Evaluation of the ICRC's Health Care in Danger Strategy 2020-2022

Antei Global – Evaluation report

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Expert Consulting Team:
Dr Nynke van den Broek
Mr. Fabrice Boussalem
Mrs. Caroline Grangier

ANTEI GLOBAL
31 avenue Lucien René Duchesne
78170, La Celle Saint Cloud
+33 6 73 68 53 72
caroline.grangier@antei-global.com
www.antei-global.com

TABLE OF CONTENT

ACRONYMS

AU	African Union
CCA	Cross-Case Analysis
COC	Community of Concern
DG	Director General
DRC	Democratic Republic of the Congo
FCV	Fragile, Conflict-Affected and Vulnerable
FP	Focal Point
GBV	Gender Based Violence
GHO	Global Humanitarian Overview
GVA	Geneva
HCF	Health Care Facility
HCID	Health Care in Danger
HMIS	Health Management Information System
H0D	Head of Delegation
HQ	Head Quarters (ICRC Geneva)
HWW	How We Work
ICRC	International Committee of the Red Cross
IHL	International Humanitarian Law
IS	Institutional Strategy
KI	Key Informants
KII	Key Informant Interviews
MHPSS	Mental Health and Psychosocial Support
MRG	Movement Reference Group
OBA	Outcome Based Approach
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PES	Protection and Essential Services
POC	Protection of Civilians
PFR	Planning for Results
PRF	Program Reference Framework
REC	Regional Economic Communities
SDG	Sustainable Development Goals
TBE	Theory Based Evaluation
TOC	Theory of Change
TOR	Terms of Reference
UN	United Nations
UNSC	United Nations Security Council

EXECUTIVE SUMMARY

Background

The protection of healthcare from violence was formalized in 2011 by the International Committee of the Red Cross (ICRC); originated in the first Geneva Convention of 1864. Since then, the Red Cross/Red Crescent Movement with the ICRC have worked on protecting the medical mission in different types of violence and conflicts, advocating for the respect for basic humanitarian principles, and the Protection of Civilians (PoC). This report presents the findings of an evaluation of the Health Care in Danger (HCiD) Strategy 2020-2022 which was developed in the preceding years.

The overall **Goal** of the HCiD Strategy is to: Reduce violence against healthcare and its impact in armed conflict and other emergencies. The six objectives that lead to the Goal are set out in the HCID Theory of Change (ToC).

In 2022, the ICRC commissioned an Evaluation of the Healthcare in Danger (HCiD) Strategy with as the main objectives to look at the: 1) Relevance, and 2) Effectiveness of the Strategy and embedded Theory of Change (ToC).

Evaluation Approach and Methodology

The HCiD 2020-2022 Strategy includes a clearly described ToC with well-defined indicators, targets, and timelines. The overall approach used for the evaluation was a Theory Based Evaluation. An evaluation matrix was developed setting out key evaluation questions which were addressed using document review and information obtained through 33 Key Informant Interviews (KII) with a wide range of stakeholders from across 10 countries.

Findings of the Evaluation

The evaluation gives an overview of the HCiD Strategy, its historical perspectives, and places it in the global context and understanding of violence against healthcare, conflict, and emergencies. Implementation mechanisms and context are described in the context of the wider ICRC as an organization working in partnership and through its Delegations.

Regarding Relevance of the HCID Strategy - The HCiD Strategy is considered 'highly' or 'very' relevant by most stakeholders working at global and national level including among all implementation and research partners. The HCiD Strategy is considered as being 'well set out', the ToC is clearly formulated, and the Objectives are considered 'comprehensive' and together are expected to contribute to the achievement of the Goal. All delegations providing input into the evaluation reported being able to implement activities for most (and sometimes all) of the specific Objectives. There was demonstrable commitment and enthusiasm for implementation, active thinking and development of approaches and solutions to doing so in a very wide range of settings as well as phases of and types of conflict. Sharing of experiences across and between countries is ongoing including via events, (de-)briefings, personal connections, and visits between Head Quarter (HQ) staff and country Delegations. Although 'capacity'- understood in the broadest sense - is often perceived as a limiting factor (lack of prioritization, workload, specific experience, etc.). Delegations, Partners, and HQ staff see and describe many opportunities to implement the HCiD Strategy – examples of which are given in the report. There is discussion regarding the 'mandate' and 'scope' of the HCiD Strategy regarding whether this should apply to 'all violence', 'urban violence', 'criminal gangs', 'tension and violence because of non-availability or poor-quality care, or, whether the Strategy should be focused on 'traditional', and restricted understanding of, 'armed conflict '. In line with these shifting global concepts information was obtained on the types of and range of incidents that are considered 'violence and conflict', the phases and duration of conflict and humanitarian emergencies, and the need to address Health Care in Danger via a 'continuum' of preparedness, emergency action and longer-term development.

Regarding Effectiveness of Implementation of the HCiD Strategy - The evaluation considered effectiveness for implementation of the four main objectives as well as the two cross-cutting objectives - evidence-base generation and influencing and coalition building.

Objective 1 - The majority of KI reported that there is active engagement with 'weapon bearers' and that this is 'successful' or 'effective'. The focus is mostly on influencing and effecting change in behavior regarding practical measures to protect healthcare which are usually situation specific. Evidence for change in policy or for obtaining formal commitments from armed actors is more difficult to obtain although several delegations initiated and facilitate ongoing round-table discussions which are likely to influence this. Other modalities for supporting behavior change are training and awareness raising of the International Humanitarian Law and (IHL) and HCiD Strategy, including by integrating this into curriculums (medical and military).

Delegations can struggle with the complexity of this especially in settings where the armed actors do not respect or are unaware of the neutrality of ICRC, cannot be engaged directly and/or through the community for security reasons, are not organized, do not have a formal command structure, and/or are not operating 'under' any policy or doctrine.

Objective 2 - There are examples of significant progress against this objective in several settings. In others it has been difficult to make progress largely because of contextual factors (no clear State actors, active ongoing conflict, lack of legislation or possibility to establish this). Where this has been successful this has required (longer-term) working with a range of actors (Health, Legal, Political) through effective discussion and negotiation to increase knowledge about, inform of, and discuss the need for, legislation to be in place – including described as 'agreed practice', 'guidelines', 'code of conduct' - and including highlighting this as the 'underpinning' for all ICRC's work. The importance of working at all levels (regional, national, provincial, local government) was highlighted by KIs. A strong emphasis also emerged regarding the importance of implementation (not only 'producing a law') and support to implementation of agreed legislation (sensitization and information workshops, training, involving the community).

Objective 3 - There is a wide range and types of violence reported by delegations working across ICRC constituencies. Almost all delegations are working on this objective, see opportunities to expand activities, and would like to do more, but generally report lacking capacity and/or funding to do so. Training is provided at several levels (pre- service and in-service) on practical measures to protect healthcare providers during their work, professional behavior, de-escalation of violence and recognition of mental health needs. In many settings there are 'Master Trainers' and a new option for on-line training has also been developed. In some settings reported 'behavior change' is strengthened by measures such as supportive supervision or 'follow-up' and additional efforts to implement legislation and 'code of conduct' e.g., via notices placed in healthcare facilities to make these 'weapon free areas.

Objective 4 - Across delegations there is active engagement with the community and including a range of partners, community-based opinion, and decision makers. Engagement centers around raising awareness and understanding on how healthcare facilities and healthcare providers operate, codes of conduct, increasing community ownership of 'their' healthcare facility and asking about the problems communities face as well as the solutions they propose. The focus for most delegations is on direct engagement rather than public campaigns although there are opportunities for campaigns including via radio, television and through social media.

Cross-cutting Objective 1 - Currently there are three main modalities for gathering evidence including – reporting of incidents, research – and – programmatic reporting including annual surveys. There is a wealth of information to illustrate that the reporting of incidents is effective. Reports of an incident or attack is often a 'catalyst' to taking specific action, engaging with State or Non-State actors, for community engagement and provides 'evidence' for advocacy as well as possibly for campaigns. Thus, the reporting of incidents is a 'cross-cutting' activity required for successful implementation, or at least influencing, of all the four main objectives in set out in the HCID ToC. There is an emerging research agenda and several

partnerships have been established to implement this. It is likely further capacity will need to be built at HQ and national level.

A renewed focus on obtaining program evidence of progress and success is required, as not all evidence is currently captured, analyzed, summarized, and disseminated. This is not because of lack of implementation or success, but lack of specific focus on this. HCiD is a transversal file and there is currently no centralized system to capture information (other than via annual surveys) as part of e.g., the Program for Results and/or Program Reference Framework.

Cross-cutting Objective 2 - The CoC is a collective working mechanism that can be adapted, structured, as needed based on circumstances and needs, to best serve the purpose of delivering results against the HCiD strategy overall vision and programmatic guidance. ICRC might provide inputs and/or support based on degree of leadership and ownership by national stakeholders, especially national and sub national authorities, but also other key stakeholders both within and outside the Movement. Fundamentally a CoC is a working platform that requires time and consistent follow up with its members, especially those in key positions (chair, secretariat, etc.) and/or leading specific activities implementation. Overall CoCs can be considered as effective vehicle to frame and advance the HCiD agenda and encourage results delivery. Where established, they have started fulfilling their role as collective working platforms. This requires various degrees of involvement and support by ICRC and/or other partners within the Movement, which in turn implies a certain level of leadership, engagement and internal organization and planning at the Delegation level.

Recommendations

Examples of good practice are summarized in this report including via narrative illustrative Case Studies. Recommendations are provided for each of the Objectives set out in the ToC, and, more generally, for further strengthening of the HCiD transversal file. Wider dissemination of the HCiD Strategy and lessons learnt is recommended and can be expected to lead to Delegations' ability to adapt tools and approaches that have been developed over time, have demonstrably worked in one setting or phase of conflict and emergency, and can be adopted for use in their specific setting.

1 INTRODUCTION

The protection of healthcare from violence was formalized in 2011 by the International Committee of the Red Cross (ICRC); originated in the first Geneva Convention of 1864[1]. Since then, the Red Cross/Red Crescent Movement along with the ICRC have worked on protecting the medical mission different types of violence and conflicts, advocating for the respect for basic humanitarian principles, and the Protection of Civilians (PoC). Over the past 10 years, the ICRC under the banner of the Health Care in Danger (HCiD) transversal file, structured their actions towards the protection of healthcare including with the development of a specific Strategy – the 2020-2022 Healthcare in Danger Strategy.

The overall **Goal** of the HCiD Strategy is to: Reduce violence against healthcare and its impact in armed conflict and other emergencies.

The six **Objectives** set out via a Theory of Change (ToC) include:

Objective 1: Weapon bearers adopt policies and practical measures in order to ensure respect for healthcare services and enable safe delivery of healthcare

Objective 2: States adopt and implement legislation to protect healthcare from violence

[1] See for instance: "Safeguarding the Provision of Health Care - Operational Practices and Relevant International Humanitarian Law Concerning Armed Groups", Chap. 6 outlining international legal obligations.

Objective 3: Healthcare providers are better prepared to prevent violence and to mitigate against this and to cope with its impact

Objective 4: The general population (and/or those affected by conflict and other emergencies) has greater respect for healthcare

The two cross-cutting Objectives are:

Cross-cutting Objective 1: Methodologically sounds evidence supports analysis and prevention of violence against healthcare

Cross-cutting Objective 2: Health Care Stakeholders Coordinate Closely to Prevent Violence

A Terms of References (ToR) was developed to guide the evaluation of the HCID Strategy. (Annex A)
The focus areas for the evaluation are set out to be:

- relevance and adaptability of the Strategy and formulated ToC
- operationalization at national and subnational levels
- evidence generation and use by headquarters and field-based partners, and
- influencing and coalition building at all levels (global through to local).

To inform the further fine-tuning and/or development of the HCiD Strategy and enhance its translation in practice, the evaluation is intended to achieve two strategic objectives:

- assess the relevance and the effectiveness of the strategy, and
- identify areas requiring amendment

2 METHODOLOGY

Overall Approach and Focus of the Evaluation

The HCiD 2020-2022 Strategy includes a clearly described ToC with well-defined indicators, targets, and timelines. It was assumed that there is some evidence of change or influence after two years of implementation. Therefore, the overall approach used for the evaluation was a Theory Based Evaluation. Risks and assumptions related to the ToC and implementation of the objectives as set out in the HCiD Strategy were explored considering the global contexts and variety of settings (socio-geographical and political) in which the HCiD Strategy is expected to be operationalized.

One of the key evaluation questions was to understand if the HCiD Strategy and its ToC were considered relevant by stakeholders. Secondly, whether stakeholders believed the HCiD Strategy could 'in principle' be implemented (in part or in full) and/or whether the ToC and its stated objectives required to be adjusted for particular settings. Specifically, for each of the Objectives set out in the ToC, the evidence for implementation and effectiveness of implementation was explored. Finally, the relevance, comprehensiveness, and feasibility of implementation (or operationalization) of the ToC was explored regarding whether this could be expected to lead to achieving the overall Goal of the HCiD Strategy (i.e., the 'program' or long-cycle logic) to: 'Reduce violence against healthcare and its impact in armed conflict and other emergencies'. [2]

Evaluation Questions

The ToR set out 11 main questions. The evaluation sought to refine and seek answers to these and additional questions pertaining to the HCiD Strategy overall and its six objectives (4 main objectives and 2 cross-cutting). An Evaluation Matrix was developed during the Inception Phase. (Annex B)

[2] ICRC Institutional Health Care in Danger Strategy 2020-2022 – Protecting health care from violence and attacks in situations of armed conflict and other emergencies – and please see foot note 1 page 1 of the Strategy document.

Data Collection

Information to support the findings of the Evaluation was obtained through Document Review and Key Informant Interviews:

Document Review - Documents were identified at the start of the Evaluation and through Stakeholder Interviews on a rolling basis. A list of Documents obtained is provided as Annex C

Key Informant Interviews (KII) - A Topic Guide was developed based on the evaluation questions to be explored. Snowballing technique was used to identify additional KI wherever indicated. 33 KII were conducted with a wide range of stakeholders from across 11 countries. All KII were recorded (with permission) and transcribed.

Analysis of Data

Documents reviewed were referenced in the report wherever applicable. For KII the transcriptions and interview notes were used to conduct a thematic framework analysis was conducted. Document review and information obtained from KII were combined (triaged) and used to develop a narrative summary of findings with illustrative quotes and 5 illustrative Case Studies.

Ethical Considerations

International best practice and ethical principles of data collection, storage and sharing were adhered to as per ICRC guidelines. KIIs were recorded with consent. All data (recordings and notes) will be destroyed by the evaluation team after analysis at the time the final report has been completed and approved. Given the highly sensitive nature of some of the formation obtained all information has been anonymized and summarized such that it not possible to trace this back to any specific setting, time frame, group, or person.

3 RELEVANCE - HCID STRATEGY IN CONTEXT

Key Evaluation Questions
Where does the ICRC's HCiD strategy sit within a larger global framework and partnerships addressing the need to protect healthcare? The HCiD Strategy is implemented through a variety and number of activities that represent de facto a significant contribution to SDG 3, addressing the provision of healthcare as a universal framework. Given the overall global trends in conflict and violence, with renewed risks and violence against healthcare, the key instruments of IHL, the Geneva Conventions and other instruments such as the UNSC Resolution 2286, are all highly relevant to the protection of healthcare (hence to the HCiD Strategy) and will require renewed attention and advocacy. At ICRC's global HQ level, the HCiD Strategy and the Institutional Strategy are "fully connected", mutually supportive of each other and entirely 'in-sync' with regard to contributing to institutional objectives. In addition, the HCiD thematic area is highly multidisciplinary in nature, focusing on a central humanitarian issue rather than being department-based, and, has become an emblematic example of how cross-cutting work can be developed, led and implemented within ICRC.
Is the Theory of Change (ToC) relevant to a wide variety of settings and contexts where healthcare is in danger? A clear and broadly shared consensus emerges through literature review and KII about the HCiD Strategy being relevant at all times and in an extensive range of contexts (armed conflict, IAC and NIAC, other emergencies and situations of violence). Furthermore, the terms used in various documents show openness and agility - both from a programmatic and policy point of view - to adapt to complex and evolving contexts.

3.1. EVOLVING CONTEXT AND RELEVANCE OF THE HCID STRATEGY AT ALL TIMES

Protection of healthcare from violence, especially in times of conflict is one of the foundational issues for International Humanitarian Law (IHL) since the first Geneva Convention adopted in 1864[3]. The Red Cross/Red Crescent Movement and the ICRC have therefore worked on protecting the medical mission throughout their history. Over the last decade however, the nature of violence and conflict has continued to evolve and has even shifted significantly with e.g., a change in the nature of global conflicts from international to non-international.[4] Furthermore, these new faces and patters of so-called modern conflicts (with development of new technologies, asymmetric nature, etc.) and diversifying situations of violence – such as violent extremism, acts of terrorism or domestic criminality for instance - challenge the applicability of IHL that require, like any law, careful interpretation, evolution and development[5].

In this context, despite decades of hard-won gains on the front of respect for basic humanitarian principles, global frameworks, and clear rules of engagement with the protection of civilians (PoC) as paramount principle, the situation on the ground keeps worsening in a number of contexts where healthcare systems, infrastructure, and personnel are being targeted, and this violence even sometimes being perceived as 'means of war' (more recently Ukraine, Syria, Ethiopia).

The 2020-2022 period covered by the HCiD Strategy corresponds to the COVID-19 pandemic that has resulted, among several other major consequences, in a significant rise in violence specifically against healthcare as observed and reported both within the ICRC and among some members of the global CoC.

A series of guidance documents have been developed by ICRC both for diplomatic and delegations' operational use[6]. Although specifically related to the COVID-19 pandemic, these also reflect the relevance and acuteness of healthcare being in danger in a much broader range of settings, 'in conflict and other emergencies' with evidence of an emergency (such as the pandemic) of impact on an already overburdened health system in many settings in which ICRC works.

Thus, 'In conflict' may in first instance seem straight forward although profile of modern conflicts evolved as outlined above: healthcare can be specifically targeted or not, but in the latter, it is still impacted and counted as so-called 'collateral' damage.

The term 'And in other emergencies': in practice denotes a range of settings, i.e., non-conflict, but where pressure is put on the health system for several reasons leading ultimately to various forms of violence against healthcare. These are related to: (1) the social fabric and inter groups dynamics and tensions (social-economic, ethnical/racial), (2) specific events and incidents (that could result in mass casualties), (3) access to and capacity to deliver health care, its quality and/or effectiveness (speed of treatment, need for referral), and as well as (4) perception of the public (be it formal/unformal weapon bearers and general public, including patients themselves).

It should also be noted that the ICRC Institutional Strategy 2019-2024[7] highlights the following terms/definitions: "the term 'armed conflict and other situations of violence' will be shortened to 'conflict and violence' for ease of reading". […] "the ICRC uses 'other situations of violence' (hereafter 'violence') to refer to situations of collective violence, perpetrated by one or several groups, which do not reach the threshold of an 'armed conflict', but that may have significant humanitarian consequences."

