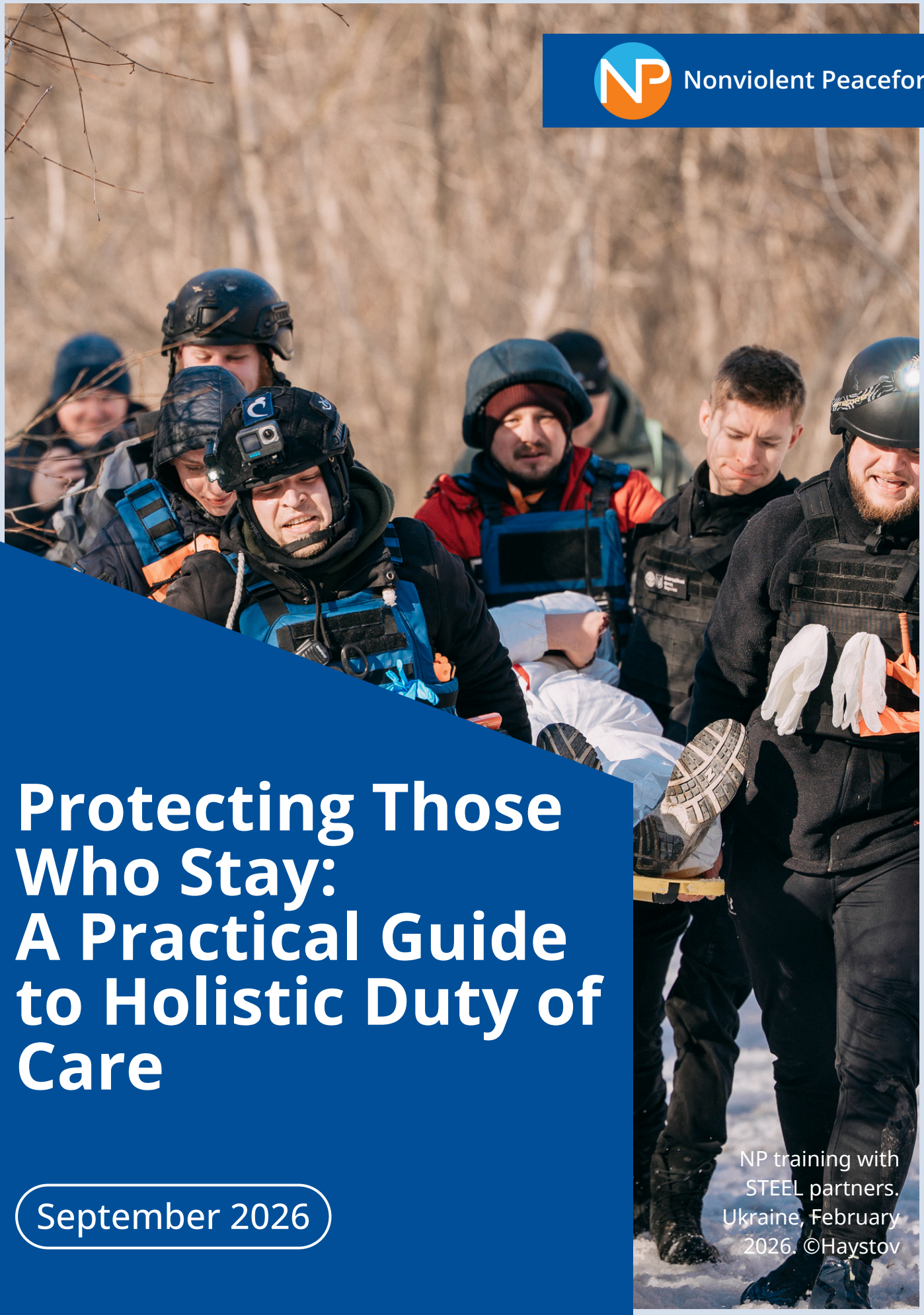
Nonviolent Peaceforce

Protecting Those Who Stay: A Practical Guide to Holistic Duty of Care



NP training with STEEL partners. Ukraine, February 2026. ©Haystov

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Duty of Care: More Urgent than Ever

The nature of armed conflict has seen a dramatic shift over the course of the past decade as technological advancements have depersonalised violence and expanded destructive capabilities. Wars have become increasingly regionalised, in many cases, with the majority of civilian casualties playing out in countries peripheral to the underlying warring parties. Civilians and humanitarians networks have increasingly become direct targets of violence, rather than collateral damage. The rapid evolution of drone warfare, such as unmanned aerial vehicles (UAVs), is extending surveillance and the threat of attack beyond conventional frontlines. Against this backdrop, humanitarian workers and affected communities face a new set of threats and heightened insecurity with disproportionate burden placed on those most affected by the violence itself.

