MINIMIZING DISRUPTIONS TO HEALTH CARE DELIVERY
RESULTING FROM ATTACKS DURING EMERGENCIES

Title of Initiative  Attacks on Health Care

Vision  Essential life-saving health services are provided to emergency-affected populations unhindered by any form of violence or obstruction

Country Focus  All countries vulnerable to emergencies, and particularly those facing emergencies

Beneficiaries  Emergency-affected populations in need of health care, and health care workers

Start date  1 January 2019
End date  31 December 2022

Organization  World Health Organization (WHO)

Outcome  Minimized disruptions to health care delivery resulting from attacks during emergencies

Outputs  Output 1: EVIDENCE  (Body of evidence and global trends)
Output 2: ADVOCACY  (Commitment to action and momentum for change)
Output 3: ACTION  (Best practices promoted and applied)

Amount requested  US$ 12,781,091
1 CONTEXT

Health care is under attack.

In the first three quarters of 2018, the Surveillance System for Attacks on Health Care (SSA) documented 134 attacks on health care in Syrian Arab Republic, causing 97 deaths including 108 attacks that affected health facilities, further weakening a health system burdened by seven years of conflict. Over the same period, the SSA reported 298 attacks causing 424 health personnel injuries in the occupied Palestinian territories. During the Ebola outbreak in West Africa, community fear and inadequate community sensitization measures led to attacks against health care workers and facilities causing the deaths of eight health care workers. These incidents are only a snapshot of the attacks reported in 2018 across many different countries and contexts.

Such attacks deprive people of urgently needed care, endanger health care providers, undermine health systems and long term public health goals, and contribute to the deterioration in the health and well-being of affected populations.

For every health care professional who dies or flees, for every hospital that is destroyed, scores of people are denied health care. Each medical professional takes years of education and professional development—usually borne by the national budget—and supported by a family. Each hospital that is destroyed is a significant economic loss to the country.

Collective efforts are required from WHO, Member States, and partners within and beyond the health sector to put an end to attacks on health care. We need to better understand the extent and nature of the problem and its impact on health service delivery and public health; we need to build momentum for real change, zero-tolerance and respect for International Humanitarian Law, Duty of Care, and the Right to Health; and we need to promote best practice to reduce the likelihood of attacks and to strengthen the resilience of health systems that are struck by violence.

In January 2017, WHO rolled out a four year project to formalize and strengthen its efforts to minimize disruptions to health care due to violence, and intensify its collaboration with Member States and partners that have been key in moving this issue to center stage, in particular the International Committee of the Red Cross and Red Crescent through its Health Care in Danger (HCID) initiative and its “Community of Concern”, and Médecins Sans Frontiers through its #NotATarget project.

Since the roll out, the Attacks on Health Care initiative has been instrumental in raising the issue further. This document outlines the second phase of the Attacks on Health Care initiative, to reflect the lessons learned from the first three years of implementation, and provide the next steps to turn the project into an initiative for sustained delivery by WHO and partners to address the issue and raise a collective voice towards preventing attacks and protecting health care globally.

Background

WHO’s Director General has been an outspoken advocate for the right to health and has made numerous statements to highlight WHO’s concern with the frequency of attacks on health care and their impact on health workers and health service delivery.

Resolutions of the World Health Assembly reinforce WHO’s strong position against violence in health care settings, including Resolution 46.39 in 1993, 55.13 in 2002, 64.10 in 2011, and 65.20 in 2012.

In 2012, the World Health Assembly called on WHO’s Director-General to provide global leadership in the development of methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health vehicles and patients in complex humanitarian emergencies, in coordination with other relevant United Nations bodies, other relevant actors, and intergovernmental and nongovernmental organizations.
Also in 2012, the International Committee of the Red Cross and Red Crescent launched its Health Care in Danger (HCID) initiative and Médecins Sans Frontiers began its Medical Care Under Fire (MCUF) project.

In 2013, WHO convened the first of a series of expert consultations to develop a methodology and tools to facilitate data collection, analysis and reporting. The methodology and tools were tested in three locations from March 2015 to March 2016; these tests and the independent evaluation that followed provided the basis for finalizing and gaining WHO endorsement on a final data collection and verification method.

In May 2015 at the 68th World Health Assembly, the Director-General stood together with the Emergency Relief Coordinator, the President of the ICRC and concerned Member States to urge for collective action to stop attacks on health care.

In 2015, WHO recognized that the magnitude of this problem requires greater leveraging of WHO’s global leadership and outreach, including as Health Cluster Lead Agency; its expertise in setting norms and making available authoritative information; its convening power; and the commitment of WHO Member States and partners to implement best practice to reduce attacks and mitigate their consequences to health service delivery. Therefore, in August 2015, WHO established a staff position in its emergency department dedicated to work on this important issue in collaboration with concerned internal and external actors.

