



International
Hospital
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HCiD PROJECT: The safety of healthcare facilities

Sara Perazzi, MSc
Membership & Project Manager
International Hospital Federation

Kevin McNeil
Student at Providence University
Intern at the International Hospital Federation

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Contents

Introduction.....	3
Health care in Danger Project Defined.....	4
Safety of Healthcare Facilities	5
Ensuring the Preparedness and Safety of Healthcare Facilities	5
Prevention and Intervention Strategies.....	6
Challenges to Safety of Facilities and Potential Strategies	7
IHF Members Engagement	8
Brief Recommendations and Conclusion	12
References.....	14



Introduction

The humanitarian mission of the International Committee of the Red Cross (ICRC) “*is to protect the life and dignity of victims of armed conflict and violence*” (ICRC, The ICRC's mandate and mission, 2016). In light of its mission, the ICRC is committed to improving the safe provision of and access to health care. This, of course, entails working to improve the safety of healthcare facilities. In this framework the ICRC seeks to address one of the most urgent and critical humanitarian issues in times of conflict or other emergencies: violence against health care. Too frequently, during an armed conflict, health-care providers come under attack, patients are discriminated against, ambulances are held at checkpoints, medical supplies are looted and hospitals are targeted. This violence has grave direct and immediate consequences for its victims but also a critical impact on the entire health-care system. Hundreds of people may be deprived of this essential service.

The ICRC has launched the Health Care in Danger (HCiD) Initiative with the aim of addressing the phenomenon of violence against health-care services in countries affected by armed conflict. The initiative is enjoying broad support from within the International Red Cross and Red Crescent Movement and the health-care community. Given the complexity of this phenomenon, the HCiD Initiative encompasses a number of issues, including the formulation of recommendations to improve the physical safety of health-care facilities. (ICRC, Ensuring the Preparedness and Security of Health-Care Facilities in Armed Conflict and Other Emergencies, 2015).

The HCiD Initiative is built on three main pillars: to raise awareness of the problem, to mobilize a wide range of stakeholders (community of concern), and to identify, promote and consolidate good practices and national responses to violence (ICRC, HCiD Project, 2016).

The historical collaboration between the IHF and the ICRC is guided by the common goal of “*enhancing the health of the people in situation of conflict, emergencies and any other crisis that may put at risk the integrity of health service provision to all that need healthcare*” (IHF, 2015).

In October 2015, the IHF Governing Council members, having taken into consideration the Resolution “Health Care in Danger: Continuing to Protect the delivery of Health Care Together”, expressed their support of the HCiD Project’s aim to ensuring safe access to health care in armed conflict and other emergencies. This support has been formalized through the submission of a pledge on “Improve Safety of Health Facilities” (IHF, 2015).

This white paper aims to provide an overview of the HCiD Project and to describe the outcomes of the survey realized among IHF Members on the assessment of healthcare facilities' resilience.



Health care in Danger Project Defined

The Healthcare in Danger project is

“an initiative of the International Red Cross and Red Crescent Movement aimed at addressing the issue of violence against patients, health-care workers, facilities and vehicles, and ensuring safe access to, and delivery of health care in armed conflict and other emergencies” (ICRC, HCiD Project, 2016).

The need for healthcare increases in situations of armed conflict and violence, where harm and injury to people are likely to happen. Violence directed against health care services, when these are needed the most, has therefore a very critical knock-on effect. To ensure timely treatment of wounded and sick patients, it is essential that health-care personnel, facilities and medical transport are protected.

How does one address the acts of violence targeting healthcare facilities? In order to answer this question, the dynamics of violence itself must be analyzed. The particular acts of violence must be studied and understood by those seeking to implement appropriate measures in response. Based on the data-collection exercise, the ICRC has observed that *“violence [against health care facilities] includes bombing, shelling, looting, forced entry, shooting into, encircling or other forceful interference with the running of health-care facilities (such as depriving them of electricity and water)” (ICRC, The Issue, 2016).*

According to the World Health Organization (WHO), violence is *“the intentional use of physical force or power, threatened or actual, against oneself, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation” (WHO, 2014).*

The ICRC defines healthcare facilities as *“hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, and the medical and pharmaceutical stores of these facilities” (ICRC, The Issue, 2016).* All of these facilities must be protected to allow healthcare services to be effective and efficient. *“In today’s environment of shooting in public institutions, the risk has never been greater for hospitals” (Swift, 2014).*

In an effort to respond to the increasing magnitude of risks affecting the provision of healthcare, including violence against healthcare facilities, the ICRC is working in three areas, which are all unique but interconnected as well. These three areas, as mentioned above, are:

Public Awareness
Campaign

Mobilization of a Broad
Community of Concern

Consolidation and
Improvement of Field
Practices and National
Responses to Violence

The *public awareness campaign* aims to highlight the impact of violence on health care. The first step in making strides forward in any project is to first spread awareness of the issue. By spreading awareness of the issue, support can be gained for fighting against the problem.