[3] See for instance: "Safeguarding the Provision of Health Care - Operational Practices and Relevant International Humanitarian Law Concerning Armed Groups", Chap. 6 outlining international legal obligations.
[4] See for instance: http://www.un.org/en/un75/new-era-conflict-and-violence
5 "Delineating the Boundaries of Violence", Editorial, International Review of the Red Cross (2014), Scope of the Law in Armed Conflict.
[6] These include for instance the following: (1) "HCiD and COVID-19, 17 April 2020"; (2) "HCiD: Global qualitative trend analysis, guidance on multidisciplinary response and selected field practices for inspiration"; (3) "Covid-19 and Violence Against Health Care – Safer COVID-19 Response: Checklist for Health-Care Services".
[7] ICRC Strategy 2020-2024. It also states in its Mission Statement: "Established in 1863, the ICRC [...] directs and coordinates the international activities conducted by the Movement *in armed conflicts and other situations of violence*."

Interestingly the ICRC Health Strategy 2020-2023 outlines and envisages strengthening the "continuum of care" approach and reinforcing respect for IHL and the right to health, together with emphasizing the importance of training and development of ICRC's health workforce and of building local health capacity. Figure - Visual 2 - "Respect for healthcare at all at all times" - highlights the relevance of an HCiD strategic framework approach along a "relief to development continuum" with a focus on prevention.

Against this backdrop, a "Health Care in Danger" (HCiD) Strategy is not only highly relevant and more than ever needed, but requires further fine-tuning and enhancement at all levels, to keep translating from policy to practice in the field. Given the global contexts, the key instruments of IHL, the Geneva Conventions and others instruments highly relevant to the HCiD Strategy such as he UNSC Resolution 2286, require renewed attention and advocacy.

3.2. CONTEXT OF THE HCID STRATEGY AS A THEMATIC FILE WITHIN ICRC

Over time the HCiD File has taken various forms (refer to visual 1, capturing the HCiD "big picture" over time and geographic scope). The initial project was designed with a specific timeline (2011-2015), that was subsequently extended for the period 2015-2017 (phase II), then again for 2017-2019, which is when the term 'project' was replaced by the term 'initiative"[8]. The thinking on "what next?" was fed by various assessments, surveys, strategic notes, and reports at critical junctures. The overall spirit at each step was meant to keep the HCiD thematic file as operational as possible in coherence with ICRC's broader way of working, in particular with regard to its responsiveness in the field and the Delegations' autonomy[9] At a global level, since the HCiD thematic area is highly multidisciplinary in nature, focusing on a central humanitarian issue rather than being department centric, it has become an emblematic example of how cross-cutting work can be led and caried out within ICRC.

Upon the adoption of DIR 2640[10], approving the new HCiD strategy 2020-2022, the ICRC Directorate requested a reflection to develop a sustainable model to maintain the organization's efforts to protect healthcare in the long term. The Note "Towards a Sustainable Model for HCiD" shows how the HCiD File is forward looking and questions internal planning and monitoring mechanisms along with other internal strategic discussions, namely on:

- The How We Work (HWW) initiative with a focus on the creation and development of Networks/Centers of Expertise.
- The establishment of the Outcome Based Approach (OBA)[11] as a specific workstream aimed at improving the planning, monitoring, and implementation of the ICRC's multidisciplinary programming to deliver meaningful outcomes for the population. In that spirit, the HCiD 2020-2022 Strategy and its embedded Theory of Change aim to provide further programmatic and organizational guidance.

Additionally, the best testimony of the centrality of the HCiD File to the ICRC core mandate and operations in the field is probably the way it echoes in the broader ICRC Institutional Strategy 2019-2024 (IS), and in other sector specific policies and strategies. In this regard the Note also describes how the HCiD, and the IS are "fully connected" (the main axes of alignment between the two being summarized), and to conclude that both strategies are mutually supportive of each other and are entirely in-sync in contributing to institutional objectives. The 2020–2023 Health Strategy outlines the intention of stepping up its action in relation to HCiD by a "stronger commitment to effectively embed into ICRC health programming actions to prevent and reduce attacks on healthcare workers, infrastructure and ambulance services". The Health

[8] The "HCiD Evaluation Report" (2017) provides a useful recap of the HCiD key evolution steps and formats.

[9] Study on the Management and Operationalization of HCiD as a Transversal File. The Study was commissioned in 2019 by ICRC, on HCiD as a cross-cutting initiative and 'Transversal File' informed by a series of eight case studies and cross-case analysis. It was learning oriented and provided better understanding on how the HCiD initiative is implemented at the field level by delegations in various contexts.

[10] DIR2640 on Health Care in Danger strategy 2020-2022, 24.06.2019 (formal approval of the Strategy by the Directorate).

[11] This is in line with major outcomes of the World Humanitarian Summit 2016: World Humanitarian Summit 2016 | Agenda for Humanity. Humanitarian Aid is being framed by broader requirements such as Accountability to Affected Population (see specific ICRC Note on the subject), but also indigenous partnerships and aid localization among others. The Agenda for Humanity includes among its five core responsibilities the "Respect Rules of War" and mentions specifically to "Ensure delivery of humanitarian and medical assistance", as well as "Work Differently to end Need", with highlights on "reinforcing local systems" and to "transcend humanitarian development divides".

Unit has subsequently produced a proposition and a Plan of Action outlining the mutual reinforcement between the HCiD approach and the health strategy[12]

Finally, the internal institutional landscape in relation to transversal thematic files has also evolved considerably. A Thematic Unit has been established under the new Directorate of Protection and Essential Services. It reinforces the ICRC's commitment to continue working on concrete humanitarian problems from the perspective of thematic files, which requires the organization to develop ways to work more effectively transversally.

3.3. THE HCID STRATEGY AND COUNTRY-LEVEL IMPLEMENTATION

The institutional arrangements and thinking on internal working mechanisms reflect the importance of the HCiD Strategy for ICRC with an understanding that it is relevant for people in numerous environments where healthcare is indeed in danger for various context specific reasons[13] as outlined in section 3.1. above.

Although the HCiD Strategy is clearly field- and action-oriented, a high degree of autonomy and flexibility is left to the delegations at country level to incorporate (or not) the HCiD file in their respective activities (e.g., via the Planning for Results (PfR) mechanism) and to request for and dedicate relevant financial and staffing resources for implementation of all or certain aspects of the HCiD Strategy. Consequently, investing on HCiD activities implies a choice and balance to be found between the need for an immediate humanitarian response to the impact of conflict or other emergencies, and a response to longer-term requirements. Both approaches will e.g., require different sets of capacity building at various levels (conducive environment, legal/policy, institutional, individual) that are (also) key for emergency preparedness, hence relevant to ICRC's core mandate. This also raises the fundamental question of coordination in the largest sense, i.e., working with a wide range of relevant stakeholders with specific and complementary mandates, capacities, legitimacy.

Elements of coordination will be considered further under the section on the cross-cutting objectives, specifically for Cross cutting Objective 2: "healthcare stakeholders coordinate closely to prevent violence". Violence against healthcare continues to be a major concern shared by a range of stakeholders. In that spirit the HCiD was facilitated by institutional mechanisms including a Movement Reference Group (MRG) until recent years, and a broader Global Community of Concern (CoC) that need shifting of focus towards national and sub national levels.

The Study on a sustainable model for HCiD has been part of the transition from a time-bound-project focused on HQ driven deliverables to a permanent and core part of operational programming. It builds on the Study of HCiD as a Transversal File and presents two management models for respectively (A) large operational delegations and (B) smaller delegations/missions with limited operational footprint, which nevertheless run a significant volume of HCiD activities. These models outline the delegation level required roles and responsibilities (leadership, technical oversight), internal ICRC coordination (across departments/units and geographically between delegation and sub delegations) as well as external coordination in the context of CoCs and possible additional coordination mechanisms (UN clusters, working groups, etc.).

Figure- Visual 1: HCiD: The Big Picture

Visual 1 was developed to make sense of and organize the volume and diversity of the information, views, and perspectives, gathered through KIIs and document reviews, and to place the current HCiD Strategy

[12] See 1. "ICRC Health Strategy 2020-2023", 2. "Walk The talk proposition – Health Unit 2020" and 3. "HCiD PoA contributing to the health strategy 2020-2023".
[13] "Researching Violence against Health care: Gaps and Priorities, ICRC/ELRHA - Also refer to a series of surveys and case studies referenced in this report bibliography.

into a dynamic and evolving institutional context. It also captures the diverse actions taken at various levels within ICRC to advance the HCiD thematic area and the implementation of its strategy.

- [Left hand strip] - **"What was done so far... and more to come"**: major steps in the HCiD evolution, i.e., from initial project, its time extensions, transition toward an Initiative to the current Strategy 2020-2022. Yellow boxes highlight structured support that exist and can be further fine-tuned, enhanced, I.e., through the setting up of a practitioners' network (or Center of Expertise) and a toolbox bringing together a range of resources relevant to various aspects of the HCiD Strategy and its implementation at all levels.
- [Right hand box] **- "ICRC transversal & multi-level approach across departments, units, Delegations"**: shows the various levels of involvement within the organization, from the highest hierarchical level and broader governance structures (DG Office, President, etc.) to Delegations and sub delegations in countries.
- [Central part] - Represents the **Multi-level Governance Approach** that prevails in large organizations such as ICRC having both global interactions and field presence and interventions across the globe:
  - Global level: CoC as platform and network for humanitarian diplomacy, advocacy, and communication. Highlighting policy achievements and other references. Feeding into the HCiD endeavor in its various forms and being informed by its implementation in the field.
  - **HCiD Strategic Framework**, connecting global, strategic/policy level, with regional and national sub national operational levels.
    - [Left pyramidal diagram] - Captures the tools and working mechanisms to advance the implementation of the strategy within ICRC (delegations/PfR), the national conductive environment (legal framework/policies) and relations with partners and stakeholders (via CoCs, ad hoc synergies, partnerships, coordination).
    - [Right pyramidal diagram] - Highlight 3 focus groups as outlined under 3 of the ToC objectives (weapon bearers, the public, health personnel), how they interact and how building their respective capacities advances the goal of the strategy.
  - Regional level: translates into regional practitioners' meetings and/or initiatives taken via regional and sub regional organizations (such as AU and RECs in Africa) to advance the HCiD agenda towards these organizations' member states.
  - National and sub national levels: highlights CoCs and other coordination and collective working mechanisms within ICRC (delegation and sub delegations) and external partnerships, synergies, and collaboration.
  - Each level has both ICRC specific boxes (white) and external, collective working mechanisms (colored boxes).
  - [Top strip] - symbolizes the **HCiD File evolution** over 2011-2022 and how its rich history and experience informs the future of the file as a longer-term endeavor within ICRC as a permanent and core part of operational programming. Current evaluation is part of that stock taking and transition process.
  - [Bottom arrow] - Formal reference to **ICRC's leadership and support** towards enhanced healthcare safety and security. It also shows that the HCiD endeavor is de facto a contribution to the broader universal) SDG Framework14, especially SDG 3 (health and well-being for all)15 in connection with SDGs 16 (peace and security, global governance)16 and 17 (partnerships) 17.

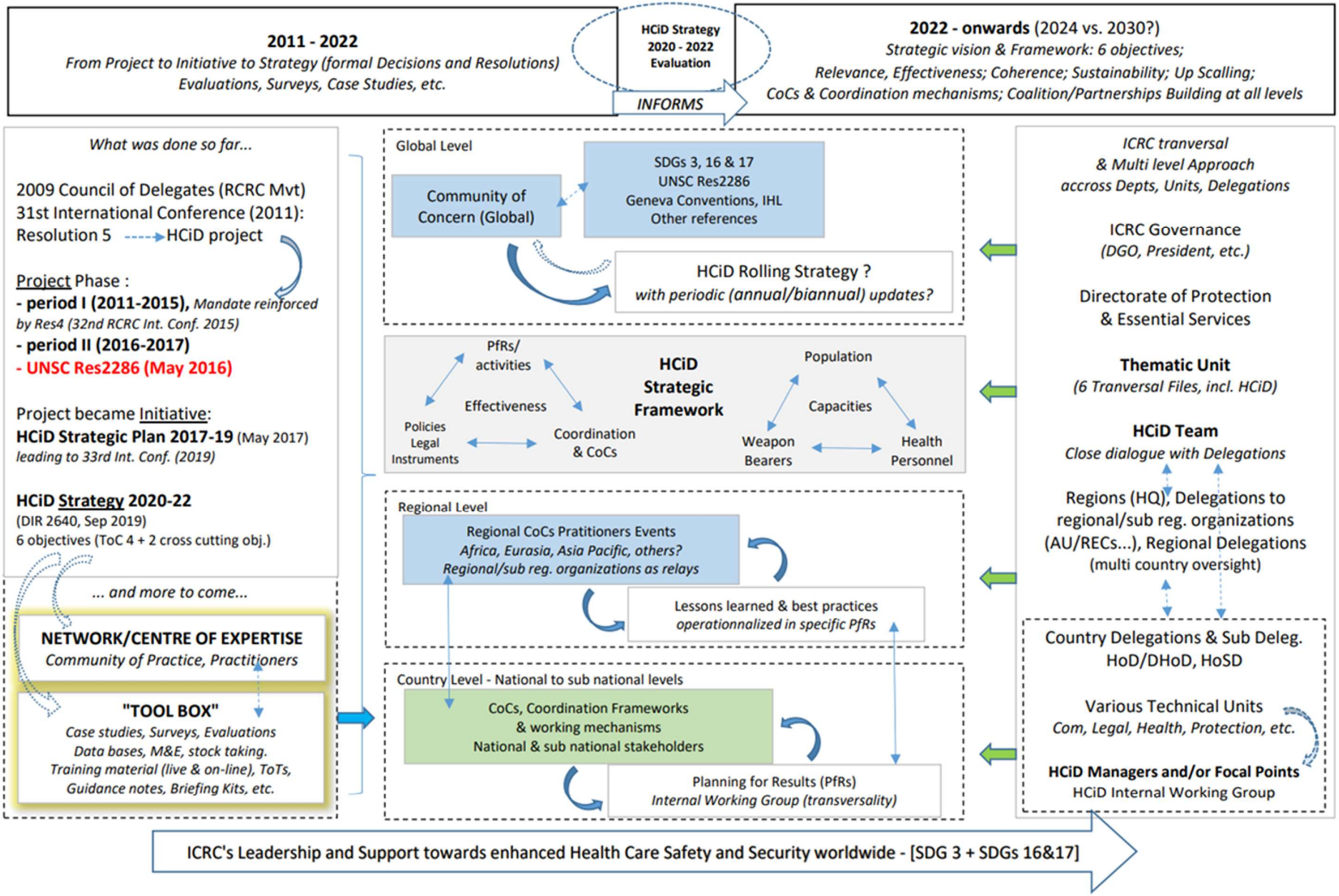
[14] See Home | Sustainable Development (un.org).

[15] SDG3:" Ensure healthy lives and promote and promote well-being for all at all ages" with a focus on target **3.8 "**Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".

[16] **Sustainable Development Goal 16** (**SDG 16** or **Global Goal 16**) is about "peace, justice and strong institutions." One of the 17 Sustainable Development Goals established by the United Nations in 2015, the official wording is: "Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels".

[17] **Sustainable Development Goal 17** (**SDG 17** or **Global Goal 17**) is about "partnerships for the goals." One of the 17 Sustainable Development Goals established by the United Nations in 2015, the official wording is: "Strengthen the means of implementation and revitalize the global partnership for sustainable development".

VISUAL 1: "Health Care in Danger: the Big Picture"



Several elements of the visual highlight the relevance of the timeframe for the HCiD Strategy: 2024 (to fit the Institutional Strategy period) or 2030 along the SDGs horizon. It could also, in any case, feature as standing pillar of operational programming (rolling strategy with possible updates as needed).

3.4. STAKEHOLDER VIEWS ON THE RELEVANCE OF THE HCID STRATEGY & TERMS USED

The document review illustrates that the HCID Strategy has been developed over time, answers a current need and links to other strategic documents and the overall aims of ICRC as well as its partners. It is to the best of our knowledge the only organizational strategy focused on the topic of protection of healthcare that sets out a clear Theory of Change, being reflected in an organization's organigram and integrated in its permanent and core part of operational programming[18].

The vast majority of stakeholders who contributed to the evaluation described the HCID Strategy as 'highly relevant'. At country level – stakeholders could identify with the Strategy, its Goal, and stated Objectives. Most Delegation level stakeholders described how aspects of the Strategy were going to be implemented. Some – mostly external – stakeholders were unsure of the capacity and positioning of ICRC to implement parts of the Strategy when this requires non-traditional skills or seen as priorities compared to emergencies. Almost all pointed out the importance of reaching out to partners and stakeholders (via partnerships, synergies, and coordination) to cover the whole range of activities and expertise required to address the large scope of the HCiD Strategy. This is discussed in greater details in the section on cross cutting objective 2 (mainly dealing with CoCs). Some questions arose regarding the 'mandate' of ICRC especially with regard to different types of violence and conflict and the different types of 'armed actors.

- The HCID Strategy specifically has as a stated Goal to: **Reduce violence against healthcare and its impact in armed conflict and other emergencies.** A footnote states that the terms 'conflict and emergencies' will be used to denote this.[19] Other terms used are 'violence and attacks in situations of armed conflict and other emergencies.

About the types and range of violence against healthcare

The use of violence against healthcare violence or attacks by 'weapon bearers' in the strict sense (as meaning in times of war, fighting parties). In practice there may be a range of types of attacks and violence[20] that pose a danger to health care provision[21]

During KII the terms 'violence' and 'aggression' against health care providers by patients and accompanying civilians and/or weapon bearers were highlighted as 'everyday' situations. Violence can be part of 'every-day life', society, 'accepted', 'normalized' rather than part of 'armed conflict'.

The term 'urban violence' was used in some settings. Although this has (as yet) no formal definition, it is often considered in political context and/or seeks to social injustice and inequality. In some settings this term is also used to describe violence related to 'gangs' and/or other 'criminal activity'. 'Weapon bearers' may be civilians rather than 'military' or 'armed forces' or 'non-state actors' (see also Objective 1 below). In some cases, 'weapon bearers' may be 'criminal gangs', 'drug cartels' rather than perceived as 'armed forces' per se.

[18] WHO's initiative – Attacks on Health Care – is time bound and runs from 1 January 2019 to 31 December 2022 and sets out the following specific vision: "Essential life-saving health services are provided to emergency-affected populations unhindered by any form of violence or obstruction". https://apps.who.int/iris/rest/bitstreams/1214448/retrieve

[19] ICRC Institutional Health Care in Danger Strategy 2020-2022 – Protecting health care from violence and attacks in situations of armed conflict and other emergencies – and please see foot note 1 page 1 of the Strategy document.

