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Health Cluster Guide

A practical guide for country-level implementation of the Health Cluster

IASC
Inter-Agency Standing Committee

Global Health Cluster

World Health Organization

Printed in France

WHO/HAC/MAN/2009.7

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Provisional version – June 2009

The web-based version of the Health Cluster Guide is available on the Internet at:

http://www.who.int/hac/network/global_health_cluster/guide

http://oneresponse.info/GlobalClusters/Health

The online version, in PDF format, uses hyperlinks to provide immediate access to the most recent versions of the reference documents quoted in the text and to the web sites mentioned. It also allows, if needed, to print the entire document.

ACKNOWLEDGEMENTS

This provisional version of the *Health Cluster Guide* has been produced by the Working Group on Guidance and Tools, co-chaired by Save the Children UK and WHO/Health Action in Crises. It has benefited from inputs from CARE, Centres for Disease Control (CDC), International Medical Corps (IMC), International Rescue Committee (IRC), Merlin, Save the Children UK, Save the Children USA, UNFPA, UNHCR, UNICEF, WHO and World Vision and has been reviewed by many other cluster partners at the country, regional and headquarters levels.

Request for feedback

This provisional version is intended to be used for extensive field testing during the second half of 2009 and first half of 2010, and feedback is sought from national health authorities and organizations providing health services in humanitarian crises, especially those participating in health clusters or other health sector coordination groups at country and sub-national levels. Following a review process in the second half of 2010, a revised and updated edition of the *Guide* will be produced.

Please send comments and suggestions for improvements
to the Global Health Cluster Secretariat at:
healthcluster@who.int
indicating "Feedback on health cluster guide"
in the subject line.

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GOAL OF THE HEALTH SECTOR RESPONSE DURING HUMANITARIAN CRISES	
To reduce avoidable mortality, morbidity and disability, and restore the delivery of, and equitable access to, preventive and curative health care as quickly as possible and in as sustainable a manner as possible.	
EXPECTED HEALTH CLUSTER OUTPUTS	
✓ Functioning health sector coordinating mechanisms involving UN agencies, NGOs, CBOs, health authorities, donors, and community members, including between the centre and the field, and with other sectors/clusters ✓ Up-to-date mapping of health actors, available health services, and service delivery activities ✓ Up-to-date information on the health situation and needs is available to all stakeholders; regular situation reports/ health bulletins	*See chapter 2*
✓ Initial rapid assessment and situation analysis, agreement on priority health problems and risks ✓ Regular joint situation updates based on monitoring of the situation and of the health services delivered	*See chapters 3 & 4*
✓ A joint, regularly updated, health response strategy in the crisis, with clear priorities and objectives for addressing priority health problems, risks and gaps ✓ A joint contingency plan for response to future events that could impact on the populations' health or partners' response activities ✓ Distribution of responsibilities among partners based on capacities to deliver in the field	*See chapter 5*
✓ Agreed standards, protocols and guidelines for basic health care delivery, standard formats for reporting ✓ Training materials and opportunities available to all partners for upgrading skills and standards of service provision, as needed	*See chapter 6*
✓ Agreed health sector elements in joint appeals and CERF applications; agreed priorities for allocation of pooled resources ✓ A common advocacy strategy and plan	*See chapter 7*
✓ Joint field visits for monitoring; joint evaluations and lesson-learning	*See chapter 8*

ABOUT THIS GUIDE

Purpose

This *Guide* suggests how the Health Cluster lead agency, coordinator and partners can work together during a humanitarian crisis to achieve the aims of reducing avoidable mortality, morbidity and disability, and restoring the delivery of and equitable access to preventive and curative health care as quickly as possible.

It highlights key principles of humanitarian health action and how coordination and joint efforts among health sector actors working in partnership can increase the effectiveness and efficiency of health interventions. It draws on Inter-Agency Standing Committee (IASC) and other documents but also includes lessons from field experience.

> Although addressed to Health Cluster lead agencies, coordinators and partners, the guidance is equally valid for coordinators and members of health sector coordination groups that seek to achieve effective coordinated health action in countries where the cluster approach has not been formally adopted.
>
> Throughout this *Guide*, the term "health cluster" may refer to "health cluster or sector coordination group".

It should also be useful in cases where, at country level, it has been decided to combine health with nutrition in a single cluster or sector group.

This *Guide* is "generic" in that it should be useful in different humanitarian crisis contexts including sudden- and slow-onset crisis and protracted emergencies. It does not address all the specificities of the different contexts. After field testing during 2009 and first half of 2010, more guidance will be inserted in relation to different contexts.

Structure

Chapter 1 explains the role of a Health Cluster at national and, where needed, sub-national levels, and suggests the principal actions that need to be taken during different phases of response. A table in section 1.2 sum-

marizes the main roles and functions of the health cluster coordinator (HCC), the country cluster lead agency (CLA), and cluster partners.

Chapters 2 outlines what needs to be done to establish and sustain an effective cluster while chapters 3 to 8 provide guidance in relation to the specific functions listed in section 1.2. Each chapter highlights the key principles, summarizes what needs to be done and considered, lists the tools and guidelines that are available, indicates the challenges likely to be faced, and provides practical hints and references for further guidance. The tools and guidelines referred to include, but are not limited to, those developed by the Global Health Cluster.[1]

The annexes and additional documents on the accompanying CD-ROM provide essential complementary information.

Different bullets indicate different types of information or guidance:

- ✓ = principles; what needs to be kept in mind
- ☑ = action points; what needs to be done
- ☹ = what to avoid
- 🕮 = reference documents; where to look for further guidance
- ● = components of the issue being discussed
- 💻 = web site address

[1] The "common gaps" boxes at the start chapters 2 to 8 are reproduced from *Gap guidance materials: assisting the health sector coordination mechanism to identify and fill gaps in the humanitarian response* (Global Health Cluster, 2008). They present common gaps found in ten country case studies covering field operations during the period 2004 to 2007.

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal care
BEmOC	Basic emergency obstetric care
CAP	Consolidated Appeal Process (sometimes also [mis]used for Consolidated Appeal)
CAF	Country Assistance Framework
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention (based in Atlanta, USA)
CEmOC	Comprehensive emergency obstetric care
CERF	Central Emergency Response Fund
CHAP	Common Humanitarian Action Plan (component of a Consolidated Appeal document)
CHW	Community health worker
CLA	Cluster Lead Agency (at the country level)
CMAM	Case management of acute malnutrition
CMR	Child mortality rate
EC	Emergency contraception
EHO	Emergency Health Programme Officer
ERC	Emergency Relief Coordinator
EWARS	Early warning and response system
FTS	Financial Tracking Service (of OCHA)
GHC	Global Health Cluster
GIS	Geographic Information System
HANDS	Health events Analysis & Nutrition Data Surveillance (formerly HiNTS)
HC	Humanitarian Coordinator
HCC	Health Cluster Coordinator
HCSS	Humanitarian Coordination Support Section
HeRAMS	Health Resources Availability and Mapping System
HF	Health facility
HIC	Humanitarian Information Centre
HIS	Health Information System
HNTS	Health and Nutrition Tracking Service
IASC	Inter-Agency Standing Committee[2]

[2] The IASC includes OCHA, UNICEF, UNHCR, WFP, UNDP, UNFPA, FAO and WHO. Standing invitees are ICRC, IFRC, IOM, ICVA (International Council of Voluntary Agencies), Inter-Action, SCHR (Steering Committee for Humanitarian Response), RSGIDP (the Representative of the Secretary-General on Internally Displaced Persons), UNHCHR and the World Bank.

ICCG	Inter-Cluster Coordinator Group
IFRC	International Federation of Red Cross and Red Crescent Societies
iHeRAMS	Initial Health Resources Availability and Mapping System
IM	Information management
IOM	International Organization for Migration
IRA	Initial rapid assessment
INGO	International non governmental organization
JAM	Joint assessment mission
KI	Key informant
MCOD	Minimum common operational dataset
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
MDTF	Multi Donor Trust Fund
MHPSS	Mental health and psychosocial services
MISP	Minimum Initial Service Package (for reproductive health)
MoH	Ministry of health
MYR	Mid-year review (of a consolidated appeal)
NAF	Needs analysis framework (for preparing a CHAP)
NGO	Non governmental organization
NNGO	National non governmental organization
OCHA	UN Office for the Coordination of Humanitarian Affairs
OPD	Outpatient department
PCNA	Post-conflict needs assessment
PDNA	Post-disaster needs Assessment
PMTCT	Prevention of mother to child transmission
RC	Regional Coordinator
RH	Reproductive health
RTE	Real-time evaluation
SADD	Sex- and age-disaggregated data
SAM	Severe acute malnutrition
SGBV	Sexual and other forms of gender-based violence
ToR	Terms of reference
UNDAC	United Nations Disaster Assessment and Coordination
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund

USAID	United States Agency for International Development
U5MR	Under five mortality rate
WASH	Water, sanitation and hygiene
WHO	World Health Organization
3W	Who is where doing what (originally: Who is doing what, where)
4W	Who is where, when, doing what

GLOSSARY OF KEY TERMS (AND CONCEPTS)

Analysis	The detailed, methodical examination of constituent elements, structure and inter-relationships. [Adapted from the *Oxford English Dictionary*]
Assessment	The set of activities necessary to understand a given situation, entails the collection, up-dating and analysis of data pertaining to the population of concern (needs, capacities, resources, etc.), as well as the state of infrastructure and general socio-economic conditions in a given location/area. [UNHCR] A structured process of collecting and analysing data to measure the impact of the crisis, and provide an understanding of the situation and any related threats, in order to determine whether a response is required and, if so, the nature of that response. An assessment is a time-bound exercise that produces a report and recommendations to inform decision-making at a particular point in time.
Cluster	A group of agencies, organizations and/or institutions working together towards common objectives – to address needs in a particular sector (such as health). [adapted from WHO] A "cluster" is essentially a "sectoral group" and there should be no differentiation between the two in terms of their objectives and activities; the aim of filling gaps and ensuring adequate preparedness and response should be the same. [IASC]
Cluster approach	The Cluster Approach is a way of organizing coordination and cooperation among humanitarian actors to facilitate joint strategic planning. At country level, it: (i) establishes a clear system of leadership and accountability for international response in each sector, under the overall leadership of the humanitarian coordinator; and (ii) provides a framework for effective partnerships among international and national humanitarian actors in each sector. The aim is to ensure that international responses are appropriately aligned with national structures and to facilitate strong linkages among international organizations, national authorities, national civil society and other stakeholders.

Cluster lead	An agency/organization that formally commits to take on a leadership role within the international humanitarian community in a particular sector/area of activity, to ensure adequate response and high standards of predictability, accountability, partnership, and to serve as provider of last resort when necessary. [IASC]
Coordination	A process (set of activities) that brings different elements into a harmonious or efficient relationship. [from the *Oxford English Dictionary*] In the context of humanitarian response, the aim is to have all participating organizations working together in partnership to *harmonize efforts* and *use available resources efficiently* within the framework of agreed objectives, priorities and strategies, for the benefit of the affected population(s). …The proactive process by which allocation of material, human, financial, and technical resources is made more efficient and effective… [Shelter cluster tool kit]
Effectiveness	A measure of the extent to which an intervention's intended outcomes (its specific objectives) have been achieved.
Efficiency	A measure of the relationship between outputs (the products produced or services provided by an intervention) and inputs (the resources it uses).
Equity	The quality of being fair and impartial. [from the *Oxford English Dictionary*]
Evaluation	An assessment, as systematic and objective as possible, of an ongoing or completed project, programme or policy, its design, implementation and results. A systematic and impartial examination (of humanitarian action) intended to draw lessons to improve policy and practice and enhance accountability. [ALNAP] Evaluation answers the questions: Have we achieved what we set out to achieve? If not, why not, and what might we need to change? [Tear Fund]

Gender equality	Gender equality, or equality between women and men, refers to the equal enjoyment by women, girls, boys and men of rights, opportunities, resources and rewards. Equality does not mean that women and men are the same but that their enjoyment of rights, opportunities and life chances are not governed or limited by whether they were born female or male. [*IASC Gender Handbook*, 2006]
Gender analysis	Gender analysis examines the relationships between females and males and their access to and control of resources, their roles and the constraints they face relative to each other. A gender analysis should be integrated into the humanitarian needs assessment and in all sector assessments or situational analyses to ensure that gender-based injustices and inequalities are not exacerbated by humanitarian interventions and that where possible greater equality and justice in gender relations are promoted. [*IASC Gender Handbook*, 2006]
Health actors	Organizations and individuals that are involved, directly or indirectly, in the delivery of health services.
Health information system (HIS)	A set of activities and procedures that collects, processes, analyses, disseminates, catalogues and stores data from primary and secondary sources and transforms those data into useful information to support decision-making in the health sector.
Health system	All the organizations, institutions and resources that are devoted to producing health actions. [WHO, 2000]
Humanitarian country team	The equivalent at country level of the IASC at the global level. Chaired by the Resident/Humanitarian Coordinator, the humanitarian country team normally includes the UN and other international organizations that are members of the IASC and present in the country together with a similar number of NGOs (national and international) chosen or elected to be representative of the NGO community as a whole.

Humanitarian reform	A process launched by the international humanitarian community in 2005 to improve the effectiveness of humanitarian response through ensuring greater predictability, accountability and partnership. The key elements are: (1) the cluster approach; (2) a strengthened Humanitarian Coordinator system; (3) more adequate, timely, flexible and effective humanitarian financing; and (4) the development of strong partnerships between UN and non-UN actors.
Impact	The effect on the affected population (e.g. reduction in measles incidence) [*Guidelines for CAP Mid-year Review*]
Information management	The process of receiving and storing data in a way in which they can be quickly retrieved whenever needed, and systematically compiling and analysing those data to generate information for early warning, programme planning, management, evaluation, and advocacy purposes.
Objective	The desired state that it is intended to achieve – the desired outcome. Objectives are defined at different levels: overall objectives (or "goals") of the emergency programme, and specific objectives (or "purposes") of individual projects that contribute to achieving the higher goals. Objectives should be "SMART" – Specific, Measurable, Accurate, Realistic and Time-bound.
Output	The actions completed to date by a project (e.g. 10 000 children vaccinated) [*Guidelines for CAP Mid-year Review*]
Monitoring	The process/act of observing and checking over a period of time; maintaining regular surveillance over something. [from the *Oxford English Dictionary*] In the context of humanitarian operations, two forms of monitoring are distinguished: (i) Monitoring (surveillance) of the situation – regularly gathering and analysing data on health conditions, risks, access to services, etc. to detect and measure changes. (ii) Monitoring the implementation and programmes and projects – regularly gathering and analysing data on project inputs and outputs to answer the questions: Have we done the things we said we were going to do? If not, why not, and what needs to change? [Tear Fund]

Partners	Individuals and organizations that collaborate to achieve mutually agreed upon objectives.
Partnership	The concept of "partnership" connotes shared goals, common responsibility for outcomes, distinct accountabilities and reciprocal obligations. Partners may include governments, civil society, UN agencies, non-governmental organizations, universities, professional and business associations, multi-lateral organizations, private companies, etc. [*WFP Programme Guidance Manual*]
Sample survey	A structured and statistically analysable and comparable method for collecting information on a specific issue. It provides a snap shot of the situation and respondents' perspectives at the time when the data were collected.
Sector	A distinct part of an economy, society or sphere of activity. [from the *Oxford English Dictionary*] In the context of humanitarian response, key sectors include: agriculture; food; health; nutrition; protection; shelter; water, etc. See also "cluster".
Stakeholder	An agency, organization, group or individual that has direct or indirect interest in a particular activity, or its evaluation. (N.B. for health, this is normally a much larger group than "health actors".)
Stakeholder analysis	Stakeholder analysis is an analysis of the interests and relative influence of the various stakeholders involved.
Strategy	The approach that will be used to achieve one or more defined objectives.
Surveillance	The systematic collection, analysis and interpretation of data in order to plan, implement and evaluate public health interventions. [WHO]

For examples of more extensive glossaries related to humanitarian and health action, see:

- 🕮 http://www.who.int/hac/about/definitions/en/
- 🕮 http://www.reliefweb.int/glossary/

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ROLE AND FUNCTIONING OF A HEALTH CLUSTER

Key points:

- ✓ The cluster serves as a mechanism for coordinated assessments, joint analyses, the development of agreed overall priorities, objectives and a health crisis response strategy, and the monitoring and evaluation of the implementation and impact of that strategy.
- ✓ The cluster should enable participating organizations to work together and with local health authorities, harmonize efforts, effectively integrate cross-cutting issues, and use available resources efficiently within the framework of agreed objectives, priorities and strategies.
- ✓ Participating organizations are expected to be proactive partners in assessing needs, developing strategies and plans for the overall health sector response, implementing agreed priority activities, ensuring attention to priority cross cutting issues and adhering to agreed standards, to the maximum extent possible.
- ✓ The cluster lead agency (CLA) is responsible to the Humanitarian Coordinator for ensuring the satisfactory functioning of the cluster and must be proactive in ensuring this.
- ✓ The CLA assigns a health cluster coordinator (HCC) and is responsible to provide the administrative and other support services required for the coordinator and the cluster to function effectively. In general, the HCC should be a full-time position without any responsibility for the lead agency's own programmes or activities.
- ✓ The HCC facilitates and leads the work of the cluster, and ensures coordination with other clusters in relation to activities relevant to public health as well as the cross-cutting issues.
- ✓ The organization of the cluster, and relationships with national authorities, depend on the context.
- ✓ The HCC takes into account all health related issues to avoid the establishment of stand alone groups in sub-areas of health cluster work such as reproductive health or mental health.

The mission of the Global Health Cluster (GHC), led by WHO, is to build consensus on humanitarian health priorities and related best practices, and strengthen system-wide capacities to ensure an effective and predictable response. It is mandated to build global capacity in humanitarian response in three ways: (1) providing guidance and tools and standards and policies, (2) establishing systems and procedures for rapid deployment of the experts and supplies, and (3) building global partnerships to implement and promote this work.

The GHC does not provide direct support to country-level clusters, which should come from the regional and international headquarters of the designated CLA, but the GHC secretariat may help to put the CLA/HCC in contact with relevant sources of technical support, if/when needed.

For information about the role, activities and products of the GHC, see:
http://www.humanitarianreform.org/humanitarianreform/

1.1 THE CLUSTER APPROACH

The basics

Why a cluster approach?

An independent review commissioned by the UN Emergency Relief Coordinator in 2005 found significant gaps in humanitarian response. The cluster approach was adopted by the IASC the same year to improve the efficiency and effectiveness of the humanitarian response in crises; to increase predictability and accountability in all the main sectors of the international humanitarian response; and to ensure that gaps in response do not go unaddressed.

The cluster approach is one of the three pillars of the humanitarian reform the other two being strengthening the Humanitarian Coordinator system and strengthening humanitarian financing through, among other things, improved appeals and the Central Emergency Response Fund (CERF). OCHA has established a Humanitarian Coordination Support Section (HCSS) based in Geneva, to support HCs and IASC partners in implementing the reform and to monitor progress.

What is the cluster approach?

The cluster approach is a way of organizing coordination and cooperation among humanitarian actors to facilitate joint strategic planning. At country level, it:

(i) establishes a clear system of leadership and accountability for international response in each sector, under the overall leadership of the humanitarian coordinator; and
(ii) provides a framework for effective partnerships among international and national humanitarian actors in each sector.

It strengthens, rather than replaces, existing sector coordination mechanisms.

The aim is to ensure that international responses are appropriately aligned with national structures and to facilitate strong linkages among international organizations, national authorities, national civil society and other stakeholders.

When should it be used?

It is used in countries where a Humanitarian Coordinator has been appointed and should be used in any country faced with a sudden major new emergency requiring a multi-sectoral response with the participation of a wide range of international humanitarian actors. Where a cluster exists, it should also be used for inter-agency contingency planning for potential major new emergencies.

Clusters build on widely-accepted humanitarian principles and the principles of partnership agreed by the Global Humanitarian Platform[3] – see the paragraphs below.

[3] The Global Humanitarian Platform (GHP) is a forum launched in July 2006 to bring together on an equal footing the three main families of the wider humanitarian community: non governmental organizations, the Red Cross and Red Crescent Movement, and the United Nations and related international organizations in order to enhance the effectiveness of humanitarian action.

Humanitarian principles

As per UN General Assembly Resolution 46/182 (19 December 1991), humanitarian assistance must be provided in accordance with the principles of humanity, neutrality and impartiality. Adherence to these principles reflects a measure of accountability of the humanitarian community.

- ✓ ***Humanity***: Human suffering must be addressed wherever it is found, with particular attention to the most vulnerable in the population, such as children, women and the elderly. The dignity and rights of all victims must be respected and protected.
- ✓ ***Neutrality***: Humanitarian assistance must be provided without engaging in hostilities or taking sides in controversies of a political, religious or ideological nature.
- ✓ ***Impartiality***: Humanitarian assistance must be provided without discriminating as to ethnic origin, gender, nationality, political opinions, race or religion. Relief of the suffering must be guided solely by needs and priority must be given to the most urgent cases of distress. (OCHA)

Principles of partnership

- ✓ ***Equality*:** Equality requires mutual respect between members of the partnership irrespective of size and power. The partners must respect each other's mandates, obligations and independence and recognize each other's constraints and commitments. Mutual respect must not preclude organizations from engaging in constructive dissent.
- ✓ ***Transparency*:** Transparency is achieved through dialogue between all partners on an equal footing, with an emphasis on early consultations and early sharing of information. Communication and transparency, including financial transparency, increase the level of trust among organizations.
- ✓ ***Result-oriented approach*:** Effective humanitarian action must be reality-based and action-oriented. This requires result-oriented coordination based on effective capabilities and concrete operational capacities.
- ✓ ***Responsibility*:** Humanitarian organizations have an ethical obligation to each other to accomplish their tasks responsibly, with integrity and in a relevant and appropriate way. They must make sure they commit to activities only when they have the means, competencies, skills, and capacity to deliver on their commitments. Decisive and robust

prevention of abuses committed by humanitarians must also be a constant effort.

- ✓ ***Complementarity*:** The diversity of the humanitarian community is an asset if we build on our comparative advantages and complement each other's contributions. Local capacity is one of the main assets to enhance and on which to build. Whenever possible, humanitarian organizations should strive to make it an integral part in emergency response. Language and cultural barriers must be overcome.

[Global Humanitarian Platform, *A statement of commitment*, July 2007, http://www.icva.ch/ghp.html and on the CD-ROM attached]

Decisions at country level

Decisions on the *clusters required* at country level are made on a case-by-case basis by the Humanitarian Coordinator in close consultation with the IASC agencies present and following consultations with national authorities. They are approved by the UN Emergency Relief Coordinator in consultation with the IASC principles.

Cluster lead agencies are designated taking account of the capacities of the different agencies in country to fulfil the required functions. They may, or may not, coincide with cluster leadership at the global level.

Where a number of humanitarian "hubs" are established for planning and managing the overall humanitarian response in different zones of a large geographic area, corresponding *"zonal" clusters* may be established with focal points designated by the respective cluster lead agencies.

Where zonal/sub-national-level clusters are established, the national level cluster normally focuses on policy issues and strategic planning while the zonal clusters focus on local planning and implementation issues.

While clusters are established on a sector basis it is recognized that there are cross-cutting issues that are important for all sectors. Typically these include gender, age, HIV/AIDS and the environment. Coordination among clusters on these and other issues is assured by an *Inter-Cluster Coordination Group*, convened by the OCHA team leader, that brings together the coordinators of all clusters.

Additional guidance

The key document on the cluster approach, developed after extensive consultation among agencies at the international level and endorsed by the IASC principals is:

- IASC. *Guidance note on using the cluster approach to strengthen humanitarian response*. Inter-Agency Standing Committee, 24 November 2006. Annex I presents the generic terms of reference for sector/cluster leads at the country level.

For additional information, see:

- IASC. *Operational guidance for cluster lead agencies on working with national authorities*. Inter-Agency Standing Committee, December 2008 (draft).
- IASC. *Operational guidance on designating sector/cluster leads in major new emergencies*. Inter-Agency Standing Committee, 23 May 2007.
- IASC. *Operational guidance on designating sector/cluster leads in ongoing emergencies*. Inter-Agency Standing Committee, 23 May 2007.
- IASC. *Rome statement on cluster roll-out*. Inter-Agency Standing Committee Working Group, 5-7 November 2007.
- IASC. *Strengthening NGOs participation in the IASC, a discussion paper*. Inter-Agency Standing Committee, 24 April 2006.
- *Principles of partnership, a statement of commitment*, approved by the Global Humanitarian Platform, 12 July 2007.

For information about the humanitarian reform, see:

- http://www.humanitarianreform.org/

1.2 ROLE OF A HEALTH CLUSTER

The purpose of the Health Cluster

The country-level Health Cluster (or existing sector coordination group adopting the cluster approach) should serve as a mechanism for participating organizations to work together in partnership to *harmonize efforts and use available resources efficiently* within the framework of agreed objectives, priorities and strategies, for the benefit of the affected population(s). This includes avoiding gaps and/or overlap in the international humanitarian health response and resources (human and financial).

The cluster should provide a framework for effective partnerships among international and national humanitarian health actors, civil society and other stakeholders, and ensure that international health responses are appropriately aligned with national structures.

The specific outputs usually expected from a Health Cluster are listed on page 9.

Membership of the Health Cluster

The Health Cluster at *national* level should normally include:

- organizations providing or supporting health services in the affected areas – UN agencies (WHO, UNICEF, UNFPA), other international organizations (e.g. IOM, IFRC), the national Red Cross/Red Crescent society, international and national NGOs, and representatives of key private-sector health service providers; and
- the main health-sector donors and other important stakeholders.

Clusters at *zonal* (sub-national) level should normally include the health agencies active in the zone and any donor representatives or other health stakeholders present at that level.

The Health Cluster, national health authorities and existing coordination mechanisms

The Health Cluster lead agency (CLA) serves as a bridge between the national and local health authorities and international and NGO humanitarian health actors. A key responsibility of the CLA is to ensure that international humanitarian actors build on local capacities and that they develop and maintain appropriate links with relevant government and local authorities (notably the ministry of health – MoH) and local civil society organizations involved in health-related activities.

The nature of those links will depend on the situation in the country and on the willingness and capacity of each of these organizations to lead or participate in humanitarian activities:

- Where the MoH is in a strong position to lead the overall humanitarian health response, the cluster should organize the international humanitarian response in support of the host government's efforts. This would typically be the case following a natural disaster.

- In other cases, particularly in a situation of ongoing conflict, the willingness or capacity of the Government or State institutions – including the MoH – to lead or contribute to humanitarian activities may be compromised, and this will clearly influence the nature of the relationships which it establishes with international humanitarian actors. [IASC. *Guidance note on using the cluster approach to strengthen humanitarian response*, 24 November 2006]

Practical arrangements may vary accordingly. It has often been found appropriate for a MoH representative and the CLA to co-chair meetings at both national and sub-national levels. Some useful ideas are provided in:

📖 IASC. *Advocating with national authorities.* Cluster-Sector Leadership Training Tip Sheet, Inter-Agency Standing Committee, 6 July 2007.

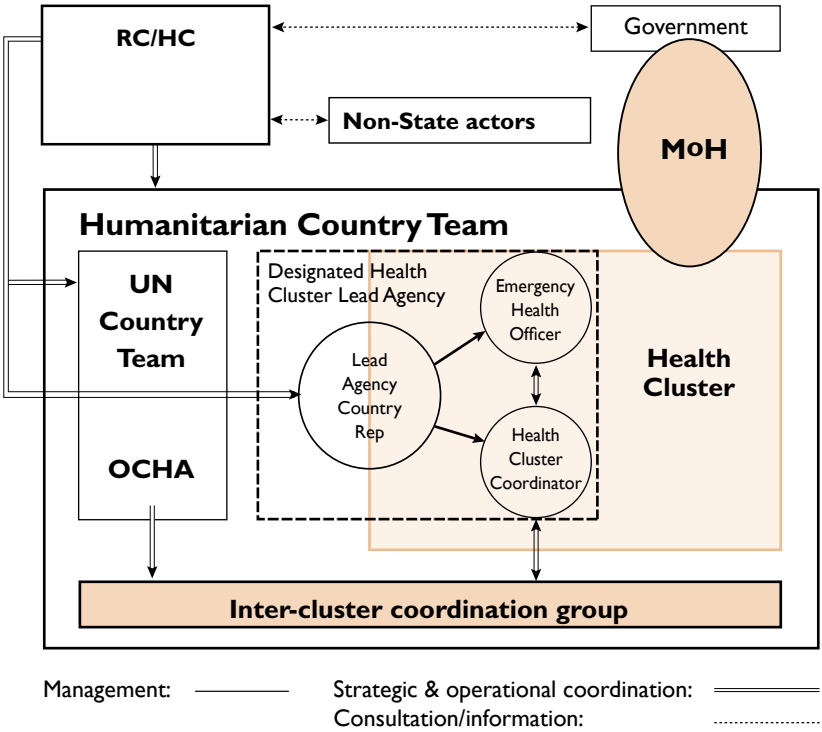
The relationships among the Cluster Lead Agency Representative (CLAREP), the HCC, the cluster, the RC/HC and the government/MoH are shown in Figure 1a. Note that:

- The CLA Representative is accountable to the RC/HC for the satisfactory fulfilment of the overall CLA function.
- The HCC is a staff member of the CLA who reports to the CLA Representative and represent of the cluster as a whole.
- As one of the health partners with programme activities that contribute to the overall health response, the CLA should normally be represented in the health cluster by the CLA Emergency Health Officer.
- Inter-cluster coordination is assured at two levels, namely:
  - At the policy level, the country representatives/directors of the designated CLAs meet together under the chairmanship of the RC/HC in the context of the humanitarian country team or in separate meetings, when needed.
  - At the strategic and operational levels, the coordinators of all clusters meet regularly together under the chairmanship of the OCHA team leader in the context of an inter-cluster coordination group.

The Inter Cluster Coordination Group (ICCG) is a key mechanism for the clusters to work together, identify humanitarian needs that require a multi-sectoral response, and strategize and plan accordingly. This is the body where the cluster coordinators have to report and discuss how the different cross-cutting issues and other humanitarian needs have been mainstreamed and where and how concerted action with other clusters is

needed. This is particularly relevant for the response to HIV, sexual violence, disabilities and MHPSS.

Figure 1a The Health Cluster and the wider architecture in countries affected by a humanitarian crisis



1.3 ROLES OF THE CLUSTER LEAD AGENCY, OF THE COORDINATOR AND OF PARTNERS

Responsibilities of the Health Cluster lead agency

The CLA has to ensure the establishment of an adequate coordination mechanism for the health sector. This includes: adapting the generic TOR for and appointing a country-level health cluster coordinator (HCC); ensuring appropriate relations with the MoH and avoiding duplication with any existing health sector coordination

mechanisms; assuring information management and other support services necessary for the satisfactory functioning of the cluster; designating health cluster focal points at sub-national (zonal) level where needed; and advocating for resources for all humanitarian health partners. The CLA also serves as "provider of last resort" – see the box below.

The generic responsibilities of cluster leads at the country level are spelt out in:

📖 IASC. *Guidance note on using the cluster approach to strengthen humanitarian response*. Inter-Agency Standing Committee, 24 November 2006. Annex I presents the generic terms of reference for sector/cluster leads at the country level.

The CLA country representative is accountable to the Humanitarian Coordinator (HC) for fulfilling these responsibilities.

The specific responsibilities of the health CLA are shown in the first two columns of the Figure 1b and 1c.