In May 2016 at the 69th World Health Assembly, the Director-General again stood together with the President of the ICRC and the International President of Médecins Sans Frontiers to call for collective action to stop attacks on health care.

Also in May 2016, the United Nations’ Security Council unanimously adopted Resolution 2286—sending a strong message around the world that health care must be protected during conflict. WHO supported this Resolution and commended the countries, including Canada and Switzerland, and the organizations, most notably MSF and ICRC, that tirelessly championed this Resolution.

A group of Geneva based diplomatic missions, led by Canada and Switzerland, entitled the “Friends of 2286” was created and meets on a regular basis in Geneva. WHO is an active member of the group, where WHO’s work on the data and research are shared and used for further advocacy on the topic.

In July 2016, WHO launched its WHO Health Emergencies Programme (WHE) with attacks on health care as a priority issue. In October 2016, the WHE Directors from headquarters and the six regional offices gathered with the WHO representatives of the 17 countries with the largest emergency-affected populations—marking the first three-level WHE meeting since its establishment. Demonstrating the importance of the issue of attacks on health care, one of the three days of this meeting was dedicated to the way forward with concrete decisions on data collection, advocacy and the identification and promotion of best practice to reduce risk of attacks and strengthen resilience and care for victims after attacks.

In December 2017, WHO launched the Surveillance System on Attacks on Health Care (SSA) which aims to collect data of attacks on health care, to generate a body of evidence that will support advocacy and preventive measures. The system allows for direct input of information on attacks by partners into a confidential data collection system that will be collated to generate an amalgamated view of attacks on health care globally. The system went live on 1 January 2018. The information can be accessed at: http://ssa.who.int.
In May 2018, Member States of WHO again reinforced the message on the need to protect health care from attacks through a side event at the World Health Assembly. A Call to Action from Member States released in the UN General Assembly in September 2018 requests WHO and partners to continue collecting evidence of attacks and research the impact of attacks on health care. The call identifies attacks on health care as one of the main impediments to achieving universal health care, and calls on all to work towards protecting health care and preventing attacks on health care.

2 OUTCOME AND OUTPUTS

The vision of this initiative is that essential life-saving health services are provided to emergency-affected populations unhindered by any form of violence or obstruction. Universal Health Coverage cannot be achieved if health facilities are systematically destroyed and health care workers attacked.

Ultimately, WHO seeks to ensure that:

- health workers everywhere can provide health care in a safe and protected environment;
- health workers are protected, resilient, equipped with knowledge and resources;
- parties to conflict understand and uphold their responsibilities under International Humanitarian Law;
- health care delivery is not disrupted by attacks; and
- all forms of violence against health care stop.

The expected outcome of this initiative is minimized disruptions to health care delivery resulting from attacks during emergencies. This will be delivered through three outputs:

1. First, the initiative will continue to develop a body of evidence to better understand the extent and nature of the problem and its consequences to health care delivery;

2. Second, the initiative will increase commitment to action through strong advocacy for an end to attacks on health care, ensuring the right to health of all, the sanctity of health care in all circumstances, the delivery of health care unhindered by violence, and the application of International Humanitarian Law;

3. And third, the initiative will develop and promote the implementation of best practices for the prevention of attacks and the mitigation of their consequences to health service delivery, particularly through the actions of WHO’s country offices, Member States and other health actors in countries facing emergencies.

Here below is an explanation of each output and the activities and approaches that will lead to its achievement.

Output 1: EVIDENCE (Body of evidence and global trends)

The open source data that WHO has consolidated since 2014 to date shed light on the severity and extent of the problem and show that in some of the world’s most tragic emergency settings—where health care is needed most—health care workers and facilities are themselves subject to, in some cases extreme, violence.

Reliable quantitative and qualitative information is needed to better understand the extent and nature of the problem. Only with a comprehensive understanding of the issue and its impact on health service delivery...
Attacks on Health Care Initiative 2019 - 2022

can we move forward to advocate effectively to stop attacks and identify global as well as context-specific best practice to reduce their occurrence and impact and strengthen the health sector’s resilience to such attacks.

The data that is available make clear that a more standardized approach is needed for gathering information on attacks on health care and their consequences to health service delivery. This approach should include standard definitions for attacks on health care, for health care workers and for health care facilities. Also necessary are agreed classifications for object types and attack types. Standardization would allow for improved aggregation, comparative analysis, trend analysis and a more comprehensive evidence base. A more complete set of data would in turn lead to more effective and targeted advocacy to stop attacks, and concrete actions to reduce the risk and impact of attacks during emergencies. Building a body of evidence and global trends is the first output of this initiative.