These are not isolated or regionally confined trends.[1] Across conflict settings globally, drone attacks increased by an estimated 4,000 percent between 2020 and 2024, rising from roughly 4,525 recorded attacks in 2023 to nearly 19,700 in 2024, with drone-related incidents affecting healthcare or aid delivery climbing from fewer than ten per year prior to 2022 to 308 in 2024 alone. Attacks on humanitarian personnel have followed the same trajectory: 2024 was the deadliest year on record for aid workers, with 383 killed, and violent incidents recorded across 40 countries,[2] marking the second consecutive year that both the number of victims and fatalities set new records, rising 37 and 31 percent respectively. Since 2022, the number of aid workers killed annually has more than doubled, and this burden falls overwhelmingly on those closest to the communities they serve: across conflict contexts, national and locally recruited personnel account for more than 90 percent of all victims, a proportion that reached 97 percent in 2025.[3]

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[1] ALNAP, State of the Humanitarian System 2026: In Brief - drone attacks, displacement, civilian casualty figures; Nonviolent Peaceforce, "Nonviolent Peaceforce Rolls Out Frequency Analysers in Ukraine to Help Protect Civilians from Attacks," August 2025; CIVIC (Center for Civilians in Conflict), Protection of Civilians Trends Report, cited in Just Security, "Drones are Changing How Wars Harm Civilians" (Nov 2025) - drone attack volume and healthcare/aid impact figures; UN Security Council Report, "Protection of Humanitarian and UN Personnel," April 2026 Monthly Forecast - AWSD fatality figures, national staff proportion; CARE, "Record Number of Attacks on Aid Workers as Crimes Go Unpunished" (Aug 2025); Humanitarian Outcomes, Aid Worker Security Report 2025: Defenceless - incident trend data by country; Humanitarian Outcomes / Aid Worker Security Database, Figures at a Glance 2025 (Aug 2025 release) - country-level breakdowns; UN News, "Aid Workers Under Fire as Drones Reshape Warfare" (Aug 2026); UN Global Humanitarian Overview 2025 - national/local staff proportion of victims, Sudan-specific figures; UN Myanmar / OCHA, Myanmar Humanitarian Needs and Response Plan 2025 - landmine and explosive ordnance casualty figures, access constraints.

[2] UN Security Council Report, "Protection of Humanitarian and UN Personnel," April 2026 Monthly Forecast

[3] Humanitarian Outcomes & Aid Worker Security Database, 2024 Summary Figures (Aug 2025 release)

This pattern is evident across the very contexts in which NP operates. South Sudan, Sudan, Ukraine, Syria and the Democratic Republic of the Congo were each among the ten most dangerous operating contexts for aid workers in 2024, with South Sudan, the DRC, Sudan and Ukraine again among the highest-incident contexts in 2025.[4] In Sudan specifically, more than 50 Emergency Response Room volunteers are reported to have been killed since the war began in April 2023, while armed drones alone were responsible for 80 percent of civilian deaths recorded in the first four months of 2026. Myanmar, meanwhile, now has the highest number of landmine and explosive ordnance casualties of any country globally, amid a humanitarian response that remains severely underfunded and access-constrained.[5] Ukraine's experience, from which NP's Duty of Care model has been most fully developed, is therefore best understood not as an exceptional case but as an early and acute expression of a risk environment now facing frontline responders worldwide, underscoring why a model built to address it must be designed for adaptation across contexts, not treated as context-specific to Ukraine alone.

As the humanitarian system undergoes yet another transformation, largely driven by reduced funding and shifting geopolitical priorities away from the humanitarianism that characterised much of the 1990s and into a much more security focused world order, localisation is once again emerging as a catch-all solution to reducing cost, sustaining humanitarian operations, ensuring acceptance and securing institutional sustainability. As international presence contracts and response models adapt, local actors are not only sustaining frontline action but increasingly absorbing operational responsibility and risk, often without commensurate resources, protections or safeguards. The ‘reset’, as it’s been coined, thus risks missing an opportunity for true power shift and transformation, wherein locally driven responses are not peripheral to international structures, but foundational.

The enabling conditions that allow local responders and affected communities to carry out and sustain their work safely, including physical protection, psychosocial support, operational resources, and meaningful risk-sharing mechanisms, are not secondary considerations. Yet the humanitarian system continues to distribute risk inequitably. International organisations often commonly retain greater access to security resources, insurance, evacuation mechanisms and institutional protection, while local actors and communities absorb the greatest exposure to violence, as a result of being closest to it, with fewer safeguards and less decision-making power. The unequal allocation of protection perpetuates a hierarchy of whose safety is considered most worthy of investment.