At the same time, the CLA is a partner in the cluster and should be represented in cluster meetings by its own emergency health programme manager.

PROVISION OF LAST RESORT

Where necessary, and depending on access, security and availability of funding, the cluster lead, as provider of last resort, must be ready to ensure the provision of services required to fill critical gaps identified by the cluster. This includes gaps in relation to early recovery needs within the health sector.

Where critical gaps persist in spite of concerted efforts to address them, the cluster lead is responsible for working with the national authorities, the Humanitarian Coordinator and donors to advocate for appropriate action to be taken by the relevant parties and to mobilize the necessary resources for an adequate and appropriate response.

The Health Cluster lead agency's responsibility for "Provision of Last Resort" should be activated when all three of the conditions below are met:

1. the Health Cluster agrees that there is an important life-threatening gap in the Health sector response, and
2. one or more of the agreed benchmarks for the health sector response as a whole is not being met, and
3. evidence suggests that a significant proportion of the target population is at risk of avoidable death if the gap is not filled urgently.

What is expected of the Health Cluster Coordinator (HCC)

The generic ToR for a HCC is reproduced in the second column of the Figure 1e below. In summary, the coordinator is expected to:

- ☑ Enable cluster partners to be more effective by working together, in coalition, than they could individually, and to maximize the benefit for the target population of the cluster partners' individual inputs and efforts.
- ☑ Provide leadership to and work on behalf of the Cluster as a whole, facilitating all cluster activities and maintaining a strategic vision.
- ☑ Ensure that needs, risks, capacities and opportunities are assessed and understood as best possible at all stages of the humanitarian response, and that information is shared.
- ☑ Generate the widest possible consensus on priorities and a health response strategy to the crisis that addresses the priority needs and risks in the sector, incorporates appropriate strategies, and promotes appropriate standards.
- ☑ Work with cluster members collectively and individually to identify gaps in response and try to ensure that available resources are directed to addressing priority problems and that assistance and services are provided equitably and impartially to different areas population groups on the basis of need.
- ☑ Ensure the effective integration of cross-cutting issues into the cluster's activities and strategies.
- ☑ Ensure coordination with other clusters in all activities relevant to public health.

The role is to "facilitate" and "lead", not to direct. The HCC should not be the emergency health programme manager of the CLA.

What is expected of cluster partners

Health Cluster partners are expected to subscribe to the overall aim of the cluster (see page 9) and to:

- ✓ be proactive in exchanging information, highlighting needs and gaps and reporting progress, mobilizing resources, and building local capacity;

- ✓ share responsibility for Health Cluster activities including assessing needs, developing plans and guidelines, and organizing joint training; and
- ✓ respect and adhere to agreed principles, policies and standards, and implement activities in line with agreed priorities and objectives.

However, it is up to individual organizations to determine their levels of participation. The cluster approach does not require that humanitarian actors be held accountable to the HCC or CLA. Individual organizations can only be held accountable to the CLA when they have made specific commitments.

The roles and responsibilities of the CLA Representative, the HCC and cluster partners are summarized in the Figures 1b and 1c below.

Additional guidance

📖 IASC. *Guidance note on using the cluster approach to strengthen humanitarian response*. Inter-Agency Standing Committee, 24 November 2006. Annex I presents the generic terms of reference for sector/cluster leads at the country level.

📖 IASC. *Operational guidance on the concept of "provider of last resort"*. Inter-Agency Standing Committee, May 2008 (draft).

Accountability framework for the Health Cluster at country level: definitions of the RASCI diagram

RESPONSIBLE	Those who do the work to achieve the task. There can be multiple resources responsible.
ACCOUNTABLE	The person/people ultimately answerable for the correct and thorough completion of the task.
SUPPORT	Those who may help in the task.
CONSULTED	Those whose opinions are sought. Two-way communication.
INFORMED	Those who are kept up to date on progress. One-way communication.

Figure 1b presents an example of the attribution of accountability, responsibility and other roles as defined by the RASCI diagram to the main health cluster constituencies. Country-specific context may need different attributions of roles and responsibilities to the health cluster main actors. This should be part of the discussions among partners that have to take place at the beginning of the work of the health cluster and periodically discussed thereafter.

Figure 1b RASCI diagram for the Health Cluster functions at country level

Functions	CLA Rep.	Health Cluster Coordinator	Cluster Partners
1. Coordination mechanisms and inclusion of key actors within the Health Cluster and inter-cluster	A	R	R, S
2. Relations with other key stake-holders	A, R	R	S, C, I
3. Needs assessment, situation monitoring & analysis, includ-ing identifying gaps in health response	A	R	R, S, C
4. Strategy development and gap filling	A	R	R, S
5. Contingency planning	A, R	R	R
6. Application of standards	R, S	R, S	A, R
7. Training and capacity building, including emergency preparedness	A	S	R, S, C
8. Monitoring and reporting	A, R	R	R, S
9. Advocacy and resource mobilization	A, R	S, C	S, C
10. Provider of last resort	A, R	S	S, C

Figure 1c Roles within a country-level Health Cluster

Functions[1]	Cluster Lead Agency (CLA)		Cluster Partners[4]
	Cluster Lead Agency Representative (CLA Rep.)[3]	Health Cluster Coordinator (HCC)[2]	
1. Coordination mechanisms and inclusion of all health actors within the Heath Cluster and inter-cluster (1+2) *See chapters 1 & 2*	Appoint an HCC and assure the support services necessary for the effective functioning of the cluster. [CLA Rep.] Use the CLA's existing working relations with national health authorities and with national and international organizations, civil society and non-State actors that are active in the health sector to facilitate their participation in the Cluster and relationships with the HCC, as needed. [CLA Rep./EHO] Ensure that sectoral coordination mechanisms are adapted over time to reflect the evolution of the crisis and the capacities of local actors and the engagement of development partners. [CLA Rep.] Work within the Country Humanitarian Team to help ensure appropriate understanding and prioritization of health concerns and appropriate inter-sectoral/ inter-cluster action, when required. [CLA Rep.]	1a. Identify and make contact with health sector stakeholders and existing coordination mechanism, including international organizations. 2. Hold regular coordination meetings with country health cluster partners, building when possible on existing health sector coordination fora. 3. Collect information from all partners on Who's Where, since and until When, doing What, and regularly feed the database managed by OCHA (4W). Provide consolidated feedback to all partners and the other clusters. 10. Represent the Health Cluster in inter-cluster coordination mechanisms at country/field level, contribute to jointly identifying critical issues that require multi-sectoral responses, and plan the relevant synergistic interventions with the other clusters concerned.	Participate actively in Cluster meetings and activities at national and local levels. Coordinate with local authorities and local health actors in the areas where working. Share information on the situation and own organization's activities. Encourage local health actors to participate in relevant peripheral health coordination mechanisms, where such exist. Propose ways by which the Cluster can be more effective in supporting the delivery of, and equitable access to, health services in the field.
2. Coordination with national authorities & other local actors (3) *See chapter 1*	In coordination with the Humanitarian Coordinator, maintain appropriate links and dialogue with other national and local authorities, State institutions, local civil society and other relevant actors (e.g. local, national and international military forces, peacekeeping forces and non-State actors) whose activities affect humanitarian space and health-related programmes. [CLA Rep.]	1b. Identify and make contact with national authorities, national NGO and civil society.	Consult with the HCC/ CLA concerning their own relations with key stakeholders in the field.
3. Needs assessment & analysis including identifying gaps (6) *See chapters 3 and 4*	Make CLA technical expertise and other resources available for cluster and inter-sectoral assessments, as required. [CLA Rep.] Participate actively in the analysis of available information on health status and risks, health resources, and health service performance, and the ongoing monitoring of these key aspects. [EHO] Ensure the rapid establishment of an appropriate early warning and response system (EWARS) in coordination with national health authorities. [CLA Rep./WHO]	4. Assess and monitor the availability of health resources and services in the crisis areas provided by all health actors using GHC tool: Health Resources Availability Mapping System (HeRAMS). 5. Ensure that humanitarian health needs are identified by planning and coordinating joint, inter-cluster, initial rapid assessments adapting to the local context the IRA tool, as well as follow-on more in-depth health sub-sector assessments, as needed. 6. Mobilize Health Cluster Partners to contribute to establishing and maintaining an appropriate Early Warning and Response System, and regularly report on health services delivered to the affected population and the situation in the areas where they work.	Participate in joint assessments and data analysis making staff and other resources available as required and possible. Provide regular monthly activity reports on the health services supported at all levels of care Collaborate in assuring prompt EWAR sentinel site reporting from the selected health facilities.

Functions[1]	Cluster Lead Agency (CLA)		Cluster Partners[4]
	Cluster Lead Agency Representative (CLA Rep.)[3]	Health Cluster Coordinator (HCC)[2]	
4. Strategy development & planning (8), including: Community based approaches (4), attention to priority cross cutting issues (5), and filling gaps *See chapter 5*	Participate actively in gap analysis, priority setting and the development of a health crisis response strategy and cluster action plan. Ensure that humanitarian responses build on local capacities and that the needs, contributions and capacities of vulnerable groups are addressed. [EHO] Ensure that Cluster/sector plans take appropriate account of national health policies and strategies and lessons learned, and incorporate appropriate exit, or transition, strategies. [CLA Rep./EHO] Ensure that opportunities to promote recovery and appropriate re-building of the health system are identified and exploited from the earliest possible moment, and that risk reduction measures are incorporated in Cluster strategies and plans. [CLA Rep./EHO]	7. Lead and contribute to the joint health cluster analysis of health-sector information and data (see points 3, 4, 5 and 6) leading to joint identification of gaps in the health sector response and agreement on priorities to inform the development (or adaptation) of a health crisis response strategy. 12a. Provide leadership and strategic direction to the Health Cluster in agreeing on priorities and strategies, and planning coordinated action to address critical un-covered gaps. 15. In a protracted crisis or health sector recovery context, ensure appropriate links among humanitarian actions and longer-term health sector plans, incorporating the concept of 'building back better' and specific risk reduction measures.	Participate in gap analysis, priority setting and the elaboration of a health crisis response strategy and cluster action plan. Ensure that own organization's project activities contribute to the agreed health crisis response strategy and take appropriate account of priority cross-cutting issues. Plan/adapt own activities to contribute to filling identified gaps. Ensure that own organization's project activities promote recovery from the earliest possible moment, and contribute to risk reduction, where possible
5. Contingency planning (7) *See section 5.5*	Participate actively in cluster/inter-agency contingency planning and preparedness for new events or set-backs. [EHO]	11. Lead joint Health Cluster contingency planning for potential new events or set-backs, when required.	Conduct the joint contingency planning for possible future events/ set-backs in the areas of operations with the other partners
6. Application of standards (9) *See chapter 6*	Ensure that all Cluster partners are aware of relevant national policy guidelines and technical standards, and internationally-recognized best practices. [CLA Rep./EHO] Where national standards are not in line with international standards and best practices, negotiate the adoption of the latter in the crisis areas. [CLA Rep.]	13. Promote adherence of standards and best practices by all health cluster partners taking into account the need for local adaptation. Promote use of the Health Cluster Guide to ensure the application of common approaches, tools and standards.	Adhere to agreed standards and protocols and promote their adoption in the delivering of health services whenever possible
7. Training and capacity building (12) *See chapter 6*	Promote/support training of staff and capacity building of humanitarian partners, and support efforts to strengthen the capacities of the national authorities and civil society to assure appropriate, sustainable health services. [CLA Rep./EHO]	14. Identify urgent training needs in relation to technical standards and protocols for the delivery of key health services to ensure their adoption and uniform application by all Health Cluster partners. Coordinate the dissemination of key technical materials and the organization of essential workshops or in-service training.	Ensure that own staff are adequately trained for the activities undertaken Identify own training needs, make these known, and assign staff to attend trainings as and when opportunities are made available Collaborate in organizing training for staff of local health actors and other partners, making trainers and other resources available when possible

Functions[1]	Cluster Lead Agency (CLA)		Cluster Partners[4]
	Cluster Lead Agency Representative (CLA Rep.)[3]	Health Cluster Coordinator (HCC)[2]	
8. Monitoring and reporting (10) *See chapter 8*	Produce and disseminate Cluster sitreps and regular Health Bulletins using HCC input. [EHMP/Communications Officer]	9. Ensure partners' active contribution to and involvement in joint monitoring of individual and common plans of action for health interventions; collate and disseminate this and other information related to the health sector in Cluster sit-reps and/or regular Health Bulletins.	Participate in defining and agreeing on any information and reports that Cluster partners should provide to the HCC, and provide such information and reports a timely manner.
9. Advocacy and resource mobilization (11) *See chapter 7*	Provide information regularly to the news-media and, where consensus points are agreed with cluster partners, represent the Cluster in press conferences, interviews, etc. [CLA Rep./ Communications Officer] Advocate for donors to fund priority health activities of all Cluster partners. [CLA Rep.] Represent the interests of the health sector in discussions with the Humanitarian Coordinator and other stakeholders on priorities, resource mobilization and advocacy. [CLA Rep.]	12b. Provide leadership and strategic direction to the Health Cluster in developing the health sector components of FLASH Appeal, CHAP, CAP and CERF proposals and other interagency planning and funding documents.	Contribute to overall Cluster efforts to advocate for appropriate attention to all public health needs (and humanitarian principles in general). Present own activities in the context of the overall health sector effort whenever possible and appropriate Emphasize the importance of – and own commitment to – coordination and collaboration
10. Provider of last resort (13)	Act as the provider of last resort (subject to access, security and availability of funding) to meet agreed priority needs. Inform the Humanitarian Coordinator and CLA's own headquarters of resource needs and work with them to secure the necessary resources. [CLA Rep. /EHO]	8. Inform the CLA Representative of priority gaps that can not be covered by any health cluster partner and require CLA action as provider of last resort.	Call attention to the need for activation of the POLR function, when needed.

Notes:

1 In this first column, [#] = corresponding points in the generic ToR for CLAs

2 Once the Cluster Approach is activated and a country CLA designated, the CLA country representative and country office are responsible for fulfilling HCC functions to the maximum extent possible pending the designation and arrival of an assigned HCC.

3 The CLA Representative (CLA Rep.) is responsible for assuring that all these functions are satisfactorily fulfilled. Certain functions may be delegated to the CLA Emergency Health Programme Manager (EHO) and other CLA staff, as indicated, but those marked [CLA Rep.] should be fulfilled by the CLA Representative personally or be delegated to the HCC.

4 Cluster partners would normally be represented in Cluster meetings by their country directors or emergency health programme managers. The CLA would normally be represented by its EHO as one of the cluster partners.

1.4 CLUSTER ACTIVITIES DURING THE DIFFERENT PHASES OF THE HEALTH RESPONSE

Figure 1d lists the main actions to be taken during four distinct phases of response. The time frame and the focus of response during each phase depend on the nature of the disaster/crisis. Note that:

- Phase 1 needs to be completed very quickly in case of a sudden-onset disaster. A little more time may be taken in case of a slow-onset crisis but the activities are similar.
- For some emergencies, there may be an early warning phase in advance of the onset of the crisis.
- In some cases, particularly in case of a complex (conflict) emergency, the situation may evolve differently in different parts of the country; the acute phase may last longer in some areas than others, and certain areas may regress.

Figure 1e outlines the programme planning and management processes that Cluster partners need to keep in mind and that the coordinator must facilitate. Note that:

- Assessment, analysis, the development of agreed objectives, priorities and strategies, and monitoring the implementation of the health crisis response strategy is the responsibility of the *Cluster as a whole, led by the HCC.*
- The detailed planning, implementation, monitoring and evaluation of individual projects are the responsibility of the *individual organization concerned.* However, where the cluster approach is fully adopted and organizations work in partnership, the HCC and Cluster partners *may* organize joint monitoring and jointly-sponsored, independent evaluations of projects including real-time evaluations under the leadership of the HCC.
- The process of assessment, analysis, and planning is *iterative:* refinements and adjustments are made as up-dated information becomes available – see chapter 3, especially Figure 3b.

Note that Figure 1e reflects an *ideal* process of agreeing a health crisis response strategy (step 2) and individual organizations then producing their own action plans in the context of that response

strategy (step 3). This should be feasible from the outset in two situations: (i) in case of a slow-onset crisis; (ii) when an inter-agency contingency plan had been prepared in advance.

In other cases, steps 2 and 3 will be undertaken in parallel during the initial stages:

- the HCC will have to work to bring together as many as possible of the main health actors to share information and progressively develop a shared analysis of the situation and needs, agree on overall goals, response strategies and, eventually, an overall health crisis response strategic plan; while, at the same time,
- individual organizations draw up their own initial action plans taking account the overall health cluster's agreed strategic plan, and of what is known about the response plans of other actors, while remaining flexible to adjust their plans if/when needed to better address priority needs.

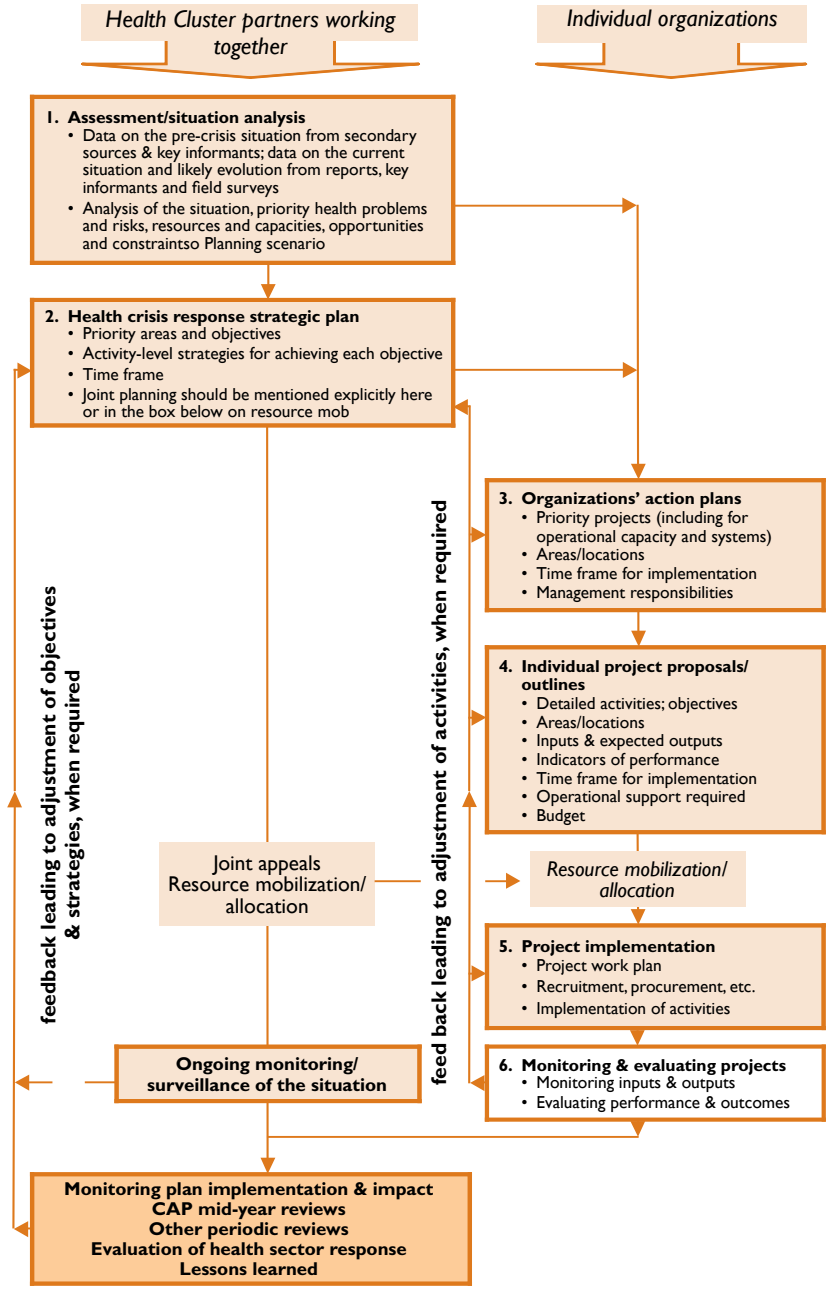
In each situation, health cluster partners (led by the HCC) should agree on the overall joint, or collaborative, process of assessment, analysis, strategy development and planning to be followed.

Figure 1d Principal cluster activities during the different phases of emergency response

Phase 1 ***Sudden-onset crisis:*** First 24 to 72 hours ***Slow-onset crisis:*** First 1-2 weeks	☑ Preliminary contacts, activation of the inter-agency contingency plan (if any) ☑ Preliminary enquiries and consolidation of information ☑ First health cluster coordination meeting(s) – national and sub-national levels ↳ preliminary working scenario (anticipated health needs and risks) ↳ preliminary "who-where -when-what" (4W) resource inventory and gap analyses ↳ identification of initial, gender-sensitive response priorities and actions ☑ Establishment of a health coordination office and database ☑ Preparation and dissemination of first health cluster/sector bulletin ☑ Participation in initial inter-cluster/inter-sectoral coordination meetings; contribution to initial inter-cluster/sectoral analysis and planning ☑ Collection of pre-crisis information ☑ Planning the initial rapid assessment (IRA) ☑ Initiate the EWARS
Phase 2 ***Sudden-onset crisis:*** First 4 to 10 days ***Slow-onset crisis:*** First month	☑ Implementation of *i*HeRAMS ☑ Launching the initial rapid assessment (IRA) ☑ Fully implement the EWARS ☑ Establishment of emergency health information system (field reporting) ☑ Definition of standards and protocols ☑ Regular health coordination meetings – national and sub-national levels ↳ up-dated working scenario, resource inventory and gap analyses ↳ agreement on up-dated, gender-sensitive response priorities and actions ☑ Formulation of initial health sector strategic plan ☑ Preparation of health component of the UN-OCHA flash appeal (if any) ☑ Preparation of proposals for CERF funding (if any) ☑ Preparation and dissemination of regular health-sector bulletins ☑ Continuing participation in inter-cluster/inter-sectoral coordination meetings; contribution to inter-cluster/sectoral analysis and planning and effective integration of cross-cutting issues including gender equality.

Phase 3 ***Sudden-onset crisis:*** ≈ 4 to 6 weeks (disaster) to up to 3 months (conflict) ***Slow-onset crisis:*** ≈ 2–3 months	☑ Establishment of full HeRAMS and emergency health information system (HIS) ☑ Coordination of contributions to surveillance and early warning and response ☑ Continuation of regular health coordination meetings (e.g. weekly) ☑ Development of health crisis response strategy ☑ Planning scenario (identified health problems and risks) ☑ Overall objectives, strategies, health cluster action plan ☑ Implementation and monitoring of initial response (with gender-sensitive indicators) ☑ Preparation of CHAP and consolidated appeal ☑ Resource mobilization ☑ Frequent up-dating of resource inventory and gap analyses ☑ Establishment of technical working groups, as/when needed ☑ Organization of joint training, as/when needed ☑ Coordination of logistics support for health activities ☑ Monitoring implementation of the health crisis response strategy & cluster action plan
↓	
Phase 4 (continuing humanitarian response & progressive recovery)	☑ Continuation of regular health coordination meetings (e.g. bi-weekly) ☑ Periodic up-dating of the planning scenario, HeRAMS, and gap analyses ☑ Coordination of the replacement of departing international teams ☑ Establishment/suspension of technical working groups, as needed ☑ Maintenance of HIS, surveillance and EWARS ☑ Real-time or interim/mid-term evaluation of sector response ☑ Comprehensive assessment/in-depth sub-sector assessments, as needed ☑ Updating of strategic/action plan with increasing focus on recovery ☑ Contingency planning for possible changes in the situation
↓	
Phasing out	☑ Phase-out plan for emergency programmes as recovery programmes increase ☑ Final (ex-post) evaluation and lessons-learned exercise

Figure 1e Process of planning and implementing a health sector humanitarian response



2

EFFECTIVE COORDINATION

Key points:

- ✓ All health cluster partners must be committed to the overall objective of addressing the priority health problems and risks and providing the best possible health services to the affected population – and avoiding gaps in response – through coordinated, collaborative action.
- ✓ The health cluster lead agency (CLA), health cluster coordinator (HCC) and cluster partners must fulfil their respective roles and responsibilities as outlined in section 1.2.
- ✓ The HCC must be a facilitator and, at the same time, provide leadership. S/he must, among other things, maintain regular direct communications with cluster partners individually, the CLA country representative, and the MoH emergency coordinator.
- ✓ Good information and information management must be assured including, in particular, information on "Who is Where, When, doing What" (4W). Up-to-date disaggregated data on the situation and health response activities must available at all times to all stakeholders.

Expected Health Cluster outputs

- ✓ Functioning health sector coordinating mechanisms involving UN agencies, NGOs, CBOs, health authorities, donors, and community members, including between the centre and the field, and with other sectors.
- ✓ Up-to-date mapping of health actors and service delivery activities.
- ✓ Up-to-date information on the health situation and needs is available to all stakeholders; regular situation reports/health bulletins.

Common "gaps" in relation to health sector coordination
Findings from 10 country case studies (2004-07)

Examples	Some proposed remedies
Ineffective health sector coordination mechanism, failing to include affected community, national and local governments, donor governments, multilateral agencies, national and international NGOs, academic institutions, military and the media, as well as the private sector and religious groups. Poor coordination of plans and communication of activities between the capital and the field coordination mechanism. Multiple coordination mechanisms operating simultaneously. Meetings time-consuming, resulting in information sharing rather than action planning. Unclear distinction between health leadership roles of different UN agencies. Inadequate inter-sectoral coordination.	Deploy authoritative lead with group facilitation skills to act as dedicated coordinator with no additional implementation responsibilities early in an acute crisis. Nominate field level coordinator(s) as well as central coordinator as indicated by the situation. Consider putting in place a decentralised Cluster Approach with a Cluster lead agency in the field, conducting field–level sector-wide planning which is then forwarded to central level for review and support. Orient meetings towards common actions; disseminate standards, guidelines and country planning documents (e.g. on CD) to partners. Establish interagency Letters of Understanding covering field operations to clarify agreed roles and responsibilities where confusion exists. Conduct regular inter-sectoral coordination meetings, ensuring attendance by sectoral representatives with decision making capacity.

2.1 ENGAGING PARTNERS – BUILDING AN EFFECTIVE HEALTH CLUSTER

Some basic principles

- ✓ *Be inclusive:* identify and involve all health actors including local organizations and authorities. Ensure translation at meetings, where necessary.
- ✓ *Complement and strengthen existing coordination structures and processes* at both national and sub-national levels. Avoid parallel systems.
- ✓ *Start with realistic objectives,* demonstrate value added and build trust, hence get buy-in, then broaden the scope (see box below). Focus on the

key health priorities starting with what is most feasible and expand incrementally to address other concerns as and when possible.

- ✓ *Make sure all partners have something to gain.* Benefits may include access to more/better information or expertise, opportunities for common strategizing and planning, facilitated access to the affected areas, access to resources (transport, funds, etc.) from a common pool or through the identification of opportunities for sharing.
- ✓ *Learn from the past*. Find out how health sector coordination processes operated in previous emergencies in the country, what worked well and what did not, and why.
- ✓ *Ensure transparency* in all cluster activities and the use of resources.

Identifying potential cluster partners

- ☑ Get lists of health actors – and their contacts – through the MoH, existing health-sector coordination mechanisms, organizations working in the sector for a long time, and the "grapevine". Contact them, explain the aims of the cluster and invite them to the first/next meeting.

Engaging partners and getting buy-in

- ☑ Build relationships and maintain regular contact with all health actors.[4] Encourage dialogue.
- ☑ Build trust through transparency and openness. Acknowledge constraints.
- ☑ Respect differing mandates, priorities and approaches. Seek to build consensus on needs, risks, objectives and how best to address them equitably with the resources available.
- ☑ Understand partners' expectations and constraints; ensure that expectations are realistic and seek ways to help them overcome constraints.
- ☑ Keep an up-to-date registry of organizations involved in health activities including information on operations and capacities.
- ☑ Establish clear understanding on the information that is required from cluster partners and other health actors, in what form and how often it should be presented.

[4] Achieving coordination depends heavily on behaviour and interpersonal skills.

- ☑ Use the preparation of a flash appeal, a CHAP and CAP, and other inter-agency planning processes as opportunities to build a culture of collaboration, participation and partnership. Ensure that all partners have the opportunity to contribute to defining overall priorities and develop their own activities accordingly.
- ☑ Make sure that information about meetings, decisions and current health issues are readily available to all actors. Make sure that meetings are productive – see section 2.2. Allow partners to contribute to setting meeting agendas.
- ☑ Seek feedback from cluster members on the effectiveness of the Cluster and how it could be enhanced.

Engaging with local health actors

National and local NGO involvement is often constrained by lack of funding or resources, language, organizational culture, access to information and the overall organizational capacity of civil society. To increase their participation:

- ☑ provide information and resources in a local language;
- ☑ keep reporting and information management tools simple;
- ☑ work within existing local structures; and
- ☑ facilitate partnerships among more experienced cluster partners and less experienced national and local NGOs through training, small-scale funding, and shared cluster responsibilities.

Ensuring coordinated action in specific sub-sectors

The reproductive health (RH) area (including the three subsectors of STI&HIV, maternal & newborn health and sexual violence) requires increased attention in humanitarian settings. To ensure adequate coverage of these essential services, an organization that is a partner in the health cluster and has specific expertise and capacity in country must be assigned the responsibility to support, promote, advocate for and lead actions in the reproductive health area . The assignment of an RH area focal point agency should be discussed and agreed within the health cluster with all partners agreeing on the terms of reference, and the organization concerned committing to fulfilling the agreed ToR. The ToR should be linked to the agreed health crisis response strategy/plan of action. It should be consistent with agreed minimum standards (MISP) taking account of the situation and the available technical and operational capacity.

Coordination of gender based violence prevention and response and mental health and psychosocial support (MHPSS) activities needs specific, joint arrangements between health and other clusters – primarily the protection cluster. These arrangements should be inclusive and health aspects of these cross cutting issues have to be discussed and addressed within the health cluster. For technical guidance, see:

- IASC. *Guidelines on mental health and psychosocial support in emergency settings*. Inter-Agency Standing Committee, 2007, and a forthcoming document on MHPSS specifically addressed to health and protection cluster coordinators.
- IASC. *Guidelines for gender-based violence interventions in humanitarian settings focusing on prevention of and response to sexual violence in emergencies.* Inter-Agency Standing Committee, September 2007.

A progressive approach to effective coordination

Coordination is teamwork: make each cluster partner feel part of it. Without being too strict on the sequence, you can adopt a progressive approach:

As a start, have the partners *sharing information* on:
- mandates, objectives, roles and responsibilities,
- resources and capabilities,
- areas of operations, priorities and projects,
- sources of data and perception of the general context.

As next step, have the partners *working together* at:
- assessing needs, setting standards, and mobilizing external resources,
- ensuring access to the affected populations,
- building local and national capacities, and training their own staff.

In a more advanced phase you will find that partners can *share plans and resources* through:
- joint planning – strategic, operational and contingency planning,
- implementing joint operations,
- sharing their experts, security systems, and logistics arrangements /capacities.

Where to look for technical and operational support

A Country Cluster Lead Agency (CLA) is responsible for assuring the necessary support. The CLA must look for resources (knowledge, experience, expertise, technical guidance, funds, staff, etc.):

- firstly in country – within its own office, within the cluster (partners), and within the humanitarian community at large through the Humanitarian Country Team and the Humanitarian Coordinator;
- secondly, through its regional and international headquarters;
- finally, if further support is required, a request may be made to the global lead agency (WHO).