[20] On typology of violence refer for example to:" World Report on Violence and Health", World Health Organization, Geneva, 2002

[21] including (but not limited to); a cyber-attack, destruction of infra structure of the whole or part of a healthcare facility, looting of equipment and drugs, preventing patients from accessing care because it is not safe/protected, preventing movement of a patient in an ambulance or by other means, occupying a healthcare facility and using this as a military operating base or barracks, killing patients or health care providers or allied staff, kidnapping healthcare providers and allied staff, any violence against a health care provider or allied staff (including physical, mental, verbal).

In discussion with delegations and considering the 'real life' situation on the ground, in some settings, it is not clear (e.g., to KII) what the specific 'mandate' of the ICRC is nor what the specific (if any) focus of the ICRC's HCiD Strategy should be. Discussion points were raised regarding whether ICRC's 'mandate' extends to 'any type of violence' including e.g. aggressive behavior in a healthcare setting where patients are dissatisfied and react to e.g., long waiting times, queue jumping, unprofessional behavior from healthcare providers and allied staff (poor quality of care, unconducive attitudes, etc.) and does it extend or include 'criminal' behavior and violence as in e.g., drugs-related 'warfare'.

As the ICRC develops expertise and a toolbox of approaches and methods to 'de-escalate violence', 'provide training', 'work in partnership' 'enter into dialogue with', it is clear to many KII that these can be used in a wide range of other situations of violence than 'armed conflict' per se. And there are already examples of effective use of this approach.

About "armed conflict and other emergencies"

A (humanitarian) emergency is defined as' an event or series of events that represents a critical threat to the health, safety, security or wellbeing of a community or other large group or people, usually over a wide area'.[22] In practice the term '(humanitarian) emergency' is used to denote a wide range of situations and conditions and often not related to or the result of 'armed conflict' per se – although the 'emergency' itself may result in armed conflict.

Emergencies requiring Humanitarian Assistance include extreme weather events, conflicts, disease outbreaks and the impacts of COVID-19. humanitarian needs have continued to grow in the last decade, driven by conflict, the climate crisis, and disease. The Global Humanitarian Overview (GHO) refers to a total of 274 million people worldwide who will need emergency aid and protection in 2022, a 17 per cent increase compared to 2021. 183 million people across 63 countries are considered 'most at need'[23]

Political conflict can be classified according to its intensity into low, medium, or high.[24] Low-intensity political conflict is non-violent; it includes political disputes and non-violent crises. Medium- and high-intensity political conflict includes the use of violence.

An estimated half of all today's crises are considered 'somewhat predictable'. Anticipatory action mitigates the shock impact and reduces humanitarian needs, helping to enhance resilience and making resources more efficient. (GHO 2022). Interestingly, the need for a range - or continuum - of approaches is highlighted in GHO reports including 'prevention', 'anticipatory action projects' as well as 'continued support'. Multisectoral and multidisciplinary approaches and responses are needed and recommended. An analysis of conflict and peace over the last 100 years tell a more nuanced story[25]: the shift from large-scale conflicts toward increasing internal conflict, had a critical negative impact on civilians with an increased number of refugees, internally displaced people, and stateless people. For the first time in modern history, displaced people, including refugees, made up almost 1% of the global population in 2017. This is a rate 12 times higher than the rate in 1951, when data collection began with the inception of the refugee convention, hence translating in massive humanitarian needs with specific challenges such as access, volatile security, unpredictability, etc.

Finally, the timing of an emergency 'during an emergency or conflict' – varies widely and is not clearly defined in most settings. Emergencies last several years and have different phases (active conflict, temporary ceasefire) - and post-conflict (for how long?) A recent UN report notes that the average length of a humanitarian responses has increased from 5.2 years in 2014 to 9.3 years by 2018.[26] ICRC Delegations and Partners contributing to this evaluation described implementation that could happen 'during active

[22] Definition from the Humanitarian Coalition
[23] Global Humanitarian Overview 2022
[24] Heidelberg Institute for International Conflict Research, Conflict Barometer 2020.
[25] See: https://www.visionofhumanity.org/world-become-peaceful-since-wwi
[26] OCHA, Global Humanitarian Overview 2019

conflict' and during times of 'calm' when 'expecting an escalation' as sometimes being different, as being reactive and as having to be opportunistic. Essentially this implies that there is a requirement and opportunity for the HCID Strategy to consider the need for protection of healthcare over a continuum of phases of armed conflict and (other)emergencies. This is captured in Figure/Visual 2

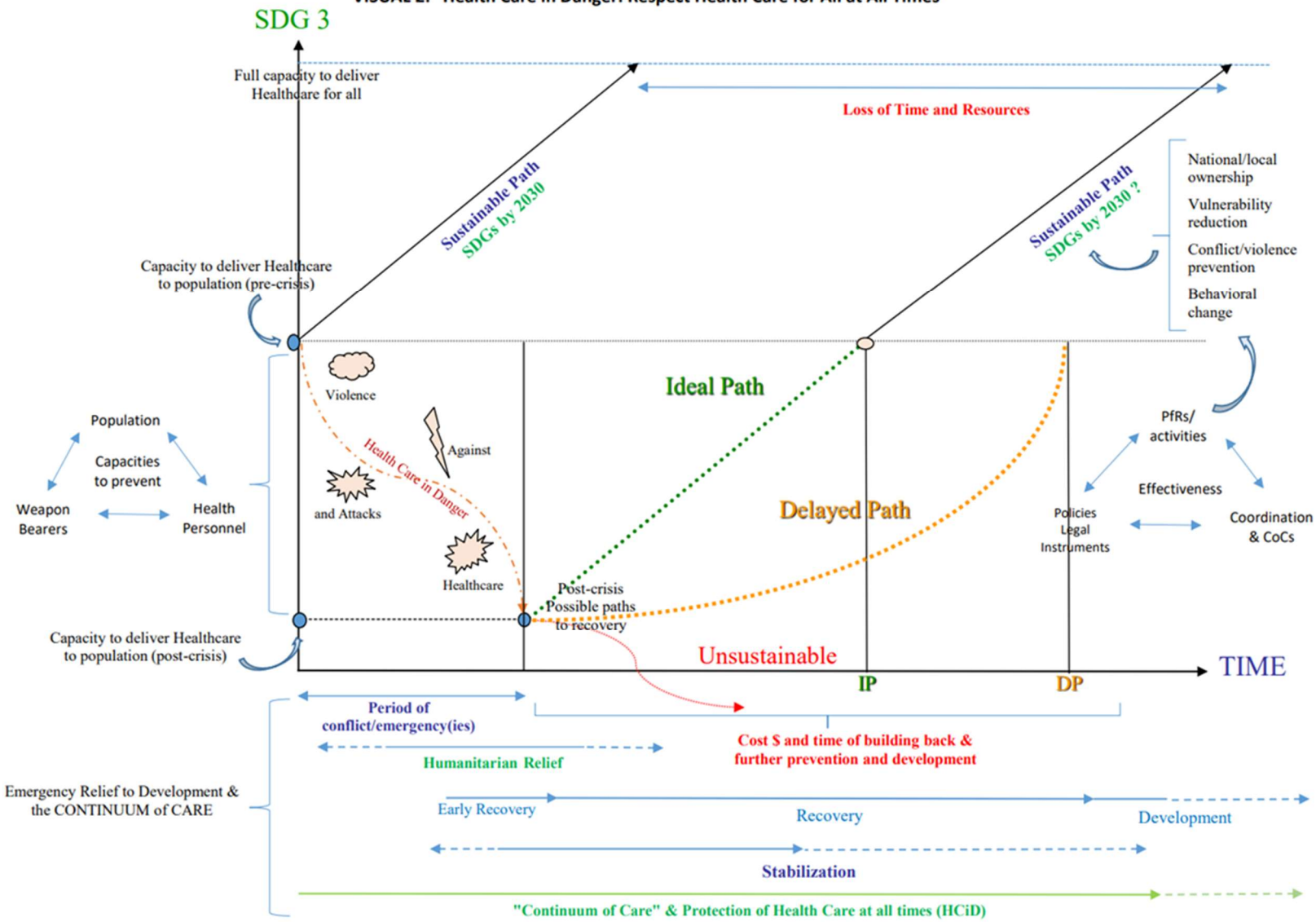
Conclusions:

- A clear and broadly shared consensus emerges through literature review and KII about the HCiD strategy being relevant at all times to an extensive range of contexts (armed conflicts, IAC and NIAC, other emergencies and situations of violence).
- ICRC's HCiD is a unique brand addressing the issue of violence against health care, which has been carried forward over time in a consistent manner and being incorporated in its organigramme and program as a longer-term endeavor.
- The terms used in various documents show openness and agility – both from a programmatic and policy point of view - to adapt to complex and evolving contexts. These evolutions together with the ICRC own institutional evolution don't make it always easy for some staff members and external partners and stakeholders to identify strict limits of ICRC's mandate in a blurred environment.
- The HCiD strategy is implemented through various and numerous activities that represent de facto a significant contribution to SDG 3, addressing the provision of health care, as the most universal framework in the matter.
- HCiD requires both short- and long-term activities, especially when it comes to capacity development and/or strengthening. It is within each Delegation's responsibility to determine those activities that fall under its specific scope of responsibilities according to the overall vision and approach of the "continuum of care" as outlined in the ICRC Health Strategy.

Figure-Visual 2: "**HCiD: Respect Healthcare for All at all Times**"

- The diagram is organized around two axes: horizontal axis representing the time and vertical axis representing the level of capacities in a given setting (national/sub national constituency) to deliver healthcare to the population as a contribution towards SDG 3 (an ideal to make progress towards). The ICRC Health Strategy outlines the concept of "continuum of care" as its backbone and overall vision. It resonates with a longer-term approach and the spirit of preparedness to emergencies. Adequate partnerships should be built in anticipation of times of crisis and for ICRC field teams to identify own activities (with comparative advantage) and in complementarity with other health system actors.
- Violence and attacks against healthcare lead to a decline in the health system capacity to deliver adequate healthcare to the population.
- The post crisis (conflict, violent incidents, and attacks) recovery can take different paths with various speeds to return to the level of capacity that prevailed prior to the crisis depending on various factors (level of stability, security, access, resources available, etc.).
- The impact on healthcare (facilities destruction, overall impact on personnel, reduced capacities) has a cost associated with regards to 'building back', it also leads to a (further) delay in reaching and maintaining a satisfactory level of healthcare delivery (let alone the ideal encapsulated in SDG3).
- Overall, the diagram also highlights the value of prevention through the implementation of the comprehensive framework around 6 objectives of the HCiD Strategy. This is illustrated by the two smaller pyramidal diagrams in the Figure capturing elements of the strategic framework: Prevention capacities through three target groups: the population at large, the healthcare personnel, and the weapon bearers.
- Overall effectiveness via combination of conducive/supportive legal environment, CoCs and other coordination mechanisms, and ICRC's own activities.
- The lower part of the diagram shows the relevance of the HCiD strategic framework along a continuum of - emergency relief to development - highlighting the importance and priority put on a prevention approach throughout with regard to cost and time saved.

VISUAL 2: "Health Care in Danger: Respect Health Care for All at All Times"



4 EFFECTIVENESS OF IMPLEMENTATION OF THE HCID STRATEGY AND THE OBJECTIVES SET OUT IN THE THEORY OF CHANGE

Key Evaluation Questions
Is there evidence of effective implementation of the HCiD Strategy? The documents reviewed and a wide range of KIIs reflect the significant volume of activities undertaken to implement the HCiD strategy. They provide abundant examples of results, achievements, success stories. Documentation on how these activities trickle up to the higher level and translate into outcomes is nevertheless missing. In other terms, it is difficult to appreciate if progress is actually being made (or not) and if overall efforts add up towards longer term goals (i.e., reducing violence against healthcare, which is indeed ambitious and does require a larger, coalition type of, engagement as well as connection with other broader frameworks).
Is there evidence to assess effectiveness of implementation for Objectives 1-4 of the Theory of Change set out in the HCiD Strategy There is ample evidence from KII and surveys that all six Objectives are being implemented across a wide range of settings and are effective in a variety of contexts. Targets have been exceeded for Objectives 1,3,4 and for cross cutting Objective 1. Formal commitments have been obtained in 5 countries with 7 different armed actors (Target Objective 1 is 5) including with Municipal Guards, Police and Security Forces, National Defence Forces and Armed Forces. Round-table discussions and/or training is ongoing in several other countries which can be expected to lead to additional formal commitments in the coming years. The majority of delegations contributing to this evaluation through KII agreed that to adopt and implement legislation (Objective 2) was important, many were unsure how to go about this and/or unable to set out activities to work towards this Objective specifically. However, by Quarter 2 in 2022 there were 5 constituencies where proposed laws have been adopted including in Brazil, Pakistan, Nigeria and Colombia. (Target met) Survey reports from 23 countries show that all are taking at least one measure, with 7 countries in which at least 3 measures are taken to improve preparedness and resilience of healthcare providers (Target exceeded) The HCiD Strategy recognises that 'the civilian population is a major source of the insecurity affecting the delivery of healthcare' and that 'it will be difficult to hold weapon bearers to account if the civilian constituencies are not themselves respectful of healthcare.' To address Objective 4 the actions to be taken include to engage with opinion makers and to roll out behavioral change campaigns. Active and wide-ranging engagement was reported by all delegations contributing to this evaluation with 11 campaigns completed (Target is 4- exceeded).
For cross-cutting Objective 1
Are the indicators set out in the HCiD Strategy appropriate and feasible to obtain? Indicators for each objective are well defined. However, the concept and types of 'violence against healthcare' vary markedly across settings as do the 'root causes' and 'arms bearers. This needs further clarification regarding what is or is not within the 'mandate' of the HCiD Strategy. Refinement and consensus-building around some key definitions and indicators will provide further clarity yet allowing for flexibility of operationalisation.
Are there systems and processes in place for collecting and sharing evidence of effectiveness of implementation? At least 9 research studies have been conducted (Target 4 – exceeded) with more in development. To date these are mainly descriptive studies seeking to assess the 'prevalence' or frequency of

violence, 'violent incidents', or 'stigma' experienced by healthcare providers and/or the determinants of this. There is an opportunity for ICRC to lead the development of a global research agenda with a new focus on implementation research to assess effectiveness of actions that seek to protect healthcare from danger.
For cross-cutting Objective 2
Are the current partnerships effective, is there a need to further expand this and how is this best done? The Community of Concern (CoC) is the HCiD brand for a collective, flexible, and adaptable working platform, bringing together diverse stakeholders. The CoC can be adapted, structured, as needed based on circumstances and needs, to best serve the purpose of delivering results – in the context of a broader alliance/partnership - against the HCiD strategy overall vision and programmatic guidance. It requires time and consistent follow up with its members, especially those in key positions (chair, secretariat, etc.) and/or leading specific activities' implementation.
Are systems and processes in place to support effective coordination to prevent violence? CoC and, in broader terms, gathering of relevant stakeholders under various names, to address one or several issues contributing to prevent/reduce violence against healthcare have been initiated and have taken place in a number of countries (16 in total, among which 8 new CoCs with only 2 already working on activities implementation, and 8 convened earlier and already active). Overall CoCs can indeed be considered as effective vehicle to coordinate, frame and advance the HCiD agenda, and encourage results delivery. Where established, they have started fulfilling their role as collective coordination and working platforms.

4.1. IMPLEMENTATION OF THE HCID STRATEGY AND THEORY OF CHANGE

As part of the evaluation of effectiveness all KII were asked regarding the relevance as well as comprehensiveness of the ToC and whether they thought this could be implemented in principle. Although the ToC was considered 'new' by some KI, the vast majority of KI could identify with the HCID Strategic aims, the ToC, and the specific Objectives.

I think they do provide a very overarching '360 degrees' approach to the problem because you talk from the perpetrators up to back to the community. (KI-External)

Although most KI had not read the HCID strategy (a minority were not aware of it before participating in the evaluation), KII from delegations were enthusiastic and quick to identify examples of implementation in their settings for several (or all six in the minority of cases) of the objectives.

As a strategy, I would say that the four objectives that have been defined are very relevant (KI-Delegation)

I can easily see similarities between our experiences and the Strategy and the ToC, apart from the work with weapons beaters both state and non-state. That is one area where, because of the context because of our contextual limitations, we have never been active per se. (KI-Delegation)

The main discussion and question points raised were around the concepts of 'weapon bearers' (see also Objective 1 below) and the concept of 'civilians as victims' as civilians were also known to be 'perpetrators' in many of the settings in which the HCiD Strategy is being implemented.

However, there are some short-comings that puts the arm-bearers as perpetrators and the community as the victim... (implies.....when this may not be the case) (KI-Delegation)

The Document - Field Implementation of the HCiD Strategy 2020-2022 [27] clearly summarizes level and examples of implementation of the HCID Strategy to date. (Table 1) This information was obtained by the HCiD team via surveys (including from 54 delegations) and document review (including program reports). The information gathered is confirmed in many ways by what is reported by Delegations and external partners who contributed to this evaluation through KII or provision of additional documentation. In addition, the KII raised questions on aspects that were not clear and/or where contextual factors were determining factors in what could or could not be implemented 'in the field'. This will be further illustrated below though the analysis of information obtained via KII for each of the 4 main and 2 cross-cutting Objectives of the ToC.

Table 1: Summary Achievements Implementation of HCiD Strategy 2020-2022

Strategic Objective	Target – The ICRC has:	2020	2021	2022	Total	Target
1 – Commitments from armed actors	Obtained **formal commitments** from **five armed actors** to change their policies, practices and sanction mechanisms in this regard, including actors in two of the ten largest ICRC operations	3	2	2	7	5
2 – Domestique legal frameworks	Influenced **five constituencies** to adopt legislative change on protection of healthcare, including in two of the ten largest ICRC operations	2	2	1	5	5
3 - Health-care provider's preparedness[2]	Incorporated such measures in **four constituencies**, including in two of the ten largest ICRC operations	14	7	6	27	4
4 – Behaviour of general population[1]	Carried out such campaigns in **four constituencies** and;	10	1	0	11	4
	***three** of them will have been accompanied by impact evaluation studies*	*2*	*0*	*0*	*2*	3
Evidence-base generation	Carried out (in partnership with local research institutes) **four studies** on prevalence of violence against healthcare, or on the effectiveness of HCiD activities, including in one of the ten largest ICRC operations	0	5	4	9	4
Coalition building	Convened **eight** regional, national or sub-national **CoCs** in a way that the actors gathered are either strongly integrated into the process of designing and implementing the ICRC's HCiD programming or lead relevant initiatives themselves	2	0	0	2	8

4.2. OBJECTIVE 1 – INFLUENCING THE POLICIES AND PRACTICE OF WEAPON BEARERS

Objective 1: Weapon bearers adopt policies and practical measures to ensure respect for health care services and enable the safe delivery of healthcare

The intent is to assess the extent to which measures to protect healthcare have been incorporated in the policies and/or operational procedures and practices. This is meant to include State and non-State weapon bearers. The aim is to influence armed actors – where needed – to make the necessary changes through 'protection dialogue, behavioral-change programming and humanitarian diplomacy'.

