, the HCiD also suggests managing

communication and information system within the facility as a way to mitigate violence, and get rapid help (Recommendation 3). During peacetime, this entails clear communication and sharing of information among the medical and nonmedical staff as a way to mitigate patient’s behavior. As emphasized by the interviewees, most violent intrusions are difficult to predict, and what is needed is a preemptive mechanism that will deter potential intruders. Thus, emergency preparedness and personal training of each individual health-care provider remain crucial. Additionally, the interviewees added the need to increase the penalties for attacks on the health-care personnel, and transform all health-care staff into public officials, in order to deter potential violent outbursts.

**Ethical, national and minority issues**

The interviewees reported having only verbal confrontations based on ethical, national or minority grounds. Interviewee #1 works in a hospital situated in a multiethnic city, where half of the population are Muslim Serbs. He reported having no major incidents besides occasional quarrels, mostly stimulated by current political situation in the country. The interviewee stated that a dissatisfied patient of a different ethnic or religious background usually finds a lack of medical supplies or long waiting times as a sign of discrimination. As the interviewee noted, health-care providers at his facility are perceptive and sensible to such issues, and mostly manage arising problems through conversation.

Interviewee #2, who is the deputy director of a tertiary clinic, stated having problems with instilling an ethical code into the health-care personnel. Serbia has a large Roma population, which has free health-care insurance, and thus would visit medical facilities on a regular basis. Some of his health-care personnel, as the interviewee noted, would complain to him about having to constantly treat Roma families. However, since the implementation of the code of patients safety, doctors became more sensible to ethnical and minority issues. Interviewees working in primary care stated having no verbal or physical confrontations with Roma population, except occasional theft of medical equipment.
Yugoslavia was a multiethnic society, and Serbia has inherited its diversified assortment of people. During and after the war in the 1990s, Serbia registered 451,980 refugees coming from Croatia, Bosnia and Kosovo. Three of the interviewees, one from Bosnia and the other two from Kosovo, have managed to successfully integrate, however with certain costs. The interviewees stated having issues finding a job in the field, due to a widespread belief that “we are stealing jobs from the local population.” Today, there is still some animosity toward refugee health-care workers, especially toward those workers coming from Kosovo. As with the issue of ethical and religious differences, it is the political and socioeconomic situation that resurfaces these differences, rather than people’s rooted xenophobia.

As a remedy, interviewees believe that time heals everything. The situation today is much better than it was 20 years ago. Confrontations do take place, but they are mostly fueled by low wages, organizational issues, and a lack of understanding between the doctor and the patient. The HCiD Ottawa and Pretoria workshops are mindful and highly cognizant of the violence arising from cultural, ethical or religious issues. The workshops suggest that the recruitment of health-care staff should be transparent, and that staff composition should reflect the ethical, gender or religious aspects of a community as means toward bridging societal differences (Recommendation 12.1). Either in conflict or in peacetime, medical workers need to be perceptive of cultural differences. Therefore, the HCiD Ottawa and Pretoria workshops add that each health-care facility has a responsibility to educate its staff on what is appropriate behavior (Recommendation 12.3). In the case of Serbia, as emphasized by the interviewee #2, implementing ethical code, and the code on patients’ safety made a significant change in the patient/doctor relationship.

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Corruption

As testified by the interviewees, one of the driving reasons as to why health-care workers are marginalized in Serbia is due to public’s high perception of corruption inside the health-care system. When a loved one’s life is at stake, most people will do whatever it takes to acquire best medical treatment, even if “a few lines are blurred in the process.” Patients or patient’s relatives may offer bribes, or the health-care personnel may solicit bribes in exchange of preferential treatment. The citizens of Serbia are blasted with news articles about corrupted surgeons that indirectly ask for hundreds or thousands of euros for a certain treatment.

It is difficult to know the true extent of corruption in the Serbian health-care system. The interviewee #3 testified that corruption in the health-care is present, and that is undermining the efficiency and perception of competence in the health-care system. This particular interviewee created a policy paper addressing corruption, with a goal of implementing it across Serbia. So far, he was able to implement it in half of the public hospitals across Serbia. However, as noted by other interviewees, the resistance to novelties and change is particularly strong. Interviewee #3 recognized three means by which corruption takes place. The first, are the public procurements, the second are the individual contracts between health-care facilities and businesses, and the third is the relationship between the patient and the doctor. Public procurements serve as a regulatory role, to select drugs, and new forms of treatments covered through the health-care funds. However, the process is not transparent, and in most cases it is difficult to distinguish as to whether “public or private interest is a matter of concern.” The individual contracts follow the same rule. They are not transparent, usually involving large amounts of money, leading to manipulation and abuse of funds.

Lastly, the relationship between the doctor and a patient is a complicated one, rooted in Serbian tradition. During the monarchy and continuing with the communist rule, medical professionals were highly valued, especially in the rural areas. People felt grateful and wanted to reward knowledge, and commitment by offering gifts to the person who was helping them. Such traditions were reinforced during the 1990s collapse of the Serbian health-care system. People were in grave need of limited health-care services, and they were ready to pay as much as possible in order to get necessary treatment. As noted by the interviewee #3, when creating the plan for tackling corruption in health-care sector, it is important to understand what drives corruption, and what activities fall under its umbrella. Is buying chocolate or flowers as a thank you gift considered a bribe? In Western Europe yes, but as the interviewee noted, when translating different plans of actions taken from various European countries, it is important to contextualize them. Instead of punishing people for offering flowers or chocolate for a job well done, we should, as suggested by the interviewee #3 educate citizens and health-care personnel on how to make cognizant decisions when in such situations. Especially, since such situations heighten the relationship between the patient and the doctor.

“Ibid, Mužić

“Classic corruption in the primary health-care sector is minimal. Working as a primary doctor, I am not in the position to act corruptive... But, here, in Serbia there is a certain attitude among people, that no matter how I act, there is always the other side. For example, occasionally I would have a parent that would ask me for my phone number, and if I can come and visit their child if something comes up, underlining that they would pay for my time. I personally do not consider that as corruptive behavior, since they are willing to pay for my time when I am not on duty. However, such activities are not regulated by law.” (Interviewee #7)
The primary and secondary health-care workers said that the only form of ‘corruption’ they experienced are the occasional chocolate, flowers, etc. The health-care personnel working in the capital did identify higher forms of corruption as an impediment to a violence-free relationship between the patient and the doctor. Personally, none of the interviewees reported having incidents on such basis, but they did identify it as contributing factor to violence in the health-care system.

Besides cultural heritage, unsuccessful socioeconomic reforms characterized by low wages, lack of regulations and loopholes in the law, are also some of the reasons for corruption in Serbian health-care. In order to tackle corruptive activities, besides addressing governmental regulatory bodies, it is important to break into the “corruption habit” through a bottom up approach.\(^58\) Starting with educating citizens on acceptable and unacceptable activities, or changing the cultural notion of corruption through education of youth.

