MANAGING VIOLENCE IN HEALTH CARE SETTINGS

STUDENT HANDBOOK

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VIOLENCE AGAINST
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LIST OF ABBREVIATIONS

AIPH   APPNA Institute of Public Health

DSM   Diagnostic and Statistical Manual of Mental disorders

HC   Healthcare

HCF   Healthcare Facility

HCiD   Healthcare in danger

HCP   Healthcare professional

ICRC   International Committee of the Red Cross

IFRC   International Federation of the Red Cross

JPMC   Jinnah Postgraduate Medical Centre

PTSD   Post Traumatic Stress Disorder

SOP   Standard Operating procedure

WHO   World Health Organization

GLOSSARY OF TERMS USED IN THIS CURRICULUM

Assault/attack: Intentional behaviour that harms another person physically, including sexual assault.

Harassment: Any conduct based on age, disability, HIV status, domestic circumstances, sex, sexual orientation, gender reassignment, race, color, language, religion, political, trade union or other opinion or belief, national or social origin, association with a minority, property, birth or other status that is unreciprocated or unwanted and which affects the dignity of men and women at work.[1]

Health care: Prevention, diagnosis, treatment or control of diseases, injuries or disabilities, as well as measures ensuring the health of mothers and young children. The term also encompasses activities that ensure, or provide support for, access to these health care services for the wounded and sick; that is, activities such as searching for, collecting or transporting the wounded and sick or the administration of health care facilities.[2]

Health care personnel: All persons working in the area of health care. This includes:
- 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 of hospitals, or personnel working within 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 the armed forces.
- Personnel of health-oriented international and non-governmental organizations.
- First aiders.

Physical violence: The use of physical force against another person or group that results in physical, sexual or psychological harm. This includes, among others, beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching.
Threat: The promised use of physical force or power (i.e. psychological force) resulting in fear of physical, sexual, psychological harm or other negative consequences to the targeted individuals or groups.[3]

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1 Wiskow, C. Guidelines on Workplace Violence in the Health Sector – Comparison of major known national guidelines and strategies: United Kingdom, Australia, Sweden, USA. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper

2 International Committee of the Red Cross. Health Care in Danger. (2012). The responsibilities of health care personnel working in armed conflicts and other emergencies. ICRC

3 Krug, E. et al., eds. (2002). World Report on Violence and Health. Geneva: World Health Organization.

Threat: The promised use of physical force or power (i.e. psychological force) resulting in fear of physical, sexual, psychological harm or other negative consequences to the targeted individuals or groups.

Victim: Any person who is the object of act(s) of violence or violent behaviour(s) as described above.

Perpetrator: Any person who commits act(s) of violence or engages in violent behaviour(s) as described above.

Workplace: Any health care facility, whatever the size, location (urban or rural) and the type of service(s) provided, including major referral hospitals of large cities, regional and district hospitals, health care centers, clinics, community health posts, rehabilitation centers, long-term care facilities, general practitioners' offices, other independent health care professionals. In the case of services performed outside the health care facility, such as ambulance services or home care, any place where such services are performed will be considered a workplace.

Workplace violence: Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.[4]

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04 Adapted from ILO/ICN/WHO/PSI (2002).Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector

FOREWORD

Violence, both actual and threatened, during armed conflicts and other emergencies, as well as in peace time, against health care personnel and facilities and medical transports is widespread and on the rise globally. It affects individuals, families and communities. It is probably one of the most serious humanitarian issues before us; the number of people affected by it and the effects on chronic and acute needs warrant this conclusion. Yet it remains largely unrecognized.[5]

Health care personnel who work in the midst of crisis are subject to considerable physical and emotional stress from a number of different sources. It is therefore important to prepare the health care personnel as to what measures to take to prevent violence from happening inside the health care facility, how to deal with violent situations and dissipate the various triggers of violence. There is also a need to increase the awareness on the issue of violence both among the general public and the health care professionals themselves. Civil society organizations, academics, health professional associations and individual health care providers and their well-wishers all need to work together to stop the violence and minimize its consequences.

The International Committee of the Red Cross (ICRC), within the framework of its global project Health Care in Danger (HCiD), seeks to improve the protection of all health care personnel from violence through humanitarian diplomacy, advocacy, the promotion of law and practical interventions.

The recent study on violence against health care conducted in Karachi[6] as well as other studies conducted in other parts of the world stresses the importance of training to enhance the capacity of health care personnel to handle violent situations and to be able to diffuse and decrease tension in potentially violent situations. In the violence study conducted in Karachi, it was recommended that elements of such training should be incorporated in the curriculum of students and training opportunities should be organized.

This student handbook and the accompanying training is a part of the curriculum that has been developed in light of the findings of the above mentioned study with a focus on increasing the awareness of students, house officers and residents of the health care professions in health care institutions in Karachi with respect to violence, its types, its effects and the methods to dissipate/manage it when it happens. It also includes a brief description of the rights and responsibilities of health care personnel in situations of violence and discusses

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5 Health Care in Danger Experts' Workshop: Ensuring the safety of health care facilities. Pretoria, South Africa, April 8-10, 2014. Jointly organized by the Department of International Relations and Cooperation (DIRCO), Republic of South Africa and the International Committee of the Red Cross (ICRC)

6 International Committee of the Red Cross (2015), Violence against health care: results from a multi-center study in Karachi. Health Care in Danger Project, ICRC

some actions that need to be taken at the institutional level to decrease the occurrence of violence.

Teaching institutions are encouraged to incorporate this subject matter into their curricula and are welcome to use the manual in its entirety or adapt parts of this manual for this purpose.

OVERVIEW OF THE CURRICULUM

Violence is a common feature of mega-city landscapes, and health care providers (HCPs) are not immune to it. This creates hindrances to the delivery of health care to the sick and needy. In many contexts, the safe delivery of health care services is challenged by the lack of respect for health care personnel who face insults, threats and violence. Consequences include the disruption of health services, a high staff turnover in health facilities, high levels of stress impacting the quality of the services and health care personnel being forced to flee.

This curriculum has been developed based on the needs identified by the study carried out in Karachi as a part of the Health Care in Danger (HCiD) project of the International Committee of the Red Cross (ICRC) by the APPNA Institute of Public Health (AIPH) at the Jinnah Sindh Medical University (JSMU) in collaboration with Jinnah Postgraduate Medical Centre and other medical institutions. It was emphasized that the undergraduate students, house officers and residents should be aware of the causes and impacts of violence in healthcare settings and should have the capacity to identify triggers of violence, prevent potentially violent situations and deal with such situations when they do happen. In addition, they should be able to ensure their own, their institutions' and their families' safety at all times while being aware of their own rights and responsibilities, institutional policies and procedures as well as relevant legal protection that is available.

Every effort has been made to make the curriculum contextually relevant. Consultations with stakeholders including students, service providers and academicians have helped in enriching the material presented and in making it contextually relevant. The findings of other studies and manuals developed by the ICRC, WHO and OSHA have also informed the development of this curriculum.

The handbook is supplemented by training programs for medical and nursing students, house officers and residents. The objective of the training is help health care professionals build skills to respond appropriately to situations of violence and harassment directed towards them and the health care facilities. It provides information that should be readily available to all health care providers for preventing, de-escalating and managing violent situations that arise in the course of health delivery.

GOALS & OBJECTIVES

This curriculum aims at addressing important aspects of preventing and managing violence in health care, and the training has been designed with a focus on adult learning principles and is to be delivered using participatory learning approaches and interactive strategies.

The goal of the curriculum is to enhance the knowledge and skills of the health care personnel to decrease the number of incidents of violence that occur within different health care facilities.