The Specific HCID Target is to:

Obtain formal commitments from five armed actors to change their policies, practices, and sanction mechanisms. The HCID Strategy explicitly states that this refers to a formal commitment from the armed actor in question such as the signing of a unilateral declaration or the commencement of a

[27] Field Implementation of the HCiD Strategy 2020-2022

formal process to secure such a commitment (not the ICRC effort to secure such a commitment or resulting behavior change). [28]

By Quarter 1 2022, formal commitments have been obtained with seven different armed actors including in Brazil (Municipal Guards, Policy, and Security Forces), Ethiopia (National Defense Forces), El Salvador (Mara Maquinna), Peru (Joint Command of the Armed Forces) and Philippines (Armed Forces). In addition, proposed formal commitments have been prepared and are ready in the Central African Republic (multiple actors) and Afghanistan with ongoing round table discussions and/or training ongoing in several other countries. [29]

The majority of KI contributing to this evaluation reported that there is active engagement with 'weapon bearers' and that this is 'successful' or 'effective'. The focus is mostly on influencing and effecting change in behavior regarding practical measures which are usually situation specific. (See Case Study 1.1 - Table 2) Influencing 'policy' or 'doctrine' was considered by the majority of KI as more difficult. In some cases, this was reported as having been 'informally' achieved or was reported as likely to be achieved in future through a process of active facilitation of dialogue and information sharing. Training (e.g., in first aid) and round-table discussion as well as highlighting and discussion following specific incidents or 'attacks' were common modalities used to influence practice of weapon bearers as reported by KII. (See also incident reporting under Objective 2 and Cross Cutting Objective 1 below).

'We see ICRC working towards some very concrete actions, towards protection of healthcare, whether it's in around weapons, entry of weapons, prohibiting weapons in the facilities. (KI-External)

Recently, we did a training session with the police with pictorial representation of some of the issues {weapons coming into a hospital, doctors being forcibly kidnapped/to treat someone else}. We use those pictures to get them talking about it (... they can't read and write) ...do they think it's an issue. It is at a practical level ... no way at the level of discussion IHL. (KI-Delegation)

The main challenges raised by KII were the different types and wide range of weapon bearers or armed actors to engaged with, and lack of knowledge about or availability of doctrine and policy for which formal commitment is needed.

Who are the 'weapon bearers?

KII reported that depending on the setting there can be a wide range of 'weapon bearers' or 'armed actors', not all of whom can be engaged. This was reported to include formal defense and security forces, police, as well as sometimes paramilitary groups. In many cases KI referred to non-State armed groups (NSAG), groups of actors that cannot be named for 'security reasons' and are 'organized' to a greater or lesser extent. Thus, at country delegation and sub-delegation levels there is an understanding and sometimes a 'mapping' of who the weapon bearers are, but this is different across delegations and in any one country this may differ per sub- delegation.

We have a delegate who works with the military, and another who works with the police and civil defense. We want to try to work with them to define who does what. At what point do the more hardcore military intervene, and when they intervene, how do they manage it? ….. If we can get them all around the table to give them some basic SOPs and ways of communicating with each other if something happens. (KI-Delegation)

In some settings civilians are one of the main groups of 'weapon bearers' (see also Objective 4). Finally in some settings KII reported that engagement with weapon bearers could be 'dangerous' and 'complicated', and it was possible that they were 'caught in the middle' and 'used' by one or other

[28] HCID Strategy 2020-2022 Footnote 16 page 8

[29] Field Implementation of the HCiD Strategy 2020-2022

weapon bearer groups with no respect for the 'neutrality' of ICRC delegations. (See Case Study 1.2 - Table 2)

What are the 'doctrines and policies'?

Among KII (external and delegation) there is often no clear knowledge of which specific doctrines and/or policies are in place (if any) that can be influenced (see also Objective 2 below). In addition, the practice and behavior of weapon bearers (in the field) may not be guided by doctrine and policy – there may be no doctrine or policy, local troops/groups even if formally trained military or paramilitary (police) may not be aware of policies and/or may not be guided by them. Several delegations mentioned doctrines and policies are (expected to be) in place as part of training in e.g., the military academy. However, many weapon bearers are not 'trained'. There is an expectation that (and experience of) the 'commandants to know this and instruct their troops'. However, commandants may or may not have 'control' over their often remotely stationed troops/staff.

... these groups... are not controlled....we need to find a way to engage with this group as well…. this is one of the huge gaps, let's say, because it's easier when you know that you're in a controlled area and you engage and secure access for the population…. But it's completely different and quite challenging when you're working with different gangs that have different agendas... (KI-Delegation)

Influencing the weapon bearers

Not all weapon bearers can be influenced in every setting – sometimes only the 'national' defending military groups and/or police can be engaged but it is not 'possible' 'unsafe' to engage with other weapon bearers in the context of the on-going conflict especially if these are 'extremist' groups. Also, the weapons bearers may themselves not respect the ICRC as a 'neutral partner'. ICRC staff may be themselves at risk and may need to take measures to avoid being targeted - 'we have removed all our logos'; 'are using third-party (hired in) local drivers for transport of drugs and equipment to supported HCF'; 'are not able to reach that area'; 'cannot engage with them'; 'do not use their name'. With regard to 'criminal groups or gangs' these are sometimes referred to as 'outside our mandate', 'not really sure this is within the mandate'.

A study on operational practices concerning armed groups[30] lists factors influencing armed groups' behavior towards the provision of healthcare, namely: the extent of territorial control, the availability and accessibility of healthcare services, the level of organization, the level of command and control within the groups and the tactics adopted by the groups and their opponents. Ultimately, influence is also reported as being a matter of trust. Most examples of successful implementation of the HCiD Strategy are specific to the setting (country or within country) and timing (during conflict, post conflict, in expectation and/or preparation for renewed conflict or escalation) and most delegation reported taking these factors into account.

Almost all KII from delegations reported activities that are ongoing to try to implement Objective 1 including via:

- Action following reporting of incidents - Discussion with armed actors of reported incidents at local (sub delegation) and national (delegation) levels and with resulting behavior change in the field (see also Cross cutting Objective 1)
- Round-table Discussions (general or linked to specific reported incidents)
- Training - Incorporation of IHL and HCID in first aid training provided to weapon bearers directly, training and awareness-raising sessions on IHL and HCID in the curriculums of military academy

[30] Safeguarding the Provision of Health Care – Operational Practices and Relevant IHL concerning Armed Groups", ICRC

It's extremely important to be able to speak to those weapons bearers... Once we are able to speak to them IHL is our tool that we are using really... to discuss the conduct of war, the respect for noncombatant, the respect for the common good is something we are really working on when we can. (KI-Delegation)

4.3. OBJECTIVE 2 – STATES ADOPT AND IMPLEMENT LEGISLATION

Objective 2: States adopt and implement legislation to protect healthcare from violence

The HCiD Strategy states that 'domestic legislation has to enshrine measures protective of healthcare'. ICRC intends to work to analyze the quality of domestic legislation, where needed (and possible) propose new laws or lobby for amendments to existing legislation based on a contextual needs analysis and which is expected to focus on solving specific problems that constitute or contribute to prevalence of violence against healthcare (for suppression of violations and 'non-criminalization' of access). This has also been formulated as 'to support safe and impartial provision of healthcare during armed conflict and other emergencies'

Legislation is described as including regulatory, administrative, medical-accountability, policing frameworks as well as legally sanctioned coordination mechanisms to support 'safe and impartial provision of healthcare during conflict and other emergencies.

The Specific HCID Target is to: have influenced five constituencies to commence legislative change including in two of the ten largest ICRC operations. By this is meant – the existence of a formal process to amend the legislation of the State or other legislative Unit in question... not (just) the ICRC's efforts to bring about such amendment … or the resulting behavior change.[31]

By Quarter 2 in 2022 there were five constituencies where proposed laws were adopted including in Brazil (2 areas), Pakistan (2 areas), Nigeria, Colombia.[32] There is a variety of type of legislation that has been adopted. Examples include municipal legislation to protect healthcare, a national bill to ensure any person (including members of non-state actors) have access to healthcare resulting from weapon-related incidents, contribution to/component of a National Public Health Emergency Bill, provincial level legislation for the protection of healthcare personnel, sanction mechanisms, medical ethics, and confidentiality.

Analysis of legislation is ongoing or completed in up to 11 countries. This pertains to the availability and content of a wide range of legislation related to topics including (but not limited to) non-discrimination, protection against attacks, medical ethics and confidentiality, the search for and collection of the wounded and sick, protection of the emblem, protection of the wounded and sick, health care personnel and facilities and medical transport.

Understanding of Domestic Legislation

KII highlighted that the majority of focal points and/or delegation leads responsible for the implementation of the HCiD Strategy, and Its Objectives are not experienced regarding the development, presence or not, meaning and applicability of bills of law or 'domestic legislation' that are relevant to the HCiD Strategy. Among the majority of the Delegations contributing to this evaluation, 'legislation' is not well understood, it is not clear what it is specifically and/or if this is in place or not in their respective settings. Frequent reference was made to 'the IHL' as the 'highest

[31] HCID Strategy footnote 18 page 3
[32] Field Implementation of the HCiD Strategy 2020-2022

legislation'. In addition, KI referred to a 'code of conduct', doctrines, standard operating procedures (SOPs), and sometimes 'guidelines. However, the intention of Objective 2 is to deal with legal frameworks. The majority of KI found this a difficult area to work on or make progress in. Many KI reported that a mapping and/or analysis of existing legislation had not been possible but would be useful to them.

A minority of KII reported that in settings in which they work there is in fact no 'operating legislation'. Delegations - especially if in the context of ongoing or expected escalation of armed conflict - sketched a situation where the majority of armed actors (both state and non-state) involved were not 'well organized', might not have a 'clear chain of command' and were not operating under any kind of legislation per se or certainly not one known or recognized as being in place. Some KI were of the opinion that legislation was needed but would not work unless there was supported to ensure implementation.

In this country they have this medical act law, I don't know exactly the name, which is never applied. (KI-Delegation)

In this country we have two different contexts. One which is an international armed conflict and one which is another situation of violence, where there are secessionist groups who want to be independent. So, we have two different legal frameworks. (KI-Delegation)

So, we intend (for this legislation) ... we expect to have a code of conduct ... weapons are forbidden to carry weapons within the health facility. We need to involve other stakeholders as well to make sure that at least what we put within the health facilities, that this code is actually respected. Otherwise, it doesn't make sense to have a code. (KI-Delegation)

Honestly…... you need states and governments to grab it, run with it, put it properly in their domestic legislation and not just have a law that lets doctors carry guns, because doctors have other things to do. (KI-Delegation)

Legislations are necessary, but that can't be seen as a be all and end all to the problem. There are countries who will use their position of power to, deliberately or non-deliberately, they do not protect healthcare workers or healthcare facilities from attacks. So, legislations are necessary and good in a situation where the government is in a position to implement these. (KI-External)

<u>Stakeholders involved in the development and implementation of legislation to protect healthcare from violence</u>

During KI there was frequently a discussion about the various stakeholders who were involved or should be involved in the development and implementation of domestic legislation to protect healthcare from danger. The stakeholders mentioned most frequently during KI were the Ministry of Health (which might operate at national and/or provincial levels), Professional Associations and 'the Military' or Ministry of Defense.

Healthcare is the remit of the Ministry of Health (MoH) which may not be functioning or under severe strain (during active conflict) and in many countries is 'fragile' or 'under development'. In several settings healthcare is (also) devolved to provincial and/or local government areas. Healthcare providers are generally employed by a (central) MoH or in case of conflict/emergencies/humanitarian settings by NGOs (national, international) but then still under the MoH of their country with regard to legislation. Professional Associations are in place in most countries but are often described as 'do not have any capacity' and may be 'aligned' politically instead of 'neutral' making it difficult for ICRC to engage with these bodies. It is not clear whether any of these groups (MoH, Professional Associations) have any 'legislation' in place or mainly a 'code of conduct'. Military groups (in the sense of state-recognized armed military groups) as well as police or paramilitary groups who have an organized structure of command and for which cadres there is formal training in place via e.g., the Military

Academies are expected and/or in some cases known to have 'legislation' in place (which may in fact be regulations rather than legislation) to which can be referred during discussion and/or negotiation with these groups.

The file was started by the National Society, with the Government, with the Ministry of Health and they produced a document for the protection of health services. *(KI-Delegation)*

Everything that we're doing, all these efforts that we are making, they are owned by the Health Department and also the Law Department, all the partners that we work with, it becomes a part of their system.(KI-Delegation)

(Re round-table discussions with Ministry of Health and Ministry of Defense on legislation) .... the ambitions would be to hold similar conversations as provincial level and replicate this central level roundtable but in a more contextually granular environment. *(KI-Delegation)*

Adopting and implementing (new) legislation

Although the majority of delegations contributing to this evaluation agreed wholeheartedly that this was an important objective and one that requires to be addressed, many were unsure how to go about this and/or unable to set out activities to work towards this.

This (Objective 2) is the most complicated to be honest with you. As far as I understand, we are at the stage of understanding where the legislation is existing and where it is not existing. I know that we have a number of countries that are good example when it comes to legislation and others where nothing happens. (KI-Delegation)

The report on field implementation of the HCiD Strategy shows that a gap analysis or internal review of legislation is ongoing in up to 15 countries. In addition to the successes already documented, during KI examples of activity emerged which can be expected to lead to progress against this objective (See also Case Study 2.1, Table 2) These included examples of effective working with local groups to increase knowledge about, inform of, and discuss the need for, legislation to be in place and including highlighting this as the 'underpinning' for all ICRC's work. The importance of working at all levels (regional, national, provincial, local government) to develop as well as implement legislation (or what is considered as legislation currently) was also highlighted in the KII.

4.4. OBJECTIVE 3 – HEALTHCARE PROVIDERS ARE BETTER PREPARED

Objective 3: Healthcare providers are better prepared to prevent violence and to mitigate against this and to cope with its impact

The HCID Strategy refers to 'resilience of the health system' to manage violence and/or mitigate and cope with the impact of violence. Resilience is referred to as 'the ability of individuals, communities, institutions, and systems to anticipate, absorb, adapt, or respond to and/or recover from shocks and stressors arising from conflict or other violence or hazards without compromising their long-term prospects'. [32] Measures referred to in the HCID Strategy include staff training, securing of facilities and standard operating procedures.

The Specific Target is to: incorporate such measures in four constituencies

The Implementation of this Objective is ongoing. Survey reports from 23 countries show that all are taking at least one measures with 7 countries in which at least 3 measures are taken.[33] 11 different measures for which reports of implementation are reported (number of countries) include; training in de-escalation of violence (11), facility survey with review and formulation of recommendations (8), development and implementation of standard operating procedures (5), mental health and psycho-

[33] Field Implementation of the HCiD Strategy 2020-2022

social support) (MHPSS) (4) , introduction of policy on 'no weapons' (3), training in safer access (3), posters to illustrate de-escalation of violence (3), awareness raising on IHL law, HCiD, rights and responsibilities of healthcare staff, armed actors and the larger community accessing care (3), training on medical ethics (3) and support to incident reporting systems (2)

In general measures are implemented on a small (number of healthcare facilities) to medium scale (across districts, provinces) for ICRC-supported healthcare facilities or staff, after specific incidents of violence) in countries and/or the scale is not known specifically. In some countries measures are implemented 'at scale' including through working with multiple partners involved at national level, integration into medical curriculum, co-development, and delivery with national (medical) societies and in one country supporting a national level reporting mechanism for violence against health care through the inclusion of indicators in the Health Management Information System (HMIS)

Through KII it is clear that there is a wide range and types of violence that healthcare providers incur and/or have to deal with. (See also sections 3.5 and 3.6 above) Almost all KI involved in this evaluation reported opportunities to expand activities, and would like to do more, but generally report lacking capacity to do so. There is frequently talk of 'scaling up' including to/with other partners but no consistent model for doing this emerged during the KI. See also Illustrative Case Study 3 in Table 2.

What is needed?

In many settings the health system is 'fragile', 'lacks emergency preparedness' is destroyed and/ or rendered inaccessible including through destruction and/or occupation by armed actors (State or Non-State) when e.g., hospital premises are effectively used as 'operational centers' or 'barracks'. The immediate working environment of healthcare providers is therefore often non-existent, lacking in essential infra-structure, equipment, drugs and with barriers to referral systems (ambulances attacked, patients not permitted to cross check points and other examples). Approaches to implementation and needs to be addressed highlighted through KI included:

Sharing of practical knowledge about what to do, how to behave (professional behavior, body language, not making things worse, security measures) and about the rights and responsibilities of healthcare providers

We had incidents where armed perpetrators stormed a clinic and forced a doctor to conduct surgery on their patients..... they have to conduct surgery under gunpoint.... this is common… (KI-Delegation)

Training focused on de-escalation of violence, how to deal with stress, what to do if attacked was frequently mentioned as a needed and positive approach. Scale-up of training is planned for in several countries via Training of (Master-) Trainers/Facilitators (TOT). In some cases, delegation work together with other partners with expertise and/or funding.

Measures to ensure a safe and protected working environment – includes related to healthcare providers' risk of being attacked/kidnapped in their places of work (healthcare facility, ambulance) or even when not at work (at home, on way to work). In KI examples were provided of healthcare facilities requiring support/ being reestablished assisted with support from ICRC (e.g., staff appointed and paid a supplement, facility reconstructed, ensuring drugs, consumable and equipment re-supplied with regular top-up supplies organized). This form of assistance is seen as a necessary complementary action to a focus on HCiD per se.

Some healthcare providers they don't want to do activities, like they don't want to go to vaccinate, to certain places and this is because they're scared of their protection. Even if there are guidelines to protect them, they still lack transport.... they have to walk.... simple things like this... they cannot give them their work ID, or they cannot give them the vest with the logos they need to wear to help mitigate the risk when they go and do activities outside the healthcare center. (KI-Delegation)

Several KI mentioned that more consideration should be given to MHPSS (including stress, burn out, lack in confidence, post-traumatic stress disorder etc.)