The HCiD Pretoria and Ottawa workshops do not address corruption as an impediment to safe and equitable provision of health-care. However training on ethical code and moral behavior, addressed in ICRC study on domestic normative framework could be partially applied. This particular ICRC study recommends that government authorities need to bring awareness of do’s and don’ts into the relationship between health-care providers and different stakeholders. Additionally, this study suggests the need for “comprehensive understanding” of roles and responsibilities each stakeholder has in relation to provision of safe and equitable health-care.\(^59\)

Furthermore, there is growing evidence that besides decreasing physicians’ ability to provide effective care, corruption in the health-care causes a decrease in the health status of the most vulnerable groups, by increasing inequality and impoverishing populations.\(^60\) Therefore, corruption in the health-care “has spill over effects on the macro-economy.”\(^61\) Frequently, health-care providers engage in “entrepreneurial activity” by abusing and taking

\(^58\) Ibid, Mužić
\(^61\) Ibid, WHO/Europe
advantage of public health-care supplies and patients, “rather than [establishing] their own clinics and mechanisms for recruiting patients.”

As suggested, tackling corruption in the health-care is a complex procedure, which requires an “effective system of auditing and accountability” that will reveal and scrutinize corruptive behavior. Such a system needs to be transparent and “scrupulously enforced” by enforcing patients’ rights, by ensuring complaints are heard and acted upon, as well as ensuring public access to how the public health-care sector is “funded and regulated.” Besides ensuring transparency of public procurements, regulated by NHIF in the case of Serbia, more pressure needs to be put on pharmaceutical companies to implement anti-corruptive practices.

Other issues

The interviewees agreed that there is an underlying factor responsible for most situations of violence against health-care personnel, which is the current state of livelihood in Serbia. Each interviewee pointed out that the low standard of living and years of conflict have demoralized Serbian society. Media plays an important factor in disseminating sensational and romanticized news about current state of affairs, which in turn intensifies people’s temperament. As noted by an interviewee, the health-care sector is one of the rare places, where one does not have to pay for anything. You come, you wait, you get a diagnosis and you get treated free of charge. Thus, it comes easy to relinquish all your anger and frustration on a health-care worker.

Next, as the interviewee #7 pointed out, there is no law protecting a health-care worker against an attack or unfounded suspicion. The interviewee argued that the media takes advantage of the present situation, by criticizing medical workers on a regular basis, and

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62 Ibid, WHO/Europe
63 Ibid
64 Ibid
66 Ibid
further causing marginalization of health-care professionals. As noted by the HCiD, manager of a health-care facility needs to be well equipped to deal with media interlocutors, in order to reduce the safety risk on the patients and the medical personnel (Recommendation 7). Developing a proactive media strategy, as suggested in the Pretoria workshop is important in creating a healthy image of health-care providers. Thus, besides making sure that media outlets are respectful of confidentiality and ethical code, the medical personnel similarly needs to use local media outlets to share information to the general public and increase tolerance (Recommendation 9).

Next, many years of conflict have led to a rise in psychosis, depression and posttraumatic stress disorder (PTSD). Treating a psychological illness is a taboo subject in Serbian society. Over the years, crimes committed by psychologically unstable individuals have been increasing. One interviewee, who is an emergency doctor, had an incident while working a night shift. She reported going out to the field for an emergency, where she and her team needed to take care of a disabled woman with a serious illness, who they had treated several times before. While taking the woman out of the house, her husband who is a war veteran took a shotgun and fired at the health-care workers inside the ambulance car. The interviewee noted that such incidents happen throughout Serbia, and that they mirror the systematic lack of political, and social action on recognizing and treating mental illnesses.

The HCiD workshops do not address PTSD issues that arise in post conflict societies. Nevertheless, the interviewees described PTSD incidents as alarming, and constantly increasing. Being a post-conflict society, with thousands of refugees, Serbia is in need of a widespread education and treatment of mental illnesses. Treating veterans and war survivors is essential for any post-conflict society. Primary health-care providers need to develop screening procedures in order to recognize patients with PTSD symptoms and thereby promptly provide necessary physical and mental examinations. Behavior of people with PTSD can gravely affect the “patient-provider communication, impede compliance with treatment regimens, and generally, frustrate the practitioner.”

experiences of one member of the family spills over to their relatives, therefore a kind attitude can help mitigate some of the barriers people with PTSD and their relatives may encounter or feel when confronted with health-care personnel. Working with trauma survivors is a complex task, which involves educating health-care staff on “interpersonal boundary problems” and on certain “aspects of the medical setting that may trigger trauma-related symptoms.” One of the ways by which a physician can overcome interpersonal barriers caused by PTSD is through dialogue, by being well organized, and by respecting patient’s needs.

As noted many times throughout this paper, there is no immediate cure or a solution to a problem of violence in the health-care system. A well-structured, contextualized policies addressing governmental regulations and managing individual behavior are needed. Small steps in educating people, followed by responsible media, and transparent government regulations will bring the desirable results in the long run.

69 Ibid, vi
70 Ibid, vi
Case Study: Brazil

Across the different types of violent incidents collected from interviews and from news reports, there were no attacks with the deliberate intent of interrupting the delivery of health care itself. Thus, it is possible to say from the outset that violent attacks in peacetime differ significantly from the violence that seeks to gain military advantage by disrupting medical assistance, which can be common in conflict\(^1\). Instead, findings from this section show that armed violence is surgical and targeted only against individuals within a facility. These events were, in the cases found, caused by personal grudges or supposed involvement in external criminal activities. Other, more frequent but less critical incidents, were rage attacks caused by frustration with long waiting times or with the service itself and outbursts caused by intoxication or by an altered psychological state conducive to violence.

Brazil’s Unified Health System (SUS) “is based on the principles of health as a citizen’s right and the state’s duty” and it seeks “to provide comprehensive, universal preventive and curative care”. Nevertheless, the system suffers from underfunding and its coverage across different regions of the country is uneven\(^71\). In 2015, a national poll asking participants to rate their trust in different public institutions gave the public health system (SUS) a rating of 33 out of 100\(^72\). This statistic is confirmed by the view of a resident doctor interviewed for this paper, who said that “[the population] arrives [at the hospital] with a certain degree of mistrust, being reserved towards the professional.”

\(^{71}\) Paim, Jairnilson; Travassos, Claudia; Almeida, Celia; Bahia, Ligia; Macinko, James, 2011, “The Brazilian health system: history, advances and challenges”, The Lancet, vol. 377, issue 9779, pp. 1778-97

Given the character of this research, however, this issue will not be directly addressed here. While there is a case to be made that deficiencies in the public health system may lead to violent incidents, the aim here is to tackle the problem at the level of health-care facilities.