[4] Humanitarian Outcomes & Aid Worker Security Database, 2024 Summary Figures (Aug 2025 release)

[5] UN Myanmar / OCHA, Myanmar Humanitarian Needs and Response Plan reporting

The question is not only how to protect local actors within the existing system, but how to build the conditions for a fundamentally different one in which locally driven responses are not peripheral to international structures, but foundational, especially in contexts where foreign aid funding declines or international agencies reposition.

If humanitarian response is to remain viable in a future where foreign aid funding may be reduced, reconfigured, or politically constrained, then localisation cannot mean the downward transfer of responsibility without a corresponding redistribution of power, resources and Duty of Care.

A holistic Duty of Care framework cannot be seen as an optional benefit or add-on, but as a fundamental obligation towards those who bear the greatest burden of violence and humanitarian action. Localisation without protection for those most at risk is questionable, if not unethical. A holistic Duty of Care framework recognises local communities and responders as central rights-holders and agents of life-saving work, rather than expendable or opportunistic resources within an international system. It therefore embeds practical, material, psychosocial, and operational safeguards into the design and delivery of that work, while establishing mechanisms through which risk is anticipated, shared, mitigated and addressed collectively. NP's own integrated model, piloted in Ukraine since 2022, is detailed below. In doing so, Duty of Care can help transform localisation from a cost-saving or access-oriented measure into a genuine shift in responsibility and agency, enabling local actors to operate more safely. This type of shift is also enshrined in the international commitments that several States, including those that the United Kingdom, Switzerland and Australia have made.

What is Duty of Care?

A responsible approach to localisation cannot mean risk outsourcing. Duty of Care, as NP defines it, is the ethical, legal, and organisational responsibility to anticipate and mitigate foreseeable risks that could cause physical and/or psychological harm to people undertaking humanitarian action, through shared protection, equitable access to resources, and informed decision-making. It is grounded in humanitarian principles and Do No Harm.

Minimum Standards:

While the specific configuration of Duty of Care will vary by context, NP holds that certain protections constitute a non-negotiable floor, applicable regardless of resource constraints or operational setting. These include: access to basic protective equipment and training appropriate to the threat environment; a functioning mechanism for confidential incident reporting and referral; access to psychological first aid or equivalent peer support; clear, updated information on risks and safe movement options; and an agreed process for responders to pause, adapt, or withdraw from activity without penalty. Where a context's resourcing or access constraints prevent NP or its partners from meeting this floor, this will be treated as a programmatic risk requiring escalation and mitigation, not an acceptable operating condition.

NP's Duty of Care approach is rooted in Unarmed Civilian Protection (UCP) - a nonviolent, civilian-to-civilian methodology that prioritises the prevention of violent conflict, and the mitigation of and response to it where prevention is not possible. Central to this methodology is the principle of primacy of local actors.

For NP, the primacy of local actors is not a rhetorical commitment. It is foundational in shaping how NP understands its own role and its commitment to Duty of Care, including through NP's Responsible Partnerships Approach. NP does not replace, direct, or manage local responses, but to stand alongside local responses through civilian-to-civilian action that seeks to strengthen and amplify existing local capacities. It further challenges the assumption that Duty of Care pertains only to humanitarian staff but also front-line responders irrespective of organisational affiliation, with a particular focus on those who stay and deliver. When NP finds that its role no longer adds value beyond what local actors and initiatives can sustain independently, NP seeks to fully hand over and exit, leaving behind strengthened local capacity rather than dependency.

Exit planning under this model explicitly includes the sustainability of Duty of Care measures themselves, not only programmatic activities. Where NP has provided equipment, insurance access, referral pathways, or psychosocial support mechanisms, transition planning will identify whether and how these can be sustained by local actors independently, transferred to another accompanying partner, or phased out in a manner that does not leave responders newly exposed. NP will not consider an exit complete where it results in a net reduction of protective capacity for those continuing frontline work.

In concrete terms, this means embedding physical, technical, psychosocial, and operational safety measures as integral components of partnership arrangements, supported by clear accountability mechanisms to ensure that international actors uphold these commitments in practice. It also requires sustained accompaniment rather than transactional collaboration, recognising that local actors continue to carry risk and responsibility well beyond individual project cycles.

Partnership, therefore, is not about positioning local actors as implementers of externally defined agendas, but about creating the conditions in which they retain leadership and determine the terms of engagement with international systems.