Most KI observed that in general more effective implementation of policy/legislation to protect healthcare is needed and this is clearly linked to Objectives 1 and 2

Reporting mechanisms – the majority of KI observed that in practice this was difficult, violence was largely 'under reported'. Some KI highlighted the need for healthcare providers to be able to report somewhere (in confidence) if they were threatened, unsafe, experienced violence e.g., via a helpline, a dedicated reporting system/space. It was also highlighted that there is a significant 'fear' of reporting amongst healthcare providers and allied staff as well as feelings of 'desperation' ('nothing changes anyway') and/or acceptance ('it is normal, we are used to it')

You talk to them, and they say ...'we know, and how can you protect us? How can you help us? ' It has been difficult. So, we would ask for data, we would ask them to report things, but largely speaking, they would tell us... 'Why? You don't change. Nothing changes.' At one point, we had people saying 'Just ask them to stop attacking us. Even if they don't let us have the supplies, just tell them, please stop attacking us'…(KI-Delegation)

4.5. OBJECTIVE 4 – THE GENERAL POPULATION HAS GREATER RESPECT FOR HEALTHCARE

Objective 4: The general population in countries affected by conflict and other emergencies has greater respect for healthcare

The HCiD Strategy recognizes that 'the civilian population is a major source of the insecurity affecting the delivery of healthcare' and that 'it will be difficult to hold weapon bearers to account if the civilian constituencies are not themselves respectful of health care.' To address this objective the action(s) to be take are to: 'Engage with opinion makers' and to 'Roll out behavioral change campaigns'.

The Specific Target is to: carry out (behavior-change) campaigns in four constituencies and three with impact evaluation studies.

Internationally it is recognized that local leaders and communities are seen as more and more important as first responders in a crisis and providers of long-term support. They are reported as being critical to sustaining humanitarian operations.[33] ICRC has already consistently engaged with local stakeholders in the realization that this is needed as part of a 'long-term solution approach'. Specific campaigns have been conducted in up to 15 countries [34]. The target audience for these is mostly the general public but, in some cases, also specifically healthcare providers and armed actors. A wide range of effective methods are used including via radio and TV (spots or story lines over several episodes), social media (e.g., Facebook), newspaper articles. Posters, pamphlets, and information leaflets. Ins several countries the response to this has been assessed which shows very good reach and engagement with content (in some cases 'higher than expected') and by the public.

KI gave multiple examples which focused mainly on the importance of engagement with the community as a key 'stakeholder' for implementation of the HCiD strategy to be successful. (Also linked to Cross Cutting Objective 2, Objectives 1-3 above). However overall, the least information was obtained about the implementation components of 'public campaigns' per se with the majority of KII reflecting that it 'would be good but don't have time/capacity to do this'.

Identification of the Opinion Leaders: There are multiple examples and relevant quotes to conclude that the opinion makers or leaders in each setting have been identified and are well 'mapped' by the

[34] Field Implementation of the HCiD Strategy 2020-2022

Delegations who generally report good access and/or communication with these stakeholders in most settings. The role of civil society organizations was highlighted in several KI.

What we need to do is work closely with the civil society organizations because there are many small organizations working in different activities that perhaps have good access and are well respected within these communities that can facilitate or introduce within their activities these type of interventions. (KI-Delegation)

Respect for and Trust in the healthcare system and in healthcare providers is often reported as already 'weak' and has eroded further (because of conflict as well as the COVID 19 pandemic). KII spoke at some length about expectations of the community which are sometimes based on bad experiences of access to and receiving healthcare including through having been at the 'receiving end' of un-professional behavior from healthcare providers. KII generally recommend that the community needs 'educating on this'. Some of approaches when working with the community are to support increased 'ownership' of and co-responsibility for the way in which healthcare is provided including through agreement and development of 'codes of conduct' in a healthcare facility and towards healthcare providers (and vice versa), improved understanding of healthcare providers' position and ways of working (e.g., prioritization according to severity of illness/condition) and 'when to complain and when not'

By involving the community, we are really trying to create a sense of ownership, the community to tell us what might work, we involve the communities in the design of the code of conduct. (KI-Delegation)

There was some consensus among KI that direct engagement (with the community) might 'work better' or be 'more effective' than 'public campaigns'. For some Delegations there are (additional) opportunities to have campaigns including via TV or radio but there was reported to be limited time and capacity for implementing this.

Through the Project of Healthcare Protection… they made a publicity campaign that has messages like - they protect our health, protect our mission to protect the healthcare centers and personnel. They have flyers, they have banners but still there's a lot of violence going on. (KI-Delegation)

{Reaching out to the general public} is relevant. We had a plan to survey healthcare personnel to get an idea what do they think are the main issues they'd like to see addressed in a public communication campaign. But the security incident happened, and everything was put on hold. We have not done nearly enough in this area. (KI-Delegation)

4.6. CROSS-CUTTING OBJECTIVE 1 – EVIDENCE TO SUPPORT ANALYSIS AND PREVENTION OF VIOLENCE AGAINST HEALTHCARE

Cross-cutting Objective 1: Methodologically sounds evidence supports analysis and prevention of violence against healthcare

Generating evidence is considered one of the three main axes of engagement for the HCID Strategy (operationalization, evidence-base generation, influencing and coalition building). ICRC aims to 'link operational work to data and research developed through partnerships with healthcare organizations (including local research partners, public health institutes and others) in countries affected by conflict and other emergencies' with a view to 'accumulate a critical mass of evidence and tested different operational approaches' , with dissemination planned to 'UN Members States and specialized

international bodies'. Capturing 'the amount and patterns of violence' is considered most relevant 'at local level' as well as 'data and research at field level'. [35]

The specific Target for Cross-Cutting Objective 1 is to: By (2024) ... ICRC Delegations will have carried out four studies on the prevalence of violence in healthcare settings or studies on the effectiveness of HCID activities

Overall, by 2022 quarter 2 this target is already exceeded in the sense that at least nine research studies have been conducted. The Field Implementation of the HCiD Strategy 2020 -2022[36] reports a range of research studies and/or surveys conducted or planned in 12 countries. These are largely descriptive studies seeking to assess the 'prevalence' or frequency of violence, 'violent incidents', or 'stigma' experienced by healthcare providers and/or the determinants of this. In addition, two multi-country studies are underway. The first study seeks to assess prevalence of violence against healthcare providers in two countries (in Africa and the Middle East) and to assess the effectiveness of de-escalation of violence training. The second multi-country study will look at access to and barriers to access to healthcare among internally displace populations (IDP) in four African countries with a view to also assessing challenges regarding the implementation of any existing legislation and policies. A study will look at level of implementation (of Legislation to Protect Healthcare). Studies on effectiveness include a mapping of interventions that seek to protect healthcare and a study to assess the effectiveness of a behavior change intervention to reduce violence against healthcare providers)

A range of research partners are engaged including in-country Universities and external international research institutes or organizations. A situational analysis or 'gaps' identification was commissioned by ICRC.[37] The report illustrates that overall; more research is needed. The structured literature review (2021) presented highlighted that only the minority of research is from conflict or post-conflict areas and that the majority of the 'perpetrators' of violence against healthcare providers (as documented in research) are patients. the majority of available research is focused on measurement of prevalence of violence (including physical, psychological, verbal aggression) with only a quarter of studies reporting on effectiveness of interventions (mainly training) to reduce violence.

The established relationship between ICRC (HCiD) and the Charity Enhancing Learning and Research for Humanitarian Assistance (Elrha), aims to develop a funding stream, commission, and oversee research that will provide more evidence for strategies and approaches that prevent violence against health care and/or mitigate its effect.[38] Safety and quality of healthcare provision in weak health systems is a global concern among development and increasingly humanitarian actors. With violence resulting from patient dis-satisfaction with poor quality care and/or in overburdened health systems (overcrowding) being reported (and researched) by several ICRC Delegations working in HCiD it may additionally be relevant to take note of the global research agenda on Safety and Quality of Care. [39]

Implementation of the HCID Strategy is expected to include the generation of 'methodologically sound evidence of the impact of the ICRCs protection and prevention related activities' to 'also stimulate thinking on ICRC work in other thematic areas'.[40] The HCID file in this sense can be seen as 'catalytic'. In addition to research studies, it must be noted that in practice there is additional and different types of evidence being collected that can provided data regarding the Implementation of the HCiD Strategy, and to 'support analysis and prevention of violence against healthcare' as stated in this cross-cutting Objective. This is set out below.

[35] HCiD Strategy 2020 – 2022 pages 3,4,5
[36] Field Implementation HCiD Strategy 2020-2022
[37] Researching Violence Against Healthcare – Gaps and Priorities - RAND Europe through ELRHA - 2020
[38] Funding stream for research on violence against healthcare - Healthcare in Danger Initiative, ICRC and Elrha - Concept Note
[39] Lancet Global Health Commission. High Quality Health Systems in the Sustainable Development Goals Era: Time for a revolution; 2018. https://www.thelancet.com/commissions/quality-health-systems
[40] HCID Strategy 2020-2022 – p4

Reporting of incidents of 'attacks on healthcare'

For ICRC Delegations a system and process are in place for reporting incidents to guide their operational response. This can be expected to provide data on the (operational research) question 'what is happening where'. Incident reporting (and follow up) is seen as a 'key task' for many of the KI contributing to this evaluation. External KI from other organizations/partners who have 'reporting of incidents' as one of their key activities were obtained. These KI highlight that – although there is a wish, and it is seen as 'beneficial', to work together amongst organizations (including with ICRC which are seen as a key partner) at both local and global level - there is currently no single central global or national system and agreement on incident reporting. This is reported to be because there are 'differing reasons for collecting the information', significant differences in the methodology (including regarding definition of indicators – see below) with a number of (external to ICRC) organizations having as a main focus the need for validation (with process and methodology to do this), 'accountability' and the 'wish' or 'need' to name 'perpetrators'.

In KI questions around the 'surveillance' and 'quantification of burden of violence'[41] aspects (also referred to as prevalence of violence) were frequently raised. It is clear that only a minority of 'attacks' or 'violence' against healthcare is captured. More incidents will be recorded in settings where this is more 'permissible', incidents that are 'huge' e.g., bombings of healthcare facilities are more likely to be reported compared to 'normalized' aggression e.g., towards healthcare workers in an overburdened health system, with 'dissatisfied' patients and attendants. As with many other types of adverse events, increased awareness/knowledge of leads often results in an increase in the number of incidents reported- certainly in first instance after effective awareness raising- rather than decreased (prevalence of) violence per se. In practice, the question whether reporting of incidents leads to a reduction in prevalence of violence was considered by most KI as 'not the point'.

Among KI with Delegations, there is a wealth of information to illustrate that the reporting of incidents is 'effective' in the sense that reports of an incident or attack is often a 'catalyst' to taking specific action, engaging with State or Non-State actors, for community engagement and provides 'evidence' for advocacy as well as possibly for campaigns. Thus, the reporting of incidents is in itself considered a 'cross-cutting' activity required for, or at least influencing, all the four main objectives set out in the HCID ToC.

Several KI (ICRC Delegation and External) expressed the views that the question 'why' is probably more important than (only) documenting the number incidents saying that this understanding is needed to develop solutions to preventing or mitigating violence. Several alluded to a wish for, and opportunity to, conduct implementation (or operations) research for 'what works, when and how'. Overall, the research studies have focused on mapping of violence and determinants (the why) of this rather than on measurement of effectiveness of interventions to decrease or mitigate violence against healthcare.

Program Implementation Reports

Currently, most of the 'evidence of implementation' (what is done where) has to be 'extracted' from various sections of the (quarterly) program reports (which report against Planning for Results (PFR) indicators. The Program Reference Framework (PRF) and PFR) are the key documents and systems used. PFR (Planning for Results) is done annually but mainly linked to requested budget (financial system) - reporting is against an approved PFR quarterly. This is effectively the 'workplan'. There is currently no central section for HCID indicators. Discussion has been ongoing regarding if it would be possible to adapt/amend the PFR to have a dedicated section for HCID – however the sections are headed by other 'units' e.g., Health, Protection etc. and not by HCID (which is one of the transversal files under the Thematic Unit). For any indicator for HCID (existing or newly developed) to be included – this would first need to be approved for inclusion in the PRF

[41] HCiD Strategy 2020-2022 – p 5 footnote 7

For this reason, annual surveys were started in 2020. A survey tool was developed by a small team at HQ and a questionnaire is sent out. The response rate is not high but important information is obtained (and can potentially be improved) as is summarized in the document: Field Implementation of HCiD Strategy 2020-2022. The reasons for a low response rate include lack of time, capacity, and understanding of monitoring and evaluation at country level. With changing staff and reporting the 'timeline' during which implementation took place and evidence for this was obtained can vary and sometimes overlap across surveys. Currently all survey information as well as programmatic reporting is compiled at HQ by one staff member.[38] It has not been decided how this compiled report can be summarized or developed into e.g., an annual report for the HCiD Strategy. Some information is used for communication purposes (e.g., website) but otherwise is - till now – mainly used for internal monitoring of progress.

One of the evaluation questions is to assess **if the indicators set out in the HCiD Strategy are appropriate and feasible to obtain?** For the HCiD Strategy and ToC this relates both to specific 'measurements' and to concepts. For the conduct of research (including development of research questions) the attributed meaning and definition of each is important and needs clarification especially if comparisons are to be made across programs and settings. This was also one of the many important aspects highlighted during a round table held in 2019.[42]

During KI the two main concepts and indicators raised as requiring expansion or clarification were:

The term 'healthcare in danger' is generally clear and it is accepted that this is the case. The concept of 'settings in which healthcare is provided' is also clear but in practice can include a range – health care facility (clinic, hospital, under a tree etc.), an ambulance/during transfer and/or in the community (outside of a healthcare facility) e.g., for vaccination purposes. The indicator 'Incidents of attacks on healthcare' - is more difficult to define and in practice can include a wide range of types of 'incidents' with different underlying determinants or reasons for non–protection of and non-access to health care including cyber-attack, looting, kidnapping of hcp, failure to let patients travel at night, destruction of HCF, occupation of a healthcare facility by armed actors etc. There is also the effect of violence - e.g., general insecurity and/or fear among a population to access healthcare because of conflict - which is difficult to 'measure'.

It has been widely suggested that the definition/concept of 'violence' needs a 'rethink', is not limited to 'conflict' settings in the sense of traditional 'war' - includes civilians with weapons, 'criminal gangs' and a variety of armed actors more generally. ICRC operates in settings where there is no 'war' per se but there is violence and the main reasons for violence and aggression are e.g., long waiting times, unprofessional behavior by healthcare providers where patients were not treated with respect, resulting in unruly behavior and dissatisfaction among patients and their attendants. The question was asked - does ICRC remit extend to this? are these 'incidents we should report'?

Monitoring and Evaluation

The ICRC has an Evaluation Strategy [43] which was completed February 2022, and this is in the first year of implementation. 'Coverage' or number and types of evaluations planned are included in the PfR (and annual evaluations plan). The primary role of the Evaluation Office is to 'provide centralized oversight and to develop the ICRC's evaluation strategy, guidelines and systems to ensure the quality and uptake of learning'.

A range of policies, guidance documents and procedures are already defined and in place as well as an Evaluation Office Steering Committee. Budget allocation in place for 'initiatives that promote embedding evaluation practice into the organization'. Evaluation is an integral part of the ICRC's

[42] Promoting Peer-to-Peer Exchanges on Data Collection Systems to analyse Violence Against Healthcare - Report of a Round Table, Madrid, November 2019.
[43] ICRC Evaluation Strategy 2022-2024 - February 2022

Planning for Results (PFR) system. Evaluations can be commissioned (externally, mixed internally externally, or wholly internally) and actors will include e.g., consultants, academic partners, internal staff who conduct evaluations. ICRC uses the term 'evaluation' as being 'an assessment, as systematic and objective as possible of an ongoing or completed program or policy, its design, implementation, and results.[44] Although evaluation and research are often described as being separate and different both are conducted to generate knowledge and inform practice and at best they should be seen as complementary including for the Monitoring and Evaluation of implementation of the HCiD Strategy and its stated Objectives.

4.7. CROSS-CUTTING OBJECTIVE 2 – HEALTHCARE PROVIDERS COORDINATE CLOSELY TO PREVENT VIOLENCE

Cross-cutting Objective 2: Healthcare stakeholders coordinate closely to prevent violence

Cross-cutting objective 2, "Healthcare stakeholders coordinate closely to prevent violence", is understood as a continuation of influencing and coalition building activities in a multi-level governance approach, i.e., across global, regional, urban, and national platforms. This objective is cross cutting as it contributes to the achievement of each of the four main objectives under the ToC of the HCiD Strategy and also links with cross cutting objective 1. In addition, these platforms are meant as communities of concern (CoCs) at these various levels. This section therefore explores the relevance and effectiveness of CoCs in their support to operationalizing the strategy.
The Specific Target is that: by the end of the reporting period, ICRC delegations will have convened eight regional, national CoCs in such a way that the actors gathered in those CoC are either strongly integrated into the process of designing and implementing the ICRC's HCiD programming or lead relevant initiatives themselves.

The initial years' Diplomatic and Advocacy Momentum

The document "Global Community of Concern for HCiD – Internal Working Proposal 2020" provides a consolidated background, analysis, and evolution over time of the CoC as a collective working mechanism and outlines the way forward under the 2020-2022 HCiD Strategy. The CoC had different definitions and its purpose, objectives and membership evolved along the HCiD File structure and implementation phases. The CoC first served the initial purpose and started as a platform for high level diplomacy, advocacy, and communication, mostly raising awareness and including the subject in the global agenda. There is a broad recognition and awareness that during the initial years of the HCiD endeavor, the Diplomatic Track was undeniably successful[45] as it brought global attention to the issue of attacks against health care and led to the adoption of a series of landmark resolutions and commitments[46]. This work culminated with the adoption of the **UN Security Council Resolution 2286** in May 2016 which condemns attacks against medical facilities and personnel **(S/RES/2286)**. These achievements were indeed made possible, among other elements, through open and constructive dialogue with governments, armed forces, and other stakeholders.

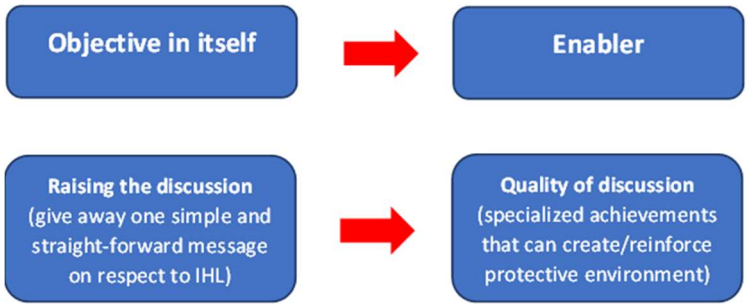
From Global to Local and Operationalisation

The HCiD Strategy 2020-2022 builds on this decade long experience and goes further in the operationalization and so does the CoC mechanism. It shifts the focus from the global to the regional and national/sub national levels (i.e., local/operational). The cross-cutting objective 2 of "healthcare stakeholders coordinating closely to prevent violence", goes through the creation and facilitation of communities of concern, broadly defined as a "coalition or consortium of organizations working

[44] ICRC Evaluation Strategy 2022-2024 page 3
[45] See for instance the ICRC HCiD Evaluation Report, December 14, 2017.
[46] A way forward in protecting health services in conflict: moving beyond the humanitarian paradigm, Opinion Note, Volume 95 Number 889 Spring 2013, International Review of the Red Cross, Leonard S. Rubenstein

together to improve protection of health care from violence within a given country/territorial boundaries". There is also a conceptual shift whereby the CoC is understood as a means to an end rather than an end by itself, captured as follows[47]:

Figure 3: Community of Concerns' conceptual shift



The CoC at the Global Level

The Global CoC membership has evolved over time "from an open setting of gathered stakeholders to a well-defined group that encompasses the health and health professional organizations"[48]. Members' profiles are still diverse in terms of mandate, focus (policy setting vs. operations/technical), constituencies (ranging from states to professional organizations and/or individuals) and expectations as a consequence thereof. KIIs have shown that the participation is still uneven, with a core group of organizations involved from the beginning in a consistent manner (sometimes represented by the same focal point, which enhances continuity). In addition, only a limited number of organizations have a field/operational presence (i.e., structured office, staffing and activities on the ground, beyond their members' independent activities).