Thus, the public awareness campaign also aims at *mobilizing a wide range of*



stakeholders to express their concerns for the issue. Local ownership is important as well; communities must express their support and implement strategies to combat violence affecting health care and healthcare facilities.

Actions at the local level lead to better *actions and practices at the national level*. There is a clear connectedness between the three initiatives. Awareness campaign and support at the local level allow to garner support on the national level, which in turn is crucial for the mobilization at the international level. One of the important practical measures in this regard is to ensure that governments strengthen domestic law on the protection of health-care personnel, facilities and medical transport (ICRC, *The Issue*, 2016). Strengthening domestic legislation is but one of the areas for action. The other five priority areas include (ICRC, *What can be done*, 2016):



Safety of Healthcare Facilities

Ensuring the Preparedness and Safety of Healthcare Facilities

The threat of violence and armed conflict in healthcare facilities is not necessary new. However, the incidence occurrence and the use of weapons is increasing on a daily basis, posing a higher threat to the protected status of healthcare facilities.

Hospitals and healthcare facilities are naturally supposed to be open to the public (Swift, 2014). One of the biggest issues that has been gaining more and more attention in recent years is the insufficient access to healthcare. There is a movement to expand access to care, yet at the same time there is a movement to make healthcare facilities more secure and more restrictive to open entries. The problem is that hospitals and other healthcare facilities physically are not meant to restrict or limit access to the majority of the building. They are rather meant to be welcoming and open to new patients, as their missions are usually to serve the public to create an overall healthier, happier community.

The other problem is the emotions of human beings are very much different in healthcare facilities than other places (Swift, 2014). Emotions of fear, anger, frustration, sadness, etc. often occur within healthcare facilities. The emotions invoked in subjects in healthcare facilities, often due to injury, soreness, sympathy, hopelessness, and other negativities, can easily lead to violence, whether intentional or not. The underlying factor of it



all is that healthcare facilities are naturally vulnerable to attacks and violence.

Though healthcare facilities are very susceptible to violence and other dangers, there is always a solution to problems. The key is prevention and intervention strategies.

Prevention and Intervention Strategies

According to the ICRC definition, violence against health care facilities includes different modalities of forceful interference with the running of health-care facilities such as bombing, shelling, etc. However, it is important to note that violence is not constrained or limited to these events. This definition notes what violence can include but there are multiple other incidents that can pose threats to the safety of healthcare facilities. The best way for prevention and intervention strategies to be developed is to first understand the reason and causality of the violence in the first place.

The ICRC conducted a research study on violence against healthcare in Karachi, Pakistan and its findings, published in 2015, shed light on potential reasons for violence in healthcare facilities. The study generated a report based on collections of data from hospitals, ambulance services, and non-governmental organizations. The report is comprehensive and evidence based on 822 questionnaires which were received and analyzed. The principal investigator, Professor Lubna Ansari Baig, and his team pointed out the most important and most prevalent reasons for violence against healthcare professionals and healthcare facilities:

Unreasonable
expectations

Unexpected
outcome

Communication
failure

Human error

Poor quality of service provided by the healthcare facilities, besides the low capacity of healthcare professionals, is also reported to have contributed to these violent incidents. The report has also pinpointed that a vast majority of the perpetrators of this violence were the patient's attendants (Lubna Ansari Baig, 2015).

It is extremely important to note that the vast majority of violence comes from the patient's attendants. The information of why and from whom violence is carried out is crucial to implement effective strategies that will successfully minimize future recurrences of violent incidents. Furthermore, it is important to know where and when the violence is occurring to have any hope of combatting it. The report indicated that 41.8% of violent incident occurred in Accidents and Emergency department, 39.4% occurred in emergency obstetrics, and 13.6% occurred in wards. The majority of such incidents were reported by public hospitals (Lubna Ansari Baig, 2015). As with any study it is important to consider the incidents that were not reported as well. This suggests a viable reason for hospitals and other healthcare facilities to make reporting incidents mandatory.