In December 2017, WHO rolled out the Surveillance System for Attacks on Health Care (SSA), an online based tool that is easily accessible and is a user-friendly global repository allowing for data collection using WHO’s methodology and tool. This allows for collection, consolidation and analysis of information on attacks on health care and their impact on health service delivery and the health of the population in general. The data is disaggregated by gender and age.

In the first year of the roll out of the SSA, WHO aimed to have 11 countries that have suffered recent attacks reporting to the system. By the end of this cycle (2019-2022), WHO aims to have all relevant countries with attacks reporting through the tool. WHO will work closely with global and country-level partners involved in data collection and reporting to encourage harmonized approaches and to collaborate on data collection and research on the health impact of such attacks.

To achieve this objective, WHO will complete the following activities:

1. Apply the data collection methodology and tools in all countries and territories with emergencies using the SSA;
2. Collect and analyse available data;
3. Manage the SSA web system and the attacks on health care webpage, including a global repository of related information;
4. Develop and disseminate quarterly dashboards on attacks;
5. Develop and disseminate annual reports on the nature and extent of the problem, its consequences to health service delivery, and global trends.

The activities will be implemented using the following approaches:

1. Systematic collection of information using the WHO Surveillance System for Attacks on Health Care (SSA) tool
2. Conduct country missions and regional workshops to train WHO staff and partners on how to collect and use data on attacks using the SSA
3. Interface regularly with the IT development team to ensure that the tool is updated to include feedback provided by country offices

WHO will measure its achievement of this output using two indicators:

1) that all countries and territories with attacks on health care report through the SSA (to be measured using percentage of countries with attacks reporting through the SSA); and
(2) that the annual reports showing available comparative data and trends are produced and disseminated through on-line promotion and through specific events and media coverage to raise the profile of the issue of attacks on health care in emergency settings with all key stakeholders.

Output 2: ADVOCACY  
(Commitment to action and momentum for change)

WHO advocates for the right to health for everyone, everywhere. Universal Health Coverage is a WHO priority. The available data on attacks on health care highlights the need for intensified action from a broad spectrum of actors to ensure that health care is provided universally during emergencies to all those who need it. Building a commitment to action and momentum for change to reduce attacks on health care so that health services can be provided is the second output of this initiative.

To achieve this output, WHO has developed an advocacy strategy, with a strong communications component, to raise awareness globally and locally, exercise WHO’s leadership role, maintain momentum for change, and motivate key actors to uphold the right to health, protect health care, uphold International Humanitarian Law, implement preventive measures to reduce attacks and protect health care, report on attacks, mitigate consequences of attacks, and support victims and restore health services. The advocacy strategy aims to have decision-makers take concrete actions to reduce attacks and ensure that attacks against health care are recognized as unacceptable globally at all levels.

This advocacy strategy is fully aligned with WHO’s corporate advocacy and communications priorities and will describe in detail the ways in which WHO will position itself and advocate for action including through dialogue, representation, communications, press briefings, presentations, events and social media. In 2019-2022, WHO will focus on implementing the advocacy strategy, at all levels.

To achieve this output, WHO will complete the following activities:

1. Develop an advocacy workplan including communication strategy and procedures at all levels.
2. Systematically develop and disseminate advocacy and communications products as per strategy, including through social media.
3. Organize and/or participate in key events (Human Rights Day, World Humanitarian Day, UN General Assembly side events, WHA, ECOSOC-HAS).
4. Establish and continually update and disseminate key messages and talking points for use by the three levels of the Organization.
5. Engage in health diplomacy to promote implementation of best practice during emergencies, and particularly in conflict settings, at global, regional and country levels.
6. Engage in the Monitoring Reporting Mechanism at global and at country level.

Multiple methods will be used to further advocate for this issue. They include the following:

1. Present advocacy efforts from a WHO perspective: WHO’s advocacy will center on the effects that attacks on health care have on efforts to achieve universal health coverage, the Sustainable Development Goals, global health security, and health as a human right – values that have been embraced by Member States. WHO will lead and/or participate in key events (World Humanitarian Day Human Rights Day, General Assembly (GA), World Health Assembly (WHA), Security Council briefings, ECOSOC-HAS (Humanitarian Affairs Segment)).
2. Work across all levels of the organization: Advocacy efforts will be pursued by WHO through its global, regional and country offices, leveraging existing links with ministries, Health Cluster partners, WHO collaborating centers, international non-governmental organizations (NGOs) and others.

3. Engage stakeholders, collaborate and coordinate with partners: WHO works closely with partners at country, regional and global levels, including the Health Care in Danger initiative of the International Committee of the Red Cross, the Medical Care Under Fire project of Médecins Sans Frontières, and the Safeguarding Health in Conflict coalition.