ICRC's leadership is widely acknowledged and appreciated for several reasons (including technical capacity, reliability as international actor, mandate specificity, etc.) and there is also a strong consensus among KIs feedback that ICRC should keep the lead. The global CoC needs nevertheless to align with the current strategy. Suggestions have therefore been outlined in an internal note to pave the way forward[49], for example:

- The traditional annual meeting in Geneva will be discontinued and replaced by regional meetings (see next paragraph).
- Common working goals could be identified (based on each organization's specifics, mandate/agenda, constituencies, technical focus, etc.) and feed into an annual action plan. "ICRC may work to allow its voice and other organizations voices to be equalized inside the community".
- What is at stakes here is to maintain a positive dynamic among global CoC members, hence the idea of nurturing new goals among members of the global Community understood as a working network.
- Finally, this refreshing and reframing process led to redefining the status (permanent active vs. Permanent inactive), roles/responsibilities, and ultimately relationships with ICRC.

[47] Global CoC for HCiD – Internal Working Proposal 2020. The CoC being defined as an enabler means an executive actor towards the goals. In this sense there is no distinction between the global CoC and the national ones, as the idea of the CoC is expressively used as a tool (as a coalition of stakeholders that might act for change, either as individuals or as a group).

[48] Global CoC for HCiD – Internal Working Proposal 2020. The document also recalls that "Within the Red Cross/Red Crescent Movement, a specific cluster was created (the Movement Reference Group - MRG) and practitioners of ambulances and pre-hospital services were later gathered in a third group called "Community of Action". Finally, States were certainly integrated in the diplomatic-advocacy and influencing tracks but treated in a dual role as "target population" and action partners, never horizontally compared to ICRC as the other CoC global organizations".

[49] Global Community of Concern for HCiD – Internal Working Proposal 2020

- Identifying new partners/members to the global CoC as deemed necessary to address gaps in support to the implementation of the strategy (organizations working on security or violence issues for instance, i.e., not exclusively on healthcare).

Regional level: *Meetings of HCiD Practitioners...*

The annual meeting has been replaced by regional meetings[50], which provide adequate space for HCiD practitioners (focal points and managers) and key partners (points of contact, counterparts) to share experiences. The very purpose of this approach is indeed more to stimulate peer-to-peer exchanges and possibly to promote context specific (national/sub national) and regional synergies contributing to operational measures to protect health care and/or to prevent violence impacting it. Organization of these regional meeting also imply strong delegations' ownership and leadership with support from the HQ HCiD team as deemed necessary. Results from these regional meetings are then meant to be brought back to the global CoC by ICRC.

… and the role of regional and sub regional organizations

Regional and sub regional organizations (such as the African Unions and the Regional Economic Communities/RECs in Africa) can also play a strategic role and serve as relays to their member states in order to advance the protection of health care at all times and investment (national budget) and policy development thereof.

CoCs at National and Sub-National levels

The national and sub national level CoCs have different composition, in line with the potential to address the scope of the strategy and its full set of objectives which require a range of expertise and capacities. As a consequence, and as stated in the strategy, CoCs will "play a role in mobilizing a broader range of government and civil society stakeholders, generating evidence, and jointly designing and implementing activities or responses aimed at providing more effective protection for healthcare." In practice local actors have already often taken the lead of CoCs, contributing to frame and advance the agenda, and eventually to start achieving practical goals. Their profile – name, membership, and specific working arrangements - are really context-tailored and can take various forms. The work with CoCs, at national and sub national levels, has been analyzed through a series of case studies.[51] Some key points are captured under the following headings:

<u>Diversity of contexts and Institutional drives:</u>

Addressing the HCiD file can be quite complex, especially if this should be done in a comprehensive manner as outlined in the Strategy ToC, with sometimes various contextual situations in various parts of the country or territory, with sometimes various modes of governance and control, between central/national and sub national levels (province; governorates), in volatile sensitive security situations.

Some KIs highlighted indeed the extreme diversity of contexts and their various degrees of relevance to the HCiD file in the same country, ranging from humanitarian relief, emergency to development, via recovery, stabilization, and peacebuilding efforts. All these parameters require focused attention, staff time and proper follow up, as well as the right expertise. Common goals and interventions of each CoC could therefore flow from a shared context analysis.

<u>Participants/members to the community(ies):</u> Several reference documents on CoCs and KI make reference to a set of organizations, namely:

- As an initial (inner) circle, the organizations within the Movement are usually considered as partners of choice. Some National Societies demonstrated specific interest and stand out as major

[50] See minutes of regional meeting for Africa, Eurasia, and Asia Pacific.
[51] Case Studies and Practical Tips – CoC HCiD"

contributors to the HCiD agenda, especially though the funding of national and international human resources.

- Prominent authorities from national and sub national/local governments (health-related or not), with the legitimacy to take the lead in the long term.
- Other, non-traditional members include professional associations, humanitarian organizations, public health institutions, research institutes and universities, celebrities and media channels, private sector organizations, to name a few.
- Interestingly, according to the Case Studies document, "affected populations should be represented in the group of interlocutors and reflect its perspectives in the network to enhance accountability and ultimately improve the humanitarian impact"[52].

Organization and working mechanisms:

- Lead: most often taken up by a government entity.
- Goal setting: should flow from a collective context and problem set analysis and strategic choice of activities that can be monitored and have potential significant impact.
- The CoC Case Studies also offers operational guidance such as templates for action plans (setting deadlines and responsibilities for example) and other material such as: short letter of commitment, MoU or other formal formats outlining roles and responsibilities).

Achievements against Target

The surveys "Field Implementation of the HCiD Strategy 2020-2022"[53] provides a stock-taking on progress towards the set of quantitative indicators outlined in the strategy. The document demonstrates the volume and diversity of activities undertaken, as far as the reporting accuracy permits. CoC and, in broader terms, gathering of relevant stakeholders under various names, to address one or several issues contributing to prevent/reduce violence against healthcare have been initiated and have taken place in a number of countries (16 in total, among which 8 new CoCs with only 2 already working on activities implementation, and 8 convened earlier and already active). Overall CoCs can be considered as effective vehicle to frame and advance the HCiD agenda and encourage results delivery. Where established, they have started fulfilling their role as collective working platforms. This requires various degrees of involvement and support by ICRC and/or other partners within the Movement, which in turn implies a certain level of leadership, engagement and internal organization and planning at the Delegation level.[54]

5 SUMMARY OF FINDINGS AND CASE STUDIES

- A clear and broadly shared consensus emerges through literature review and KIIs about the HCiD strategy being always relevant and to an extensive range of contexts (armed conflicts - IAC and NIAC -, other emergencies and situations of violence).
- After a decade long evolution, the HCiD File is being incorporated in ICRC's institutional organigramme at HQ, and to its permanent and core part of operational programming. Reciprocally, HCiD, as a transversal File, also served as a pilot informing deeper internal discussions and evolution on the way the ICRC works.
- The evaluation of the HCiD Strategy 2020-2022 is an opportunity to take stock of these evolutions and progress towards longer term approach to HCiD, by contrast to incremental changes in short to medium term.

[52] Further specific reference can also be made to the note "HCiD and Accountability to Affected People" - Integrating beneficiary perspectives into ICRC activities aimed at preventing violence and attacks against healthcare, Geneva, June 2019.
[53] " Field Implementation of the HCiD Strategy 2020-2022", internal ICRC
[54] Field implementation of the HCiD Strategy 2020-2022

- The HCiD team at HQ and the network of HCiD practitioners need to consider a balance between short- medium- and longer-term activities. This is of particular importance with regard to capacity development and/or strengthening. It is within each Delegation's responsibility to determine those activities that fall under its specific scope of responsibilities according to the overall vision and approach of the “continuum of care” as outlined in the ICRC Health Strategy. This might also require considering multi annual planning and follow up mechanisms beyond personnel turn-over.
- Regarding the broader context (geopolitics, volatile security, conflict and violence, social unrest, etc.), the respect, protection and enhancement of healthcare require constant attention, awareness raising, advocacy and follow up on the ground. This is true at all levels, from global to local.
- The HCiD long term vision also needs to be translated at field – delegation/sub delegation(s) - level. In addition to staff turn-over, conflicting priorities in sensitive contexts is a risk to lose sight of longer-term planning and follow up. There is sometimes discrepancy between past case studies showing a certain level of organization of the HCiD File in the Field and recent KII that seem to reflect a much looser approach in relation to workload and emergencies requiring immediate attention, hence less time and energy dedicated to HCiD more structured, longer-term type of engagement. This should ultimately also reflect in staff profile and experience).
- The HCiD is fully aligned and coherent with the ICRC 2019-2024 Institutional Strategy and other specific internal strategies (Health Strategy and Protection Policy in particular).
- Many activities are relevant to the implementation of the HCiD strategy without necessarily being labelled and reported as such. Consequently, HCiD overall achievements and progress are probably underreported and underestimated.
- The documents reviewed – noteworthy regular surveys over 2020-2022 - and a wide range of KIIs reflect the significant volume of activities undertaken to implement the HCiD strategy. They provide abundant examples of results, achievements, success stories. Documentation on how these activities trickle up to the higher level and translate into outcomes is nevertheless missing. In other terms, it is difficult to appreciate if progress is being made (or not) and if overall efforts add up towards longer term goals (i.e., reducing violence against healthcare, which is indeed ambitious and does require coalition type of engagement as well as connection with other broader frameworks even if more focused/specific).
- The Community of Concern is the HCiD brand for a collective, flexible, and adaptable working platform, bringing together diverse stakeholders:
- The Global CoC was initiated at the very beginning of HCiD as a campaign to raise awareness on the impact of violence against healthcare and bring it to the global agenda through diplomatic channels, which was undoubtedly successful. The platform was adapted as needed over time, and in recent years to the COVID-19 pandemic implications, as a working network with virtual gathering. This timely adaptation probably contributed to a renewed momentum and interest.
- National and subnational CoCs have taken various forms, names, and memberships to fit and reflect local contexts and partnership opportunities and circumstances. Advancing the HCiD agenda might indeed require various levels of engagement and time invested from the ICRC teams in country to complement the degree of leadership and ownership by, and overall capacities of, national and sub national authorities and other national and/or international actors.
- The CoC can be adapted, structured, as needed based on circumstances and needs, to best serve the purpose of delivering results – in the context of a broader alliance - against the HCiD strategy overall vision and programmatic guidance. It requires time and consistent follow up with its members, especially those in key positions (chair, secretariat, etc.) and/or leading specific activities implementation.
- This working mechanism isn't exclusive of additional and specific bilateral partnerships developed by ICRC as required for the implementation of certain activities.

Table 2: Illustrative Case Studies selected by Objective of the Theory of Change

Case Studies
Objective 1: Weapon bearers adopt measures to enable safe delivery of healthcare
CASE STUDY 1.1 So, we have a big area and population here served by one main hospital. They came and burnt it down (arms actors). They (State actors) managed somehow to secure it again but then they decided to operate from there and the healthcare providers sort of managed to provide some services working from under the trees. And there was a nearby clinic we supported and then they operated from there. We persuaded some of the staff to stay and we give them some incentives ('top up salary') after discussion with the local authorities – they are the ones responsible now – the Ministry of Health – they do not come here now. But the (armed actors) we cannot even mention their name – we cannot speak with them – and we sometimes fear for our own safety, so we are not able to access that healthcare facility anymore ourselves for security reasons – we also removed all our logos from cars and so on. We manage to send supplies and drugs through hired outside transport. Of course, there is the risk of looting but from the health facility they can let us know if they received things in good order. Once they (arms actors) attacked the ambulance, removed the patients, and took it with them for their own use. We discussed the whole situation with the commandants (State actors) even at high level this was done and gave them all the examples. Then their senior commandant also came up here and discussed with the soldiers what to do. So, they (State actors) evacuated the hospital and are now stationed somewhere else. And when a patient needs referral, we let them know - the car number, the time and so on – and they will let that patient cross the checkpoint. So, with all these discussions at least we see some improvement. And it was at all levels we had to talk to them. And it took time and was a bit risky especially here in the field. But we did it.
CASE STUDY 1.2 We did a lot of mobilization with the Ministry of Health (MoH). We had a lot of credibility - if we sat in front of them and they tried to tell me they didn't need X, Y and Z in a certain area, we could tell them we had been there the previous week and they would be quite shocked. But the MoH is a relatively weak ministry, meaning that they don't have the same power as others. And unfortunately, we also came to know that they were under significant pressure themselves and so they had to refuse us. And getting access to these areas was very important - we were constantly trying to try to appeal to whatever side we could, but we really struggled. Even we would try to ask for access to hospitals on two sides of the front line and we would not only be ignored, but then we would see those hospitals and ambulances actually attacked. It was really difficult. Then it seems there was a kind of agreement signed (by political actors). Several towns in area A and several other towns in area B. And the ones in A were government besieged by opposition, and the ones in B were opposition besieged by government. And they came to a deal that what you gave to one side you could give to the other. So, it had to be synchronized. And it got to the point of ridiculousness, whereby if they needed to urgently evacuate wounded from one side, they would refuse unless they could find equivalent people who needed evacuation from the other side. People died because they were not allowed to access healthcare.

Objective 2: States adopt and implement legislation to protect healthcare from violence

CASE STUDY 2

We do not have a Ministry of Health because with devolvement the provinces are now autonomous, they can have their own laws and policies. Health is a department. It's not a Ministry anymore.

Our Province is the first province in the country that came out with a law specifically for the protection of health care. It is called the Healthcare Service Providers and Facilities Prevention of Violence and Damage to Property Act 2020.

It is a very self-explanatory, very simple law describing the various offenses that should not be committed so as that we protect healthcare. It looks at the whole of healthcare provision including the communities. For example, it has a chapter which reminds healthcare workers of their responsibilities towards their patients and attendants. We will now continue work with the Department of Health on guidelines for the implementation of this law as a policy in various healthcare facilities of the province. And there is a dedicated unit in the health Department to oversee the implementation of this legislation and every six months they have to do an audit to see that the things that are in the guidelines are being respected and are being used. So, it's not like there is a law with a number and stuff, but it is seen as important, and it has to be done.

We have dissemination sessions with the law enforcement agencies in which we tell them about the law and then how to protect health care. What role can they play. What we want is that this will also be authorized and 'legitimated' by the community leaders We will identify the stakeholders in the community that might be more concerned by this situation of violence. We ask them to share their concerns, to think of solutions and then we want to raise this to a different level, meaning that we want authorities to say yes, we authorize, we think this law and what is contains are a good concept solution that we want to see implemented.

Objective 3: Healthcare providers are better prepared to prevent violence and/or mitigate and cope with its impact

CASE STUDY 3

We have trained Master Trainers and now we have identified all the main training institutions here (pre-service). So, we have our Master Trainers over there. Then we have a big Private Hospital they have requested us to come and train a new group of Master Trainers for them. We are signing a Memorandum of Understanding with the Department of Health and we have trained 15 Master Trainers from the Department who will trickle down these trainings to rest of the public healthcare facilities (in-service training).

The training workshop is about improving the healthcare providers' knowledge and skills in terms of communication skills, de-escalation of violence, stress management, professional behavior in general. How to manage aggression - which is to help them mainly at the individual level. With angry families, threatening crowds, people upset because their family member is sick or dying etc. And that at least gives a little bit of control, a little bit of power back to the health staff.

One of the first responses of the healthcare providers and the Medical Association (after incidences of violence) was "give us an arms license". This has become part of the social discourse, in terms of training, change in legislation and implementation of the legislation.

Of course, you can enhance communication skills, you can improve knowledge, and attitudes of the healthcare providers. But at the same time, this doesn't seem to be enough to reduce the frequency of this violence. So therefore, we thought of adding this sort of a code of conduct that means that we would like to introduce like a notice. For example, you should not carry weapons within the hospital. And so, we introduced notice boards that stated that 'this is a weapon-free zone'. Together

with the community we developed a 'code of conduct' - where it is written down what you should do, what you should not do - which should also be placed in the healthcare facilities.

We are not always sure exactly what competencies are needed and how to develop these. I don't think these are written anywhere. But we decided we need to hear more of the needs directly from the healthcare providers. We organized a workshop on HCiD with the Director of Health and all the health staff in that area. The aim was to give them an awareness about the HCID Initiative but also to hear from them what the issues are they are confronting. From there, we identified certain areas for the training where they could control some of the factors within their control which contributed to the eruption of violence.

Also, we are following up after the workshops – there is supposed to be supportive supervision every six months for them. We also hope to have an impact on a series of psychological outcomes at healthcare provider level. We want to know do they suffer of any post-traumatic stress? Do they suffer of any burnout? Are they like increasing their absence? Are they taking more days off because of injuries? Because of the psychological stress?

We hope to decrease the incidents, to decrease the severity of violence, to improve all these outcomes.

Objective 4: The general population in countries affected by conflict and other emergencies has greater respect for healthcare.

CASE STUDY 4

We are doing media campaigns to keep on telling our community to please respect healthcare, to not get aggressive towards health care providers because in the end, the health system stops working and that affects the patients and the attendants.

We did an evaluation of two of our media campaign that were specifically about giving right of way to ambulances. And we did notice that there was some form of behavior change in people when on the roads. They started giving way to ambulances. And now, even when I am on the road and I hear an ambulance, siren, and I look around, I just try to observe whether people are actually giving way to ambulances. And I'm very happy to see that - Yes, they are! They always give way to ambulance unless there's a bad traffic block.

6 RECOMMENDATIONS

General Recommendations

HCiD as a transversal File

- Clarify the status of HCiD as permanent and core part of operational programming and the implications for delegations' mandatory reporting. Suggest a template accordingly (to facilitate global stock taking and further analysis).
- Consider the opportunity to adopt an HCiD standing strategy with regular updates as deemed necessary. In the same vein consider optional timeframes for HCiD: 2024 to fit with the IS and/or 2030 to fit with SDG3 (HCiD being de facto a contribution towards it, with no reporting implications).
- Highlight the HCiD relevance at all times in a range of contexts in sync with the "continuum of care" outlined in ICRC's Health Strategy. Underline the complementarity of actions taken at various levels (global, regional and national/sub national, i.e., local/operational). Visuals 1 and 2 of this report can be used to that end.