According interviewee #10, “Brazilian health-care culture” is such that the population seeks hospital emergency departments as their primary choice for health-care, in the belief that they are better equipped and able to treat a broader variety of cases. There is a belief among patients, according to the interviewee, that they will end up receiving some form of treatment notwithstanding the long waiting times they may face. For that reason, the scope for the Brazilian case will specifically be hospitals, as opposed to other types of health facilities, as they experience a higher flux of people and therefore greater pressures on managing safety. Furthermore, while location, i.e. proximity to areas with high levels of violence, may influence the occurrence of violent incidents, the researchers were unable to account for that factor in a discriminate manner due to resource limitations.

Recent research tracing the profile of nursing in Brazil\textsuperscript{73} highlighted that 70% of nurses do not feel safe, while 19.6% say they have been victims of violence in the workplace (66% of which reported to have been victims of psychological violence). The report also underscores the lack of safety measures for nursing professionals, who are vulnerable to outbursts of violence, often in the form of verbal abuse, by a population frustrated with the health-care system. Professionals participating in the study reported that cursing followed by statements such as “I pay your wages” were common during the busiest shifts. Finally, the research pointed to the problem of sexual violence against female nurses\textsuperscript{74}, which is underreported by victims due to fear of reprisal and by managers because it computes as a work accident.

On the broader theme of urban violence, Interviewee #10 commented that violence was never directed against the health-care facility itself. Instead, they may suffer consequences of external dynamics such as stray bullets and individuals involved in shootings seeking refuge inside the facility. On the other hand, a research study\textsuperscript{75} conducted


\textsuperscript{74} As a sensitive subject however, the latter topic will not be addressed in this paper, as the researchers did not feel adequately trained to speak to health-care staff about their experiences with sexual violence.

\textsuperscript{75} Borge, Dorian; Cano, Ignacio; Cabral, Cristiane; Pinto, Alessandra, 2014, “O impacto da violência no acesso à saúde nas comunidades de baixa renda”, Humanitarian Action in Situations Other than War (HASOW), Discussion Paper 13, p. 2
in four *favelas* in Rio de Janeiro showed that only 10% of participants saw insecurity as a factor constraining access to health-care. The impact of violence was greater on the side of the offer of services. In the most violent *favela* surveyed, 31% of participants had heard of health-care professionals missing work and 34% had heard of temporary service interruptions due to insecurity. Finally, the research concluded that the sheer presence of “irregular armed groups” in itself did not suffice to cause such impacts on access or offer of services, but that the main factor was the level of armed violence. Armed violence against health-care in *favelas* is a topic worthy of inquiry, but it will not be addressed in this paper, as there is little public information available and access to interviewees is restricted.

**Waiting Times and Frustration**

While armed violence was present in the findings of this research, the most common types of incidents according to interviewees were outbursts of verbal violence caused by frustration with the service provided. This was identified as a routine issue in both interviews and media cases, and it confirms the findings of the Brazilian nursing report previously mentioned (Annex 3).

Interviewees converged in saying that verbal abuse is a common occurrence in situations where patients wait for long hours or when, already in a state of agitation, they demand to be treated first. Interviewee #9 mentioned that, during busy shifts, it would be common for patients to knock on his door to complain about the waiting. In

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76 Ibid.
one event, a patient in the waiting room kicked the office door and shouted that he had been waiting for eight hours. With time, the medical resident developed his own strategy to manage tensions during busy shifts.

He reported having had less turbulent shifts after adopting this stance, but insisted that this was his own way of working, and that no instruction was given, formally or informally, on how to manage such situations. Other medical residents were said to adopt similar strategies, while others still preferred to stay inside their rooms for the entire duration of their shifts, only opening the door to call patients inside. Furthermore, in the course of the research for this report, no official protocols or training for the management of such incidents were found (the interviewee had no knowledge of either). However, in the private hospitals he worked in, where there are normally comfortable seats and televisions in the waiting areas, and usually only up to two hours of waiting time, less incidents of that kind happened. In both private and public facilities, whenever a situation escalated, guards stationed in the hospital would be called.

Frustration with waiting times culminated in rage attacks in incidents #2 and #7 (Annex 3) found in media reports. In both cases, after 9 and 12 hours of waiting, respectively, attackers damaged the glass barrier separating hospital reception staff from patients, without physically hurting anyone. In each case, the aggressors spoke with staff or guards for repeated times, asking for information on the estimated waiting time or demanding to be treated before situations escalated. In incident #2, a patient involved explained to the media that the head nurse was impolite to her, impatiently replying, “we are only treating urgent cases”, in response to her question. In a second moment, the patient’s husband inquired a receptionist whether his wife would still be treated, but received the reply that there was nothing they could do. After that last attempt, he went on to hit the glass separating staff from patients. In incident #7, the patient argued with the hospital security guard before having the same reaction. Unfortunately, there was not detailed information about the latter case.

What both the findings from the interviews and the media reports highlight is the need to have personnel trained to manage pressures from individuals entering the facility (Recommendation 8). The training should enable responsible personnel to manage the
expectations of patients and relatives regarding waiting times in specific. The successful story of the medical resident (interviewee #9) highlights that transparency regarding the existing staffing and resource circumstances can help diffuse tensions between patients and healthcare staff. On the other hand, the less communicative approaches seen in incidents #2 and #7, where the patient is not provided with an explanation, are seen to increase tension. Furthermore, a question that needs to be considered in these two incidents is whether the glass separating staff and patients served as protection or whether it contributed to exacerbating tensions by creating distance between them.

Rage attacks caused by frustration with the service itself or with the state of a relative were also found, including the case of outbursts by relatives after the death of a patient (incident #5) or after being barred from entering the infirmary after visiting hours (incident #1). While there was insufficient information to establish how the aggressors were handled by hospital staff, it was seen that property was damaged and one patient hurt (incident #1) before guards managed to contain the situation. This confirms the idea that staff need to be well prepared to deal with patients and relatives with approaches that prevent outbursts, especially in sensitive situations such as the loss of a relative.

Furthermore, the cases explored in this section suggest that guards should also be well prepared to manage pressures from patients and relatives, with whom they routinely interact as sources of information. As reported by interviewee #10, hospital guards often are central points of information about the service, telling the population whether certain staff were not working that day, for instance. From personal experience in Brazil, guards in most establishments such as banks and government buildings often taken on that same “extra” or “informal” role, to the extent one can suggest it has become part of “culture”.

Recommendation 11.3 suggests the use of guards in facilities, but it does not account – and neither do the workshop reports – for the informal roles played by guards. The recommendation could thus be supplemented by considering whether such roles should be encouraged, overlooked or discouraged, in light of the effect they have on security and perception. The perception of guards in Brazilian hospitals, according to interviewee #9, tends to be positive, especially in public hospitals that experience a high number of violent.
incidents. At the same time, in cases of rage and frustration with the service, the population may momentarily see guards not as individuals responsible for maintaining the appropriate flow of persons, but as individuals impeding access.

