**Healthy Communities Profile**

A UK-based NGO specialising in community health programmes and emergency medical care. The country office of HC is based in ***City, Country***, from where it is running its ***Neighbouring Country*** response.

Currently, HC has two clinics running in ***Regional*** governorate and a 15-bed trauma surgery clinic was recently set up in a house in ***City***. It includes an operating theatre, emergency department and resuscitation room. The clinics not only treat the war-wounded but also offer obstetric and other kinds of emergency care, as well as basic health services. As access to health services has worsened, HC has extended its activities to include basic healthcare, vaccinations and maternal care. At the end of the 2013, despite repeated requests, HC still had not received government permission to work in the country.

***Country Office City, Country***

The Incident Management Team (IMT) consists of:

Country Director: David Jones, is a British citizen who has been working with HC for 3 years and is accompanied by his wife and 2 children.

Senior Programme Manager and Security Focal Point: Anne Lenny, a UK citizen, has been in post for 10 weeks.

Human Resources: Adem Telek, from Istanbul and has had international experience with HC in Libya.

***Regional Field Office***

Most of the HC’s work in the region is coordinated from the HC Field Office. The ***City*** clinic has recently resumed running after a year of avoiding travel between ***City*** and ***City*** (***between the Field Office and a nearby city where the non-mobile clinic is located****)* where car-jacking and vehicle attacks were taking place. The programme resumed after a security review; there have been no reported attacks in the last three months.

Staff:

* Area Manager for HC Field Office: Ghayth Nahas, originally from ?? who has worked for HC since 2006.
* Assistant Area Manager for HC Field Office: Sadiq Kuzbari , originally from ?? and is new to HC.
* Logistics Manager: Mahmoud Al Qasem, originally from ??.
* Driver: Mohamed Ahmed Hussein, local from ??.
* Doctor: Dr Jamil Zogheib, originally from ??, but lives in ?? with his Syrian wife and their two children.
* Nurse: Elissar Helal, from ??.
* Nurse: Nour Khoury, from ??.
* Various other temporary and volunteer staff also work with the organisation in all three clinics.

***City clinic***

Staff include a managing doctor, a nurse, a health project officer and a driver. All staff are from the area.

**Healthy Communities, Security Assessment, *Field Country* Programme (given to participants)**

**Context Assessment**

There are a lot of armed groups operating in this area; all opposition groups are represented. The Islamic Front has a big presence; also present are Jabhat Al Nusra, ISIS and numerous FSA groups. There are several ongoing inter-group clashes at present and the area is prone to airstrikes from government forces. In recent weeks, car bombings have become more and more frequent and the general level of operational security in the area is tense and difficult. There is a major, ongoing smuggling operation in the areas where we operate which can at times cause insecurity, particularly at checkpoints inside ***Regional*** Governorate.

The overall increase in conflict and espcially random acts of violence such as car and suicide bombings has also caused the ***neighbouring*** authorities to tighten security. As a result delays are long and frequent at border corssings which can impeded access and egress into ***Field Country***.

**Programme Assessment**

Healthy Communities (HC) established a field office in ***Region***, with activities two mobile health clinics and more permanent, but temporary, clinic in ***City***. These are all currently operated by locally recruited staff:

Acceptance is generally good within the communities. But it is worth mentioning that such ‘acceptance’ does not seem to have much influence in regards to banditry and other criminal activities.

In recent months, donor concerns over programme quality and compliance issues have resulted in a security assessment. This assessment was commissioned to review the viability for staff being based in each area of operations and, ideally, for the regional mobile clinics to be able to travel within the directorate, and for ongoing road access between ***City*** and ***City***.

**Risk Assessment**

The main risks for staff in general are as follows:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Threat** | **Nature** | **Risk** | **Remarks** | **Recommended Mitigation Measures** |
| Ambush | Indirect | Moderate | Wrong Time/Place | Stay abreast of changes in road safety in the region |
| Carjacking | Direct | Moderate | ACGs | Use vehicles rented from local community |
| UXO/IED | Indirect | Moderate | Wrong Time/Place | Never be the first to use the road each day |
| Abduction | Direct | High | Expats | High profile, heavy armed security |
| Extortion | Direct | High | Checkpoints | Negotiate access with community elders |

**Current Standard Operating Procedures**

* Expat visits can be carried out only with updated security briefings in the ***Regional*** governorate and are not guaranteed of happening; ***City*** area is a higher risk due large presence of armed groups and bandits.
* The CMT in ***Country Office or HQ (at whatever level the crisis will be managed from)*** has a functioning Crisis Management Plan and has considered the scenario of an attack or abduction. This is an important mitigation measure as there is an ongoing possibility of criminal gangs or bandits doing both.
* Security training for all staff is planned but not yet completed