IHL and the Role of States

Duty of Care does not displace the obligation of states, which bear the formal responsibility to protect civilians under international law. The Geneva Conventions and their Additional Protocols place that duty on parties to a conflict, states included, and no amount of local or international protective action changes where that legal responsibility sits.

What Duty of Care reflects instead is the operational reality of contexts where that obligation is not being met, where states are absent, under-resourced, or themselves party to the violence civilians are experiencing. In these conditions, local communities are consistently the first to respond, and they remain central to sustaining protective action long after external actors can reach an area.

Supporting that response is not an alternative to holding states accountable, it runs alongside it. NP's advocacy for stronger IHL compliance, set out elsewhere in this document, is the other half of the same position: civilians should not need this layer of protection in the first place, and until states meet that obligation, the people already doing the work of protecting their communities should not be left to do it without support.

Core Components of NP's Duty of Care Approach

NP's Duty of Care model prioritises prevention, presence, dialogue, accompaniment, community-led protection, early action, informed choice and local ownership. It recognises that no single intervention is sufficient and that effective Duty of Care requires interconnected measures at individual, team, organisational and community levels.

This guide offers practical measures for organisations, donors, and local partners to build Duty of Care into partnerships and programmes. It is not a fixed checklist but rather is intended to provide a non-exhaustive menu of options and a guide to decision making in support of locally led processes. Furthermore, NP strives to conceive of Duty of Care as beyond the confines of organisational affiliation or institutional recognition to extend to all actors involved in front line humanitarian response with a particular focus on those who stay and deliver when crisis strikes.[6]

The model posits three core components underpinned by eight core principles that look at the continuum of early action, prevention, mitigation, response, support and learning.

The three core components that make up the package are:

1. Physical Protection and Safety

Physical protection and safety form a foundational pillar of NP's work, including in Duty of Care. For local and national actors engaged in responder work in contexts of violence, exposure to physical harm is a persistent and unacceptable reality. It cannot be normalised or treated as an inherent cost of frontline action. Yet in many contexts, frontline responders are not incidental victims of violence but are deliberately or indiscriminatingly exposed to harm because of their proximity to communities, evacuation routes, and sites of active conflict.

This category addresses measures that prevent and reduce exposure to physical harm, improve preparedness and strengthen the capacity of individuals, teams and community-based responders to mitigate, withstand and respond to threats.

[6] To this end, NP intentionally conceives of DoC for all humanitarian and frontline responders, even if they are not formal staff of an I/NNGO or other formal structure. This can include, though isn't limited to, mutual aid group members, community volunteers, emergency response room members and others.

Physical safety is understood broadly. It includes safer movement, protection from explosive hazards, environmental and climate-related preparedness, safe evacuation and mitigation of sexual, gender-based violence and access to health care.

Examples of ways of supporting physical protection in a Duty of Care package could include:

- Conducting joint risk analysis with local partners, including threat mapping, scenario planning, and agreed decision points for when to pause or withdraw
- Providing context-appropriate protective equipment including PPE or Frequency Analysers, through lending and subgrant models that keep ownership and agency with local actors
- Establishing community-based early warning and response systems, including drone detection tools, integrated into broader security protocols rather than used in isolation
- Providing communications equipment, SIM cards, and connectivity solutions calibrated to low-resource environments, alongside digital safety training and tools
- Building scenario-based preparedness skills so responders can make informed decisions under pressure including agreed protocols for when to continue, adapt, pause, or withdraw

Practical decision-making criteria can include:

- *What could cause harm?* Consider physical, emotional, social, informational, legal, health, environmental, mobility and SGBV-related risks.
- *Who is most exposed, and why?* Consider differentiated risks, power, access, identity, disability, age, gender, family responsibilities and social position.
- *What can reduce exposure without escalating violence?* Prioritise prevention, acceptance, dialogue, accompaniment, protective presence, route adaptation, community-led action and safer programme design.
- *What additional resources are justified?* Consider equipment, transport, connectivity, insurance, training, specialist services and self-relocation funds based on assessed and specific needs.
- *Is formal evacuation feasible, safe and timely?* Are locations secure, accessible and are basic services available? If not, assess whether flexible self-relocation assistance could materially reduce risk.
- *How will safe arrival and follow-up be supported?* Consider check-ins, family communication, accommodation, health care, legal support, education and psychosocial needs.
- *What are the decision points?* Agree when to continue, adapt, pause, relocate, evacuate or stop activities.
- *How will we know whether the approach is working?* Monitor safety, wellbeing, inclusion, unintended consequences, accountability and local ownership.