**Rage caused by factors other than the service**

Incidents in this category can be attributed to patients that were intoxicated or in any altered psychological state conducive to outbursts of violence e.g. psychotic breaks. This type of incident was the most common found in media reports and figured pre-eminently with interviewee #9. A running trend in these cases was the lack of early warning or prevention mechanisms and a delay in containing the aggressor.

While again mentioning the lack of relevant training, interviewee #9 mentioned that firefighters would sometimes drop this category of patient at the hospital and immediately leave. In this case, it is possible to suggest the need for preparedness and a standard procedure on how to deal with the arrivals of agitated patients or with the unexpected outbursts from patients already inside the facility.

Such details are not addressed in existing recommendations. In addition to the aforementioned, there could be consideration for appropriate communication between firefighters – or other actors performing the same role – and the facility receiving such persons, in order to make the necessary preparations for their arrival. The presence of a nurse specifically trained to contain and administer sedatives to such patients, for instance, could be included.
Treating convicts

Special categories of patients such as convicts need to be especially considered in the case of Brazil, as they are sometimes treated in public hospitals. The medical resident interviewed mentioned that he and his colleagues were at times required to treat adult female and juvenile convicts when working in public hospitals distant from the city center. He expressed his wish to have had received special instruction on how to treat that type of patient.

In one specific occasion, the interviewee treated a juvenile detainee with an open wound on his arm, who was accompanied by a police officer. During the suturing procedure, the officer remained inside the room and had the detainee’s good arm handcuffed to his. When the resident finished suturing the wound, he placed his scalpel on a surface next to the patient and turned on his back to reach for a piece of lint. Suddenly, the patient reached for the scalpel with his free arm but was stopped by an alert police officer before he could use it. After describing the scene, the interviewee asked: “How should I proceed? How should I position myself? Can I turn around? Can I look away? How should I position my surgery tools?”

The recommendations from the HCiD workshops do not cover the treatment of special categories of patients such as convicts, in a particular manner. In addition to the questions posed by the interviewee above, a recommendation addressing this theme could address the communication between law enforcement and hospital security and the number of officers needed to escort the patient, as well as the logistical preparation for the arrival, treatment, and departure of such patients in the hospital. Should the patient enter the facility through the main entrance? What impact would that have on patients who witness the entrance of a convict accompanied by police officers? Should officers be inside the room?

while the patient receives treatment and compromise medical confidentiality between the convict and staff?78

**Armed Entries**

Armed entries are a category of incident that may happen both in conflict and in peacetime. In three cases identified in Brazilian media, all aggressors entered the hospital alone (one of them had a getaway driver waiting outside) to target a specific patient inside the facility.

Three cases of armed entry were identified in media reports. In incident #9, a man attempted to shoot a patient in the infirmary of a hospital, having gained entry into the facility by claiming to be in urgent need of treatment. The news report further mentions that the aggressor claimed having had his documents stolen when asked for identification at the reception. The patient had previously been the victim of an attempted murder, and was being treated for the gunshot wounds from that same incident. This case strongly illustrates the need for immediate post-incident support to patients and staff. In the immediate aftermath of the shooting, a patient begun to shout criticizing the Brazilian president and the governor of the state. She then proceeded to break hospital property and attack staff, further aggravating the psychological effect of the incident on those around her.

Incident #10 is similar to the last one in that the victim was also recovering from an attempted murder when he was shot three times by a man who invaded the hospital. This time, the aggressor jumped the wall surrounding the facility and entered the infirmary through a window.

Incident #11 shows footage of a patient being forcefully removed from the hospital by her ex-husband, who later shot and killed her outside of the facility. In the process, the aggressor shoots an unarmed guard who is seen following him into the emergency department and attempting to reason with him. In all cases, the vulnerability of hospitals in

terms of access was highlighted as all aggressors managed to enter restricted areas with existing mechanisms to control fluxes, such as reception and unarmed guards.

Interviewee #9 explained that the picture in public hospitals where he worked was similar. While there were unarmed police officers subcontracted to the hospital itself, he commented that their response was often not timely and depended on external back-up when critical incidents occurred. Furthermore, access to restricted areas of hospitals was also pointed as a vulnerability. While staff were technically required to wear badges and show them to guards controlling the flux, the interviewee reported that it was common for him to cross these points without a badge.

These incidents highlight the need for proper control of flows of people inside the facility, which is directly covered in recommendation 14. This includes controlling the flow of persons entering the facility and moving within it by using security guards, and having a “No weapons” or “Weapons Free” zone. Additionally, as seen in the incident #10, there is a need to consider the vulnerabilities of the facility’s perimeters (recommendation 2), which can be used for furtive entry by criminals targeting someone inside.

Media

Issues about dealing with the media figured strongly in the interview with the resident doctor in Brasilia. In his view, the media contributes to constructing a discredited picture of doctors, who are seen as “[refusing] to work in the countryside, [refusing] to treat the poor; the doctor, he wants to be in urban areas, he wants to live a comfortable, healthy life”, according to interviewee #9. For that reason, the interviewee said he had never given any interviews to the media, and never would.

In June 2015, three hospitals in the Federal District reported an increase in the cases of the multi-resistant bacteria KPC. Interviewee #9 mentioned that, in its reporting, the media wrongly explained that the main cause for increased contamination was that healthcare staff did not wash their hands. The real cause, according to the interviewee, was the use

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of cheaper, less effective antibiotics leading to the proliferation of multi-resistant bacteria. Therefore, such media portrayal reinforces the mistrust the population has towards health-care personnel, which in turn contributes to cases of verbal abuse or rage attacks.

It must be added, however, that media relations in Brazil are not managed directly by the hospital but by the Secretaria de Saúde, the state-level public health body. The Secretaria can then make the pronouncement itself or authorize the media to speak directly with hospital managers or staff. While questions about transparency were raised by the interviewee when he spoke about this subject, we see here that recommendation #9 would then apply not as much to hospitals, but to the different state Secretarias. Furthermore, it could be suggested that the recommendation be amended to suggest media strategies that enhance the credibility of health-care staff.
Conclusion

The concluding remarks below are divided into the four broad themes of the Pretoria and Ottawa workshops mentioned in the introduction, and will be followed by suggestions on how to move forward.