The objectives of the curriculum are that by the end of the training the participants should be able to:
1. Demonstrate an understanding of the background and rationale of the training in light of the findings of the research on violence against health care conducted in Karachi.
2. Demonstrate an understanding of violence in health care settings.
    a. Discuss types of violence and its effect on health care professionals.
    b. Identify factors that could lead to violence in different health care settings.
3. Recognize the role of communication in health care.
4. Demonstrate strategies to dissipate violent situations.
    a. Recognize warning signs that have the potential of flaring into a violent situation.
    b. Instituting strategies to prevent violence from erupting.
    c. Demonstrate strategies for de-escalating stress and tension.
5. Discuss post-traumatic stress disorder and learn various strategies to deal with it.
6. Discuss the rights and responsibilities of HCP vis-à-vis violence.
7. Identify measures for improved safety of staff, patients and the facility.

The curriculum is structured around the five modules listed below:
Module 1: Understanding violence, its types and consequences on HCPs (This includes an introduction to the Health Care in Danger Project and the research on violence against health care conducted in Karachi)
Module 2: De-escalating violent situations
Module 3: Importance of communication in health care
Module 4: Stress and Post-Traumatic Stress Disorder
Module 5: Rights and responsibilities of HCPs

TRAINING SCHEDULE

Module	Topic	Purpose	Duration
	Introduction of trainers and participants, and ground rules		10min
	Pre-training assessment (Pre-Test)		10min
1	Introduction to the Health Care in Danger Project and the research on Violence against Health Care study conducted in Karachi	Understand the rationale for the training, involve participants and create contextual relevance	20min
	Understanding violence, its types and consequences on HCP	Discuss types of violence and the effects on HCP	20min
2	De-escalating violent situations	Identify warning signs in a situation with a potential to turn violent; Demonstrate behaviors that are helpful in preventing violence; Suggest ways of dealing with situations that have become violent	50min
3	Importance of communication in health care	Realize the role of communication and demonstration of compassion in preventing violent situations; Demonstration of breaking bad news in health care settings	50min
4	Stress and Post Traumatic Stress Disorder (PTSD)	To develop an understanding about one's own mental processes in a time of threat and to recover from PTSD associated with violence in healthcare	20min
5	Rights and responsibilities of health care providers	Awareness of the rights and responsibilities of health care providers in situations of conflict or violence; Increased awareness of local laws and steps to take in difficult situations; Suggest policies and standard protocols to improve the safety of staff, patients and the facility	20min
	Summarization of key learning points, Feedback and Post-test		40min
	Total Time		**240min**

Adil Shahryar-MT/ICRC

MODULE 1
UNDERSTANDING VIOLENCE, ITS TYPES, CAUSES & EFFECTS

MODULE 1: UNDERSTANDING VIOLENCE, ITS TYPES, CAUSES & EFFECTS

Learning Objectives

By the end of the module the students will:

- Have developed an understanding of the role of the ICRC and the HCiD project;
- Have been introduced to the research findings regarding violence against health care;
- Be able to discuss types of violence in health care settings;
- Identify factors that lead to violence in different health care settings;
- Be able to discuss the effect of violence on health care professionals.

Session Outline

No.	Topic	Content	Time
1	Introducing the training, ICRC and Health Care in Danger Project	Explaining the concept behind Health Care in Danger	10 min
2	Introduction to the Health Care in Danger Project and the Research on Violence against health care conducted in Karachi	Develop an understanding of the people's perceptions regarding causes of violence; Explaining the setting, respondents and main findings of the study	
3	Define Violence	Understand the different concepts of violence	5 min
4	Types of Violence in health care settings	Identify the types of violence reported in health care settings	10 min
5	Causes of violence in healthcare settings	Discuss the causes of violence and categorize the factors that instigate violence in health care settings	10 min
6	Summarize	Group understanding of HCiD challenges and the issues at stake	5 min
Total Module Time			**40 min**

Introduction

Workplace violence has become a global problem in crossing borders, work settings and occupational groups; it has dramatically gained momentum in recent years to the extent that it is now a priority concern in both industrialized and developing countries.[7] Workplace violence affects the dignity of people; it is considered a major source of inequality, discrimination, stigmatization and conflict at the workplace. At the same time, workplace violence is increasingly appearing as a serious, sometimes lethal threat to the efficiency and success of organizations.

Violence causes immediate and often long-term disruption to interpersonal relationships, the organization of work and the overall working environment. While workplace violence affects practically all sectors and all categories of workers, the health care sector is at a major risk. Violence in this sector may constitute almost a quarter of all violence at work.[8]

The negative consequences of such widespread violence heavily impact the delivery of health care services which could lead to deterioration in the quality of care provided and the decision by health workers to leave the health care profession. This, in turn, can result in a reduction in health services available to the general population and an increase in health costs. In developing countries in particular, equal access to primary health care will be threatened if health workers, who are already a scarce resource, abandon their profession because of the threat of violence.[9]

It has been estimated in a number of reliable studies that stress and violence together possibly account for approximately 30% of the overall costs of ill-health and accidents. Based on the above figures, it has been suggested that stress/violence may account for approximately 0.5 –3.5% of the GDP per year.[10] This evidence clearly indicates that workplace violence is far too high and that interventions are urgently needed. Health care personnel working in insecure environments may find it particularly challenging to identify and discharge their responsibilities precisely when it is most difficult to think clearly about these responsibilities. They may have to think about their rights for the first time; they may even be unaware of what these rights are.

The International Committee of the Red Cross (ICRC)

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect

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07 International Labour Office/International Council of Nurses/World Health Organization/Public Services International Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva, International Labour Office, 2002 ISBN 92-2-113446-6

08 Nordin, H. (1995). Occupational Injury Information System, Swedish Board of Occupational Safety and Health

09 International Labour Office/International Council of Nurses/World Health Organization/Public Services International Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva, International Labour Office, 2002 ISBN 92-2-113446-6

10 Hoel, H.; Sparks, K.; Cooper, C. (2000). The cost of violence and stress at work and the benefits of a violence and stress- free working environment, University of Manchester Institute of Science and Technology, http://www.ilo.org/public/english/protection/safework/whpwb/econo/costs.pdf

the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.[11] The ICRC also endeavors to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles.

The ICRC engages with all stakeholders including governments, law enforcement authorities and armed forces, to improve legal frameworks and institutionalize successful approaches through international humanitarian diplomacy, expert workshops and operational engagement at national level in countries where it works. It realizes that it is, however, the engagement of local medical communities that can bring lasting solutions to each country's specific problems.

The Health Care in Danger Project
In November 2011, the 31st International Conference of the Red Cross and Red Crescent asked the ICRC to initiate consultations with international experts, the International Red Cross and Red Crescent Movement and others in the health care sector with the intention to make the delivery of health care services in armed conflicts and other emergencies safer and to report to the 32nd International Conference in 2015 on the progress made.

The Health Care in Danger project, which was launched in support of this objective, focuses on the illegal and sometimes violent acts that impede or prevent the delivery of health care. It also focuses on attacks, discrimination, armed entry into protected facilities, illegal obstructions, and so on as well as their consequences for the wounded and sick, healthcare facilities and personnel, and medical transports.[12]

The Health Care 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 situations affected by the presence of violence. Providing an overview for the participants on the Health Care in Danger project can take many forms, and it is up to the facilitator to introduce this the way she or he deems most effective.

Multi-Center Study on Violence Against Health Care in Karachi
The International Committee of the Red Cross (ICRC), within the framework of its

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11 International Committee of the Red Cross.(2011).Violence and the use of force. ICRC
12 Norwegian Red Cross Training Manual on Interpersonal Violence Prevention and Stress Management in Health Care Facilities. ICRC

global project Health Care in Danger (HCiD), seeks to improve the protection of medical personnel from violence through humanitarian diplomacy, advocacy, the promotion of law and practical interventions. In order to pave the way for improving the safety of health care professionals, facilities and ambulance services and hence also the patients, the ICRC, in collaboration with the APPNA Institute of Public Health at Jinnah Sindh Medical University, Karachi, conducted a research study on violence against health care from January 2015 to August 2015.[13] The objectives of the study were to identify different types of violence and assess the perception, tolerance threshold and impact of violence on all types of stakeholders, thus contributing to the identification of policies to better protect health care from violence and its consequences.