Anticipating and overcoming barriers to coordination

Common barriers to coordination	Tips to overcome them
"Autonomy is threatened": The perception that coordination will reduce participants' freedom to make decisions and run their own programmes.	Have frank and open discussions about shared goals. Show how collective problem-solving and strategizing can benefit all concerned and still allow freedom of action within the overall health crisis response strategy.
"Too many players": Concern that the process will be complicated and any consensus or agreement difficult to achieve due to a large number of organizations involved.	Establish small working groups with representation from all stakeholder groups to address specific issues and make recommendations to the cluster as a whole.
Decision-makers do not attend meetings, so participants constantly have to refer back to their managers/HQ before committing their organizations, or agreements are not ratified.	Clearly indicate when decisions need to be taken, communicate this early and use an appropriate forum. Establish decentralized coordination mechanisms at sub- national level. Establish deadlines for decisions.
Decisions are imposed; a few organizations dominate: The process of decision-making is not transparent. Many partners do not have the opportunity to contribute.	Ensure appropriate cluster leadership and facilitation. Form small working groups, with representation of all stakeholder groups and rotating chairpersons, to work on specific issues and make recommendations to the Cluster. Record all decisions together with the reasons.

Common barriers to coordination	Tips to overcome them
Unilateral actions: Individual organizations ignore established coordination processes and do not respect joint decisions.	Discuss with the organization concerned in a non-confrontational manner. Engage the cluster (including donors) in clarifying the role of the cluster, renewing agreements on priorities and best practices, and finding ways to avoid disruptive unilateral actions in future.
"No benefit – a waste of time": Many partners feel that the process does not provide sufficient benefits to justify the time invested.	Provide useful information and services. Establish a cluster action plan with clear, agreed objectives and concrete, actionable deliverables. If resources (human or financial) are insufficient for the cluster to function well, include a convincing project proposal with an adequate budget in the flash appeal or the next CAP. Organize periodic participatory evaluations of partners' satisfaction with cluster processes, activities and decision-making to determine how they might be improved.
Staff turnover: New staff (of the cluster team or individual partners) lack commitment to the Cluster Approach or are unaware of previous joint decisions and agreements.	Explain the role of the cluster and the reasons for previous decisions and agreements. Encourage all partners to involve senior national staff in the work of the cluster in order to assure continuity in thinking and action.

Additional guidance

- 🕮 Global WASH Cluster. Sections 2.3 "Managing contacts and communication" and 2.5 "Negotiating, consensus building and conflict resolution", in *WASH cluster coordination handbook*. Global WASH Cluster Coordination Project, January 2009.
- 🕮 IASC. *Leadership in Clusters and Building Consensus*. Cluster-Sector Leadership Training Tip Sheets, Inter-Agency Standing Committee, 2007.
- 🕮 Seeds for change. *Consensus decision-making*. Useful detailed guidelines on consensus building.
- 🕮 Seeds for change. *Consensus in large groups*. Useful detailed guidelines on facilitating consensus building in large groups.

2.2 MAPPING HEALTH ACTORS

The mapping of health actors throughout the crisis-affected area(s) is a pre-requisite for coordinated planning and action. It should be undertaken rapidly at the *onset* of a crisis, not later than the first cluster meeting, and be *updated* continuously during the early stages of response and at regular intervals once the situation has stabilized. It is also key to monitor whether the population has real access to the services being offered and/or whether these services are being utilized as expected.

Arrangements for "mapping" must be adapted to the country context but should generally include:

☑ Mapping the *services* and specific health *resources* available through different actors in different areas using the Health Resources Analysis and Mapping System (*HeRAMS*) – the initial "i-HeRAMS" version in the first instance – see section 3.2.

☑ Provide regularly to OCHA the information collected through HeRAMS, in order to feed the Who is where, when, doing what (4W) database.

☑ Complementing these "activity-related" data with additional elements such as:

- the mandate, role, objectives, areas of expertise, and the priorities they want to address;
- the resources they have, and what they hope to mobilize, and the types and quantities of assistance they intend (or might be able) to provide;
- the geographic and service areas into which they plan (or might be able) to extend their activities;
- when they expect to initiate any new activities, or extend activities to new geographic areas, and when phase down and close particular activities;
- their commitment (or willingness) to collaborate with others and work in partnership, and their interest in contributing to Cluster activities;
- their commitment to equity and cross cutting issues including gender equality programming and SGBV response and prevention activities.

☑ Undertaking a *stakeholder analysis* – systematically examining the interests of each agency, organization, group and individual that has a direct or indirect interest in health, health services, and the activities of the Health Cluster, and whose attitudes and actions could have an

influence on health and the outcomes of humanitarian health activities – see Annex E.

(Stakeholders may include militias and other non-State actors, for example, as well as donors and local political entities in addition to organizations actually providing health services.)

The combined information is important for assessment and planning purposes but also provides the HCC with the understanding necessary to work with the various actors individually, or in groups, to increase their commitment to the Cluster's objectives (or at least to reduce opposition).

Linking with the OCHA-managed 3W/4W database

The OCHA-managed 3W (Who is doing what, where) database has catalogued agencies, their current projects and donor support by sector and in relation to defined administrative areas. From early 2009, the GHC asked OCHA to move to a 4W (Who is where, since/up to when) database that also integrates the global health cluster's standard list of health sub-sectors (see section 9.1) in order to refine the What tasks the health cluster partners have to report on.

The GHC HeRAMS tool, once customized to the country, uses the same, "OCHA's" list of geo-referenced place names and administrative areas, and records the actual services provided, and the human and other resources available, at particular locations (see section 3.2).

The HCC is responsible to establish and maintain HeRAMS and to ensure health sector inputs to the OCHA 3W/4W database. Possibilities for arranging the direct transfer of common data between the two systems are being examined but, at the time of writing, the HCC will have to work with OCHA locally to determine how best to share data and ensure consistency between the two systems.

N.B. For health cluster purposes it is essential to also know the period – from when, until when – during which the actor concerned expects to provide the service. This is particularly important for NGOs that may be present for only a limited period as well as organizations that are in the process of expanding their operations. The HCC must therefore keep an up-to-date record of "when" even if this information is not recorded by OCHA.

HCC and Health Cluster action

☑ Get the area and population data sets from OCHA and customize HeRAMS.

☑ Check what information the MoH and OCHA already have or are collecting at national and field levels concerning organizations active in the health sector. This might include contact addresses, general information about the organization, and the geographic areas where they are working. Cross-check that information to ensure that everyone is "on the same page".

☑ Collect information on the health services/service sub-sectors that each health actor is providing, or plans to provide in specific areas using HeRAMS:

- make the data available to OCHA for inclusion in the 3W/4W database health module;
- work to ensure maximum possible complementarity among the service delivery activities of different that partners/health actors (for example, one partner may provide primary health care services in a particular area while another supports hospital care).

☑ Collect information on mandates, objectives, roles, resources, and the types and quantities of assistance each partner can provide, and the areas and priorities they want to address; analyse their respective comparative strengths and look for consistency in the integration of cross-cutting concerns in their activities.

☑ Make sure all these data are regularly updated and emphasize (and support, if necessary) the collection of sex- and age-disaggregated data (SADD).

Lessons and practical hints from field experience

In many places it has been found convenient for organizations to provide information on their activities and capacities by completing a simple form.

In some places it has been found useful to have wall boards, or flip-chart sheets, posted permanently on a wall of the place used for cluster meetings, where organizations can write in – and up-date as and when necessary – their own data as well as see what others have entered. The information is transcribed into the 3W module and printouts are distributed periodically by the HCC.

Now, once HeRAMS is installed and staff trained in its use, it may be possible to collect data directly on the HeRAMS data collection form and display HeRAMS outputs for scrutiny and up-dating when needed.

Additional guidance

📖 Annex E on the CD-ROM – *Stakeholder analysis* (which also provides a detailed list of further references).

2.3 HOLDING SUCCESSFUL CLUSTER MEETINGS

Meetings are essential but careful planning and good facilitation is necessary to ensure that they are worthwhile. Many take too much time and produce limited outcomes, and attendance can fall off rapidly as a result.

Organizing a cluster meeting

☑ Include all relevant governmental and other national entities.

☑ Get the MoH to chair or co-chair the meeting, if possible. Otherwise, if a UN agency is the CLA, meetings may be co-chaired with an appropriate NGO.

☑ Prepare a realistic agenda – see the example in the box below; focus on key issues identified and agreed in advance with the MoH.

☑ Select a venue that is suitable in terms of accessibility, facilities, space, ventilation.

☑ Prepare handouts with new information and maps.

☑ Prepare formats and/or flip charts to record the information you want to get from others, or cross-check, during or at the end of the meeting. (For the early meetings this includes, in particular, information on who is where and providing what kind/level of health care.)

☑ Ensure the rapid preparation and distribution of a concise record of key items of information shared in the meeting, decisions reached, and follow up actions required with responsibilities.

The CLA should be represented by an emergency programme manager. The HCC should not be asked to wear two hats during coordination meetings.

The *first meeting* must be convened by the lead agency within the first 24-48 hours for a sudden-onset crisis (the first 2-3 days for a slow-onset crisis) even if the individual designated as cluster coordinator has not yet arrived. If there is *no existing* cluster or coordination group, the CLA should contact the MoH and the other main health actors to arrange a first meeting with as many participants as possible. Invite heads of agencies (country directors) to the first meeting.

Making sure that meetings are productive

☑ Be clear about the *purpose* of the meeting and sure that a meeting is the best format.[5] Specify in advance the outputs to be produced and the decisions to be taken.

☑ Ensure that meetings *focus* on problem solving, prioritization and planning, and do not simply become occasions for sharing information. Enforce time-keeping.

☑ Keep meetings as *short* as possible and adjust their frequency to the needs of phase of operation.

☑ Arrange for small *sub-groups* to work on specific problematic issues and bring recommendations back to the next cluster meeting, when necessary. But avoid a proliferation of meetings. Ask for email feed back on drafts and limit discussion in cluster meetings to the key issues only.

☑ *Involve* partners in formulating agendas and identifying issues requiring specific work.

☑ During the first month, ask *newly-arrived organizations* to come half-an-hour earlier for a quick briefing on the role of the cluster and what has been discussed and decided at previous meetings. This will avoid time being lost during the meeting itself.

[5] Some purposes may be served better by using email, on-line googlegroups (or similar), phone calls, written communications.

POSSIBLE AGENDA FOR A FIRST HEALTH CLUSTER MEETING

1. Welcome, introductions (if needed); explanation of the purpose of the cluster; agreement on the agenda.
2. *Short briefing by MoH and the HCC* (or the Cluster Lead representative if the HCC is not yet in place) on what is known about the situation, health needs, and actions already taken or planned.
3. *Sharing information:* what each participating organization knows, is doing, plans to do (when and where), and the problems and constraints faced.
4. *Information gaps:* identification of any major gaps in information concerning specific areas and/or health aspects; discussion and agreement on how critical information gaps will be filled (who will do what when).
5. *Priority health problems, risks, service gaps:* identification of major, life-threatening health risks and gaps in services to address those risks; discussion and agreement on how those gaps will be filled (who will do what, where, when).
6. *Arrangements for an initial rapid assessment:* possible designation of sub-working group to organize the IRA within an agreed time frame.
7. *Information clearing house:* agreement on an emergency health information focal point to receive and collate information from all partners.
8. *Bulletin:* arrangements for the production and dissemination of an emergency health bulletin.
9. *Next meeting:* date, place, time, agenda items and anything participants are requested to prepare.

N.B. The above is what would be an ideal agenda. However:

- If the cluster is only just being formed, item 1 may require considerable time and a more modest agenda be needed. For item 1, it may be useful to: (i) present the functions-responsibilities matrix in section 1.2; (ii) ask whether and how it might need to be amended to suit the context of the country and the current emergency; (iii) get a few, initial reactions; and (iv) ask for specific suggestions to be provided by email before the next meeting.
- If many organizations are present, items 3, 4 and 5 may take the form of a quick review and up-dating of (i) a preliminary working scenario – see section 3.1, and (ii) a table prepared in advance by the HCC/CLA showing who is present and currently providing or supporting community-, primary- and secondary-level health care in each of the affected districts.

Lessons and practical hints from field experience

In Uganda, the use of thematic working groups within the cluster shortened the duration of meetings while improving their quality, hence making meetings more productive.

Additional guidance

📖 IASC. *Coordination Meetings*. Cluster-Sector Leadership Training Tip Sheets, Inter-Agency Standing Committee, 2007.

📖 Global WASH Cluster. Section 2.4 "Managing and facilitating cluster meetings", in *WASH Cluster Coordinator Handbook*. Global WASH Cluster Coordination Project, January 2009.

2.4 WORKING WITH OTHER CLUSTERS AND COORDINATING ENTITIES

Coordinating with other clusters/sector groups

Several key aspects and determinants of public health are covered by other clusters, especially the Nutrition, Shelter, and WASH (water, sanitation and hygiene) clusters. Close coordination with these clusters should be assured by:

- ✓ the CLA in the context of the Humanitarian Country Team, chaired by the HC;
- ✓ the HCC through the inter-cluster coordination group[6] chaired by the OCHA team leader and any other multi-cluster/multi-sectoral groups that may be constituted; and
- ✓ arranging joint activities and attendance at each others' meetings, as outlined below.

Working with other clusters

☑ Invite other clusters/sector groups to assign representatives to attend health Cluster meetings.

[6] The inter-cluster coordination group also provides the forum for discussion and coordination on cross-cutting issues including gender.

- ☑ Assign representatives of the health Cluster to attend the other Cluster meetings and report back to the HCC and the next health Cluster meeting.
- ☑ Organize joint activities such as a multi-cluster Initial Rapid Assessment (IRA), see section 3.3.
- ☑ Identify as early as possible the cross-cutting issues that have particular significance for the health sector and use the inter-cluster coordination meetings and mechanisms to plan joint (or complementary) activities to address them appropriately.
- ☑ Establish joint plans with relevant other clusters (notably WASH, Nutrition and Protection) for addressing issues relating to specific priority public health problems of common concern (such as preparing for or responding to a cholera outbreak or a coordinated response to GBV or mental health and psychosocial support) and HIV/AIDS (a cross-cutting concern).

Note that *mental health and psychosocial support* should be coordinated within the Inter-Cluster Coordination Group. Similar arrangements should be in place in relation to *sexual and gender-based violence* (SGBV).

Working with other coordinating entities

The HCC must work closely with:

- the *OCHA* team and, in particular assure cooperation with the humanitarian information centre (HIC) managed by OCHA, avoiding duplication of effort;
- the emergency coordination cell of the *MoH* (if there is one); and
- any existing general *NGO* coordination forum.

Provide the RC/HC and OCHA with information on the health situation. Get from OCHA (and the humanitarian information centre, HIC, when established) information compiled on other sectors, especially WASH, nutrition and shelter.

The HCC and cluster partners should cooperate with any *UNDAC* team present during the first few weeks of a sudden-onset emergency. Agree on arrangements for collecting and compiling information on the health situation and needs during an initial assessment/reconnaissance in the first few days pending the findings of the IRA (see section 3.3).

2.5 ENSURING GOOD INFORMATION MANAGEMENT

Good information and good information management are essential for coordination and one of the keys to successful emergency response. They are also necessary to support requests for resources. A good information management system is needed from the first day.

Some basic principles

- ✓ Information management capacity must be mobilized early to establish appropriate systems and tools including a database and web site accessible to all partners and other stakeholders. A full-time information manager is needed in many cases and space to manage the receipt and organization of information, to display it in an accessible manner, and manage dissemination.
- ✓ Links should be established with the OCHA Humanitarian Information Centre (HIC), other information management initiatives and groups to ensure collaboration, including with the MoH.

HCC and Health Cluster action

- ☑ Ensure information management *capacity* by mobilizing the skills needed from the CLA, partners, the MoH, byrecruiting for a cluster project, or by collabrating with OCHA/HIC. The skills needed usually include:
  - An information management specialist
  - GIS and database design and management specialists
  - Communications and news-media relations (see section 2.6)
- ☑ Define the *types of information* to be collected, stored and disseminated for the benefit of health cluster partners and other stakeholders and to support cluster activities. This may include:
  - list of cluster partners and other main stakeholders with contact details
  - sex- and age-disaggregated health data (SADD)
  - cluster/health-sector situation reports and health bulletins (see section 2.6)
  - health crisis response strategy (see section 5.1)
  - assessment reports (see chapter 3)
  - health resources (HeRAMS) data (see section 3.2)

- appeals documents (see chapter 7)
- guidelines on standards and best practices
- press releases and other formal cluster communications
- summary minutes of cluster meetings including working groups
- periodic reports, reviews and evaluations of cluster activities and health-sector response
- background information including reports of previous emergency operations, epidemiological studies and other pre-crisis data, health-sector profiles, etc.

☑ List the *tools* (standard formats, templates, etc.) for use by health cluster partners that should be made available through a suitable web site[7] together with the above information.

☑ Ensure active participation in *inter-agency initiatives* in information management (HIC, information management working groups) to improve inter-agency sharing of information, get access to information on the potential causes of health problems or risks and initiatives of other clusters that could affect public health (e.g. shortage of water, pollution of sources, lack of sanitation, etc. as well as gender analysis and other contextual information), and participate in establishing inter-agency information management standards.

☑ Ensure that health-related data from *all sources* (including news media reports) are systematically compiled, stored and reviewed for reliability and relevance.

☑ Arrange for systematic *analysis* – including a gender analysis – of all data to generate information for planning, management, evaluation, and advocacy purposes.

☑ Ensure that information is handled and used responsibly, see box below.

[7] OCHA plans to establish an *inter-agency web site* at the onset of every major crisis. Country-level clusters will be responsible for posting and managing the content of their own sector pages. Once available, the CLA and HCC must ensure the development of the health page. In the meantime, use an existing platform.

HANDLING AND USING DATA AND INFORMATION RESPONSIBLY

- ✓ Verify and record the sources and probable reliability of all data and information received.
- ✓ Cross-check – "triangulate" – data from different sources, whenever possible.
- ✓ Consider possible margins of error in data and the implications for decisions.
- ✓ Specify the sources – and the limitations – of any data issued or disseminated.
- ✓ When quoting data or reporting information, always provide analysis of its significance.
- ✓ Respect the confidentiality of medical records: ensure that any copies of documents that contain patients' names are stored securely and not copied, distributed or left lying around.
- ✓ In any situation of conflict or repression, respect the confidentiality of informants who do not wish their identities to be revealed.

Data and information on the nature and extent of sexual and gender-based violence (SGBV) – especially rape – and the clinical management of the issue is particularly sensitive and should be handled and used with extreme care. Seek expert advice.

Additional guidance

- 🕮 IASC. *Operational guidance on responsibilities of cluster/sector leads and OCHA in information management*. Inter-Agency Standing Committee, IASC Task Force on Cluster Approach, October 2007.
- 🕮 IASC. *Information Management*. Cluster-Sector Leadership Training Tip Sheets, Inter-Agency Standing Committee, 2007.
- 🕮 WHO. *WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*. World Health Organization, 2007.
- 🕮 Fact sheets Stop Rape Now, UN Action against Sexual Violence in Conflicts on *"dos and don'ts" for reporting and interpreting data on sexual violence from conflict-affected countries*, 2008.

2.6 DISSEMINATING INFORMATION – MANAGING EXTERNAL COMMUNICATIONS

Information on the health situation, health-related activities and outstanding (unmet) needs should be issued regularly.

Some basic principles

- ✓ The best possible up-to-date disaggregated data on the situation and health response activities (disaggregated by area, population group, age and sex, as much as possible) must be available at all times to all health cluster partners, other clusters and other stakeholders in useful, readily understandable formats.
- ✓ All health actors should be regularly updated on the contextual factors (political, social, economic, security, etc.) that may have implications for the planning and implementation of their activities.
- ✓ Information on the health situation, health-related activities and outstanding (unmet) needs should be issued regularly to all stakeholders (including donors) and the news-media.

Health Cluster lead agency

- ☑ Arrange for the regular production of a Health Cluster bulletin (presenting health data and trends) and newsletter (providing technical and general information on health, cross-cutting issues) with procedures and deadlines for the submission of information and articles, and the rapid clearance of drafts by a small, cluster-appointed editorial board. (Do not under-estimate the time required for the compilation and preparation of material.)
- ☑ Disseminate the bulletin widely – to MoH facilities at all levels, all other relevant government entities, UN agencies, NGOs, donors, news-media, etc.
- ☑ Establish and regularly up-date a "health" web site, or provide inputs to be integrated in another, inter-sectoral news and reporting forum. Where there is a humanitarian information

centre (HIC), for example, health sector issues may be integrated in the HIC web site.

☑ Establish and cultivate contacts with local and international journalists/news-media representatives.

☑ Prepare press releases and organize press briefings whenever there is important information to publicize.

☑ Organize question-and-answer briefings and field visits for national and international journalists.

☑ Establish a photo-library and systematically collect and catalogue photos of the health situation and significant events.

Lessons and practical hints from field experience

In Uganda, the health cluster issues a quarterly Newsletter and Bulletin. In addition, monthly cluster reports, and daily or weekly situation reports are disseminated. Distribution channels include: mailing list, cluster web site, and a Google share group.

Additional guidance

📖 An example of a Health Cluster bulletin can be found on the CD-ROM.

3

ASSESSMENT AND HEALTH SITUATION MONITORING

Key points:

- ✓ Information is needed on: health status and risks, health resources availability (including services), and health system performance.
- ✓ The situation analysis provided by an assessment should be regularly up-dated on the basis of information from ongoing situation monitoring and early warning system reports.
- ✓ Assessments should be undertaken, situation monitoring assured, and information managed and disseminated with the maximum possible involvement of national and sub-national-level health authorities as well as other partners. All should use common, gender-sensitive indicators, standards, protocols and case definitions.
- ✓ Information and knowledge generated by the information collected should be disseminated, in time to inform decisions on the planning and management of response activities. Data should be disaggregated by geographical area, population group, age and sex, as much as possible.

Expected Health Cluster outputs

- ✓ Joint needs assessments.
- ✓ Regular joint situation updates based on monitoring of the situation of the health sector response.

The following are the key requirements:

✓ Good health *pre-crisis secondary data* including sub-national (e.g. district) level profiles;	
✓ Quality health *assessments* completed in a timely manner at the beginning of a crisis and whenever necessary during an ongoing crisis covering; – the *health status* of affected population groups, and health risks; – the *access* different population groups have to health services (including a gender analysis); – the capacity and functioning of the *health system* and *services*; *and* – information on the overall social, economic, security and humanitarian *context* that must be taken into account in the analysis of the health situation;[8]	See sections 3.3 & 3.4
✓ An appropriate *early warning and response system* for epidemic-prone diseases and other critical conditions;	See section 3.5
✓ An appropriate health *monitoring*/surveillance system that provides regular data on mortality, morbidity, injury treatment and rehabilitation, potential health risks, health service performance, and changes in the overall context that could affect health or health services;	See section 3.6

Good health *information management* including *dissemination* is also needed and should assure:
– systematic screening, compilation, analysis and storage of data;
– shared databases and/or a web site (linked with OCHA/HIC or equivalent); *and*
– the production and publication of regular health bulletins and, when appropriate, special reports.

See sections 2.5 and 2.6.

[8] Normally, such context information should be available from the Humanitarian Coordinator/OCHA and other sources so that health teams should not need to invest time and effort in collecting them.

"ASSESSMENT" AND SITUATION "MONITORING/SURVEILLANCE"

Assessment and ongoing situation monitoring are complementary elements. Together with an understanding of the pre-crisis situation, they progressively enhance knowledge and understanding of (i) the situation and possibilities for addressing the identified needs, and (ii) expediting the [re]establishment of essential health services and equitable access to them.

- *Assessments* are time-limited exercises that provide information on the situation at a particular point in time and on how the assessment team *expects* the situation to evolve, and the risks that *might* be faced.
- *Situation monitoring/surveillance* is a continuous activity that provides information on a regular basis to up-date the situation analysis provided by the last assessment, identify trends and detect any significant changes or new threats. It is broader than disease surveillance in that it also examines changes in the context as well the resources available, that could influence health and health risks.

Cluster partners must agree on a coherent, coordinated set of assessment and situation monitoring activities adapted to the local context that identifies priorities and provides timely information to decision- makers in relation to both humanitarian and early recovery needs.

Common "gaps" in relation to needs assessment Findings from 10 country case studies (2004-07)	
Examples	**Some proposed remedies**
Sector-wide assessment of health needs of the affected population not comprehensive, inclusive or timely. Examples include being conducted at central level, excluding the periphery, lacking gender- and age-based analysis of population needs; or being too slow to influence planning. Poor representation of health actors in inter-sectoral emergency assessments.	Conduct early epidemiological assessment of the whole affected population, with data disaggregated by age and gender. Ensure that needs assessment process is gender sensitive, involving men and women from the affected community, male and female assessors and translators, and that needs are analysed by gender and age. Ensure that joint assessments are linked to an outcome – e.g. funding mechanism or joint planning process – and that the conducting of joint assessments does not replace or delay individual agency assessments used for programme design, monitoring and evaluation. Ensure adequate representation of health agencies in early joint rapid assessments.
Common "gaps" in relation to health information	
Lack of data for monitoring and planning including malnutrition, mortality, and morbidity. Health Information System inappropriate to the phase of the response. For example, continued use of sentinel site surveillance rather than population based data in the early recovery phase.	Establish a common health information system coordinated by one agency aiming for timely complete reporting from all facilities. Put in place effective mortality data collection system (such as community-based mortality data collection using community health workers). Conduct mortality survey where indicated. Implement population-based Health Information System in early recovery (as appropriate).

3.1 KEY HEALTH INFORMATION NEEDS, PROCESSES AND TOOLS

Good, shared information is essential if overall health response and the actions of individual cluster partners (and other health actors) are to appropriately and effectively address the priority problems.

Some basic principles

- ✓ Data must be collected and analysed – and the resulting information and recommendations provided to decision-makers – in time to inform policy and operational decisions for the health response.
- ✓ Maximum use should be made of secondary data but all such data, whether on the current situation or pre-crisis, should be reviewed for reliability and the precise area(s) and population(s) and time periods to which they relate.
- ✓ Data should be disaggregated by, as a minimum, geographic area, age and sex in order to determine who is affected and who is being reached and, therefore, provide a basis for planning.
- ✓ Local professionals who know the context must be mobilized and contribute to the assessment and analysis process.
- ✓ Arrangements must be designed to meet health information needs throughout the crisis while at the same time preparing the ground for the rehabilitation – and, where needed, upgrading of – the pre-existing health information and surveillance systems.

Specific assessment, monitoring and information management tools are needed to collect, analyse and manage health information during a crisis. They are needed because crisis usually disrupt regular health information and surveillance systems and also generate specific information needs that are not (or rarely) covered by routine systems.

Information needs

Data need to be collected and systematically analysed on three core aspects:

Health Status and Risks	***Health Resources and Services Availability***	***Health System Performance***
The current health status of affected population groups (e.g. mortality, morbidity and their major causes) and health risks (e.g. potential outbreaks or further interruption of services or critical disease control programmes).	*Initial focus on*: the facilities, personnel, supplies and services of national health authorities, other national and non-state actors, and international partners. *Later,* once the initial, acute phase is over and especially when seeking to promote recovery: the above plus other health system components (management systems, financing, etc.)	The coverage and quality (effectiveness) of the services currently available; The access (physical and temporal access) that men, women, boys and girls' have to those services and their utilization of them.

Figure 3a shows the tools available for the collection, collation and analysis of data on these core aspects and how – through comparison with established benchmarks – priorities and gaps are identified and a response strategy defined. Ongoing monitoring and evaluation provide feedback to enable information to be up-dated and plans adjusted. The *pre-crisis* situation, in order to put everything in context and understand what has changed, is critical for these three core aspects.

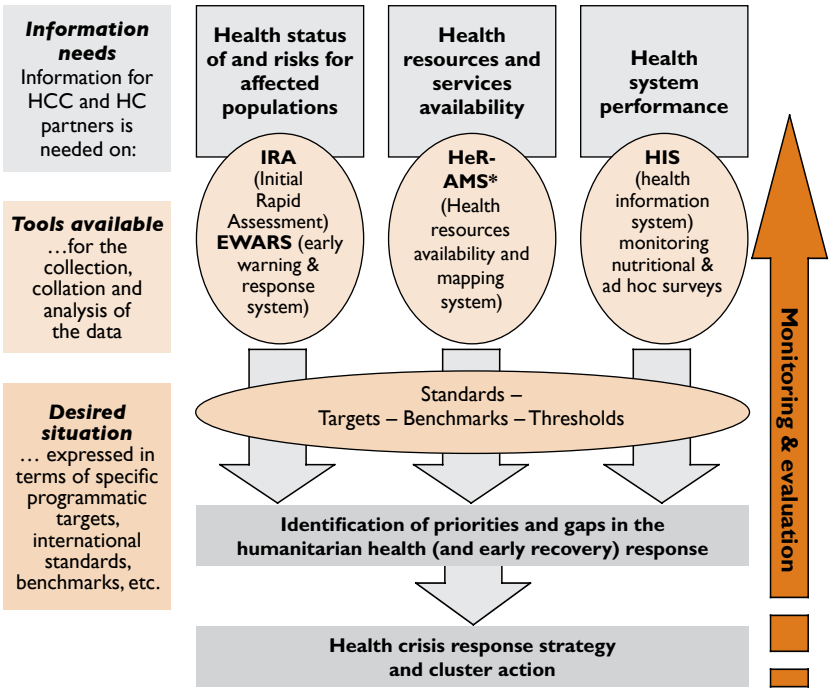
In addition the three core aspects, information is needed on:

- ✓ the *context* – political, social, economic and security conditions, etc. – to inform recommendations on actions to address priority health problems and gaps in services (see section 3.6);
- ✓ *lessons* from responses to previous crisis in the country, or in neighbouring countries, in order to be able to build on successes and avoid repeating mistakes.

The tools referred to are:

- the multi-cluster/multi-sectoral initial rapid assessment (IRA) – see section 3.3;
- the Global Health Cluster health resources availability and mapping system (HeRAMS) – see section 3.2;

Figure 3a Core information needs, tools and outputs



* HeRAMS is linked to the OCHA.-managed 4W database that also provides information on resources

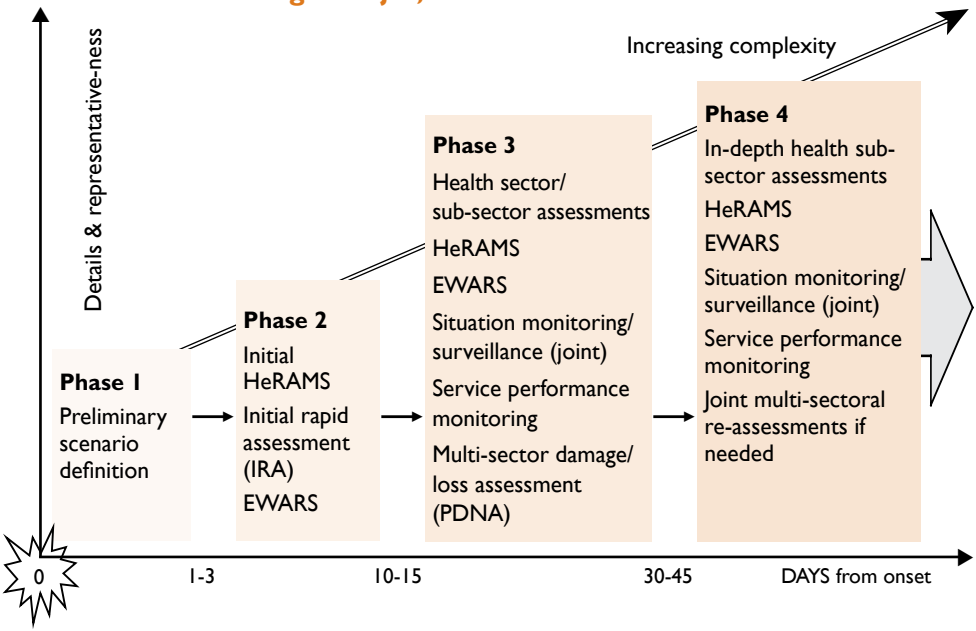
- the WHO/global health cluster early warning and response system (EWARS) and the *HINTS* software produced by the health and nutrition tracking service – see section 3.5;
- regular health information system (HIS) – see section 3.6.