The Karachi report in conjunction with studies conducted in China, India, Bangladesh, Saudi Arabia, Kuwait, and Australia all report increasing incidents of violence. While studies indicate increasing incidents of violence, they provide positive and essential information that



point towards which intervention strategies can be developed and be effective. The first suggestion of the report is for effective administrative measures to be taken starting with improved communication skills of healthcare professionals to eliminate the communication gap between them and their patients (Jawaid, 2016).

The study sheds light that ordinary people, patients' attendants and visitors, are actually the most likely to initiate a violent incident. Therefore, prevention and intervention strategies must be aimed to reduce miscommunication between healthcare personnel and their patients as well as the patients' attendants (especially regarding decisions involved with patients' health). For prevention and intervention strategies to be effective, all areas of causality of violence must be covered.

Challenges to Safety of Facilities and Potential Strategies

While prevention and intervention strategies of reducing miscommunication between healthcare professionals, patients, and patient's attendants can and should reduce violent incidents, effective strategies need to be taken a step further. The actual infrastructure of healthcare facilities alone can be an essential aspect of reducing and minimizing violence in hospitals and other public health facilities. For healthcare to be safe, it must be accessed in a safe environment. In order to make healthcare facilities reside in a safe environment and to make patients feel safe, additional measures must be taken such as setting up:

“proper boundary walls with adequate security system and controlled exit points, allowing patients attendants only during visiting hours, posting experienced staff in Emergency, appointing liaison officer by healthcare facilities to speak to the media, banning entry of media to [healthcare facilities] without permission, improving the services, adequate explanation of likely complications of surgical procedures, avoiding negligence and giving 100% assurance of cure, avoiding over confidence by the [health care professionals], initiating self-monitoring of the healthcare professionals by the respective professional specialty organizations in collaboration with the institutions where they work and above all ensuring ethical medical practice.

ICRC report has also come up with useful recommendations for institutions, society at large, social reforms, role of stake holders like merit based culture, doing away with VIP culture, training of healthcare professionals, provision of adequate facilities, role of law enforcing agencies as well as professional bodies” (Jawaid, 2016).

Conducting studies to develop reasons for violence and constructing which measures will be effective in combatting this violence is only the first step. The challenge exists in the area of implementation of such measures and strategies. The ICRC and IHF must encourage all their members to push for support of implementation in their communities. Support and motivation is needed to face the challenge of uneasiness of change.

The first challenge to the safety of facilities as noted above is hospitals, by nature, are



supposed to be open and welcoming so measures such as boundary walls, advanced security systems, controlled entry and exit, restricted hours to visit, etc. may tarnish the image of healthcare facilities.

Another challenge is protecting the interests of both patients and healthcare professionals. The interests of patients should be a willingness to seek care in healthcare facilities and the interest of healthcare professionals should be to provide care for those seeking it. However, when violent incidents occur and the media portrays the breaking news, the interests of both patients and doctors can fade.

Additionally, there is a challenge to get government officials involved to initiate and implement new measures. The political agenda of government officials is very widespread and complex, but the fact of the matter is the safety of healthcare facilities is vital to human health and is a very eligible issue to be placed on the immediate political agenda.

Perhaps one of the ultimate challenges to the safety of healthcare facilities is innovative strategies and measures take a long time to be implemented, especially when funding for changes is limited. Jawaid suggests how to handle this challenge: “In many cases no additional funding is required but just ensuring judicious use of existing facilities and resources and administrative measures will go a long way in improving the situation to a great extent immediately while long term plans can be prepared and implemented later on” (Jawaid, 2016). The simple awareness of the danger involved in healthcare will contribute to a safer environment in anticipation for safety measures that are on their way.

IHF Members Engagement

The IHF pledge on “Improve safety of healthcare facilities¹” is based on two major commitments:

Increasing the
resilience of hospitals

Ensuring the protected
status of hospitals

To monitor the engagement of IHF members on the pledge, the IHF Secretariat has developed a short online survey, which was sent to 34 national hospitals and healthcare organizations from 29 countries.