Stakeholders included doctors, nurses, paramedics, security guards and other hospital staff, ambulance service drivers and staff, media and law enforcement agencies (CPLC, police and Rangers).

A mixed-method (quantitative-qualitative) study approach was used. A total of 822 questionnaires were collected through consecutive sampling, and 17 focus groups and 42 in-depth interviews were conducted. Analysis was carried out by a team of academics meticulously adhering to appropriate methodological rigors.

Almost two-thirds of the participants had either experienced or witnessed some kind of violence in the past year and one-third reported having experienced some form of violence. Verbal violence was experienced more than physical violence. More commonly experienced or witnessed forms included abusive language, pushing and pulling, threats, and use of sticks and feet. Multiple perpetrators were involved in almost half of the incidents. Patients' attendants were found to be the chief perpetrators, followed by unidentified persons. The emergency department and wards were the most common sites of violence.

The main reasons for violence included unreasonable expectations, communication failure, human error, unexpected outcomes and a perception of substandard care. The effects of violence included becoming overly alert, feeling hopeless, and having repeatedly disturbing memories about the incident. Two-thirds of the participants thought that the event could have been prevented. More than half of the affectees did not take any action against the attackers. Almost one-third considered it useless to report, while a few were afraid of the negative consequences of reporting the event. The majority were not aware of any specific institutional policy to deal with violence. More than half of the respondents were not aware of any significant changes that had taken place in the last two years to deal with violence in their organization. The presence of metal detectors, panic button and patient screening methods were only reported by slightly more than one third of the respondents.

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13 International Committee of the Red Cross (2015), Violence against health care: results from a multi-center study in Karachi. Health Care in Danger Project, ICRC.

Physicians, security staff and ambulance staff reported significantly higher frequencies of verbal violence as compared to other job positions. Security and ambulance staff were significantly more likely to report experiencing physical violence. In comparison to public-sector hospitals and ambulance services, private hospitals and NGOs were significantly less likely to report physical violence. Women were also significantly less likely to experience physical violence.

Qualitative interviews revealed that there was general acceptance of HCPs and ambulance staff for verbal and even minor forms of physical offence. Law enforcement agencies (LEA) personnel reported tolerance among doctors for paying extortion money. While the HCPs and ambulance staff complained of unreasonable behavior and expectations of attendants, poor facilities and high workload, the media and LEAs pointed to negligence in the behavior of HCPs, poor quality of services and low capacity of HCPs as contributing heavily to violent incidents. The deficiencies in preparedness to deal with violence included inadequate security staff, inadequate security facilities and a lack of training to manage violence by all stakeholders. HCPs and ambulance staff responded to violence mainly by counseling the attendants. Infrequently, in serious circumstances, FIRs were lodged and police help was sought.

Institutional recommendations included improvement in availability of facilities, improved clinical skills of HCPs, training of HCPs in communication skills, enhanced security facilities, restricted access of attendants inside the hospital, clear mechanisms of triage, and strict regulation of HCPs. Respondents also suggested societal reforms such as improving awareness of respect for HCPs in emergency situations, awareness of respect for the law, performance of LEAs, literacy rate, judicial system and reduction in political interference in institutions. The importance of giving way to ambulances and respecting ambulance staff was emphasized by most of the stakeholders. Respondents emphasized the importance of media when it came to playing a positive role in raising awareness and accurately reporting on healthcare issues.

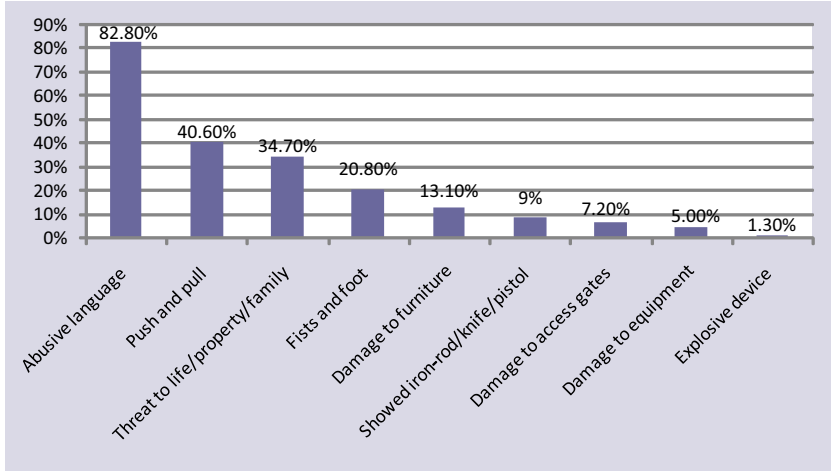**Figure 1.1 Predominant Nature of Violence Experienced or Witnessed (n=542)**

Figure 1.2 Chief Perpetrators in the Violent Events Experienced/Witnessed (n=542)
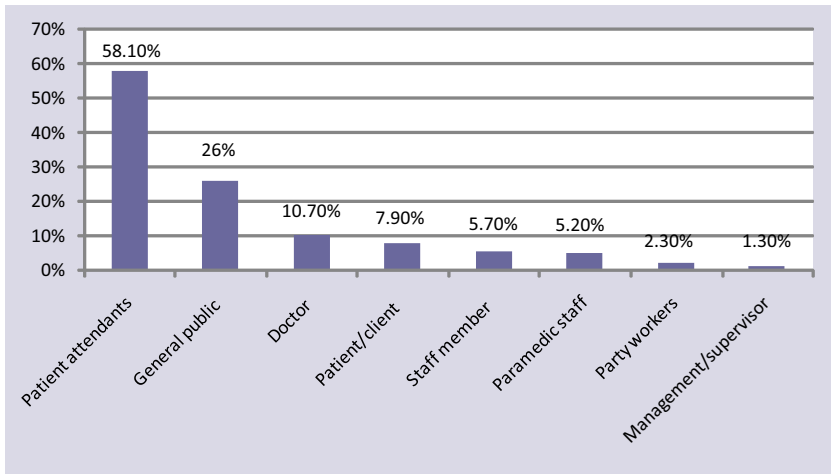
Figure 1.3 Predominant Factors that Played a Role in the Development of an Incident (n=542)
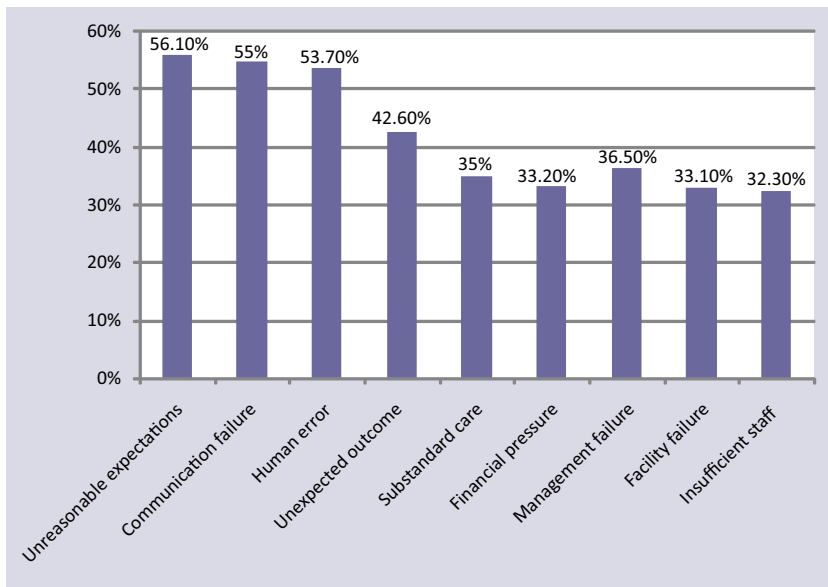