There is significant experience and expertise, both in terms of valuable human resources and documentary corpus which could be made easily accessible though the two following:

For the development of a 'Centre of Expertise'

- Set up a database of HCiD practitioners. This could be made up of HCiD full time personnel and focal points at HQ and field level. For each of them outline specific experience with HCiD in a given context, roles/responsibilities, etc.
- The network of practitioners will serve as a source of experts but will need to be facilitated to maintain a certain level of interest and momentum.

For the development of a Toolbox

- The toolbox can build on a wealth of resources developed over time across field experiences and organized in a user-friendly manner to facilitate access. These could include (indicative, not exclusive):
  - Available research papers providing overviews of actual violence against health care in each context (city, province, given geographic area, etc.).
  - Case studies.
  - Evaluations and various assessments.
  - M&E material (set of quantitative/qualitative Indicators, sources of verification, proxies, etc.)
  - Action plans: templates and practical cases.
  - Training material: on-line modules, modules to adapt for in person sessions, ToT material, etc.
  - Data bases –example of HCiD specific and/or related legal instruments.

  For each topic identify existing resources and gaps to outline the way forward.

Dissemination of the HCID Strategy

During the evaluation and KII it became clear that not all Delegations and/or External Stakeholders were aware of and/or had reviewed the HCiD Strategy and the ToC. The HCiD Strategy is not currently in the same format as other ICRC Strategic documents (e.g., Health, Evaluation).

- Further efforts can be made to reformat and share the HCiD Strategy including e.g., via (on-line) presentations and workshops for each Delegation.

Recommendations per Objective

Recommendations Objective 1

Related to the 'mandate' as mentioned by KII of the HCID Strategy and as related to the evolving nature and different types of 'violence against healthcare'.

The HCID Strategy states as its goal: to 'Reduce violence against healthcare and its impact in armed conflict and other emergencies'

- Need to consider if this includes all violence especially regarding whether this relates to e.g., violence and aggression from patients to healthcare providers in overcrowded and/or fragile health systems, in environments where criminal gangs are the main 'armed actors
- A comprehensive mapping and dissemination across Delegations of types of armed actors /weapon bearers with guidelines for implementation and/or case examples illustrating what works in what type of setting to effectively engage the different types of state and nonstate armed actors

- Support the dissemination and better understanding across Delegations of IHL and other international legislation and policy available that seeks to protect healthcare e.g., via a generic training/workshop package focused on IHL and HCID that can be adapted to specific country settings as needed

Recommendations Objective 2

- Ensure across countries there is a mapping and better understanding of which (if any) national level doctrine and policy is in place and which are areas for priority development.
- Conduct a detailed study/analysis of countries where legislation has been developed, adopted and is being successfully implemented. (e.g., expanding on as described in the Field Implementation Report) Identify and map specific legislation available (types, wording, status in legal sense), the stakeholders that need to be involved, practical examples of successful roundtable and other discussions to initiate and develop legislation. Work withing and between delegations to understand how 'success stories' can be adapted and adopted in each specific setting. Identify criteria/conditions under which it is possible and effective to work on this objective.

Recommendations Objective 3

- Review of current training package(s) on de-escalation of violence and (where available) practical measures for healthcare providers' protection. Consider developing a training package on identification and support to mental health problems (if not in place already).
- Strengthen work /scale up practice of having notices in healthcare facilities that prohibit the carrying of weapons.
- Have generic packages and materials that can be adapted and adopted by all delegations working on this objective.
- Include more models of scaling up of effective training e.g., via expanded TOT models, cascade training, supportive supervision, integration into curriculums.
- Consider better recording of e.g., numbers trained in each setting and include embedded evaluation (e.g., self-assessed before and after knowledge and skills), follow-up of change in practice, identification of the challenges to, and opportunities for, implementation of 'good practice'.

Recommendations Objective 4

- Detailed case studies of how and in what context public campaigns have been effective together with examples of measurements of engagement by the public, uptake of messages and where possible to assess- change in perception or behavior.
- Production of generic 'campaign materials' that can be used across Delegations.
- Sharing of codes of conduct and a generic roundtable format to be used by Delegations to support community ownership and inputs into safe delivery of respectful high-quality healthcare including during periods of conflict or emergency.

Recommendations Cross cutting Objective 1 – Methodologically sound Evidence supports analysis and prevention of violence against healthcare

- Strengthen M&E components and capacity at all levels – (re)focus on evidence of effectiveness of implementation of HCiD Strategy including via programmatic reports.
- Rethink indicators – agree a core set and collect systematically e.g., quarterly across all delegations with a dedicated section in reports for the Objectives set out in the ToC of the HCiD Strategy (Rather than look for this under relevant headings as Protection, Health etc.). The HCID file can still be transversally implemented. Consider what is done for other transversal files in ICRC.

- Strengthen dissemination of findings. Develop a Dissemination Strategy. Anonymization may be required but it should be possible to pull out generic 'good practices', models of what works where when and how to inform all Delegations.
- Develop and chair an international working group to set a global research agenda and priorities, agree on definitions of key indicators and concepts, harmonize reporting systems and methods where possible and facilitate dissemination, and discussion of findings. This is in part ongoing through the association with Elrha (with many relevant stakeholders already identified) but could be further expanded with components directly led by ICRC as the global lead on Protecting Healthcare in Danger.
- Consider the scope and role of using evidence for 'what works where how and why', examples of good practice and effectiveness of implementation of the HCiD Strategy for wider advocacy purposes and global campaigns led by ICRC.

Recommendations Cross Cutting Objective 2 - Healthcare stakeholders coordinate closely

ICRC might provide inputs and/or support based on degree of leadership and ownership by national stakeholders, especially national and sub national authorities, but also other key stakeholders both within and outside the Movement.

Relevant to all level CoCs:

- Prepare a short guidance note on CoC, outlining its purpose, possible objectives (general/specific), possible membership, indicative roles, and responsibilities (chair/co-chair, secretariat, etc.) as relevant. Attach existing templates (action plan, letter of engagement, MoUs, etc.) .
- Prepare an additional note on ICRC delegations' possible roles towards CoCs in terms of initiating/mobilizing, facilitation, supporting.
- Facilitate synergies between different level CoCs.
- Think of regional and sub regional organizations (such as African Union and Regional Economic Communities in Africa) as possible relays for advocacy to their member states.

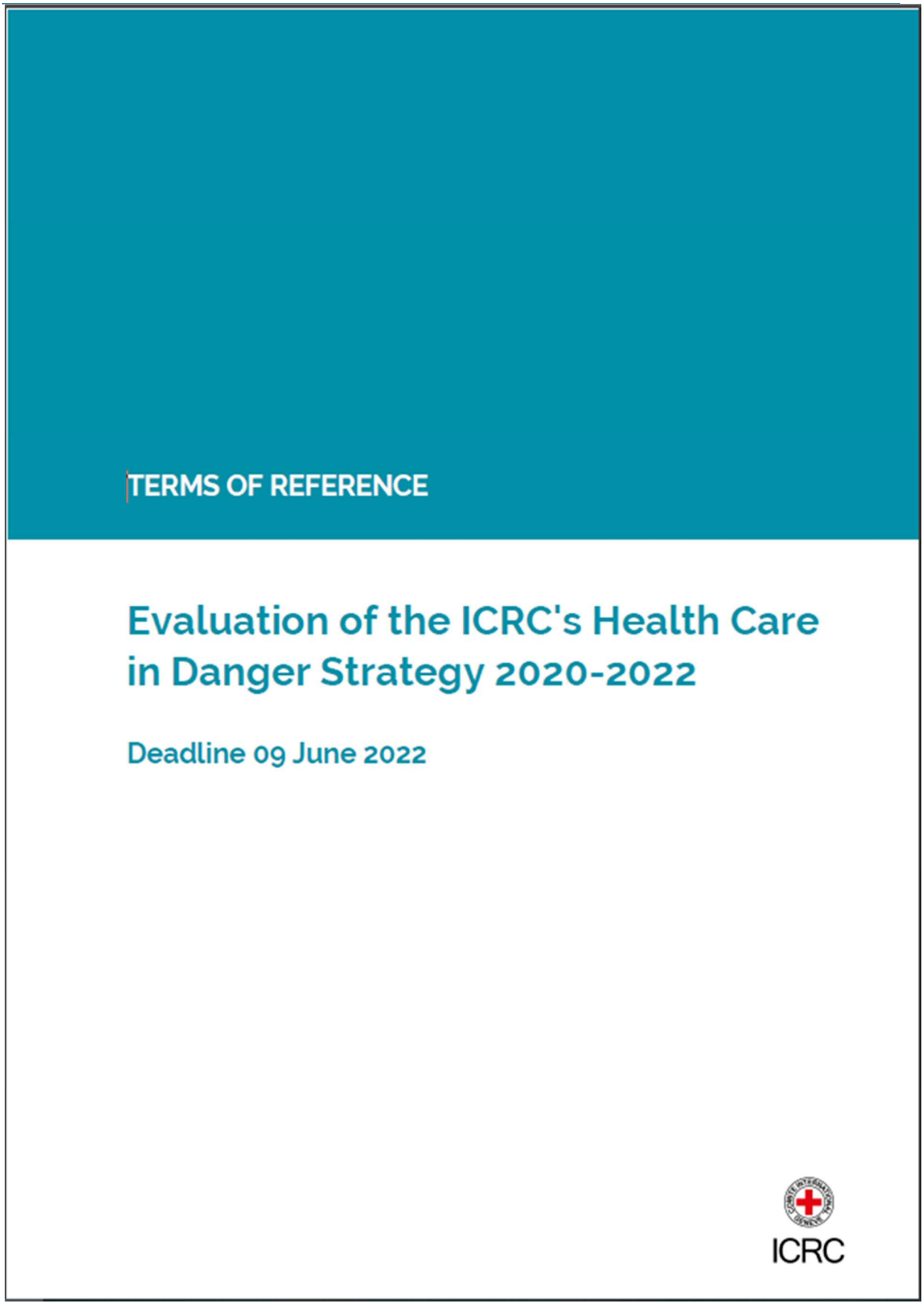
Relevant to the Global CoC:

- Follow up on the way forward outlined in the internal 2020 Working Paper on Global CoCs.
- In particular the new approach of the global CoC as a working network could valuably balance ICRC on-going and appreciated lead role (convener) with other members' voices and specific expertise.
- This also implies identifying new members better equipped to address certain specific technical issues (violence/security related for instance).

Relevant to the National & sub national CoCs:

- Identify key organizations that could join each CoC based on national and/or local context(s) and play a critical role in the delivery of results relevant to the HCiD strategic framework, including the four ToC objectives and cross cutting objective 1.
- Consider the development of a simple needs assessment tool to identify capacity gaps that could be addressed by ICRC and/or other stakeholders through ad-hoc partnerships.
- CoC needs to remain a platform as light as possible to manage with clear outputs/outcomes (hence based on annual work plans outlining roles and responsibilities). It's a means to an end not an end in itself.

7 ANNEXES


TERMS OF REFERENCE
Evaluation of the ICRC's Health Care in Danger Strategy 2020-2022
Deadline 09 June 2022
ICRC

Terms of Reference

External evaluation of the ICRC institutional HCiD strategy 2020-2022

May 2022

Deadline for proposals Thursday 09 June 2022 23:59pm

The International Committee of the Red Cross (ICRC) is an **impartial, neutral and independent organization** whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC seeks the respect for the rights of the victims by promoting and strengthening humanitarian law and championing universal humanitarian principles.

Health Care in Danger (HCiD) is an initiative of the International Red Cross and Red Crescent Movement aimed at addressing the issue of violence against patients, health workers, facilities and vehicles, and ensuring safe access to and delivery of health care in armed conflict and other emergencies.

Rationale and background

In September 2019 the ICRC directorate approved the HCiD strategy 2020-2022[1] which conceptualises the institution's approach to protection of healthcare across its programmatic spectrum and with a particular focus on the practical operationalisation of measures through field operations. At the time, the strategy's duration was capped at the end of 2022 in line with the duration of the Institutional Strategy (IS). Following the extension of the ICRC's IS until the end of 2024, the institution has expressed the desire to extend the thematic strategies until that date. This creates an opportunity not only to maintain the momentum on the implementation of the institutional approach to protection of healthcare, but also to update the content of the strategy should the internal and external contexts warrant such an update.

Strategic objectives and evaluation questions

In light of the above, the ICRC has planned for an external evaluation of the HCiD strategy to take place in 2022. The evaluation is expected to achieve the following strategic objectives:

- To assess the relevance and effectiveness of the strategy with a particular focus on the substance of the ICRC's field programming and the quality of the HQ support
- To identify areas requiring amendment in the strategy for the period up to 2024

The criteria of relevance and effectiveness are prioritised above other potential criteria in support of understanding the strategy sufficiently to make adjustments during the implementation period.[2] The evaluation will deliver these objectives by answering the following evaluation questions:

Relevance and adaptability

1. How well has the strategy remained relevant and applicable given significant contextual changes that have affected patterns of violence against healthcare? (e.g. the onset of covid-

[1] https://healthcareindanger.org/wp-content/uploads/2020/10/ICRC-HCiD-strategy-2020-2022.pdf
[2] Other OECD DAC criteria of efficiency, sustainability and impact are excluded on this basis.

19, particular sensitivities around vaccination programmes, increased social unrest, surge of violence or changes in conflict dynamics).

2. How well does the ToC convey the complexities of the phenomenon of violence against health care to the realities in the field in ways that are accessible to colleagues?

3. Specifically, how relevant are the specific objectives of the ToC (i) influencing the doctrine and practice of weapon bearers, ii) assisting States in strengthening their domestic legislation, iii) building up the resilience of health-care systems to violence, and iv) campaigning for behavioural change among civilian populations) in addressing the issue of violence against healthcare across the diversity of contexts where the ICRC operates?

4. What are the levels of utilisation of the ToC and strategy in relation to integrated/ multidisciplinary planning?

Operationalization

5. To what extent has programming in the field been implemented according to the six objectives of the HCiD strategy?

6. What are the enabling factors and barriers to implementation of HCiD measures at national and sub-national levels? Both internal (e.g. support and tools from HQ) and external (on the ground opportunities and challenges).

7. What are there gaps on the existing tools that might be needed to address the complex realities in the field (e.g. availability of tools to address this issue for situations of armed conflict vs. other situations of violence [OSV], or the multidisciplinary response to target populations [such as detainees and IDPs])

Evidence-base generation

8. How effectively have HQ and field-based partnerships implemented the strategy component on generating evidence on HCiD?

9. Has field research contributed to an increased quality of programming for HCiD?

Influencing and coalition building

10. How effective has the mobilisation and influencing component of the HCiD strategy been in supporting the strategy's main goal? Has the ICRC invested appropriately to support its decision to move mobilisation efforts from global to local?

11. What have the opportunities and challenges been related to engagement within the Movement? What lessons from Movement engagement should inform the remainder of the strategy period?

Scope of the evaluation

The evaluation will cover the period from 2020 to the second quarter of 2022. The HCiD HQ team has monitored the level of implementation of the HCiD Strategy via field surveys conducted in 2020, 2021, and 2022 (currently underway), case studies will be selected based on the delegation's level of

implementation of the HCiD strategy, as well as bearing in mind practical issues, such as the current workload and concurrent institutional processes.

Audience of the evaluation findings and recommendations

The primary audience for the evaluation is the HCiD team in Geneva, the results of the evaluation will inform the contents of the updated HCiD Strategy and scope the objectives for 2023-2024. The secondary audience are ICRC colleagues working on HCiD, and key external stakeholders including but not limited to members of the Community of Concern, the Movement and research partners.

Methodology

The evaluator is expected to outline a suitable methodology in the proposal, for example a theory-based evaluation, or a criteria-based mixed methods approach, informed by the principles set out in the ICRC's guiding principles on Accountability to Affected People.

In order to answer the evaluation questions and deliver on the strategic objectives the HCiD team will work with a consultant to refine the methodology defined by the following key parameters and based on the delivery of these key outputs:

- An inception report outlining the detailed methodology for this work following consultation with the HCiD team in Geneva
- A review of internal and external documentation compiled with the help of the HCiD team. This includes previous evaluation reports, monitoring reports and survey results of the field implementation.
- Interviews with key informants in ICRC HQ and in the field, as well as among key Community of Concern[3], Movement partners and research partners
- A workshop with the HCiD team
- A report of no more than 30 pages including an executive summary summarising the findings obtained throughout the process

Timing of the evaluation

The work on this evaluation is expected to commence in June and must be concluded by the end of July 2022. Within this period, it is expected the consultant(s) will spend a total of around 30 working days on the work. A detailed timeline will be agreed at the beginning of the assignment.

Ethical considerations

Evaluators will adhere to international best practices and standards in evaluation. The evaluator will abide by the Professional Standards for Protection Work; the ICRC's Code of Conduct; the ICRC's Code of Ethics for Procurement; and the ICRC Rules on Personal Data Protection. Informed consent of all interlocuters will be sought and gained, and their anonymity and confidentiality will be

[3] A "community of concern" (CoC) is a coalition or consortium of organizations working together to improve protection for health care from violence within a given country/territorial boundaries. The ICRC's global HCiD CoC currently consists of the following: the International Committee of Military Medicine; the International Council of Nurses; the International Federation of Medical Students' Associations; the International Hospital Federation; the International Pharmaceutical Federation; the International Pharmaceutical Students' Federation; Johns Hopkins University; the Junior Doctors Network; Médecins Sans Frontières International; Médecins Sans Frontières Switzerland; Médecins du Monde; the Centre for Ethics, University of Zurich; the World Confederation for Physical Therapy; the World Health Organization; and the World Medical Association.

maintained. The methodology does not anticipate the participation of civilians affected by conflict, and therefore formal Ethics Review Board is not required.

Management of the evaluation

The evaluation will be managed by the HCiD Unit in HQ who will be responsible for overseeing the evaluation and will be the evaluation consultant's first point of contact. The ICRC evaluation manager is responsible for approving the final version of deliverables and outputs.

The ICRC evaluation manager will work with the Evaluation Advisory Group to seek their review and inputs at key stages of the evaluation.

The evaluation will use the ICRC's guidance and quality criteria for developing inception reports and evaluation reports. Feedback on these deliverables/outputs will be provided by the Evaluation Office as part of the ICRC's quality assurance process.

The final report will be published on the ICRC's website after being approved for publication via the ICRC's internal copying-editing and formatting process.

Desired profile

- Lead consultant(s) must have experience in research methods and/or evaluations, development including collecting information via interviews, surveys and focus groups;
- Solid experience in strategy evaluation;
- Experience working for the ICRC or other experience of health programming and responses in multidisciplinary humanitarian contexts is preferable;
- Solid understanding of monitoring and evaluation methods and project cycle;
- Ability to provide consultancy services in Switzerland or another country with ICRC presence is essential
- The workload is estimated to be at up to 30 days of work paid according to standard ICRC consultancy rate to be spread across a period of up to two months to accommodate the availability of informants
- Ability to work in English is essential with additional languages such as Arabic, French and Spanish an additional asset

Instructions to bidders

Proposals should be submitted and must include: proposed methodology and workplan specifying milestones towards key deliverables (max 2 pages), CV (please include relevant references), and daily rate in CHF.