We have received 12 valid answers from the following hospitals/organizations:

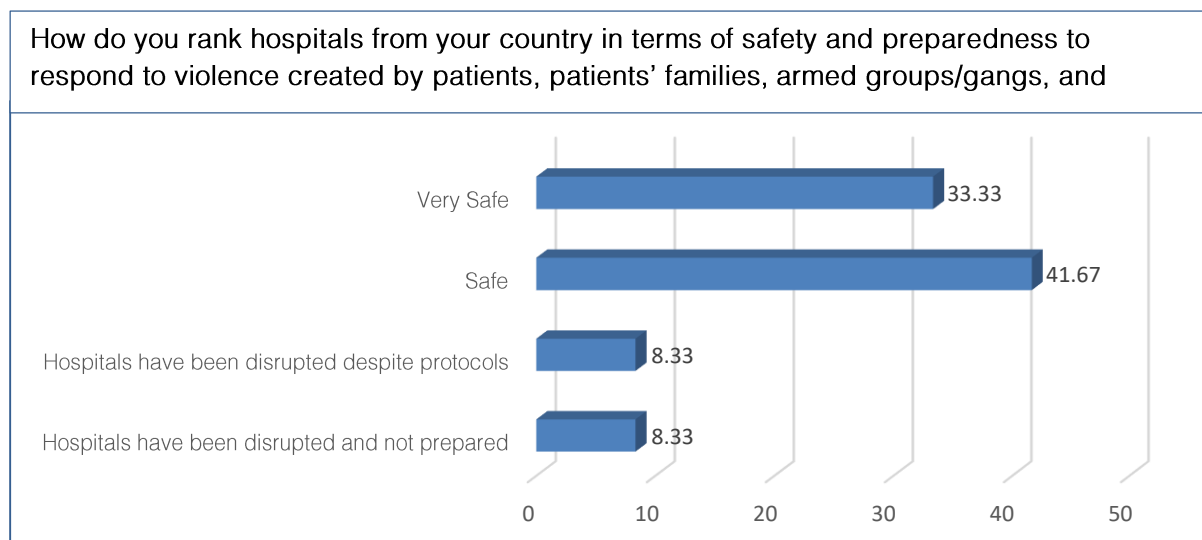
¹ Available at https://www.ihf-fih.org/download_doc_file.php?doc=a6237c0533de31bd96e5614373254d19.



Country	Hospital/Organization
Australia	Australian Healthcare and Hospital Association
Belgium	University Hospital Brussels
Brazil	Brazilian National Health Confederation
Colombia	Fundación Santa Fe de Bogotá
Finland	Hospital District of Helsinki and Uusimaa
France	CH ARPAJON
Hungary	Bajcsy-Zsilinszky Hospital
Norway	Norwegian Hospital and Health Service Association
Spain	Unió Catalana d'Hospitals
Switzerland	H+ The Swiss Hospitals
United Arab	Dubai Health Authority
United States	American Hospital Association

When asked if interested in being involved in the development of an index for safe assessment of healthcare facilities' resilience, respondent answered positively at 58 %. Those who expressed no interest in participating underlined a lack of competence in this field.

As can be noticed from the chart below, hospitals are mostly considered safe places (41.7%).



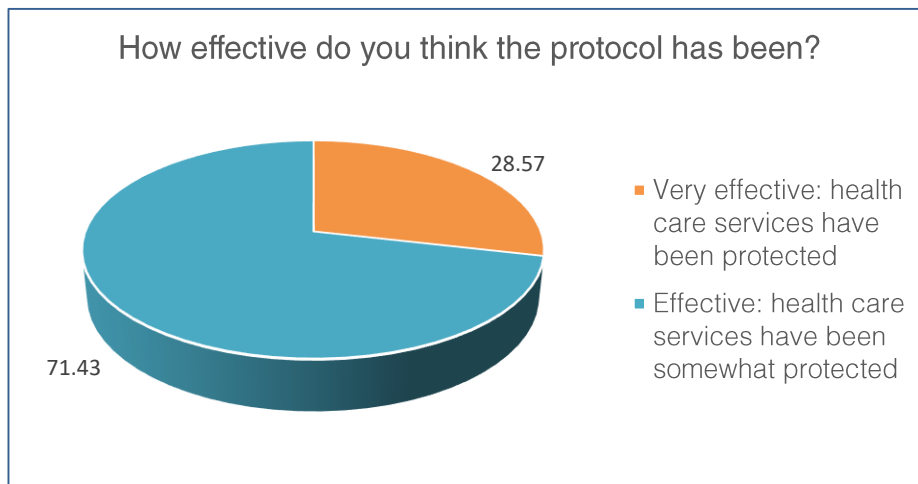
In Australia, Finland, Switzerland and United Arab Emirates, hospitals are considered very safe and prepared to resist all sources of violence to maintain protected status.

In Hungary, Belgium, France, Norway and Spain, hospitals are considered safe but preparedness to deal with violence is marginal and potential violence could pose a threat to the protected status of the hospital.