Figure 1.4 Predominant Effect of Violence on Victim (n=549)
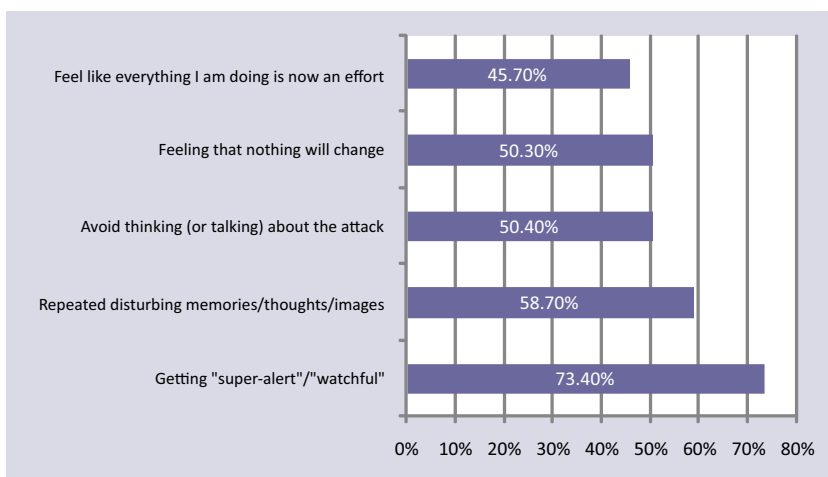
The above results indicate that health care providers work in an environment characterized by a multitude of conflicts and types of violence. In light of the findings, the study proposed a framework for a multi-pronged response to the complex problem of violence against HCPs. Projects were initiated focusing on designing interventions to decrease violence at multiple levels and the implementation of a zero tolerance policy for any kind of violence against health

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care. Skill-building for HCPs in communicating with patients, counseling patients and their relatives and improved security arrangements at the workplace have been undertaken. Awareness campaigns for emphasizing respect for doctors and laws will soon be initiated. A mass education campaign for giving way to ambulances has already been started. Planned efforts to promote improvements to the legal framework are also being initiated.

Types of Violence

Violence is most often rooted in the social, organizational, cultural and economic factors operating within a society, and, hence, dealing with it requires an integrated and holistic approach targeted at the root. It is also important to have a dialogue and discuss these matters openly with all stakeholders and devise a strategy in keeping with the specific social and cultural norms.

Proactive violence

A cold-blooded, pre-planned act of violence to gain some reward, e.g. a bomb blast, target killing. This is the least common type of violence in health care settings although the results of such occurrences are often severe. Preventing such violence can often be beyond the means of health care professionals and institutions.

Reactive violence

Emotional, angry, affective aggression to take revenge or to retaliate to provocation, carried out in anger, in frustration or in a heightened emotional state. This the most common type of violence experienced by health care personnel. This type of violence can be prevented by being sensitive to the needs of the patients and their attendants and by responding in a positive, polite and courteous manner.

Some aspects that need to be looked at while discussing violence are given below. However, these may not be comprehensive and can be expanded based on personal experiences and observations.

Health Care Facilities with a Higher Risk of Violence

While all kinds of health facilities are potentially exposed to workplace violence, some are at a higher risk than others. These include healthcare facilities that are:[14,15],

- Located in suburban, highly populated and high crime areas.
- Small and isolated.
- Understaffed.
- Working alone.
- Overcrowded, uncomfortable waiting rooms.
- Working with insufficient resources, including inappropriate equipment.
- Long waits for service.

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14 Centers for Disease Control and Prevention/NIOSH. (2002). Violence: Occupational hazards in hospitals (No. 2002-101): CDC: National Institute for Occupational Safety and Health.
15 ICRC (2015) Violence Against Health Care: results from a multi-centre study in Karachi.

- Functioning in a culture of tolerance or acceptance of violence.
- Working directly with volatile people, especially, if they are under the influence of drugs or alcohol or have a history of violence or certain psychotic diagnoses.
- Transporting patients.
- Inadequate security.
- Lack of staff training and policies for preventing and managing crises with potentially volatile patients.
- Access to firearms.
- Unrestricted movement of the public.
- Poorly lit corridors, rooms, parking lots, and other areas.

Factors that Often Lead to Violence in Health Care Settings
Appearances/attitudes/behaviors that may provoke violence can include:
- Being inexperienced.
- Display of unpleasant, irritating attitudes.
- Absence of coping skills.
- Wearing uniforms or name tags. Uniforms or name tags have proved to act both as a deterrent to and a trigger of workplace violence depending on the circumstances. Consequently, recourse to them and the way uniforms or name tags are used, is a matter that should be carefully assessed and decided upon according to the specific situation under consideration.

Potential Perpetrators and their Characteristics
The potential perpetrator could be a member of the public, of the organization where the incident occurred or of other organizations in the health sector or he/she could also be a patient or attendant. Consideration should be also given to the fact that, in a number of cases, perpetrators themselves are victims of violence.

Characteristics that may help in identifying perpetrators can include:
- A history of violent behaviour;
- A difficult childhood;
- Problems of psychotropic substance abuse, especially problematic is alcohol use
- Severe mental illness, the symptoms of which are not being adequately identified or controlled through therapeutic regimes;
- Access to firearms or objects that can be used as weapons.

Behaviors suggestive of a potential to become violent
- Aggressive/hostile postures and attitudes, e.g. hands on hips;
- Muscle tension;
- Alterations in tone of voice, raised voice, and sweating;
- Rapid and loud speech;
- Excessive hand gestures;
- Repeated manifestations of discontent, irritation or frustration;
- The escalation of signals and the building up of tense situations.

Potential Victims

Although all professions in the health sector are potentially at risk of workplace violence, some appear to be at special risk:

- Nursing and ambulance staff: at extremely high risk;
- Doctors, support and technical staff: at high risk;
- All other allied professionals: at risk;
- Members of ethnic or religious minorities;
- People in training, interns or temporary workers;
- Workers in unstable job situations;
- Young people;
- Women.

Situations that Place the Health Care Providers in an Unsafe Situation

- Working alone or in isolation;
- Increased exposure to the public;
- Working with objects of value (e.g. cashiers, persons dealing with dispensing/storage of drugs, etc.);
- Working with people in distress (e.g. HCP in ER/casualty, psychiatric unit, those working in substance abuse rehabilitation centres, etc.);
- Resource constrained settings (non-availability of essential medicines, diagnostic services or relevant healthcare providers).

Implications of Violence

Individual health care provider: The suffering and humiliation resulting from violence usually lead to a lack of motivation, loss of confidence and reduced self-esteem. If the situation persists, consequences such as physical illness, psychological disorders or tobacco, alcohol and drug abuse are often observed.

Health care facility: Violence causes immediate and often long-term disruption to interpersonal relationships, the organization of work and the overall working environment, usually leading to deterioration in the quality of service provided. Employers bear the direct cost of legal liabilities, work hindered by or unaccomplished due to violence or security issues and more expensive security measures. They are also likely to bear the indirect cost of reduced efficiency and productivity, deterioration in the quality of service provided, difficulty in recruiting or retaining qualified personnel, decline of the company image and a reduction in the number of clients.

Community: Violence may eventually result in unemployment, psychological and physical problems that adversely influence an individual's social position. The costs of violence include health care and long-term rehabilitation costs for the reintegration of victims and unemployment and retraining costs for victims who lose or leave their jobs as a result of such violence; there are also disability and invalidity costs where the working capacities of the victims are impaired by violence at work. Public access to quality health services is also threatened.

Adil Shahryar-MT/ICRC

MODULE 2

DE-ESCALATING
VIOLENCE IN HEALTH CARE

MODULE 2: DE-ESCALATING VIOLENCE IN HEALTH CARE

Learning Objectives

By the end of the session/module the students will be able to:
- Identify the warning signs of impending violence;
- Identify elements in given situations that lead to violence;
- Discuss strategies that would help de-escalate situations with a potential to become violent;
- Practice behaviors that would prevent violent situations from happening or aid in de-escalating them.