Ukraine: How Practice Shaped the Duty of Care Model

NP's holistic Duty of Care approach has been most fully developed through NP's engagement in Ukraine since 2022. As international actors struggled to establish or sustain frontline presence, local NGOs, volunteer collectives, and informal networks became the backbone of the humanitarian response. These actors operated in high-risk environments characterised by shelling, mines, missile strikes, and, more recently, targeted attacks by improvised combat unmanned aerial vehicles (ICUAVs or drones).

Early assessments highlighted a stark imbalance. Local responders were assuming extreme operational risks without being trained in first aid, nor having access to personal protective equipment (PPE), insurance, psychosocial support, or other adaptive security tools. At the same time, many international humanitarian actors evacuated, and when they returned found themselves constrained by security protocols, risk management frameworks, and administrative requirements that limited their ability to operate at the frontlines. Institutional discussions often centred on insurance coverage, legal liability and compliance thresholds, considerations that, while legitimate, were structurally different from the immediate life-and-death calculations being made daily by local responders.

In practice, this meant that risk was unevenly borne with local responders absorbing danger in real time, often without adequate support, protection, or shared responsibility. For many, risk was not only operational but existential - they were responding within their own communities, families, and neighbourhoods, where proximity meant both greater exposure and greater stake in the outcome. While international actors faced their own forms of institutional risk, including liability and security thresholds that shaped operational decisions, the nature and immediacy of risk were structurally different.

Rather than accepting this divergence in risk exposure as inevitable, NP worked to reframe partnership around shared responsibility. In response, and hand in hand with local responders, NP progressively developed a Duty of Care model that addressed risk from multiple angles, including physical safety, psychological wellbeing, operational sustainability, and legal and ethical considerations, embedding these measures into the fabric of frontline action rather than treating them as addons.

This evolution began with practical measures such as PPE lending schemes and context-adapted first aid, psychological first aid training and volunteer

insurance and, as the threat environment evolved, the introduction of armoured vehicles and Frequency Analysers to provide effective drone mitigation and protection measures. In parallel, NP piloted and scaled a psychosocial protection dimension within its Unarmed Civilian Protection (UCP) approach, later formalised as the Peer Welfare Programme (PWP). This shifted the emphasis from individualised clinical responses toward peer-based, community-led wellbeing and stress regulation practices that strengthen collective resilience.

The protective value of this approach has been documented directly. In August 2025, an NP-supported evacuation team operating in the high-risk Kupiansk area received a real-time signal from a frequency analyser indicating an incoming drone. Applying NP's drone awareness training, the team accelerated to evade the attack and reached a pre-identified shelter; the drone struck nearby without causing casualties. In a separate incident, an NP-supported team responding to an early warning chose to shelter rather than proceed with a planned evacuation, and the vehicle sustained damage from subsequent artillery fire while all personnel remained safe. These cases illustrate the shift frequency analysers represent - from reactive protection, armoured vehicles, PPE, emergency medical response - toward proactive threat avoidance, giving responders the ability to see a threat coming rather than absorb its consequences after the fact.

Over time this integrated approach reshaped humanitarian practice in Ukraine by demonstrating that localisation without protection amounts to risk transfer, rather than principled partnership, by placing responsibility for emergency assistance on local actors without the protective measures international staff routinely receive.

In response, NP, with the support of the UK's Foreign, Commonwealth & Development Office and the Swiss Agency for Development and Cooperation, developed and piloted the first fully integrated and operationalised Duty of Care model of this kind for local first responders operating in active conflict in Ukraine - bringing together physical protection, digital safety, insurance mechanisms, early warning tools, legal safeguards, and peer-based psychosocial protection within a coherent framework. To our knowledge, comparable models remain extremely rare in other contexts, if they exist at all.

With several years of applied learning now behind it, NP is positioned not only to refine this approach further but to make it accessible and adaptable for local actors and partners operating in other high-risk contexts.

2. Emotional Wellbeing and Social Support

This category supports the mental and emotional wellbeing of responders, partners and communities. Responders working in conditions of violence, displacement, uncertainty and prolonged responsibility may experience cumulative stress, grief, exhaustion, isolation, moral distress and trauma-related reactions. These impacts can be intensified where people are simultaneously caring for families, coping with loss or displacement, navigating discrimination or insecurity and continuing to provide support to others.

A Duty of Care approach should therefore not treat wellbeing as a personal matter, a sign of individual resilience or an issue to be addressed only after a critical incident. It requires organisations and partners to create conditions in which people can speak openly about strain without stigma or negative professional consequences, receive timely, appropriate support, maintain trusted relationships and social connection, and make informed decisions about workload, rest, adaptation, relocation or pause.