Ensuring the functioning of health-care facilities

In and out of conflict, there are similar to identical management and organizational vulnerabilities addressed by ICRC HCiD study. The Pretoria and Ottawa reports illustrated several recommendations concerning the importance of contingency planning, organization, management of personnel, medical supplies and security procedures. As such, these recommendations tackle similar to identical organizational vulnerabilities healthcare facilities experience in conflict and in peacetime. The interviewees in both case studies, Serbia and Brazil addressed the need for better coordination among healthcare workers and management staff. However, it is the case of Serbia that thoroughly illustrates vulnerabilities arising in the lack of staff preparedness and coordination among major healthcare actors. On the contrary to Brazil, Serbia’s healthcare system has suffered greatly during the conflict, thereby the level of networking and harmonization between different stakeholders has decreased.

Concerning human resources and staff management, several HCiD recommendations were found pertinent for peacetime. In the case of Serbia, the lack of healthcare personnel and a lack of staff preparedness in dealing with security issues, were identified as serious vulnerabilities leading to security threats. In many situations as identified by the interviewees, the lack of medical staff on duty further increased tensions, which in some cases led to outbursts of verbal and physical violence. The HCiD recommends ensuring clarity of roles and tasks, managing risky behavior and maintaining neutrality so as to insure flexibility and adeptness to arising security threats (Recommendation 6). The interviewees in Serbia,
stressed that although financially constrained, health-care facilities should practice being more managerially and logistically proficient when it comes to managing staff on duty. This entails having well-organized working hours, coordinated day/night shifts, regulating amount of free days and providing non-financial incentives. Additionally, the importance of remaining impartial and detached from ethical, racial or minority issues carries equal significance in and out of conflict. In Southwestern Serbia, many hospitals need to manage patients coming in from diverse ethical or cultural backgrounds, thereby stressing the importance of adequate staff composition that reflects community’s structure (recommendation 12.1). Health-care facilities in multiethnic societies need to strive for a diverse staff composition complemented with well-defined roles and responsibilities.

In relation to preparedness and contingency planning, HCiD recommends “identifying and prioritizing threats, developing impact scenarios and checking these scenarios against the reality of the context” (Recommendation 1 and 13.1). In peacetime, such strong measures are not needed, however it is important to beware of potential ‘small scale’ threats and the chances of them occurring. In both Serbia and Brazil, night shifts are the most threatening. All the interviewees emphasized that during nighttime there are higher chances of dealing with intoxicated individuals, robberies, stressful parents and a lack of medical supplies. Therefore, health-care facilities in peacetime should develop impact scenarios based on previous experiences, public opinion, and on vulnerabilities of different social groups.

In the case of Serbia, the lack of medical supplies is a reoccurring issue. The HCiD recommends reviewing medical supply contracts with external partners so as to insure continuous flow of medical supply (recommendation 4.5). The HCiD also suggests reducing reliance on a single source (recommendation 10.3), however these may not be viable solutions in the case of Serbia. The NHIF in Serbia manages the flow of medical supply, and until structural and regulatory changes takes place in the public sector concerning public procurements, healthcare facilities will remain highly dependable on NHIF. However, there are supplementary techniques on how to manage to lack of medical supply. The HCiD recommends having minimum stock of medical supplies for emergencies (recommendation
4.3), therefore ensuring that, as in the case of Serbia when parents bring their child during night shift, they feel safe that their child will receive proper care.

Ensuring proper functioning of the healthcare facility also entails a controlled flow of individuals (Recommendation 2). During conflict such measures involve security screening, dealing specifically with vulnerable groups and managing the relationship between non-state and government actors. Peacetime entails a much lower security risk, however as noted in the case study of Brazil, unarmed security guards are necessary to control the flow of individuals into the health-care facility, so as to insure managing expectations and establishing procedures for certain patients (such as in the case of convicts). Controlling the flow of entry during peacetime does not necessitate establishing perimeters, having a minimum number of entrances or using control points to secure certain areas; it involves having a medical or nonmedical staff politely receiving patients, and practicing cue recognition in order to reduce instances of verbal or physical violence. Therefore, the essence of the recommendation #2 is relevant, however in order to fully apply to instances of violence against health-care in peacetime, it needs to be contextualized.

Regarding external and internal communication, HCiD stresses the significance of having continuous flow of communication among health-care staff and in relation with other stakeholders (Recommendation 3). Even in peacetime, various emergencies may arise such as the current refugee crisis in Serbia, thus underlining the necessity of open communication and the need for “situational awareness” so as to avoid isolation and manage the incoming flow of patients. However, such internal and external communication does not entail using VHS or satellite, but rather a better organization in sharing of information among health-care staff, access to Internet, telephone and email responsiveness.

Management issues do not solely depend on the good organizational skills of the health-care personnel. A lot of dilemma surrounding inefficient management of medical and nonmedical staff depends on the hospital’s financial capability. Most post-conflict and low-income countries experience a severe underfunding, which consequently stimulates a lack of organization and increase in corruptive behavior. As emphasized by the interviewees, living

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HCiD, 2014, p. 26
in a post-conflict society is a challenge. The lack of basic social services and general underfunding of the public health-care system stimulates people and health-care staff to engage in over the table practices. Nowadays, the healthcare system in Serbia has been significantly improved, however corruptive practices such as bribery have survived. A lot of incidences take place due to medical staff asking for money in exchange for treatment. Even in cases where medical staff is not engaged in dishonest practices, the public image of a corrupted health-care staff endures. Corruption is not solely a characteristic of peacetime – it takes place in conflict as well, and probably entails a much serious security risk. The interviewees noted that educating medical and nonmedical staff on acceptable and non-acceptable behavior and making hospital practices more transparent, such as well-defined procurement practices, could help improve health-care’s public image as well as deter health-care practitioners from bribery.

**Managing stress under pressure**

Most of the questions asked to the Pretoria workshop participants remain relevant in the cases studied in this paper, namely: how to manage stress and tension related to patients and relatives; how to manage disruptive armed entries; how to manage tension between different communities, in the case of Serbia specifically; and how to manage media pressures. Furthermore, findings from the research suggest additional questions, such as: how to manage intoxicated or mentally ill patients and how to manage the treatment of convicts, in the case of Brazil.

Brazil and Serbia facilities routinely face tensions from patients and relatives that sometimes escalate into verbal abuse or rage attacks. Transparent and communicative approaches by staff dealing directly with patients and relatives were seen to reduce the likelihood of outbursts. Often, patiently explaining that the facility is understaffed, in order to justify long waiting times, or providing a full account of a patient’s situation to relative can help diffuse tensions.

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81 Ibid, p.4
In some cases, long waiting times or lack of medicine was perceived by patients from ethnic minorities as a form of discrimination. In order to manage such tensions, it was suggested that staff be sensitive to ethnic differences and that, as outlined in Recommendation 12.1, staff recruitment should reflect the ethnic composition of communities. Incidents identified in this category amounted only to verbal abuse or cases of theft, but no serious cases of physical violence were identified. It was noted that time would have to heal ethnic tensions, and that the impartial delivery of health-care could contribute to that.