Session Outline

No.	Topic	Purpose	Time
1	Introduction to the module	Escalation and de-escalation occur in crisis situations. There should be a regular protocol to communicate with the attendants.	10 min
2	Warning signs of escalation	Critically analyze situations that became violent for causes; identify warning signs of escalation of tension.	20 min
3	Strategies for de-escalating a potentially violent situation	Understand and demonstrate strategies to de-escalate tense situations.	15 min
4	Summarizing	Give the participants time to write down their own patient protocol in groups of 4.	5 min
Total Module Time			**50 min**

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Introduction

In many instances when a situation is getting bitter, it simply takes a person who can perceive the situation and communicate with the concerned in a tactful manner to control it.[16] This requires a demonstration of understanding, compassion and empathy coupled with active listening and showing respect to the angry person. It is most important to have a high degree of sensitivity in such situations. Situations of reactive violence can be managed and taken care of by de-escalation techniques. For this, you need to be aware of signs of escalating emotions so that you may react in an appropriate manner for decreasing the tense situation.

Escalation: Build-up of a Situation Towards Aggression

Escalation happens because two people are in conflict and each person is trying to win an argument. Things escalate when someone are judgmental. When someone attacks you, your first response is to defend; this causes stress and an adrenaline rush. The aggressor is experiencing the exact same feelings. So there are two people who are dysregulated. If you remain calm, this would automatically lead to de-escalation.

Warning Signs of a Situation with a Potential to Become Violent
Early signs:
- Tensed body language (yours or the other person's)
- Moving very close (taking up personal space)
- Touching or grabbing to emphasize one's point
- Raised voice
- Rapid speech
- Excessive sweating
- Excessive hand gestures, e.g. balled fists, hands on the hips etc.

Tips for De-Escalating a Potentially Violent Situation:
- Give Attention: Receiving attention makes the other person feel he/she has been heard and understood, and this decreases stress. Demonstrate attention by:
- Directing all your faculties and senses towards a stimulus;
- Listening to what someone is saying, noticing physical gestures;
- Making frequent eye contact, as opposed to staring;
- Showing interest in what he/she has to tell you;
- Paraphrasing what you have heard;
- Reflecting back what you have noticed. e.g. "You look really stressed; please sit down."

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16 Health Care in Danger (2015) De-escalating and Managing Violence: Participants' handbook. ICRC

Empathize with the patient
Empathy encompasses:
• The ability to feel other's pain and happiness;
• Refraining from judgment;
• Perspective taking (seeing things from another's point of view);
• Recognizing emotion and communicating that (e.g. "You look really devastated.");
• Offering help rather than solutions (Instead of saying, "Stop crying," say, "How can I make you feel better?").

Signals of Aggression and De-Escalation Strategies
The first and only objective in de-escalation is to reduce the level of arousal so that discussion becomes possible. De-escalation techniques are counterintuitive. Our mind prepares the body to fight, flight or freeze when scared. However, in de-escalation, we can do none of these. We must appear centered and calm even when we are frightened. Therefore, these techniques must be practiced before they are needed so that they can become "second nature."

Strategies for De-escalating Potentially Violent Situations

Action of the Aggressor	Actions by the Health Care Provider
Frequent queries	Be polite, appear calm and composed giving the impression of attending their concerns seriously. Stand next to but not directly in front of the aggressor.
Shoulders squared and dominating	Avoid directly facing the agitated person and stand at an angle so as not to appear provocative.
Tight jaw with clenched teeth	Open hands to the aggressor.
Clenched fists or pointing fingers	Avoid concealed hands which implies a concealed weapon. Speak in a matter-of-fact and not threatening manner. Body language should also demonstrate empathy and concern.
Staring	Respond with broken eyes contact.
Assaulting private space	Maintain a comfortable distance from the aggressor. Give him/her the space but also give yourself the space needed to move should he/she strike.
Using offensiveness or	Do not be provocative; do not challenge or

cynicism	insult the aggressor or do anything else that may be perceived as insulting.
Shouting	Try to regain control by asking for information in a calm and peaceful manner.
Wandering	Establish a rapport with them and, using gentle instructions, ask him/her to sit down. Ask him/her to slow down so that you can pay full attention and help. Make them share their concerns calmly.
Hasty breathing	Demonstrate gestures that convey concern and compassion such as lightly touching the shoulders of the aggressor and asking him/her to sit down and breathe gently.
Abrupt or no reply	Demonstrate assertiveness with active listening skills. Engage the aggressor in a dialogue that will assure him/her that you care which, in turn, fosters de-escalation.

Tips for De-escalating a Verbal Discussion:
- Do not be defensive even if you have a point to defend by using phrases such as, "First let me explain to you. " (magar meri baat pehley sunien).
- Do not be reactive (phrases such as "Do you really think that you are more knowledgeable than me" - aapko mujh se behtar pata hai - are reactive in nature).
- Listen carefully; listening will give you the necessary time to regulate yourself, relax and focus on the situation. This will also help you understand the situation better. Once you understand the situation better, you feel more empowered to deal with it.
- Do not argue or try to convince another person even if you are right; remember, when someone is dysregulated (angry) he/she is in no position to learn, analyze, reflect or problem-solve.
- Find something in their narrative to agree with.
- When we are too focused on ourselves and getting our needs met, we can be aggressive.
- Reflect his/her feelings by saying, for example, "I see that you are getting really angry right now."
- Acknowledge that the agitated person(s) are frustrated and there might be something that is bothering them. This would help them feel heard and help them to regulate themselves. Because you are not attacking, they will perhaps not continue to defend either.
- Do not use sarcasm. For example, do not use phrases such as, "I do not think that you are so superior to others by any means that I should see you first ("aap nawab sahib hain kiya kea apka patient pehley dekhon?").
- Control your tone of voice. We tend to not notice when we raise our voices.

- Do not be judgmental. For example, do not use phrases such as, "Look at your way of talking. I feel it's totally inappropriate." ("aap zara apna bolney ka tareeqa dekhien").
- State consequences of rude behavior, if any, in a non-threatening manner.

Adil Shahryar-MT/ICRC

MODULE 3
THE IMPORTANCE OF EFFECTIVE COMMUNICATION IN HEALTH CARE

MODULE 3: THE IMPORTANCE OF EFFECTIVE COMMUNICATION IN HEALTH CARE

"Extensive research has shown that no matter how knowledgeable a clinician [health care provider] might be, if he or she is not able to open good communication with the patient, he or she may be of no help".[17]

Learning Objectives

By the end of the module the students will be able to:

*   Realize the importance of communication and professional behavior in averting/de-escalating violent situations;
*   Demonstrate effective communication skills with patients, health care teams and peers;
*   Demonstrate breaking bad news.

Session Outline

	Topic	Purpose	Time
1	Inform the participants about the session objectives; relate the overall objectives of the curriculum and share the schedule	Identify what will be taught, Schema formation	5 min
2	Role of communication in health care Tips for effective communication Normal protocol for communication	Discuss the importance of communication in health care Discuss normal communication protocol	15 min
3	Breaking bad news	Develop an understanding of the effect of bad news and the importance of breaking bad news in a compassionate and empathic manner	15 min

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17 Asnani MR. (2009). Patient-physician communication. West Indian Med J, 58(4):357-61

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4	Preventing situations from becoming violent	Critically analyze situations that became violent for causes and suggest measures so that such situations can be prevented	10 min
5	Summarize key learning points	Re-enforce the topics covered	5 min
Total Module Time			**50 min**

Introduction

Communication means being able to give people the information they need in a clear and concise manner and with the right attitude. Good communication leads to more satisfying interaction with colleagues, helps the health care professional to manage time better and makes him/her a more effective team member and leader. Patients' perceptions of the quality of the health care they receive are highly dependent on the quality of their interactions with their health care personnel.[18]   The connection that a patient feels with his or her health care provider can ultimately improve their health thereby mediating the patients' participation in their care, adherence to treatment and patient self-management.[19,20], Research indicates that communication challenges have a negative impact on:[21]

• Participation in preventive measures;
• Ability to obtain consent;
• Ability of health professionals to meet their ethical obligations;
• Quality of care, including hospital admissions, diagnostic testing, medical errors;
• Patient follow-up;
• Quality of mental health care;
• Patient safety;
• Patient (and attendant) satisfaction.