4. Optimize use of evidence, research and technical knowledge: The Advocacy Strategy aims to further the use of the data and analyses generated by Outputs 1 and 3, creating evidence-based advocacy in citing the extent of the problem and the resulting impact on health. Where possible, linkages will be made with the Monitoring and reporting mechanism to ensure further investigation of specific incidences.

5. Seize opportunities: Every attack or risk of attack on health care is an opportunity to be an advocate. WHO aims to react quickly and communicate effectively when a crisis occurs. Systematically developed media outputs like feature stories, materials for WHO’s social media, and videos in various languages will be disseminated to explain the issue for the global audience. This material will be available on the WHO website and social media platforms.

WHO will measure its achievement of this output using two indicators:

1. that the advocacy strategy is supported by a concrete workplan with specific outcomes; and

2. that the graphic representation is developed and consistently used so that all products associated with the project are identifiable.

Output 3: ACTION
(Best practices promoted and applied by WHO, Member States and partners)

At country level, health care workers and other partners are most interested in knowing what they can do to reduce the risk of attacks and to strengthen health systems to be resilient when faced with violence so that health services can continue to be delivered to those in need. Working with all relevant stakeholders, WHO aims to document and promote, with Member States and other relevant health actors, concrete measures with proven effectiveness in certain context to reduce attacks and mitigate their disruptions to health care. Gathering, promoting and applying best practice is the third output of this initiative.

Preliminary information suggests that such practices include adapting emergency response planning, engaging communities, conducting security analyses, training, making hospitals safer, removing administrative and legal obstacles to health care delivery, and implementing the Sendai Framework for reducing risks before, during and after emergencies. Gathering qualitative information with partners and through WHO’s country offices will allow WHO to develop and make available a compendium and simple checklist of measures that have worked in one context that may help those who are looking for solutions in similar contexts.
A. Conduct research on impact of attacks on health care on the health of the affected population

The first step to action needs to start from an understanding of the impact of attacks on the health of the population. The impact of attacks on health care may seem obvious in terms of facilities damaged and human lives lost from the attack. However, the indirect impact on the health of the disaster affected population who would have otherwise benefited from the health care is not yet clear. In view of the increased health needs of people in crises, it can be assumed that the impact is much higher than what meets the eye. For example, if a cholera centre that is specifically set up to respond to a cholera outbreak in a region is taken out of service, the impact would not only be on those patients requiring immediate treatment, but also on the community who would be left at higher risk of suffering from the disease due to lack of proper care.

It is important to have a broader understanding of the short and longer term impact that attacks have on health outcomes, access to health care, and the economic consequences to better advocate for the need to stop attacks on health care. Such understanding is also critical to implement work to stop attacks, and enable the health sector to achieve Universal Health Coverage and the health goals as outlined in the Sustainable Development Goals.

To achieve this output, WHO will complete the following activities:

1. Identify research questions and settings (at least 3 different settings) to answer key questions on the impact of attacks on health care and health service delivery.
2. Conduct data collection in selected settings.
3. Generate publishable research reports.

B. Document best practices

Even when operating in places that are susceptible to attacks, many health facilities, health care workers and organizations continue to deliver health services. It is important to capture the means taken by these health providers to safeguard health care on the ground, and deliver critical services to those in need. Information on such practical means to reduce the risk of attacks and strengthen health systems against violence is critical for those operating on the ground.

To achieve this output, WHO will complete the following activities:

1. Identify and document best practices for preventive, response and remedial measures.
2. Integrate best practice into existing programmes including safe hospitals, emergency trainings (e.g. pre-deployment training, health cluster coordinator training), the Emergency Response Framework, and global health emergency workforce documents.
3. Develop guidance on protecting health care from attacks based on best practices and research.
4. Promote and provide technical assistance to Member States, WHO country offices, and partners, for the application of best practice.
5. When relevant, include attacks as key issue in country-level Humanitarian Needs Overview and adapt programmatic priorities and operational plans to minimize attacks and resulting disruptions to health care delivery.
WHO will measure its achievement of this output using three indicators:

1. that research strategy is developed and implemented in at least 3 different settings;
2. that a best practice document is developed and promoted; and
3. that countries that have experienced attacks applying the guidance on protecting health care.

### 3 THE APPROACH

#### Partnership and collective action

The community of concerned states, organizations and other stakeholders that consider stopping attacks on health care as an urgent priority are already working together on data collection, on advocacy and on looking for solutions that protect health care.

This initiative will continue to build on and reinforce the work already underway by many including Member States, ICRC, MSF, UNICEF (including through the application of the Monitoring and Reporting Mechanism), OHCHR, non-governmental organizations, academic institutions, the Safeguarding Health in Conflict Coalition and many others to optimize our collective effectiveness in bringing change.