In USA hospitals have been disrupted by violence despite appropriate protocols in place to respond to acts of violence while in Brazil hospitals have been disrupted and are not prepared to face any acts of violence.

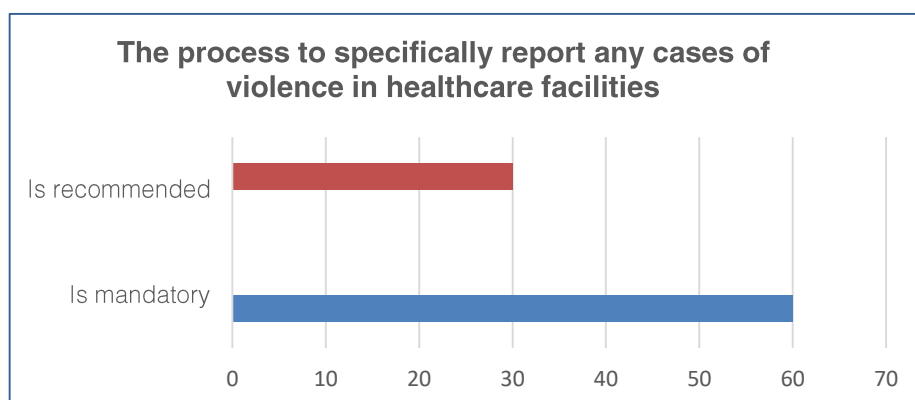
Colombia underlined the high diversification of hospitals situation and therefore the difficulty to assess hospitals safety and preparedness to respond to violence created by patients, patients' families, armed groups/gangs, and terrorists.

In seven countries out of ten there is a protocol in place to safeguard health-care services which is considered effective, although some improvements are required, in particular for major threats. The two remaining respondents are not aware about the existence of a protocol.



Almost 55% of respondents reported on cases of healthcare workers injured/killed by acts of violence occurred in the last 18 months. Two respondents reported on cases of patients injured/killed by acts of violence and threats to people in the facility by external group(s) creating a feeling of fear.

In nine out of twelve countries, there is a process to specifically report any cases of violence in healthcare facilities. This process is mandatory for the 60% of cases.



The principal safety measures in place in healthcare facilities are:

- Cameras and alarms - 92 %
- Accessible evacuation plan - 83 %
- Monitored public entrance (visible to security guards) - 75 %



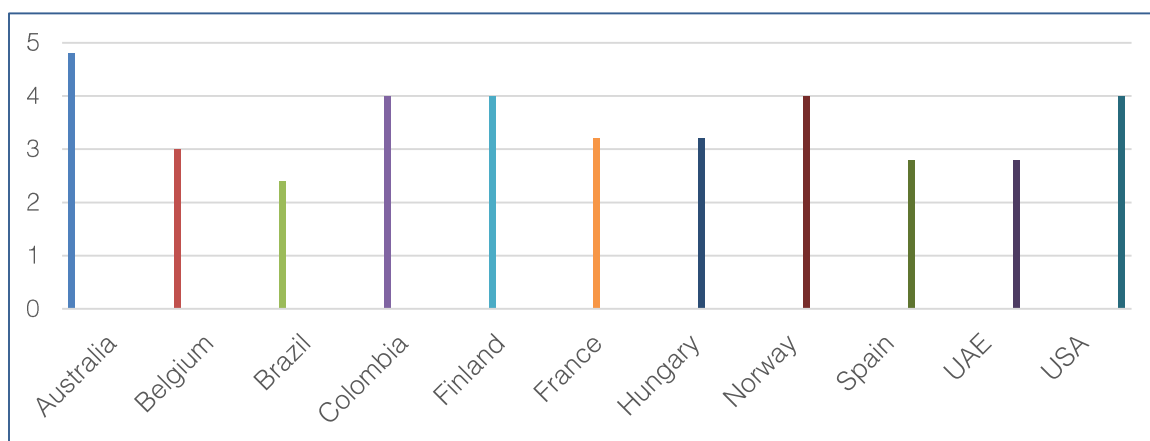
- d.Reinforcement of barriers and screening at entrances of critical areas inside the facility such as spaces containing equipment, people, and/or supplies - 50 %
- e.Guard-controlled entry points - 33 %
- f. Separated staff and public entrance - 25 %
- g.Perimeter fence and/or barrier closing 100% of the compound - 17 %
- h.Screening of people/vehicles entering the facility - 17 %
- i. Warning system of intrusion - 8 %
- j. Safe rooms (for cases of emergency) - 8 %

To ensure the safety of both themselves and patients in emergency situations against threats of all nature, healthcare personnel follow mandatory training sessions for 67 % of respondents. In USA and France is mostly done through voluntary training sessions and practice scenarios for those considered most exposed.