Data collection and analysis processes and tools

It is useful to recognize four distinct phases for data collection and analysis, linked to response planning and management decisions following a major sudden-onset crisis. These four phases are shown in Figure 3b.[9] It shows the characteristics of each phase, the tools used, the information outputs, and the decisions they inform at different points in time.

[9] These four phases were proposed by OCHA and adopted by participants in a multi-organization "common needs assessment" workshop in Bangkok in January 2009. They are expected to be reflected in IASC guidance.

Figure 3b Phases of data collection, analysis and planning following a major, sudden-onset crisis



Phase 1 *(0-3 days)*	Phase 2 *(4-10/15 days)*	Phase 3 *(15-30/45 days)*	Phase 4 *(30/45 + days)*
Assessment methods			
• Expert interpretation of initial reports & remote data • Few site visits	• Rapid appraisal methods only (KI, O & GD) • Purposive sampling	• Household level survey + rapid appraisal methods • Representative sampling	• Household level survey + rapid appraisal methods • Representative sampling
↓ **Information outputs** ↓			
• Preliminary working scenario	• Identification of main problems, risks and gaps – initial planning scenario	• Initial analyses of problems, risks and gaps – updated planning scenario	• Comprehensive and updated analyses and planning scenario *(ongoing, regular)*
↓ **Use of the information** ↓			
• Preliminary health crisis response strategy (for response in the first few days)	• Initial health crisis response strategy • Adjustment of initial responses • Specific project proposals • Flash appeal	• Detailed health crisis response strategic plan • Refinement of ongoing projects • Additional project proposals • Consolidated appeal	• Updated health crisis response strategy, projects and appeals

Where arrangements for initial assessments and information management have been agreed *in advance* in the context of inter-agency contingency planning, those activities can be implemented rapidly and efficiently. Otherwise, much time is likely to be lost in the first few days and initial responses may be uncoordinated or delayed (some may even be inappropriate).

The time frames of the different phases may be adapted to each particular context including slow- and gradual-onset crisis. However, good information is required within 10 to 15 days of any crisis onset in order to inform early response and funding decisions and the OCHA Flash Appeal.

HCC and Health Cluster action

At the onset of a crisis

- ☑ Establish a basic initial *health resource availability and mapping* system (*i*-HeRAMS) immediately at the onset of a crisis. Expand this to a full-HeRAMS as soon as possible. See section 3.2.
- ☑ Work with the nutrition, WASH and other clusters and the MoH (and with relevant cross-cutting issues advisors, as necessary) to undertake a joint *initial rapid assessment* (IRA) in the first 10 to 15 days and produce a joint, initial analysis of priority problems, risks and gaps. See section 3.3.
- ☑ Establish, with the MoH whenever possible, an *early warning and response system* (EWARS). See section 3.5.
- ☑ Establish arrangements, with the MoH whenever possible, to *monitor the situation* and produce *regular reports* on the health situation and service usage. See section 3.6.

Later and during an ongoing crisis

- ☑ Keep up-to-date the *health resource availability and mapping* system (HeRAMS). See section 3.2.
- ☑ Collaborate in detailed *health sector/sub-sector assessments* or sample surveys focusing on aspects identified by the IRA as being important and needing more in-depth assessment. These may be led by the MoH, individual cluster members or other competent bodies. See section 3.4.
- ☑ Jointly *monitor* the situation on an ongoing basis. See section 3.6.

☑ Organize *joint rapid assessments* (using the IRA or similar) following any significant change in the situation or when a previously inaccessible area becomes accessible. See section 3.3.

☑ Collaborate in multi-agency, inter-sectoral "post-disaster" and "post-conflict" needs assessments – *PDNAs and PCNAs* – led by UNDP and the World Bank once the situation has stabilized, focusing on damage and related recovery and reconstruction needs. These assessments should benefit from information already available from the IRA and in HeRAMS as well as the additional, more detailed and up-to-date information available to cluster partners. See section 3.4.

Where a Cluster already exists at the onset of a sudden-onset crisis, it may jointly compile a "best-guess" situation analysis based on *preliminary assessment/ reconnaissance* findings in the first 1 to 2 days. It can usefully be summarized in a "preliminary working scenario" that provides the basis for response actions by all parties in the first few days and the design of the IRA.[10]

Additional guidance

📖 Annex B, on the CD-ROM – *Types of assessment – when, why and how they are undertaken.*

📖 Annex C, on the CD-ROM – *Guiding principles for all data collection activities – assessments, surveys & surveillance.*

📖 Darcy J, Hofmann C-A. *According to need? Needs assessment and decision-making in the humanitarian sector*. HPG Report # 15, September 2003.

📖 IASC. *Shared Assessment and Analysis*. Cluster-Sector Leadership Training Tip Sheets, Inter-Agency Standing Committee, 2007.

📖 Lippeveld T, Sauerborn R, Bodart C (eds). *Design and implementation of health information systems*, Geneva: World Health Organization, 2000 (not available on the CD-ROM).

📖 Pavignani E, Colombo A. *Analysing disrupted health sectors – A modular manual*. Geneva: World Health Organization 2009.

[10] See *Managing WHO Humanitarian Response in the Field*, WHO 2008, sections 3.2, 3.3, and annex B8.

3.2 MAPPING HEALTH RESOURCES AND SERVICES – USING HERAMS

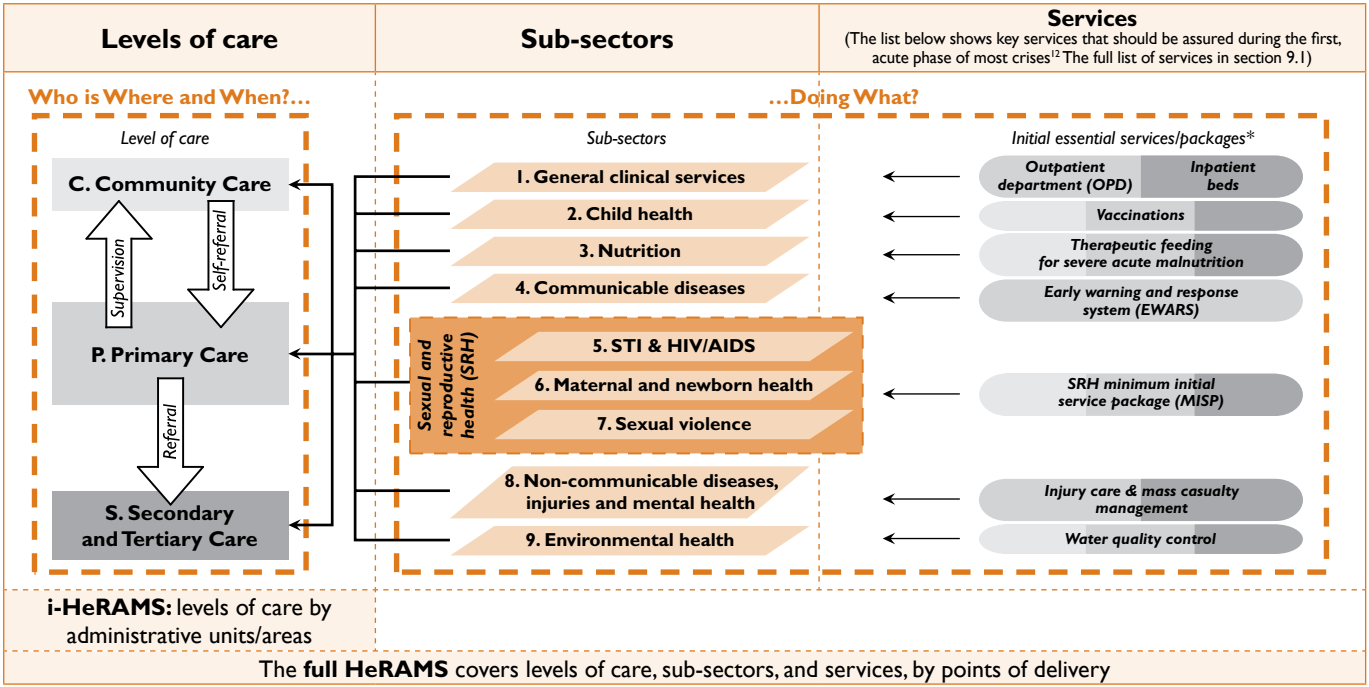
HeRAMS is a software-based information system developed by the global health cluster to support the collection, collation and analysis of information on the availability of health resources in different areas and locations and by type of point of delivery and level of care. Health "resources" include health facilities (infrastructure), personnel, and also the services provided. While HeRAMS can be used to map geographical provision of services it does not monitor population access and utilization. These must be assessed and monitored separately, either using routine Health Information System and surveys. There are two versions:

- The *Initial HeRAMS* ("i-HeRAMS") is the tool for use during the *first few days/weeks of an acute crisis* to record and analyse aggregate data on the numbers of active health partners, numbers of functioning health facilities by type, numbers of key health staff (doctors, nurses, midwives), and the *level* of health services available *by administrative level* (e.g. district, sub-district).
- The *("Full") HeRAMS i*s the tool that should be used *as soon as feasible* and then throughout the duration of a crisis to record and analyse data on the resources available and the *specific services* being delivered at each "*point of delivery*". Services are recorded against the checklist in section 9.1.[11]

"Points of delivery" are the precise locations at which health services are delivered and are not only health facilities. Services may be delivered by a health facility, mobile clinic or community-based health worker. To allow for a precise mapping of health resources and services, HeRAMS characterizes locations (town, rural village, IDP camps…) and modalities (health facility, mobile clinic, community base services…) independently, in order to make a retailed analysis and monitoring of the health sector response (see as an example the *Darfur HeRAMS Case Study – Sudan*, WHO, June 2008 – included in the CD ROM as a PowerPoint file).

[11] The system also records who owns each facility, who is currently managing it, who (if anyone) is providing support to the delivery of specific health services.

Figure 3c Levels of care, sub-sectors and initial essential services/packages



[12] The "initial essential services" or packages indicated in Figure 3c are suggested as the minimum that should be provided at the beginning of a crisis. The services proposed for the child health, nutrition, communicable and non-communicable diseases, and environmental health sub sectors may be substituted by other priority services as required by the nature of the crisis or the local context. For the other sub sectors, the recommended services or packages should be in place in full before expanding other services in the respective sub-sectors.

Inputs to and outputs from HeRAMS

Data are collected through structured *interviews* with health facility or health programme managers. Interviews are conducted by trained interviewers – usually health officers – based in the affected areas. They enter the data directly into a standardized data collection form/spreadsheet. (This enables the system to be deployed rapidly, ensure data homogeneity and quality, and to cover areas where access is restricted.)

A standard list of administrative areas and place names from OCHA is integrated into the system at the outset. This is a key element of the minimum common operational dataset (MCOD). This ensures compatibility and transferability with their "4W" database and other inter-agency information systems. The system includes *automatic validation* as data are entered to ensure correct, standardized entries and increase the reliability and consistency of the information.[12]

The standard list health service levels, sub-sectors and component *services* presented in section 9.1 is integrated in HeRAMS. These are the services that should be assured, to the maximum extent possible, for any crisis-affected population.

In addition to making information readily available on the services and resources at particular locations, the HeRAMS generates *standard aggregate reports* at different administrative levels, and summary and analytical reports on facilities, staff and health partners present. Additional reports can be generated in response to specific requests from decision-makers.

The system can also be used to *illustrate* the effects on resource and service availability of changes that might occur, e.g. the withdrawal of an organization when their project expires or funding runs out.

Data can be exported (in Excel format) for other, *more detailed analysis* in any database programme by a competent analyst. Standard locations are geo-referenced so data can be imported into any GIS software to *map* health resources, support decision-making in planning and make advocacy.

[12] As of end 2008, the system is based on an Excel spreadsheet and linked Access database. It may be up-graded in 2009. Automatic validation eliminates the need for – and the time often lost in – a separate data cleaning step.

HCC and Health Cluster action

☑ Adapt the definitions of health facilities to match the structure of the health system in the country.

☑ Identify, discuss and agree upon all standards related to the variables on which data is collected (staff, typologies…)

☑ Identify and train the health officers who will conduct the interviews to collect and manage HeRAMS data.

Lessons and practical hints from field experience

Experience in Sudan demonstrated the value of assigning responsibility for collecting HeRAMS data to Primary (district) Health Officers. Their understanding of the situation in their areas guaranteed a high standard of quality of the data gathered. The exercise also reinforced their relationships with all partners involved.

Face-to-face interviews are not always necessary. Data can be collected using telephone contacts.

Additional guidance

📖 See on the CD-ROM the document *HeRAMS health resources availability mapping system*.

3.3 ORGANIZING AN INITIAL RAPID ASSESSMENT (IRA)

The initial rapid assessment (IRA) tool was developed jointly by the global health, nutrition and WASH clusters.[13] It serves to collect, compile and analyse information on the health status of the population, the determinants of health (nutrition, water supply, sanitation, etc.), and current health services characteristics (coverage, resources, services available, access, etc.). The tool includes guidelines, a standard data collection form, an associated aide memoire for field teams, and a data entry and analysis template and software. It is designed to provide a quick, initial description of the current situation and identify the priority public health problems, risks and gaps in service provision. A 4-level ("severe"/of concern"/relatively normal"/more

[13] An IRA is a multi-sectoral, multi-stakeholder assessment and it has been suggested that the name (IRA) might be modified to reflect this. (One suggestion is to rename it as "multi-sectoral initial rapid assessment".)

data required") severity ranking system for each sector is integrated in the summary sheet completed for each site.

Some basic principles

- ✓ An IRA should be conducted as a joint effort of the health, nutrition, WASH and shelter clusters, coordinated and planned by the HCT or the ICCG and in collaboration with the MoH and other relevant government and/or non-governmental entities.
- ✓ An IRA should normally be initiated within 2 to 4 days of the onset of a crisis. A report with at least preliminary results should be produced within 10 to 15 days of crisis onset in order to inform initial response planning and the UN Flash Appeal. (An IRA may also be undertaken any time when a previously inaccessible area can be reached or when reassessment is required following a significant change in the overall humanitarian context.)
- ✓ The content of the IRA data collection form may be customized to country needs but changes should be kept to a minimum. To facilitate this, 4 open questions are presented at the end of each of the 5 technical sections. The data entry and analysis software include these open questions for each sector.
- ✓ The success of an IRA and the value of the report are heavily dependent on the quality of the planning done *before* the field visits. This is facilitated by inter-agency contingency planning in advance of the crisis.[14]

Data recorded on the IRA forms are to be entered into the Excel-based IRA data entry and analysis tool. Automated analysis produces a report for each individual site and aggregated reports for multiple sites (e.g. all sites within a district), as required. The reports present the data in a standard template that provides space for assessment teams and sector specialists to add their own comments and interpretation.

The key elements of planning, undertaking and reporting on an assessment are indicated in Figure 3d. In most cases, planning steps 3 to 10 will be undertaken more-or-less concurrently. Brief guidance on analysis is provided in section 4.1.

[14] It can be difficult and time-consuming to get inter-agency agreement on a common tool and how to undertake an assessment. Where such agreements have not been established in advance, weeks have been lost and the quality of information gathered from untested questions was low.

Figure 3d Main steps in organizing and undertaking a rapid assessment

(1) Initial decision	Agreement among health-related agencies and the MoH that an assessment is needed.
↓	
(2) Planning the assessment 1-2 days	Half-day planning meeting and follow-up work by individuals and sub-groups to: 1. compile available (secondary) data and agree a working scenario; 2. agree the objectives, scope of work and timeframe (dates) for the assessment, and its relationship to other assessment activities; 3. agree information requirements, data collection methods, and criteria for deciding where to go (site selection procedures) and with whom to talk; 4. design/customize the IRA form and translate into local language(s) if necessary; prepare related interview guides; adapt sensitive questions to the local context, identify any additional question(s) observation that eventually need to be added; 5. identify personnel (and interpreters, if required) for fieldwork; 6. prepare maps, supplies, equipment (including tents, food, if necessary) and background information kits for field teams; 7. assemble and train fieldwork teams; 8. arrange transport (including fuel), security and communications for teams; 9. inform key persons (MoH and others) in areas to be visited; *and* 10. plan (arrange for) the processing and analysis of data during and after the fieldwork.
↓	
(3) Field work 5-6 days	Visits by teams to purposively-selected areas/sites to: • interview and collect data from officials and other key informants in administrative centres and health facilities; *and* • interview community groups and households.
↓	
(4) Analysis and reporting 3-4 days	• Processing and analysis of data (primary and secondary) • Identification of priority problems, needs, risks and gaps • Analysis of possible strategies and development of recommendations • Preparing the report • Disseminating the report

Figure 3e indicates the main outputs that are expected from an IRA: these must be kept clearly in mind by all concerned when planning and undertaking an IRA and preparing the report.

Figure 3e Outputs expected from an IRA in relation to health, including variations among geographic areas or population groups

Health status and risks	*Health resources available **	*Health system performance*
Indications of : • main causes of mortality and morbidity including changes from normal • potential sources of future morbidity and mortality • availability of a functioning early warning system for epidemic-prone diseases • Measles vaccination coverage for children under five	• Functioning of health facilities • Human resources available • Supplies and equipment available • Which humanitarian actors are doing what, and since when • Levels of care and service sub-sectors provided – current situation and what's changed • Disease control programmes – current situation and what's changed	Indications of : • People's access to health facilities and services • People's use of health services • Change in number of consultations per day • Change in preventive care activities • Overall functioning of sub-sectors and services

** includes i-HeRAMS data*

Conclusions and recommendations

- → Priority health problems (including any gender disparities)
- → Main foreseeable health risks
- → Critical gaps in health services (gaps in geographic coverage or particular sub-sectors)
- → Contextual factors that affect health status, health services and possibilities for humanitarian health action
- → Specific recommendations for initial health response actions
- → Specific recommendations for follow-on, more detailed sub-sector assessments or surveys

HCC and Health Cluster action

☑ As soon as possible after crisis onset, discuss within the HCT or the ICCG, and consult relevant government and/or non-governmental entities, to agree on arrangements IRA. (Do this within the framework of the inter-agency contingency plan, where there is one.)

☑ Get as many as possible of the main health actors to attend a planning meeting together with key actors from the other sectors, on day 1 if possible:
- Agree the purpose/objectives and time frame for the assessment.
- Define responsibilities and timeframes for all preparatory actions.
- Adapt the standard IRA data collection format to the local context, if necessary, and define how any additional data will be input and analysed. Contact the global health cluster support hub for guidance, if needed.[15]
- Get advice on gender and other cross-cutting issues that may be critical in the local context.

☑ Rapidly review health-related *secondary data* available at national level (unless this has already been done as a part of contingency planning) – see IRA guidance note especially table 2.

☑ Then, jointly with the other clusters:
- Assemble multi-disciplinary *field assessment teams*. Ensure they are balanced in terms of expertise and sex, and between national and international personnel. Prioritize general public health experience – see IRA guidance note.
- *Select the areas* to be visited. Use stratified sampling to select not only areas that are believed to be particularly badly affected but also ones covering a range of different conditions and population groups that may be differently affected and face different health problems and risks – see IRA guidance note.
- Define the criteria and procedures to be applied by assessment teams in *selecting individual sites* to be visited within the selected areas.
- Specify the (few, key) items of data on *other sectors* that health members of assessment teams should collect in the absence of team members for the other sectors, and vice-versa.

[15] Adaptation may be necessary if (i) significant urban populations are involved or there are a variety of population groups (e.g. refugees, IDPs and residents), or (ii) to take account of locally-endemic diseases [IRA form sections 5.2.2 & 6.2.2] and the structure of local health services [section 6.3]). Modifications should focus on clarification, removing items that are clearly inappropriate or highly-sensitive, or adding content. The core structure of the form should be preserved.

- Provide *guidance notes* (including case definitions) and organize rapid *training* – and security briefing, where needed – for all field assessment teams.
- Provide field teams with available *secondary data* on the areas they will visit *before* they start field visits, so their interviews and primary data collection can be appropriately focused.
- Plan *logistics* carefully and ensure that all teams have necessary permits (where needed), transport (including fuel, etc.), communications (radios and/or access to telephones), GPS (and are trained in its use), and access to accommodation (camping equipment, if necessary), water and food.
- Make arrangements to receive and rapidly collate and analyse incoming reports from assessment teams, health facilities, relief teams and other sources. (These arrangements *must* be made in advance, as part of the planning for the assessment. Too often, analysis of data from "rapid" assessments has taken several weeks!)
- Prepare a realistic budget for the whole assessment process – including field travel and the analysis of the data – and secure funds.

☑ Ensure constant monitoring of and support to the field assessment teams during field work.

☑ Ensure arrangements for the safe receipt of reports from field teams and the prompt entry of the data into the IRA analysis tool (and arrangements for any additions to the standard IRA form to be input separately).

☑ Arrange for the assessment team leaders/teams to review the automated reports for each site and to insert their own comments and interpretations, and for data from any questions added to the standard IRA form to be to analysed and inserted separately.

☑ Specify the administrative levels at which aggregate reports are required, and arrange for a multi-disciplinary group of sector-specialists and experienced generalists to:
- review the automated aggregate reports and insert their comments and interpretations; and
- produce the overall report and recommendations.

☑ Arrange rapid clearance of the overall report by all clusters (and relevant government entities where necessary) and disseminate it immediately to all health actors, donors and other stakeholders using email, a web site, and hard copies.

If such joint planning is not feasible in the first few days: call a quick meeting with the main health actors; try to agree on a standard, common core of key information for inclusion in data collection formats and a standard approach to data collection; try to ensure reasonable coverage of all main areas; and then compile data from different organizations' assessments and facilitate a joint analysis exercise.

Additional guidance

- Annex D, on the CD-ROM – *Drawing up an assessment plan, schedule and budget*, from WFP. *Emergency Food Security Assessment Handbook*, first edition. World Food Programme, 2005.
- IASC. *Initial rapid assessment tool guidance note*. Inter-Agency Standing Committee, June 2009.
- IASC. *Need Analysis Framework*, strengthening the analysis and presentation of humanitarian needs in the CAP. Inter-Agency Standing Committee, IASC Sub Working Group on the CAP, April 2007.
- IASC. *Women, girls, boys and men, different needs, equal opportunities. Gender Handbook in Humanitarian Action*. Geneva: Inter-Agency Standing Committee, 2006.
- UNHCR. *Tool for participatory assessment in operations*. Geneva: United Nations High Commissioner for Refugees, 2006

3.4 ORGANIZING FOLLOW-UP ASSESSMENTS AND SURVEYS

Depending on the findings of the initial assessment, the context and type of crisis, detailed follow-on assessments or sample surveys may need to be undertaken in particular localities in relation to some or all of the following:

- ✓ Mortality rates (CMR and U5MR) and morbidity rates.
- ✓ Main causes of death, injury and disease and their distribution among different population groups (disaggregated by age, sex, geographic area and other locally relevant characteristics).
- ✓ The psychological impact on the population and on health and relief workers.
- ✓ The impact on disease vectors and vector control programmes.

- ✓ The impact on the ability of men, women, boys and girls to access health services.
- ✓ Damage to health facilities – detailed surveys by competent technicians and engineers to prepare specific plans and cost estimates for repair/ reconstruction.
- ✓ The human and other resources and capacity to assure health services in the medium term.
- ✓ Other health system components: policies, infrastructure, financing, supplies and management.

All follow-on assessments and surveys need careful planning. Surveys require considerable resources (human, financial and logistic) if the results are to be reliable and useful. The results may sometimes be politically sensitive and need careful handling. Care must always be taken to avoid over-loading a survey by trying to respond to too many disparate demands for data!

HCC and Health Cluster action

When planning or contributing to follow-up assessments or surveys:

- ☑ Define objectives and scope carefully, and draw up an analysis plan.
- ☑ Mobilize relevant specialist expertise as well as cluster partners.
- ☑ Thoroughly review available secondary data *before* defining primary data collection requirements.
- ☑ Pre-test data recording formats and interview guides *before* training field teams.
- ☑ Clearly specify sampling procedures and sample size (for both population and facility surveys).[16]

[16] A more comprehensive list is being compiled by the Global Health Cluster in 2009.

Examples of tools for subsequent, detailed assessments	
1.	UNHCR. *Public health facility toolkit* (Tool for the evaluation of public health facilities). January 2008.
2.	WHO. *Health facility survey* (Tool to evaluate the quality of care delivered to sick children attending outpatients facilities). 2003.
3.	UNICEF, WHO, UNFPA. *Guidelines for monitoring the availability and use of obstetric services*. 1997.
4.	OMS. *Safe motherhood needs assessment*. 2001.
5.	USAID, CDC. *Reproductive health assessment toolkit for conflict-affected women* (Reproductive health, assessment tool for women victims of conflicts). 2007.

Additional guidance

- Annex D, on the CD-ROM – Drawing up an assessment plan, schedule and budget, from WFP. *Emergency food security assessment handbook*, first edition. World Food Programme, 2005.
- Pavignani E, Colombo A. *Analysing disrupted health sectors – A modular manual*. Geneva: World Health Organization 2009.
- ECLAC. *Handbook for estimating the socio-economic and environmental effects of disasters* (chapter IV on the health sector). Economic Commission for Latin America and the Caribbean (ECLAC), 2003. A document also used and promoted by the World Bank.
- UNDG, UNDP, World Bank. *Practical guide to multilateral needs assessments in post-conflict situations*. United Nations Development Group, United Nations Development Programme, World Bank, 2004.
- Cluster Working Group on Early Recovery. *Guidance note on early recovery*. Cluster Working Group on Early Recovery in cooperation With the UNDG-ECHA Working Group on Transition, April 2008.

3.5 ASSURING EARLY WARNING AND RESPONSE – ESTABLISHING AN EWARS

In a crisis situation – especially a protracted emergency – a very responsive system is required to rapidly detect selected epidemic-prone conditions and implement immediate outbreak control measures, when needed. An *early warning and response system* (EWARS) is needed with weekly routine reporting and immediate reports of specified critical conditions by regular health facilities and all health and medical relief teams (an early warning and response network). It may be built around a pre-existing disease surveillance system but that system alone will rarely be adequate.

Some basic principles

- ✓ The active participation of *all* humanitarian health actors is essential.
- ✓ Experienced epidemiologists should take the lead in choosing a small number of conditions (max. 10) to be monitored. These may include severe acute malnutrition (SAM) and toxic poisoning.
- ✓ Information should be gathered from a wide range of sources including the news-media and informal sources. Rumours should be investigated and either addressed or dispelled.
- ✓ Specific expertise should be mobilized – normally from WHO – to establish an EWARS.

HCC and Health Cluster action

Work with the MoH, as appropriate, to:

- ☑ Review pre-crisis surveillance procedures and agree on appropriate arrangements for early warning and response (EWAR) within the crisis-affected areas.
- ☑ Ensure that a central EWAR team is in place – with precise tasks and responsibilities and in an appropriate location – within the first few days of the onset of a crisis.

☑ Ensure that all the essential elements listed in the box below are in place.

☑ Ensure the inclusion of, and prompt reporting from, all cluster partners.

☑ Ensure that information is fed back to reporting units and disseminated to all other interested parties within a few hours in case of an outbreak (or other event requiring an immediate response).

ESSENTIAL ELEMENTS OF AN EFFECTIVE EWARS

- ✓ Consensus among all health agencies on a short list of priority conditions to be monitored, corresponding syndrome-based definitions, and a standard reporting format, and building on existing early warning systems.
- ✓ Reliable and rapid means of communication.
- ✓ Guidelines for field units including the criteria or thresholds at which they should make the alerts and take specified actions.
- ✓ Training of clinical workers at the primary and secondary care levels in the operation of the system.
- ✓ Laboratory support capacity and clear procedures for taking and dispatching biological samples, and providing feed back to reporting units.
- ✓ Stockpiles of sampling kits, drugs and vaccines.
- ✓ Contingency plans for comprehensive response to epidemics, including plans for isolation wards in hospitals.

Tools and additional guidance

📖 The *events Analysis & Nutrition Data Surveillance,* HANDS, an application developed by HNTS, should be used to capture and analyse the data generated by the weekly early warning and response surveillance system, as well other routine facility based surveillance morbidity and mortality data. HANDS, together with a user guide (available in English and French), is available on the Global Health Cluster web site and on the CD ROM annexed to this guide.

3.6 MONITORING THE HEALTH SITUATION – RE-ESTABLISHING A REGULAR HIS

Up-to-date information is needed on a continuous basis throughout the crisis to inform decisions on response actions, monitor the effects of health interventions and enable adjustments to be made when necessary, and to support resource mobilization efforts.

Some basic principles

- ✓ Monitoring during the crisis should build on the existing HIS/diseases surveillance system, where possible, but can be *adapted to the context and needs of the crisis* and cover:
  - the overall health situation;
  - the social (including gender and age) and economic determinants of public health;
  - the performance of the health system (including responsiveness, quality and equitable access); and
  - the progress and outputs of humanitarian (and early recovery) health activities.
- ✓ Information is best gathered through a *combination* of:
  - regular reports from health facilities and field teams – either *all* of them or a carefully-defined selection that serve as *sentinel sites*;
  - ad hoc or periodic sample surveys; or, very usefully,
  - regular reporting from community-level health committees ("community-based surveillance").
- ✓ An appropriate national HIS should be re-established in a sustainable manner as quickly as possible.
- ✓ One organization – the CLA or another cluster partner – should take responsibility for coordinating the monitoring system and leading the international effort to (re)establish an appropriate HIS, where needed.

In many cases, especially where there have been repeated disasters and inadequate periods for recovery, national HIS capacity may be limited. Support to the re-establishment of an adequate HIS should then be an important component of the health crisis response strategy.

HCC and Health Cluster action

Work with the MoH, as appropriate, to:

- ☑ Agree on a set of key, gender-sensitive indicators adapted to the local situation and capacities, and on how, from where and at what frequency information will be collected.
- ☑ Regularly compile and analyse information from all sources on the health situation, the determinants of health, and health service performance, and thus identify any emerging problems, critical gaps or areas needing action.
- ☑ Agree on a strategy to progressively enhance the coverage and content of reporting from health facilities, health teams and other health actors, and strengthen or re-establish a national HIS including zonal-level HIS teams where appropriate.
- ☑ Agree on the organization (CLA or other) to take the lead in supporting the national HIS, and how other cluster partners will contribute in a coordinated effort.
- ☑ Ensure that the essential elements listed in the box below are in place and monitor the performance of the system.
- ☑ Ensure that monitoring findings are published promptly and delivered regularly to decision-makers in all the main stakeholder entities – MoH, the national relief coordination body, international agencies, the main national NGOs, donors, news-media, etc. (Reports may be distributed in conjunction with the regular *Health Bulletin*).