Learning to communicate effectively means making the most of every opportunity to interact with others: be positive and encouraging with the team, show empathy and concern for the patients, and be able to deal with demands and difficult emotions.

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18 Clark, P. A. (2003). Medical practices' sensitivity to patients' needs: Opportunities and practices for improvement, Journal of Ambulatory Care Management, 26(2), 110-123

19 Duffy, F. D., Gordon, G. H., Whelan, G., Cole-Kelly, K., & Frankel, R. (2004). Assessing competence in communication and interpersonal skills: The Kalamazoo II report. Academic Medicine, 79, 495-507.

20 Renzi, C., Abeni, D., Picardi, A., Agostini, E., Melchi, C. F., Pasquini, P., Prudu, P., & Braga, M. (2001). Factors associated with patient satisfaction with care among dermatological outpatients. British Journal of Dermatology, 145, 617-623

21 (http://santeipe.ca/wp-content/uploads/PositionPaper_FLHSN_EN.pdf)

Tips for Effective Communication

- **Use clear language:** Avoid jargon and tailor your language to the patients' understanding and information needs.

- **Be conscious of non-verbal communication:** It is important to maintain eye contact, reading notes or looking at the computer screen may convey negative messages.

- **Negotiate an agenda:** Ask patients what they expect from the health care provider and explain what can be done for condition of the patient with the resources available.

- **Establish a dialogue:** Determine whether your patient/attendant agrees with you, especially with respect to the diagnosis and management plan. Patients who disagree with the diagnosis probably won't adhere to the treatment.

- **Be flexible in your consultation style:** Tailor your approach to the individual patient. A more directive style may be appropriate for patients who want less involvement in decision making. A supportive style, e.g. listening attentively and asking questions about psychosocial issues, helps facilitate the disclosure of sensitive information.

- **Provide the information that patients want:** Doctors tend to talk too much about drug treatment, whereas patients want to know about causes and the likely diagnosis and prognosis. They want more openness about side effects and advice on how to relieve pain and emotional distress and what they can do for themselves. Providing this information helps their symptoms, reduces distress, improves physiological status and improves the quality of interaction.

- **Reflect on the outcomes of your interactions with others:** Why do some health care personnel work well and others not so well? Communication difficulties are one of the main reasons that patients complain about health care staff. The most common criticism is not about the doctors' competence but that they have failed to listen or to offer sufficient explanation.

- **Apologize when mistakes occur:** Apologizing and expressing regret at the suffering experienced by a patient is very highly appreciated and will convince the patient that you care.

- **Empathize and listen:** Empathy is the ability to understand what another person is experiencing and to communicate that understanding to the person. As the patient begins to relate his or her story, it is necessary to silence our own internal discussion, including the diagnostic reasoning process, which can interfere with our ability to listen.

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- **Mindful practice:** This is your ability to observe not only the patient but your own performance during the interaction as well because your conduct is easily identified by patients and colleagues.

- **Establish rapport:** Recognition and explicit acknowledgment of the emotional content in your patient's story is particularly important in establishing rapport. Do not dismiss or downplay their emotions.

Normal Protocol of Communication

It has been reported that, most often, violence is caused by the patients' attendants and not the patients themselves. Hence, when communicating with attendants make sure to:

1. Greet the patient and the attendant; then introduce yourself and what you do.
2. Tell attendants that you are going to talk to them right after you have examined the patient.
3. Be attentive and listen to the patient's history.
4. Verbalize what you have understood. For example, "So you have been having these symptoms off and on for 2 months."
5. Do not use medical jargon.
6. Examine the patient with respect and empathy. Maintain privacy when examining.
7. Give clear and adequate explanations to the patient and the attendant about the patient's condition.
8. Go through important information slowly; especially do not rush through negative information. If you have to repeat yourself, that is fine.
9. Tell them what treatment options are available.
10. Help them decide; do not decide for them right away. This will make them feel more empowered.
11. Keep the patients and their attendants in the loop regarding further management and prognosis.

BREAKING BAD NEWS

When asked the reason for violence in health care settings, many people opined that the person at the reception, nursing staff and doctors do not inform them about the situation of their patients and are very callous in their mannerism and talk. This is especially important in situations when patients cannot be revived and pass away because of they were brought too late or because of the seriousness of their condition. It is therefore important that health care providers are aware of the steps for breaking bad news. In this section, we will describe a five-step model for breaking bad news adapted from Buckman's six-step protocol'[22] for breaking bad news and will provide you an opportunity to practice this skill in a safe environment.

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22 Buckman R. Breaking Bad News: A Guide for Health Care Professionals. Baltimore: Johns Hopkins University Press, 1992:15.

Definition
"Information likely to drastically alter a patient's view of his or her future"
(Buckman, 1992)

"…situations where there is either a feeling of no hope, a threat to one's mental or physical well-being, a risk of upsetting an established lifestyle, or where the message given conveys fewer choices in his or her life…"

Effect
Hearing bad news results in a cognitive, behavioral or emotional impact that persists for some time after the news is received. The news may be perceived as bad from the perspective of the giver, the receiver, or both. While the perception of severity varies for each person, the impact of bad news cannot be estimated prior to determining the recipient's expectations and understanding.

> **How bad news is given is important**
> "…some unhappiness is caused by what the client is hearing, but dissatisfaction with the way they hear it is most commonly caused by:
> * The doctor not listening or not appearing to listen
> * The doctor using jargon
> * The doctor talking down to the patient."

The emotional reactions to traumatic news or events may take the form of any one or more of the feelings listed below:
Shock and disbelief
* Fear
* Sadness
* Helplessness
* Guilt
* Anger
* Shame

How to Break Bad News
It is important to prepare in advance prior to breaking bad news. The health care provider must obtain all relevant clinical information; mentally rehearse how the bad news will be given and think about specific words or phrases to use and to avoid.

Model for Breaking Bad News
Step 1: Setting up the meeting
* If the news is serious or the patient is dead, identify a sensible person among the available attendants and take him/her to a separate room.

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- Delay the delivery of bad news and first tell the attendant(s) to pray as the patient's condition is serious (even if the patient is dead). This will divert their attention and you will get time to organize security to be able to deal with the consequences. Arrange for important family members to be present; try to get a separate, private place (select a place with no access to sharp instruments or any hazardous material which can be used against you in case of escalation of aggression or violent behavior). Ideally you should have another health care team member with you (if that is not possible, let the other doctors / nurses / receptionist / guard know that you are imparting the bad news to the patient/attendant).
- In case of a high risk situation with a higher probability of reactive violence as a response to bad news, such as the death of a public figure / celebrity / politician or religious leader always call security forces / guards to the location before you break the bad news.
- Be respectful; use appropriate names, keep a comfortable distance, pay attention to your own body language, make eye contact. Be conscious of patient's / attendant' s body language and be watchful for signs of escalation of aggression or signs of violent behavior. Make sure that you are sitting/standing at a place with easy and safe access to an exit (so you will be able to take leave quickly if a patient / attendant becomes violent).
- Some examples to initiate the talk with are: "I'm sorry to have to tell you this"; "I know this is not good news for you"; "Unfortunately, I have some (unexpected) (bad) news to tell you"; "I'm sorry, but the test results are not what you were hoping for…"

Step 2: Discuss the patient`s /attendant`s understanding of the disease and its probable outcome
- Utilize your full concentration and listening skills to get to know their (patient/attendant) understanding of the situation. Let the patient/attendant know that you are trying to listen and that you are interested in what s/he thinks is going on.