This initiative will continue to work horizontally and vertically within WHO for maximum results: WHE will work closely with country offices in priority countries on the three outputs of this project. And WHE will continue to work closely with WHO programmes outside of WHE that are involved in the safety of healthcare including the departments of Human Resources for Health, Occupational Safety and Health, Medical Services, Gender, Equity and Human Rights, and Violence and Injury.

WHO’s unique strengths within this collective effort include its leadership and convening power, its strong collaboration with Member States, its leadership of the Health Cluster and ongoing collaboration with many health related non-governmental organizations, its normative and technical as well as operational roles in emergencies, its presence in 150 countries, and its respected voice as the world’s health leader.

#### Geography

The initiative is global but its main geographic focus is at the country level to minimize disruptions to health care delivery in emergency settings that result from attacks on health care. Data suggests that countries with the highest numbers of reported attacks on health care are also the countries facing prolonged and complex humanitarian emergencies. An analysis of the SSA data in the first three quarters of 2018 found that reported attacks increased in occupied Palestinian territory and Syrian Arab Republic in specific locations where unrest or conflict intensified, demonstrating that access to health care is at greater risk during periods where it may be needed most by the local population. This initiative will focus on the priority countries as identified by the WHO Health Emergencies Programme (WHE). Keeping in mind that the priority countries of WHE change depending on the situation and new developments, the list will be kept flexible.

#### Beneficiaries

The direct beneficiaries are the health facilities, health workers and patients who are victims of violent attacks, and the emergency-affected populations who are deprived of health care due to the resulting disruptions to health care delivery. The beneficiaries also include the scores of potential victims such as these, the health workers who flee or are afraid to work, and entire communities that are deprived of health care when medical workers, transport, supplies and facilities are partially or fully dysfunctional for any period of time due to violence.
4 IMPLEMENTATION AND MONITORING

A WHO technical officer at headquarter is responsible for the implementation of this initiative. The technical officer will develop an organization-wide Attacks on Health Care Network to engage relevant WHO departments and offices. Each regional office and all country offices facing emergencies will be asked to identify a focal point for the network. The technical officer will collaborate with all relevant external partners and organizations on joint activities, ensuring that collective actions are complementary and synergistic. Together this network will work to achieve the three outputs of this initiative:

- Develop a body of evidence to better understand the extent and nature of the problem and its consequences to health care delivery;

1. Increase commitment to action through strong advocacy for an end to attacks on health care, the sanctity of health care in all circumstances, the delivery of health care unhindered by violence, and the application of International Humanitarian Law; and

2. Develop and promote the implementation of best practices for the prevention of attacks and the mitigation of their consequences to health service delivery, particularly through the actions of WHO’s country offices, Member States and other health actors in countries facing emergencies.

Risk analysis and mitigating measures

The risks identified are the following:

- Lack of human and financial resources
- Lack of organizational-backing at HQ and Regional Offices
- Lack of Member State support
- Lack of interest and will a country-level to track data on attacks
- Lack of compliance with best practices
- Political or security issues that prevent WHO from being involved in gathering and disseminating information about Attacks on Health Care

Mitigating measures associated with these risks are the following:

- Strong and individualized fund raising with specific donors
- Building internal and external networks that encourage engagement, concrete action and problem solving.
- WHA resolution(s) that oblige reporting on attacks by Member States, and application of best practices

Monitoring

This initiative sits within the WHO Health Emergencies Programme in the department of Emergency Operations (EMO). The work will be monitored annually as per WHO’s regulations and will be reported on in the Mid-Term Reviews in 2020 and 2022 and the Programme Budget Performance Assessments at the end of 2019 and 2021. The annual monitoring will be conducted against this document, its activities and output indicators.

At the end of 2019, an evaluation of this project will be conducted jointly with partners to determine it strengths and weaknesses, achievements and failures, and to make recommendations regarding its possible extension for an additional time period.
Logical framework (2019-2022)

**Project title**  
ATTACKS ON HEALTH CARE (2019-2022)

**Impact/goal**  
Essential life-saving health services are provided to emergency-affected populations unhindered by any form of violence or obstruction

<table>
<thead>
<tr>
<th>Outcome indicator A</th>
<th>Baseline</th>
<th>Target</th>
<th>Sources of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of health facilities that are compromised due to attacks on health care by country in 3 selected countries</td>
<td>N/A</td>
<td>0</td>
<td>Reporting using WHO's alert and validation tools; WHO situation reports; secondary open source data; Member State reporting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome indicator B</th>
<th>Baseline</th>
<th>Target</th>
<th>Sources of verification</th>
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</thead>
<tbody>
<tr>
<td>Percentage of countries (where attacks on health care have occurred) that have officially communicated on attacks calling for a stop of attacks</td>
<td>unknown</td>
<td>&gt;90%</td>
<td>Communication products, statements</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome indicator C</th>
<th>Baseline</th>
<th>Target</th>
<th>Sources of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of countries (where attacks on health care have occurred) that explicitly programme to minimize disruptions to health care from attacks</td>
<td>N/A</td>
<td>80%</td>
<td>SRPs, health response plans, country plans</td>
</tr>
</tbody>
</table>