Zonal health cluster focal points supported by epidemiologists or other experienced data analysts, when available, should assure quick, local analysis in collaboration with district/provincial health authorities and other stakeholders. This should identify priorities for immediate action and provide the HCC and central HIS team with local interpretation together with the raw data.

Lessons and practical hints from field experience

In Uganda, the Health Cluster uses village health teams to conduct community-based disease surveillance to monitor disease trends at community level. Such an innovative approach might be replicated in other settings once the situation has stabilized.

ESSENTIAL ELEMENTS OF AN EFFECTIVE SYSTEM FOR MONITORING THE HEALTH SITUATION

- ✓ Starts early with a core set of few key (gender-sensitive) indicators (see table 9.2) and expand it to include more once the system is functioning and capacity allows.
- ✓ All main health actors in all areas are involved including, when feasible, local authorities and community organizations.
- ✓ Reporting formats are simple, designed to facilitate completion and subsequent data extraction, use precise language and are translated.
- ✓ Guidelines and training are provided for all health facilities, field teams and others who are expected to report. They clearly explain the purpose and importance of the reports and provide practical instructions to promote consistently good reporting by all facilities and teams.
- ✓ Arrangements for the transmission of reports are clearly defined and capacity is available to receive and rapidly screen, compile and analyse them with a focus on identifying changes, trends, and divergences from the established standards.
- ✓ A central HIS team has dedicated (full-time) staff and an appropriate workspace with dedicated computers, telephones and other equipment (e.g. radios), as needed.
- ✓ Clear procedures ensure the rapid clearance of reports. (Bureaucratic delays in producing and issuing information can greatly reduce its validity and usefulness.)

Additional guidance

- 🕮 WHO. *Setting priorities in communicable disease surveillance*. Geneva: World Health Organization, 2007.
- 🕮 WHO. "Surveillance". In *Communicable disease control in emergencies – A field manual*. Geneva: World Health Organization, 2005.
- 🕮 WHO. *Rapid health assessment protocols for emergencies*. Geneva: World Health Organization, 1999.
- 🕮 WHO, UNAIDS. *WHO recommended surveillance standards*. Geneva: World Health Organization, 2000.

📖 WHO, PAHO. "Epidemiologic surveillance and disease control". In *Natural disasters – protecting the public's health*. Washington, D.C.: Pan American Health Organization, 2000.

📖 PAHO. *Epidemiological surveillance after a natural disaster*. Washington, D.C.: Pan American Health Organization, 1982.

💻 www.unhcr.org/his (UNHCR Health Information System 2008).

3.7 MONITORING THE PERFORMANCE OF HEALTH SERVICES[17]

Some basic principles

✓ Performance monitoring should focus on the services that are most critical in the prevailing situation.

✓ One or two gender-sensitive indicators should be chosen and tracked for each critical service.

General issues that deserve to be addressed relate to *monitoring the availability of key services and their coverage*.

The box below presents guidance on calculating coverage: changes in coverage are an important measure of the effectiveness of the overall health response and also of individual service-delivery projects.

Figure 3f provides example of indicators from Sudan showing how the level of compilation and analysis can be refined as the situation evolves from the initial acute phase through recovery. In Sudan, different conditions exist simultaneously in different parts of the country – some areas are still in an acute emergency phase while others are well into recovery; monitoring varies accordingly.

Where sexual and gender based violence is an important concern, it may be appropriate to include information on coverage of medical services for rape survivors and referral systems for legal, protection and psychosocial services.

[17] The Global Health Cluster has not (yet) developed specific guidance on this topic; this will be an activity for 2009. The present section provides some preliminary indications with an emphasis on "coverage".

Figure 3f Example of key health service performance indicators and levels of geographic analysis during the different phases of the response[1]

N°	Key indicators for the health & nutrition sector	Initial acute phase	Continuing humanitarian focus	Early recovery	Recovery & transition to development
1	Geographical availability of health facilities (HF): average population covered per HF and by type of HF	by State & locality	by administrative unit		
	Move to % of the population within 5km of a HF				by administrative unit
2	Out patient utilization: average # of consultations per year		by State & locality	by administrative unit	
3	Measles vaccination coverage (9 months to 15 years)	by State & locality			by administrative unit
4	Coverage of fully immunized children under one		by State & locality		by administrative unit
5	% of HF with family planning service	by State & locality	by administrative unit		
	Add contraceptive coverage rate			by administrative unit	
6	% of HF with antenatal care service		by State & locality	by administrative unit	
	Add antenatal care (3 and more visits) coverage rate				by administrative unit
7	% of expected deliveries which required caesarean section	by State	by locality		
8	% of outbreaks with investigation and response activated within 48 hours from the alert	by State	by locality		
9	% of HF having zero stock-out days for the 4 sentinel drugs[2]		by State & locality		by administrative unit
10	Coverage of targeted supplementary and therapeutic feeding programmes[3]	by State & locality			by administrative unit
	Add coverage of growth monitoring in children under five				by administrative unit

[1] Adapted from the Sudan UN Work Plan 2008.
[2] Sentinel drugs: one for each of the following essential groups of drugs: anti-malarial, antibiotics, analgesic/antipyretics, antihelminths.
[3] Targeted supplementary and therapeutic feeding programmes for estimated acute moderately and severely malnourished children under five, recovery rates for severe acute malnutrition among children under five.

A more detailed list of indicators is provided in section 9.2 together with some notes on estimating mortality rates. The table includes widely-accepted benchmarks and thresholds for concern, and shows whether the indicator relates to inputs, outputs or outcomes.

HCC and Health Cluster action

Work with the MoH and other health actors, as appropriate, to:

☑ Identify a minimum set of performance indicators relevant to the country situation, including gender-sensitive indicators, through a consultative process (e.g. an M&E group, a workshop).

☑ Ensure the inclusion of these indicators (or relevant data) in the standard reporting formats.

☑ Ensure that all cluster partners – and as many other health actors as possible – understand the indicators and report relevant data regularly.

Additional guidance

📖 Griekspoor A, Loretti A, Colombo A. *Tracking the performance of essential health and nutrition services in humanitarian responses*. General conference document prepared for the workshop "Tracking health performance and humanitarian outcomes" organized by the World Health Organization on 1 and 2 December 2005.

ESTIMATING COVERAGE

Coverage, for epidemiological purposes, is "*a measure of the extent to which the services rendered cover the potential need for these services in a community. It is expressed as a % in which the numerator is the number of services rendered and the denominator is the number of instances in which the service should have been rendered*". [Last JM. *A Dictionary of Epidemiology*. Oxford University Press, 2001]

Coverage estimates are usually calculated as a percentage:

$$\text{Population coverage (\%)} = \frac{\text{No. of people with access to service} \times 100}{\text{Total population concerned (N)}}$$

In a humanitarian crisis, coverage can be calculated in relation to the total affected population, the total affected population that can be reached, or, for a targeted intervention, the total targeted population.

These different coverage rates may be expressed as:

- *potential humanitarian* coverage, where N = Total affected population.
- *operational humanitarian* coverage, where N = Total affected population that can be reached
- *targeted population* coverage, where N = Total target population

Changes in coverage can be used to monitor how well a programme is performing in reaching its target population. For purposes of evaluation, a change in coverage is a simple measure of the difference between coverage levels at different time points:

$$\% \text{ Change in coverage} = \frac{\text{Coverage at Time2} - \text{Coverage at Time1} \times 100}{\text{Coverage at Time1}}$$

For the comparison between estimates to be valid, coverage levels must be estimated using the same, standardized methodology at each time point.

[Synthesized from Griekspoor A, Loretti A & Colombo A. *Tracking health performance and humanitarian outcomes*. WHO, 2005]

4

ANALYSIS AND PRIORITIZATION

Key points:

- ✓ Data are only useful once analysed and interpreted in context.
- ✓ Analysis and interpretation requires a combination of technical expertise and local knowledge.
- ✓ The field assessment (data collection) teams themselves must be involved in the initial analysis.
- ✓ Data must be examined from different perspectives and in different combinations to see what they reveal.
- ✓ In addition to analysis and interpretation, presentation is important. Appropriate, imaginative use must be made of tables, charts, maps, timelines and the combination of data from different data sets. An assessment generally provides a snap-shot; it is important to find ways of visually presenting changes and trends.
- ✓ The situation analysis provided by an assessment should be regularly up-dated on the basis of information from ongoing situation monitoring and early warning system reports.
- ✓ Seasonal variations such as rainy and lean seasons – and seasonal upsurges in violence in some complex emergencies – and their usual effects on diseases patterns and service delivery and access, must be taken into account.

Expected Health Cluster outputs

Joint health sector situation analysis; agreement on priority health problems and risks to be addressed by the Health Cluster partners.

4.1 IDENTIFYING AND ANALYSING PROBLEMS, RISKS AND GAPS

Analysis for planning purposes involves two steps:

1. A *gap analysis* including *identification* of health *problems, risks* and *gaps in services* and *prioritization* of them on the basis of the health risks posed – the number of people (women, men, girls and boys) at risk of death, serious illness or disability due to each problem.

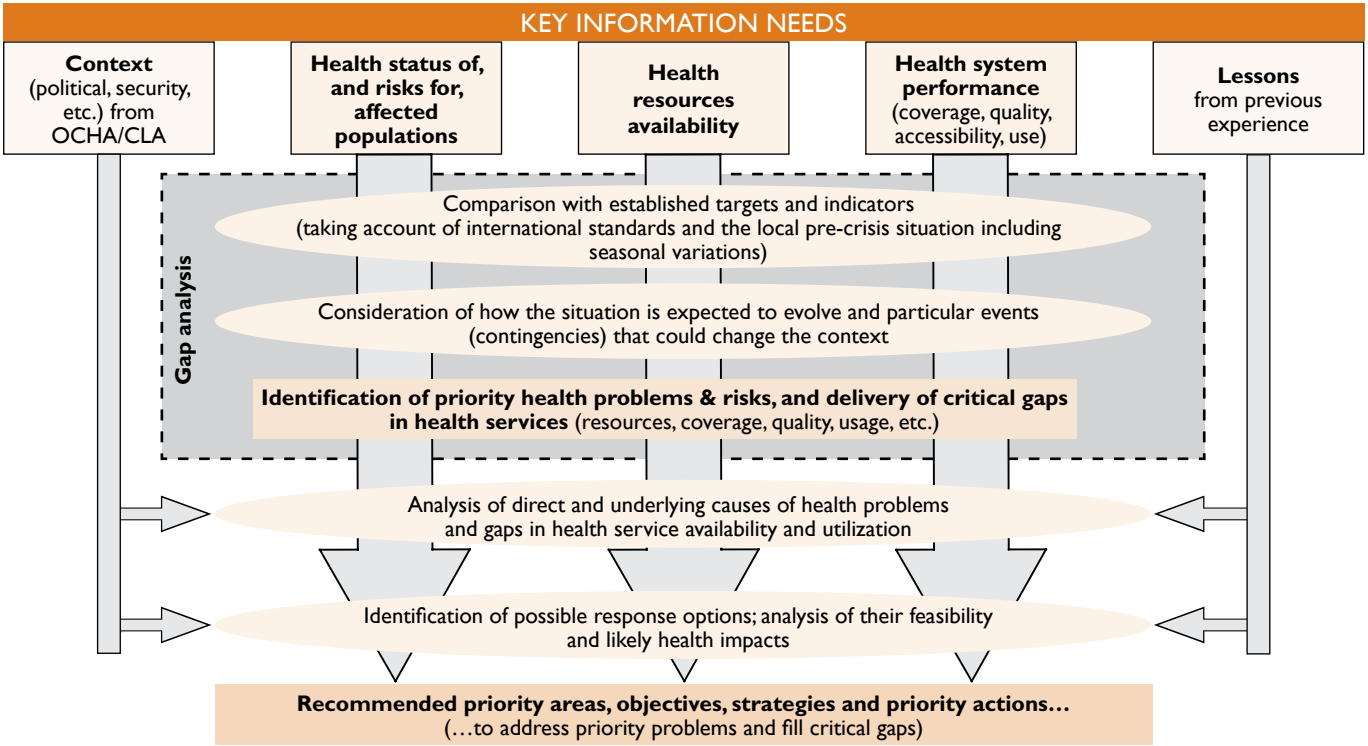
2. An analysis of the *options* available (feasible and acceptable) to address the priority gaps/ problems and the prioritization of health *actions* taking account of the resources that would be required and the health benefits that could be expected in the prevailing local context including security conditions, operational constraints and other contextual factors. This often involves an element of subjective, professional judgement.

The processes of identifying and prioritizing problems and actions must be *transparent*. The criteria for prioritization must be explicitly *recorded*. The analysis must consider all 3 key aspects but also the context and lessons from previous experience, as outlined in Figure 4a.

As with all other elements of the assessment and response process, the identification and prioritization of problems, risks and gaps, and the analysis of causes, should be a continuous, iterative process:

- A *preliminary* analysis – the preliminary scenario definition – in the first 24-72 hours informs response action during the first few days.
- An *initial* analysis in the context of the initial rapid assessment completed within 10 to 15 days provides the basis for more substantial initial planning decisions. It can be useful to synthesize the analysis in an "initial planning scenario".
- An *updated* situation analysis and planning scenario whenever necessary, notably following each periodic review exercise or re-assessment following any substantial change in the overall situation.

Figure 4a Framework for analysing the health situation



Problem and gap analysis

A problem analysis is the essential first step. It must identify:

- the *levels* of mortality and morbidity and *changes* compared with what would be normal for the season;
- the *immediate causes* of avoidable mortality and morbidity (these may be injuries, communicable disease, malnutrition, etc.) and the numbers of people at risk (disaggregate by age and sex insofar as possible);
- the *underlying (root) causes* of particular immediate problems – e.g. poor sanitation, polluted water, lack of access to or inadequacy of medical and health care services, food insecurity, poor feeding habits, etc. among different population groups;
- *additional health threats* that can be anticipated including both seasonal and exceptional risks, and the numbers of people at risk (disaggregate by age and sex insofar as possible);
- *gaps* in the availability of health services for the population affected by the humanitarian crisis and the coverage of priority quality services;
- any important gaps in health *information;* and
- cross-cutting issues that would affect priorities and the planning and implementation of responses (gender, age, HIV/AIDS, etc.)

Some widely accepted benchmarks are provided in section 9.1.

The *Gap Guidance Materials* provide examples of gaps identified in health response in a number of recent emergencies and indicates some possible remedial actions. They cover aspects of health status, services and information, and the document suggests benchmarks for some aspects for which no international standards exist.

Once the initial acute emergency stage is over, the analysis should consider problems in relation to specific elements of the health ***system*** including policies, health infrastructure, human resources, health financing, medical supplies and management, and health services delivery. Problem trees can help in identifying hierarchies of problems and their causes. They can help to identify the problems on which attention should be focused to have the greatest health benefits.

Context analysis

The context analysis must include analyses of:

- the *political, social and cultural factors* (including but not limited to gender considerations) that influence – positively or negatively – heath status, health care services, and the feasibility of health care interventions;
- the *security* situation including the causes of conflict and the implications for health action;
- the *resources* and *capacities* available, and what might reasonably be expected to be mobilized;
- the roles and influence of any new health actors or *stakeholders* (e.g. military forces, non-State entities);
- the *opportunities* available for improvements or innovation in health-related behaviours or health service delivery;
- the *constraints* on health action, including logistic, operational, administrative and cultural constraints; and
- the *expected evolution* of the overall situation and the implications for health and health service delivery and access.

The analysis tools that can be useful include:

- stakeholder analysis (essential in all cases) to identify the interests of all "stakeholders" that may affect or be affected by the health situation and health response actions – see annex E;
- SWOT (strengths-weaknesses-opportunities-threats) analysis; force field analysis (examining forces for and against a particular decision or course of action); impact analysis (anticipating the full consequences of proposed changes in a system);
- conflict analysis and "do-no-harm" analysis in any situation of conflict or repression.[18]

It will also be useful to review *lessons* from previous experience in the country and in similar situations in neighbouring countries and consider their potential relevance in the current situation.

[18] Conflict analysis is the systematic study of the profile, causes, actors, and dynamics of conflict. It helps development, humanitarian and peace building organizations to gain a better understanding of the context in which they work and their role in that context.

HCC and Health Cluster action

☑ Work with national and local health actors and other stakeholders, as appropriate, at all stages of assessment and response to agree analyses of both *problems* and relevant *contextual factors* at each stage of assessment and response. This includes getting agreement on:
- the specific impacts of the crisis on health status, systems and staff;
- the *most critical* health problems, gaps and risks *at each stage*;
- criteria for the prioritization of health problems and ensuring that the criteria are recorded and understood by everyone;
- a prioritized list of problems (including gaps and risks) that is updated whenever needed; and
- the specific *opportunities* and *constraints* that influence health status and the delivery of health services taking account of how the overall situation is expected to evolve.

☑ Make sure that analyses are thorough and evidence-based:
- clearly indicate any extrapolations and assumptions;
- triangulate data from different sources and consider (evaluate) the reliability of the various data and sources;
- take account of gender, protection and human rights issues, the impact of HIV/AIDS, security conditions, and any limitations on access; *and*
- identify – look for – differences among localities and different population groups, and age- and gender-related differences (consider the different situation and needs of men and women, girls and boys).

☑ Examine carefully any discrepancies in information, or instances where reported findings differ from what might have been expected. What might explain these differences? What is their significance?

☑ Look out for possible sources of error or bias in reported data. Ensure that the needs of isolated areas (with disrupted communications) are not under-estimated or over-looked, and that needs are not over-estimated by concentration on data from the worst-affected areas.

☑ Identify any topics, areas, or population groups for which information is lacking or particularly unreliable. Why is information lacking or unreliable? What is the significance? Which are the most important information gaps? What can be done to fill them, when and by whom?

Additional guidance & tools

- Annex E, on the CD ROM — *Stakeholder analysis*.
- GHC. *Gap guidance materials – Assisting the health sector coordination mechanism to identify and fill gaps in the humanitarian response*. Global Health Cluster, 26 October 2007.
- IASC. *Need Analysis Framework, strengthening the analysis and presentation of humanitarian needs in the CAP*. Inter-Agency Standing Committee, IASC Sub Working Group on the CAP, April 2007.
- MSF. *Refugee health: an approach to emergency situations*. Médecins Sans Frontières, Paris, 1997.
- Pavignani E, Colombo A. *Analysing disrupted health sectors – A modular manual*. Geneva: World Health Organization 2009.
- WHO, UNFPA, UNHCR. *Inter-Agency Field Manual for Reproductive Health in Refugee Situations*. Geneva: World Health Organization, United Nations Population Fund, United Nations High Commissioner for Refugees, 2001.
- WHO, PAHO. *Guidelines for the use of foreign field hospitals in the aftermath of sudden impact disasters*. World Health Organization, Pan American Health Organization, 2003.
- FEWER, International Alert, Saferworld. *Conflict-sensitive approaches to development, humanitarian assistance and peace-building: A resource pack*. Africa Peace Forum, Center for Conflict Resolution, Consortium of Humanitarian Agencies, Forum on Early Warning and Early Response, International Alert, Saferworld, 2004.
- IASC. *Women, girls, boys and men, different needs, equal opportunities. Gender Handbook in Humanitarian Action*. Geneva: Inter-Agency Standing Committee, 2006.

4.2 PRIORITIZING PROBLEMS AND RESPONSE ACTIONS

The following are some key questions to be answered:

- ☑ What are the principal causes of avoidable mortality at present?
- ☑ What are the principal causes of avoidable morbidity and disability at present?
- ☑ What are the principal health risks in the coming months?
- ☑ Which of these problems affect the greatest number of people?

Data disaggregated by age and sex as well as geographic area are needed to answer these questions. The next step, described in section 5.1, will be to answer the question: What options are available to address these problems, what resources would be required, and what impact could be expected?

HCC and Health Cluster action

Enable all cluster partners to participate in the process of prioritizing problems and response actions in order to achieve the widest possible consensus and ownership of the conclusions.

Focus on identifying and dealing with immediate threats to life and the most pressing public health risks first. Gather adequate, reliable data and conduct a thorough analysis of the situation, risks and sustainability issues before proposing new programmes.

The format in Figure 4b may serve as a worksheet and a record of the reasons for the decisions made.

Figure 4b Sample worksheet for identifying priorities

	Issues of concern		
	Issue # 1	Issue # 2	Issue # 3
Current measure and trend			
Comparison with international benchmarks (e.g. SPHERE or other standards) [% deviation?]			
Comparison with pre-crisis situation [% deviation?] or neighbouring country levels			
Risk of mortality, morbidity or disability [rate 1–5][1]			
Urgency – immediacy of risk [rate 1–5][1]			
Number of people directly at risk			
Based on the above: priority health problems and risks [rate 1–5][1]			
Underlying causes; links to other factors			
Feasibility of addressing and having a measurable impact in the short term [2]			
Contribution of action to rebuilding the health system and protecting public health[3]			
Based on the above: priority for humanitarian/early recovery action [1–5[1]			

[1] Risk/Urgency/Priority ratings: 1 = very low; 5 = very high (based on professional judgement).

[2] Feasibility includes the *accessibility* (security, logistics, etc.), the *acceptability* of possible actions (culture, history, etc.) and the *capacities* available, or expected to be available, to carry out those actions within the planning period (skills and numbers of health workers, facilities, cold chain, etc.).

[3] In some cases it may also be appropriate to prioritize something that is "the right thing to do". For example, toxic waste dumped in a crisis-affected locality may not be the most immediate health concern but it may be appropriate to prioritize action to redress the collective grievance and defuse public concern.

5

STRATEGY DEVELOPMENT AND PLANNING

Key points:

- ✓ Agreement on a health sector response strategy, including specific objectives and activity-level strategies, is essential for coherent, coordinated humanitarian health action. All main health actors should be engaged in defining these elements and they must be understood by all stakeholders. They must be agreed with the national and local health authorities, whenever possible.
- ✓ Assessment, analysis, strategy development and planning are iterative processes. The response strategy statement, which provides the cornerstone for all Cluster activities, should be developed and refined progressively (see figure 3b in section 3.1):
  - A *preliminary*, response strategy ***outline*** should be prepared early, within the first few days, and provide the basis for initial responses by Cluster partners and a framework for the Flash Appeal [see section 7.1] and a package of proposals for any CERF application [see section 7.2].[19]
  - A first, *more detailed* health sector response strategy statement should be prepared on the basis of the findings of the initial rapid assessment (IRA). It should be linked with development of the revised flash appeal and later the common humanitarian action plan (CHAP) that is required for the first consolidated appeal, if any, typically after within 2 months of onset [see section 7.3].

That strategy should be *updated* as and when necessary on the basis of new information from subsequent sub-sector assessments and situation monitoring, following any major change in the situation, and prior to the preparation of any new CHAP (and CAP).

[19] A preliminary "working scenario" can help in preparing such a preliminary, outline strategy – see section 3.3 and annex B8 of *Managing WHO Humanitarian Response in the Field*, Geneva: World Health Organization, 2008.

- ✓ The overall strategy, objectives and individual activity-level strategies must be reviewed and up-dated as and when needed.
- ✓ The HCC should guide partners in their choice of areas to work and activities to prioritize, and any pooled resources available to the Cluster should be used to fill the most critical gaps.
- ✓ Contingency plans should be drawn up to deal with foreseeable threats to health or health services.

Expected Health Cluster outputs

- ✓ A joint, regularly updated, health crisis response strategy with clear priorities and objectives for addressing priority health problems, risks and gaps in an equitable manner and promoting early recovery (including building capacity)
- ✓ Distribution of responsibilities among partners based on capacities to deliver in the field.
- ✓ A joint contingency plan for response to future events that could impact on the populations' health or partners' response activities

"HEALTH CRISIS RESPONSE STRATEGY" AND "ACTIVITY-LEVEL STRATEGIES"

A *health response strategy* is a concise statement of the overall approach to which Cluster partners should contribute with the aim of *reducing avoidable mortality, morbidity and disability* and *restoring the delivery of, and equitable access to, preventive and basic curative health care as quickly as possible and in as sustainable as possible a manner*. It should define the priority areas to be addressed during a given time period, the specific objectives of the Cluster/sector, and the approaches adopted to accomplish those objectives within that period.

Individual, *activity-level strategies* are the approaches adopted to accomplish specific objectives (such as preventing – or reducing the risk of – a measles outbreak, assuring a continuous supply of essential drugs, or re-establishing and upgrading the health information system) within a defined period.

In a crisis, planning horizon tends to contract and its scope becomes reduced to projects. The result is fragmentation, with proliferation of

special planning units that work in isolation. An agreed upon strategy, and the development of an overall macro-plan, can help reduce the fragmentation.

Selecting activity-level strategies is deciding how to address particular priority problems and risks in order to achieve the objectives and avoid any potential negative effects. For example:

- To limit the risk of a measles outbreak, one option would be a mass measles immunization campaign. But, if you deem that the current coverage is good enough, it may be better to strengthen the routine immunization systems while focusing effort and resources on other health priorities.
- If there is a shortage of drugs, options could be to import drugs in bulk, import drug kits, or purchase drugs locally. A choice has to be made taking account of various factors including speed of deliveries and the likely effects on drug supply arrangements in the medium term.

Some additional examples, and examples of unintended negative effects, are provided in Annex G.

Common "gaps" in relation to planning
Findings from 10 country case studies (2004-07)

Examples	Proposed remedies
No implementation plan relevant to the phase of the response (particularly structural rehabilitation) addressing the whole affected area. Implementation driven by agency capacities and mandates, availability of funds, and 'contextual opportunism', rather than needs (e.g. support to hospital capacity and tertiary care over primary care).	Conduct a joint evidence-based prioritization exercise, identifying major causes of morbidity and mortality, prioritizing preventive and curative health services to these causes. Agree on a minimum package of health services (including reproductive health MISP) to be delivered by each level of health facility, appropriate to the phase of the emergency. Develop a common action plan together with NGOs, affected community, and MoH, focused on health priorities, within the principles of primary health care, and, particularly in the early recovery phase, finding the balance between urgent service delivery needs and longer term system building.

5.1 DEVELOPING A HEALTH SECTOR RESPONSE STRATEGY IN CRISIS

The health sector response strategy in crisis is the principal tool for ensuring that the actions of all health actors are coordinated and, in particular, the actions of external health actors are well coordinated with, and appropriately support, those of the national and local health authorities and other local actors. It provides a framework for planning health response throughout the affected area(s), including the allocation of resources among areas.

Some basic principles

- ✓ Focus on ensuring the delivery of essential services initially; plan to broaden the scope only when essential services have been assured. It is easier to scale up the provision of health care than scale it down.
- ✓ When resources are insufficient to meet all needs – as is almost always the case – concentrate effort and resources where they can make difference. Diluting scarce resources across the board can be ineffective.
- ✓ Produce an initial strategy rapidly and improve it and make it more specific as more solid information becomes available, consensus with stakeholders is reached and resources materialize. Don't waste time preparing very detailed, comprehensive plans that could quickly become irrelevant.
- ✓ There must be clear, demonstrated links among (i) the identified priority problems, risks and gaps, and (ii) the specific objectives and chosen strategies. Alternative options for addressing the priority problems must be examined and the reasons for the choice of particular strategies explained in the strategy document.
- ✓ Seasonal variations and their usual effects on diseases patterns and service delivery and access, must be taken into account. This includes rainy and lean seasons, and seasonal upsurges in violence in some complex emergencies.
- ✓ The crisis response strategy should include phasing to ensure effective coverage of minimum initial services before providing broader essential services. It should address all aspects: human resources, facilities, equipment and supplies.

- ✓ Recovery should be promoted from the earliest possible moment, implying long-term thinking in the planning. Efforts must be made to use and strengthen existing structures and (re-)build local capacities, whenever possible. Potential negative effective must be considered and minimized.
- ✓ Cross-cutting concerns such as gender, HIV/AIDS, the environment and protection must be integrated into the planning process.

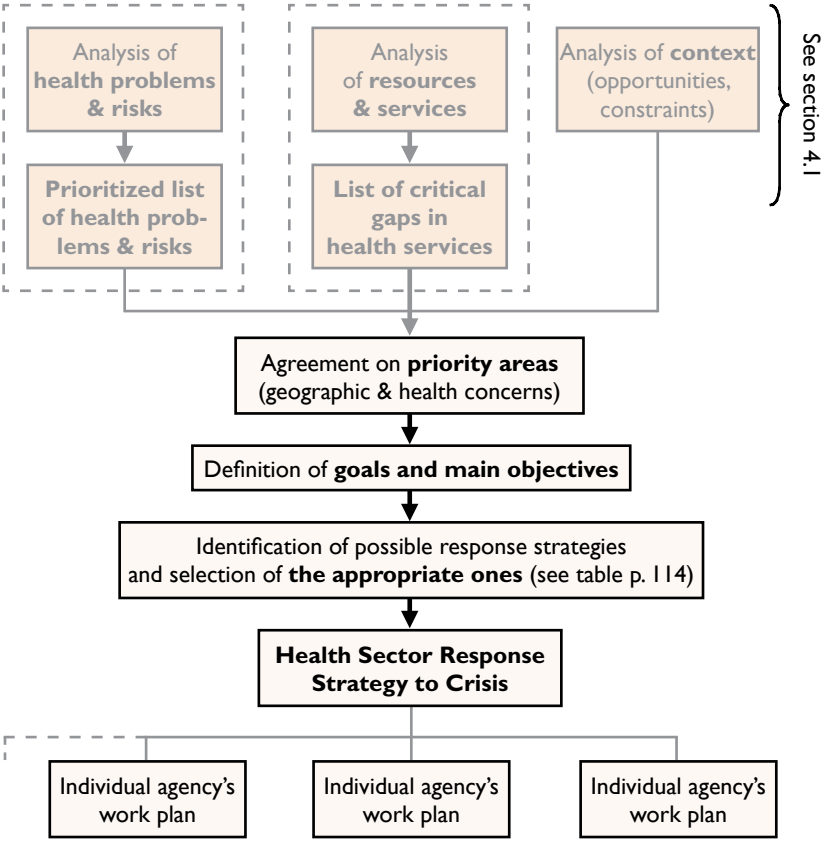
Steps in developing a health sector response strategy in a crisis situation

The process of developing a health sector response strategy based on the situation analysis is shown schematically in Figure 5a.

The context analysis, including issues of capacities, resources and constraints, is critical to the definition of objectives (which must be realistic), the analysis of response options and selection of activity-level strategies (which must be both appropriate and feasible), and the preparation of the overall health sector response strategy (which must also be realistic).

Fortunately, it is not always necessary to start from scratch when defining priority areas and strategies. Certain responses may be "givens" in many contexts on the basis of long experience in many crisis and the required managerial decisions are clear. For instance, a campaign of measles immunization is often an appropriate response in settings where routine systems have been disrupted. The probable need for such responses must be recognized and analysed. This is important, especially during the first, acute phase of response when time is at a premium. In general, however, specific objectives must be defined and activity-level strategies chosen on the basis of assessment findings and careful prioritization in order to achieve maximum health benefits with the resources expected to be available during the particular planning period.

Figure 5a From analysis to a health sector response strategy



Defining priority areas

☑ Define affected geographical areas in relation to the priority health problems and risks. They should focus on addressing the main causes of death and illness in the local context and the major constraints to delivery of and access to health care services.