Instances of disruptive armed entries were identified in the case of Brazil. In these cases, unarmed guards were unable to prevent aggressors from acting or the control of flows of patients was inappropriate. Interviewee #9 reported that, in facilities experiencing a high number of incidents, patients expressed their wish that there were more guards present and that they were armed. The authors of this paper suggest that fact that guards in Brazilian public hospitals are often contracted police officers may contribute to more positive perception by the population. Finally, as illustrated in one media case, medical or psychological support to those witnessing a disruptive armed entry is important also to prevent subsequent outbursts by witnesses, especially patients and relatives who may have already been under stress before the incident.

Convicts are a category of patient in Brazilian public hospitals that deserves special attention. Interviewee #9 was threatened by a juvenile convict he was treating and reported never having had received relevant training on how to manage such situations. Therefore, additional recommendations on how to manage convicts as patients in times of peace would be useful in countries like Brazil. This could include training for staff treating convicts and standard procedures covering the entry, treatment, and exit of the patient from the facility.

Other special categories of patients are the mentally ill or the intoxicated. In Serbia, PTSD caused by past civil wars has been blamed for increased outbursts of violence, including against health-care staff, while social stigma prevent them from seeking treatment. At the same time, intoxicated patients in the Brazilian context are “dropped” by firemen at public hospitals, leaving staff to manage them. Rage attacks related to mental illness or
intoxication were also found in the case of Brazil, often resulting in damage to facility property and verbal abuse of staff. Given the high number of occurrences of such incidents, it is paramount that additional recommendations specifically targeting the management of mentally ill and intoxicated patients and relatives. This could include, for instance, training of staff on how to contain outbursts.

Finally, the paper identified pressures from the media in the form of portrayals that discredited the image of health-care staff. In the case of Serbia, media was said to highlight stories of corrupted surgeons, while in Brazil it picked up hospital contamination with multi-resistant bacteria, for which health-care staff who reportedly “did not wash their hands” were to blame. Both cases equally highlight the need for more proactive media strategies (Recommendation 9.1). This could include, for instance, providing comprehensive explanations about the problem of multi-resistant bacteria or communicating decisions taken after and disapproval of confirmed cases of corruption that capture the attention of the media. A more instructive recommendation on media for peacetime, in this sense, would have to focus on maintaining a good public image of health-care staff.

Physical security of health-care infrastructure

Either in conflict or in peacetime there are no sure means of fully protecting a healthcare facility. Types and severity of attacks differ across cases, e.g. health-care facilities in Syria mostly fear aerial bombardment, or in the case of Serbia and Brazil health-care facilities are prone to stress induced individual violence targeting medical staff. The HCiD report focuses on preventative physical protection measures such as controlling access to health-care (which entails training security guards on cue recognition), strengthening facility’s infrastructure, undergoing a safety assessment, creating a safe room and establishing perimeters.

For post-conflict countries, measures such as strengthening infrastructure, creating safe rooms or establishing parameters around a health-care facility may not be necessary. However, the dilemma of post-conflict societies lies in their ambiguity as to whether
peacebuilding was effective and whether one can easily dismiss the need for physical security. Serbia differs from Syria or Afghanistan, since its hospitals were not targeted during the war. The fragilities of health-care facilities in Serbia during war could be found in the lack of personnel, underfunding, lack of medical supplies and corruption. Following 25 years post-conflict, those same issues continually reoccurred in Serbia’s health-care system. Although the need for strengthening facility’s infrastructure may be unnecessary, in the case of Serbia, the interviewees acknowledged that robberies very often take place, thereby security guards and a surveillance system are fundamental. Additionally, in both case studies there were no attacks on the hospital itself, however in the case of Serbia, during night shift the medical staff kept the entrance to the emergency ambulance closed so as to prevent violent individual entries. Such action does not portray insecurities concerning hospital’s physical safety – but it does entail a concern regarding violent entries and ways by which hospital’s physical structure serves as a deterrent to violent individual outbursts.

Overall, the findings from this study do not identify physical insecurities of health-care facilities during peacetime. However, one must have in mind that different post-conflict societies are in different stages of reconciliation and statebuilding, hence physical security may be a vulnerability.

**Creating temporary safe solutions**

The findings from this research did not identify any instances of relocating of a facility, or parts of its service, to another location. Temporary disruptions in the service instead resulted in the temporary relocation to another sector within the facility itself. Interviewee #9 reported that these disruptions happened after accidents for which external police officers had to be brought inside the facility. In these situations, the service was relocated until the police investigation was concluded, but no standard operating procedures (SOPs) were known by the interviewee on the subject. In the case of Serbia, there were no instances of relocating or hiding a health-care facility.
The findings from Brazil suggest that the ICRC recommendations on this topic could be replaced by or complemented with measures to consider when relocating services within the facility itself. Types of incidents and threats identified throughout this paper were never so critical as to threaten to compromise the structure of a facility, but were in some cases sufficient to disrupt specific sectors for a short period of time. Potential recommendation could consider, for instance: the creation of SOPs for the relocation of a service; whether the threats identified in threat analyses had the potential to cause disruptions; and how to manage relations with the police in the aftermath of such incidents.

**How to move forward**

This report has provided insights into how recommendations for the safety of health-care facilities for times of conflict and other emergencies can be useful in times of peace. In initial conversations, the HCiD project contact for this research expressed their intention to move from quantitative and generalizing research to qualitative and in-depth inquiry into their problematic. Findings from this research project confirm the value in such shift. For example, while it was seen that incidents caused by frustration with waiting times were found in both cases, existing ethnic tensions in Serbia meant that is was perceived by patients as a sign of discrimination. The first suggestion therefore, is that HCiD should continue to issue qualitative, in-depth studies on the issue of health-care in danger.

As suggested in the paper, post-conflict societies differ amongst each other, in the longevity of the conflict, the level and extensity of deterioration and structure of the society. Therefore, international organizations employing different strategies to tackle post-conflict health-care systems need to strategize and contextualize their policies so as to address different cultural, social and economic variances among the post-conflict society itself. If not addressed, the organizational and management inconsistencies during peacetime will only deepen during conflict. While both case studies acknowledge management issues as a priority in discouraging violence in the health-care system, patients in Brazil and Serbia have different motivations for initiating verbal or physical attacks. Therefore, employing
abovementioned management techniques and recommendations should be balanced with cultural awareness. In general, it is important to conceive the role of national societies in educating medical and nonmedical staff on different techniques how to manage threatening situations and how to address vulnerabilities within the health-care facility.
Annex 1 – Standard Interview Questions

1. Can you explain what your current role is, and what type of activities you participate in, at [health facility]?

2. During your time at [health facility], have there been any violent attacks taking place within or in the perimeter of the facility?

3. What is the standard procedure in your health facility to prevent and address such violent attacks?

4. How did the facility staff deal with the incidents?

5. What measures do you believe were efficient?

6. What were the points in need of improvement?

7. [Serbia] How is stress related to the tension between different communities? Have there been attacks based on ethical, national or minority differences, and how were they handled?