NP's approaches are locally appropriate, confidential, voluntary and accessible to people with different languages, identities, disabilities, family responsibilities and levels of formal affiliation. They centre on existing community-based practices of mutual care, peer support, faith, culture and solidarity, rather than relying solely on external or clinical models. Where specialised mental health or psychosocial services are already appropriate and available, NP's role is to strengthen the everyday organisational practices that reduce avoidable stress and share responsibility for wellbeing, working alongside those services rather than positioning itself in their place. Wellbeing should be treated as a collective and organisational responsibility systemwide, rather than individual obligations to cope with unsafe or unsustainable circumstances.

Examples of ways of supporting emotional wellbeing and social support in a Duty of Care package could include:

- Prioritising organisational wellbeing including through trainings, EMDR sessions, sensorimotor psychotherapies, access to helplines and other practical wellbeing activities
- Facilitating access to collective care and social connection opportunities
- Building on experience from NP's Peer Welfare Programme to train, mentor and scale out the approach
- Providing training on psychological first aid and other methods for addressing traumatic stress

Practical decision making criteria could include:

- *What could cause harm?* Consider physical, emotional, social, informational, legal, health, environmental, mobility and SGBV-related risks.
- *Who is most exposed, and why?* Consider differentiated risks, power, access, identity, disability, age, gender, family responsibilities and social position.
- *What are the decision points?* Agree when to continue, adapt, pause, relocate, evacuate or stop activities.
- *How will safe arrival and follow-up be supported?* Consider check-ins, family communication, accommodation, health care, legal support, education and psychosocial needs.
- *How will we know whether the approach is working?* Monitor safety, wellbeing, inclusion, unintended consequences, accountability and local ownership.

3. Information, Communication and Awareness

Reliable, accessible and responsible information is itself a protective resource. This category covers the systems, skills, relationships and messages that enable people to understand risks, make informed choices, coordinate safely and maintain dignity and agency.

Organisations should provide local and frontline responders with timely, accessible, conflict-sensitive and regularly updated information to support informed decisions during acute emergencies. Information should be based on ongoing analysis of conflict dynamics, threats, vulnerabilities, capacities and protective opportunities, using multiple trusted sources and two-way feedback from responders and affected communities. Where feasible, communities should participate in producing and validating safety information.

Information should clearly distinguish verified information from unconfirmed reports, rumours, warnings and known gaps and indicate when it was last updated. Risk, service and route mapping should identify relevant threats, safe locations, routes, destinations and available assistance without disclosing information that could expose individuals or communities to harm. Information-management arrangements should minimise collection of personal data, restrict access appropriately and include procedures to correct inaccurate or outdated information.

Examples of ways of supporting emotional wellbeing and social support in a Duty of Care package could include:

- Facilitating access to information services
- Facilitating access to referral mechanisms

- Facilitating access to communications materials including telecoms equipment and tools for digital safety
- Providing trainings on scenario-based awareness and skills
- Ensuring access to information on organisational and institutional security protocols

Practical decision-making criteria could include:

- *What could cause harm?* Consider physical, emotional, social, informational, legal, health, environmental, mobility and SGBV-related risks.
- *What information and services are needed?* Identify medical, legal, transport, education, accommodation, communication, financial, psychosocial and protection resources.
- *What are the decision points?* Agree when to continue, adapt, pause, relocate, evacuate or stop activities.
- *How will we know whether the approach is working?* Monitor safety, wellbeing, inclusion, unintended consequences, accountability and local ownership.



First Aid Training for partners.
Izium, Ukraine, March 2023.
© Kristina Preiksaityte

Duty of Care Principles

The principles that underpin these components and guide NP's action beyond its Duty of Care approach are:

- ***Locally led:*** Local responders and communities define needs, priorities, and acceptable risk.
- ***Context specific:*** Duty-of-care measures should be based on context-specific analysis and reviewed and adapted as threats, services, mobility and community priorities change.
- ***Inclusive:*** Measures should be accessible and responsive to gender, age, disability, language, identity, family responsibilities and differences in power and access.
- ***Layered:*** Measures should operate across individual, team, organisational and community levels. No single intervention should be treated as sufficient.
- ***Conflict-sensitive:*** Measures should consider how assistance, information, visibility, resources and relationships may affect conflict dynamics or expose people to additional risk.
- ***Rights-centred:*** Protection should uphold consent, confidentiality, dignity, autonomy, informed choice and control over decisions.
- ***Nonviolent:*** The approach should prioritise prevention, presence, dialogue, accompaniment, acceptance, early action, civilian agency and other nonviolent means of reducing harm.
- ***Accountable:*** Systems should include feedback, complaints, safeguarding, monitoring, learning, transparent decision-making and appropriate remedies.
- ***Sustainable:*** Duty of care should include training, supervision, maintenance, replacement, financing, organisational support and responsible transition or handover.