**Output 1: EVIDENCE**  
Establish a body of evidence and global trends

<table>
<thead>
<tr>
<th>Indicators and description</th>
<th>Baseline</th>
<th>Target</th>
<th>Sources of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output indicator 1.A</td>
<td>Percentage of countries (where attacks on health care have occurred) reporting on Surveillance System on Attacks on Health Care</td>
<td>0</td>
<td>&gt;90%</td>
</tr>
</tbody>
</table>

| Output indicator 1.B | Annual report showing available comparative data and trends | 1 | 4 | Annual report disseminated |

**Activities**

**Activity 1.1**  
Apply the data collection methodology and tools in all countries and territories with emergencies using the SSA

**Activity 1.2**  
Collect and analyse available data on the trend of attacks

**Activity 1.3**  
Manage the SSA web system and the attacks on health care webpage, including a global repository of related information

**Activity 1.4**  
Develop and disseminate quarterly dashboards on attacks

**Activity 1.5**  
Develop and disseminate annual reports on the nature and extent of the problem, its consequences to health service delivery, and global trends
### Output 2: Advocacy

**Commitment to action and momentum for change**

<table>
<thead>
<tr>
<th>Indicators and description</th>
<th>Baseline</th>
<th>Target</th>
<th>Sources of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output indicator 2.A</td>
<td>0</td>
<td>1</td>
<td>Disseminated videos, articles and social media communications</td>
</tr>
<tr>
<td>Advocacy strategy and workplan developed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Output indicator 2.B</td>
<td>0</td>
<td>1</td>
<td>Project products have same layout and design</td>
</tr>
<tr>
<td>Graphic representation developed and consistently used</td>
<td></td>
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**Activities**

- **Activity 2.1**
  Develop an advocacy workplan including communication strategy and procedures at all levels

- **Activity 2.2**
  Systematically develop and disseminate advocacy and communications products as per strategy, including through social media

- **Activity 2.3**
  Organize and/or participate in key events (Human Rights Day, GA, WHA, ECOSOC)

- **Activity 2.4**
  Establish and continually update and disseminate key messages and talking points for use by the three levels of the Organization

- **Activity 2.5**
  Engage in health diplomacy to promote implementation of best practice during emergencies, and particularly in conflict settings, at global, regional and country levels

- **Activity 2.6**
  Engage in the Monitoring Reporting Mechanism at country level

### Output 3: Standards/Action

**Roles, responsibilities and best practice**

<table>
<thead>
<tr>
<th>Indicators and description</th>
<th>Baseline</th>
<th>Target</th>
<th>Sources of verification</th>
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</thead>
<tbody>
<tr>
<td>Output indicator 3.A</td>
<td>0</td>
<td>3</td>
<td>Document disseminated</td>
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<td>Research strategy is developed and implemented in at least 3 different settings</td>
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<td></td>
<td></td>
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<tr>
<td>Output indicator 3.B</td>
<td>0</td>
<td>1</td>
<td>Documented cases</td>
</tr>
<tr>
<td>Best practice document is developed and promoted</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Output indicator 3.C</td>
<td>0</td>
<td>60%</td>
<td>Country-level health response plans</td>
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<tr>
<td>Percentage of countries that have experienced attacks applying the guidance on protecting health care</td>
<td></td>
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**Activities**

- **Activity 3.1**
  Identify research questions and settings (at least 3 different settings) to answer key questions on the impact of attacks on health care and health service delivery

- **Activity 3.2**
  Conduct data collection in selected settings

- **Activity 3.3**
  Generate publishable research report

- **Activity 3.4**
  Identify and document best practice for preventive, response and remedial measures

- **Activity 3.5**
  Integrate best practice into existing programmes including safe hospitals, emergency trainings (e.g. pre-deployment training, health cluster coordinator training), the Emergency Response Framework, and global health emergency workforce documents

- **Activity 3.6**
  Develop guidance on protecting health care from attacks based on best practices and research

- **Activity 3.7**
  Promote and provide technical assistance to Member States, WHO country offices, and partners, for the application of best practice

- **Activity 3.8**
  When relevant, include attacks as key issue in country-level Humanitarian Needs Overview and adapt programmatic priorities and operational plans to minimize attacks and resulting disruptions to health care delivery