Initially the focus will be on *ensuring that life-threatening humanitarian needs are met*, while always looking for opportunities to promote recovery and rebuild systems. As soon as *life-threatening needs* are met, the focus should shift progressively towards *re-building national systems and capacities* while ensuring that any remaining humanitarian needs are met.

Defining objectives

☑ Ensure that objectives address coherently the priority problems and risks identified in assessments, are tailored for specific phases of the response take account of:
- the context, the capacities and resources available;
- seasonal variations and the expected evolution of the overall situation; and
- any protection and human rights issues, the impact of HIV/AIDS, security conditions, any limitations on access, and any other constraints on people and the delivery of services, and differentiate among men and women, girls and boys.

They may also need to take account of *expectations* that must be met – the policies and values of the various stakeholders that will affect the evolution of the overall situation and the implementation of health-related activities. Specific objectives may include improving information and reinforcing systems as well as achieving direct health outcomes.

Selecting activity-level strategies

Response strategies must be *appropriate* – address the priority problems and risks effectively, coherently and efficiently in a manner suited to the local context, *and feasible* – able to be implemented in the local context and with the resources expected to be available. To the extent possible, they should contribute to "building-back-better".

☑ Choose strategies on the basis of an explicit, recorded analysis of the advantages and disadvantages of the available response options – the possible alternative ways of addressing specific problems and accomplishing particular objectives.

☑ Analyse options carefully to identify the most appropriate strategies – ones that will achieve the defined objectives while minimizing any potential negative effects (especially in a conflict situation). Note that short-term actions taken to address an immediate systemic problem in service delivery may have significant distorting effects on the entire health system in the longer term – see the examples in Annex G.

☑ Draw on experience in previous crisis in the same area or among similar populations in neighbouring countries. If actions are proposed on the basis of experiences further a-field, ensure a thorough analysis of the differences as well as the similarities

between the two contexts. What worked (or failed) in one context will not necessarily work (or fail) in another!

Identifying and choosing among alternative response options requires an analysis of the context as well as relevant health sector information. It also requires abilities to compare the current situation with other, similar contexts, to learn from the past, and to engage with a broad range of stakeholders possibly including new players (civil society, non-state actors, etc) as appropriate and relevant. It involves value judgements and requires diplomacy and political wisdom to ensure that the perspectives of all main stakeholders are recognized in the process of analysis and taken into account in the final strategy.

A matrix such as the one below may be helpful to map out and record the main issues/problems and response options.

Problem/ risk/ issue	Key situation analysis points	Specific objectives	Response options	Advantages (arguments for)	Disadvantages (arguments against)	Relevant experience from similar contexts
			1:	1:	1:	
			2:	2:	2:	
			1:	1:	1:	
			2:	2:	2:	

HCC and Health Cluster action

During the first few days

☑ *Where an inter-agency/health-sector contingency plan exists* for the type of crisis concerned, review the objectives and strategies envisaged in that plan and adjust them to the current initial working scenario. *Where no relevant contingency plan exists*, develop initial objectives and strategies from scratch based on the initial working scenario.

☑ Prepare a very concise statement of the overall goals of the health response, the priority problems to be addressed during the initial plan period (perhaps 1 month), the specific objectives for that period, the principal strategies to be applied, who will do what where, and the principal gaps (uncovered priority needs/activities).

Ensure that the initial objectives are realistic and focus on life-threatening humanitarian needs while capitalizing on any opportunities that may exist to initiate recovery straight away.

Focus on filling gaps in critical life-sustaining services in areas where large numbers of people are known, or believed, to be seriously affected, and filling gaps in information that are critical for determining needs and planning an appropriate response.

Try to make sure each organization taking responsibility for a particular area or activity has, or will have, the capacity and systems to support the planned field activities.

Once the initial assessment has been completed

☑ Elaborate objectives for the coming 6 to 12 months on the basis of the initial rapid assessment and as new information becomes available. Include both continuing humanitarian response and a progressively increasing focus on recovery. Take account of foreseeable seasonal variations and the expected evolution of the overall situation.

☑ Include projects/activities to consolidate or enhance, where needed, the capacity assure and manage health information and facilitate coordination while working to progressively reduce dependence on external assistance, as and when possible.

☑ Re-examine the defined objectives and strategies at regular intervals in the context of periodic progress reviews. Check whether

they are still appropriate and realistic. Revise/refine them if and when necessary in agreement with all concerned stakeholders.

☑ Prepare contingency plans for events (contingencies) that could impact on the health of the population and/or the ongoing humanitarian assistance operations of health-sector actors during the coming months. See section 5.5.

At regular intervals or after any significant change in the overall situation

☑ Review the strategy and the impact of the activities implemented, and make adjustments as needed, ensuring that it is adapted to the context as it evolves.

Strategies that are directed towards the humanitarian goal of reducing excess [avoidable] mortality, for example, can become inappropriate in a recovery or transitional context when excess mortality is under control and the goal has shifted to the reactivation of essential health services. Activity-level strategies can, and should be changed if they prove ineffective to achieve the set goals/objectives. If necessary, objectives may need to be re-adjusted, often reducing their ambition and scope.

WHAT TO INCLUDE IN A HEALTH SECTOR RESPONSE STRATEGY DOCUMENT

The document must present the priority areas, the objectives and response (activity-level) strategies and the rationale. The rationale must explain, concisely, the reasons – the justification – for the priorities and the chosen strategies. This will be very brief for the preliminary strategy document, more detailed for subsequent ones. It should:

- provide a concise analysis of the situation including the prioritized list of the main problems and their underlying causes, and explain the choice of priority areas;
- present the objectives for each main area of intervention (e.g. prevention and control of communicable diseases, injury rehabilitation, surveillance, drug supplies management) and the strategies proposed to achieve the objectives, showing how the objectives and strategies derive from the assessment findings and situation analysis; *and*
- highlight the operational constraints and inter-sectoral cross-cutting concerns that have been identified as being particularly important for health in the current situation and explain how they have been taken into account, and show how general emergency programming principles have been applied.

PHASED PLANS AND INCREMENTAL APPROACHES

In some situations it may be possible to define – and agree – from the outset a *phased plan* to address a particular problem. For example: "In a particular recovery context, there is a serious imbalance in the workforce, with a large shortfall of midwives, mainly in rural areas. A substantial investment is required to accelerate the training of new staff in this category. In the meantime, a package of incentives is envisaged for midwives willing to move to underserved areas for the next 3 years, when new midwives will have been trained. A comprehensive human resource development plan for the next 10 years will be launched with technical assistance provided by donor X."

In many cases, especially where there are conflicting perspectives and pressures, it is necessary to adopt an *incremental approach* and proceed gradually towards the set goals, taking into account the resistance and opportunities that emerge during the process. This involves getting consensus on *intermediate* objectives, achieving them, and then moving to a higher objective as soon as the context is conducive. Good monitoring, and perhaps a real-time evaluation, is essential to track the intermediate outcomes and facilitate agreement on the next, follow-on phase.

Additional guidance

- Annex G, on the CD-ROM – *Analysing response options; examples of negative effects*, adapted from *Managing WHO humanitarian response in the field*. Geneva: World Health Organization, 2008.
- IASC. *Need analysis framework, strengthening the analysis and presentation of humanitarian needs in the CAP*. Inter-Agency Standing Committee, CAP Sub-working group, April 2007.
- IASC, GHC. *Health Cluster guidance note on health recovery*. Inter-Agency Standing Committee, November 2008 (final version expected for 2010).
- Pavignani E, Colombo A, *Analysing disrupted health sectors – A modular manual*, Geneva: World Health Organization, 2009.
- UNDG, ECHA. *Transitional strategy guidance note*. United Nations Development Group and ECHA Working Group on Transition, 25 October 2005.

- Cluster Working Group on Early Recovery. *Guidance note on early recovery*. Cluster Working Group on Early Recovery in cooperation with the UNDG-ECHA Working Group on Transition, April 2008.
- United Nations. *Integrated mission planning process guidelines*. United Nations, 13 June 2006.
- UNDG, World Bank. *An operational note on transitional results matrices*. United Nations Development Group and World Bank, January 2005.
- IASC. *Women, girls, boys and men, different needs, equal opportunities. Gender Handbook in Humanitarian Action*. Geneva: Inter-Agency Standing Committee, 2006..

5.2 PREPARING THE HEALTH COMPONENT OF A COMMON HUMANITARIAN ACTION PLAN

The common humanitarian action plan (CHAP) is an overall strategic plan for humanitarian response covering all relevant sectors. It constitutes the core of a consolidated appeal (see section 7.3) but can also serve as a reference for organizations that decide not to participate in such an appeal. A CHAP includes:

- an analysis of the context and humanitarian consequences (humanitarian needs and risks taking account of the capacities and vulnerabilities of different affected population groups);
- scenarios – best, worst, and most likely scenarios;
- strategic priorities including clear statements of longer-term objectives and goals; and
- prioritized plans for each sector (of which health is one).

The CHAP/HAP is developed by the IASC/Humanitarian Country Team under the leadership of the Humanitarian Coordinator. Non-IASC members, such as national NGOs, can be included. Other key stakeholders in humanitarian action should be consulted, in particular the host government and donors.

HCC and Health Cluster action

Contributing to overall, inter-sectoral elements

The HCC will lead the discussion among the health cluster partners and consult with the national/local authorities in order to develop: (i) the section on the overall context and humanitarian consequences; (ii) strategic

priorities for the humanitarian operation as a whole, and (iii) general criteria for selecting and prioritizing projects.

In doing so, it should be ensured that:

- ✓ all current and potential health consequences are adequately taken into account;
- ✓ inter-relationships among public-health-related needs and risks are clearly recognized; *and*
- ✓ the situation and vulnerabilities of all distinct population subgroups are taken into account (depending on the context, subgroups might be based on ethnicity, disability, gender, age, HIV/AIDS, etc.).

Drawing up a CHAP health strategy

- ☑ The cluster should agree on a two-page strategy for the health sector (including psycho-social needs). The summary from a health sector Needs Analysis Framework (NAF) report may be used or information from an alternative, evidence-based, inter-agency needs and response analysis.
- ☑ Projects to support critical health system elements and health coordination should be included, when needed, as well as projects for the delivery of supplies and services. All should take account of cross-cutting issues (protection, gender and age considerations, etc.)

Selecting and prioritizing projects (for inclusion in the CHAP)[20]

- ☑ Arrange a special meeting to select and prioritize projects for inclusion in the CHAP and consolidated appeal. If the cluster is large, it may be useful to form a *technical working group* for this purpose including representatives each main group of stakeholders, e.g. government, large INGOs, large NNGOs, small INGOs, small NNGOs, other national institutions, donors. Elect a chair and co-chair at least one of which from an NGO or the Red Cross/Crescent.
- ☑ Review the criteria established by the Humanitarian Country Team for the selection and prioritization of projects in general and agree on the specific criteria to be used for health projects.
- ☑ Ask organizations participating in the cluster to prepare 1-page project sheets following the CAP technical guidelines and submit them to the chair and co-chair. Emphasize that the projects

[20] Edited from *Guidance for CAP Project Selection and Prioritisation*, IASC June 2004

should address agreed priority needs and support the implementation of the agreed health sector strategy.

☑ Review the proposals – discussion facilitated by the designated chair and co-chair. Send back to the originating organizations any proposals that do not meet the agreed criteria.

☑ Submit the selected proposals to the Humanitarian Coordinator/OCHA. The chair and co-chair should then participate in a peer (inter-cluster) review to ensure overall consistency in the proposals for different sectors.

The HC makes the final decision and is accountable to the Emergency Relief Coordinator for ensuring that projects included in the appeal are in line with the agreed overall humanitarian needs and strategic priorities.

Note that any support needed to assure the effective functioning of the health cluster, and the ability of the cluster lead agency and coordinator to fulfil their responsibilities, must be included in the package. Budget lines may be needed for, e.g. information management, communications, and evaluations.

WHAT SHOULD BE INCLUDED IN A HEALTH STRATEGY FOR A CAP/CHAP

A CHAP – section 3 of a CAP – should normally include:

✓ the priority health needs and risks;

✓ a corresponding health strategy with no more then five *objectives* for the health sector and no more then five key health *indicators* for measuring progress towards objectives;

✓ a list of the organizations that will contribute to this health strategy, and a outline or chart showing the complementarity between proposed activities;

✓ a brief explanation of how the cluster/sector group will monitor implementation and the achievement of objectives;

✓ the implications if the health strategy is not implemented.

The strategy must be evidence-based and clearly linked to one or more of the agreed overall strategic humanitarian priorities, and include the main organizations working in the health sector.

Individual projects must be reviewed and agreed upon by the health cluster/sector group and support the defined health response strategy (see next box below).

[Adapted from *Technical Guidelines for Consolidated Appeals*, IASC 2006]

SAMPLE CRITERIA FOR PROJECT SELECTION/ PRIORITIZATION

- ✓ Strategy: the project addresses priority areas in the agreed health crisis response strategy and will help to achieve specific agreed objectives using agreed activity-level strategies.
- ✓ Organizational capacity: the appealing organization has the technical expertise in country, capacity, and mandate to implement the project, or can mobilize this operational capacity as required.
- ✓ Population: the project targets one or more of the priority, vulnerable population groups identified by the IASC/ Humanitarian Country Team.
- ✓ Geographic area: the project will be implemented in a region that is considered to be a priority for humanitarian health action.
- ✓ Timing: the project can make a measurable impact in the time-frame of the appeal (usually one year).
- ✓ Other context-specific criteria: e.g. projects that promote gender equality, include a focus on HIV/AIDS (where this is a major concern) and/or help to build local capacity.

[Adapted from *Guidance for CAP Project Selection and Prioritisation*, IASC June 2004]

Additional guidance

📖 See the IASC web page devoted to the Consolidated Appeal Process at: http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-common-default&sb=12. See also on the CD ROM, the documents Consolidated appeals 2009 guidelines and Consolidated Appeal for Liberia 2007.

5.3 SUPPORTING HEALTH SYSTEM RECOVERY

Following a *sudden-onset disaster*, the strengthening/re-building of local health systems and capacity can be initiated from day-1 by designing and implementing all emergency health programmes and activities in ways that contribute to that objective. The recovery

phase after a disaster provides a window of opportunity for "building back better" – ensuring an appropriate, sustainable health system, building preparedness systems and capacity to deal with future crisis, and instituting vulnerability reduction measures.

After a *prolonged crisis*, or towards the end of one, recovery is a complex and long process. Internal and external partners need to work together to rebuild the State's capacity to deliver health and other essential services while also re-establishing economic activities. Planning health system recovery should start early. Formulating sound policies, adequate strategies and flexible plans, are essential steps to provide a framework for action in a highly fragmented environment.

The post-disaster or post-crisis period offers important opportunities. The enthusiasm for reconstruction may be high, the generosity of donors considerable, and resistance to change reduced. Gender roles and responsibilities may have changed during a protracted crisis and there be opportunities for women's empowerment and increased levels of gender equality. If the health system before the crisis contained (as it is often the case) distortions and inequities, the recovery phase may offer the possibility of laying the ground for improvements. These opportunities must be seized.

Guiding principles

The following are a few basic principles:

- ✓ ***Think long-term***: be aware that decisions and investments made in the initial phases of a crisis may have detrimental long-term consequences extending well into the recovery and reconstruction phases.[21]
- ✓ ***Adopt a "systems" approach and focus on the six building blocks***: recognize that there are many inter-related components that contribute to the delivery of health care and that action affecting one component may affect all the others. Analysis and understanding of all health system components and of their interactions are the necessary basis of sound, non-disruptive interventions. Knowledge and understanding of the historical, political, economic and social background signifi-

[21] For example: health units may be built or expanded in towns or safer areas and become redundant when the situation reverts to normal; low-level health workers may receive ad hoc, short-course training leading to expectations of being integrated in the health system; multiple drug supply channels may be used to the detriment of the official ones; multiple information systems may be put in place undermining the functioning of a uniform one, etc.

cantly strengthen the analysis of the health system and, consequently, the effectiveness of interventions. The box at the end of this section outlines some key issues in relation to the six core building blocks of a health system, as defined by WHO.[22]

- ✓ ***Focus on goals and outcomes***: give attention to the quality, coverage, access and safety of services to ensure that they are responsive and efficient and produce improved health for all (equity).
- ✓ ***Promote –and capacitate – national leadership***: the planning and implementation of recovery activities must be led by relevant national authorities and agencies at central and sub-national levels. (Re-)Build the capacity of these entities, as needed, taking account of any constitutional changes that enable greater *decentralization* than before the crisis.[23]
- ✓ ***Work with new actors/partners***: develop working relations with international financial institutions and other development-oriented entities.
- ✓ ***Ensure coordination with other sectors***: efforts in health (and other basic social services) need to be planned and implemented in parallel with activities to achieve good governance and community recovery.
- ✓ ***Use the Millennium Development Goals* for health** (mid-decade goals) as targets to focus recovery activities following a protracted crisis. In such cases, it is rare that health services can be rebuilt as they were before. More or less extensive reforms are invariably needed. The Goals may provide a useful beacon to assess strategies and programmes during recovery.
- ✓ ***Work with and strengthen the capacity of local partners and civil society***, including those from poor and marginalized groups, to engage in health service delivery including management, monitoring and the development of accountability mechanisms.

[22] WHO, *Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*, World Health Organization, 2007.

[23] There is need for an overarching, nationally-driven plan to which all donors agree, with a "lead actor" who provides and shares a clear vision, inspires and oversees joint assessments, and prepares policies, strategies and broad plans. The MoH should normally be the "lead actor" but, if it still lacks the adequate capacity, a respected international agency may play this role in agreement with the government.

- ✓ ***Promote a locally-driven and -owned reform and change agenda.***
- ✓ ***Ensure appropriate phasing***: policy and sector reform must not overload fragile institutions or overwhelm existing weak capacity.
- ✓ ***Align donor-supported activities with the government's strategy, policy and systems***. If this is not possible, donors should harmonize their approaches with an emphasis on developing mechanisms that will enhance not undermine the government's role in the stewardship of the health sector.

Note that *efficiency* must sometimes be neglected to achieve *equity*, for instance, using mobile units to deliver services in isolated and underserved areas.

HCC and Health Cluster action

Protecting and reinforcing local capacities from the outset

- ☑ Work together and with the MoH, as appropriate, to ensure that all emergency health programmes and activities are designed and implemented in ways that contribute to re-building local capacities. Try, in particular, to ensure that:
  - existing facilities and systems are used, reactivated and repaired, whenever possible – and that new, parallel systems are avoided, unless absolutely necessary;
  - existing in-country competencies are identified and used as much as possible;
  - local personnel are involved in all assessment, planning and response activities;
  - (re)training needs are identified and appropriate, task-oriented training provided as early as possible;
  - there is equality of opportunity in participation and training for women and men.
- ☑ Try to get agreement among all the main health actors on:
  - the importance of maintaining and, where possible, strengthening the MoH and sub-national level health structures; and
  - how to avoid denuding these structures. (Possibilities might include paying incentives to MoH staff to stay at their posts. Use imagination to find ways, together with partners.)
- ☑ Discourage all health actors from creating new parallel systems, unless absolutely necessary.

- ☑ Facilitate international/ national partnerships with and among NGOs to help build local capacity.
- ☑ Promote the Principles of Partnership reproduced in section 1.1.

Promoting the early recovery of health systems

- ☑ While still assuring public health action to protect lives and reduce avoidable disease and disability, give progressively increasing attention to recovery taking account of overall socio-economic conditions, the institutional capacity of government and non-state actors and the nature of the crisis, and differences between different geographical areas.
- ☑ Collaborate in post-conflict needs assessments (PCNAs) – usually led by the UN and the World Bank and carried out in close consultation with the national authorities – and other inter-agency, recovery-oriented, post-crisis assessments such as joint assessment missions and post-disaster needs assessments (PDNAs).
- ☑ While using the CAP to mobilize resources for some initial early recovery activities, when agreed with the HC and humanitarian country team, explore possibilities for funding more substantial recovery-related activities through bilateral or multilateral agreements including multi-donor trust funds (MDTF) and include priority activities in the UN Country Assistance Framework (CAF).
- ☑ Accelerate capacity building within national agencies to enable them, and national enterprises, to take the lead in rebuilding facilities and services and thereby accelerate the process of national ownership of the process and results. (Demonstrate the existence and willingness of national agencies to take on significant roles in the recovery process, and thereby accelerate the shift from dependency on external sources to self-reliance.)
- ☑ Identify well-functioning local agencies and enterprises that can serve as models or support for malfunctioning health facilities or services.

When the emergency is over and some external health actors are leaving, handover of health services to the government should be carefully planned – sequenced progressively, step-by-step over a defined period of time.

- ☑ Promote/support health workforce mapping/needs in light of health sector gap analysis.
- ☑ Promote (support the MoH) in the mapping and tracking of financial investments/contributions to the health sector.
- ☑ Encourage all health sector stakeholders to base financial commitments and recovery plans on evidence from recent health sector analysis and especially HeRAMS data as a basis for estimating drug and other material needs.
- ☑ Support the MoH and other health sector actors to develop a clear evidence-based stance on user fees (including identification / securing alternative funding where user fees are abolished or significantly reduced).

Additional guidance

- 🕮 Cluster Working Group on Early Recovery. *Guidance note on early recovery*. Cluster Working Group on Early Recovery in cooperation with the UNDG-ECHA Working Group on Transition, April 2008.
- 🕮 Pavignani E, Colombo A. *Analysing disrupted health sectors – A modular manual*. Geneva: World Health Organization 2009.
- 🕮 Smith JH, Kolehmainen-Aitken RL. *Establishing human resource systems for health during post-conflict reconstruction*. Management Sciences For Health (MSH), occasional paper No.3, 2006.
- 🕮 WHO. *Strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: World Health Organization, 2007.
- 🕮 Islam, M (ed.). *Health systems assessment approach: A how-to manual*, Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners for Health Reformplus, Quality Assurance Project and Rational Pharmaceutical Management Plus. Arlington, VA, Management Sciences for Health, 2007.
- 🕮 Smith J. *Guide to health workforce development in post-conflict environments*. Geneva: World Health Organization, 2005.
- 🕮 WHO (2007) *Towards a framework for health recovery in transition situations*. Global Consultation on Health Recovery in transition situations. Montreux, Switzerland, 4-6 December 2007. World Health Organization, background Document.

THE SIX CORE HEALTH SYSTEM BUILDING BLOCKS – KEY CONSIDERATIONS DURING RECOVERY

The following are the core building blocks defined in *Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*, WHO 2007. All need to be considered during recovery without loosing the essential focus on health outcomes:

1. *Leadership and governance*

Leadership and governance are key to set overall health policy and translate this into health strategies and annual plans that can be resourced and implemented, but are often seriously affected during a prolonged crisis/conflict. The following are some elements to consider:

- ✓ Capacity building to enable a MoH to assure the necessary leadership (may need technical assistance in the short term, and capacity building activities for the longer term).
- ✓ Formulating policies and strategies to give a sense of direction and provide a common framework for action (negotiation and sharing being as important as final product)
- ✓ Developing coordination platforms involving all critical stakeholders.
- ✓ Supporting decentralization by strengthening planning and managerial capacity at provincial and district levels. Responsibilities and procedures must be clear, adequate resources (human and financial) distributed, and management support provided.

Encourage health sector partners (including donors) to engage in strengthening health management capacity (at whatever level) as a standard part of any recovery plan/project proposal.

2. *Human resources*

To assure a competent, functioning, affordable health workforce it is necessary to:

- ✓ ensure the early establishment of a human resources database and information system for both short- and long-term HR planning;

- ✓ examine salary issues and recent trends in training and in- and out-migration, and potential recruitment and training of lay personnel for specific tasks; and
- ✓ plan early for appropriate human resources and their development based on sound reflection and analysis.

Avoid an undue expansion of the health network (without the human resources to manage it adequately or the funds to meet future recurrent expenditures) and ensure appropriate training and retraining activities. But avoid a host of inadequate *ad hoc* training activities. (Training of lower-level health workers may be justified in the short term but long-term planning for pre-service training is essential.)

The *contracting out* of services is sometimes proposed to scale up coverage of essential health services in an insecure environment and poorly resourced health sector (e.g. Afghanistan in 2008). It may indeed be useful when the State is virtually absent but contracting should be used with caution so as not to jeopardize the long term development of the State itself.

3. *Financing*

Realistic estimates are required for both the costs of recovery activities and the levels of funding likely to be available from the government budget, continuing (but diminishing) humanitarian funding, new development schemes, bilateral funding, various global funds, and loans from international financial institutions. Elaborating strategies and formulating plans without linking them to the resources realistically going to be available, is a futile exercise. The issue of user fees – whether they should be introduced, maintained or abolished – is likely to be contentious.

4. *Medicines and technology*

In case of a prolonged crisis, supply arrangements for drugs and other medical material will usually have changed considerably and become fragmented. The (re-)establishment of a central pharmaceutical store or similar mechanism must be carefully planned based on detailed analysis of the factors impeding the supply of essential drugs and supplies to the public health facilities. Promote the essential drug concept and standardized treatment protocols.

5. ***Information***

A first priority during recovery is to (re-)establish an appropriate Health Management Information System (HMIS) that collects relevant, reliable sex- and age- disaggregated data and provides a sound information basis for both short- and longer-term planning. Thorough health facility assessments will be needed to establish a baseline using existing data and through surveys. Factors impeding the recording and transfer of information from central to sub-regional and local authorities, and the transfer of reports from local to sub-regional and central authorities, must be identified. Epidemiologic surveillance and early warning systems must be mainstreamed into regular provincial and district operations.

6. ***Service delivery***

During recovery it will be crucial to strengthen primary health care services emphasizing the services listed in the table in Figure 3e (in section 3.3). This includes planning the restoration of service delivery, including expansion to underserved areas (difficult balance between politics, equity and efficiency) as well as introducing new service delivery models, where needed. Combine lessons from other countries with an understanding of local context. Specific areas such as blood safety, sterilization in health facilities, disposal of injections and sharp medical supplies, and medical waste disposal, will need to be addressed.

5.4 TAKING ACCOUNT OF CROSS-CUTTING CONCERNS

All activities must be planned taking account of human rights, gender and environmental concerns and risks and constraints related to HIV/AIDS.

Checklist for cross-cutting concerns[24]

Human rights and protection

☑ Do proposed strategies and implementation modalities assure equality of access to assistance and services for ALL population groups and adequate protection for beneficiaries and humanitarian/health workers?

☑ Might they reinforce existing patterns of discrimination or increase risks?

☑ Could activities or implementation modalities be modified to better assure respect for human rights and protection, especially for groups determined to be at particular risk (e.g. female-headed households, women and men with disabilities, people living with HIV/AIDS, adolescent boys)?

☑ Is there effective collaboration between the health and protection clusters in ensuring protection, treatment and psycho-social support for the above-listed groups at particular risk, unaccompanied children, and survivors of sexual and gender-based violence?

Gender

☑ Do proposed strategies and implementation modalities promote gender equality and minimize risks of sexual and gender-based violence?

☑ Might they increase existing inequalities?

☑ Could activities or implementation modalities be modified to better promote gender equality?

HIV/AIDS

☑ Do proposed strategies take account of the prevalence of HIV/AIDS and minimize the risks of transmission in a culturally appropriate manner?

[24] This checklist is based on key questions in the CHAP guidelines + add-ons for HIV/AIDS and psychosocial support

- ☑ Could activities or implementation modalities be modified to better provide for people suffering from HIV/AIDS and reduce risks of transmission?
- ☑ Are standard precautions being effectively implemented in all areas (the first priority before considering any other measures)?
- ☑ Are arrangements in place to assure continuing treatment for patients already on ART?
- ☑ Are preventive strategies that were in place prior to the crisis being maintained?

Environment

- ☑ Do proposed strategies and implementation modalities assure protection of the environment and natural resource base?
- ☑ Might they create additional unnecessary waste?
- ☑ Could activities or implementation modalities be modified to better protect the environment?

Psychosocial support

- ☑ Do proposed strategies involve a coordinated, multi-sectoral response that involves providing basic psychosocial supports to the population?
- ☑ Do proposed strategies facilitate conditions for community mobilization, community ownership, community control, community self-help, community support, and cultural healing practices?
- ☑ Do proposed strategies and implementation modalities take into account social considerations (safe aid for all in dignity, considering cultural practices and existing community resources)?

Additional guidance

- 🕮 Annex F, on the CD-ROM, which summarizes the main issues in relation to these concerns.
- 🕮 IASC. *Guidelines for gender-based violence interventions in humanitarian settings focusing on prevention of and response to sexual violence in emergencies*. Inter-Agency Standing Committee, September 2007.
- 🕮 IASC. *Guidelines for HIV/AIDS interventions in emergency settings*. Inter-Agency Standing Committee, 2003.

📖 IASC. *Guidelines on mental health and psychosocial support in emergency settings*. Inter-Agency Standing Committee, 2007.

📖 IASC. *Women, girls, boys and men, different needs, equal opportunities. Gender Handbook in Humanitarian Action*. Geneva: Inter-Agency Standing Committee, 2006.

5.5 DEVELOPING (IN-CRISIS) CONTINGENCY PLANS

The contingency plans referred to here are "in-crisis" contingency plans prepared to deal with possible future events ("contingencies") that could further complicate the current situation.

Some basic principles

- ✓ Events that could further impact on the health of the population or on the ongoing humanitarian assistance operations during the coming months must be anticipated.
- ✓ Contingency plans must be prepared to respond to possible new health threats and to ensure, as much as possible, the continuity of services and humanitarian assistance to the target populations. They should be included as annexes to the health crisis response strategy.

Events (contingencies) that might need to be anticipated include, for example:

- secondary disasters: recurrence of the primary hazard or secondary phenomena such as epidemics of communicable diseases or a forthcoming cyclone season;
- deterioration of the security situation, notably the possibility that renewed conflict could affect certain health facilities, cause [further] population displacements, or disrupt supply corridors;
- breakdown of in-country supply chains due to overburdened provincial services.

N.B. Seasonal variations such as rainy and lean seasons, and their usual effects on diseases patterns and service delivery and access, must also be taken into account but this should be integrated in the basic health crisis response strategy. Contingency plans should cover other, more exceptional events.

HCC and Health Cluster action

In collaboration with the MoH and other stakeholders:

- ☑ Identify and prioritize possible contingencies that, during the coming months, could impact on:
  - the health of the population; or
  - the ongoing humanitarian assistance operations in the health sector.
- ☑ Decide within the cluster, in coordination with the MoH and other main health actors, how such events will be managed – how the new health needs will be responded to and how operational support and services will be maintained if/when such events occur.
- ☑ Estimate the additional resources – human, material, financial – that could be needed to respond to the new situation, determine how they would be mobilized and where to pre-position stocks.
- ☑ Ensure the constant, ongoing monitoring of contingency stocks and their replenishment whenever needed.
- ☑ Write up a joint health cluster contingency plan that describes the anticipated scenario(s), specifies arrangements for immediate joint assessment and planning, outlines the response strategy, actions and resources that would probably be needed, and assigns specific roles and responsibilities for action if/when such events occur and for immediate preparedness measures.
- ☑ Disseminate the plan to all stakeholders and ensure that all cluster partners take necessary measures internally to be ready to fulfil their role/responsibilities if/when such events occur. If needed, prepare specific projects to enhance preparedness and seek to mobilize the necessary resources from donors.
- ☑ Regularly review (i) the list of possible contingencies and scenarios, and (ii) the contingency plan. Update them when necessary.

Additional guidance

- 🕮 IASC. *Inter-agency contingency planning guidelines*, Inter-Agency Standing Committee, November 2007.
- 🕮 IASC. *Contingency planning.* Cluster-Sector Leadership Training Tip Sheets, Inter-Agency Standing Committee, 2007.