Finally, we have asked respondents to rate the overall level of security measures taken in the following categories in the midst of emergencies and violence (such as natural catastrophe, terrorist attack, etc.). Out of twelve respondents, only one skipped the question.

<i>R=respondent</i>	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	Average
The security and safety of the physical building itself	2	2	4	5	5	3	4	1	2	4	2	3
The safety of healthcare personnel treating patients	3	3	4	4	5	3	4	3	3	4	2	3,45
The safety of patients in the facility	4	4	4	4	5	3	4	4	3	4	3	4
Security of supply chain of medical supplies	4	1	4	4	4	3	4	1	3	4	3	3
The security of utilities to self-sustain for a period exceeding 2 days	3	5	4	3	5	4	4	5	3	4	2	3,82

The chart below shows the overall security (facility, personnel, patients, etc.) by country. The highest level of security is in Australia (average 4.8), followed by Colombia, Finland, Norway and USA. The lowest level is in Brazil (average 2.4).





Brief Recommendations and Conclusion

In light of the Health Care in Danger Project and recent studies, it is evident that some new measures and strategies need to be implemented in hospitals and other health care facilities. The first recommendation is to review the infrastructure of the facility itself: is it safe?

According to the ICRC, “The integrity of services provided in a health-care facility can only be protected if threats are addressed from a number of angles. It is necessary to understand the risks and vulnerabilities of the infrastructure and management of the health-care facility, and to have an appreciation of how a given situation may affect the health-care personnel and patients in their care” (ICRC, Ensuring the Preparedness and Security of Health-Care Facilities in Armed Conflict and Other Emergencies, 2015).

Healthcare facilities are complex buildings with complex operations being run inside them on a daily basis. Incidents of violence can arise on any given day from any given cause. Therefore, it is recommended to assess the safety-level by looking at the facility and its operations from all angles. In fact, the ICRC outlines 16 different angles that must be considered when determining the safety of a health care facility:

1. General information about the health facility;
2. Safe Hospitals Checklist to assess the level of safety of 145 items;
3. Safety Index;
4. Hospital safety levels help authorities to determine which facilities most urgently need interventions;
5. Location of the health facility and possible scenarios of armed conflict, civil unrest, terrorist attack, violence and crime;
6. Level of security of the perimeter of the health facility;
7. Level of security at the hospital entrance and of its internal circulation.
8. Existence of provisions for the circulation of ambulances, other vehicles, staff, patients and visitors;
9. Specific identification and permits for health-care personnel according to their areas of responsibility;
10. Identification of areas of restricted or limited access inside the health facility;
11. Safety standards regarding the location of the hospital’s emergency operations centre;
12. Security protocols and procedures for internal and external telecommunications;
13. Security against robbery and violence inside the health facility;
14. Protocols and procedures to prevent the kidnapping of patients and health-care workers;
15. Restrictions on the use of weapons inside the health facility;
16. Provisions to prevent, limit and respond to attacks on health-care workers inside and outside the health facility (ICRC, Ensuring the Preparedness and Security of Health-Care Facilities in Armed Conflict and Other Emergencies, 2015).

Referring to the recommendations above is the first step to restoration of the protected status of healthcare facilities worldwide.



The infrastructure of a healthcare facility itself can aid in creating a safe environment. In addition to infrastructure, protocol in response to violent incidents is very important. Lockdown procedures should be in place. Proper protocols to safe-guard healthcare services are essential in ensuring the safety of patients and healthcare personnel at any given point in time. In the case that a protocol does have to be used, it is recommended that these incidents are reported. Reported incidents can help define how issues are arising and help hospital managers assess what steps need to be taken.

Ongoing training for healthcare professionals is also recommended. The more trained the healthcare personnel is, there will be less miscommunication, which will lead to satisfied patients. Practice scenarios and mandatory training for how to avoid violent incidents and how to act in one can truly enhance the ability of healthcare professionals to make healthcare facilities a safer place.

This research has provided important insights about the challenge for the healthcare sector to ensure that hospitals and healthcare facilities are safe. The outcome of the IHF survey gives an uneven picture of the level of hospitals and healthcare facilities safety.

Considering the IHF commitment to the HCiD project and the ongoing collaboration with the ICRC, the next step should be to further investigate IHF Members preparedness and collect first hand experiences to identify good practices.



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