8. What role does the media play?

9. [Looking at some of the recommendations related to persisting challenges faced in health facilities, ask the interviewee if he/she believes they would be useful]
Annex 2 – List of Interviewees

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Sex</th>
<th>Occupation</th>
<th>Health-care institutional level</th>
<th>Nationality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewee #1</td>
<td>Male</td>
<td>Advanced medical technician, working in ambulance, emergency room</td>
<td>Secondary health-care</td>
<td>Serbian</td>
</tr>
<tr>
<td>Interviewee #2</td>
<td>Male</td>
<td>Deputy director of a health-care clinic</td>
<td>Tertiary health-care</td>
<td>Serbian</td>
</tr>
<tr>
<td>Interviewee #3</td>
<td>Male</td>
<td>Lawyer</td>
<td>Tertiary health-care</td>
<td>Serbian</td>
</tr>
<tr>
<td>Interviewee #4</td>
<td>Female</td>
<td>Doctor, general medicine</td>
<td>Primary health-care</td>
<td>Bosnian refugee</td>
</tr>
<tr>
<td>Interviewee #5</td>
<td>Female</td>
<td>Emergency doctor, former head of the ambulance service for 14 years</td>
<td>Primary health-care</td>
<td>Serbian</td>
</tr>
<tr>
<td>Interviewee #6</td>
<td>Female</td>
<td>Nutritionist doctor</td>
<td>Secondary health-care</td>
<td>Kosovar refugee</td>
</tr>
<tr>
<td>Interviewee #7</td>
<td>Male</td>
<td>Pediatrician, former director of a primary health-care facility</td>
<td>Primary health-care</td>
<td>Kosovar refugee</td>
</tr>
<tr>
<td>Interviewee #8</td>
<td>Male</td>
<td>Emergency doctor</td>
<td>Primary health-care</td>
<td>Serbian</td>
</tr>
<tr>
<td>Interviewee #9</td>
<td>Male</td>
<td>Medical resident</td>
<td>NA (Serbia only)</td>
<td>Brazilian</td>
</tr>
<tr>
<td>Interviewee #10</td>
<td>Male</td>
<td>Humanitarian worker involved in projects around armed violence and health-care</td>
<td>NA (Serbia only)</td>
<td>Brazilian</td>
</tr>
</tbody>
</table>
### Annex 3 – Media reports of violent incidents in Brazilian hospital

<table>
<thead>
<tr>
<th>Incident #1</th>
<th>Rage</th>
<th>A relative was barred from entering the infirmary to see a patient outside of visiting hours. He had rage attack and hurt a patient after kicking a door.</th>
<th>Homem tem ataque de fúria no Hospital de Amargosa, fere senhora e acaba na delegacia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident #2</td>
<td>Rage</td>
<td>After his wife waited for 9 hours to be treated, a man repeatedly punched and broke an acrylic window at the service desk separating patients from hospital staff.</td>
<td>Homem espera 9 horas por atendimento em hospital, tem ataque de fúria e acaba preso</td>
</tr>
<tr>
<td>Incident #3</td>
<td>Rage</td>
<td>The patient broke windows with her hands, threatened and verbally abused hospital staff, then slit her wrists, hands, and feet. The hospital night watcher attempted to stop her, but failed.</td>
<td>Mulher é detida após quebrar vidraças de hospital em ataque de fúria</td>
</tr>
<tr>
<td>Incident #4</td>
<td>Rage</td>
<td>A patient who had just started being treated got up from the stretcher and proceeded to throw computers and office materials nearby on the ground.</td>
<td>Paciente tem ataque de fúria no maior hospital público de Goiás</td>
</tr>
<tr>
<td>Incident #5</td>
<td>Rage</td>
<td>A three-month baby died after delayed treatment at the hospital. The father had a rage attack, broke x-ray equipment, and damaged other hospital property.</td>
<td>Pai tem ataque de fúria em hospital ao saber da morte da filha</td>
</tr>
<tr>
<td>Incident #6</td>
<td>Rage</td>
<td>A patient, allegedly intoxicated, who wanted to be treated first than anyone else, had a rage attack after triage and returned to the reception to damage property (chairs were kicked). His sister, who was accompanying him, attacked one hospital staff member with her fists.</td>
<td>Paciente tem ataque de fúria em Hospital de Poço Fundo</td>
</tr>
<tr>
<td>Incident #7</td>
<td>Rage</td>
<td>After waiting for 12 hours to be treated, a patient argued with one of the hospital guards, then proceeded to grab a loose brick and throw it at the glass separating receptionists from patients.</td>
<td>Paciente depreda hospital público após esperar por 12 horas</td>
</tr>
<tr>
<td>Incident #8</td>
<td>Rage</td>
<td>Shortly after a shooting in the hospital (Incident #9 below), a patient started shouting, complaining about government. She broke windows with a broomstick, threw objects on</td>
<td>Video mostra momento em que mulher abaixa as calças durante ataque de fúria em hospital do DF</td>
</tr>
</tbody>
</table>

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83 Media sources call these incidents cases of “rage” but some of them may be defined otherwise or more precisely. We do not make such distinction, however, given the lack of sufficient information.
<table>
<thead>
<tr>
<th>Incident #9</th>
<th>Armed Entry</th>
<th>The victim had been in the hospital since the week before after being shot three times. The aggressor pretended to be patient and explained that he did not have any identification because he had been robbed. He then entered the infirmary, aimed at the victim from behind a glass window and shot ten times, without hitting anyone.</th>
<th>Homem invade hospital público do DF e atira dez vezes contra paciente</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident #10</td>
<td>Armed Entry</td>
<td>The victim was recovering from an attempted murder a few days before the incident. The aggressor jumped the wall surrounding the hospital and entered the facility through the infirmary window. He shot the patient three times, hitting the neck and the abdomen.</td>
<td>Urgente: homem invade Hospital Macrorregional e atira contra paciente</td>
</tr>
<tr>
<td>Incident #11</td>
<td>Armed Entry</td>
<td>The patient had been attacked by her ex-husband and went to the hospital after being told by the police she needed medical evidence to file a complaint. The ex-husband invaded the emergency room waiting area, closely followed by an unarmed guard, and grabbed the victim. The guard tries to reason with the aggressor but he is shot. The aggressor took the victim outside of the hospital and killed her with three shots.</td>
<td>Mulher é assassinada por ex diante de hospital; imagens registram ataque</td>
</tr>
</tbody>
</table>
Annex 4 – Relevant recommendations identified from Pretoria workshop

Overarching

• Recommendations should be guided by the impartial nature of health-care services;
• International and national advocacy against legislation that results in criminalising any type of health-care should be promoted;
• Security assessments should be carried out to guide the preparedness planning;
• Existing assessment tools should be used in the preparedness planning process;
• Baselines should be developed, subject to what is appropriate and feasible in a given context.