Adapting Duty of Care Across Contexts

While NP's Duty of Care approach has been most clearly shaped through experience in high-intensity conflict settings such as Ukraine, its core principles are transferable across operational contexts. The Ukraine experience demonstrates that comprehensive support for local responders is feasible when it is treated as an operational responsibility rather than an optional add-on, supported by sustained engagement with donors, partners and coordination actors. Given the variety of contexts within which NP operates and the non-linear effects of violence on communities and local actors, the emphasis is not on a static commitment, but a flexible menu of options adaptable as the contexts and needed of responder change.

While the Ukraine experience has most fully shaped NP's Duty of Care model, its application is not intended to be replicated uniformly. Each context presents a distinct configuration of threat type, actor landscape, resource availability, and institutional access, which shapes how the three core components are prioritised and delivered. Duty of Care principles translate differently into each operating context,



NP partners and volunteers incorporate EMDR-based grounding technique into emotionally intense meetings. Kherson, Ukraine, February 2025. © Dr. Sofiia Vecherok

with the intensity, sequencing, and form of support necessarily differing from one setting to the next. Neither will every context currently benefits from the same level of clarity or investment that Ukraine has had, where sustained donor support and acute contextual analysis have aligned.

A dedicated mechanism, a Duty of Care Advisory Group, could help translate the principles underpinning this model into context-specific application, defining what Duty of Care should look like in a given setting based on available resources, the nature and intensity of risk, and ongoing contextual analysis. While minimum and equal standards of protection must be maintained across all contexts, the specifics and delivery of Duty of Care should be shaped by the realities of each operating environment rather than applied uniformly.

Duty of Care cannot remain contingent on the appetite or capacity of individual organisations. It must also be streamlined across a response, with common, transparent and predictable forms of support available to local actors regardless of which organisation they are affiliated with. Because Duty of Care will look different from one context to the next, a formalised mechanism is needed to ensure local actors are systematically included in defining what it looks like in their own context, rather than this being negotiated ad hoc, inconsistently, or left to individual relationships.

This is not a theoretical proposal. NP has already developed and documented the role of a Duty of Care Advisory Group, comprising protection specialists, IHL and security experts, and local humanitarian representatives, to guide the responsible implementation of jamming equipment in Ukraine. A Duty of Care Advisory Group would extend this same governance logic across all protective technologies and measures, providing a standing space where local actors, partners, coordination bodies and donors can collectively shape recommendations for what context-specific Duty of Care standards should look like, rather than establishing new governance arrangements for each emerging threat or treating local input as a one-off consultation.

NP's Institutional Commitments

Nonviolent Peaceforce embeds holistic Duty of Care throughout its programmes, partnerships and operational decision-making. Through this approach and complemented by the broader work NP supports in communities, we work to ensure that local responders and partners can access practical protection measures, including context-appropriate risk analysis, safety resources, reliable information and communication tools, psychosocial and peer support, training, referral pathways and support to adapt, pause, relocate or recover where necessary. These measures are planned with local actors, resourced as core operational costs and reviewed regularly as risks, capacities and priorities evolve.

NP budgets Duty of Care measures as core operational costs within programme and partnership budgets, rather than as contingency or discretionary spend. This includes dedicated budget lines for physical protection equipment, psychosocial support mechanisms, and information/communication tools from the outset of programme design, not added retroactively following an incident. Where donor funding does not initially accommodate these costs, NP will engage in dialogue with donors to advocate for their inclusion, using evidence from the Ukraine experience to demonstrate both the operational necessity and the comparative cost of inaction. NP works toward establishing minimum resourcing thresholds below which a programme or partnership cannot proceed without unacceptable risk transfer to local actors.

NP designs its Duty of Care approach to strengthen local agency rather than transferring responsibility or risk downward. Local responders and communities remain central to defining priorities, identifying acceptable risk and making informed decisions about whether and how to engage in activities. NP seeks to make its own resources, analysis, networks and protective capacities accessible to partners where appropriate, while designing programmes and partnerships that recognise differentiated exposure to risk, including risks related to gender, age, disability, identity, family responsibilities and social position. Where risks cannot be sufficiently reduced, NP adapts activities, reduces operational demands, supports locally determined protective options, or pauses engagement rather than expect local actors to absorb unacceptable exposure.