- Keep on watching for signs of escalation or aggressive behavior, such as:
  1. Recurrent or frequent queries
  2. Shoulders squared and dominating
  3. Tight jaw with clenched teeth
  4. Clenched fist or pointing fingers
  5. Staring
  6. Assaulting personal space
  7. Using offensiveness or cynicism
  8. Shouting
  9. Wandering
  10. Hasty breathing
  11. Abrupt or NO reply

Step 3: Sharing the information
- Align the information that you are going to provide with what the patient or attendant already knows. This gives them the confidence that you have heard them and understand their concerns.
- While delivering bad news, make sure you use small sentences and pause frequently while talking. Do not use medical jargon and difficult words.
- Allow time for silence; this often means that the patient/attendant is thinking or feeling something which is bothering him/her (so be receptive to their concerns). Allow time for tears; offer tissues to convey the message that crying is allowed. Touch the shoulder/arm (if culturally appropriate) or move closer to imply that it is OK to show emotion.

Step 4: Identify and acknowledge the patient's reaction
- Offer realistic hope but avoid trying to be overly reassuring. Remember! "The success or failure of the breaking bad news ultimately depends on how the patient reacts and how you respond to those reactions and feelings."
- If the patient/attendant gets violent or tries to harm you, immediately exit the room (push the panic button or safety alarms if available).

Step 5: Demonstrate an understanding of the patient's/attendant's problems
Arrange for all possible help and assistance in the case the patient has not survived. Provide comfort, a place to sit, water, connect to an ambulance service and see if paper work can be moved quickly. At all times, demonstrate compassion and respect for their loss.

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MODULE 4
STRESS AND POST TRAUMATIC STRESS DISORDER

MODULE 4: STRESS AND POST TRAUMATIC STRESS DISORDER

Learning Objectives
By the end of the session the HCP should be able to:
- Identify signs and symptoms of stress and Post-Traumatic Stress Disorder (PTSD) resulting from violence;
- Identify effective recovery mechanisms and to manage PTSD.

Session Outline

	Topic	Purpose	Time
1	Introduction to stress and the body`s physical responses to stress	Defining stress; Identifying and explaining physical responses to traumatic events	10 min
2	Introduction to Post-Traumatic Stress Disorder (PTSD)	Defining PTSD and understanding common signs and symptoms of PTSD	
3	Introduction to Relational Trauma	Understanding Relational Trauma	5 min
4	Introduction to the body`s emotional response to stress	Identifying and explaining emotional reactions to traumatic events	10 min
5	Managing Traumatic Stress	Learning strategies for recovery from traumatic events	
6	Summary of module	Summarization of all topics with emphasis on key learning points	5 min
Total Time			**30 min**

Introduction to stress and the body`s physical response to stress

What is stress?
Stress is your body's way of responding to any kind of demand or threat.

"Fight or flight" stress response
- When you feel threatened, your nervous system responds by releasing a flood of stress hormones, including adrenaline and cortisol, which prepares the body for emergency action.

- Your heart pounds faster, muscles tighten, blood pressure rises, breath quickens, and your senses become sharper. These physical changes increase your strength and stamina, speed up your reaction time and enhance your focus.
- This is known as the "fight or flight" stress response and is your body's way of protecting you. When working properly, stress helps you stay focused, energetic, and alert. In emergency situations, stress can save your life — giving you extra strength to defend yourself or, for example, spurring you to slam on the brakes to avoid an accident.
- Critical thinking and judgment is impaired during situations of high stress, and higher mental processes (rational thinking, analysis) are hijacked by the limbic system (your emotional brain).
- When the threat has passed, the body tries to regain its natural balance. However, the excessive energy that is released in that situation stays in the body and later appears as symptoms of stress, PTSD, body aches/pains and, at times, chronic illnesses such as heart diseases and minimized functioning of the immune system due to prolonged stress. That is why most animals shrug their bodies once they have managed to avoid a threat.

> Trauma can get stored in your body;
> ## WHAT THE MIND FORGETS,
> ## THE BODY REMEMBERS
> Babette Rothschild

- If you look at the graph "Effects of Violence on HC Staff" (Fig. 1) again, you will notice classic symptoms of PTSD. These symptoms are also mentioned in the research study (Page 23, paragraph 2) when participants mention hopelessness and helplessness; these are classic examples of negative cognitions as a result of repeatedly experiencing traumatic events.

Introduction to Post Traumatic Stress Disorder (PTSD)

What is Post Traumatic Stress Disorder?
- **Trauma or traumatic stress:** Any psychological, emotional or physical distress experienced as a result of a traumatic effect, e.g. the failing of a normal coping mechanism, feeling overwhelmed (refer to figure 4.1).
- **Post-Traumatic Stress Disorder:** any physical, emotional, or psychological anxiety continued to be experienced after safety has resumed. (Please see the PTSD fact sheet attached for DSM symptoms.) Some symptoms include, but are not limited to, hyper arousal in the absence of threat, negative mood and cognitions, avoidance behavior, and re-experiencing.
- **Signs and symptoms of traumatic stress:** The symptoms of traumatic stress

can arise suddenly, gradually, or come and go over time. The most common signs and symptoms of traumatic stress are:
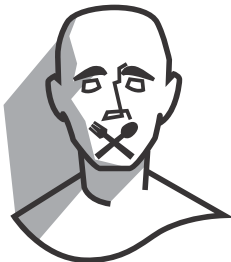
Figure 4.1 Effects of violence

Isolation   **Negative mood**   **Nightmares**

Change in appetite   **Avoidance of reminders of the incident**   **Alertness without threat**

- Mental and physical discomfort when reminded of the traumatic event
- Negative thought patterns
- Periodically occurring painful dreams
- Bad memories of the traumatic event
- Reduced interest or participation in significant activities
- Feeling disconnected from others or reality
- Prolonged psychological distress
- Sleep disturbances

Introduction to Relational Trauma

Relational Trauma
When your trauma is not understood by others, it can bring further distress. When people around you say things such as, "Oh, get over it already"; "This is part of your job"; "Why are you even bothered by what happened? Let it go," it makes you feel misunderstood and may lead to isolation and/or not sharing your feelings.

Emotional Reactions to Traumatic Events:
- Shock and disbelief
- Fear
- Sadness
- Helplessness
- Guilt
- Anger
- Shame
- Racing thoughts

After a traumatic experience, it's normal to feel frightened, sad, anxious, and disconnected. But if the distress doesn't fade and you feel stuck with a constant sense of danger and painful memories, you may be suffering from post-traumatic stress disorder (PTSD). It may seem like you'll never get over what happened or feel normal again. However, by seeking treatment, reaching out for support and developing new coping skills, you can overcome PTSD and move on with your life.

PTSD can affect those who personally experience the catastrophe, those who witness it and those who pick up the pieces afterwards, including emergency workers and law enforcement officers. It can even occur in the friends or family members of those who went through the actual trauma.

Managing Traumatic Stress

Tips for Recovering from Traumatic Events
Recovery Tip 1:
- Spend time with loved ones.
- Connect with other survivors of the traumatic event or disaster.
- Do "normal" things with other people, things that have nothing to do with the disaster.
- Participate in memorials, events, and other public rituals.
- Take advantage of existing support groups: your worship place, community organizations and tight-knit groups of family and friends.

Recovery Tip 2:
- Limit your media exposure to the disaster. Do not watch the news just before bed. Take a complete break if the coverage is making you feel overwhelmed.
- Information gathering is healthy, but try to avoid morbid preoccupation with distressing images and video clips. Read the newspaper or magazines rather than watching television.
- Protect yourself from seeing or hearing unnecessary reminders of the disaster or traumatic event.
- After viewing disaster coverage, talk with your loved ones about the footage and what you're feeling.