6
ENSURING STANDARDS

Key points:

- ✓ Aim for high coverage with quality.
- ✓ Build consensus on the application of best practices.
- ✓ Monitor the application/implementation of evidence-based interventions.
- ✓ Promote an enabling environment for implementation/ adoption of evidence-based practices.

Expected Health Cluster outputs

- ✓ Agreed standards, protocols and guidelines for basic health care delivery; standard formats for reporting.
- ✓ Training materials and opportunities available to all partners for upgrading skills and standards of service provision, as needed.

Common "gaps" in relation to health service delivery standards Findings from 10 country case studies (2004-07)	
Examples	**Proposed remedies**
Malnutrition Global acute malnutrition among children 6-59 months of age often excessive, even in longstanding emergencies and early recovery situations. Health care for the malnourished not always in line with international standards, particularly routine malaria treatment in therapeutic feeding centres. For example, deaths due to malaria were very high in one therapeutic feeding centre. Promotion of breast feeding inadequate.	Create linkages between the health sector and the nutrition coordination mechanism. Ensure adequate data for decision making on prevalence of malnutrition. Disseminate operational guidance to partners, together with nutrition partners, with focus on community based care (including community based therapeutic care and promotion of breast feeding).
Waterborne diseases Lack of prevention, hygiene promotion, and standardized clinical management of diarrhoea, with linkages to the WASH activities. Inadequate access to adequate quantities of safe water in many settings.	Create linkages between the health sector and the Water, Sanitation and Hygiene (WASH) coordination mechanism to ensure access to water meets minimum international standards, and to develop and disseminate standards and operational guidance on hygiene promotion and the management of diarrhoea.
Measles Measles vaccination coverage not in line with international standards, particularly in non-camp situations.	Organize well monitored mass measles vaccination together with agencies and national authorities where indicated. Reinforce routine vaccination programme as indicated by phase of response.
Outbreaks Lack of standard reporting and case definition, no real time analysis and slow feedback. Delayed laboratory confirmation of outbreak. Slow response times (greater than 48 hours).	Appoint one agency to coordinate disease surveillance, outbreak detection and response. Plan for outbreak response, including identification of laboratories (local, national, international) for confirmation. Prompt establishment of Early Warning Alert and Response System. Establish contingency supply stock for emergency response.
Malaria Lack of standardized prevention and treatment of malaria, appropriate to the epidemiological setting and phase of response, and for special groups such as severely malnourished.	Develop and disseminate standards and operational guidelines, advocate for evidence-based treatment guidelines, and plan for additional support to drug and materials supply as necessary.

Examples	Proposed remedies
Reproductive health (incl. obstetrics) High maternal mortality, with limited access to emergency obstetric care and comprehensive reproductive health care.	Disseminate phase-specific minimum package of care among partners (including distribution of clean delivery kits to pregnant women in acute emergencies and promoting deliveries in a health facility with a trained practitioner in more stable settings).
Gender-based violence (GBV) lack of effective multisectoral effort to prevent and respond to GBV (poor intersectoral coordination).	Ensure that the health sector participates in an inter-sectoral strategy for preventing and responding to GBV. Develop and disseminate standard operating procedures for GBV including identification of roles and responsibilities standardized reporting, info management clinical management and referral Collaborate with the Protection Cluster and define a 'local framework' for prevention measures and for legal and psychosocial support early in the emergency response.
HIV/AIDS & sexually-transmitted infections (STIs) Services for HIV/AIDS prevention and care neglected, inadequate, or not integrated into health service delivery. Lack of age- and gender- appropriate prevention and treatment of STIs and HIV/AIDS, coordinated with other sectors. Waste disposal not always safe. Blood transfusion not always safe.	Initiate a community based minimum service package for STI and HIV prevention, sensitive to gender and age. Provide adequate supplies for prevention, diagnosis and treatment, including antiretroviral drugs where rolled out. Provide condoms through various channels to ensure universal access. Develop and disseminate standards and operational guidelines for implementation and monitoring of safe waste disposal and blood transfusion.
Mental health and psychosocial support Stage-specific planning for mental health and psycho-social support disorganized or absent, particularly for the management of alcohol dependence. Lack of community based approach to mental health.	Collaborate with Protection Cluster and define a 'local framework' for mental health and psychosocial support early in the emergency response. In the emergency phase, actions should be mainly social, with community workers raising social supports and delivering psychological first aid, while protecting the severe mentally ill.
Disposal of dead bodies (forensics) Socially and culturally inappropriate burial of corpses, mass graves.	Disseminate standards and operational guidelines. Advocate with national authorities for culturally appropriate burial as indicated.

6.1 ENSURING STANDARDS – PROMOTING BEST PRACTICES

Quality is essential if emergency health response is to decrease mortality and morbidity. For example, if a measles vaccination campaign does not achieve 95% coverage it would have failed to prevent the risk of a measles outbreak. Service quality is also a key determinant of health service utilization, which is critical in an emergency.

Some basic principles

- ✓ The services and activities of all health actors should normally be in accordance with national treatment policies and guidelines but, where these are not in line with the latest global evidence or recommended practices, the CLA and HCC should facilitate dialogue among all stakeholders to agree on the application of best practices and enhance relevant national policies and guidelines.
- ✓ Where guidelines and protocols exist but are not widely implemented, or practised, at community and facility levels, effort should be directed to improving knowledge and practices and monitoring the implementation of standards and protocols at facility and community levels.

For cluster purposes, the *Humanitarian Charter and Minimum Standards in Disaster Response* of the Sphere Project (2004, chapter 4 on Health) is a key reference but not the only one. Others are indicated in the table below.

HCC and Health Cluster action

- ☑ Ensure that national guidelines are known by all health actors.
- ☑ Agree on the standards and best practices to be applied if national policies and guidelines are not in line with the latest global evidence or recommended practices.
- ☑ Ensure an enabling environment for the implementation of the best clinical and public health practices. Facilitate and promote adherence to best practices and standard of care.
- ☑ Arrange for the preparation and dissemination of technical guidelines and organize joint training, if needed (see section 6.2).

- ☑ Ensure that the monitoring and surveillance system collects and compiles the data necessary to monitor the application of standards (see section 3.6).
- ☑ Jointly monitor the implementation of the national/agreed standards and share experiences with a view to achieving a consistently high standard of services for all communities.

If deemed useful, experts on relevant to the crisis context cross-cutting issues may be invited to provide the appropriate support for the effective integration of the subject matter in all health cluster activities.

Specific CLA action

- ☑ Make sure that international NGOs and all other cluster partners are aware of national health policies and priorities, and international protocols and best practice, and their relevance in the prevailing situation. Encourage them to respect those policies and protocols and to preserve and strengthen local capacity with a view to developing services (including health information/warning systems and health facilities) that are sustainable in the long term.
- ☑ Discourage any organization from actions not consistent with the established standards.
- ☑ Where there is disagreement on standards of care, facilitate dialogue with the aim of ensuring that the "best" care is available equitably to all communities.
- ☑ Ensure that data are systematically disaggregated by sex and age and that health partners are supported in the collection of such data, if required.
- ☑ Create opportunities to share learning and jointly analyse data on service performance.
- ☑ Monitor the indicators of health status and public health service provision and, when necessary, draw attention to divergences from national standards and international best practice and suggest what could be done to improve standards. Ensure that indicators are gender-sensitive.
- ☑ Arrange briefings for new organizations arriving in the country to work in the health sector; when required, help the MoH to arrange such briefings. This may include:

- the country's epidemiological profile, national health policies and programmes, and pre-emergency health service coverage;
- national and international expertise available (e.g. for tropical diseases specific to the country which may be beyond the experience of some foreign NGOs);
- the structure of the MoH and the list of health focal points in other organizations;
- details of arrangements for emergency health coordination.

The CLA/HCC may provide foreign relief teams that are new to the country with advice on measures to protect their own health and try to ensure that they have arrangements for emergency medical evacuations.

The table below summarizes some best practices and provides references for further guidance.

Good practices & recommended reference materials by sub-sector	
General health services	✓ At least1 basic health unit per 10 000 people. ✓ Basic emergency obstetric care (BEmOC), providing 6 signal functions, available at health centre level, these numbering 1/30 000 people. ✓ Recommended standard is of 1 service providing comprehensive emergency obstetric care (CEmOC) and 4 services providing BEmOC for 500 000 people but, in a conflict setting, services should be available as near to the population as possible as referral might be impossible. ✓ Mid-level medical practitioner's (nurses, midwives, health officers) role in the provision of curative health services enhanced. ✓ Role of CHW in provision of curative care for childhood illness e.g. community-case management of pneumonia in remote locations, a potential strategy to reach remote scattered communities and inaccessible displacement camps. ✓ Risk assessment for disease outbreaks.
	• Sphere minimum standards. • IAWG. *Reproductive Health in refugee situations: an inter-agency field manual.* United Nations High Commissioner for Regugees, 1999. • MSF. *Refugee health. An approach to emergency situations.* Médecins Sans Frontières, 1997.
Child health	✓ Children with pneumonia have access to adequate treatment within 24-48 hours of symptoms. ✓ Zinc supplementation for treatment of childhood diarrhoea. ✓ Vitamin A supplementation for all children under five. ✓ Oral rehydration salts available at home level. ✓ Malaria treatment – recommended artemsinin-based combination therapy (ACT), with rapid diagnosis testing or microscopic diagnosis.
	• WHO. *Child health in complex emergencies.* World Health Organization, 2009. • OMS. *Malaria control in complex emergencies : an interagency field handbook.* World Health Organization, 2005. • MSF. *Clinical guidelines: diagnosis and treatment manual.* Médecins Sans Frontières, 2010.
Nutrition	✓ Management of cases with severe acute malnutrition at health centre level. ✓ If acute malnutrition level is above national standard or >10 GAM and >1 SAM – coordinate with Nutrition Cluster for possible initiation of community case management of acute malnutrition.
	• OMS. *Management of severe malnutrition: a manual for physicians and senior health workers.* World Health Organization, 2000. • Valid International and Concern Worldwide. *Community-based therapeutic care: a field manual. Valid International*, 2006.

Sub-sector	Good practices & recommended reference materials
Communicable diseases	✓ Early Warning and Response system (EWARS) established, including data collection from service providers, data analysis and dissemination. ✓ Outbreak response initiated within 24-48 hours of case reporting. ✓ Case fatality rate during cholera and measles outbreaks <1%. ✓ Measles vaccination campaign conducted with the objective to achieve >95% coverage among children aged 6 to 59 months.
	• MSF. *Management of epidemic meningococcal meningitis*. Médecins Sans Frontières, 2008. • MSF. *Management of a measles epidemic*. Médecins Sans Frontières, 1996. • WHO. *Cholera outbreak: assessing the outbreak response and improving preparedness*. World Health Organization, 2004. • WHO. *Communicable diseases control in emergencies: field manual*. World Health Organization, 2005.
STIs & HIV/AIDS	✓ Standard precautions at facility level. ✓ Continuity of ARTs for those who are on treatment (restocking). ✓ Safe blood transfusion. ✓ Free condoms available and accessible to the community. ✓ Syndromic case management of STIs. ✓ Rapid test for syphilis as part of focused ANC. ✓ Initiate PMTCT in contexts where HIV/AIDS is the main cause of death (e.g. sub-Saharan Africa).
	• WHO. *Practical guidelines for infection control in health care facilities*. World Health Organization, Regional Office for South-East Asia, Regional Office for the Western Pacific, 2004. • WHO. *Sexually transmitted and other reproductive tract infections*. World Health Organization, 2005.
Maternal and newborn health	✓ The minimum initial service package (MISP). ✓ Provision of clean delivery kits to pregnant women with counselling on how to use the kit and birth preparedness plan. ✓ Immediate postnatal (maternal & newborn) care within 24-48 hours after delivery by medical personnel (or trained community health workers). ✓ Provision of BEmOC signal functions at health centre level. ✓ Availability of referral mechanism, with special attention to CEmOC. ✓ Neonatal resuscitation materials and adequately trained staff available at all health service delivery points and staff trained on essential newborn care including neonatal resuscitation. ✓ Aim to increase proportion of deliveries at facility level
	• MSF. *Obstetrics in remote settings: a guide for non-specialized health care*. Médecins Sans Frontières, 2007. • WHO, UNFPA, UNICEF, World Bank. *Integrated management of pregnancy, childbirth, and newborn care*. World Health Organization, 2009. • Women's Commission. *Minimum initial service package for reproductive health in crisis situations*. Reproductive Health Response in Conflict (RHRC) Consortium, 2006.

Sub-sector	Good practices & recommended reference materials
Sexual violence	✓ Medical staff have the skills to medically manage cases of sexual violence. ✓ PEP for HIV/AIDS, STI treatment, hepatitis B vaccine, emergency contraception (EC) – available from basic health unit level with no stock-out. ✓ Provision of, or programme link with, psychosocial support.
	• IASC. *Guidelines on gender-based violence interventions in humanitarian settings*. Inter-Agency Standing Committee, 5 December 2007. • WHO, UNFPA, UNHCR. *Clinical management of rape survivors*. World Health Organization, United Nations High Commissioner for Refugees, 2005.
Non-communicable diseases, injuries and mental health	✓ Rescue and evacuation, first aid, and surgical care needs are immediately available following natural disasters like earthquakes. ✓ Re-stocking of supplies for chronic diseases in circumstances where the burden of chronic diseases is high. ✓ Protect and care for people with mental disorders and others in institutions.
	• IASC. *Guidelines for mental health and psychosocial support in emergency settings*. Inter-Agency Standing Committee, 2007.
Environmental health	✓ Safe sharp and medical waste disposal system in place in all facilities. ✓ Health facility staff trained on standard precautions.

6.2 DEFINING AND MEETING TRAINING NEEDS – BUILDING CAPACITY

Training for health workers and auxiliaries is often needed to improve standards especially during a protracted crisis. Broader capacity-building activities including the development of policies and systems and the upgrading of equipment are often needed to facilitate recovery especially in a complex (conflict-related) crisis.

Some basic principles

- ✓ All training should be designed to meet specific gaps in service provision or performance and be based on an assessment of training needs.
- ✓ National standards, norms, curricula, and training material should be used as initial platforms and updated, integrated or simplified in consultation with the national/local health authorities.
- ✓ Training should be coordinated among health actors to ensure reasonable consistency in content and standards.
- ✓ During the initial response period, focus on supporting the implementation of priorities such as MISP and EWARS (early warning including standard case definitions) and in-service training on key issues where there are immediate problems.

HCC and Health Cluster action

- ☑ Identify priority training needs for personnel of both MoH local health sectors and cluster partners based on identified gaps in services and service-delivery capacities. Include training for both service delivery and the use of cluster tools, as needed.
- ☑ Coordinate the development (or up-dating/adaptation) of training materials based as much as possible on national standards and curricula and make them available for use by all cluster partners.
- ☑ Coordinate the planning and implementation of training activities among partners and facilitate joint training events whenever possible.
- ☑ Keep up-to-date information on training activities that are ongoing or planned, or have been completed.

☑ Identify other capacity-building that is needed to facilitate early recovery; coordinate the planning and implementation of such activities among partners to maximize complementary.

Lessons & practical hints from field experience

In Uganda, a three-day health, nutrition and HIV/AIDS workshop was organized for members of the three clusters (from UN agencies, NGOs and government). A wide range of topics were covered including the Cluster Approach, management of health information during crisis, joint health strategy development, and transforming health priorities into action. The training provided a good opportunity for joint planning by cluster members which resulted in a joint health, nutrition and HIV/AIDS plan for Karamoja. The cluster also supported some of its members to attend various international courses organized by the Global Health Cluster, WHO and the NGO Merlin.

7

ADVOCACY AND RESOURCE MOBILIZATION

Key points:

- ✓ The CLA and HCC must advocate for overall health sector priorities and needs using all available opportunities, including humanitarian/IASC country team meetings and donor meetings, to highlight the health situation and needs and, within the framework of the agreed health crisis response strategy, the funding needs of all partners.
- ✓ The health sector components of joint appeals – notably flash appeals and consolidated appeals – should be prepared through collaborative processes, led by the HCC, involving as many health cluster partners as possible.
- ✓ All health cluster partners should advocate for agreed health-sector priorities and present their own activities in the context of the overall health sector effort – and the agreed health crisis response strategy – whenever possible and appropriate.
- ✓ The CLA should: request the Humanitarian Coordinator to activate the CERF rapid response window if/when indicators show that the health situation is deteriorating and there is a need for emergency intervention; and consolidate health cluster inputs for applications to the CERF underfunded emergencies window when critical gaps exist and no other resources can be mobilized quickly.
- ✓ Where critical gaps persist in spite of concerted efforts to address them, the CLA is responsible for working with the national authorities, the Humanitarian Coordinator and donors to advocate for appropriate action to be taken by the relevant parties and to mobilize the necessary resources for an adequate and appropriate response. (See *Provider of last resort* at the end of section 1.4)

Expected Health Cluster outputs

- ✓ Agreed health sector elements in joint appeals and CERF applications; agreed priorities for allocation of pooled resources
- ✓ A common advocacy strategy and plan

Examples of CERF applications, flash appeals and CAP project sheets are included on the CD-ROM.

Common "gaps" in relation to resources
Findings from 10 country case studies (2004-07)

Examples	Proposed remedies
Inadequate resources to implement essential actions to minimize avoidable mortality and morbidity. In the acute phase, compounded by inflexibility of emergency funding, and lack of transparency in disbursement to NGOs. Resource gaps often reported when moving from emergency to early recovery phase.	Advocate with donors and national governments for greater, more transparent resource allocation. Improve the evidence-base for advocacy such as through joint assessment or evaluation, and disseminate results. Encourage popular media coverage, including by high profile personalities as 'roving ambassadors'. Avoid the introduction of user fees, which in most settings will not liberate adequate funds to improve quality and coverage and will disproportionately affect the poor.

7.1 PREPARING HEALTH INPUTS TO A "FLASH" APPEAL

The flash appeal is a tool for structuring a coordinated humanitarian response for the first three to six months of an emergency and mobilizing the necessary resources from donors. The Humanitarian Coordinator (HC) triggers a flash appeal in consultation with all stakeholders and defines the time frame for preparation.

Normally, the HC and humanitarian country team should complete a draft within 5 to 7 days of the onset of a crisis. The appeal is then issued by OCHA in Geneva about 48 hours later. Usually, there is a scheduled revision about a month later based on additional information and including more early recovery projects. (The flash appeal may be developed

into a consolidated appeal if an inter-agency response is needed beyond six months.)

Some basic principles

- ✓ The CLA/HCC is responsible for submitting to the HC an initial response plan for the health sector that is prepared in collaboration with health partners and in consultation with the MoH.
- ✓ The response plan should include an initial health crisis response strategy, a statement on roles and responsibilities, and outlines of specific proposed projects – all based on available information, early estimates and best guesses.
- ✓ The initial response plan should focus on urgent life-saving needs plus whatever early recovery projects can be identified, planned and implemented within the first few months.
- ✓ Appeals and projects (including budgetary requirements) can be updated online through FTS at any time.

The Flash Appeal may include projects from UN agencies, international organizations, and NGOs. It may include project partnerships with the national Red Cross or Red Crescent Society. Government ministries cannot appeal for funds directly in a flash appeal, but can be partners in UN or NGO projects.

HCC and Health Cluster action

The CLA/HCC should:

- ☑ Bring together all significant health actors and facilitate a process of:
  - analysing available assessment information and agreeing an initial response strategy (see section 5.1);
  - vetting projects proposed by individual organizations; *and*
  - building consensus on the projects to be included in the appeal ensuring that they are all relevant, high-priority, coordinated and feasible.
- ☑ Consult with the MoH and keep local donor representatives informed.
- ☑ Write up the plan in the required appeal document format.
- ☑ Liaise with other clusters – notably nutrition and WASH – to ensure that all public-health-related activities are complementary and appropriately address the priority problems.

Normally, the health sector draft should be submitted to the HC within 3 or 4 days of the decision to launch a flash appeal; the actual deadline will be specified by the HC in each case.

Activities	Conditions
Criteria: Activities that have an immediate impact on the health of population affected by an emergency.	
Coordination of health aspects in the context of natural disasters and complex emergencies.	As part of a wider initiative (it may be included in overall inter-sectoral coordination).
Disease surveillance and dissemination of critical health information and laboratory reagents for early diagnosis.	Case detection action and epidemiological surveillance through existing early warning systems.
Ensuring equitable and timely access to Emergency Primary Health Care, including: establishment of facilities and support systems, core health staff, complementary pharmaceuticals, basic equipment, waiving user-fees and individual referral to secondary health care. Provision, distribution and replenishment of quick-turnover emergency stockpiles.	All of these in the context of specific emergency response.
SGBV medical and psycho-social support to survivors of rape. Including PEP kits and EC.	
Mass casualty management.	
Addressing life-threatening conditions related to communicable diseases (immunizations, outbreak control).	
Maternal and neonatal risk, reproductive health emergency interventions (including provision of emergency reproductive health kits based on the Minimum Service Package MISP).	
Secondary Level Health Care (only as follow up to natural disasters).	Case-by-case basis
Psychosocial support for survivors of emergencies.	Case-by-case basis
HIV/AIDS emergency awareness and provision of education material/condoms. HIV counselling, testing and treatment for vulnerable groups.	Case by case basis and only in the context of natural disasters or complex emergencies.

Additional guidance

- 🕮 CERF *application form* available from the list of reference documents on the CD ROM.
- 🕮 IASC. *CERF life-saving criteria and sectoral activities guidelines*. Inter-Agency Standing Committee, 7 August 2007.
- 🕮 IASC. *Revised flash appeal guidance*. Inter-Agency Standing Committee, March 2009.

7.2 PROPOSING CERF APPLICATIONS FOR THE HEALTH SECTOR

The Central Emergency Response Fund (CERF) is a stand-by fund established by the United Nations to enable more timely, reliable and equitable humanitarian assistance to victims of natural disasters and other types of emergency. It is intended to complement – not substitute for – flash and consolidated appeals. There are two funding windows:

- Rapid response – CERF may provide seed funds to jump-start critical operations.
- Under-funded emergencies – CERF can fund life-saving projects in an ongoing emergency situation that is under-funded (priority projects that are not yet covered by other donors).

The Fund is intended to support emergency response in general but NGOs are not eligible to access CERF funds directly. Only UN agencies can submit requests for CERF funding. The CLA (or a relevant UN agency if the CLA is not a UN agency) can – and should – compile and submit a proposal incorporating the project funding requirements of other, non-UN cluster partners. The CLA/UN agency is then responsible for ensuring that CERF funds allocated to NGO projects are passed through to the NGOs concerned.

HCC and Health Cluster action

☑ Produce a CERF request in parallel with the flash appeal. The appeal serves as the contextual analysis for the CERF application.

☑ Select from the flash appeal the highest-priority projects that have not yet received any clear indications of donors support: the organizations concerned must then prepare concise project summaries in the CERF format.

☑ Submit the health package to the HC for inclusion in the overall CERF request.

Life-saving activities in the health sector that may be considered for CERF funding

The table on page 150 is reproduced from *CERF Life-saving Criteria and Sectoral Activities*, OCHA August 2007. For any up-date, check: http://ochaonline.un.org/FundingFinance/CERF/tabid/1109/Default.aspx

7.3 PREPARING, MONITORING AND REVIEWING A CONSOLIDATED APPEAL

The consolidated appeal is more than a fund-raising document. It is also intended to be a tool to plan, coordinate, implement and monitor humanitarian activities in response to a major or complex emergency or natural disaster. A consolidated appeal is prepared when the Emergency Relief Coordinator (ERC) and IASC decide, in consultation with the Humanitarian Coordinator and the IASC Country Team that a consolidated approach to resource mobilization is needed.

Some basic principles

✓ A consolidated appeal is developed among agencies in the field, led by the HC. The process typically takes about a month.

The CLA, HCC and health cluster partners:

✓ contribute to the development (by the HC and OCHA) of the overall, inter-sectoral priorities and response strategy;

✓ prepare the health section of the common humanitarian action plan (CHAP) and propose a coherent set of projects corresponding to the agreed priorities and strategy;

✓ monitor contributions against the health component of the appeal and conduct a mid-year review.

A mid-year review (MYR) should:

- ✓ *measure* progress made in achieving the goals and objectives of the Common Humanitarian Action Plan (CHAP) and report findings to stakeholders;
- ✓ *determine* whether or not the agreed strategy is having the desired impact, and if necessary *change* the strategy to adapt to new conditions;
- ✓ *update* the portfolio of projects;
- ✓ *reprioritize* humanitarian response activities and projects;
- ✓ *analyse* funding and, on that basis, *advocate* for donor support.

HCC and Health Cluster action

Preparing a consolidated appeal

- ☑ Convene a health cluster planning meeting – or form a planning group – to prepare specific proposals. The meeting/group should be co-chaired by a UN agency and an NGO.
- ☑ Prepare the health section of the CHAP as described in section 5.2.
- ☑ Agree clear criteria for the selection of projects for inclusion in the appeal.
- ☑ Organizations participating in the appeal prepare one-page *Project Sheets* according to CAP Technical Guidelines and submit them to the Chair and Co-Chair of the planning meeting/group. The projects should address agreed priorities and contribute to achieving specific objectives in the health crisis response strategy.
- ☑ Agree on the projects to be included in the appeal based on the previously-agreed criteria.
- ☑ Liaise with other clusters – notably nutrition and WASH – to ensure that all public-health-related activities are complementary and appropriately address the priority problems.

Tracking contributions against an appeal (monitoring)

- ☑ Use the *Financial Tracking Service* (FTS) database to track contributions against the health component of the appeal.

FTS is a global, on-line, real-time database of humanitarian funding needs and contributions. It provides a series of analytical tables showing humanitarian aid flows to specific crisis and allows users to produce custom tables on demand.

Conducting a mid-year review (MYR)

☑ Review the CHAP health sector in the light of up-to-date information from assessments and monitoring, and propose adjustment if needed.

☑ Review all projects proposed in the CAP and validate that each remains relevant (has not become not redundant), feasible, and is economically budgeted. Project proposals that do not meet these requirements should be deleted, or revised by the proposing organization.

☑ Prioritize remaining unfunded or under-funded projects using at least a two-tier system (top priority and medium priority).

☑ Ensuring that all relevant proposals and projects are taken into account (including those of NGOs that are relevant although not shown in the original appeal document).[25]

Individual agencies should give their headquarters an early look at their new or revised projects during the MYR process, to minimise misunderstandings and last-minute changes.

Additional guidance

Preparing a consolidated appeal

📖 IASC *Consolidated Appeal Process Guidelines*. Inter-Agency Standing Committee, 2009.

📖 IASC. *Guidance for CAP project selection and prioritization*. Inter-Agency Standing Committee, June 2004.

Tracking contributions

📖 OCHA. *OCHA field offices and the FTS*.

Conducting a mid-year review

📖 OCHA. *Guidelines for Mid-Year Review*. United Nations Office for the Coordination of Humanitarian Affairs, April 2009.

[25] Projects already funded but not yet counted in the CAP should be taken into account as part of the MYR (as long as they are consistent with the CHAP), in order to accurately measure funding against need.

7.4 WORKING WITH DONORS – ACCESSING FUNDS FROM OTHER SOURCES

Working with donors

The Cluster Lead and HCC, on behalf of the cluster and health sector as a whole, should:

- ☑ Take initiative to contact local donor representatives, any foundations and potential private-sector donors represented in the country to explain health sector priorities and resource needs. Map their particular interests and keep them informed on a regular basis.
- ☑ Encourage potential donors to participate in cluster coordination meetings and briefings.
- ☑ Invite donors to join assessment missions and project site visits. Support joint donor fact-finding missions.
- ☑ Prepare concise, "donor-friendly" briefing materials and presentations, including graphics. Prepare and provide detailed technical material and presentations only when requested by a particular donor.
- ☑ Link potential donors with specific cluster partners, when appropriate.
- ☑ Establish system to record contacts with donors (proposals given, indications of interest received).

Ideally, joint planning and the coordinated implementation of agreed activities would be followed by *joint reporting back to donors* – the preparation of a joint narrative report to be submitted to all donors together with the separate financial reports of each organization to each donor. The CLA and HCC should propose this to cluster partners and donors and, where agreed, take the lead in preparing an overall narrative report based on the strategy and expected results presented in a flash or consolidated appeal.

Accessing funds from other (non-traditional) sources

In certain circumstances, funds for humanitarian and/or early recovery activities may be sought from:

- Common Humanitarian Funds (established for specific countries)
- Multiple Donors Trust Fund
- Community Peace and Stability Fund

For recovery activities, funding may be sought through the mechanism of the UN Development Assistance Framework (UNDAF).

Funds may also be sought from foundations and the private sector.

Sharing resources

When "pooled" resources are available for health action:

☑ agree within the cluster – in a cluster meeting – on criteria for the selection of project activities in priority areas and the allocation of resources to individual agencies;

☑ invite agencies to submit proposals (e.g. using the CERF application format) in accordance with the agreed criteria;

☑ form a project appraisal group including representatives from each main group of stakeholders (e.g. government, large INGOs, large NNGOs, small INGOs, small NNGOs, other national institutions and donors) to review proposals and select projects to be funded.[26]

☑ Ensure that the procedures for transferring funds (e.g. from CERF) to the concerned implementing organizations are clear and understood by all concerned.[27]

[26] The same appraisal group may also screen and select proposals for inclusion in a Flash Appeal or a CAP, and applications for CERF funds.

[27] For example, when WHO is cluster lead, CERF funds will be transferred initially to WHO/HAC in Geneva and from there to the international headquarters of the organizations concerned after signature of a corresponding agreement. (This normally enables the organization concerned to begin operations more quickly than if funds were transferred directly to an account in the country of operations.)

Additional guidance

- Development Initiatives. *Review of trust fund mechanisms for transition financing, Phase 2 Report*. Development Initiatives, 28 April 2006.
- Stoddard A, Salomons D, Haver K, Harmer A. *Common funds for humanitarian action in Sudan and the Democratic Republic of Congo: monitoring and evaluation study*, Draft 1, Center in International Cooperation New York University in collaboration with the Humanitarian Policy Group, Overseas Development Institute, November 2006.
- UNDP. *Memorandum of Understanding regarding operational aspects of the peacebuilding funds.* United Nations Development Programme, 2007.
- Multi-donors Trust Fund (MDTF) of the United Nations Development Programme. More details at http://www.undp.org/mdtf/overview.shtml

8

CLUSTER PERFORMANCE MONITORING AND LESSONS LEARNED

Key points:

- ✓ Monitoring and evaluation should be an integral part of the response strategy.
- ✓ Health cluster partners should collectively monitor the implementation of the overall health crisis response strategy and ensure evaluation of the overall health cluster/sector response.
- ✓ When the Cluster Approach is fully implemented and participating health actors work together in partnership, the cluster may also organize joint monitoring and evaluation of individual projects.
- ✓ Monitoring and evaluation should be gender-sensitive and take account of other locally-relevant cross-cutting concerns. (A multi-partner working group may provide input and achieve consensus on gender-sensitive indicators and other aspects of the design and implementation from the early stages of response planning.)
- ✓ Monitoring and evaluation should be participatory, as much as possible. The more participatory the activities, the more likely they will represent the real situation and the opinions of health sector stakeholders including local communities.
- ✓ Monitoring should be initiated from the early stages of response and focus on a few key indicators. It may be refined and extended later. The start must not be delayed while waiting for a sophisticated monitoring system to be developed.
- ✓ Care must always be taken to not collect more data than will actually be used.
- ✓ A real-time evaluation (RTE) can be useful in the early stages of response and the health cluster should be ready to organize one or, better, to participate in an inter-sectoral RTE.