Structure

1. Structure Resilience
Managers of health-care facilities need to carry out an assessment of the health-care facility’s structural resilience in order to identify measures for protection. Existing assessment tools, such as the Hospital Safety Index could be used for this purpose.

2. Perimeters
Managers of health-care facilities need to manage access and control entries to facilities through perimeters surrounding the buildings, with measures that do not compromise a smooth and efficient access for patients, relatives and staff.
Overall perimeters should consider to:

2.1. Surround the health-care facility with appropriate protection between perimeter and facility;
2.2. Be restructured to have a minimum number of entrances;
2.3. Use control points at the entrance and throughout the hospital to protect certain areas;
2.4. Have adequate lighting.

3. Management of Infrastructure (Communication and Information)
Functioning communication and information management systems within a health-care facility are essential for the running of services and managers of health-care facilities need to

84 HCID, 2014, pp. 16-22
have back-up systems in place in case of breakdown in normal communication channels, subject to what is appropriate and feasible in a given context.

Measures to consider:

3.1. Internal communications: rely on wired telecommunications and VHS;
3.2. Switchboard powered through solar energy;
3.3. External communications: use VHS and satellite;
3.4. IT systems; ensure back-up systems are secured and create stand-alone system for critical information.

4. Management of Infrastructure (Medical Logistics)
Functioning medical logistics is essential in the provision of health care and managers of health-care facilities need to:

4.1. Ensure well-trained and professional staff in charge of logistics;
4.2. Ensure safe storage facilities for medical supplies;
4.3. Establish a level of minimum critical supply for the contingency stock;
4.4. Ensure stock supply of emergency health-care kits;
4.5. Make agreement with national authorities in relation to the importation of medical supplies which may grant exemption from standard procedures.

People

5. Personnel Training
Health-care personnel need to be prepared to tackle challenging working conditions in contexts prone to violence. Training components need to be included in the curriculum for medical students and opportunities for training to staff should be given in

5.1. Emergency preparedness;
5.2. Communication skills;
5.3. Dealing with interlocutors (including media);
5.4. Psychological first aid and self-care;
5.5. Management;
5.6. Fire-drilling;
5.7. Self-defence (in specific environment, particularly with reference to women).

6. Personnel Management
Managers of health-care facilities need to promote initiatives that contribute to viable working conditions in situations with changing demands and stress exposure to staff. Measures:

6.1. Ensure clear understanding of roles and responsibilities;
6.2. Provide training for staff, both medical and non-medical personnel;
6.3. Ensure regular breaks for staff;
6.4. Organize recreational team activities;
6.5. Emphasize non-material values to keep staff motivated;
6.6. Establish referral systems (psycho-social support) when needed;
6.7. Use international guidelines for reference material.

7. Patients
Managers of health-care facilities need to ensure that patients in their care are protected and respected while being sensitive to the risks that some patients can bring to the infrastructure.

Measures:
7.1. Ensure professional services (regardless of patient status);
7.2. Respect patient confidentiality, to the extent possible in the light of counterveiling legal duties to report certain information to authorities;

8. Relatives
Managers of health-care facilities need to ensure welcoming and cooperative environments for relatives of patients, with an understanding of their situation and an acknowledgement of potential tensions that may occur.

Measures:
8.1. Get relatives’ consent in cases of major surgical procedures (for example amputation);
8.2. Planning for relatives:
   – Limit the number of relatives into the facilities;
   – Create a waiting room;
   – Use relatives as resources in the context of providing health care;
   – Include social workers to provide emotional support to relatives;

8.3. Interaction with relatives:
   – Absorb their outburst, if any;
   – Be humble.

9. Media
Requests from media require managers of health-care facilities to be prepared to respond to journalists without compromising the impartial nature of health-care services.

Measures:
9.1. Develop a proactive media strategy;
9.2. Identify a spokesperson;
9.3. Issue press releases where possible/appropriate;
9.4. Maintain patient confidentiality to the extent possible;
9.5. Provide general information regarding number of patients and types of injuries rather than specific information revealing the identity and other personal information concerning individual patients;
9.6. Practice good communication and transparency to the extent possible.

Processes

10. Preparedness and Contingency plans
Primary focus in planning: Strengthen resilience within own hospital regarding functioning and structure. Secondary focus: Strengthen planning with other hospitals, especially those

11. Security of Health-Care Infrastructure
Managers of health-care facilities need to establish security procedures to reduce risks for human intrusion or disruptive armed entry.
Measures:
   11.1. Establish early warning systems in case of intrusion;
   11.2. Ensure that critical areas within the hospital are protected in the event of a disruptive armed entry;
   11.3. Consider use of guards;
   11.4. When appropriate, use cameras to monitor the facility;
11.5. Ensure adequate surge capacity for dealing with mass casualty situations, factor into the original design of the facility.
Annex 5 – Relevant recommendations identified from Ottawa workshop

12. Reference to Human Resources and Staff Management

12.1. To enhance acceptance in the community, transparency should be sought in the recruitment process; staff composition should be carefully considered, reflecting community structure, ethnical and cultural aspects, as well as gender and religious factors.

12.2. In the enhancement of security, while responsibility in the first instance lies with state authorities, engaging with the local community to build ownership through regular communication and interaction should be striven for.

12.3. Consider ethical issues or dilemmas: Should staff be sanctioned if they do not come to work because of security risks, lack of safety or fear of violence? Recognize institutional responsibility to provide staff training on risky behavior and maintaining neutrality, for example through guidelines and training on what behavior is expected inside and outside the facility in order to mitigate violence. Important that people are aware that some behavior has consequences and that equipment provided can bring risk.

13. Reference to Preparedness and Contingency Plan

13.1. Develop a review process for contingency planning which includes identifying and prioritizing threats, developing impact scenarios.

14. Reference to Accessibility of Infrastructure

14.1. Control flows of individuals coming into the facility: patients, families, friends, media, armed actors.

14.2. Be prepared to manage pressures from these individuals.

14.3. Controlled access: establish procedures for receiving patients outside of emergency room; organizing space.

14.4. Consider use of hospital security guards to manage this flow.

14.5. Be sensitive that measures you take to manage access are not perceived as barriers to access (e.g. use of armed guards is generally not recommended).

14.6. Consider adopting a “No weapons” or “Weapons free” policy within the health-care facility.

14.7. Consider training and appointing individuals for security screening and/or to deal with pressures and to manage expectations coming from others than patients.

14.8. Be sensitive to cultural factors and to reactions/consequences of response.

85 These recommendations were originally produced during the Ottawa workshop and amended during the Pretoria workshop. *Ibid*, pp. 24-29
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