NP also uses advocacy to influence donors, international organisations, authorities and other duty bearers who hold greater power and protection. This advocacy pursues two parallel goals. The first is to establish Duty of Care as a minimum

standard across humanitarian responses, applied by donors, INGOs and national NGOs alike. NP advocates for equitable access to resources, institutional safeguards, security information, flexible financing, psychosocial support, insurance or comparable protection mechanisms and safe mobility or relocation options for local and frontline responders. The second is to strengthen recognition of and compliance with IHL. Through evidence, dialogue, relationship-building and policy influence, NP challenges practices that treat localisation as a means of outsourcing risk, promotes accountable and adequately funded Duty of Care commitments across the humanitarian system, and presses those with greater power to meet their responsibilities without undermining the leadership, autonomy or choices of local actors.

Duty of Care is not a single intervention but an ecosystem of protections, each of which must be nuanced to acknowledge and match the specific needs of the populations it is intended to serve. NP contributes to that ecosystem through three mutually reinforcing pillars: direct physical protection and accompaniment for at-risk frontline responders, mental health and psychosocial support, and reliable access to timely, actionable information on threats and safe options. This focus is intentionally complementary to, rather than duplicative of, other duty of care initiatives. The Protect Aid Workers (PAW) project, for example, provides rapid cash disbursements that unlock legal aid and emergency evacuation or relocation, while Legal Action Worldwide (LAW) supports frontline responders facing arrest, detention, or legal charges connected to their work. Where PAW addresses the financial barrier and LAW the legal one, NP works upstream and alongside them on the physical, psychological and informational dimensions of risk, helping prevent harm before it escalates and sustaining responders through it. Taken together, these approaches cover distinct pillars of a shared architecture of duty of care, and NP fills a particular and complementary niche within it.

About Nonviolent Peaceforce (NP)

NP is an international nongovernmental organisation specialising in the protection of civilians through unarmed strategies. Founded in 2002, NP brings more than two decades of experience working in some of the world's most complex, conflict-affected contexts, where it has worked side-by-side with communities to prevent violence, reduce harm, and strengthen locally led protection and peacebuilding efforts. At the time of writing, NP operates in ten countries, including Iraq, Syria, Sudan, South Sudan, the Democratic Republic of the Congo, Ukraine, Indonesia, Myanmar, the Philippines, and the United States.

NP envisions a worldwide culture of peace in which conflicts within and between communities and countries are managed through nonviolent means. Guided by principles of nonviolence, non-partisanship, primacy of local actors, and civilian-to-civilian action, NP's work advances a shift in the global security paradigm from force protection to unarmed civilian protection.

NP's work is grounded in Unarmed Civilian Protection (UCP), an innovative, evidence-based methodology that radically centres those most impacted by conflict in efforts to prevent violence and promote positive peace. UCP is the practice of unarmed civilians protecting themselves and other civilians from harm by preventing, mitigating and responding to threats of violence. In parallel, UCP strengthens local capacities for conflict management, social cohesion and sustainable peace. In doing so, NP's approach operates across the Humanitarian-Development-Peace Nexus, addressing immediate protection risks while contributing to longer-term peacebuilding and community resilience.

Rather than relying on armed protection, UCP focuses on security through relationship-building, nonviolent engagement and community-led protection strategies that interrupt cycles of violence. A few key UCP methods include:

- Direct protection including protective presence and accompaniment,
- Strengthening community protection structures, including women and youth protection and peacebuilding teams, as well as community-led early warning/early response (EWER) mechanisms, and
- Multi-track dialogue, shuttle diplomacy and mediation.

UCP has been recognised for its effectiveness and is reflected in 27 United Nations (UN) and UN-related policies, recommendations, and resolutions, including six UN

Security Council resolutions adopted in the past five years. Notably, UN Security Council Resolution 2717, which defines the current mandate of the UN Organisation Stabilisation Mission in the Democratic Republic of the Congo (MONUSCO), underscores the importance of community-based protection approaches and engagement with civilian actors. Similarly, UN Security Council Resolution 2579, which renewed the mandate of the UN Integrated Transition Assistance Mission in Sudan (UNITAMS), reinforces the role of civilian-led and unarmed strategies in strengthening protection of civilians within UN peacekeeping contexts.

Duty of Care extends NP's core commitment to preventing and responding to violence against civilians to the people who respond to humanitarian needs, whether or not they are affiliated with a formal organisation. Guided by the primacy of local actors that underpins NP's work, it prioritises local and frontline responders, while also covering the wider range of national and international actors NP works alongside, beyond the community protection structures NP already supports.