**Approach**

Work closely, and ensure complementarity of work, with all internal and external stakeholders
## PROJECT BUDGET 2016 - 2019

### A. ACTIVITY COSTS

#### Activities under output 1: Establish a body of evidence and global trends

<table>
<thead>
<tr>
<th>Activity number</th>
<th>Activity Description</th>
<th>Activity Cost Description</th>
<th>Total US$</th>
<th>Start date</th>
<th>End date</th>
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<tr>
<td>1.1</td>
<td>Apply the data collection methodology and tools in all countries and territories with emergencies using the SSA</td>
<td>Translation of content to French, Arabic, Russian and Spanish</td>
<td>10 000</td>
<td>Jan-19</td>
<td>Jun-19</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support missions to countries</td>
<td>100 000</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td>5 missions/year x US$ 5000/trip</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regional trainings</td>
<td>160 000</td>
<td>Jan-19</td>
<td>Dec-20</td>
<td>2 regional trainings</td>
</tr>
<tr>
<td>1.2</td>
<td>Collect and analyse available data on the trend of attacks</td>
<td>Staff cost</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Manage the SSA web system and the attacks on health care webpage, including a global repository of related information</td>
<td>Maintenance cost for IT</td>
<td>60 000</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td>US$ 15,000/year x 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IT updates (for major changes)</td>
<td>50 000</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td>US$ 25,000 x 2 (based on biannual review)</td>
</tr>
<tr>
<td>1.4</td>
<td>Develop and disseminate quarterly dashboards on attacks</td>
<td>Layout, translation</td>
<td>20 000</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td>US$ 5,000/year</td>
</tr>
<tr>
<td>1.5</td>
<td>Develop and disseminate annual reports on the nature and extent of the problem, its consequences to health service delivery, and global trends</td>
<td>Layout, translation, printing</td>
<td>80 000</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td>US$ 20,000/year Staff cost</td>
</tr>
</tbody>
</table>

Subtotal Output 1: US$ 480,000

#### Activities under output 2: Build commitment to action and momentum for change

<table>
<thead>
<tr>
<th>Activity number</th>
<th>Activity Description</th>
<th>Activity Cost Description</th>
<th>Total US$</th>
<th>Start date</th>
<th>End date</th>
<th>Comments/calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Develop an advocacy workplan including communication strategy and procedures at all levels</td>
<td>Staff time only</td>
<td>Jan-19</td>
<td>Jun-19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Systematically develop and disseminate advocacy and communications products as per strategy, including through social media</td>
<td>Development of communication products (video, graphics, etc), printing, layout, dissemination</td>
<td>100 000</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td>US$ 25,000/year</td>
</tr>
<tr>
<td>2.3</td>
<td>Organize and/or participate in key events (Human Rights Day, GA, WHA, ECOSOC)</td>
<td>Travel as required (3 events per year); printing, promotional materials</td>
<td>72 000</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td>US$ 5,000/travel x 3 x 4 years US$ 12,000 for promotional materials</td>
</tr>
<tr>
<td>2.4</td>
<td>Establish and continually update and disseminate key messages and talking points for use by the three levels of the Organization</td>
<td>Translation</td>
<td>8 000</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>Engage in health diplomacy to promote implementation of best practice during emergencies, and particularly in conflict settings, at global, regional and country levels</td>
<td>Training</td>
<td>270 000</td>
<td>Mar-19</td>
<td>Dec-22</td>
<td>US$ 80,000/training x 3 trainings US$ 30,000 for trainers and material development</td>
</tr>
<tr>
<td>2.6</td>
<td>Engage in the Monitoring Reporting Mechanism at country level</td>
<td>Support missions</td>
<td>60 000</td>
<td>Jan-19</td>
<td>Dec-22</td>
<td>US$ 5,000 x 3 times/year</td>
</tr>
</tbody>
</table>

Sub-total output 2: US$ 510,000
### Activities under output 3: Establish and promote best practice for WHO, Member States and partners