Recovery Tip 3:

- Give yourself time to heal and to mourn the losses you have experienced.
- Don't try to force the healing process.
- Be patient with the pace of recovery.
- Be prepared for difficult and volatile emotions.
- Allow yourself to feel whatever you're feeling without judgment or guilt.
- Talk to someone you trust about what you're feeling.

Recovery Tip 4:

- Do relaxing activities such as meditating, listening to soothing music, walking in a beautiful place or visualizing a favorite spot.
- Exercise (Trauma- and stress-releasing exercise is demonstrated in the video. Other forms of exercise are also helpful, such as a gym routine, running, yoga)
- Mindfulness training: to help strengthen the frontal lobe which helps regain judgment and composure; mindful eating is suggested as an exercise to practice.
- For example: When you take a bite of an apple, look at it first, be aware of the smell, the sensation of holding it in your hand, then biting into it, chewing it and then swallowing it. If you perform this entire process with attention and awareness, you are strengthening your frontal lobe, thereby protecting yourself against stress.
- Schedule time for activities that bring you joy such as, a favorite hobby or pastime, a chat with a cherished friend.
- Use your downtime to relax. Savor a good meal, read a bestseller, take a bath or enjoy an uplifting or funny movie.

Recovery Tip 5:

- Go to sleep and get up at the same time each day.
- Do something relaxing before bed, like listening to soothing music, reading a book, or meditating.
- Avoid products containing caffeine in the afternoon or evening, especially tea, coffee, Coca-Cola/Pepsi, etc.
- Get regular exercise, but not too close to bedtime.

MODULE 5
RIGHTS AND RESPONSIBILITIES OF HEALTH CARE PROVIDERS IN VIOLENT SITUATIONS

MODULE 5: RIGHTS AND RESPONSIBILITIES OF HEALTH CARE PROVIDERS IN VIOLENT SITUATIONS

Objective

By the end of the session the HCP should be able to:

1. Discuss his/her rights and responsibilities in violent situations.
2. Identify provisions available in the constitution of Pakistan to protect health care providers from acts of violence.
3. Discuss interventions for preventing violence that should be implemented at the institutional level.

Session Outline

	Topic	Purpose	Time
1	Introduction to the module	Understand the relationship of this module with the overall curriculum.	5 min
2	Rights and responsibilities in the face of violence	Discuss the rights and responsibilities of HCPs in situations of violence.	10 min
3	Legal provisions	Create awareness of the legal provisions in the Pakistani context (the Sindh Provincial Health Commission Act).	5 min
4	Institutional interventions to reduce instances of violence in health care	Suggest interventions and be able to advocate for the implementation of these interventions in the work place.	5 min
5	Summary	Consolidate what has been learned.	5 min
Total Module Time			**30 min**

Introduction

Health care providers have many responsibilities based on the principle of humanity; these responsibilities are mainly drawn from humanitarian laws, human rights laws and health care ethics. Some responsibilities are absolute: you must fulfil them. Others may be difficult to fulfil under certain circumstances: hence, you should if possible.

There are certain rights that health providers have in violent situations. These

include the right:
- To be respected and protected, as do the wounded and sick you are caring for.
- To demand that the authorities assist you in carrying out your work.
- To not be punished for discharging your responsibilities in accordance with accepted standards of health care.
- To not be compelled to act in a manner contrary to the law and/or health care ethics.
- To not be punished for disobeying an illegal or unethical order.
- To maintain your general well-being; you should do everything to ensure your own safety, not take unnecessary risks, get enough rest and know your limits.

Responsibilities of Health Care Providers[23]

You must in all circumstances:
- Not take undue risks while discharging your duties.
- Provide effective and impartial care for the wounded and sick without any distinction.
- Not take part in any act of hostility.
- Respect every wounded or sick person's wishes with confidence and dignity.
- Respect the right of a family to know the fate and whereabouts of a missing relative.
- Do everything within your power to prevent reprisals against the wounded and sick or against health care workers and facilities.
- Refuse to obey orders that are unlawful or that compel you to act contrary to health care ethics.

You should if possible:
- Reflect on and try to improve the standards of care appropriate to the situation.
- Report the unethical behaviour of colleagues to your superiors.
- Be identifiable as a health care provider and by means of a distinctive emblem if authorized to wear one.
- Keep adequate health care records.

The Provincial Health Commission Act of Sindh[24]
The following aspects of the Sindh Provincial Health Commission Act relate to harassment of health care providers:
- (7) The Commission shall take cognizance of any case of harassment of healthcare service provider or damage to healthcare establishment property and may refer such a case to the competent forum.

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23 David Lloyd Roberts, Staying Alive: Safety and Security Guidelines for Humanitarian Volunteers in Conflict Areas, ICRC, Geneva, 1999.
24 PROVINCIAL ASSEMBLY OF SINDH NOTIFICATION KARACHI, THE 20TH MARCH, 2014. NO.PAS/Legis-B-09/2013- The Sindh Healthcare Commission Bill, 2013 having been passed by the Provincial Assembly of Sindh on 24th February, 2014 and assented to by the Governor of Sindh on 19th March, 2014 is hereby published as an Act of the Legislature of Sindh. THE SINDH HEALTHCARE COMMISSION ACT, 2013 SINDH ACT NO. VII OF 2014

- (10) The Commission may authorize members of the staff to administer oaths and to attest various affidavits, affirmations or declarations, which shall be admitted in evidence in all proceedings under this Act without proof of the signature or seal or official character of such person.
- (13) The Commission shall frame the guidelines to save health service provider from harassment, undue pressure and damage to property in performing their professional duties.
- (14) The Security and protection while on duty of the Health Care Worker should be the responsibility of the organization availing their services.
- (15) The organizations, public or private, government, local, provincial or federal for which the doctors and Health Care Workers are working must provide them full protection, both physical and legal.
- (16) In case of physical injury incurred while performing the duties, the
  - o Doctors and health care workers should be fully compensated.
  - o Doctors and healthcare workers should have legal protection and in case of litigation, the administration must own the responsibility of legal cover and provide full financial and legal help accordingly.

Interventions to Reduce Instances of Violence in Health Care
Successful interventions to reduce and manage violence against health care workers will need to incorporate a multi-component, collaborative approach.[25],[26] ,Some proposed interventions are:
i) Developing an environment based on the culture of safety and dignity, non-discrimination, tolerance, equal opportunity and cooperation.
ii) Issuing an institutional policy that clearly states the following:
  - A definition of violence so that people know exactly what is being referred to.
  - A caution stating that no violent behavior or behavior intentionally generating violence will be tolerated.
  - Identification of individuals or teams responsible for the implementation of this policy.
  - Raising awareness among the management, health care staff, patients, clients, suppliers and local communities of the harmful effects of violence and of the advantages of undertaking immediate action to eliminate or reduce violence.
iii) Adequate presence of staff, in terms of number and qualification. This includes arranging an efficient system of triage and clear specifications for patients who will be dealt on priority.
iv) Provision of timely information to patients and their attendants in situations involving distress and long waiting periods.
v) Installation of alarm systems/panic buttons and surveillance cameras in potentially dangerous areas such as emergency departments, labor rooms, operation theaters, blood banks and laboratories.
vi) A reliable response system when an alarm is triggered.

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25 http://nursing.uc.edu/content/dam/nursing/docs/edviolence/Intervention.pdf
26 Rio de Janeiro, ICRC (2013) Building safer access: a guide for health care professional. ICRC

VIOLENCE AGAINST
HEALTH CARE MUST END

IT'S A
MATTER
OF LIFE
& DEATH

vii) The effective presence of guards is a deterrent to violence.

viii) Effective communication channels such as providing emergency codes so that staff can request help without having to explain the situation and, therefore, without alerting an assailant.

ix) Maintaining links with the local police to acquire up-to-date information on problem locations or patients known to be violent.

x) The staff should not be overworked; long working hours should be avoided.

xi) Training of health care providers to cope with workplace violence.

SUMMARIZATION OF KEY LEARNING POINTS, FEEDBACK AND POST-TEST (40 minutes)

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