Expected Health Cluster outputs

✓ Joint field visits for monitoring; joint evaluations and lesson-learning.

Common "gaps" in relation to monitoring and evaluation findings from 10 country case studies (2004-07)	
Examples	**Proposed remedies**
Monitoring Lack of monitoring of quality, outcomes or impact. Where monitoring does exist, focus is on coverage and inputs (particularly health promotion), and not linked to follow-up mechanisms.	Formalise responsibility for monitoring of quality control to one agency, with adequate dedicated budget. Ensure monitoring includes access by vulnerable groups and on the basis of gender and age. Publish agency activities and outcomes using standard indicators quarterly (long-standing emergency). Link programme funding mechanisms to performance.
Evaluation No evaluation of the sector wide impact of humanitarian health services from a population perspective.	Conduct an Interagency Health Evaluation.

8.1 MONITORING IMPLEMENTATION OF HEALTH CLUSTER RESPONSE

Project/programme *monitoring* is an integral part of day-to-day project management. It provides information by which management can identify and solve implementation problems, and assess progress in implementing the planned activities. The HCC and health cluster are concerned with monitoring the implementation of the health crisis response strategy and the cluster partners' collective contribution to the overall health sector response.

Arrangements are needed for *standard implementation reporting* by all cluster partners – by all health actors, if possible – and for receiving, collating and analysing the reports. This should be done in collaboration with the MoH (or other relevant national authorities). There should not be separate, parallel reporting to the cluster and the MoH!

Periodic joint *reviews* are essential. All concerned health actors should be involved and examine not only the progress of specific kinds of activity but also whether the cluster is meeting its objectives in terms of partnerships, standards and gap filling, and whether it is sufficiently responsive to changing needs. Reviews should examine data from both programme monitoring and situation surveillance (see section 3.4).

The mid-year reviews (MYR) of the consolidated appeal are important exercises but intermediate reviews every 2 or 3 months may also be useful in some cases.

SOME QUESTIONS TO BE ADDRESSED DURING MONITORING AND REVIEWS[29]

- ☐ Which activities are underway and what progress has been made?
- ☐ At what rate are resources being used and how does usage compare with progress in implementation (outputs)? How do costs incurred compare with the budget? [efficiency]
- ☐ Are the desired results being achieved (e.g. quarterly update)? [effectiveness]
- ☐ To what extent are these results furthering the purposes of the health strategy (e.g. half-yearly analysis)?
- ☐ What changes have occurred in the overall context? Do the original assumptions hold true?
- ☐ Have response activities been sufficiently refined and adapted in the light of new information? [responsiveness]
- ☐ How has the health cluster itself functioned? What has been the quality of the relationship among partners?
- ☐ How effective has been the work with other clusters?

HCC and Health Cluster action

☑ Updated status of activities – and the who-what-where actor map – at every coordination meeting by getting partners to enter new information into formats provided (not lengthy statements in plenary!)

[28] *Manual Project Cycle Management*, June 2005, European Commission, ECHO

☑ Organize MYRs on the required schedule, and intermediate reviews if agreed by cluster partners to be useful.

Additional guidance

📖 IASC. *Guidelines CAP Mid-Year Review.* United Nations Office for the Coordination of Humanitarian affairs, April 2009.

📖 The Sphere Project. *Humanitarian Charter and Principles of Humanitarian Response*, revised edition 2004. Geneva, 2004.

8.2 ORGANIZING EVALUATIONS AND LESSONS-LEARNED EXERCISES [29]

An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the decision-making process of both recipients and donors[30]. An evaluation can be done during implementation ("mid-term"), at its end ("final evaluation") or afterwards ("ex post evaluation"), either to help steer the project or to draw lessons for future projects and programming.[30]

A widely-accepted OECD definition established five basic evaluation criteria: the relevance and fulfilment of objectives; efficiency; effectiveness; impact; and sustainability. ALNAP[31] has suggested three more for the evaluation of humanitarian actions: connectedness, coherence and coverage.

Key principles for evaluations and lessons exercises

✓ Joint evaluations or lessons-learning exercises should be organized – usually separately – at appropriate moments. They must be organized at a time when it is feasible to generate information that is accurate, reliable and useful.

✓ They may be organized at national level or within particular operational zones. They must identify critical health and operational issues

[29] The Global Health Cluster has not (yet) developed specific guidance on this topic. The present section presents reminders of some well-established key principles and suggests how a country health cluster should approach evaluations and lessons-learning exercises.

[30] *Manual Project Cycle Management*, June 2005, European Commission, ECHO

[31] ALNAP is the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) was established in 1997, following the multi-agency evaluation of the Rwanda genocide. See http://www.alnap.org/

and fine-tune the strategies to address them. Areas of weakness must be identified so that steps can be taken to rectify them. The findings should lead to policy, operational and technical recommendations.

- ✓ A real-time evaluation (RTE) may be appropriate during the early stages of a major humanitarian operation. The purpose will be to help ensure the best possible outcomes for the affected population by identifying – and suggestions solutions to – any problems in the coordination, planning and management of the response, and ensuring accountability.
- ✓ For any major crisis, a final lessons-learning exercise should be undertaken not later than one month after the end of humanitarian operations. It should cover both programme and operational aspects. This should be included in the work plan and budget of the Cluster/sector coordination group.
- ✓ The purpose of each evaluation or lessons exercise must be clearly defined, the terms of reference (ToR) drawn up with care – see box below – and an adequate budget established.
- ✓ Evaluations and lessons exercises should review performance not only against the defined health crisis response strategy but also against the goal of reducing avoidable mortality, morbidity and disability, and restoring the delivery of, and equitable access to, preventive and curative health care, and responsiveness to changes in the crisis situation.
- ✓ A key success factor in sector programme evaluation is the involvement of all sector partners, including the MoH, in the planning of the evaluation to ensure their ownership of the results. All the main health actors should be involved in planning the exercise and agree the ToR. (A sector programme evaluation is more complex than a single-intervention evaluation!)
- ✓ An evaluation manager must be designated for each evaluation or lessons exercise. S/he must be able to devote sufficient time to managing the process. Evaluation teams should include a mix of relevant skills and experience, and be gender-balanced.
- ✓ Reports, findings and recommendations must be promptly disseminated to all concerned and brought to the attention of the managers who need to know and take action.

✓ An action plan is developed to follow up on recommendations. The plan clearly specifies responsibilities for follow-up actions and its implementation is monitored.

Take care to ensure that "effectiveness" and "efficiency" are properly distinguished, and are assessed separately:

- *Effectiveness* is a measure of the extent to which an intervention's intended outcomes (its specific objectives) have been achieved.
- *Efficiency* is a measure of the relationship between outputs (the products produced or services provided by an intervention) and inputs (the resources it uses).

HCC and Health Cluster action

Work with the MoH and other important health actors, as appropriate, to:

☑ Identify the appropriate timing for a joint evaluation or lessons-learning exercise, and get support for the proposal from the main stakeholders.

☑ Organize a consultative process to: (i) identify both the issues (the broad areas that need to be explored) and the specific questions that need to be answered; and (ii) agree on ToR and a plan.

☑ Ensure the designation of an evaluation manager and support him/her as needed.

DRAWING UP TERMS OF REFERENCE FOR AN EVALUATION OR LESSONS EXERCISE

Whatever the purpose and approach, well-thought-out ToR are important. They should be directly relevant to the decisions to be taken by intended users. The time and effort invested in preparing good ToR have big payoffs in terms of resulting quality, relevance and usefulness.

✓ The ToR should spell out the objectives (purposes) of the exercise, the methodology to be used, the steps to be gone through, and the roles and responsibilities of all concerned parties.

✓ Limit questions to the most important issues and ones that can realistically be answered in the prevailing circumstances; prioritize them.

☺ Do not overload the ToR! Overloading is a frequent problem when many people add their own questions, especially in joint agency evaluations. The need to focus requires a prioritization of the diverse needs of the various possible users or stakeholders.

☺ Be cautious about combining lesson-learning and accountability purposes in a single evaluation – the issues and the intended users are different and it may result in ambiguity in emphasis and approach.

ToR are as important for internal teams as they are for external teams, although external teams may require more detail on background context and on intended audiences and uses. ToR may need to be translated for in-country use. For a *sector-wide* evaluation, the ToR must be agreed among all stakeholders. The methodologies and tools to be used may need to be adapted/developed and piloted during an initial design phase.

ROLE OF AN EVALUATION MANAGER

The evaluation manager is part of the evaluation team, albeit with a special role and perspective. S/he must, amongst other things:

- ✓ *Ensure financial and logistical preparation*: careful budgeting and thorough logistics preparations are essential – don't under-estimate the cost, time and resources required, especially the field work component of an evaluation
- ✓ *Devote adequate time to the process*, be systematic (in planning and supervising), sensitive (to the needs of the team and others involved), and solutions-oriented (anticipate and respond promptly to the problems that will inevitably arise)
- ✓ *Ensure that sufficient time is given* to building the appropriate level of interaction and ongoing reporting back between the evaluation team, the evaluation manager, operational personnel and other stakeholders
- ✓ *Ensure follow-up* – that the report/findings and recommendations are promptly disseminated to all concerned and brought to the attention of the managers who need to know and take action.

Additional guidance

📖 Beck T. *Evaluating humanitarian action using the OEDC-DAC criteria*. An ALNAP guide for humanitarian agencies. London: Overseas Development Institute, March 2006.

📖 IHE. *Guidelines for implementing interagency health and nutrition evaluations in humanitarian crises*. Inter-Agency Health

and Nutrition Evaluations in Humanitarian Crisis (IHE) Initiative, August 2007.

📖 Turner R, Baker J, Zaw MO, Naing SA. *Inter-agency real time evaluation of the response to Cyclone Nargis.* 17 December 2008.

9

STANDARD SERVICES AND INDICATOR LISTS

9.1 LEVELS OF HEALTH CARE, SUB-SECTORS AND SERVICES

The following standard list of sub-sectors and health services is used for all data collection, recording and analysis purposes including HeRAMS, the IRA and other assessments (see sections 3.2, 3.3, 3.4), and for gap identification and planning (see sections 4.1 and 5.1). The list of sub-sectors is also used in the OCHA-managed 4W database.

HEALTH SERVICES CHECKLIST by level of care and health sub-sectors				
Level of care	**Area/ Sub-sectors**		**Health Services (RH MISP services in bold)**	
C. Community care	C0	Collection of vital statistics	C01	Deaths and births
			C02	Others: e.g. population movements; registry of pregnant women, newborn children
	C2	Child health	C21	IMCI community component: IEC of child care taker + active case findings
			C22	Home-based treatment of: fever/malaria, ARI/pneumonia, dehydration due to acute diarrhoea
			C23	Community mobilization for and support to mass vaccination campaigns and/or mass drug administration/ treatments
	C3	Nutrition	C31	Screening of acute malnutrition (MUAC)
			C32	Follow up of children enrolled in supplementary/therapeutic feeding (trace defaulters)
			C33	Community therapeutic care of acute malnutrition
	C4	Communicable diseases	C41	Vector control (IEC + impregnated bed nets + in/out door insecticide spraying)
			C42	Community mobilization for and support to mass vaccinations and/or drug administration/ treatments
			C43	IEC on locally priority diseases (e.g. TB self referral, malaria self referral, others)
	C5	STI & HIV/ AIDS	C51	Community leaders advocacy on STI/ HIV
			C52	IEC on prevention of STI/HIV infections and behavioural change communication
			C53	**Ensure access to free condoms**

Level of care	Area/ Sub-sectors		Health Services (RH MISP services in bold)	
C. Community care	C6	Maternal & newborn health	C61	**Clean home delivery**, including distribution of clean delivery kits to visibly pregnant women, IEC and behavioural change communication, knowledge of danger signs and where/ when to go for help, support breast feeding
	C8	Non-communicable diseases, injuries and mental health	C81	Promote self-care, provide basic health care and psychosocial support, identify and refer severe cases for treatment, provide needed follow-up to people discharged by facility based health and social services for people with chronic health conditions, disabilities and mental health problems
	C9	Environmental Health	C91	IEC on hygiene promotion and water and sanitation, community mobilization for clean up campaigns and/or other sanitation activities
P. Primary care	P1	General clinical services	P11	Outpatient services
			P12	Basic laboratory
			P13	Short hospitalization capacity (5-10 beds)
			P14	Referral capacity: referral procedures, means of communication, transportation
	P2	Child health	P21	EPI: routine immunization against all national target diseases and adequate cold chain in place
			P22	Under 5 clinic conducted by IMCI-trained health staff
			P23	Screening of under nutrition/ malnutrition (growth monitoring or MUAC or W/H, H/A)

Level of care	Area/ Sub-sectors		Health Services (RH MISP services in bold)	
P. Primary care	P3	Nutrition	P31	Management of moderate acute malnutrition
			P32	Management of severe acute malnutrition
	P4	Communicable diseases	P41	Sentinel site of early warning system of epidemic prone diseases, outbreak response (EWARS)
			P42	Diagnosis and treatment of malaria
			P43	Diagnosis and treatment of TB
			P44	Other local relevant communicable diseases (e.g. sleeping sickness)
	Sexual and reproductive health area	P5 STI & HIV/AIDS	P51	Syndromic management of sexually transmitted infections
			P52	**Standard precautions:** disposable needles & syringes, safety sharp disposal containers, Personal Protective Equipment (PPE), sterilizer, P 91
			P53	**Availability of free condoms**
			P54	Prophylaxis and treatment of opportunistic infections
			P55	HIV counselling and testing
			P56	Prevention of mother-to-child HIV transmission (PMTCT)
			P57	Antiretroviral treatment (ART)
		P6 Maternal & newborn health	P61	Family planning
			P62	Antenatal care: assess pregnancy, birth and emergency plan, respond to problems (observed and/or reported), advise/counsel on nutrition & breastfeeding, self care and family planning, preventive treatment(s) as appropriate

Level of care	Area/ Sub-sectors		Health Services (RH MISP services in bold)	
P. Primary care	Sexual and reproductive health area	P6 Maternal & newborn health	P63	Skilled care during childbirth for **clean and safe normal delivery**
			P64	**Essential newborn care:** basic newborn resuscitation + warmth (recommended method: Kangaroo Mother Care – KMC) + eye prophylaxis + clean cord care + early and exclusive breast feeding
			P65	**Basic emergency obstetric care (BEmOC):** parenteral antibiotics + oxytocic/anticonvulsivant drugs + manual removal of placenta + removal of retained products with manual vacuum aspiration (MVA) + assisted vaginal delivery **24/24 & 7/7**
			P66	Post partum care: examination of mother and newborn (up to 6 weeks), respond to observed signs, support breast feeding, promote family planning
			P67	Comprehensive abortion care: safe induced abortion for all legal indications, uterine evacuation using MVA or medical methods, antibiotic prophylaxis, treatment of abortion complications, counselling for abortion and post-abortion contraception
		P7 Sexual violence	P71	**Clinical management of rape survivors** (including psychological support)
			P72	**Emergency contraception**
			P73	**Post-exposure prophylaxis (PEP) for STI & HIV infections**

Level of care	Area/ Sub-sectors		Health Services (RH MISP services in bold)	
P. Primary care	P8	Non communicable diseases, injuries and mental health	P81	Injury care and mass casualty management
			P82	Hypertension treatment
			P83	Diabetes treatment
			P84	Mental health care: support of acute distress and anxiety, front line management of severe and common mental disorders
	P9	Environmental health	P91	Health facility safe waste disposal and management
S. Secondary and Tertiary care	S1	General clinical services	S11	Inpatients services (medical, paediatrics and obstetrics and gynaecology wards)
			S12	Emergency and elective surgery
			S13	Laboratory services (including public health laboratory)
			S14	Blood bank service
			S15	X-Ray service
	S2	Child health	S21	Management of children classified with severe or very severe diseases (parenteral fluids and drugs, O2)
	S6	Maternal & newborn health	S61	**Comprehensive emergency obstetric care**: BEmOC + caesarean section + **safe blood transfusion**
	S8	Non communicable diseases, injuries and mental health	S81	Disabilities and injuries rehabilitation
			S82	Outpatient psychiatric care
			S83	Acute psychiatric inpatient unit

9.2 INDICATORS AND BENCHMARKS

The table below presents some commonly-used indicators together with corresponding widely-accepted benchmarks. The table below provides guidance in relation to estimating mortality rates.

Category	#	Name of indicator	Type	Data Collection Method	Benchmarks
Health resources availability	A.1	Average population covered by functioning Health Facility (HF), by type of HF and by administrative unit	Input, proxy	HeRAMS	SPHERE standards: 10 000 for 1 Health Unit, 50 000 for 1 Health Centre, 250 000 for 1 District/Rural Hospital
	A.2	# HF with Basic Emergency Obstetric Care / 500 000 population, by administrative unit	input	HeRAMS	>= 4 BEmOC /500 000
	A.3	# HF with Comprehensive Emergency Obstetric Care / 500000 population, by administrative unit	input	HeRAMS	>= 1 CEmOC /500 000
	A.4	% of HF without stock out of a selected essential drug in 4 group of drugs, by administrative unit	input	IRA	100 %
	A.5	# of hospital beds per 10 000 population (inpatients & maternity), by administrative unit	input	HeRAMS	> 10
	A.6	% of HF with availability of clinical management of rape survivors + emergency contraception + PEP available	input	HeRAMS	100%
	A.7	# of health workforce (MD+nurse+midwife) per 10 000 population, by administrative unit (%m/f)	input	HeRAMS	> 22
	A.8	# of CHWs per 10 000, by administrative unit	input	HeRAMS	>= 10

Category	#	Name of indicator	Type	Data Collection Method	Benchmarks
Health services' coverage	C.1	# of outpatient consultations per person per year, by administrative unit	output	HIS / EWARS	> = 1 new visit/person per year
	C.2	# of consultations per clinician per day, by administrative unit		HIS	Less than 50/ day per clinician
	C.3	Coverage of measles vaccination (6 months-15 years)		HIS, survey	> 95% in camps or urban areas > 90% in rural areas
	C.4	Coverage of DPT3 in < 1 year, by administrative unit			> 95%
	C.5	% births assisted by skilled attendant			> 90%
	C.6	% expected deliveries by Caesarean section, by administrative unit		prospective HF based surveillance	>= 5% and <= 15%
Risks factors	R.1	# of cases or incidence rates for selected diseases relevant to the local context (cholera, measles, acute meningitis, others)	Outcome	EWARS, IRA, prospective HF based surveillance, surveys	Measure trends
	R.2	# of cases or incidence of sexual violence	Outcome	prospective HF based surveillance, surveys	Measure trends
	R.3	CFR for most common diseases	Outcome, proxy	prospective HF based surveillance	Measure trends
	R.4	Proportional mortality			Measure trends
	R.5	# of admissions to SFT and TFC			Measure trends
	R.6	Proportion/number of U5 GAM and SAM cases detected at OPD/IPD			Measure trends
	R.7	Proportion of people with <15L of water/day			Measure trends
Health outcomes	O.1	CMR	outcome	HH survey	>=2x base rate OR >1/10 000 per day*
	O.2	U5MR			>=2x base rate OR >2/10 000 per day*

Category	#	Name of indicator	Type	Data Collection Method	Benchmarks
Health outcomes	O.3	Prevalence of GAM	Out-come	HH survey	< 10%, Measure trends
	O.4	Prevalence of SAM			Measure trends
	O.5	% of the population in worst quintile of functioning, including those with severe or extreme difficulties in functioning		WHODAS II HH survey*	Thresholds have to be defined according to the local context and nature of the crisis. Measure trends

* Üstün B, Kostanjsek N, Chatterji S, Rehm J (eds). *Measuring health and disability, Manual for WHO disability assessment schedule, WHODAS 2.0*. Geneva: World Health Organization, 2010 (in press).

ESTIMATING MORTALITY RATES

To be able to compare mortality rates over time in the same population, or among different populations, 'death counts' must be converted into rates using a standard *population denominator* and a standard *time period*. Mortality rates are expressed in one of two ways, depending on the situation:

Situation	*Usual frequency of data collection*	*Calculation of mortality rate*
acute emergency period	each day, or every few days	Deaths/10 000/day
when the health situation has stabilized	once-a-month	Deaths/1000/month

N.B. In many situations, only a rough estimate is available for the total population and there may be ongoing population movements with high rates of in- and out-displacement. The denominator is then uncertain and changing. In such cases, calculate the mortality rate using the average (arithmetic mean) of the population estimates during the time period concerned.

Additional guidance

- Checchi F, Roberts L. *Interpreting and using mortality data in humanitarian emergencies*. HPN Network Paper No. 52, Sept. 2005.
- SMART. *Measuring mortality, nutritional status, and food security in crisis situations: SMART methodology*. Version 1 April 2006.
- CDC, WFP. *A manual: measuring and interpreting mortality and malnutrition*. Centers for Diseases Control and Prevention, World Food Programme, 2005.

WHAT YOU WILL FIND ON THE ENCLOSED CD-ROM

(the exhaustive list is in the table of contents on pages 7-8)

1. **The electronic version of the *Health Cluster Guide***
2. **The Health Cluster tools**
3. **Annexes to the *Health Cluster Guide* (as referred to and lettered in the text)**
4. **Relevant background documents:**

- Beck T (2006). *Evaluating humanitarian action using the OEDC-DAC criteria. An ALNAP guide for humanitarian agencies.*
- CDC, WFP (2005). *A manual: measuring and interpreting mortality and malnutrition.*
- CEPALC (2003). *Handbook for estimating the socio-economic and environmental effects of disasters.*
- *CERF Application Template 2009.*
- Checchi F, Roberts L (2005). *Interpreting and using mortality data in humanitarian emergencies.* HPN Network Paper No. 52.
- Cluster Working Group on Early Recovery, UNDG-ECHA Working Group on Transition (2008). *Guidance note on early recovery.*
- Darcy J, Hofmann C-A (2003). *According to need? Needs assessment and decision-making in the humanitarian sector.* HPG Report # 15.
- Development Initiatives (2006). *Review of trust fund mechanisms for transition financing. Phase 2 report.*
- ECHO (2005). *Manual Project Cycle Management.*
- FEWER, International Alert and Saferworld (2004). *Conflict-sensitive approaches to development, humanitarian assistance and peace-building: A resource pack.*
- Global Humanitarian Platform (2007). *Principles of partnership, a statement of commitment.*
- Global WASH Cluster Coordination Project (2009). *WASH Cluster Coordinator Handbook.*
- Griekspoor A, Loretti A et Colombo A (2005). *Tracking the performance of essential health and nutrition services in humanitarian responses.*
- IASC (1999). *Reproductive health in refugee situations: an inter-agency field manual.*
- IASC (2003). *Guidelines for HIV/AIDS interventions in emergency settings.*
- IASC (2004). *Guidance for CAP project selection and prioritization.*
- IASC (2006). *Strengthening NGOs participation in the IASC. A discussion paper.*
- IASC (2006). *Women, girls, boys and men, different needs, equal opportunities. Gender handbook in humanitarian action.*
- IASC (2007). *Advocating with national authorities, Building and managing Consensus, Contingency planning, Information Management, Leadership in Cluster, Shared assessment & analysis, Smarter Coordination Meetings.* Cluster-Sector Leadership Training Tip Sheets.
- IASC (2007). *CERF life-saving criteria and sectoral activities guidelines.*
- IASC (2007). *Guidelines for gender-based violence interventions in humanitarian settings focusing on prevention of and response to sexual violence in emergencies.*
- IASC (2007). *Guidelines on mental health and psychosocial support in emergency settings.*
- IASC (2007). *Inter-agency contingency planning guidelines.*
- IASC (2007). *Need Analysis Framework, strengthening the analysis and presentation of humanitarian needs in the CAP.*
- IASC (2007). *Rome statement on cluster roll-out*, 5-7 November 2007.
- IASC, Global Health cluster (2008). *Health Cluster guidance note on health recovery* (final version due 2010).
- IAWG, UNHCR (1999). *Reproductive health in refugee situations: an inter-agency field manual.*
- Inter-Agency Health and Nutrition Evaluations in Humanitarian Crisis (IHE) Initiative (2007). *Guidelines for implementing interagency health and nutrition evaluations in humanitarian crises.*
- Islam, M ed. (2007). *Health systems assessment approach: A how-to manual.* USAID, Health Systems 20/20, Partners for Health Reformplus, Quality Assurance Project, Rational Pharmaceutical Management Plus, Management Sciences for Health.
- Moss WJ et al. Child health in complex emergencies. *Bulletin of the World Health Organization* 2006: 84(1).
- MSF (1996). *Management of a measles epidemic.*
- MSF (1997). *Refugee health. An approach to emergency situations.*
- MSF (2007). *Obstetrics in remote settings: a guide for non-specialized health care.*
- MSF (2008). *Management of epidemic meningococcal meningitis.*
- MSF (2010). *Clinical guidelines: diagnosis and treatment manual.*
- OCHA (2007). *Consolidated appeal 2007 for Liberia.*
- OCHA (2009). *Consolidated appeal 2009: guidelines.*
- OCHA (2009). *Guidelines for mid-year review.*
- OCHA (2009). *Revised flash appeal guidance.*
- OCHA. *OCHA field offices and the FTS.*

The CD contains the entire Health Cluster Guide with hyperlinks to reference documents. For users in settings with limited or no access to the internet, the CD's disc menu **also contains downloaded versions of most of the reference documents** for easy access.

To access the CD's material, place it into a CD player (computer or external CD drive). If it does not run automatically, open the CD file from your computer and double click on the file index.html.

- PAHO (1982). *Epidemiological surveillance after a natural disaster.*
- Pavignani E, Colombo A (2009). *Analysing disrupted health sectors. A modular manual.*
- ReliefWeb (2008). *Glossary of humanitarian terms.*
- Seeds for change. *Consensus decision-making.*
- Seeds for change. *Consensus in large groups.*
- SMART (2006). *Measuring mortality, nutritional status, and food security in crisis situations.*
- Smith J (2005). *Guide to health workforce development in post-conflict environments.*
- Smith JH, Kolehmainen-Aitken RL (2006). *Establishing human resource systems for health during post-conflict reconstruction.*
- SPHERE Project (2004). *Humanitarian charter and principles of humanitarian response.*
- Stoddard A, Salomons D, Haver K et Harmer A (2006). *Common funds for humanitarian action in Sudan and the Democratic Republic of Congo: monitoring and evaluation study.*
- Turner R, Baker J, Zaw M O, Naing S A (2008). *Inter-agency real time evaluation of the response to Cyclone Nargis.*
- UNDG, ECHA (2005). *Transitional strategy guidance note.*
- UNDG, UNDP, World Bank (2004). *Practical guide to multilateral needs assessments in post-conflict situations.*
- UNDG, World Bank (2005). *An operational note on transitional results matrices.*
- UNDP (2007). *Memorandum of Understanding regarding operational aspects of the peacebuilding funds.*
- UNHCR (2006). *Tool for participatory assessment in operations.*
- UNHCR (2008). *Public health facility toolkit.*
- UNICEF, UNFPA, WHO (1997) *Guidelines for monitoring the availability and use of obstetric services.*
- United Nations (1991). UN General Assembly Resolution 46/182 of 19 December 1991 on the strengthening of the coordination of emergency humanitarian assistance.
- United Nations (2006). *Integrated mission planning process guidelines.*
- United Nations (2008). *"Dos and don'ts" – Reporting and interpreting data on sexual violence from conflict-affected countries.* Fact sheets Stop Rape Now, UN Action against Sexual Violence in Conflicts.
- USAID, CDC (2007). *Reproductive health assessment toolkit for conflict-affected women.*
- Valid International and Concern Worldwide (2006). Community-based therapeutic care: a field manual.
- WHO (1999). *Management of severe malnutrition: a manual for physicians and senior health workers.*
- WHO (1999). *Rapid health assessment protocols for emergencies.*
- WHO (2001). *Safe motherhood needs assessment.*
- WHO (2003). *Health facility survey: tool to evaluate the quality of care delivered to sick children attending outpatients facilities.*
- WHO (2004). *Cholera outbreak: assessing the outbreak response and improving preparedness.*
- WHO (2004). *Practical guidelines for infection control in health care facilities.*
- WHO (2005). *Communicable disease control in emergencies – A field manual.*
- WHO (2005). *Malaria control in complex emergencies. An inter-agency field handbook.*
- WHO (2005). *Sexually transmitted and other reproductive tract infections.*
- WHO (2007). *Setting priorities in communicable disease surveillance.*
- WHO (2007). *Strengthening health systems to improve health outcomes. WHO's framework for action.*
- WHO (2007). *Towards a framework for health recovery in transition situations.* Global Consultation on Health Recovery in transition situations. Montreux (Switzerland), 4-6 December 2007.
- WHO (2007). *WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies.*
- WHO (2008). *Health Cluster bulletin* (Mozambique). 10-22 February 2008.
- WHO (2008). *Managing WHO humanitarian response in the field.*
- WHO (2009). *Child health in complex emergencies.*
- WHO (2009). *HeRAMS. Health Resources Availability Mapping System.*
- WHO, PAHO (2000). *Natural disasters – protecting the public's health.*
- WHO, PAHO (2003). *Guidelines for the use of foreign field hospitals in the aftermath of sudden impact disasters.*
- WHO, UNAIDS (2000). *WHO recommended surveillance standards.*
- WHO, UNFPA, UNHCR (2001). *Inter-agency field manual for reproductive health in refugee situations.*
- WHO, UNFPA, UNICEF, World Bank (2009). *Integrated management of pregnancy, childbirth, and newborn care.*
- WHO, UNHCR (2005). *Clinical management of rape survivors.*
- Women's Commission. *Minimum initial service package for reproductive health in crisis situations.*

GOAL OF THE HEALTH SECTOR RESPONSE DURING HUMANITARIAN CRISIS	
To reduce avoidable mortality, morbidity and disability, and restore the delivery of, and equitable access to, preventive and curative health care as quickly as possible and in as sustainable a manner as possible.	
EXPECTED HEALTH CLUSTER OUTPUTS	
✓ Functioning health sector coordinating mechanisms involving UN agencies, NGOs, CBOs, health authorities, donors, and community members, including between the centre and the field, and with other sectors/clusters ✓ Up-to-date mapping of health actors, available health services, and service delivery activities ✓ Up-to-date information on the health situation and needs is available to all stakeholders; regular situation reports/ health bulletins	*See chapter 2*
✓ Initial rapid assessment and situation analysis, agreement on priority health problems and risks ✓ Regular joint situation updates based on monitoring of the situation and of the health services delivered	*See chapters 3 & 4*
✓ A joint, regularly updated, health response strategy in the crisis, with clear priorities and objectives for addressing priority health problems, risks and gaps ✓ A joint contingency plan for response to future events that could impact on the populations' health or partners' response activities ✓ Distribution of responsibilities among partners based on capacities to deliver in the field	*See chapter 5*
✓ Agreed standards, protocols and guidelines for basic health care delivery, standard formats for reporting ✓ Training materials and opportunities available to all partners for upgrading skills and standards of service provision, as needed	*See chapter 6*
✓ Agreed health sector elements in joint appeals and CERF applications; agreed priorities for allocation of pooled resources ✓ A common advocacy strategy and plan	*See chapter 7*
✓ Joint field visits for monitoring; joint evaluations and lesson-learning	*See chapter 8*