<table>
<thead>
<tr>
<th>Activity number</th>
<th>Activity</th>
<th>Cost description</th>
<th>Total US$</th>
<th>Start date</th>
<th>End date</th>
<th>Comments/calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Identify research questions and settings (at least 3 different settings) to answer key questions on the impact of attacks on health care and health service delivery</td>
<td>Meetings to scope and identify key research questions</td>
<td>50 000</td>
<td>Dec-18</td>
<td>Jun-19</td>
<td>2 meetings</td>
</tr>
<tr>
<td>3.2</td>
<td>Conduct data collection in select settings</td>
<td>Travel to selected settings</td>
<td>60 000</td>
<td>Jul-19</td>
<td>Jun-20</td>
<td>US$ 10 000 x 2 persons x 3 sites</td>
</tr>
<tr>
<td>3.3</td>
<td>Generate publishable research report</td>
<td>Cost for publishing</td>
<td>4 500</td>
<td>May-20</td>
<td>Dec-20</td>
<td>US$ 1500 /paper</td>
</tr>
<tr>
<td>3.4</td>
<td>Identify and document best practice for preventive, response and remedial measures</td>
<td>Travel to selected settings</td>
<td>60 000</td>
<td>Jul-19</td>
<td>Jun-20</td>
<td>US$ 10 000 x 2 persons x 3 sites</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Layout and printing</td>
<td>10 000</td>
<td>Jul-20</td>
<td>Dec-20</td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>Integrate best practice into existing programmes including safe hospitals, emergency trainings (e.g. pre-deployment training, health cluster coordinator training), the Emergency Response Framework, and global health emergency workforce documents</td>
<td>Staff time</td>
<td></td>
<td>Jul-20</td>
<td>Dec-22</td>
<td></td>
</tr>
<tr>
<td>3.6</td>
<td>Develop guidance on protecting health care from attacks based on best practices and research</td>
<td>Guidance development process (meetings, writing, layout, printing, dissemination)</td>
<td>120 000</td>
<td>Jul-20</td>
<td>Jul-21</td>
<td></td>
</tr>
<tr>
<td>3.7</td>
<td>Promote and provide technical assistance to Member States, WHO country offices, and partners, for the application of best practice</td>
<td>Support missions</td>
<td>25 000</td>
<td>Jul-20</td>
<td>Dec-22</td>
<td>2 missions/year x US$ 5000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trainings</td>
<td>100 000</td>
<td>Jul-20</td>
<td>Dec-22</td>
<td>2 trainings</td>
</tr>
<tr>
<td>3.8</td>
<td>When relevant, include attacks as key issue in country-level Humanitarian Needs Overview and adopt programmatic priorities and operational plans to minimize attacks and resulting disruptions to health care delivery</td>
<td>Staff time</td>
<td></td>
<td>Jan-19</td>
<td>Dec-22</td>
<td>Can be integrated into country support missions</td>
</tr>
</tbody>
</table>

**Sub-total output 3**  
US$ 429 500

**A. TOTAL ACTIVITY COSTS**  
US$ 1,419 500
## 5 PROJECT BUDGET 2016 - 2019

### B. STAFF COSTS

<table>
<thead>
<tr>
<th>Job title</th>
<th>Total US$</th>
<th>Comments/calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>HQ Project Leader P5</td>
<td>1 340 700</td>
<td>P5: US$ 335 175/yr for 4 yrs</td>
</tr>
<tr>
<td>Technical officer - operationalization of protecting health care P4</td>
<td>412 500</td>
<td>P4: US$ 275 000/yr x 1.5 yrs</td>
</tr>
<tr>
<td>Technical Officer - data management and advocacy P2</td>
<td>800 000</td>
<td>P2: US$ 200 000/yr x 4 yrs</td>
</tr>
<tr>
<td>RO Project focal point P4 in AFRO and EMRO</td>
<td>1 452 000</td>
<td>P4 regional (AFRO) US$ 266 000/yr x 3 yrs + (EMRO) US$ 218 000/yr x 3 yrs</td>
</tr>
<tr>
<td>Project focal point P4 in AMRO, EURO, SEARO and WPRO at 20%</td>
<td>600 000</td>
<td>US$ 250 000 x 3 yrs x 20% x 4 posts</td>
</tr>
<tr>
<td>CO Project focal point P4/P5 (WHE team lead or HCC)—at no extra cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data manager P4 at 100% in 5 countries</td>
<td>3 750 000</td>
<td>US$ 250 000 x 3 yrs x 100% x 5 countries</td>
</tr>
<tr>
<td>Data manager P4 at 20% in 10 countries</td>
<td>1 500 000</td>
<td>US$ 250 000 x 3 yrs x 20% x 10 countries</td>
</tr>
<tr>
<td>Data manager NPO at 20% in 12 countries</td>
<td>36 000</td>
<td>US$ 5000 x 3 yrs x 20% x 12 countries</td>
</tr>
</tbody>
</table>

Sub-total staff costs: US$ 9 891 200

### B. TOTAL STAFF COSTS

US$ 9 891 200

### A + B (SUB-TOTAL FOR ACTIVITIES AND STAFF COSTS)

11 310 700

### C. PROGRAMME SUPPORT COSTS (13%)

1 470 391

### GRAND TOTAL

US$ 12 781 091

FUNDING AVAILABLE AS OF JANUARY 2019

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FUNDING NEEDS 2019-2022

US$ 12 781 091