Note: ICRC procurement protocols require proof of self-employment to issue contracts.

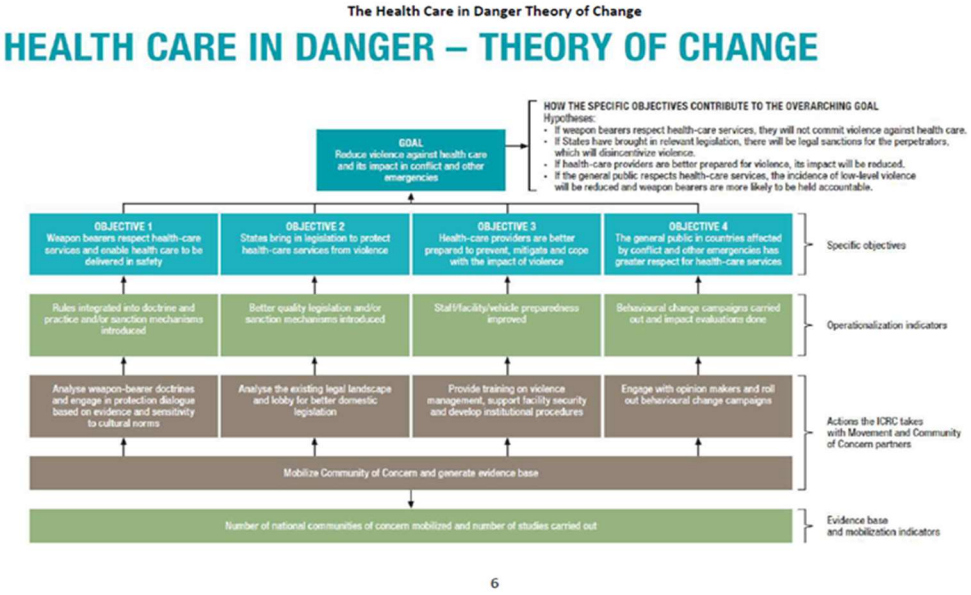
Deadline for proposals Thursday 09 June 2022 23:59pm

Submit proposals to gva_hcid@icrc.org

7.1. ANNEX A – THEORY OF CHANGE

Annex

The Health Care in Danger Theory of Change



7.2. ANNEX B - EVALUATION MATRIX

Key evaluation questions	Evaluation Sub-questions	Indicators	Anticipated data sources
RELEVANCE – The extent to which the ICRC HCiD Strategy and Theory of Change consider global, national and partners' needs and wishes to address healthcare in danger			
Where does the ICRC's HCiD strategy sit within a larger global framework and partnerships addressing the need to protect healthcare?	Are there any other (partner) strategies addressing Health Care in Danger and specifically: - To address the issue of violence against patients, health workers, facilities, and vehicles - To ensure safe access to and delivery of healthcare in armed conflict and other emergencies	The HCiD strategy is focused and comprehensive to address issues of violence against the health sector and to ensure safe access to and delivery of health care services The HCiD strategy is unique and/or complementary to other strategies addressing Healthcare in Danger	**Document Review:** Other ICRC strategies including (but not limited to): Health and Protection Strategy, other Partner/Organizations' related strategies **Key Informant Interviews:** ICRC Deputy Director of Operation, Head of HCiD, HCiD Advisor in the Health Unit, and Head of Health Sector, In-country delegations, focal points for HCiD; CoC members and other Partners
	Is the HCiD strategy considered relevant at global as well as national level?	The HCiD strategy adds value to - Global agreement/strategies to protect healthcare in danger for example International Humanitarian Law (IHL) - National level ICRC strategy and work programs/files including Health and/or Protection	
	Who are the key stakeholders when it comes to development and implementation of the HCiD strategy?	A mapping of key stakeholders at global and national levels (internal to ICRC and external where this is clear) is available The Membership of the Community of Concern includes all relevant stakeholders	
	Are key stakeholders aware of the ICRC HCiD Strategy, have they helped develop or inform the strategy?	The HCiD strategy was developed in a collaborative manner with key stakeholders.	

		Internal coordination mechanisms are in place and functioning with regards to the HCiD Strategy development and communication	
	Is the HCiD Strategy and the Theory of Change comprehensive and sufficiently ambitious?	The strategy comprehensively links outcomes, outputs, and the ToC's objectives No 'missing' objectives are identified by key stakeholders There is consensus among stakeholders that the defined Objectives - if addressed - result in the Goal being achieved	
Is the Theory of Change (ToC) relevant to a wide variety of settings and contexts where healthcare is in danger?	Can the ToC be adopted and adapted to a variety of settings in which Health care is in danger? Which are the main contextual factors to be considered?	The ToC reflects the complexity of operating in a wide range of settings Global and National stakeholders agree the stated objectives are relevant and can be 'in principle' implemented across a variety of settings. Examples of factors that prevent or facilitate the implementation of the HCiD Strategy at global and national levels.	**Document Review:** ICRC and HCiD overall and health strategies, ICRC Evaluation strategy and HCiD evaluation reports, delegation's action plan, HCiD resource center **Key Informant Interviews:** ICRC Deputy Director of Operation, Head of HCiD, HCiD Advisor in the Health Unit, and Head of Health Sector, and In-country delegations
	For a variety of settings: how relevant are each of the four main objectives of the ToC	Each of the four main objectives of the ToC is considered relevant in the majority of settings in which the HCiD strategy is implemented by ICRC delegations.	**Document Review:** Walk the Talk proposition, HCiD PoA, HCiD selected experiences reports, Surveys on violence against health care, HCiD evaluation reports **Key Informant Interviews**: HCiD delegations, CoC

EFFECTIVENESS - The extent to which the HCiD Strategy and its Theory of Change can be implemented in a variety of settings and has achieved or can be expected to achieve its objectives.			
Is there evidence of effective implementation of the HCiD Strategy?	Are there country level examples of work programs and/or activities demonstrating implementation of the HCiD strategy? (*What is being done where how by whom?*) Are there examples of activities related to the overall Objective of the HCiD strategy but not directly related to the specific objectives stated in the ToC?	In a variety of settings at country level activities are implemented that seek to achieve one or more of the main four objectives of the HCiD Strategy Evidence of success or not of implementation available. Contextual factors are identified and documented.	**Document Review:** Walk the Talk proposition, HCiD selected experiences reports, Survey on violence against health care, delegations' activity and mission reports, national legislations on health care protections **Key Informant Interviews:** Head of HCiD, HCiD Advisor in the Health Unit, and Head of Health Sector, and In-country delegations; and Geneva based CoC representatives
Is there evidence to assess effectiveness of implementation of the four main objectives of the Theory of Change set out in the HCiD Strategy	Exploration of the ability to implement the HCiD Strategy for each of the four main objectives, the contextual factors affecting implementation and evidence for success (or lack of this):	<u>For each objective:</u> - Evidence of implementation at country level - Activities identified which can be implemented to be responsive to the needs of the concerned vulnerable groups - In-country capacity in place for implementation and documentation of progress (or lack of this)	**Document Review:** Surveys on violence against health care, delegations' activity and mission reports, national legislations on health care protections, national HCiD communication campaigns **Key Informant Interviews:** ICRC Deputy Director of Operation, Head of HCiD, HCiD Advisor in the Health Unit, and Head of Health Sector, and In-country delegations; and Geneva based CoC representatives
	<u>Objective 1:</u> Influencing the doctrine and practice of weapon bearers ('weapon bearers adopt policies and practical measures to ensure respect for health care services and enables safe delivery of healthcare')	Understanding and mapping of who are the 'weapon bearers' Identified policies and practices of weapon bearers which can be adapted or developed.	
	<u>Objective 2</u>: States adopt and implement legislation to protect healthcare from violence.	Understanding and mapping of relevant legislation	

		Opportunity and ability to influence those responsible for the development and implementation of relevant legislation	
	Objective 3: Healthcare providers are better prepared to prevent violence and to mitigate against this and to cope with its impact	Understanding and mapping of which healthcare providers are in danger and where, and those responsible for these providers. Understanding and mapping of e.g., training or other needs. Training packages/materials are available that are relevant to the setting and can be used to train healthcare providers regarding violence prevention and violence mitigation (or other training identified as required).	
	Objective 4: The general population (and/or those affected by conflict and other emergencies) has greater respect for healthcare	Evidence of activities identified to address this objective in a variety of settings. Evidence of campaigns carried out. Knowledge and understanding regarding the adverse consequences of violence against healthcare providers among the general population Attention is raised on the consequences of violence against healthcare providers at different levels	
Are the indicators set out in the HCiD strategy appropriate and feasible to obtain? **Are systems and processes in place for**	Exploration of the ability to implement the two cross-cutting objectives and evidence for success (or lack of this):	Program documentation is in place to provide evidence of activity against any (or all) of the six objectives of the HCiD Strategy	**Document Review:** ICRC and HCiD strategies, ICRC Evaluation strategy and HCiD evaluation reports, HCiD CoC Case Studies, Global HCiD CoC MoM **Key Informant Interviews:** HCiD Movement and Operational Officer, Community engagement Advisor, HCiD Advisor in the Health Unit and In-
	Cross cutting Objective 1:	Information is obtained and can be disseminated used to illustrate what is done and how at global and national levels to	

collecting and sharing evidence of effectiveness of implementation?	Methodologically sounds evidence supports analysis and prevention of violence against healthcare What type of information is needed and should be obtained to know if and where the HCiD Strategy is implemented, to what level and effect? What is the capacity, system, and process in place to obtain, analyse and disseminate evidence? What type of (additional) support is needed?	implement the HCiD strategy, to contextualize the implementation, and to ensure regular monitoring and evaluation of effectiveness. The types, occurrences and/or pattern of violence against healthcare is identified and documented (at national and global level) Studies are conducted and results available on the prevalence of violence in healthcare setting and how this can be prevented	country delegations; and Geneva based Community of Concerns representatives
Are the current partnerships effective, is there a need to further expand this and how is this best done? **Are systems and processes in place to support effective coordination to prevent violence?**	<u>Cross cutting Objective 2:</u> Healthcare stakeholders coordinate closely to prevent violence What are the opportunities and mechanisms in place for effective partnerships? Are there examples of effective coordination at global and national levels? Is the mandate of a CoC clear and is it possible to 'replicate' a CoC at national level? Are all relevant partners member of the CoC (at each level)? Is there evidence of effectiveness of (a) the CoC or relevant other coordination mechanism?	Partners are identified and mapped. Coordination mechanisms between ICRC and relevant external stakeholders are in place, and objectives agreed upon There are harmonized tools to communicate and advocate on the HCiD strategy The Community of Concern at global level is replicated at 'national' level.	

7.3. ANNEX C - LIST OF DOCUMENTS REVIEWED

ICRC - Institutional Health Care in Danger strategy 2020–2022 - Protecting health care from violence and attacks in situations of armed conflict and other emergencies
ICRC - HCiD strategy - libellé de decision (Internal exchanges)
ICRC - HCiD Study on the Management and Operationalization of Health Care in Danger as a Cross-Cutting Initiative 2019
ICRC - Evaluation Strategy 2022-2024
ICRC - Strategy 2019-2024
ICRC - Health Strategy 2020-2024
ICRC - Field Implementation of the HCiD Strategy 2020-2022
ICRC - HCiD Revised Strategy 2012-2015
ICRC - HCiD Strategy 2015-2017 Phase 2
ICRC - HCiD Evaluation Report 2017
ICRC - Towards a sustainable model for Health Care in Danger
ICRC - Safeguarding the Provision of health care – Operational Practices and Relevant International Humanitarian Law Concerning Armed Group
ICRC - HCID global qualitative trend analysis guidance on multidisciplinary response and selected field practices for inspiration
ICRC - HCiD Initiative
ICRC - Regional-Eurasia-meeting-2021-Maciek-presentation HCiD Initiative (healthcareindanger.org)
ICRC - HCiD and Accountability to Affected People
ICRC - HCiD Resource Center HCiD - Resource Centre (healthcareindanger.org)
World Report on Violence and Health_WHO_2002
A Guide to implementing the recommendations of the WRVH
L. S. Rubenstein – A way forward in protecting health services in conflict: moving beyond the humanitarian paradigm – Volume 95 Number 889 Spring 2013
Protection of health personnel, sanction mechanisms, medical ethics, and confidentiality by the Khyber Pakhtunkhwa government (2020)
ICRC - Trainings on de-escalation of violence at healthcare facilities (Pakistan Delegation), 2017
ICRC - HCiD Communication Campaign (Colombia Delegation), 2021 Colombian Campaign - YouTube & Cuando se ataca a la Misión Médica, el mundo está al revés - YouTube
ICRC - HCiD Communication Campaign (Lebanon Delegation), 2021 إنها مسألة حياة أو موت - YouTube
ICRC - Violence against HCWs working in covid19 healthcare facilities in three big cities of Pakistan
ICRC partners FG on protection of Healthcare in Conflict Zones (Nigeria) % ICRC partners FG on protection of Healthcare in Conflict Zones - FRCN HQ (radionigeria.gov.ng)
ICRC - Joint statement on the protection of healthcare Joint statement on the protection of healthcare | International Committee of the Red Cross (icrc.org)
ICRC - HCiD Plan of Action for Libya
ICRC - Walk the talk proposition – Health Unit 2020
ICRC - HCiD PoA contributing to the health strategy 2020-2023
ICRC - Partnering Cities for More Secure Healthcare (January 2019-July 2021)
ICRC - Protecting Health Care from Violence - Legislative Checklist
ICRC - Safer COVID 19 Response Checklist for Health care Services
ICRC - Defusing Violent Behavior in Health Care Settings
ICRC - End of Mission Report - Support Mission to HCiD File in Libya

ICRC - Selected Experience: Lebanon SELECTED EXPERIENCE: LEBANON | ICRC Health Care in Danger
ICRC - HCID Selected Experiences ICRC – Tackling Violence Against Health Care in Iraq, Lebanon, Lebanon, and the Philippines
ICRC - HCiD Initiative - Security Resources & Tools Scanning Report. S. Bickley.2021
ICRC - Consultancy-Joint Survey on violence against healthcare.2021
ICRC - Prevention of entry of weapons into health facilities – A toolkit NO WEAPONS | ICRC Health Care in Danger
ICRC - Researching Violence Against Health Care: Gaps and Priorities Researching Violence Against Health Care: Gaps and Priorities - Elrha
ICRC - Measuring Urban Capacity for Humanitarian Crisis: Piloting an Urban Health Response Measuring Urban Capacity for Humanitarian Crisis: Piloting an Urban Health Response - Elrha
ICRC - Promoting Peer-to-Peer Exchanges on Data Collection Systems to Analyze Violence Against Health Care Promoting data collection systems | ICRC Health Care in Danger
ICRC - Mapping the Interface Between Healthcare and Law Enforcement Related to Violence Against Healthcare. A, Clement.2021
ICRC - How to take a snapshot of a city's preparedness to mass casualties Launch event CAMERA tool | ICRC Health Care In Danger
ICRC - ToR Review of materials on de-escalating tension in healthcare settings
ICRC - HCiD Communities of Concern Case Studies and Practical Tips
ICRC - HCiD Africa Regional Meeting Report 2020
ICRC - Eurasia Regional HCiD Meeting. 2021
ICRC - 2nd Asia Pacific Regional HCID Meeting Report. 2021
ICRC - Global HCiD CoC – Meeting-Aug-2021
ICRC - Meeting-Global HCiD CoC – Meeting-1st-Quarter-2020
ICRC - Meeting-Global HCiD CoC – Meeting-2nd-Quarter-2020
ICRC - Meeting-Global HCiD CoC – Meeting-1st-Quarter-2021
ICRC - Meeting-Global HCiD CoC – Meeting-3rd-Quarter-2021
ICRC - Meeting-Global HCiD CoC – Meeting-1st-Quarter-2022
ICRC - Global Community of Concern for HCiD – Internal Working Proposal 2020
ICRC - Ministers of Health Protection of Health Care Report.May2022
A New Era of Conflict and Violence | United Nations
"Delineating the Boundaries of Violence", Editorial, International Review of the Red Cross (2014), Scope of the Law in Armed Conflict.
Home | Sustainable Development (un.org).
WHO's initiative – Attacks on Health Care – is time bound and runs from 1 January 2019 to 31 December 2022 and sets out the following specific vision: "Essential life-saving health services are provided to emergency-affected populations unhindered by any form of violence or obstruction". https://apps.who.int/iris/rest/bitstreams/1214448/retrieve
Heidelberg Institute for International Conflict Research, Conflict Barometer 2020.
Report of the UN Secretary-General on the Protection of Civilians in Armed Conflict S/2021/423
OCHA, Global Humanitarian Overview 2019
World Humanitarian Summit 2016: World Humanitarian Summit 2016 | Agenda for Humanity.

7.4. ANNEX D - INTERNAL QUALITY ASSURANCE

Quality Criteria	1. Adequacy with the terms of reference 2. Relevance and reliability of the information and data used 3. Methodological rigor 4. Triangulation of all data to produce credible results 5. Clarity and usefulness of recommendations 6. Clarity of presentation (wording and formatting), visualization of key messages and graphical/schematic representation
Internal Quality Assurance Tools	7. Internal meetings between team members to coordinate actions and compare results; these meetings make it possible to identify and remove any blocking points in connection with the mission management 8. Participation in work meetings with the team during the preparation of the concept note and the final report 9. Verification mechanisms to measure the quality of deliverables and compliance with deadlines
KII Ethical consideration and safeguarding	As part of the collaboration with the ICRC, all Antei team members have stated their understanding of the ICRC Code of Conduct and Terms of Reference and stated the content is applied to the work done under Antei Global. **Quality of the deliverables** The mission lead is focal point for the consultants made available within the framework of the mission. They are required to carry out reviews of the deliverables provided to the ICRC to ensure their quality. **Quality of service delivery** Caroline Grangier will monitor the quality of the service delivery. It is understood by this: 10. The compliance with the procedures on data protection 11. The compliance with the framework of the deliverables 12. The respect for ICRC employees and other stakeholders being part of the CoC 13. The compliance with the contractual framework **Consent of the participants** 14. An invitation email will include a section aimed at explaining the informed consent of the participant to the evaluation, including a summary presentation of the project, its challenges, and the reasons for the evaluation team's presence 15. The evaluation team will systematically proceed to a contextualization of the participation in the evaluation, by explaining the stakes and expectations to the beneficiary, in particular in order to encourage their commitment to the process initiated by the ICRC 16. Both in the construction of the topic guide and during the interviews, the interviewers will insist on the possibility for its interlocutors to freely express their opinions and points of view